Friday, 6 September 2024

General Insurance Code of Practice Review Initial Report Released

The independent panel reviewing the General Insurance Code of Practice (Code) has released its initial report with recommendations for amendments to the Code.

The independent three-member panel, chaired by former APRA Deputy Chair Helen Rowell, thanked all stakeholders for their valuable feedback on their first of two consultation papers.

The Review Panel received 23 submissions from across the consumer and advocacy sectors, the insurance sector, regulators and other interested parties. These submissions touched on a range of subjects including customer vulnerability, the applicability of the Code to small businesses, and ways in which the Code can be enhanced to maintain and improve customer protection particularly following major catastrophe events.

The initial report includes recommendations that address the key areas covered in the consultation paper and submissions including:

- Financial hardship
- Customer vulnerability
- How the Code interacts with the law, and clarifies or goes beyond the law
- Application of the Code to retail and wholesale insurance and customers
- Claims handling
- Emerging issues such as affordability and helping reduce risks
- The structure, enforceability and governance of the Code.

Code Review Panel Chair Helen Rowell reiterated the Review Panel's gratitude to submitters for sharing their experiences with the Code.

> "We are very thankful to all who provided submissions in response to the first consultation paper, and the thoughtful way in which submitters engaged with the themes and issues outlined in the paper," Ms Rowell said.
>
> "It is clear that the Code is an important document that supports consumers in their dealings with insurers, and clarifies for insurers the ways in which they can best support consumers."
>
> "There is an exciting opportunity to uplift and enhance protections and supports for individual and small business consumers, and my co-panellists and I look forward to working with the insurance industry on their response to our recommendations."

The Code sets minimum service standards for general insurers and is reviewed at least every three years.

The Independent Review Panel also includes consumer expert Gerard Brody and insurance industry representative Paul Muir.

A second consultation paper will be released by the Independent Review Panel towards the end of 2024.

The Insurance Council of Australia intends to apply for approval of the new Code once a new Code has been developed following the completion of the review.

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Independent Review: Initial Report

September 2024

www.codeofpracticereview.com.au

Independent Review: Initial Report

About this paper

This paper is the Initial Report for the independent review of the 2020 General Insurance Code of Practice being undertaken over 2023/4.

September 2024

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1. Background, context and process

The General Insurance Code of Practice was introduced in 1994 by the Insurance Council of Australia (ICA) as a voluntary Code. It has been regularly reviewed and updated. The 2020 General Insurance Code of Practice (2020 Code or Code) is due for formal independent review as part of the regular 3-year continuous improvement cycle (the Code Review).

The Code sets out the standards—such as honesty, openness and fairness—that general insurers commit to meeting when serving their customers. It seeks to influence industry practices across all aspects of general insurance, including product disclosure, reporting obligations, claims handling and investigations and relationships with people experiencing vulnerability.

The Code covers general insurance products such as home contents, building, car, pet and travel insurance and commercial insurance for business (not otherwise excluded). It does not cover statutory scheme insurance such as Workers Compensation, medical indemnity, motor vehicle injury, and domestic builders insurance or domestic builders warranty and indemnity. It also does not cover reinsurance, life or health insurance.

This Code Review is being undertaken by an independent three-person panel (the Review Panel) with backgrounds in financial sector regulation, consumer advocacy and the insurance industry. They are former Australian Prudential Regulation Authority (APRA) Deputy Chair Helen Rowell (Panel chair), consumer expert Gerard Brody, and industry expert Paul Muir.

The Terms of Reference for the Review Panel set out the guiding principles for the Code Review. The overarching principle is to maintain and enhance consumer protections, while also seeking to observe guiding principles of modernisation, enhancing customer experience, accessibility, effectiveness and efficiency, and providing consumer value without unnecessarily adding to claims cost pressures.

The Terms of Reference for the review highlight a focus on relevant external developments, including changing expectations and practices related to catastrophe response, financial hardship, and vulnerable customers, and the interaction of the Code with the law in light of legislative changes since the 2020 Code was implemented.

The Code Review commenced on Tuesday 14 November 2023 and is being conducted in two phases to enable insights and recommendations from the current House of Representatives Standing Committee on Economics Inquiry into Insurers' response to 2022 major flood claims (Flood Inquiry) to be considered.[1]

This Initial Report and Recommendations (Initial Report) concludes the first phase of the Code Review and provides observations and recommendations following extensive engagement with stakeholders, including the general insurance industry, Australian Securities and Investments Commission (ASIC), APRA, Australian Financial Complaints Authority (AFCA), the Code Governance Committee (CGC), relevant industry bodies and consumer representatives.

