GENERAL INSURANCE
Code Governance Committee

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7 June 2024

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Independent Review of the 2020 General Insurance Code of Practice

As the General Insurance Code Governance Committee (CGC), we welcome the opportunity to contribute to the Independent Review of the 2020 General Insurance Code of Practice.

The role of the General Insurance Code Governance Committee

We are an independent body that monitors compliance with the General Insurance Code of Practice (the Code).

By monitoring compliance with the Code, we aim to improve standards of service in the Australian insurance industry and promote best practices to, ultimately, help insurers create better experiences for customers.

Our work involves:

- Examining insurers' practices
- Recommending improvements to practices
- Monitoring the effectiveness of customer remediation
- Identifying current and emerging industry-wide problems
- Applying sanctions to insurers when necessary
- Consulting with stakeholders and the public on issues and keeping them informed.

Although our funding comes from the industry, we operate independently. We sit within the Australian Financial Complaints Authority (AFCA) which provides support for our operations and infrastructure.

Our role is not to oversee insurers' compliance with the law. It is to oversee their compliance with the General Insurance Code of Practice.

Codes of practice are an important part of a broad customer protection environment. When implemented well and supported by the industry, codes of practices are an effective layer of customer protection on top of the minimum requirements of the law.

Monitoring compliance with the Code

We draw on a wide range of data and information to identify potential areas of non-compliance with the Code.

Our sources of data and information include:

- Annual data collection from insurers that subscribe to the Code
- Notifications of significant breaches from insurers
- Inquiries we conduct into insurers' compliance with certain Code obligations
- External dispute resolution data from AFCA
- Customer groups and other key stakeholders.

The wide range of data and information allows us to identify issues and trends across the industry and work to promote better practices.

Our submission draws on the insights from our monitoring work and our observations on the impacts of Code breaches.

Overview

Insurance provides crucial protection when people need it most, offering financial security and supporting overall economic stability. For a customer, having confidence in the service and conduct of their insurance provider is essential.

It has been a challenging number of years for the general insurance industry and its customers. We have seen an increased frequency of natural disasters, ongoing impacts of COVID-19 and persistent inflationary pressures. Arguably, this congruence of challenges has tested insurers' business models, frameworks, systems, and processes like never before.

As a result, insurers have struggled to meet their Code commitments to customers.

We have seen year-on-year increases in reported breaches, largely driven by non-compliance with obligations regarding claims handling timeframes and communications. Our data shows that in 2022-23 insurers reported 77,886 breaches of the Code, a 34% increase from the previous year.

We recognise some factors were outside insurers' control. However, many factors were within insurers' control, and they must do better.

Having systems and processes are under pressure, such as with increased claims and economic and supply chain challenges, reveals their strengths and weaknesses, providing valuable opportunities for insurers to learn, innovate, and improve.

While many insurers have improved and continue to improve practices, including in response to the industry-commissioned Deloitte review, there is much more that all insurers can do.

This Code review provides a critical and timely opportunity to improve practices across the industry and ensure the Code reflects a truly progressive conduct model. It is an opportunity to respond to identified failings and restore trust and confidence in the industry.

The Code and our independent monitoring are an important part of a broad customer protection environment that includes legislation and oversight by other agencies such as ASIC, APRA, and AFCA. We must ensure that it continues to provide crucial protections for customers and accountability to the industry.

Contents

Claims handling

Timeframes and communication

The Code must strengthen obligations for timeliness and communication on claims handling.

Insurers must be able to handle claims and provide communications to customers within set timeframes, especially during periods of heightened needs and vulnerability.

Responding to catastrophes is the business of insurers. Their business models must ensure they can meet community expectations for conduct and service standards in the aftermath of a catastrophe and must consider the increasing frequency of catastrophic events.

Our data shows that the most breached obligation of the Code is the commitment to tell customers about the progress of their claim at least every 20 business days (paragraph 70). In 2022-23, insurers reported 28,189 breaches of this obligation – an increase of 59% on the previous year. These breaches constituted 36% of the total breaches reported by insurers in the 2022-23 period.

We consider 20 business days to be a reasonable expectation for an insurer to provide updates on claims to its customers and this obligation should be maintained.

The Code should be strengthened by removing the broad discretion for insurers to not report breaches of claims handling timeframes in certain circumstances (paragraph 84).

Currently, an insurer does not have to report a breach if:

- it determines its conduct and timing were reasonable in the circumstances, or
- an expert's report is delayed, and the insurer determines it did all it could to obtain the report in time.

This broad discretion at paragraph 84 risks concealing the true extent of non-compliance with Code obligations. We have identified instances where it has been applied inappropriately, resulting in substantial under-reporting of non-compliance with obligations for claims handling.

Insurers must ensure they can cope with surges in demand. ASIC set these expectations clearly in its letter to general insurers dated 6 March 2024.

Clear and accurate information on breaches provides transparency and indicates areas for improvement. It allows insurers to identify root causes and take steps to improve practices and deliver better outcomes for customers. Broad discretion to not report breaches risks concealing issues, allowing poor claims handling practices to continue unaddressed.

The Code should set a timeframe within which an insurer must make a settlement offer on an accepted or partially accepted claim. Similarly, it should set a timeframe for an insurer to commence repair or recovery work on an accepted claim.

These timeframes are currently not specified in the Code and have been a recurring issue in allegations of Code breaches.

Reasons for decisions

A crucial obligation in the Code, at paragraph 81b, requires insurers to provide the reasons for their claim decisions. Insurers must be clear with customers about decisions and provide sufficient detail for a customer to understand the outcome of their claim.

However, the Code should be strengthened to commit insurers to provide detailed reasons in plain English. Simply noting an exclusion within a Product Disclosure Statement (PDS) or attaching an expert report should not suffice as a reason for a decision.

Cash settlements

The Code obligations regarding cash settlements must be strengthened to include clearer standards.

Cash settlements have significant implications and risks for customers, including inaccurate valuations, changes in costs over time, and the administrative burden to coordinate repairs.

It is critical that the information insurers provide to customers is clear so customers can make considered and informed decisions on cash settlements.

The Code should be strengthened to improve obligations regarding cash settlements. It should be clear about the considerations an insurer must have when determining a cash settlement amount and it should specify the information an insurer provides a customer about the cash settlement.

The Code should commit insurers to the following when determining the amount of a cash settlement:

- Providing a quotation for work that is actionable for the customer.
- Offering an allowance for unforeseen items or transfer or risk to the policy holder (for example, future price increases).
- Ensuring an offer incorporates all other benefits that may be applicable to the claim (for example, temporary accommodation, removal of storage of contents, or professional fees).

Paragraph 79 of the Code should be strengthened to specify the nature of information required. It should commit insurers to:

- Communicating in plain English
- Clarifying the reasons for offering a cash settlement
- Presenting to customers other types of settlements that are available
- Explaining to customers the risks associated with accepting a cash settlement and the review period available
- Providing a full breakdown of costs for the agreed or established scope of work
- Clarifying any uplift payments.

Furthermore, the Code should commit insurers to consider a customer's individual circumstances before making a cash settlement offer to determine whether they can carry out the required repairs. This is particularly relevant for vulnerable customers.

Given the risks associated with accepting a cash settlement may not be apparent to a customer in the immediate to short term, the Code should ensure a customer has the right to request a review of the cash settlement offer within 12 months of accepting it, regardless of the time it has took the insurer to finalise the cash settlement.

The Code should mandate the consideration of a contingency uplift to manage the risk of higher repair costs and the transfer of risk to the customer for managing repairs. For example, customers living in remote or regional areas may require a higher contingency uplift due to limited supply of resources and tradespeople, which may increase costs.

Consideration of a contingency uplift should not be limited to payments over a certain dollar value. This would reduce its effectiveness because an uplift may be necessary regardless of the amount, and customers should not be left out of pocket when accepting a cash settlement.

AFCA's submission to Treasury's consultation on insurance claims handling being made a financial service states:

> *"AFCA often award an additional percentage on the insurer's quotes when assessing a cash settlement. This takes into consideration several factors including the transferred risk, whether the insurer's quote is actional (that is, available to the complainant) and the possibility of additional damage. The percentage often ranges between 10-25%."*

AFCA notes that a wide range of factors need to be considered to ensure the offer of a cash settlement is fair. Consequently, the contingency uplift factor should be applied depending on the circumstances of each claim as opposed to payments over certain amounts.

The risks associated with cash settlements apply to all insurance types and protections in the Code should be extended to all cash settlement payments.

Temporary accommodation

Issues and delays with arranging temporary accommodation can cause significant distress to a customer.

We have heard concerns regarding temporary accommodation that is provided on a short-term basis and then extended as required. The need to constantly extend these arrangements causes uncertainty for customers and unnecessary distress.

We have also heard concerns regarding the end of temporary accommodation entitlements where insurer-led delays should have resulted in extensions to the temporary accommodation.

Insurers must be proactive in offering temporary accommodation and flexible in managing the arrangements.

