Submission to the Independent Review of the 2020 General Insurance Code of Practice

Date of submission: 31 May 2024

About Financial Counselling Victoria and the financial counselling sector

Financial Counselling Victoria (FCVic) is the peak body and professional association for financial counsellors in Victoria. We provide resources and support to financial counsellors and their agencies who assist vulnerable Victorians experiencing financial difficulty. We work with insurers, governments, banks utilities, debt collection and other stakeholders to improve approaches to financial difficulty for vulnerable Victorians.

Financial counselling is a free, confidential, and independent service. It provides vital help for people experiencing, or at risk of, financial hardship. Financial counsellors are uniquely qualified professionals, specially trained to deal with complex financial matters. They assist more than 23,000 Victorians each year – including newly arrived migrants and refugees, family violence victim-survivors, and particularly pertinent to this submission, people impacted by catastrophic natural disasters.

In recent years, communities across Victoria have been dealing with the aftermath of catastrophic disasters, ranging from devastating bushfires to destructive storms and floods. Financial counselling services have played a vital role in aiding the financial recovery and physical wellbeing of impacted individuals and communities.

While the impacts are experienced most severely by vulnerable and less resilient communities, households and individuals whose capacity to recover is lower, disasters create financial stress and hardship that can affect anyone, including people who have not previously needed assistance. Disasters can exacerbate underlying or unaddressed financial issues which may have been present prior to the disaster, and those financial impacts can be experienced for many years after the event.

Financial counsellors working in this space have highlighted a wide range of insurance-related issues which have caused significant detriment and additional trauma to their clients following their experiences of natural disasters, specifically in relation to standards of service from general insurers.

About this submission

We welcome the opportunity to provide a submission to the first phase of the Independent Review (the Review) of the 2020 General Insurance Code of Practice (the Code). Our submission is informed by what our members have told us about the needs of vulnerable Victorian clients who are struggling with insurance issues – mostly after a natural disaster, but more general insurance issues as well. We note that the second phase of the Review will have a specific focus on flood related topics, and intend on providing a further submission to this phase of the Review.

We give special thanks to financial counsellors Emma Brelsford, Kellie Davis, Lylia Martion, Bridget Morcom and Laura Powell for their significant contributions to this submission. We also thank members Lisa Stoddart, Leonie Cook and Kathryn Swinton for their contributions over the years and University of Melbourne researcher Dr Antonia Settle for her expertise in cash settlements.

We use several acronyms in this submission with the knowledge that the Independent Review Panel will understand these references. This includes acronyms such as ACCC (Australian Competition and Consumer Commission), AFCA (Australian Financial Complaints Authority), ASIC (Australian Securities and Investments Commission) and more.

The commentary and recommendations provided in this submission should be read in conjunction with a wide body of work already produced by FCVic on the topic of insurance, including:

- Submission to the House Standing Committee on Economics Inquiry into insurer responses to the 2022 floods
- Submission to Treasury's consultation on Standard definitions and standard cover for insurance
- Submission to the General Insurance Code Governance Committee 2024/25 Monitoring and Compliance Priorities consultation
- Submission to the General Insurance Code Governance Committee 2023/24 Monitoring and Compliance Priorities consultation
- Actions Report from the FCVic 'The Changing Face of Hardship' Summit held on 20 March 2024
- Key issues and future pathways for home and contents insurance, a summary from the FCVic 'Insurance in a Changing Climate' forum held on 26 July 2022

Further questions about this submission can be sent to achan@fcvic.org.au.

Our commentary and recommendations

As an introduction, we note that we hold reservations about the voluntary nature of the Code and the lack of substantial consequences for non-compliance by insurers. As it is, the Code is currently a 'toothless tiger', and is largely inaccessible to consumers unless they have an advocate or representative such as a financial counsellor working on their behalf.

We recommend that the Code be mandated (as has been done for credit law) to have significant effect on compliance. This should be accompanied by financial consequences for insurers that are significant and punitive enough to their profitability to make it worthwhile to comply, with associated greater powers granted to AFCA to enforce compliance. Supporting this with publication of breaches of the Code to ensure visibility will also have an informative effect for the public and incentivise compliance by insurers.

We have provided further commentary below to specific questions in the consultation paper.

2.1. Does the Code provide adequate protections to ensure customers facing financial difficulties are obtaining suitable and appropriate assistance from insurers? If not, how can it be improved? For example:
a) Should the Code adopt the expectations identified by ASIC relating to financial hardship? If not, why not?
b) Should the Code more explicitly address financial hardship in relation to the payment of premiums or distinguish between assistance available to those with short-term financial hardship, compared to those for whom financial hardship is more entrenched. If so, how?

We believe that the Code currently does not provide adequate protections for consumers in financial hardship. Financial counsellors have recommended several measures that may assist, including:

- In response to item A, the Code should adopt ASIC's expectations relating to financial hardship, specifically in improving communication of hardship assistance to consumers. The insurance industry currently lags behind the banking sector in standards of open public communication.

- In response to item B, we believe that there's a case for the Code to distinguish and explicitly address the difference between those experiencing hardship in relation to their premiums and those experiencing long or short-term hardship – however, we note that there are individual nuances that may not be easily addressed within the rigidity of the Code.

  We acknowledge that distinguishing between long and short-term hardship can be difficult in some circumstances. Sometimes it can be easily identified – a gap between jobs or a short-term illness can be short-term hardship; and permanent income reduction, long-term illness and entrenched poverty can be long-term hardship. Other times, it's difficult to know how long hardship may continue and often comes down to an individual case basis. Additionally, in the case of natural disasters, hardship that is perceived by many as being short-term can often have longtail effects that lasts for many years.

  In these circumstances, we suggest that one way in which the Code could be improved is to specifically reference the need for individualising hardship supports – a requirement for insurers to tailor their responses for each individual consumer, including reference to acceptance of the assessment of financial counsellors where the consumer has an existing relationship.

- Further measures include:

  - Creation of designated financial hardship teams in insurers who sit separately to claims and collections teams. These hardship teams should have mandated training on trauma-informed care, vulnerabilities, referrals, and more. There should be designated access to these teams for financial counsellors.