A Consultation Paper, with a list of questions for stakeholders, was released in early April 2024, with submissions requested by Friday 31 May 2024. The Review Panel accepted submissions into June and would like to thank the organisations and individuals that made

[1] House of Representatives Standing Committee on Economics, *Inquiry into insurers' response to 2022 major flood claims*, ongoing.

submissions for their time and effort in responding to the consultation. Overall, 23 submissions were received representing 33 organisations and individuals.

The Review Panel has considered the information and views submitted to it, including the information and suggestions set out in submissions, but this Initial Report reflects the views of the Review Panel. The ICA and its members have appointed the Review Panel and are funding the review, however the Review Panel is acting independently of the ICA.

The second phase of the Code Review will assess information, insights and recommendations from the Flood Inquiry (expected later in 2024). The second and final report for this Code Review may include additional findings and recommendations arising from the Flood Inquiry and will also outline any adjustments to the Code Review's first phase findings and recommendations.

The ICA and its members have indicated that they remain committed to continuously improving the Code. Hence, following receipt of the Review Panel's recommendations there will be a process whereby the ICA and its members consider each report to determine what changes should be made to the Code and prepare a revised draft of the Code. This revised Code will be submitted to ASIC for approval and ASIC may undertake further consultation. Once the Code is approved, there will be an appropriate transitional period before the revised Code takes effect, to provide time for general insurers to train staff and update their systems, processes and procedures.

The remaining sections of this Initial Report set out the Review Panel's observations on the themes and issues set out in the Initial Consultation Paper, and the Panel's Initial Recommendations. A summary of the Initial Recommendations is at Appendix 1.

2. Key areas to be considered

2.1 Financial Hardship

The Review Panel has been asked to consider financial hardship, including new developments and better practices, to ensure Code commitments are up to date with current expectations. This section addresses the following:

- Eligibility for financial hardship support
- Types of support available for those in or at risk of financial difficulty
- Measures to improve access to financial hardship support
- Promoting compliance with financial hardship commitments

2.1.1 Eligibility for support

The 2020 Code recognises that insurers have a role in assisting consumers experiencing financial difficulties. Part 10 of the Code describes people eligible for support as those who owe money under an insurance policy (including an excess), and those an insurer is seeking to recover money from because they caused damage or loss to an insured or third party. The Code specifically excludes support with the payment of premiums (paragraph 108).

Consumers with premium payment difficulties

Several submitters consider that there is a need to expand the support provided by insurers to include premium payment support. These included the CGC, the Australian Competition and Consumer Commission (ACCC) and AFCA submissions from consumer groups also urged the Code to adopt the expectations set out by ASIC in a letter to insurers in 2022, which included help to maintain premiums.[2]

In its submission, the ICA notes that not all insurers would be able to offer premium support options to existing customers, but that insurers would support a principles-based approach for how discretionary support might be offered. Others, like the Underwriting Agencies Council (UAC) and Insurtech Australia, note that financial support applied to individuals with longer term financial hardship would lead to increased pricing in other segments of the community.

The Review Panel considers that cost-of-living and community concerns relating to insurance affordability are significant, and important to address, and hence are of the view that the Code should enhance its commitments relating to financial hardship and payment difficulties. We observe that various other sectors, including banking, energy, and telecommunications, have either industry-specific commitments or legislative requirements to provide financial hardship support, particularly for those struggling to pay for essential services. The Review Panel believes that the community expects a broad, inclusive and flexible approach to financial hardship, which should include assistance in maintaining premium payments, while also acknowledging that insurers need flexibility to determine the specific mechanisms that they may make available in this regard.

Promoting a broad, inclusive and flexible approach to financial hardship

The 2020 Code includes various paragraphs about identifying and assessing financial hardship. However, it does not provide a clear, minimum standard, rather requiring insurers to have internal policies and training to help identify and assess financial hardship (paragraph 109). The 2020 Code commits insurers to only request information where it is reasonably

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[2] Legal Aid Queensland, Legal Aid NSW, Financial Counselling Victoria and the Joint Consumer Groups.

necessary to assess a financial hardship application (paragraph 115) and provides some examples of the types of evidence (paragraph 114).

In its submission, the ICA notes that there could be an agreed definition of what financial hardship means. Legal Aid NSW also call for a clear definition of premium hardship while AFCA proposes the Code could be more explicit about examples of circumstances in which hardship might arise.

