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Independent Reviewer of the Life Code of Practice
by email: reviewer@lifecodereview.org.au

Supplementary Submission to the Life Code Review

Thank you for the opportunity to provide comments on the Independent Life Insurance Code of Practice review Interim Report. This submission is on behalf of Financial Rights Legal Centre, Dr Jane Tiller and the Justice and Equity Centre (formerly Public Interest Advocacy Centre).

We have had the opportunity to read the interim report and provide:

1. feedback on the discussion regarding mental health commitments under the Life code as well as responses to the questions posed, and
2. further comments on the remainder of the report.

Overall, we welcome the recommendations made in the Interim Report and commend the review for its thorough consideration of a set of multiple complex issues.

We also welcome further consideration of the issues raised with respect to mental health and blanket exclusions. There is significant complexity here, complexity made worse by the historical approach taken by life insurers to meeting the requirements of the *Disability Discrimination Act 1992* (**DDA**).

This supplementary submission seeks to clarify understanding of the law as it applies to life insurers and its interaction with their code obligations. In doing so, we clarify that:

- Meeting the requirements of Section 46 of the DDA is *not* an either/or test, (that is, life insurers can either rely on actuarial or statistical data, or other relevant factors). This is incorrect.

- Section 46 *requires* a consideration of "other relevant factors" under its two limbs and other relevant factors including factors that may increase the risk to an insurer as well as those that reduce it.
- Considering "an "individual's particular circumstances" as one "relevant factor" ought to have particular prominence. An insurer cannot and should not wilfully ignore this information.
- Further, decision-making processes which are formulaic or which tend to stereotype individuals by reference to their disability should be avoided. Insurers need to ensure that applications that reveal a mental health condition or symptoms of a mental health condition are not automatically declined.
- Since blanket exclusions in standard forms are the most formulaic, automated approaches a life insurer can take – these too should be avoided.
- The DDA provides another, more general exception under Sections 11 and 29A, that of "unjustifiable hardship." However, life insurers face a difficult path to meet the statutory standard since additional costs and effort, and prudential requirements will not necessarily amount to "unjustifiable hardship." This is especially the case given the series of circumstances that need to be considered equally in meeting the Section 11 standard.
- The CALI position seeking to introduce blanket exclusions into product designs is in our view counter to AHRC guidance and would potentially breach the law.

Ultimately, the consumer position as it pertains to the interaction of the above to the Life Code is straightforward:

- The current wording of Clause 2.1(b) referencing a prohibition on blanket exclusions in standard form contracts is not an elaboration on the law – it is a clarification of the law. It should remain to serve this purpose.
- Any attempt to remove it will:
    - be seen to be a backward step in consumer protections because it will make less clear to consumers where they stand and consequently lead to poorer outcomes
    - be seen as a signal to insurers - who have already historically not met the current requirements of Clause 2.1(b) as outlined by the recent LCCCC report – to introduce blanket exclusions at will, leading to significant discrimination and harm
    - not erase the (implied or otherwise) prohibition of blanket exclusions that exists under the DDA, and
    - most likely lead to increased litigation
- Any new product designs referenced by CALI in their supplementary submission must comply with the requirements of the DDA.

- We recommend that CALI meet with the AHRC to work with them to ensure that any innovations that touch on different treatment of mental health issues in their products meet the requirements of the DDA.
- We further ask that the Independent Reviewer not recommend any changes to the Code on the basis of the CALI position in its supplementary submission, that it seeks to remove the explicit prohibition on blanket exclusions in standard form contracts. Doing so would accept that CALI has either:
    - met, or somehow can meet, the requirements of Section 46 or
    - made out a case of unjustifiable hardship which is as yet uncertain, legally fraught and tenuous at best.
- We do however support recommendations at 2, 3 and 6 in the Interim Report and recommend that the Code:
    - commits life insurers to annually review and update the statistical and actuarial evidence and other material relied on in their underwriting decisions
    - commits life insurers to annually review and publish (at an aggregate level) data on claims for mental health-related conditions through super. This must include claims numbers, condition/s for which claims are made, claims outcomes and disputes data.
    - specifies the criteria and process an insured is required to satisfy to have an exclusion removed or premium reduced
    - clearly explains which associated conditions that may arise from the initial condition, including mental health, are covered by an insurance policy, and
    - explicitly commits life insurers to develop their own action plans under Part 3 of the DDA.