  - Improving communication of hardship options – including mandating the listing of hardship options including the National Debt Helpline on all

insurance invoices and product disclosure statements, insurer websites and apps, and any other communication channels.

This communication also needs to be proactive - where a consumer has requested hardship considerations for their insurance, they should also be referred onto the National Debt Helpline for further assistance as they are likely to be experiencing hardship in other aspects of their financial life.

- Establishing a range of short-term hardship relief options including moratoriums, payment arrangements or once-off reductions in insurance premiums. There may be verification processes required to access these options, and we recommend that these not be too onerous while ensuring that the system is not abused.
- Streamlining documentation required to verify hardship, including acknowledging that those on Centrelink benefits should only need to provide evidence of receipt of these benefits as proof of their experience of hardship and an explanation of the arising circumstance. For others, if they have already engaged with a financial counsellor, then a Statement of Financial Position should be sufficient to verify hardship and the insurer should not need to reassess a consumer's position.
- Addressing the 'poverty premium' of charging more for monthly payments when compared to annual lump sum payments. This creates further hardship for those who are already unable to pay lump sum payments due to their financial situation. We recommend that the 'poverty premium' be eliminated and that any additional charges for monthly payments should only be connected to the cost of the transaction.
- Addressing the hurdle of payment of the insurance excess for those in financial hardship with a range of payment options.

  For instance, after a natural disaster, many people can't afford to pay their insurance excess as they're busy meeting their essential needs including housing and medical costs, in situations where they may have lost employment. One financial counsellor reported an instance where an application for a waiver for the excess was declined by an insurer as they deducted it from the final cash settlement. While a simple process for the insurer, this does not represent a true commitment to hardship support.

  FCVic has more feedback to provide on the issues relating to cash settlements later in this submission.
- Inclusive and accessible product design – for instance, insurance products that are specifically designed for those on lower income brackets which cover the basic essentials but exclude extras. One example of an existing product that works well is AAI Essentials and third party car insurance – incentivising transfer to this insurance for those who can't afford comprehensive car insurance can help to prevent consumers in financial hardship from having no insurance at all.

  Financial counsellors report that where individuals can't afford insurance,

they generally stop paying it rather than looking for alternatives (e.g. fully comprehensive versus extended third party). Individuals don't 'shop around' beyond price as they are confused and overwhelmed by the different insurance products available and find it difficult to understand what they might get in a cheaper product.

- Protections for consumers who are temporarily 'locked in' to an insurer (e.g. where an insurer is completing repairs on their home or car), to ensure that premiums cannot be substantially increased during this time.
- Insurance premium support for those escaping family violence – e.g. a one month waiver on premium payments as policies can inadvertently lapse in the immediate aftermath of a decision to leave.
- Updating specific terms in the Code in recognition of additional vulnerabilities and extenuating circumstances – for instance, updating the '21 Calendar Days' under point 117. We recommend that in post-disaster situations, this timeframe should be extended to six weeks recognising that documentation may have been lost or is not otherwise accessible.
- Reviewing the definitions of Catastrophe and Extraordinary Catastrophe in the Code to reflect the human impact of catastrophic events.
- Considering partnership models to deliver additional support for vulnerable consumers – for instance, Suncorp's "CareRing" model as a partnership with Uniting provides additional expertise and professional care to support vulnerable people with essential community services.

  While we recognise that there are limitations on these models, an investment by insurers into consumers' overall wellbeing can assist to deliver better outcomes for their bottom line as consumers will be more inclined to continue engaging in the insurance market.

We acknowledge that it is not the responsibility of insurers to address premium affordability in a broader sense – there needs to be a wider systemic consideration of the health and wellbeing role that insurance plays in our society as an essential service. This service should be supported by governments where there is a service and equity gap to manage risk and deliver ongoing public and economic benefits to the community and local small business economies.

We note that a guiding comment on this question in the discussion paper raised questions about consumer personal insolvency playing a part in insurance denials.

We affirm that a past insolvency, current bankruptcy or debt agreement should *not* be relevant to eligibility for general insurance policies. These are lawful actions, and allow consumers to establish a more stable position than being in unmanageable debt. We believe that discrimination on this basis stems from beliefs that there is a character deficit on the part of the individual, however we also know the majority of personal bankruptcies have their root cause in external factors outside of individual control. More than one bankruptcy is statistically rare. We recommend that this disclosure reference be removed by insurers altogether.

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

Further to our response to 2.1, we suggest that training for insurance employees to recognise and address financial hardship should be enhanced, and perhaps standardised across the industry to ensure a consistent response regardless of insurer.

When it comes to third party debt collectors, we recommend that their conduct and adherence to the Code be the insurer's responsibility, and compliance should be dealt with accordingly. Further, third party debt collectors should still be beholden to the ACCC and ASIC Debt Collection Guidelines.

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

We recommend that per our earlier recommendation, the voluntary Code be made mandatory. This is the most likely change to have a significant effect on compliance.

2.4. Is the Code in line with community expectations regarding customer vulnerability? If not, how can it be improved? For example:
a) Should the Code promote inclusive product and service design to better address customer vulnerability? If so, how?
b) Are there other types of vulnerability or disadvantage that need to be more explicitly addressed by the Code?
c) How could the Code require or encourage better identification of potential vulnerabilities, other than at the point of claim? Should the assumption of vulnerability in the Code be reversed in certain situations such as those involving trauma? If so, how could the Code be amended to achieve this?
d) How should the Code promote enhanced responses to customers experiencing heightened levels of vulnerability, particularly during a catastrophe?

Financial counsellors have recommended several opportunities for improvement including:

- In response to item A, the Code should include inclusive product design as one of its core principles. Insurers should be compelled through the Code to provide inclusive products that have been co-designed to support vulnerable members of our community, such as those experiencing family violence.
- In response to item B, other types of vulnerability or disadvantage that should be more explicitly addressed by the Code should include:
    - Experience of a natural disaster or catastrophe
    - LGBTIQA+ consumers

- Where the consumer has had a recent bereavement or separation
- Advanced age
- Trauma as a distinct category of vulnerability. Supporting this inclusion, the Code should provide guidance on the impacts of trauma following a significant event (including a disaster) on cognitive capacity, and the extra care and additional support that this may entail, and the requirement of staff to practice at a trauma informed level of competency. We provide further information below in a separate note on trauma-informed care.