The Banking Code of Practice has a well-developed section on financial hardship and includes a broad and clear definition—'financial difficulty means you are unable to repay what you owe, you expect to be unable to pay upcoming repayments, or you are experiencing financial difficulty meeting your repayment obligations' (paragraph 168). It then describes examples such as an illness or injury, loss of employment, pandemic, or natural disaster.

The Review Panel considers there would be benefit in the Code aligning with the Banking Code of Practice in this regard. This would support the goal of a broad, inclusive and flexible approach to financial hardship. Expanding financial hardship to include those who expect to be unable to pay upcoming obligations is likely to support early intervention and effective recovery.

Eligibility for urgent financial support

The Review Panel notes that Part 10 of the Code applies to both retail and wholesale insurance. However, the commitment to fast-track claims where there is urgent financial need, including making an advance payment (discussed further below), does not appear to apply to wholesale insurance, which may exclude some forms of small business insurance. Uniting provides an example of a business owner affected by the Northern Rivers floods who, with a small cash injection from his insurer, would have been able to fix up the worst of the damage and reopen his shop and then supply, in his case, carpeting to local households. Instead, he remained closed, and carpeting was supplied by businesses outside of the affected area, bringing no economic benefit to the local community.

Given Part 10 that deals with financial hardship applies beyond retail insurance, and given the important role that small businesses play in community rebuilding following a disaster event, the Review Panel considers it appropriate to extend the existing commitments to all small business insurance.

Recommendations:

1. **Paragraph 107 should be expanded to require insurers to provide financial hardship support to all customers who require it, including people who need help maintaining premium payments.**
2. **The Code should define financial hardship broadly to include where someone is unable to pay what they owe, where they expect to be unable to pay upcoming obligations or they are experiencing difficulties meeting obligations.**
3. **Paragraph 65 regarding the fast-tracking of urgent claims, including making an advance payment to help ease an urgent financial need, should be extended to small business insureds.**

2.1.2 Financial hardship support

Paragraph 123 of the 2020 Code provides examples of the types of support that can be provided to people experiencing financial hardship, including delaying when payments must be made, paying in instalments, paying a reduced lump sum, deducting any excess from claim payment, and waiving cancellation fees. The Code also recognises that insurers may release, discharge, or waive debt—however this is not an automatic entitlement (paragraph 126).

Clarifying and expanding the types of financial hardship support available

Several submitters, including the CGC, Legal Aid Queensland and the Joint Consumer Groups, consider that the Code could be enhanced by expanding the types of assistance and support insurers will consider when a customer is experiencing financial hardship. These include applying the existing types of support in paragraph 123 to premiums, removing the loading for monthly premiums, and undertaking a review of policy coverage or reassessing risk profile to reduce premiums.

Uniting suggests that where a product remains unaffordable, an insurer could consider if there are other products that they offer that would meet the needs of the customer, noting that the Design and Distribution Obligations (DDO) and related personal advice exemption enables this approach. Insurtech Australia similarly recommend that customers in financial hardship can be referred to other mechanisms offering essential products or group arrangements. Particularly for customers with more entrenched or complex hardship, suggestions included making referrals to financial counselling to help customers overcome more significant financial hardship.

The ICA and Suncorp consider that the Code should not mandate specific remedies to financial hardship.

The Review Panel agrees that the Code should not prescribe specific responses for supporting customers experiencing financial hardship, as the causes and experiences of financial hardship are diverse and require tailored responses. However, the Panel strongly recommends that the Code include a comprehensive list of potential support options that insurers may consider offering. The Panel is also of the view that the Code should commit insurers to adopting some of the listed options and being transparent about the options that they do make available. This transparency will help consumers and their advocates, and also promote the adoption of better practices in financial hardship responses. At a minimum, the existing examples in paragraph 123 should be expanded to include:

- Providing short-term premium waivers and discounts;
- Permitting a hold or deferral of premium payments;
- Removing the loading for monthly premiums;
- Reassessing the consumer’s risk profile so as to reduce premiums;
- Making available alternative products that meet the customer’s needs; and
- Providing referrals to financial counselling and related support services where financial hardship is more entrenched.

Financial hardship support during a claim

The Review Panel also considers that support should be available to consumers who have made a claim and are experiencing financial hardship, including providing options for paying the excess to progress the claim. Uniting highlighted ongoing misunderstandings where insurers deny claims due to non-payment of the excess. While section 54 of the *Insurance Contracts Act 1984 (Cth)* (Insurance Contract Act) is relevant to this scenario, it does not specifically address excess payments. Therefore, it would be valuable for the Code to clarify that claims cannot be denied solely because of unpaid excesses, ensuring a consistent approach across insurers. The Code could outline various options available to insurers in this scenario, such as deducting any excess from claim payments, waiving the excess entirely or partially, or allowing the excess to be paid in instalments.