The Code currently does not include specific obligations on temporary accommodation and should be strengthened to improve standards and outcomes for customers.

Paragraph 59 of the Code should commit insurers to advise customers of temporary accommodation entitlements.

The Code should commit insurers to have adequate systems and processes to track and monitor temporary accommodation bookings and payments to avoid unnecessary disruptions for customers.

Use of external experts

Our report Making Better Claims Decisions highlighted inconsistencies in claims decision-making and instances where insurers relied on poor-quality reports from external experts to make decisions on claims.

Almost one-third of the files we assessed during our inquiry contained expert reports with inconsistencies or ambiguities. Furthermore, we found insurers were using inconsistent formats for assessments and reports.

Our inquiry indicated that insurers did not have requirements for external experts to provide a standard set of information in an established format.

Our data showed that in the 2021-22 financial year, a quarter of denied home claims proceeded through to Internal Dispute Resolution (IDR). Nearly half of these denied claims were subsequently overturned in favor of the customer following a complaint. The Code must be improved to help improve the quality of initial claims decisions.

When relying on expert reports as part of claims decision-making, insurers must ensure the reports clearly outline the facts and evidence and how these support the assessment.

The Code should prescribe minimum requirements for the content of expert reports used in claims decisions. It is essential that expert reports are clearly supported by facts and evidence.

For insurers to rely on expert reports as part of their claims decision-making, they need to ensure the reports clearly outline the facts and evidence, and how these support their assessment.

The Code should include commitments for insurers to ensure that external expert reports provide:

- Clear facts and evidence presented in plain English to support opinions
- Evidence of the link between loss and wear and tear or lack of maintenance
- Opinion on matters only within the expert's area of expertise.

In Making Better Claims Decisions, we note that 45% of the expert reports we analysed offered a recommendation for a decision on a claim.

While an expert may be technically proficient in a certain field, making a recommendation to accept or deny an insurance claim goes beyond that. We are concerned with an overreliance on experts' recommendations and how this limits a claims manager's critical assessment of the expert report. It may also prejudice other facts and evidence the expert may not have access to.

Paragraph 24 of the Code requires insurers to only allow their employees and distributors to provide services that match their expertise. Similarly, experts engaged by insurers should

provide advice only on their area of expertise and not make recommendations on claims decisions.

Strengthening the Code obligations to ensure experts only provide advice on areas of their expertise will encourage closer scrutiny from claims managers.

The Code should require a specific commitment from insurers to only allow external experts to provide services and advice that match their expertise.

The onus is on insurers to ensure that external experts hold the relevant skills, qualifications, and licenses.

Paragraph 75 of the Code should be strengthened to reflect this. It should remove the words "we believe":

> *We will engage an external expert only if ~~we believe~~ they have the appropriate expertise to provide the opinion we ask them for and that they comply with the rules and regulations relevant to their area of expertise.*

If an insurer is denying a claim or not paying it in full, the insurer should include copies of any service supplier or external expert reports it relied on to make that decision.

Transparency will improve scrutiny and quality assurance efforts. It will also ensure customers are better informed about the reasons for decisions.

In the Code, customers are entitled to this information, but they need to ask for it (paragraph 82). Because the expert reports are likely to be a key factor in a decision, customers should receive the information without having to request it.

The Code would be strengthened by removing existing paragraph 82 and updating paragraph 81 with an additional commitment:

> *We will provide you with copies of any reports from Service Suppliers or External Experts reports that we relied on.*

The Code should include a commitment for insurers to have adequate quality assurance and oversight in place to assure the performance of external experts. This must include the proactive collection and analysis of a range of data, including complaints and over-turn rates of denied claims or partially denied claims where experts are involved.

The Code should also include a commitment for insurers to have appropriate controls and measures in place to ensure an expert's independence.

External experts often interact with customers through their assessment process. It is essential that Code obligations for identifying and responding to vulnerable customers and professional conduct extend to external experts. This could be achieved by a broader definition of third-party service providers within the Code.

Financial hardship

The current cost of living crisis and increasing cost of insurance premiums is making it difficult for people to obtain and retain appropriate insurance cover.

Additionally, the parliamentary inquiry into insurers' responses to the 2022 major flood claims highlighted areas where insurers could have better supported customers experiencing financial hardship or vulnerability.

ASIC's report Hardship, hard to get help: Findings and actions to support customers in financial hardship (Report 782) provided a range of practical actions insurers can take to improve hardship support arrangements.

Although ASIC's report focused on lenders regulated under the National Credit Code, the fundamental practices are equally applicable to insurers' hardship functions. This report is in addition to ASIC's 22 April 2021 letter to Directors of general insurance companies which set out expectations to ensure hardship functions are working effectively.

The Code provides important protections but can be significantly improved to uplift practice and ensure that insurers better support customers experiencing financial hardship.

The Code currently limits financial hardship support to certain classes of individuals, such as insured individuals, third-party beneficiaries, and those the insurer seeks to recover money from (paragraphs 107 and 108).

Eligibility for hardship support should be broadened to include existing customers having difficulty paying their premiums. Insurers should be doing everything possible to minimise the number of customers who could become uninsured or underinsured due to increasing financial pressures.

For many customers, financial hardship may be short to medium term, and arrangements with premium assistance will reduce the risk of final hardship being exacerbated by underinsurance or non-insurance. Some insurers already provide premium hardship support. We recommend including this in the Code as a hardship support offering.

The Code should include comprehensive hardship support options, providing greater clarity for both insurers and customers. This could be achieved by expanding the list of arrangements insurers will consider offering customers experiencing financial hardship (paragraph 123) to include:

- Providing premium waivers and discounts
- Permitting a hold or deferral of premium payments
- Removing the loading for monthly premiums
- Reassessing the customer's risk profile (for example because of changes in circumstances) resulting in reduced premiums
- Waiving the excess on the claim in part or in full
- Allowing the excess to be paid in instalments

- Suspending or waiving third-party debt recovery or allowing debts to be paid in instalments
- Adopting non-insurance initiatives such as access to free counselling, welfare checks and gift vouchers.

This approach should not distinguish between short-term and entrenched hardship. Differentiating between short-term and entrenched hardship creates unnecessary complexity, particularly when support should be tailored to the specific and unique circumstances of each customer.

The Code only requires insurers to have information about hardship support available on their website (paragraph 105).

While prominence on the website is essential, the Code should commit insurers to making information available through a range of channels and include information on the availability of hardship assistance and how customers can request that assistance. This may include providing information in renewal notices and through customer service channels. This approach is consistent with the recommendations of the ASIC Report 783 Hardship, hard to get help. Lenders fall short in financial hardship support (ASIC Report 783).

The Code places the onus on customers to self-identify and seek financial hardship assistance from their insurer. However, there is a wide range of barriers that may prevent people from seeking assistance or engaging early.

ASIC's recent hardship research found that almost one-third of people struggling to meet repayments say they would not seek hardship assistance. The Code should include an obligation for insurers to take steps to proactively identify customers experiencing, or at risk of experiencing, financial hardship.

This is consistent with ASIC Report 783, which recommended practical action such as using data to identify customers who may be at risk of experiencing financial hardship and undertake targeted communications. The proposed obligation could draw on ASIC's expectation:

> *We will regularly collect and monitor data to identify and proactively help customers experiencing financial hardship.*

The increased accountability and proactive approach should extend to engaging with customers before support ends. This will ensure the customer's circumstances are considered further and whether on-going assistance can be provided. It also reflects good customer service, so that customers are aware of when the hardship support will end. Again, this new obligation could draw on ASIC's recommendation to insurers:

> *We will proactively engage with you before the end of any support option to consider your circumstances and whether any further assistance is needed.*

The following Code obligation should be strengthened:

126 If we decide you are entitled to Financial Hardship support, ~~then you may ask us to~~ we may release, discharge, or waive a debt or obligation. However, you are not automatically entitled to this.

Paragraph 105 in the Code could be updated into two parts:

- *If you are experiencing, or potentially experiencing, financial hardship we will proactively communicate with you in a clear and transparent way about the support options available.*
- *We will have information about applying for financial hardship support easily available and prominently displayed. The information will set out the types of support options that may be available, and how you can access financial hardship support.*

The Code should also commit insurers to review and improve hardship practices. As set out in ASIC Report 783, this could include commitments to:

- Ensure that there is oversight of the hardship function by senior management, including information relating to customer experience and outcomes.
- Assess whether the hardship function is operating effectively, including through monitoring key performance measures and customer experience and outcomes.
- Quality assurance arrangements that look at the end-to-end hardship (and, if applicable, collections) process from a customer's perspective. The purpose should be assessing whether the hardship function is operating effectively and identifying continuous improvement opportunities.

Greater compliance with financial hardship obligations can be achieved by ensuring that suspending or waiving third party debt recovery, or allowing debts to be paid in instalments, is a hardship support commitment proactively considered by insurers.

Service standards for hardship applications and communication should be improved. Seeking financial hardship support can be a stressful experience for customers. Delays in responding to requests can exacerbate hardship. The Code should include an obligation for insurers to acknowledge a customer's application for hardship support within two business days.