Additionally, we suggest that the Code require insurers to specifically ask the question 'Is there anything we should be aware of which may mean you require a high level of support?' every time a policy is purchased or renewed. This will ensure inclusion of any additional vulnerabilities or disadvantage not already captured in the Code.

- In response to item C, we believe that the required inclusion of an active question on vulnerability as detailed in our response above will help to ensure a regular, systematic way of identifying potential vulnerabilities on a regular schedule – upon purchase and then upon annual renewal of policies.
- In response to item D, we recommend that the Code should state that insurers must place consumers experiencing heightened levels of vulnerability in a separate specialised claims team who are trauma-informed and provide extra levels of client-centred care during the claims process. Dedicated specialist case managers should be assigned for each claim to ensure that consumers are not required to re-explain themselves to each new representative.

Per our response to item D above, we recommend that the Code require insurers to have a dedicated hardship team, trained to a specified mandated level in providing targeted, trauma-informed support and case management for those with high levels of vulnerability. Too often, we see that existing 'special assistance' teams are made up of claims managers who either aren't equipped with decision-making powers to provide appropriate supports, or who haven't been trained to provide these additional supports.

Further amendments to Part 9 of the Code should include:

- a clearer, expanded definition of the term 'extra care' in point 91, including specific examples of what this might look like in different circumstances; and
- a requirement for insurers to ensure that vulnerable consumers, particularly those with multiple vulnerabilities, will not suffer detriment due to inconsistent implementation of Part 9 of the Code.

A model that is appreciated by some financial counsellors is Suncorp's 'customer advocate' model. They note that the power imbalance between the consumer and insurer can be large, and insurmountable when the consumer is at a heightened level of vulnerability – this customer advocate model, if implemented across all insurers, can help to address this imbalance.

Insights on trauma and vulnerability

Financial counsellors supporting disaster-impacted insurance consumers are trained in Trauma-Informed Practice (TIP) and work with their clients in a way that identifies vulnerabilities and accommodates trauma-related behaviours.

They have reported seeing the following impacts of client trauma in the first 12 months following a disaster:

- poor memory, decision-making and recovery;
- being unable to make decisions in their own best interest;
- being emotionally unable to complete forms or carry out follow up; and
- making 'decisions in a fog' or in a highly anxious state that they later regretted.

They also report the ongoing triggering of client trauma by insurers through the claims process, by:

- continually asking them to detail the extent of the event;
- insensitive enquiries, stressful negotiations and disputes with insurers;
- having to return multiple times to damaged properties with assessors, experts and builders; and
- the overwhelm of re-witnessing the widespread community damage.

In some cases, this retraumatising led to certain decisions being made by clients simply to put an end to the claims process, rather than seeing the process through to a potentially better outcome.

The level of consumer knowledge and capacity expected to manage a major insurance claim successfully is well above what the average person can achieve. This is especially the case where consumers are vulnerable or are experiencing trauma. It is far too complex and challenging and insurers take advantage of this.

Financial counsellors noted that in other cases, vicarious trauma and exhaustion had developed later amongst the following demographic groups:

- impacted residents in community roles who were supporting vulnerable people with literacy and other needs;
- farmers where farms had been devastated by flood, then further hit by a severe hailstorm which resulted in complete loss of the summer crops that had been re-established earlier; and
- small business owners previously financially impacted by the COVID-19 pandemic and then experiencing flood damage or business interruption that was likely to lead to business failure.

Location and community size was also an important risk factor when it came to vulnerability. In one disaster-impacted community, the demographic was largely quite vulnerable – many elderly people with mobility issues, numerous small businesses that

may not recover, rental properties that may not be re-tenanted, low socioeconomic families with low digital literacy and low literacy impacting their understanding and completion of complex forms. Additionally, there were some clients who shared a fear of divulging their vulnerability, concerned they might be taken advantage of or that details would get out in a small town.

Financial counsellors also noted that there were bushfire impacted clients with significant post-traumatic stress disorder more than three years after an event. These clients were unable to work again, had struggled with property claims, income protection insurance claims, total and permanent disability claims, and other compounding issues (social security, government grants, and more).

We provide this note to highlight the complexity of vulnerabilities and trauma in a disaster scenario on a person, their support networks and their community infrastructure. The Code must be mindful that the insurance claim process can re-traumatise if the level of service is poorly provided. This suggests the need for sophisticated insurer methods to identify vulnerability, respond capably, triage and fast track, case manage sensitively, and refer consumers to support services throughout a claims process.

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

Referencing our opening comments, we recommend that the Code be mandated to have significant effect on compliance – a voluntary Code without significant financial consequences will simply not be sufficient in meeting community requirements when it is competing with commercial and financial interests for insurers.

Financial counsellors report that too many people are not aware that the Code exists, that insurers don't promote their participation in the Code, and that Code obligations are frequently ignored or poorly applied. They comment that insurers know that breaches of the Code are rarely reported, and that the option of making a complaint through AFCA may not be taken up given the lack of awareness, literacy, or time and effort required.

We argue that it should not require community lawyers or financial counsellors to bring about significantly improved claims outcomes – the insurance claims model should be easy to use, so that the average insurance consumer is well-equipped to self-represent throughout the whole process.

Therefore, we further recommend that the Code should include a requirement for insurers to have a readily-accessible, transparent, detailed policy on their hardship and claims processes. This should be accompanied by a requirement for insurers to provide annual reporting on this process, the number of consumers who used each stage of the process (particularly IDR & EDR), results of feedback surveys, and any other relevant information.

Supporting these inclusions, the Code Governance Committee should ensure that the mandated training that we have recommended above be required to be delivered by those who are experts in the field and are already working with vulnerable consumers, such as financial counsellors.

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

We understand that the following recommendation is outside the scope of the Terms of Reference for the Code Review Committee, but we urge the consideration of strengthening legislative requirements for good practice and consumer protections within the insurance industry. Legislated requirements will always create greater enforceability than guidance through a Code, even if mandated.