The 2020 Code requires insurers to fast-track claims where there is urgent financial need (paragraph 64). The ICA submits that understanding and accessibility of the Code could be enhanced by adopting a definition of ‘urgent financial need’. Given the Review Panel considers that a broad, inclusive and flexible definition of financial hardship should be

adopted, the Panel also view there would be value in the Code being clearer about the nature and purpose of support where there is ‘urgent financial need’.

The ICA considers that a definition could be consistent with the provisions of the ASIC Corporations (Cash Settlement Fact Sheet) Instrument 2022/59, which refers to immediate need arising where the ‘customer expressly instruct[s] the insurer [that they] are in immediate need of a cash payment because of an insurable event the subject of the claim’. The purpose is to assist the customer purchase essential items such as food or clothing following a break-in or catastrophe such as a bushfire or flood.[3]

While the Review Panel considers that insurers should respond flexibly and proactively where a claimant expresses an urgent financial need, there would be a benefit in adopting a minimum definition focused on emergency payments to customers to meet an immediate need for essential items.

Recommendations

4. **The Code should provide a comprehensive list of potential support options that insurers may consider offering (expanded as outlined above).**
5. **The Code should commit insurers to adopting some of the listed options and being transparent about the options that they make available.**
6. **The Code should clarify that claims cannot be denied solely because of unpaid excesses. The Code should also expand on the options to pay an excess when the claimant is experiencing financial hardship, including deducting the excess from claim payments, waiving the excess entirely or partially, or allowing the excess to be paid in instalments.**
7. **The Code should adopt a minimum definition for 'urgent financial need' focused on emergency payments to customers to meet an immediate need for essential items.**

2.1.3 Improving access to support

For an institution’s financial hardship commitments to be effective, they must be communicated clearly and be easily accessible.

Promoting financial hardship information

In terms of communication, paragraph 105 of the 2020 Code commits insurers to having information about applying for financial hardship support on their websites, but it does not consider the nature of the information to be provided nor provide guidance about accessibility of the information. Compliance assessments of the existing paragraph by the CGC suggest that financial hardship information could be more easily accessible and helpful.[4]

The Joint Consumer Groups put forward a range of ways in which the commitment could be enhanced, including:

- Ensuring information is visible, easy to find, and prominent;
- Adding the availability of financial hardship support to renewals and notices of cancellation for non-payment;
- Providing distinct phone numbers and contact details for consumers to contact
- Providing financial hardship information in community languages; and
- Applying the commitments to not just websites, but also insurer phone applications (apps) which are now commonly used.

Legal Aid Queensland makes similar recommendations, while the CGC suggests that insurers should make information available through a range of channels, including customer service

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[3] Explanatory Memorandum to ASIC Corporations (Cash Settlement Fact Sheet) Instrument 2022/59
[4] CGC, *Thematic Inquiry: Information about financial hardship support in insurers’ websites*, June 2023.

channels and renewal notices. The Review Panel agrees that information about financial hardship must be widely promoted by insurers and recommends improvements be made to the Code in this regard.

Targeting financial hardship support information

The CGC notes that the onus is on customers to self-identify and seek financial hardship support, but that there can be barriers that may inhibit people from seeking assistance or engaging early. This underscores the importance of proactive communication and support from insurers.

A number of submissions recommend the benefit of including information about financial hardship support on relevant pieces of insurer correspondence, such as notices of non-payment of instalment or notices of cancellation. The Review Panel agrees that this is a reasonable and targeted communication channel.

Ensuring financial hardship application processes are flexible

The ICA also notes that there are opportunities to improve accessibility of financial hardship support by ensuring there is flexibility as to how applications are made. The Code does not appear to explicitly require financial hardship applications to be made in writing, as suggested by ICA (see paragraph 111), but the commitment might nevertheless be enhanced to respond to ICA's concern by clarifying that hardship support can be sought via a range of flexible customer service mechanisms (including via phone call or an app etc).

Overcoming evidence barriers

In terms of reducing barriers to hardship support, Financial Counselling Victoria (FC Victoria) propose streamlining documentation required to verify financial hardship, for example, acknowledging that those on Centrelink benefits should only provide evidence of benefits as proof of their experience of hardship. Paragraph 115 of the 2020 Code already commits insurers to only request information that is reasonably necessary to assess an application for financial hardship, and paragraph 116 commits insurers to be proactive in obtaining the information needed to make an assessment. However, it appears that there remain barriers to accessing support.