The following Code obligations at paragraphs 119 and 136 should include timeframes to ensure prioritisation of hardship matters:

Paragraph 119 – when we put the action on hold, we will contact any Collection Agent or solicitor that we have appointed and tell them the action is on hold.

If third-party service suppliers are brought under the definition of "we, us, our" then this obligation could be removed because the obligation at paragraph 118 would suffice. If third-party suppliers do not come under a broader definition of "we, us, our", paragraph 119 should include a timeframe.

> *Paragraph 136 – If you tell our Collection Agent or solicitor that you are experiencing Financial Hardship, then they must notify us and give you information in writing about our Financial Hardship process.*

Paragraph 136 must include a timeframe for collection agents or solicitors to notify insurers of customers experiencing financial hardship. It could be strengthened as follows:

> *We will have processes in place to ensure our Collection Agent or solicitors notify us within two business days if they identify you are experiencing Financial Hardship and give you information in writing about our Financial Hardship processes.*

Customer vulnerability

Reports and submissions to the parliamentary Inquiry into insurers' responses to 2022 major floods claims (flood inquiry) highlighted the need for insurers to do more to identify and support customers experiencing vulnerability.

Practices to identify and support vulnerable customers are constantly evolving, and there are a range of improvements that would bring the Code in line with more contemporary approaches.

A joint submission to the inquiry by Financial Rights Legal Centre, CHOICE, Customer Action Law Centre and Westjustice recommended that insurers take a proactive approach to progressing delayed claims, identifying vulnerable customers, and providing appropriate care.

AFCA's submission to the flood inquiry noted it identified issues with how insurers communicated with their customers and whether customers were in a vulnerable situation, warranting faster responses or additional care.

In its August 2023 report, "Navigating the Storm: ASIC's Review of Home Insurance Claims (Report 768)," ASIC highlighted areas for improvement in claims handling practices, emphasising the need for better treatment of vulnerable customers to ensure fairness. It stressed that insurers must identify and support customers experiencing vulnerability by tailoring their services accordingly.

The report detailed the importance of training insurer representatives to recognise signs of vulnerability, rather than relying on customers to self-identify. Additionally, ASIC called for insurers to enhance their systems and processes to automatically flag potentially vulnerable customers, such as the elderly or those living in remote or disaster-affected areas.

Deloitte, in its report, "The new benchmark for catastrophe preparedness in Australia" commissioned in the wake of the 2022 floods by the ICA, found that most insurers struggled to identify vulnerable customers. While noting that some insurers had invested in frameworks to support the vulnerable, these were often applied inconsistently, in part because of insurers' inability to identify customers with heightened levels of vulnerability. The report recommended that insurers "review the effectiveness of the definition, identification and support of vulnerable customers during catastrophes."

It is likely that a high number of customers are potentially experiencing some form of vulnerability when they require insurance. Consequently, it is essential that the Code sets high standards for the frameworks, systems, processes, and culture that insurers have to identify and support customers.

The Code lists a number of characteristics for customers at risk of experiencing vulnerability (paragraph 92). This approach does not align with best practice and risks insurers focusing on these characteristics alone or narrowing the focus of 'extra care' measures to these examples.

The Code should include a broader definition of vulnerability. We encourage a definition similar to the one found in the United Kingdom's Financial Conduct Authority's Finalised guidance: FG21/1 Guidance for firms on the fair treatment of vulnerable customers (FCA FG21/1) or the International Standards Organisation's new standard on Customer vulnerability – Requirements and guidelines for the design and delivery of inclusive service (ISO 22458).

If a list of characteristics is to be retained, it should be supplementary to a broader definition of vulnerability. The list should be expanded to include:

- Sexual orientation, gender identity and sex characteristics
- Cognitive impairment
- Family and domestic violence
- Elder abuse
- Financial abuse.

An enhanced definition of vulnerability should be accompanied by stronger commitments in the Code in specific areas as outlined below.

A commitment to proactively identify customers experiencing vulnerability

To encourage better identification of potential vulnerabilities and to address the assumption of vulnerability in certain situations such as trauma, we propose several amendments to the Code.

Currently, the Code places the onus on customers to inform an insurer that they are vulnerable. However, there are a wide range of barriers that prevent vulnerable people from seeking assistance and navigating the process can be challenging. The Code should include an obligation for insurers to take steps to proactively identify customers experiencing vulnerability.

Insurers hold a range of information that can assist them in proactively identifying customers that may be experiencing vulnerability or at risk of experiencing vulnerability. The Code should include an obligation that commits insurers to monitor data to proactively and identify customers experiencing vulnerability or at an increased risk of experiencing vulnerability.

In paragraph 96, the word "understand" should be replaced with "identify" at point (a):

> *We will have internal policies and training appropriate to our Employees' roles to help them:*
>
> *(a) ~~understand~~ **identify** if you may be vulnerable;*

The obligation at paragraph 93 should be updated. Currently it says:

> *We encourage you to tell us about your vulnerability so that we can work with you to arrange support – otherwise, there is a risk that we may not find out about it.*

It should be changed to say:

> *It is not always possible for us to identify if you are experiencing vulnerability. We encourage you to tell us about your vulnerability so that we can work with you to arrange support.*

Support people including trained professionals such as financial counsellors, lawyers and other representatives can play a pivotal role in assisting customers experiencing vulnerability. Insurers must ensure that their processes recognise the authorities of support people.

Consequently, paragraph 98 in the Code should be strengthened by removing the words “try to”:

> *If you tell us, or we identify, that you need additional support from someone else (for example, a lawyer, customer representative, interpreter or friend), then we will recognise this and allow for it in all reasonable ways. We will ~~try to~~ make sure our processes are flexible enough to recognise the authority of your support person.*

People from non-English-speaking backgrounds

According to 2021 census data, 22.3% of Australians speak a language other than English at home.

Insurance products can be complicated, and it is critical that information insurers provide is clear and accessible for all customers, irrespective of English language abilities.

It is also critical that the interpreting services provided by insurers are appropriately qualified. Insurers should not rely on staff or family members of customers to interpret or translate information because of the increased risks of misunderstanding.

Customers who require interpreting services may also face socio-economic challenges. Making customers pay for interpreting services could exacerbate financial strain and hinder their ability to access essential assistance. Insurers must bear the cost of interpreting services. Expecting customers to pay for interpreting services will likely create barriers and discourage them from seeking necessary information or services they need.

It is important that the provision of interpreting services should extend to include First Nations languages. Some insurers refer customers to the Translating and Interpreting Service (TIS National). We commend the offering of this professional service. However, TIS National does not provide interpreting for First Nations languages. There are First Nations language interpreting services available, and insurers should commit to offering this option to their customers.

Currently, paragraphs 103(c) and 103(d) do not hold insurers to a standard of practice. It is optional for insurers to publish translated materials or information for people with language barriers.

These paragraphs should be reviewed to clarify and strengthen the commitment from insurers. We recommend the following changes:

> *101. ~~Where practicable,~~ We will provide access to a qualified interpreter if you ask us to, or if we need an interpreter to communicate effectively with you. This will be provided at no cost to you. We will record if an interpreter is used ~~or if there are reasons we are unable to arrange one~~.*
>
> *103. ~~On our website there will~~ We will provide clear and easy-to find links to:*
>
> *(a) information on interpreting services, including First Nations interpreting services;*
>
> *(b) ~~teletypewriter services (TTYs~~) the National Relay Service.*

First Nations customers

The Code should introduce additional measures to support First Nations customers. This includes ensuring cultural awareness training to staff who may assist First Nations customers.

Examples from other industry Codes of practice specify additional support for First Nations' customers and could be used to inform the General Insurance Code of Practice:

Life Insurance Code of Practice (paragraph 6.17):

> *Recognising that people living in remote and regional communities may have trouble meeting the timeframes to provide documents or to take part in assessments and considering this in the underwriting and claims processes.*

Banking Code of Practice (paragraph 36):

> *Assisting customers who reside in remote communities (including remote indigenous communities) to access and undertake services.*

The Code should commit insurers to asking questions of identity and seeking explicit consent to flag them for assistance in line with the requirement of the Privacy Act, for example asking whether a customer identifies as Aboriginal or Torres Strait Islander. This can lead to insurers setting up dedicated call lines or specialist teams to support First Nations customers.

Family and domestic violence provisions

The Code only requires insurers to have policies for supporting customers affected by family violence published on their websites. It should include a commitment to comply with the ICA's Guide to helping customers affected by family violence.

An alternative approach would be to include key elements of the ICA guide in the Code.

The Code should commit insurers to making policies and support options clear and accessible to customers. It should not be limited to merely publishing documents on websites.

In March 2021 we published a report titled Assessment of compliance with new provision on family violence policies. We analysed 47 insurers and found that 96% had complied with the Code obligation by making their family violence policies available on their websites. However, for only a small number of insurers and brands (23% of insurers and 11% of brands) these were considered easy to find.