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

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

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

We suggest that both the Code and related legislation and regulatory instruments including the *Insurance Contracts Act 1984* and the *Insurance Contract Regulations 2017* require significant cross-review and cross-check given the current insurance environment and likelihood of growing demand on insurance claims.

As an example, we note that the Regulation 20 of the 2017 Regulations allow for minimum amounts of cover for prescribed contracts (including home contracts) – essentially stating that a consumer must be sufficiently indemnified for the cost of emergency accommodation. However, it's clear that this phrasing is much too general given the reported experiences of consumers post-natural disasters, and the Code doesn't reference this type of clause at all though it should be essential knowledge for any consumer.

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

We recommend that the Code provides guidance notes to insurers that align with AFCA determinations. This is particularly relevant in situations where AFCA have awarded uplifts in cash settlements to cover various contingencies and the transfer of risk.

This approach may reduce internal dispute resolution and AFCA applications to achieve the same outcomes where AFCA are involved. Financial counsellors know to ask for uplifts and can coach consumers, however recognition in the Code would ensure the insurer offers it.

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

We agree that the Code should adopt the AFCA definition of an SME as an organisation with less than 100 employees. We believe that this will assist with greater protections for SMEs, and faster dispute resolution.

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

Financial counsellors have noted a reluctance by some insurance brokers to support and advocate for their clients following a disaster and were concerned clients felt a conflict of interest existed given their commission relationship with the insurers.

We recommend that brokers should be mandated subscribers to the Insurance Brokers Code of Practice, and as such support clients in disputes with the insurer. Both insurers and brokers need to make it clear that brokers are acting for the client. The Code should be strengthened to ensure insurers take financial responsibility for disputes involving brokers they have remunerated, where they have provided poor or incorrect advice resulting in a potential financial loss.

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

We believe that the Code could ensure greater compliance with its overarching principles by expanding on these definitions. While some of the terms, for example 'timely' and 'efficient', are generally quite clear, terms such as 'fair' or 'honest' require further definition. Who defines what is fair or unfair, honest or dishonest – the consumer or the insurer? Currently, given insurance as a legal contract, 'fairness' becomes a matter for legal interpretation when parties are negotiating a claim or in dispute.

We note that unlike AFCA, insurers are not independent. AFCA's key purpose and values is to provide fair, balanced and independent decision-making in disputes between financial firms and consumers. Fairness requires complaints to be considered objectively and without bias, and by staff and decision-makers with appropriate expertise.

We would suggest that the Code focus on a definition of fairness that takes inspiration from AFCA's work, and which seeks distributive fairness (the fairness of the ends achieved) as well as procedural fairness (the means used to reach the ends).

As per our earlier recommendations, any revision to this overarching principle should be accompanied by a consideration of enforcement and compliance.

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

Yes, we believe that the overarching principle is restricted by the Code as it currently stands, which in turn, gives consumers less opportunity to claim that an insurer has breached their obligations.

We believe that there is an opportunity to include a statement in the Code along the lines of: *'The inclusions in this Code are considered to deliver a minimum service standard. Community expectations of this service standard may evolve with time. The Code should be read with the understanding that subscriber obligations should evolve along with community expectations.'*

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

We state again that there are currently insufficient consequences for breaches of the Code, which naturally results in less accountability for Code subscribers. It needs to be more clearly stated that insurers are responsible for making sure their service suppliers are capable to work with consumers experiencing vulnerability.

A financial counsellor reports seeing a client who had experienced family violence and surveillance, who was subsequently forced by the service supplier to provide male tradespeople with key access to her property, despite her advising on several occasions that it made her feel unsafe. In these circumstances, a suitable insurer representative (e.g. a woman working in the claims team, suitably trained in trauma-informed practice), could have attended onsite with suppliers given that this vulnerability has been identified.

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

Yes, the Code could be more prescriptive regarding the training required to be undertaken by staff regarding consumers experiencing vulnerability, and trauma in particular, if Code compliance is to be taken seriously. The type of training, requirements around the expertise of trainers, and the frequency of training could be set out in the Code. The guidance should extend to insurers ensuring distributors and suppliers are both competent to deal with consumers in trauma and with vulnerabilities, and competent in their technical expertise.

The Code should be more explicit about the standards expected, and coordination and oversight required by the insurer. Standardisation of expert report templates and Scope of Works templates with directions for plain language content and detail such as causation of damage (and how lack of maintenance has directly contributed) would also support consumer understanding, and we provide more information on this in a later response.

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

We have recommendations on specific sections of Part 5:

- Overall, the wording in Part 5 should be strengthened by stating that service suppliers and other agents are required to act to the highest professional standards in performing their work, and hold suitable qualifications for the specific expertise required.
- Item 38b is vague in its use of the term ‘reasonably satisfy’ – this is subjective and needs further guidance. Financial counsellors have seen evidence of insurers

choosing any supplier in times of service shortages (e.g. post a natural disaster), rather than a qualified expert (e.g. hygienist, engineer) resulting in low compliance with the Code.

- Item 41 – we note if consumers have poor experiences with an insurers service supplier, then they should have the right to request a different supplier to complete or fix the work at the insurers expense as the trust has been broken with the first supplier.

  We also recommend that this section should be strengthened to include more onerous consequences for both the insurer and the service supplier if a service supplier performs poorly and receives multiple complaints against it. This can help to maintain a higher standard of service, and prevent the insurer from opting for sub-par suppliers. This may include treating the supplier as a legal representative of the insurer, and therefore the insurer should be liable for any of their actions under the Code.

We also have some general concerns about the operation of Part 5.

The experience of financial counsellors demonstrates that service suppliers and agents appear to be motivated by retaining the contract with the insurer rather than providing a high level of service to the consumer. As such, this leads to a perceived conflict of interest, that the supplier is motivated to reduce the expenditure rather than providing a quality and fully detailed service. Consumers need to be confident that the supplier is acting ethically, without bias and be entitled to seek a second supplier quote or report from the insurer.