With respect to the remainder of the Interim Report we have made the following further recommendations:

- Any recommendations made or details provided with respect to recommendations made that are in the body of the Interim Report should be spelled out in the final recommendations.
- Include timeframes in elements of an amended "Circumstances Beyond Our Control" definition and ensure life insurers are more proactive and informative with respect to dealings with group owners.
- Address communications with respect to cancellations and the clawing back of premiums or over-payments of benefits.
- Address the key outstanding issue of legacy discrimination relating to the prohibition on the use of adverse genetic testing results, to meet expectations set by the Senate Economics Legislation Committee's expectation that this be addressed by industry and the Australian Government.

- Reconsider the issue of ASIC approval and express a view on the matter one way or the other.

Mental Health and blanket exclusions

The Interim Report notes that Clause 2.1(b) requires insurers to design new products that

> *do not incorporate a blanket exclusion specific to mental health in the general terms and conditions of the standard form contract, consistent with our obligations under the Disability Discrimination Act 1992 and equivalent State and/or Territory law.*

The Interim Report then outlines two competing interpretations of this commitment, that is Clause 2.1(b):

1. *if clause 2.1(b) only represents a commitment to comply with the DDA, then insurers could include a blanket mental health exclusion in a policy provided it is supported by actuarial and statistical data, or other relevant data, in accordance with s 46 of the DDA; or*
2. *alternatively, if clause 2.1(b) represents a commitment that goes beyond the minimum requirements of the DDA, then blanket exclusions are not allowed.*

With respect, the requirements of the DDA and the Code requirements are mischaracterised and do not present the full picture.

To explain why, it is important to take a step back and review what the actual requirements of the DDA are, before addressing what is currently in the Code and responding to what CALI are proposing that insurers be able to do in a potentially amended future Code.

Meeting the requirements of the Disability Discrimination Act

The DDA promotes the rights of people with a disability to participate equally in all areas of life (including in the provision of life insurance) by making it unlawful to discriminate against a person with a disability subject to certain exceptions. The two key exceptions that need to be stepped out are:

- Section 46's partial exemption for insurers and superannuation providers; and
- A general defence under Sections 11 and 29A of unjustifiable hardship

The partial Section 46 exemption

Section 46 of the DDA provides a partial exemption for insurers to discriminate. It does so in relation to the provision of insurance (by either refusing to offer a product, or in respect to the terms and conditions on which the policy is offered and/or obtained) if:

(f) the discrimination:

(i) is based upon actuarial or statistical data on which it is reasonable for the first – mentioned person to rely, ***and***

(ii) is reasonable having regard to the matter of the data ***and other relevant factors****; or*

(g) in a case where there is no such data available and cannot be reasonably obtained … the discrimination is reasonable having regard to ***other relevant factors****."*[1] *(****our emphasis****)*

The Explanatory Memorandum (**EM**) of the DDA summarises this as follows:

That discrimination is only permitted where it is based on either actuarial or statistical data which, in all the circumstances, it is reasonable to rely on, and the discrimination is reasonable having regard to all other relevant factors ***as well****. (****our emphasis****)*

Where there is no such data available and it cannot reasonably be obtained, discrimination will not be unlawful if it is reasonable to discriminate having regard to all other relevant factors.[2]

As both the EM and the Australian Human Rights Commission (**AHRC**) makes clear in its guidance,[3] Section 46 establishes two limbs which insurers must meet in order to rely on to be exempt. The AHRC describe these as the:

- data limb (subsection (f)) and
- the non-data limb (subsection (g))

The data limb must be considered first before an insurer can move to build a case based on the no data limb.[4] This is not a minor point. The insurer can't choose to argue the second 'no data limb' if data is available or reasonably obtainable which meets the requirements of the data limb. If such data is available the insurer cannot ignore it.[5]

[1] Section 46 of the DDA
[2] Page 18 of the Explanatory memorandum Disability Discrimination Bill 1992
[3] AHRC, Guidelines for providers of insurance and superannuation under the Discrimination Act 1992 (Cth)
[4] See QBE Travel Insurance v Bassanelli (2004) 137 FCR 88 [28] and page 6 of the AHRC Guideline.
[5] See QBE Travel Insurance v Bassanelli (2004) 137 FCR 88 [33] and page 6 of the AHRC Guideline.