The Code should adopt the recommendations in the Centre for Women's Economic Safety March 2024 Report, Designed to Disrupt: Reimagining General Insurance Products to Improve Financial Safety. In particular:

- Adopt a 'conduct of others' paragraph to address harms borne by the interaction of insurance exclusions and innocent victims of family violence. This occurs when a family violence perpetrator deliberately damages home building or home contents but the conduct, because it is by a family member, activates a policy exclusion. We welcome the fact that some insurers already offer this paragraph and would like to see it set as standard across industry.
- Treat joint insurance policies as composite when advised of separation or divorce.
- Ensure all parties have access to the indemnity where cash settlements are made to co-insureds, and provide mediation where parties are unable to agree.
- Collect and analyse data on outcomes, compliance incidents, risk issues and complaints relating to customers experiencing domestic and family violence and incorporate consideration into all parts of the product life cycle.

Mental health

One in five Australians aged 16–85 experiencing a mental illness each year. According to the Black Dog Institute, nearly half (45%) of Australians will experience a mental illness in their lifetime. Traumatic life events can trigger or exacerbate mental illness.

Consequently, it is critical that insurers set high standards of service and conduct to effectively identify and support customers with mental health issues. The Code should include a specific section setting out Mental Health related obligations.

While we welcome the ICA's Guide on Mental Health, it is not binding on insurers. Given the prevalence of mental illness within the community, the good practice set out in the ICA's Guide should be commitments in the Code.

The Life Insurance Code of Practice contains obligations that could be adopted by the general insurance industry, including:

- Paragraph 2.1(b):

  Not incorporating blanket exclusions specific to mental health in the general terms and conditions of the standard form contract, consistent with obligations under the Disability Discrimination Act 1992 and equivalent State and/or Territory law.

- Paragraph 4.12:

  If you have or have had a diagnosed mental health condition, or symptoms of a mental health condition, we will:

a) not decline to insure you before you have had the opportunity to provide information about the history, severity or type of condition allowing us to make an informed decision about whether to insure you and, if so, under what terms.

b) take into account your circumstances such as the history, severity, or type of condition when deciding whether we can offer you cover.

- Paragraph 4.13:

If you tell us about a past or current mental health condition, we will determine whether we can provide you with cover by managing any additional risk through higher premiums, exclusions, limits and caps rather than not providing cover at all.

- Paragraph 4.14:

If we offer you alternative terms, such as a higher premium or cover subject to an exclusion, we will let you know within five business days (in line with clause 4.20) and we will explain to you why, in line with clause 4.22.

- Paragraph 4.18:

We will ensure our underwriters have the appropriate skills and training, including for mental health conditions where applicable. They will not make decisions for us until they have shown technical competency and an understanding of relevant laws (including anti-discrimination laws), Life Code requirements and CALI standards and guidance.

- Paragraph 4.19:

While assessing an application, our underwriters will access professional advice and support in relevant disciplines, such as from medical specialists and accountants, when needed.

The following be included in the Code based on the ICA's Guide:

- We will only ask relevant questions when deciding whether to provide cover for a pre-existing mental health condition and only rely on relevant information.
- Exclusions for pre-existing mental health conditions will only apply if there is evidence that you have an existing mental health condition or are at risk of a recurrence of a past mental health condition, and the covered event relates to the pre-existing mental illness.
- When you make a claim against an existing policy, the claim will not be denied based on a pre-existing mental health condition if the covered event does not relate to the pre-existing mental health condition.
- Claims involving mental health conditions will be processed sensitively having regard to your ongoing medical treatment needs, using the least intrusive methods of investigation in accordance with the Claims Investigation Standards in the Code.
- If cover cannot be provided based on a mental health condition, we will provide you with the information we relied on when assessing the application. (Insurers should provide this information proactively and not only in response to a request by the customer as per the current industry Guide.)

- We will develop and implement policies and procedures to ensure our sales and claims processes are respectful and appropriate.
- We will ensure appropriate training for our employees, distributors and service suppliers working with customers with mental health conditions to help:
    - Understand the signs and symptoms of mental illness
    - Communicate sensitively and effectively
    - Understand our obligations
- We will regularly review our training – at a minimum every three years to ensure the program is effective in achieving the objectives.
- We will regularly seek to obtain better data to enable any exclusions to be narrowly designed.
- We will categorise mental health conditions according to current commonly accepted professional standards.

LGBTIQA+

The Victorian Pride Lobby's June 2022 report Worth the Risk – LGBTIQA+ experiences with insurance providers notes the Code does not include sexual orientation, gender identity and sex characteristics as factors that cause vulnerability.

The report notes insurers' role in improving practices and recommends actions insurers can take to achieve equal access to services and equal rights.

The recommendations made in the report can be incorporated into the Code should be considered.

The Code obligations can be strengthened in the following ways:

- List sexual orientation, gender identity and sex characteristics as factors that may cause vulnerability.
- Commit insurers to regularly review their practices regarding names, gender, and titles to ensure they are in line with contemporary best practice. This includes ensuring that data on sex or gender is only collected where absolutely necessary and the reason for the collection of the data is clear to the customer.
- Commit insurers to provide LGBTIQA+ training to staff, particularly customer facing staff to help them understand if customers may identify as LGBTIQA+ and how best to support LGBTIQA+ customers.

Insurers should also commit to reviewing and removing exclusions or premium loadings for people living with Human immunodeficiency virus (HIV), particularly where HIV is being effectively managed through treatment.

Vulnerability during a catastrophe

During a catastrophe, insurers should operate under the assumption that customers in the affected areas are experiencing vulnerability.

This principle applies even to customers who may not exhibit factors typically associated with vulnerability.

Having a broader definition of vulnerability within the Code will highlight the situational nature of vulnerability, as opposed to its understanding through a restricted set of characteristics.

The Code should include a commitment to embedding a trauma-informed practice. This will ensure knowledge about trauma is integrated into insurers' frameworks, policies, and procedures to create a supportive and safe environment for customers experiencing trauma.

Currently, the Code only references inclusivity in its non-enforceable principles. The Code should include standards setting out how insurers will ensure their services are inclusive and accessible. This extends beyond identifying and supporting customers experiencing vulnerability; it is about reducing barriers and making it easy for anyone to engage with an insurer irrespective of their abilities.

The Code obligations should extend to include customer testing of products and services and establishing meaningful partnerships with community organisations that can help inform improved practice.

Paragraph 32 of the Banking Code of Practice includes a commitment to improving the accessibility of banking services for people with a disability, older customers, and people with limited English, and commits to taking reasonable measures to enhance their access to services. The Code should commit general insurers to similar standards that improve accessibility.

Increasingly, insurers engage with customers digitally. For many customers this is preferred. However, the reality for people living with disability is that online content can remain inaccessible. The Australian Disability Network states that in 2018 there were nearly 4.4 million Australians with some form of disability. In relation to digital access, the Australian Bureau of Statistics (ABS) confirmed in 2018 that 28.5% of people with disability did not use the internet. This compares with 12% of the general public that do not participate online.

Digital access is also an issue for customers living in remote and regional communities. The ABS' National Aboriginal and Torres Strait Islander Social Survey (NATSISS) shows that while 85.7% of Aboriginal people living in urban and regional areas have accessed the internet in the last 12 months, only 53.1% of those living in remote and very remote areas have done so. For daily use, this drops to 64.1% and 25.2% respectively.

Although not a law, the Australian Human Rights Commission (AHRC) recommends compliance with the Web Content Accessibility Guidelines (WCAG) as a standard for digital accessibility. WCAG provides guidelines for making web content more accessible to people with disabilities. The AHRC endorses WCAG 2.0 (Level AA) as the standard that organisations should strive to meet.

The Code should commit insurers to meeting the standards set in WCAG 2.0 (Level AA). This should include a commitment to regularly review web and app content to ensure it continues to meet accessibility requirements.

Promoting inclusive product and service design

We welcome ASIC's Regulatory Guide 274 (RG274) on Product design and distribution obligations, published on 11 December 2020, highlighting the need for effective product governance arrangements.

RG 274 emphasises a customer-centric approach in the product design stage, suggesting that issuers should consider customer vulnerabilities and how these may increase the risk of products not meeting customers' objectives, financial situations, and needs. The Code should commit insurers to test new products with customers before taking them to market.

The Code should set a higher standard of commitment along the lines of ISO 22458 Customer Vulnerability – Requirements and guidelines for the design and delivery of inclusive service (ISO 22458).

This should include requiring insurers to:

- Engage with customers who have experience of vulnerability to inform new products or services
- Work with trusted stakeholders that can help:
    - develop training related to vulnerability, accessibility, and inclusion
    - design inclusive products and services based on real experiences
    - identify risks of harm and potential solutions.

Insurers often reference their customer-centric approach, and many have established partnerships with not-for-profits and other organisations that lend expertise and insights to improve practices. Including clear commitments in the Code to engage more actively with customers and stakeholders in the design of new products and services will complement and strengthen the commitments set out in ASIC's DDO obligations and ensure projects and services minimise risks and improve outcomes for customers.