We have seen situations where assessors have provided sub-standard and vague reports that insurers then use to determine claims. The difficulty for the average consumer in disputing these reports through channels such as AFCA (who tend to rely on these 'expert' reports), is notable. There is a requirement for a high level of advocacy skills, comprehension, and capability to manage these disputes.

We note the difficulty for consumers in finding and funding independent experts and suppliers who are unaffiliated with insurers, especially post-disasters where services may be in short supply. We recommend the establishment of an independent panel of experts who can provide these opinions – potentially within AFCA or another similar independent consumer rights body.

Financial counsellors also note that there have been instances where the insurer will outsource the claims management process to, for instance, a loss adjuster. In fact, there have been instances of where the service supplier (claims manager) has been a loss adjuster, panel builder, engineer, hygienist and other expert! The lack of independence, oversight and transparency and risk of bias in reports is concerning.

Further, consumers may not understand that they are dealing with a completely different company, with the option of complaining back to the insurer. This can be strengthened in the Code, with a section specifically dedicated to the obligations of oversight and accountability of claim management companies.

Finally relatedly, we note that the Agent's Code of Conduct insufficiently addresses consumer protections, and all authorised representatives of the insurer should be treated

as if they are employees of the insurer and therefore subject to the Code and all relevant rights and responsibilities.

Subcontracting issues with service suppliers – a case study

A financial counsellor provides the following case study on the use of subcontractors.

After a flood event in Rochester, I saw an insurer's service supplier subcontract the work to another tradesman, who then subcontracted the work out again. This occurred to a client where the sub-subcontractor undertook structural works to the home without the appropriate council permits. This leaves the insured in an incredibly vulnerable position, as the works were outside the insurers' scope of works and the insured was asked to pay cash for the works to be completed.

We note that Part 5 of the Code does not mention the use of subcontractors at all, leaving a significant gap in protections for consumers as:

- subcontractors have no knowledge of the Code or the obligations they're under by agreeing to complete the works; and
- insurers and service suppliers could theoretically relinquish responsibility for works if things go wrong.

We recommend that Part 5 include new items on the use of subcontractors (and sub-subcontractors) and the obligations that apply to insurers, service suppliers, and subcontractors in these situations.

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

We have specific concerns on Part 6 and 7, through two different lens – disaster and family violence.

Through a disaster lens, financial counsellors are seeing issues where policies have been cancelled after a disaster-related claim. This is the result of insurers having reviewed their risk profile and deciding not to offer insurance moving forward. Understanding that there is a commercial element to these decisions for insurers, our recommendation is that there should be Code obligations relating to:

- preventing these decisions if there is an outstanding insurance claim or matter;
- a required minimum length of notice to be provided to consumers if a decision is made to no longer provide insurance;
- a requirement for the consumer to confirm that they have read and understood communications relating to the cancellation before the insurer can act; and
- a clear acknowledgement that cancellation should be a last resort, given it has implications for insurance elsewhere. If a specific serious climate related risk is evident, consumers should be offered insurance with an exclusion.

These obligations will address scenarios that financial counsellors have reported, where 1) a consumer was given one week to source alternative insurance for their home which had an outstanding insurance claim and was still awaiting repairs from the 2022 floods and 2) a consumer only found out after a second flood event within two years that the insurer had cancelled both home and contents insurance after the first flood event.

Through a family violence lens, financial counsellors hold concerns about the approach of insurers in these sensitive situations – their understanding of family violence, the design of insurance products, requirements around timeframes for actions, and more. This includes the following recommendations which should be included in the Code:

- The issue of joint insurance policies, where a perpetrator can cancel a joint policy without the other party being told or contacted before it is cancelled is a growing concern. We suggest that both parties be required to be notified and agree to a cancellation before it is actioned.
- Case management systems within insurers which are not tailored to meet the needs of people escaping family violence are problematic – for instance where consumers are required to repeat their story multiple times or provide onerous evidence of their experience. Systems should allow for files to flagged for family violence, and appropriately trained staff should be assigned to the case.
- Timeframes for actions – people escaping family violence should be allocated additional time to liaise with their insurer of any changes or updates to their policies or claims after having notified the insurer of their situation.
- The question of liability where an insured event (e.g. damage to a family home) was caused by a perpetrator. The victim-survivor should not be held liable for these damages when making a claim.

We also suggest that item 48 in Part 6 could be strengthened to support the consumer to make an informed decision in calculating the sum insured, and additional costs that might be incurred in a major claim. This includes requiring the insurer to communicate with the consumer annually regarding the amount insured and the insurers' suggested increase of cover, together with risk and cost increase justifications, and to suggest appropriate referrals (e.g. to a financial counsellor) if any under-insurance is being considered for affordability reasons.

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

We believe that Part 8 of the Code does not, in its current state, provide protections for consumers during the claims process. We suggest that the whole section be comprehensively reviewed in light of the recommendations throughout this submission. Some of the items that should be considered in this review include:

- Having a single claims manager through the whole process, especially for clients who are particularly vulnerable, to reduce the risk of re-traumatisation;

- Communication about the Code, obligations, rights, timeframes and entitlements under the Code to be mandated in all insurance communications;
- Increase timeframes for consumers to open new disputes and complaints about insurers' decisions; and
- The use of service suppliers and dependence on expert reports from those who are not truly independent (see our response to 3.5, and focus below).

Ultimately, we know that many people are scared to challenge their insurer in instances where a claim has been managed unsatisfactorily, as they believe that there will be retribution to some degree such as a forced cash settlement. The Code must be strengthened to build consumer understanding of their rights and confidence in its obligations.

Focus on the use of 'expert reports'

Financial counsellors report that 'expert reports' are often worded in a way that:

- Is vague on causation of damage, and liability, especially with regards to alleged pre-existing conditions and lack of maintenance, and ground movement;
- Makes the report appear conclusive rather than opinion; and
- Implies that there is no point in challenging the outcome.

We know that generally, people are inclined to trust an expert. However, what if the expert has their own bias and conflict of interest due to commercial concerns, as we have detailed in our response to 3.5?

Currently, the only way for a consumer to dispute an expert report is to source and commission their own expert report – in some cases, multiple reports. There are limitations to this, not only from the perspective of a financial barrier and a personal capacity barrier, but also in terms of sheer availability of appropriately qualified experts. Additionally, independence is important, however finding one not engaged by an insurer can be difficult.