To help overcome such barriers, the Review Panel consider that paragraph 115 could be enhanced, as suggested by Legal Aid Queensland and the Joint Consumer Groups, to commit insurers to not ask for unnecessary documentation. This is a different standard to only asking for evidence that is reasonably necessary and should ensure that an insurer avoids requesting documentation that is not necessary, rather than requesting documentation and then considering if it is reasonably necessary.

Proactive contact at end of hardship support

A final important aspect of ensuring that financial hardship support is not only accessible but effective involves proactively contacting or engaging with consumers before the end of support options to consider if the circumstances have changed and whether any further assistance is needed. In its 2022 letter to insurers, ASIC emphasised the importance of such communication. It provided an example of support that involves deferral of premiums, and notes that one way to proactively manage the risk of consumers being unable to pay deferred premiums is to remind them of their obligations before the end of the deferral period.

The Review Panel supports adoption of accessible financial hardship practices including proactively engaging with the consumer before the end of the support.

Recommendations

8. **The Code should require insurers to make information about financial hardship support, including the types of support options available and how to access support, visible, easy to find, and prominent through a range of customer service channels (website, apps, renewal notices etc).**
9. **The Code should require insurers to provide information about financial hardship support on relevant pieces of insurer correspondence, such as notices of non-payment of instalment or notices of cancellation.**
10. **The Code should allow for requests for hardship support to be made flexibly, including online, via phone and other customer service channels.**
11. **Paragraph 115 should be amended to require insurers to not request unnecessary documentation or information as part of providing hardship support.**
12. **The Code should commit insurers to engage with a consumer before the conclusion of hardship support to consider whether assistance has been effective or whether further assistance is required.**

2.1.4 Improving compliance with commitments

In its early consultations, the Review Panel heard that while there are many effective commitments in the 2020 Code, there is not always compliance with the commitments. As such, the Review Panel is considering ways in which the code itself might improve compliance.

Third party debt collection

One area raised by submissions relates to collection by third parties, including debt collectors and solicitors, and particularly their compliance with financial hardship commitments. AFCA shared an example of this, being a systemic issue case study of ongoing debt collection taking place despite complaints being on foot. The issue affected more than 20 consumers, with the root cause being human error, indicating that the firm's processes and practices were inadequate to ensure compliance.

The 2020 Code requires insurers and their agents or solicitors to comply with the *Debt Collection Guideline: for collectors and creditors* published by the ACCC and ASIC. However, the Code has limited requirements for insurers to ensure accountability of its agents or solicitors to comply with the guideline. Part 5, which relates to standards for service suppliers, does not require insurers to monitor the activity of their agents.

This might be contrasted with requirements under the Banking Code of Practice, which requires signatories to have processes to monitor how the agent is undertaking collection activities (paragraph 188).

Several submissions identified opportunities to enhance compliance:

- FC Victoria recommends that third party debt collector conduct should be the insurer's responsibility.
- Legal Aid Queensland and the Joint Consumer Groups consider that the Code should require insurers to proactively and regularly monitor the performance of their suppliers (for example, by amending paragraph 41).
- Legal Aid NSW recommends that third party debt collectors be required to participate in mandatory training and accreditation regarding their financial hardship obligations, ethical collection practices, and customer communication skills.
- Uniting proposes the development of third-party debt collection standards, taking a similar approach to the development of Part 15 on investigation standards.

The Review Panel does not consider additional detailed standards are required, given the existing ASIC/ACCC debt collection guidelines are comprehensive. The gap appears to be one of systems to support compliance, so the Review Panel supports the proposal to require insurers to have systems to monitor debt collector compliance with the guidelines. This aligns with the approach taken by the Banking Code of Practice.

The Joint Consumer Groups raise a concern about the failure of insurers to confirm the reasonableness of debt collection claims made by third party agents. On its face, this appears to be a breach of paragraph 133 of the 2020 Code, which requires insurers (or their agents), when seeking recovery of monies, to provide information to show that the amount being asked for is fair and reasonable. This underscores the need for insurers to have systems to monitor agents' compliance with their obligations—the insurer should not just rely on the word of the agent but be able to ensure the claim is fair and reasonable.

Right of subrogation

Another area of debt recovery raised by submissions relates to collection under a right of subrogation.[5] The Joint Consumer Groups and Uniting both raise concerns, including several case studies, about insurers recovering debts from tenants for accidental damage under landlord or strata insurance policies. In each of the case studies, the consumer is not a party to the policy, is in a vulnerable position, and is not well-placed to manage the risk of accidental damage.