It means that "other relevant factors" is not an optional element to be met under the second limb of the test – it must be considered under the data limb first. In other words, section 46 is not an either/or test.

If the discrimination that the life insurer looking to conduct is:

- based on actuarial data **and**
- is objectively reasonable to rely on **and**
- is objectively reasonable having regard to both this data **and** "other relevant factors" of which the insurer is aware or ought to be aware

then Section 46 applies.

If the actuarial or statistical data is not available nor could be reasonably obtained, only then can the second limb be *potentially* available. At this point there is further consideration of whether the discrimination objectively reasonable having regard to "other relevant factors".[6]

What is made clear in this sequence of steps is that "other relevant factors" is *not an optional element* to be met under either limb of the test, as implied by the Interim Report. To be protected under Section 46, an insurer's discrimination needs to be reasonable in the light of "other relevant factors" which would "include any matter that is rationally capable of bearing upon whether the discrimination is reasonable"[7] and includes factors that may increase the risk to the insurer as well as those that may reduce it.[8] Put simply, the life insurer must consider factors that support a case for discrimination and not support their case.

Drawing on case law, the AHRC guideline then details a series of examples of what "other relevant material" may include. A key factor is an "individual's particular circumstances." The AHRC notes that this is not an unimportant element:

> *The circumstances of the individual ought to have particular prominence as a 'relevant factor'.*[9]

The AHRC then goes on to spell out what is required here:

> *Decision-making processes which are formulaic or which tend to stereotype individuals by reference to their disability should be avoided.*[10] *Therefore, where available,*

[6] Pages 6-8 of the AHRC Guideline provide a clear outline of the approach that life insurers must take.
[7] *QBE Travel Insurance v Bassanelli (2004) 137 FCR 88, [53].*
[8] Page 12, AHRC Guideline.
[9] Page 12 AHRC Guideline
[10] *QBE Travel Insurance v Bassanelli (2004) 137 FCR 88, [85].*

> *information about the particular person seeking insurance such as medical opinions and work records may be relevant in assessing whether they present a higher or lower risk than the average person with the disability concerned. Such records should only be relied on where it is reasonable to do so in the circumstances. Further information may be required regarding this data in order to avoid discrimination, for example the simple fact that an individual has taken sick leave cannot necessarily be linked to a particular disability without further information.*[11]

It is worth quoting Mansfield J in full from *QBE v Bassanelli*, on this matter:

> *[QBE could not bring itself within s 46 because it] applied a decision-making process which was too formulaic or which tended to stereotype the respondent by reference to her disability. Such grouping of individuals, whether by race or disability, without proper regard to an individual's circumstances or to the characteristics that they possess, may cause distress or hurt. … Legislation such as the DD Act is aimed to reduce or prevent such harm. Section 46 of the DD Act recognises that there are circumstances in which discrimination by reason of disability may be justified (or, at least, not be unlawful). It requires that the particular circumstances of an individual who is discriminated against be addressed, but not in a formulaic way. Even if the exemption pathway provided by s 46(1) (f) is utilised, the reference to 'any other relevant factors' confirms that legislative intention.*

Furthermore, to avoid unlawful discrimination, the AHRC states insurers must:

> *ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined.*[12]

The above makes clear that insurers cannot apply broad formulaic approaches that provide automatic declines when determining whether discrimination is reasonable – individual circumstances must be considered.[13]

Put simply, insurers should avoid applying blanket exclusions in standard form contracts under Section 46 of the DDA since blanket exclusions in standard forms are the most formulaic, automated approach a life insurer can take. Blanket exclusions in standard form contracts – no matter how defined – are the apotheosis of an automated formulaic decision-making.