We believe that the Code must allow for opportunities to dispute the findings of a report in a way that is not financially prohibitive for the consumer. An opportunity for substantial reform to strengthen independence in expert reports is to require insurers to source expert reports from an independent body. Another opportunity, though less innovative, is to establish an independent expert panel who can review existing reports where a dispute arises.

3.10 How could the Code be enhanced to improve understanding and better protect customers where cash settlements are used? For example:
a) Should the Code be more prescriptive in outlining better practice in administering the legal requirements for cash settlement payments?
b) Should paragraph 79 be extended to all cash settlement payments?
c) Should the Code mandate consideration of a contingency uplift factor for cash payments over a certain dollar value to better manage the risk of higher repair costs?
d) How could the Code assist in consumer understanding of cash settlement payments, the risks associated with the same, and the need to obtain independent advice before accepting the cash settlement?

We preface our response to this section with the acknowledgement that FCVic is currently producing a significant research and policy paper on the issue of cash settlements, led by University of Melbourne's Dr Antonia Settle. We expect to provide this paper to the Independent Review Panel as part of Phase 2 of this Review, which will look at disaster-related insurance in more depth given that we understand that the increasing prevalence of cash settlements is a systematic outcome of the intensification of climate change.

Our overarching recommendation in this section is that problematic cash settlements (forced and lowball offers) are a significant presenting issue and should have their own section in the Code. Item 79 in the Code is vague and doesn't provide sufficient detail nor protections for consumers from unnecessary and unfair cash settlements which may impact their access to policy inclusions such as emergency accommodation. We know that consumers often don't understand their rights, don't understand the transfer of risk, or how cash settlement figures are calculated, and feel powerless to challenge them.

Clear, simple, consistent communication about cash settlements is key – in multiple languages and formats. We note that the Insurance Council of Australia has produced a fact sheet[1] which is a good example of what basic information could be included by insurers in their communications with consumers – additional content related to rights, disputes and risk would help to make this a more useful document overall. Additionally, having content in other forms (e.g. short explanatory videos) explaining cash settlements and their relative pros and cons, and options for consumers, can help to reach a wider audience. This should be readily available on insurer websites, through the Insurance Council of Australia, AFCA, and other relevant bodies.

Guidelines on quality and standard of communication should be provided in the Code, so that the insurers ensure their consumers are fully cognisant of the process, risks, pros and cons of cash settlements. One option may be require a cover page to every cash settlement offer, which states:

"Warning, before signing this offer, you should seek your own independent advice from a lawyer or financial counsellor. If you have finance over the insured asset, you should contact your bank before signing this offer. Signing this document will mean you can make no further claim/s under the insurance contract and your policy will/may be

[1] https://insurancecouncil.com.au/wp-content/uploads/2021/07/CashSettlements-2-.pdf

cancelled immediately. You may not be able to source alternative insurance cover. Acceptance of this offer means you will lose your lifetime warranty on works."

Offers of cash settlement should include:

- Clear, simple language about exactly what the settlement covers;
- Information about the customer's consumer rights, especially in relation to disputing cash settlements and the right to seek assistance from a financial counsellor to discuss case settlements; and
- An uplift factor of at least 20 per cent (in line with current AFCA determinations) to account for increased repair costs given increased demand, service and materials costs, significant weather events, increased costs of rebuilding to relevant standards in areas of bushfire and flood risk, and ongoing impacts of the pandemic; and to cover contingencies and compensate for loss of lifetime warranty.

We add that an insurer should be restricted in the amount that they can deduct from a final cash settlement – premiums, excess payments, costs for independent reports and the like should be capped to either a percentage of the sum insured or the final cash settlement amount. This can help to prevent service suppliers from charging unreasonable fees for reports, and ensure that the consumer is not disadvantaged by having a majority of their cash settlement taken up by avoidable fees and charges. Also, cash settlements should allow at least 3-4 weeks for the consumer to consider the offer and seek any relevant advice.

An additional note on cash settlements in cases where there is a mortgage outstanding– financial counsellors report seeing insurers issue 'bank letters' when organising a cash settlement. Due to some automated processes at banks, this can result in mortgages paid out in full, leaving the consumer with no funds to rebuild their home or potentially unable to remortgage to complete the repairs due to changes in their circumstances (e.g. job loss after a disaster).

Measures should be put in place to avoid this risk, including standardising policy and developing information resources so that households can better understand their circumstances, better negotiate with their banks and better plan for how best to utilise the cash settlement that is ultimately available to them to secure housing stability and broader wellbeing. This requires specifying bank actions at various loan-to-value thresholds and clarifying the options available to households, including the right of households to challenge bank decisions.

For further consideration, and one that we may expand on in our response to Phase 2 of this Review, is how to best support particularly vulnerable groups, including those who don't have the capacity to project manage a rebuild (refer to our response to 2.4. on vulnerable groups), people impacted by gambling harm, or people affected by addiction. One option which we canvass in our upcoming cash settlements paper is the establishment of a support service similar to a 'service navigator' to assist them to navigate repairs.

A final note on vulnerable consumers - any cash settlements paid on joint policies ***must*** be paid into a joint account to avoid financial abuse.

Ultimately, the consumer should not be disadvantaged because they didn't engage an advocate, lawyer, financial counsellor, or AFCA through a cash settlement process.

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

Further to the comments we have already provided on experts reports in the responses above, we recommend that there should be a wholesale consideration of transparency and accessibility of these reports by consumers, reducing the use of technical jargon, ensuring that they are accurate, with detailed explanation and requiring the use of plain language.

Financial counsellors report a significant gap in consumer understanding of a 'Scope of Works' report. There is a presumption of a high level of capability, however it is clear that many do not know how to read it and do not understand that it may be added to and/or changed during the claim and build process. Additionally, financial counsellors have clients who have had an outlandish and unacceptable number of disputes of Scopes of Work (up to 14!) in a single case. A review on the causes of this need to be undertaken and addressed.