The Review Panel understand there has been a commitment from the insurance industry to no longer collect debts from tenants or occupants in these circumstances. Given this stance, the Review Panel consider there is benefit in the Code specifically requiring insurers not to utilise their right of subrogation over a tenant where a potential liability has arisen from a landlord of strata policy unless malicious damage was involved.

Lenders mortgage insurance

Uniting also raises a compliance issue related to financial hardship and lenders mortgage insurance (LMI). LMI protects the lender if the borrower cannot make loan payments, and the property sells for less than the owed amount.

Uniting notes that Part 10 of the 2020 Code applies to LMI insurers, but awareness and compliance may be lacking. Therefore, it would be beneficial for Part 10 to clearly state that it applies to LMI insurers. With increasing mortgage hardship, the risk of repossession and shortfall debt recovery also rises. This clarification is a low-cost way to improve compliance.

Additionally, as recommended earlier, insurers should include information about financial hardship support in their correspondence. This should also apply to LMI insurers when seeking to recover under their policies, so that consumers are aware that financial hardship support is available.

Pursuing employees

The Joint Consumer Groups and Legal Aid Queensland both raise concerns about insurers or their agents pursuing employees for the cost of damage associated with a motor vehicle accident when they are driving in the course of their employment.

While an employee is not liable for damage caused in the course of employment, disputes arise where there is a question of evidence about whether the accident occurred in the course

[5] Subrogation is a right that allows an insurer that pays a debt or obligation on behalf of an insured to step into the shoes of the insured and pursue repayment from the original debtor.

of employment. This can be an issue particularly for employees working in some more tenuous conditions (such as gig workers, or contractors).

To promote improved compliance by insurers with their commitments, the Code could require insurers to approach employers in the first instance. In the situation where employers deny liability, the Code or an industry guideline could set out the types of evidence that might demonstrate an employment relationship and link to an event in the course of employment. This will enhance protections for a class of vulnerable consumer and promote more effective dispute resolution.

Systems to monitor compliance

Another way in which insurers can promote compliance with financial hardship obligations is to ensure there are management systems to support compliance. While insurers should have management systems in place to support all aspects of Code compliance, there can be value in the Code articulating minimum requirements for the effectiveness of such systems.

This issue was identified by ASIC in its recent report on financial hardship in relation to lending.[6] In its report, ASIC identified important institutional commitments such as:

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

In its submission, the ICA notes that it has encouraged the CGC to undertake a thematic Inquiry into insurer's end-to-end processes for providing financial hardship support to customers. This would provide important insights into insurer performance against financial hardship commitments and identify better practice and recommendations to encourage continuous improvement.

The Review Panel agrees, and notes that specific quality assurance obligations in the Code can support CGC thematic inquiries.

Recommendations:

13. **The Code should require insurers to have in place effective systems that monitor and ensure compliance of third-party agents and collectors with insurers' financial hardship commitments.**
14. **The Code should specifically require insurers not to utilise their right of subrogation over a tenant where a potential liability has arisen from a landlord or strata policy unless malicious damage was involved.**
15. **The Code should clarify that Part 10 applies to insurers that provide lenders mortgage insurers. LMI insurers should provide consumers with information about financial hardship support in any communication that seeks recovery.**
16. **The Code should require insurers to seek recovery from employers where an employee causes loss in the course of employment. The ICA, through the Code or an industry guideline, should articulate standards of proof should there be disputes about the standard of employment and/or link to an event in the course of employment.**
17. **The Code should require insurers to have quality assurance systems in place regarding the effectiveness of their hardship support. Such systems should be**

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[6] ASIC, *REP 738: Hardship, hard to get help: Lenders fall short in financial hardship support*, May 2023

overseen by senior management.

2.2 Customer vulnerability

An important issue for the Code Review is customer vulnerability, and how the Code continues to meet community standards and expectations given new and emerging better practice processes. This section addresses the following:

- Use of the term 'vulnerability' and 'vulnerable consumers';
- Principles-based approach to vulnerability;
- Customer groups that may require extra care;
- Training and support measures;
- Women's financial safety;
- First Nations customers;
- Mental health; and
- Other issues relating to vulnerability.