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[11] Page 12 AHRC Guideline
[12] Page 20 AHRC Guideline
[13] Page 30, Public interest Advocacy Centre, Mental Health Discrimination in Insurance, 2021

A product that limits cover for mental health in a standard form contract in a blanket or automated fashion cannot meet the requirements of section 46 since the insurer needs to specifically address the "other relevant factors" element in the standard and that includes "relevant information about the particular individual seeking insurance." An insurer cannot wilfully ignore this information, including by choosing not to ask or seek it in the first place.

Sections 11 and 29A of the DDA: Unjustifiable Hardship

The other avenue that the life insurance sector may seek to rely on is sections 11 and 29A of the DDA which provides a more general exception to unlawful discrimination: the defence of unjustifiable hardship. However, the AHRC explains that just because not discriminating will lead to cost and effort – this is not enough to rely on the defence:

> *It is important to note that, even if providing insurance … to a person with a disability might involve some costs and effort, it will not necessarily amount to unjustifiable hardship.*
>
> *In Ingram v QBE, the Victorian Civil and Administrative Tribunal (VCAT) considered the defence in s 29A of the DDA, and explained:*
>
> > *It is apparent from the terms of section 29A that some hardship is justifiable. In order to determine whether that hardship is unjustifiable turns on the nature and degree of the hardship in the context of the section 11 DDA factors and any other relevant circumstances. A financial burden may be justified, given the objectives of the DDA in respect to the elimination of discrimination as far as possible. While the financial burden which may be imposed will be relevant, it is not the only factor to consider. If the financial burden is minor, then it is not likely to fall within the exception. If, on the other hand, it is very significant and might lead to the relevant entity not being financially viable, then the exception is more likely to apply. What is required is for an assessment to be made of whether some decision or action might be taken to avoid the discrimination and whether it would impose an unjustifiable hardship.*[14]

The AHRC then outlines a series of circumstances that should be taken into account and balanced in determining whether a hardship imposed on a life insurer is unjustifiable, in line with the requirements of Section 11:

[14] Ingram v QBE Insurance Australia Ltd (Human Rights) [2015] VCAT 1936 [127]

- *any benefits that might accrue to the customer with a disability or any other person (including other people with the same disability, the community generally, or even the insurer) if cover was provided*
- *the effect of the disability of the person concerned (the steps required to be taken to avoid discrimination against a person will depend on the nature of the person's disability)*
- *any costs or other disadvantages of providing cover, bearing in mind the financial circumstances of the insurance or superannuation provider (noting that a level of hardship that may be unjustifiable for one insurer may not be for another: 'Clearly the larger the company the more it can usually afford')the availability of financial and other assistance to the insurance or superannuation provider*
- *the terms of any action plan developed by the insurer … provider under s 64 of the DDA that are relevant.*[15]

The AHRC guideline raises prudential requirements but notes that despite their being raised by QBE in *Ingram v QBE*, no findings were made about these regulatory obligations as no evidence about the obligations was called[16]:

> *The burden of proving that unjustifiable hardship would be caused rests on the person seeking to rely on the defence, in this case the insurer QBE. VCAT Member Dea ultimately held that QBE had not adduced sufficient reliable evidence to support the conclusion that removing the exclusion clause in relation to mental illness would result in an overall reduction in profits.*

With respect to assessing the extent of the benefits that might accrue to the customer with the disability if the discrimination had been avoided, the AHRC notes that:

> *it is relevant if alternatives were offered to the complainant which would have provided some benefit, rather than just an absolute refusal to provide the service.*[17]

It is therefore relevant whether the insurer offered alternatives to refusing cover, such as offering a policy but with an exclusion for pre-existing conditions, or a policy with a higher premium.[18]

Finally, it's worth highlighting, as the AHRC does, that

[15] See DDA section 11(1)
[16] Page 21 AHRC Guideline
[17] Page 21 AHRC Guideline
[18] Page 22 AHRC Guideline.