They also report delays in claims and works arising due to lack of detail – for instance, where builders provided a very simple and 'bare bones' Scope of Works on an initial visit. It necessitated multiple reattendances and variations, which caused a delay that could have been avoided had the Scope of Works been done appropriately on the first visit. Consumers are bearing the cost of these delays.

To address these issues, we suggest that the Code prescribes for Scope of Works reports:

- the use of plain English to an agreed level – for instance, to a Flesch Kincaid grade level of 8-10;
- minimum inclusion requirements for these reports;
- full costings so that consumers can make informed decisions; and
- definitions of a 'reasonable' number of Scope of Works. If it is the fault of the insurer's contractor errors that there are additional Scope of Works, then there should be financial recompense to the consumer.

We also suggest that the Code should address the issues of under and over-quoting by insurers. If a consumer obtains a quote that is more than a 10 per cent lower cost difference to the insurer's Scope of Works, the insurer should be required to reimburse the consumer for the cost of obtaining their own quote. This would assist in ensuring insurers provide reasonable, actionable quotes.

Finally, we note that use of the word 'expert' should be considered and questioned. Using wet events as an example, we don't believe that builders are fully qualified with the appropriate scientific equipment and knowledge to properly detect and report on remediation of mould. In these circumstances, a microbiologist report should be mandatory.

Additionally, should the consumer obtain an expert report (engineer or similar) which has an impact on the claim, they should be reimbursed for this cost. We understand that AFCA currently outlines this in determinations, however not all matters go to AFCA.

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

The Code should not allow insurers to vary prescribed timeframes at all.

We argue that the timeframe listed under item 71 (routine enquiries, 10 days) is too long and could be shortened. In claims where individuals are without their primary mode of transport, or living in temporary accommodation, then every delay in communication can intensify the negative impact on that individual's health and wellbeing, and financial stability.

We hold significant concerns about the timeframes noted in item 78 – especially in relation to 'Extraordinary Catastrophes'. Financial counsellors report seeing cases where insurers are 'waiting out' the consumer's access to 12 months of temporary accommodation provisions under the *Insurance Contracts Regulations 2017*. When this provision is exhausted, the insurer either breaches the Code by going over the existing timeframes, or uses this against the insured to force cash settlement of claims, offering no uplift for contingencies or transfer of risk (see our response to 3.10.). Amendments should be made to the Code to shorten the timeframe to avoid the second outcome, and increasing penalties applied to avoid the first outcome behaviour.

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

Financial counsellors report that while Part 11 of the Code has a good level of detail, there is still significant variety in the ways that insurers have interpreted this section, delivering differing quality of internal dispute resolution (IDR) schemes for consumers. Some examples include:

- requiring complaints to be submitted through an online form, so that the complainant has no record of the complaint being made. Email addresses should be provided for transparency;
- complaints being dealt with by someone without sufficient knowledge or authority – often someone within the claims team rather than a separate IDR specialist with review powers; and
- processes that result in delays acknowledging receipt of complaints, progressing complaints, and referring complaints to decision-makers.

To address the above concerns and more we recommend that the Code provide specific guidance to insurers on the following items:

- Complaints information provided by insurers to include at a minimum, three different methods of submitting a complaint, one of which should be email;
- Complaints information to provide copies of, or links to the Code for consumers to refer to;

- Complainants to receive a copy of the Code automatically when they lodge their complaint, along with accessible information about the complaint process;
- Complaints to immediately be escalated to the complaints/IDR team, rather than staying within the claims team;
- A prescribed maximum timeframe to receive a decision from IDR; and
- Specific supports provided by the insurer for consumers with identified vulnerabilities or experiencing financial hardship to access the complaints process.

Further, where a complaint is upheld, the insurer is found to be at fault, and there is a cash settlement involved, we recommend that the Code dictate that the insurer will pay penalty interest back to the date that the claim ought to reasonably have been settled. Where there is no cash settlement involved, the insurer should be required to pay to the consumer a sum equivalent to the AFCA non-financial loss prescribed amounts at the time of settlement.

We recommend that it be required for insurers to collect pre-defined data on their complaints and report the results publicly on an accessible common portal, perhaps on the ICA website, which can be referred to by consumers looking to purchase insurance policies. Other data that should be made publicly available for transparency's sake include:

- as mentioned earlier in this submission, any breaches of the Code; and
- settlement amounts granted after an AFCA conciliation, to prevent insurers abusing this system.

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

Yes, the Code should be amended to align with ASICs guidelines, as well as changes and improvements in other areas of law and regulations relating to financial services and insurers.

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

Many consumer advocates, including financial counsellors, who have been advocating for insurance clients believe that the Code is not well implemented or working in the interests of protecting insurance consumers. This was a common theme at the recent hearings for the Federal Government Inquiry into insurer responses to the 2022 floods. The argument is that the system is currently causing considerable harm, and a regulated model would be preferable.

We believe that the main issue with the Code is the voluntary nature of it, as well the enforceability and compliance. While breaches can be investigated and may occasionally be referred to ASIC, the impact of code breaches on consumers is far greater than the possible penalty to the insurer. Our introductory recommendation on making the Code

mandatory as well as enhancing compliance, monitoring, and financial consequences for breaches will make a difference.

Our response to 2.5 provides further information about the lack of consumer awareness about the existence of the Code and includes recommendations on how this might be addressed. As such, we suspect the number of Code complaints reflects 'the tip of the iceberg' – the majority of breaches would not be actioned due to a lack of knowledge about the Code and the breach, and where there is an understanding, a lack of capacity or willingness to follow a complaint through. There are significant improvements to be made by insurers on proactive communication about the Code and how to complain.

The new Industry Funding Model for financial counselling is welcomed by financial counsellors, and the contribution of the insurance sector to this fund appreciated. We hope to see this commitment from the sector be continued on an ongoing basis, and reviewed to see if the contribution should be increased to meet any increase in demand – specifically after natural disasters.

4.1. Is it appropriate for the Code to address affordability issues, such as those outlined above? If so, how might this be done without raising competition law concerns or creating an expectation that insurers will provide regulated personal financial advice?

Per our earlier comment, we acknowledge that it is not wholly the responsibility of insurers to address affordability in a broader sense and that there needs to be a wider systemic consideration of insurance as an essential service.