For add-on insurance products the Code should commit insurers to product design principles ensuring that add-on products deliver a material value to the customer.

The Code and the law

Paragraphs 18 and 20 are sufficient to clarify the interaction between the Code and the law. They emphasise that the Code operates in conjunction with existing laws and addresses issues not covered by the law. Furthermore, they stress that the law takes precedence over the Code.

While removing regulatory and legislative duplication between the Code and the law may seem appealing, would make it more difficult for customers to navigate, understand and exercise their rights.

Codes of practice have an important role to play in not just extending protections above and beyond the law but also in clarifying or elaborating on existing laws. This makes it easier for customers, customer advocates and insurance staff to understand the conduct expected of insurers.

The removal of certain Code commitments from other industry codes, on the basis of duplication with the law, has decreased transparency and accessibility for customers and financial firms on key customer protections.

While other industry associations such as the Australian Banking Association and the Financial Services Council (previous owner of the Life Insurance Code) committed to develop a regulatory guide for customers, we are yet to see this approach achieve its objective of ensuring customers rights, protections and applicable timeframes are explained in a customer-friendly and accessible way.

Consequently, we advise caution in removing Code provisions based on perceived simplification or avoiding duplication of the law.

Should duplication between the Code and the law exist, it does not necessarily mean a duplication of efforts for insurers, the CGC, and relevant regulatory bodies. We are often better placed to act in certain areas than a regulatory entity like ASIC.

Retail insurance and wholesale insurance

The service standards and conduct expectations set out in the Code should extend to both retail and wholesale clients. High standards of service and conduct should apply irrespective of the nature of the customer. The Code should ensure that all standards apply to small and medium enterprises (SMEs)

Unfortunately, the current definition of retail client, under the Corporations Act, includes a narrow list of insurance products and fails to adequately cover the diverse insurance needs of Australian SMEs. This consequently pushes many SMEs into the wholesale client definition. Consequently, the Code's reliance on the retail/wholesale client distinction leaves many SMEs with reduced safeguards, relating to:

- Standards for service suppliers
- Buying insurance
- Cancelling an insurance policy
- Making a claim
- Supporting customers experiencing vulnerability
- Complaints (except in limited circumstances).

While the typical SME may share similar insurance needs to its larger counterparts, it does not necessarily share the size, complexity, resources, capability, and business acumen. Many small businesses operate on small budgets with limited resources and personnel. Generally, they lack the expertise and risk management capabilities of larger corporations. They are often family-owned and run operations.

The Code should make clear that all parts of the Code apply to SMEs irrespective of their insurance needs.

There will be others better placed to advise on a more contemporary definition of SME. However, we see value in adopting a simple and clear approach like that of AFCA, which defines a small business as an organisation with less than 100 employees.

Other elements of the Code

Honest, efficient, fair, transparent, and timely

The principles of honesty, efficiency, fairness, transparency, and timeliness in Paragraph 21 of the General Insurance Code of Practice guide insurers in their operations and customer service.

While specific obligations in the Code help illustrate these principles, insurers also adhere to broader obligations that reinforce practical applications of these values.

From the commencement of the 2020 Code until April 30 2024, insurers reported 228 significant breaches of Paragraph 21, accounting for 43% of all significant breaches. This underscores the importance of maintaining these overarching principles as enforceable obligations.

These high-level principles provide crucial guidance, ensuring that both insurers and customers understand the broader objectives beyond specific rules. They offer flexibility and adaptability, which are essential for addressing new risks and scenarios not explicitly covered by the Code, thereby maintaining the spirit of the Code even when circumstances change.

Accountability for the conduct of employees and distributors

All Code obligations should apply to the activities and services of an insurer's employees and any third-party service suppliers it engages to undertake activities on its behalf.

We recommend the Code adopt a broader approach, similar to the Banking Code of practice, which extends obligations to services supplied both directly and through a third-party engaged by the insurer.

The Code currently has too many separate definitions for third-party representatives and exclusions. For example, the Code contains separate definitions for Service Supplier, External Expert, Loss Assessor and Loss Adjuster, Collection Agent, Employee, Investigator, Distributor.

This creates unnecessary complexity, limits coverage of critical Code protections, including vulnerability and hardship obligations, and risks insurers inappropriately 'outsourcing' their Code obligations.

The Code also currently states:

> *"**we, us** or **our** means the organisation that has adopted this Code".*

But numerous sections of the Code are currently written in a way that suggest the onus is on third parties to ensure compliance with the Code. For example:

> *35. When our Service Suppliers are providing a service to you, **they must tell you** the service we have authorised them to provide and that they are acting on our behalf.*

> *36. If you make a Complaint to one of our Service Suppliers about either us or their conduct, then **the Service Supplier will tell us** about the Complaint within 2 Business Days. Your Complaint will be handled under the Code's Complaints process.*
>
> *37. **Our Service Suppliers must tell us within 2 Business Days** about any breach of the Code that they are aware of when acting on our behalf.*

The responsibility to ensure compliance must remain with the insurers, and the language used in the Code should reflect this.

Furthermore, moving to one broader definition for third-party service providers will allow the Code to better reflect the service and standards a customer can expect, irrespective of who they are dealing with at any part of the process.

Customers should not be expected to navigate and understand the differences of dealing with a distributor or a service supplier; rather, they should expect the same consistent high standards of service and conduct regardless.

To enhance accountability, paragraph 17 on complying with the Code should be amended to better reflect that the onus for Code compliance rests with the insurer:

> *17. We are in breach of the Code if our employees or third-party service suppliers do not comply with the Code when they are acting on our behalf. Although our third-party suppliers are not subscribers to this Code, we remain accountable for ensuring that their services and conduct (provided on our behalf) comply with the standards in the Code.*

Currently, the only obligation on insurers regarding external experts is ensuring they have the appropriate expertise. Insurers should be required to have systems, processes and controls that proactively monitor the performance of external experts and all third-party suppliers they engage.

A broadening of the third-party supplier definition within the Code will help address this. Additionally, the Code should be strengthened with obligations to:

- Ensure contracts with all third-party suppliers set standards of practice that reflect Code obligations applicable the activities and services to be provided.
- Proactively review and assure the quality of activities and services provided by third-party suppliers on an ongoing basis to ensure compliance.

Standards across third-party suppliers are inconsistent and create unnecessary gaps. For example, paragraph 30 of the Code commits insurers to having policies and procedures in place to monitor the performance of its employees and distributors. In contrast paragraph 41 of the Code, relating to the performance of 'service suppliers', is far more passive and reactive:

> *41. If we are aware that our Service Suppliers' performance does not meet the relevant standards of the Code, then we will address this — for example, by:*

a. cancelling our contract with the Service Supplier; or

b. requiring them to go through further training.

Any third-party service supplier engaged by an insurer should be subject to proactive monitoring and oversight.

Code obligations play an important role in clarifying, complementing, and extending what is required in the law. Consequently, these standards should apply to all activities and services, irrespective of whether they are provided directly or through a third party.

Training requirements for employees, distributors, and service suppliers

Training obligations within the Code can be strengthened to support a broader definition of third-party service supplier.

Insurers should ensure that all their employees and third-party service suppliers have appropriate training to:

- Understand the Code and the obligations that apply to their activities and services.
- Provide services in line with the standards expected by the Code.

Paragraph 96 should not just be limited to “employees” but should encompass any employee or third-party service supplier that may be interacting with vulnerable customers. It should be updated:

96. We will have appropriate policies and training in place to:

a. identify and understand if you may be vulnerable

b. decide how best, and to what extent, we can support you

c. take account of your particular needs or vulnerability, and

d. engage with you with sensitivity, dignity, respect, and compassion — this may include arranging additional support, for example referring you to people, or services, with specialist training and experience.

Similarly, paragraph 109 regarding identifying people experiencing financial hardship, should be broadened:

109. We will have appropriate policies and training in place to help identify if you are experiencing Financial Hardship and decide how we may be able to provide support to you.

This removes the need for the specific section 132 of the Code that covers financial hardship training of Collection Agents.

The obligations in the Code regarding training should focus on the desired outcomes rather than a list of specific types of training. A specified list of training may unintentionally limit the practice of insurers.

An outcomes-focused approach allows insurers flexibility to determine the training that will best achieve outcomes and adapt training based on new or emerging practices.

To support this outcomes-focused approach, the Code should commit insurers to regularly review their training, includes ways to test the effectiveness of training to inform continual improvements.

Purchase, renewal and cancellation processes

Parts 6 and 7 of the Code could be strengthened to ensure better sales practices and greater transparency regarding policies, renewals, and premiums.

Paragraph 44 should explicitly require insurers to prevent pressure-selling through robust frameworks, systems, processes, training, and oversight, not just by merely instructing employees and distributors that pressure-selling is prohibited.