2.2.1 Use of term 'vulnerability' and 'vulnerable consumers'

In a general sense, consumer vulnerability describes those who are especially susceptible to harm and/or are less able than others to protect their own interests, because of their overall life situation or the way in which the market operates. As described by the United Nations Conference on Trade and Development (UNCTAD):

> *'Consumers face imbalances in economic terms, educational levels and bargaining power in their commercial relations vis-à-vis businesses. Furthermore, there is a specific category of consumers who are in an even more vulnerable or disadvantaged situation, and thus require special attention.'*[7]

Several submissions to the Code Review raised concerns about the use of the term 'vulnerability'. For example, the ICA urges the Review Panel to explore whether there might be more appropriate terminology that could be inserted into the Code instead of 'vulnerability'. Both the ICA and Suncorp note that the term is stigmatising and may inhibit access to support. They propose alternate descriptions (e.g. customers requiring additional support).

The Review Panel agrees that terms like 'vulnerability' are not generally used by consumers in describing themselves, and it would be inappropriate for insurers to ask consumers if they are vulnerable. FC Victoria, for example, suggests that the Code require insurers to ask the question 'Is there anything we should be aware of which may mean you require a higher level of support?' upon insurance purchase and renewal.

However, when describing the nature of regulatory obligations, including in industry codes, there is value in a focus on 'consumer vulnerability'. This is not to say that we should be labelling individuals 'vulnerable', and provisions of the Code should be drafted in a way to avoid this outcome. Paragraph 93 of the Code, which currently says insurers will encourage consumers to tell them about their vulnerability, should therefore be reviewed. For example, it would be better for the provision to simply say that insurers will encourage customers to tell them about their circumstances so that appropriate support can be provided.

There are well-developed policy understandings of 'consumer vulnerability' with many regulators and oversight bodies adopting this term to describe their work. As described by the Essential Services Commission in its *Getting to Fair Strategy*, there is value in using the

[7] UNCTAD, *Consumer protection needs of vulnerable and disadvantaged consumers in connection with public utilities*, July 2021.

language of ‘consumers experiencing, or at risk of experiencing, vulnerability’ when communicating regulatory obligations and functions. However, in communicating about customer issues, appropriate language adapted to the community is more appropriate.

Recommendations:

18. **In redrafting the Code, language which requires consumers to identify as being in vulnerable circumstances to access support should be avoided.**
19. **Paragraph 93 should be redrafted to state: *We encourage you to tell us about your circumstances so that we can work with you to arrange the support you might need.***

2.2.2 Principles-based approach to vulnerability

Several submitters promote the benefits of the Code taking a principles-based approach to vulnerability. For instance, the ICA suggests that having non-prescriptive commitments enables insurers to provide tailored solutions, leading to better customer experiences. Likewise, Legal Aid Queensland and the Joint Consumer Groups advocate for maintaining and strengthening this broad principles-based approach to ensure flexibility and recognize that unique circumstances may need unique responses.

The 2020 Code allows for flexibility, in that paragraph 91 commits insurers to take extra care with customers who experience vulnerability, and paragraph 92 provides a list of factors which may indicate vulnerability. The Review Panel agrees that this approach can be strengthened. In a report by EY for the Customer Owned Banking Association (COBA), the authors note that:

> *[W]hile risk factors are useful in identifying people that may be susceptible to vulnerability, an approach based only on risk factors has both limitations and dangers. The limitation is that risk factors appear to not be a complete solution to identifying vulnerability. The danger is that focusing on risk factors alone may blind us to the potential causes of vulnerability, or artificially narrow the focus of protective measures.*[8]

In its submission, AFCA similarly note that anyone can become vulnerable at any time, and there is not an exhaustive set of prescriptive factors that amount to vulnerability.

In implementing a principles-based approach, several submitters pointed to existing standards that might be adopted by the Code. For example, AFCA point to the approach taken by the Financial Conduct Authority in the United Kingdom (UK). Several other submitters, including the ICA, point to the International Standard on Consumer Vulnerability (ISO 22458 Requirements and guidelines for the design and delivery of inclusive service), described further at Box 1. There is a current proposal to incorporate ISO 22458 as an Australian Standard, which will enhance its applicability to the local regulatory environment.

International Standard ISO 22458: Inclusive Service Provision – Requirements and Recommendations for Identifying and Responding to Consumer Vulnerability – Key Features

Definition and Scope

ISO 22458 defines consumer vulnerability as a state in which individuals are at a greater risk of harm due to their personal characteristics, life circumstances, or broader social factors. This standard recognises that vulnerability can be temporary, permanent, or situational.

Inclusive Service Provision

The standard emphasises the importance of inclusive service provision, ensuring that services are accessible and fair for all consumers, especially those who may be vulnerable. It promotes an approach that considers the diverse needs and circumstances of consumers.