> *the costs involved in avoiding the discrimination and the financial circumstances of the person incurring those costs should not be given any greater weight than the other factors set out in section 11. All the factors are to be considered within the context of the legislation and the circumstances of the case.*[19]

If life insurers are seeking to rely on the defence of unjustifiable hardship, the above demonstrates that this is far from a fait accompli: life insurers face an uphill battle in this regard.

We note that in its supplementary submission to the current review, CALI outlines significant challenges that the industry faces with respect to mental health coverage and increasing costs and sustainability. Given our limited resources we cannot provide comment upon this material.

However, what is clear is that neither we nor the reviewer are in any position to make a judgement call with respect to this material and a potential unjustifiable hardship defence.

Accepting the information provided with respect to increasing costs and sustainability is not the same as accepting at face value that the life insurance sector has made out a case of unjustifiable hardship under Sections 11 and 29A of the DDA. As the above makes clear this can only be part of the story and one of many factors and circumstances that would need to be considered to meet the standard required to defend conduct that is discriminatory.

The reviewer should not be placed in the position of having to make that call and should not make recommendations to amend the Life Code on the basis that life insurers have already made out that case.

It is more appropriate and prudent to proceed on the contrary basis – that CALI have not made out a case.

Impact on the Life Insurance Code

Consequent to the above analysis, the reference in the Life Code to blanket exclusions at Clause 2.1(b) is not one that strictly goes "beyond minimum legal requirements"[20] in line with ASIC RG 183.4(b)'s expectation that codes "elaborate on legislation to deliver additional benefits to consumers."[21] Clause 2.1(b) is more in line with ASIC RG 183.4(c), that is, it:

[19] Page 23 AHRC Guideline
[20] Page 12, Interim Report
[21] As suggested by the Interim Report at page 12.

"clarifies what needs to be done from the perspective of a particular industry, practice or product to comply with the legislation."

The application of the DDA to life insurance is a complex area of law subject to interpretation be it judicial, statutory and regulatory. The Code's inclusion of an explicit prohibition of "blanket exclusions" at Clause 2.1(b) simply brings clarity to consumers about the requirements of the law.

Therefore, the clarity that the current Clause 2.1(b) prohibition must remain. Any attempt to remove it will:

- be seen to be a backward step in consumer protections because it will make less clear to consumers where they stand and consequently lead to poorer outcomes
- be seen as a signal to insurers - who have historically not met the current requirements of Clause 2.1(b) as outlined by the LCCCC – to introduce blanket exclusions at will, leading to significant discrimination and harm
- not erase the (implied or otherwise) prohibition of blanket exclusions that exists under the DDA, and
- most likely lead to increased litigation.

The reference to standard forms is also required to remain since it is highly unlikely that life insurers are able to use standard forms to discriminate on the basis of mental health issues in line with the requirements of the DDA, as outlined above. The Interim Report's delineation of standard forms versus individually underwritten products also makes little sense in light of this.

Any mooted changes to the Code accommodating a call to introduce blanket exclusions in new standard form products would in our view potentially facilitate life insurers breaching the DDA. If CALI has legal advice that suggests otherwise, they should make this available to the independent reviewer, if not make it public for all, including the AHRC to consider.

If CALI and its members proceed with introducing new product designs that prima facie discriminate against those with mental health issues and have not sought advice from the AHRC with respect to these new product designs, the sector will simply be inviting further litigation. At a minimum we therefore recommend that CALI liaise and work with the Australian Human Rights Commission in developing any life insurance product that discriminate against people with a disability.

Questions posed by the Interim Report

1. **Would it be appropriate to change the current position set out in clause 2.1(b) to allow limitations on cover for mental health in standard form policies (consistent with the DDA) in light of the trends for mental health claims.**

No, as outlined in the previous section, the Code must retain Section 2.1(b).

The reviewer should not accept at face value that CALI has made out a case of unjustifiable hardship in accordance with the requirements of the DDA or somehow met the requirements of the Section 46 standard. They have not.

We therefore recommend that the reviewer proceed on the basis that life insurers have not made this case out in considering potential amendments to the code.