We see value in doing more to help customers understand if they may be at risk of being underinsured. We recognise the level of insurance ultimately remains a decision for the customer. To help customers avoid underinsurance, insurers should use an up-to-date calculator for home and building insurance (paragraph 48) and proactively inform customers if they appear underinsured at policy inception and renewal.

The Code should also be strengthened to ensure insurers only use relevant, reasonable, and transparent data for underwriting and premium setting. Additionally, customers should receive a clear breakdown of premium costs at policy inception and renewal to make informed decisions.

Insurers must provide renewal notices for home, contents, and strata insurance at least 28 days before auto-renewal, with a reminder notice at least seven days prior. This improves on the current 14-day notice period, giving customers ample time to consider their options and ensure value for money.

Complaints

Careful consideration should be given to Code commitments relating to complaints following the introduction of ASIC's Regulatory Guide 271 (RG271).

Removing obligations from the Code where they can complement or clarify obligations set out in regulation or the law should be approached with caution.

There are several changes that would support improved practices regarding complaints.

First, paragraph 146 of the Code requires insurers to keep customers informed about the progress of their complaint at least every 10 business days unless otherwise agreed. This obligation should be strengthened to specify the level of detail the insurer must provide. This update should be meaningful and include contact details if further information is required.

This recommendation is based on feedback from customer advocates regarding the quality of these updates. We have heard that insurers are delivering automated emails to satisfy this obligation, without the update providing any value to the customer.

The objective of this obligation is to keep customers informed and ensure the complaints process is efficient and transparent, however the provision of poor-quality updates can lead to increased frustration and confusion for the customer.

Second, paragraph 156 of the Code states that AFCA's decisions are binding on insurers in the way set out in its Rules. We have seen several insurers fail to act as set out in AFCA's determinations.

The Code obligation should drive greater accountability and we recommend it be strengthened to include a commitment to act on AFCA's determinations within a particular timeframe. Strengthening this obligation will support more timely action in response to AFCA determinations, improve practice and reduce disputes.

Third, complaint management conducted by a third-party on behalf of the insurer should be covered by all relevant code obligations, including vulnerability and hardship obligations.

This can be achieved by adopting a broader definition of third-party supplier in the Code. Similarly, there should be a broad obligation on insurers to have processes in place to monitor their third-party complaints suppliers to ensure they are complying with all relevant Code obligations.

Affordability

The Code plays an important role in driving greater transparency around the cost of insurance and ensuring pricing promises are met by insurers.

ASIC's June 2023 Report 765 When the price is not right: Making good on insurance pricing promises (Report 765), uncovered a range of serious concerns relating to the opaque and at times ambiguous nature of insurance pricing promises. We also frequently hear concerns about 'loyalty taxes' being applied to the premiums of long-term customers, an issue recently highlighted in media reporting of a class action against insurers.

Report 765 states:

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

The Australian Competition & Customer Commission's (ACCC) 2020 report from the Northern Australia insurance inquiry highlighted that in 2018, Australian customers renewing their combined home and contents insurance paid on average between 7 and 24% more than new customers.

The Financial Conduct Authority (FCA) in the United Kingdom and the Central Bank of Ireland have both banned this practice. We believe insurance pricing should be based on risk, not the loyalty of a customer or their likelihood to shop around for more reasonable offers.

The Code should include a commitment from insurers not to charge higher premiums or fees to existing customers compared to new customers for the same insurance products and coverage levels solely based on the length of time the customer has been, or is likely to be with, the insurer.

We would also like to see additional commitments in the Code regarding transparency of pricing. Increased transparency for customers improves insurance affordability by fostering understanding, competition, and accountability.

Insurers should disclose factors affecting the insurance premium, ensuring the disclosure promotes how the product works and how it is priced. This could include details on loadings for weather risks or applied discounts. A commitment to clear and specific pricing information should be included in the Code.

This commitment should also include disclosure of instalment surcharge costs (Recommendation 15.1 of ACCC report). Insurers should be required to provide 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.

When customers are clear on how premiums are calculated, they are better placed to make informed decisions, including what risk mitigation measures may reduce their insurance costs further. This transparency also makes it easier for comparing policies across insurers to identify the best rates.

Helping reduce risks

Given insurance pricing is based on risk, it is important that premiums consider any risk mitigation actions taken by customers. The Code should commit insurers to provide premium discounts to policyholders who implement verified risk mitigation measures.

These measures should be clearly specified and could include things such as installing security systems, taking defensive driving courses, or making home improvements that reduce risks (for example, storm-proofing and fire protection).

We appreciate that insurers will need to assess and verify the appropriateness of risk mitigation measures. This should include a commitment to a clear and transparent approach. Any documentation required for verification must be clearly communicated to policyholders.

The Code should oblige insurers to publish the discount rates for each type of approved risk mitigation measure in a way that makes this information easily accessible for customers. This transparency should extend to informing policyholders about risk mitigation measures and the associated discounts in policy documents and renewal notices. This is in line with the ACCC's recommendation 21.2:

Insurers' 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 customers have received for undertaking these measures.

Structure of the Code

The Code has several important audiences – customers, insurers and their staff, customer advocates, financial counsellors, AFCA, and regulators.

It plays a key role in clarifying an insurer's commitment to high standards of service and behaviour. It does this in a clear and accessible way that is easy for customers to understand.

Without a clear understanding of their rights, customers, particularly vulnerable customers, may not know how to seek redress when something goes wrong. This can lead to a sense of powerlessness and frustration and ultimately impact the reputation of the insurer.

The clarity and transparency of information in the Code provides customers with confidence and empowers them to engage with the insurer directly when things go wrong.

Clear and straight forward Code commitments make it easier for insurers and their employees to understand, implement and uplift practice to meet the expectations set. This can enhance consistency and operational efficiency. A clear and well-understood Code allows employees to identify and address potential risks early, reducing the likelihood of costly compliance breaches or more serious legal disputes.

Customer advocates and financial counsellors tell us how useful and easy to understand Codes are, in terms of providing support to customers, often the most vulnerable customers. With a clear Code of Practice, financial counsellors are better equipped to advocate for their clients' rights and interests, ensuring that they receive fair and appropriate treatment from insurers. It can also facilitate more efficient dispute resolution when service expectations are clear.

AFCA staff and decision-makers often rely on industry Codes of Practice. Under Rule A.14.2, AFCA must do what it considers to be fair in all the circumstances having regard to a number of factors, including applicable industry codes and good industry practice. Even for non-subscribers to the Code, AFCA may consider a standard set out in a Code if it believes the standard represents the general law or good industry practice at the time the conduct occurred.

ASIC also considers the General Insurance Code of Practice and how industry is meeting its commitments. ASIC's August 2023 report "Navigating the storm: ASIC's review of home insurance claims" has more than 80 references to the General Insurance Code of Practice or the work of the Code Governance Committee. This includes noting that the Code contains explicit indicators of what industry consider to be appropriate standards and identifying areas requiring further improvement by insurers.

The Code should continue to have a broad audience. However, it should be written and presented with customers in mind. If customers can understand it then so too will insurers, regulators, and others. This includes:

- Ensuring it is written in plain English, avoiding industry jargon and technical terms where possible
- Keeping paragraphs short
- Avoiding multiple obligations within the one paragraph
- Using clear headings and subheadings to support easy navigation
- Considering accessibility features such as easy to read font size, high contrast and alternative text descriptions for any images embedded within the Code.

As the Code compliance monitor, we are obviously a key audience for the Code. For additional clarity and enforceability of the Code, we recommend that each numbered paragraph in the Code should contain only one obligation for insurers to meet.

For example, paragraph 77 of the Code states:

> *Our decision will be made within 4 months of receiving your claim, unless paragraph 78 applies. If we do not make a decision within that time, we will tell you in writing about our Complaints process.*

This contains two obligations:

1. Making the claim decision within four months, and
2. Telling the Customer about the complaints process.

If an insurer reports a breach of paragraph 77, it is unclear which obligation they have breached. Each obligation should stand alone.

The Code contains paragraphs that would benefit from a re-draft to improve clarity and accountability. Many of the clauses in the Code are not drafted as commitments or are commitments that are too broad or vague in scope. This poses a challenge when enforcing Code obligations. Code paragraphs that could be improved are included at Appendix A.

Code governance and compliance

Overall, Code governance arrangements work well and allow us to operate independently of the ICA and its members.

That said, we recommend that the ICA align Code governance arrangements with other industry associations with Code services provided by the Australian Financial Complaints Authority. This would simplify arrangements, further reduce risks, and provide greater efficiency for the ICA, us, and the Code Team at AFCA.

To date, the contracts and indemnity arrangements for CGC members have been managed by the Code Governance Committee Association (CGCA), a separate legal subsidiary of the ICA. The CGCA is made up of both industry and customer representatives. For all other Code Committees that AFCA supports, independent contracts and indemnity are managed by AFCA.

It is critical that the Code team that supports us to deliver on our activities and functions has full oversight of our contracts and indemnity arrangements.