This comment aside, we note that affordability can be addressed by insurers in several ways, including those comments we have already made in response to 2.1 relating to payment options and other opportunities for relief. The Code can also consider how to embed transparency relating to pricing and discounts into the obligations – for instance, reforming the standardisation regime, component pricing for the purpose of easy comparison and premium reductions for mitigation measures.

We recommend that a 'resilient homes' program of buybacks and mitigation grants for all states and incentives for household level mitigation should be a key cornerstone of addressing insurance affordability issues. This should involve 'build back better' funding in insurance rebuilds and abandoning like-for-like reinstatement to increase resilience in rebuilds to reduce risk and premiums.

We acknowledge that funding schemes for household level mitigation, and government programs for resilient homes are not necessarily one that can be included fully in the Code. However, there is an opportunity to include an obligation for insurers to respond to household-level mitigation efforts with lower premiums (see our response to 4.2 below), as well as set policies to abandon like-for-like reinstatement approaches to rebuilds.

On a related issue, financial counsellors have concerns about the use of Centrepay for insurance premiums, as this may place the payment of insurance before other more pressing essentials including rent, food, and utilities. We suggest that the use of Centrepay be restricted to defined low cost policies only.

4.2. Should the Code include provisions that encourage or require insurers to respond to consumers risk-mitigation efforts where appropriate and reasonable? If so, how might the Code do this?

There is a bigger issue at hand here, relating to transparency on the calculation and costing of policies and claims. At present, these calculations are not accessible at all to a consumer, and so it makes it difficult to make decisions about undertaking any risk mitigation measures if they don't know what the impact on their insurance costs will be.

For example, many questions are asked about crime prevention measures for home insurance policies – and people can seemingly (though it's difficult to know for sure) receive a reduction on their premium depending on the measures they have taken. However, this practice doesn't seem to translate to climate risk mitigation measures, despite the obvious benefit to both the insurers and the consumer.

We suggest that if premiums could be reduced through individual risk mitigation, then this should be clearly stated in product disclosure statements or policy documents, with a cost range provided depending on the measures taken.

5.1. Should the primary audience for the Code be insurers? Or is it consumers and other stakeholders? Considering these questions, would it be appropriate to revise the structure and content of the Code to more appropriately reflect its intended audience or audiences? If so, how?

As insurers should already be aware of their obligations, we believe that the primary audience of the Code should be consumers. The Code should act as a tool for them to understand their rights, responsibilities, obligations and remedies, and as such should always be written in a plain English manner. Consideration should be given to translating the Code into multiple languages to meet the needs of those who speak English as a second (or third, or fourth) language.

We also recommend considering improving access to the Code by creating summary fact sheets for different parts of the Code, and summary headlines about the intent and purpose of each Part. These could be required to be provided to all insurance consumers with all new policies and renewals.

5.2. For which sections of the Code, if any, would more detail (similar to Part 15) be helpful and why? For example, would there be merit in providing more detail in relation to the conduct of employees, distributors and services suppliers?

Per our earlier comments, we believe that there can be more clarification relating to overall Code principles and definitions, service suppliers and agents, cash settlements, policy cancellation restrictions…and more!

5.3. What measures would improve governance of the Code and promote enhanced compliance with Code commitments? In particular:
a) Are the sanctions in Part 13 a sufficient deterrent to misconduct. Should they be strengthened? If so, how?
b) A number of the sanctions available to the Code Governance Committee are restricted to a significant breach of the Code (defined in Part 16). Should the additional sanctions in paragraph 174 apply to any breach of the Code?
c) Should the Code definition of 'significant breach' be aligned to the ASIC reportable situations regime, in RG 78 and if so, how?
d) The CGC is only able to require a Code subscriber to publish the fact that the subscriber has committed a significant breach of the Code. Should the CGC be able to name subscribers that commit a substantial breach? Should this additional sanction apply to all Code breaches? What other transparency mechanisms may better promote Code compliance?

Per our previous recommendations, we believe that all breaches of the Code should be published and made publicly available – with data on the insurer, the type of breach, the number of breaches, and penalties applied. Insurers should be ranked according to their adherence with the Code and this ranking should be made readily available to the public.

The sanctions available to the CGC should be applicable to any breach of the Code. We recognise however, that the biggest limitation for the CGC identifying and responding to breaches is resourcing. Resourcing is unable to meet increasing demand, particularly following a large-scale disaster, which results in selectiveness in its responses to breaches. This is a common tale, with AFCA experiencing similar challenges with limited resources and long waiting lists.

We suggest that the expertise of consumer advocates including financial counsellors and community lawyers could be a source for early detection of possible Code breaches. A dedicated reference group could act as a resource to alert both the CGC and AFCA of systemic issues to support early investigation.

5.4. Does the requirement to report significant breaches of the Code to the CGC duplicate or create inefficiencies related to the obligation on AFS Licensees to report reportable situations to ASIC? If so, how should this be managed given the role of the CGC in monitoring and enforcing the Code?

Ideally, there should be arrangements to share information between ASIC and the CGC to reduce duplication.

5.5. Which provisions of the Code could be considered for designation as Enforceable Code Provisions and what changes to the Code would be needed to support that?

Three provisions of the Code that could be considered for designation as Enforceable Code Provisions, after the improvements we have recommended in this submission, include Cash Settlements, Care for Vulnerable Customers, and Claims Handling.

Further Comments

Through this submission, financial counsellors have provided 24 pages worth of recommended improvements to the Code, illustrative case studies, and explanation of core systemic issues with the insurance sector.

Much of what we have said in this submission, has been said before through a number of our other submissions, papers, and documentation. We hope that in this instance, the Independent Review Panel will be able to action these important changes to protect the rights of consumers.

We acknowledge that we need successful, viable, insurance businesses in the sector – but this need not come at the expense of consumer rights and a growing power imbalance. Insurance should be an equal transaction for all parties. There is an opportunity now to level the playing field for insurers and the insured.

Thank you for the opportunity to provide this submission to the General Insurance Code Review on behalf of Victorian financial counsellors who each year, assist over 23,000 vulnerable people experiencing financial hardship.