2. **The impact the industry's proposed approach may have on consumers and insurers.**

The key impact that the industry's proposed approach may have on consumers is systemic discrimination. It will lead to increased denials based on automated decision making and blanket exclusions that are against the requirements of the DDA.

At a minimum, if the industry were to head down this pathway it will lead to increased litigation.

3. **If the prohibition on blanket mental health exclusions was removed and design features in insurance policies that limit cover for mental health were permitted:**

    a. **How could the Code help ensure that such an approach was consistent with the requirements of the DDA**

    b. **Are there some general principles or 'guardrails' that should apply in the Code to ensure fair and transparent treatment of consumers experiencing mental health conditions as these design features are developed and implemented?**

    c. **Is there information that could be specified in the Code that would help ensure consumers understand why these policy features have been introduced and how they work?**

    d. **Is there information that could be specified in the Code that would help ensure consumers understand how policy features apply to their situation? (On this point, see the discussion below on individual underwriting**

As has been made clear with the above analysis, consumer groups are a long way from accepting the premise of this question, that is, we hold that design features in insurance policies that limit cover for mental health are not permitted.

Only when the AHRC or a court has ruled that life insurers can include a blanket mental health exclusion (in any form) should the Life Code be amended to address this development.

Putting that issue aside there are in fact a number of things that the Life Code can do to further clarify and elaborate on legislation to deliver additional benefits to consumers in line with RG 183. This should apply to *all* life insurance products that touch on mental health issues.

The recommendations at 2, 3 and 6 in the Interim Report go some way to addressing some of the issues. We also reiterate a number of the recommendations that we made previously, that is:

- Commit to annually review and update the statistical and actuarial evidence and other material relied on in their underwriting decisions
- Commit to annually review and publish (at an aggregate level) data on claims for mental health-related conditions through super. This must include claims numbers, condition/s for which claims are made, claims outcomes and disputes data.

- Specify the criteria and process an insured is required to satisfy to have an exclusion removed or premium reduced
- Clearly explain which associated conditions that may arise from the initial condition, including mental health, are covered by an insurance policy

In line with the AHRC, the Code should also commit life insurers to develop their own action plans under Part 3 of the DDA. Action plans include policies and programs with particular goals and targets for an organisation to meet to further the objects of the DDA.[22]

[22] Page 20 AHRC Guidelines

Other matters arising from the Interim Report

We raise a small number of issues that we would like to see addressed in the remainder of the Interim Report.

Hardship Support Options

We recommend that Recommendation 23 regarding "setting out additional examples of flexible support options" should be amended to read:

> *"setting out additional examples of flexible support options including:*
>
> - *considering payment plans to cover a period of hardship; and*
> - *facilitating access to and/or representation by financial counsellors or similar consumer representatives.*

Further an additional recommendation should be included that meets the body of the text:

> *The Code should contain an acknowledgement that financial hardship presents differently for different people and a commitment by insurers to tailor support appropriately.*

These may seem like pedantic points. They are. However, our recent experience with code owners addressing the recommendations of their independent code review report is such that we believe it is necessary to spell the detail out in the recommendation. If there is any ambiguity in the recommendation, or the detail required to fully meet the recommendation is kept in the body of the text, there is a risk that the recommendation will be read down and not be fully met or responded to appropriately.

First Nations Customers

In line with the principle above, we recommend that Recommendation 26 include reference to the testing or development of this information with First Nations Customers. Doing so is particularly important in a First Nations context where building trust over time through empowerment is critical to addressing the harms that have historically arisen.

Further we note that the Interim Report states:

> *Insurers should examine ways to improve this access to interpreters in line with their Code commitment, and as part of the response to the LCCC review.*

This should be a standalone recommendation too.

Circumstances Beyond Our Control

We welcome the recommendations here to reign in the excessive reliance on the concept Circumstances Beyond Our Control. The recommendations here are sensible and should go some way to addressing the harms.

We would like to make 2 comments on the matter.