In June 2021 it came to our attention that our indemnity cover was inadequate. It took far longer than we or the ICA would have liked to resolve this matter. To avoid issues like this in the future we recommend that the ICA align CGC arrangements with those of other industry Code committees, to ensure the Code Team can maintain coordination and oversight of these matters in supporting our work.

The budget approval process for the CGC should be retained, whether through the current Association or a similar model. The budget approval model is a standout in terms of best-practice with both industry and customer advocates making the decision on the CGC's budget.

We understand that for the other industry codes of practice that AFCA provides secretariat support for, the budgets are approved by the industry association, without any involvement of customer advocates. This would be a retrograde step and the current approach must be retained.

It demonstrates a strong commitment to the independence of the CGC and ensures the interests of both industry and customers are considered when settling on funding arrangements for our work.

We should have the power to name insurers in our data and inquiry reports. This transparency would be in line with contemporary practice, including AFCA and ASIC reporting, and we see the following key benefits:

- Promotes increased accountability among insurers – this increased accountability can motivate firms to do more to drive improvement and meet their obligations.
- Enhanced transparency is also likely to improve trust and confidence in the self-regulatory model, including from customers and the broader public. It demonstrates a strong commitment to compliance and reinforces our independence.
- Enhanced customer protection by allowing customers to make more informed decisions based on breach reporting and inquiry reports. Lack of transparency regarding which insurers are performing poorly in Code compliance is out of step with public expectations.

The Australian Banking Association (ABA) has accepted a recommendation for banks to be named in breach reporting by the Banking Code Compliance Committee, and we would like to see this commitment from insurers.

The range of sanction powers available to us are appropriate. We commend the ICA for introducing the Community Benefit Payment as an additional sanction option available to the Committee.

With our indemnity issue now resolved, alongside improvements to our compliance and enforcement strategy, we expect to use the full suite of sanction powers more often. At this stage, we do not see a need to adjust the types of sanctions available to us.

However, we would like improvements to the range of factors we must consider in determining if a sanction is to be imposed. Paragraph 170 of the Code requires us to consider:

- the appropriateness of the sanction
- if we have not acted on — or have taken too long to act on — a request from the Code Governance Committee to remedy a breach
- if we have breached an undertaking we gave to the Code Governance Committee
- if we have not taken adequate steps to prevent a Significant Breach from reoccurring, and
- if we have not acted with the utmost good faith.

The current factors are largely backward looking, and therefore take a punitive approach. The factors should also be forward looking, particularly in terms of limiting the damage of significant breaches identified by the subscriber that have not been rectified or *will* take too long to rectify. Under a strict reading of 170(d), the significant breach must re-occur before we can consider it.

Most of the sanction considerations we have progressed under the current Code rely on consideration of the appropriateness of the sanction under 170(a), particularly in situations where a subscriber contests that a significant breach has occurred.

If we identify a serious breach that causes significant customer detriment, which has not been acknowledged by the subscriber and not been rectified, our considerations centre on paragraph 170(a). In these situations, the Code should provide guidance for the industry and us on the concept of 'appropriateness'.

When providing guidance on compliance and enforcement powers, such as sanctions, Code bodies and regulators tend towards a principles-based approach, while providing sufficient detail on the sort of considerations that underpin the principles. We propose an improved principles-based approach, which is more in line with contemporary practices:

> *The Code Governance Committee may impose sanctions on us for a breach of the Code. When determining any sanctions to be imposed, the Code Governance Committee will be guided by the following principles:*
>
> *a) Risk – the CGC will respond to the level, nature and duration of customer detriment caused by the breach.*
>
> *b) Proportionality – the type of sanction imposed by the CGC will be proportionate to the level of customer detriment caused by the breach. This includes consideration of customer vulnerability and financial hardship.*
>
> *c) Raising industry standards - the sanction's capacity to improve industry performance, both to deter future breaches and to provide information to customers.*
>
> *d) Subscriber conduct – the subscriber's capacity and commitment to remedy a breach and prevent its reoccurrence.*

We are committed to avoiding duplication of work with agencies such as AFCA and ASIC. Currently paragraph 175 of the Code includes conditions we must meet in instances where we intend to impose a sanction requiring an insurer to pay compensation or a community benefit payment:

> *175. When requiring us to pay compensation or a community benefit payment, the Code Governance Committee must take into account any compensation awarded by the Australian Financial Complaints Authority or an enforcement agency. The Code Governance Committee must also take into account any impending or ongoing investigation by the Australian Securities and Investments Commission.*

ASIC has strict disclosure provisions that do not currently allow it to share information on any impending or ongoing investigations with us.

To date, to manage this issue, we have sought explicit authority from the insurer to disclose to ASIC the nature of our investigation. If the insurer provides this consent to disclose, we then engage with ASIC, share information about our own investigation and ask ASIC to confirm if it duplicates any of their own work. So far, we have not encountered any issues with insurers providing their consent for us to disclose to ASIC.

That said, we think a more efficient approach would be to include a provision in the Code that provides this consent to disclose to ASIC up-front. This could be achieved by including an obligation such as:

> *The Code Governance Committee may disclose details of its investigations to the Australian Securities and Investment Commission to ensure it does not duplicate any of its impending or ongoing investigations work.*

Increased disclosure and transparency with ASIC should be carefully contemplated should enforceable Code provisions proceed. While ASIC's approach to enforceable Code provisions is not yet entirely clear, we expect that it will be critical for us to release key breach and compliance monitoring information to ASIC to support such a regime. Ensuring these disclosures can flow freely between ourselves and ASIC will be essential.

'Significant breach' and the ASIC reportable situations regime

ASIC's Regulatory Guide 78 Breach reporting by AFS licensees and credit licensees (RG 78) provides guidance for insurers on their obligation to report to ASIC certain breaches of the law.

RG 78.147 explains that insurers (as AFS licensees) must report to ASIC any significant breach (or likely significant breach) of their 'core obligations' which are defined in s912D(3) of the Corporations Act.

We do not support aligning the Code's definition of 'significant breach' with the ASIC reportable situations regime outlined in RG 78.

While ASIC's Regulatory Guide 78 (RG 78) provides guidance for insurers on reporting certain legal breaches to ASIC, it does not encompass all incidents or breaches that insurers must report as significant breaches of the Code.

The 'core obligations' listed in RG 78.148, which must be reported to ASIC, are not as comprehensive as the criteria for significant breaches of the Code. Consequently, insurers report significant breaches to the CGC that may not meet the ASIC criteria. Aligning the definitions would narrow the scope of what constitutes a significant breach under the Code and reduce the circumstances in which incidents are reported, which we do not support.

The current broader definition in the Code is crucial for maintaining comprehensive reporting obligations and accountability.

Duplication

There will be instances where the circumstances that give rise to a significant breach of the Code also give rise to a reportable situation to ASIC.

However, we receive reports of significant breaches of the Code from insurers that have not been reported to ASIC because the insurer considers the circumstances do not meet the criteria of a reportable situation as set out in ASIC's Regulatory Guide 78 Breach reporting by AFS licensees and credit licensees (RG 78).

Since the December 2022 quarter, we have referred 160 significant breach matters to ASIC. These cover the quarters December 2022 to December 2023. We will shortly report significant breach matters to ASIC for the March 2024 quarter. We engage regularly with ASIC, and they have continued to advise us that the significant breach referrals are useful, suggesting they do not represent a direct duplication of reportable situations.

While we appreciate insurers may feel there is duplication and an associated administrative burden, it is important to note that our focus and jurisdiction is different to ASIC's. While certain non-compliance may need to be reported to both, we have different purposes and focuses.

The current regime supports a broader risk coverage and increases the likelihood that potential problems or emerging issues are identified and addressed early.

Furthermore, it can deliver a more comprehensive coverage to mitigate risks. With coordination, we ensure regulatory and compliance gaps are minimised. It also reduces the likelihood of blind spots and one-off issues becoming systemic due to a lack of oversight.

No regulator or compliance monitor is resourced to address every single risk. The broader coverage provided by both is in the interest of industry and customers.

Enforceable Code provisions

It is essential that the introduction of an ECP regime does not have the unintended consequence of reducing what should be a progressive conduct model.

We are concerned that enforceability of a self-regulatory Code could lead to the industry focusing Code standards on minimum legal requirements rather than setting and striving for higher, progressive standards.

Longer term, this could lead to a far less dynamic code, slowing industry improvement.

It is crucial to balance enforcement with flexibility and the industry-led innovation that characterises an effective self-regulatory model.

Ultimately, any Code provisions chosen as ECPs should be the obligations that pose the greatest detriment to customers in areas that ASIC does not currently have jurisdiction.

Given the most serious and significant breach matters reported to or identified by us are reported to ASIC, ECPs should be the ones where ASIC feels it does not have jurisdiction to act.

Our preferred approach to enforceability is by contract. This is consistent with the Banking Code of Practice, which is contractually enforceable in its entirety.

Other feedback

Clarifying the role of industry guidelines

Standards of practice and conduct should be set out in the Code.

This enables transparent and consistent understanding of contemporary practices and ensures that insurers can be held to account for upholding these practices.