First, we note that the Interim Report recommends that the element: "The Group Policy has requested a delay" be reviewed once those standards are finalised. We agree with this. However, we would wish to add to any further consideration of this element that life insurers should commit to providing information on what (if anything) a customer can do in engaging with the Group Owner. It is one thing to be provided the reasons for a delay – it is another to assist that customer in taking any steps that may assist in moving the Group Owner along – even if it is providing a direct contact number. Insurers have a key role to play in this regard. Further the life insurer should report to the customer what steps the life insurer has taken in moving the group insurer along. Finally, delays by super funds should be identified and captured as reasons - it's important for accountability of funds and insurers.

Second, with respect to elements "4 The claimant is undergoing rehabilitation …" and "5. The Claimant has requested a delay" it will be useful to require the life insurer to identify and make clear the expected timeframe (of the rehabilitation program or request) in writing to the customer to bring clarity confirming the situation.

Finally, it may be worth fully spelling out the expectations of Recommendation 37.

Communication

We welcome the comments at Recommendation 58, however these amendments will not address the harms that the consumer submission identified with respect to communicating with customers regarding cancellations (not mere avoidance) and the clawing back of premiums or over-payments of benefits.

While we provided extensive evidence of harm here - neither of these were even touched upon by the Interim Report. This is disappointing.

Adding these two critically important aspects of a relationship between a life insurer and their customer into Section 3's communications commitments would address consumer harms and lower levels of complaints significantly.

Interaction with the law

We note the discussion relating to the introduction of the legislative ban on the use of adverse genetic testing results in life insurance and agree with the Interim Report's Recommendation 62 that Appendix A be removed once the legislative ban comes into effect.

However, the Interim Report does not touch upon the key consequence of this legislative ban for legacy policyholders – that is how to address the discrimination faced by people who did the right thing, declared their adverse results to insurers, accepted the discriminatory penalties and in many cases have paid additional sums to insurers over a number of years.

To not raise or address this issue in this current Code Review would be unfair to those people.

Furthermore, it the Interim report has not acknowledged an expectation from the Senate Economics Legislation Committee that the issue be addressed by the Australian Government and the life insurance industry. Following the finalisation of the joint consumer submission to this review, the Senate Economics Legislation Committee released its report into the Treasury Laws Amendment (Genetic Testing Protections in Life Insurance and Other Measures) Bill 2025.[23] In it the Committee state:

> *While recognising the challenges involved in having the ban apply retrospectively to existing life insurance contracts, the committee considers this a vital area for the Australian Government to address in conjunction with industry. As such, the committee encourages the Assistant Treasurer to provide an update on efforts to extend the ban to existing life insurance contacts.*[24]

We remain of the view that this current Code review is the appropriate place to for industry to begin this dialogue (in conjunction with the reviewer and consumer interests) and potentially resolve it via the Code. The Life Code can commit life insurers to identifying customers who have previously received underwriting outcomes on the basis of adverse genetic test results and remove the loadings/exclusions from the date of the ban's commencement.

ASIC Approval

We note that the Interim Report is merely descriptive with respect to the positions expressed re: ASIC Approval. It fails to express a view one way or the other on this step. This is

[23] The Senate Economics Legislation Committee, Report into the Treasury Laws Amendment (Genetic Testing Protections in Life Insurance and Other Measures) Bill 2025, February 2026
[24] Para 2.61, Senate Economics Legislation Committee Report, February 2026

disappointing and we recommend that the Reviewer reconsider this and express a view on recommending ASIC approval or otherwise.

Most other reviews have expressed views on this matter. The Independent Review of the General Insurance Code of Practice expressed the view that the

> *"ICA should seek ASIC approval of its Code"*[25]

The review of the National Insurance Brokers Code of Practice also expressed a view when the report stated:

> *"At this stage, we do not see that work as a priority."*[26]

Whether a code is approved by ASIC or not is not a trivial matter. It is important to signal to consumers and other key stakeholders that this is a code that they can have confidence in.

We ask that the Reviewer reconsider this issue and express a view on it one way or the other.

Kind Regards,

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Senior Policy and Advocacy Officer
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[25] Recommendation 100 of the Independent Review: Interim Report, General Insurance Code of Practice Review, September 2024.
[26] Page 47, Independent Review, Insurance Brokers Code of Practice National Insurance Brokers Association Report December, 2025