However, we understand that industry guidelines can play an important role with respect to responding to new and emerging issues that pose a risk to customers.

Where there is a need to develop industry guidelines outside of a Code review cycle, the Code should make it clear that it is within our jurisdiction to consider these guidelines in assessing compliance with the Code.

The Code should clarify the role of industry guidelines, how they interact with the Code, and that we will consider practices set out in relevant industry guidelines in our compliance monitoring activities to inform the measures we expect insurers to take to meet particular Code obligations.

It also provides assurance on whether these practices are being implemented consistently and whether they are effective in addressing particular issues or customer harm.

We consider this approach provides sufficient flexibility given that industry guidelines may:

- Vary in nature – with some guidance relating to expectations for meeting a certain obligation, while others are intended to share best practices
- Be updated from time to time to respond to industry trends and evolving industry practices, regulatory changes, or new or emerging threats of customer harm.

Ceasing to be a Code Subscriber

We have seen instances of insurers deciding to cease subscribing to the Code.

This most often happens when an insurer is not taking on any new business and running off its existing books.

This concerns us because all customers should be afforded the important protection of the Code, irrespective of a business being in run-off. Additionally, customers would have taken out their policies at a time the insurer was a subscriber to the Code.

Customers should be adequately informed if their insurer ceases to become a Code subscriber. The Code should be strengthened to include new obligations requiring an insurer to:

- Advise its customers of its decision to cease being a subscriber to the Code. This should explain that we will no longer have oversight of the insurer's compliance with the Code.
- Publish a statement on its website.

This transparency will ensure customers are adequately informed and can consider whether remaining with the insurer is the right decision.

The Charter

Clause 9.2(a) of the Charter states that we will prepare an Annual Report by 31 March each year.

We have experienced challenges in reaching this deadline in previous years. The Charter should be updated to extend this timeframe until 30 April to ensure we have sufficient time to produce a quality Annual Report compliant with the Charter.

The Charter is not clear on our ability to make a significant breach decision. The Charter does refer to our ability to 'make decisions', but it does not specify what these decisions relate to.

This is evident in the following clauses:

- Clause 1.3(b)

  *The CGC is also responsible for monitoring and enforcing compliance with the Code through receiving, investigating and **making decisions** about alleged breaches and giving Code Subscribers the opportunity to respond to any allegations that they have breached the Code;* (1.3(b))

Clause 5.4

> *Notice of decision*
>
> *(a) Following an investigation in accordance with clause 5.3, the CGC may **make a decision** in respect of the alleged breach.*
>
> *(b) A decision made by the CGC will:*
>
> *(i) be in writing;*
>
> *(ii) include a brief description of the allegation;*
>
> *(iii) include a statement that in the CGC's view the reported allegation was proven in whole or in part or was unfounded;*

(iv) if applicable, state any finding by the CGC that the Code Subscriber is responsible for serious or systemic non-compliance with the Code;

(v) include reasons for the conclusions and findings of the CGC; and

(vi) be provided to the Code Subscriber.

While this wording has not created a barrier for us, we can see a circumstance in which a subscriber may rely on the Charter to dispute a determination of a significant breach in the future.

The Charter should clearly disclose our power to determine a breach or significant breach.

Travel Insurance and material value

ASIC outlined in its letter to general insurers on 22 April 2021, that acting efficiently, honestly and fairly includes ensuring that travel insurance policies provide material value.

We support this position and recommend the Code include an obligation for insurers to provide refunds where policies provide no material value. The obligation should read:

> *We expect that travel insurers will proactively offer to cancel travel insurance policies and provide a refund of premiums paid where the policies no longer provide any material value.*

Duplicate policies

At times customers hold multiple policies of a similar nature, sometimes with the same insurer.

The Code should commit insurers to review their information and data to identify when this occurs and engage proactively with customers to clarify the need for all policies.

Appendix A: Code paragraphs that require clarity

Paragraph	Comment
38. We will have measures in place to ensure that we appoint only suitable Service Suppliers. In particular, when we appoint a Service Supplier, they must: a. hold any licence the law requires; and b. **reasonably satisfy** us that they and their employees are qualified by education, training or experience (including but not limited to whether they hold membership with any relevant professional body) to provide the required service competently and to deal with you professionally.	Strengthen the commitment by removing 'reasonably satisfy us that they and'. Service Suppliers and their employees must be qualified to provide the required services.
42. We will **take reasonable steps** to make sure that our communications are in plain language.	Strengthen the obligation by removing 'take reasonable steps to'. Define 'Plain Language', similar to the 2023 Life Code: 'A communication is in Plain Language if its wording, structure, and design are so clear that the intended audience can easily find what they need, understand what they find and use that information. Plain Language can include technical terms where these words are the most relevant or precise.'
53. If we, or any intermediary acting on our behalf, offer you Customer Credit Insurance for credit cards, home loans or personal loans, then we **will take reasonable steps to** ensure that: a. you are given clear information, before the deferred sales period starts, about the cost of the Customer Credit Insurance, the options for payment, how long it lasts and its key exclusions and limits; b. you are informed that purchasing the Customer Credit Insurance has no bearing on whether your application for a credit card, personal or home loan will be approved; and c. no binding offer of Customer Credit Insurance can be made to you until the end of the deferred sales period.	Remove 'will take reasonable steps to'. 'Reasonable steps' is too broad to provide any certainty or clarity.

Paragraph	Comment
75. We will engage an External Expert **only if we believe** they have the appropriate expertise to provide the opinion we ask them for and that they comply with the rules and regulations relevant to their area of expertise.	Remove 'only if we believe'. Insurers should only engage with External experts that have the appropriate expertise.
91. We **are committed to taking extra care** with customers who experience vulnerability. We recognise that a person's vulnerabilities can give rise to unique needs, and that their needs can change over time and in response to particular situations.	Replace 'are committed to taking' to 'will take'. 'Extra care' is vague and unenforceable.
97. If you tell us, or we identify, that due to a vulnerability you need additional support or assistance, we will work with you **and try** to find a suitable, sensitive and compassionate way for us to proceed. We will do this **as early as practicable** and we will protect your right to privacy.	Remove 'and try' and 'as early as practicable'. These words make enforcement difficult. A timeframe is needed.
98. If you tell us, or we identify, that you need additional support from someone else (for example, a lawyer, customer representative, interpreter or friend), then we will recognise this and allow for it in all reasonable ways. We will **try to** make sure our processes are flexible enough to recognise the authority of your support person.	Remove 'try to'. 'Try' is not a firm commitment. It must be 'We will make…".
100. If you need support to meet identification requirements, then we will **take reasonable measures to** support you — particularly if you are from an Aboriginal or Torres Strait Islander community or a non-English speaking background. Our approach to supporting you with verification and identification will be flexible.	Remove 'take reasonable measures to'. 'Reasonable measures' is too broad to provide any certainty or clarity.
101. **Where practicable**, we will provide access to an interpreter if you ask us to, or if we need an interpreter to communicate effectively with you. We will record if an interpreter is used or if there are reasons we are unable to arrange one.	Remove 'where practicable'. 'Where practicable' provides significant uncertainty to this commitment and is solely within the power of the insurer to decide.
116. If, after we receive your application for Financial Hardship support, we need more information from you before we can make our decision, then we will: a. tell you the information we need as **early as possible**; and b. be specific about the information we need.	Clarify the existing obligation by including a definite timeframe insurer must take action to respond to a financial hardship application. Within 5 business days is reasonable.

Paragraph	Comment
133. When we, our Collection Agent or solicitor, first communicates with you about any money owed, then we will **ensure that this communication will** provide you with information to show that the amount we are seeking to recover from you is fair and reasonable. This **may** include: a. information on the relevant loss and/or damage and the claim; b. the actual cost of completed repairs; and c. the evidence we relied on when we calculated the amount.	Remove 'ensure that this communication will' and 'may'. Commit insurers to providing the listed information to ensure transparency and inform customers about the amounts being recovered.
159. Where we authorise another person to receive and handle Complaints under paragraph 158, then: a. that person must notify us of Complaints made to them; b. they must handle Complaints in accordance with the requirements as set out in this part of the Code; c. any breach of this part of the Code by them is a breach of the Code by us; d. we will have processes in place to monitor their handling of Complaints and **take reasonable steps to** ensure that they are meeting the requirements as specified in this part of the Code.	Remove 'take reasonable steps to'. Commit insurers to ensure that any third parties authorised to handle their complaints are monitored for Code compliance.
200. To ensure our investigations are appropriately focused: a. we will ensure that any requests to you for more information, or documents, are reasonable and relevant to the claim under investigation. We will: i. **use our best endeavours to** do that in one request; ii. tell you why we need the information that we are requesting. b. when we give our Investigators and Employees authority and instructions in relation to your claim, we will: i. clearly limit the purpose of the investigation to the claim in question; ii. carefully define their scope about the type of information we are requesting and the period covering the request.	Remove 'use our best endeavours'. 'Our best endeavours' provides uncertainty to this commitment.