[8] EY and COBA, *Spotlight on customer vulnerability*, December 2020.

Key Principles
The standard promotes organisational commitment to key principles at all stages of service design and delivery, including accountability, empathy, empowerment, fairness, flexibility, inclusivity, innovation, privacy and transparency.

Organisational Culture and Training
The standard highlights the necessity for organisations to foster a culture of awareness and sensitivity towards consumer vulnerability. It recommends comprehensive training programs for staff to equip them with the skills and knowledge required to support vulnerable consumers effectively.

Responsive Measures
ISO 22458 outlines practical measures that organisations can implement to respond to consumer vulnerability. These include flexible policies, tailored communication strategies, and personalised support services to ensure that vulnerable consumers receive the assistance they need.

Continuous Improvement
The standard encourages organisations to adopt a continuous improvement approach, regularly reviewing and enhancing their practices based on feedback, performance data, and emerging best practices in the field of consumer vulnerability.

The Review Panel agrees that ISO 22458 is a key development in community understanding and expectations with respect to vulnerability. The insurance industry could take a leading role by requiring insurers to meet the requirements and guidelines set out in ISO 22458 through the Code.

Alternatively, the Code could adopt key aspects of the standard, such as the principles of inclusive design and organisational commitment to a proactive, outcomes-focused approach. At a minimum, this should require insurers to design customer service and claims processes to be inclusive, that is, accessible and usable by the greatest number of consumers possible. The Code should similarly require insurers to have a range of free, easy-to-access contact channels so that consumers can choose their preferred method of communication for enquiries and complaints. This could also help deal with what the Joint Consumer Groups call 'engineered insincerity'—where the adoption of technology in customer service systems lacks empathy and builds discontinuity in service and resistance from customers.

Adopting a modern, principles-based approach would provide flexibility, foster more inclusive service cultures, and help insurers meet regulatory obligations focused on consumer-centric product design and distribution.

Recommendation

20. **The Code should adopt a broad definition of vulnerability: where someone who, due to their personal circumstances and market practices, is especially susceptible to harm.**
21. **Paragraph 91 should be amended to require insurers to comply with ISO 22458.**
22. **Alternatively, the Code should require insurers to demonstrate organisational commitment to improving outcomes for consumers in vulnerable circumstances by following the key principles in ISO 22458, including:**
    - **Requiring insurers to design customer service and claims processes to be inclusive; and**
    - **Requiring insurers to have a range of free, easy-to-access contact channels so that consumers can choose their preferred method of communication for enquiries and complaints.**

2.2.3 Customer groups that may require extra care

As part of a principles-based approach to vulnerability, there is benefit in the Code continuing to identify risk factors of vulnerability. Risk factors can play an important role in helping to identify where vulnerability may arise. Paragraph 93 of the 2020 Code provides a helpful range of risk factors, with several submitters suggesting additions to this list.

The inclusion of risk factors should not act as a checklist or definition of vulnerability but can, for example, help frontline staff identify what causes or contributes to vulnerability. Additionally, it can help insurers determine when to assess if customers experiencing vulnerability need additional support or extra care.

The ICA suggests two new factors be added to paragraph 93, being 'sexual orientation, gender identity and sex characteristics'; and 'trauma'. It also suggests the existing 'family violence' factor be updated to explicitly mention financial abuse as a type of family violence, noting this would be consistent with the National Plan to End Family Violence Against Women and Children 2022-2032 which also has a focus on addressing financial abuse. These additions are supported by several other submissions, including the CGC and consumer groups.

The factor of 'sexual orientation, gender identity and sex characteristics' responds to a 2022 report from the Victorian Pride Lobby which found that LGBTIQA+ inclusion is not effectively met by insurer practices and commitments.[9] The report provided examples of several customer groups who experience insurance exclusion or discrimination, including people living with HIV, people with a variation of sex characteristics, trans and gender diverse people and sex workers.

Including 'trauma' as a risk factor is important, especially considering recent catastrophes. The ICA-commissioned Deloitte review, and its final report *The new benchmark for catastrophe preparedness in Australia* (Deloitte Report), recommended that insurers review the effectiveness of how they define, identify and support vulnerable customers during catastrophes.[10] Deloitte noted that, after a large-scale catastrophe, most customers will be vulnerable in some way. Similarly, the CGC recommends that, during a catastrophe, insurers should assume that customers in affected areas are experiencing vulnerability. This theme has also been highlighted in the Flood Inquiry.

Several submitters caution against an approach that presumes vulnerability for every customer who has experienced trauma. The ICA suggests it would not be operationally feasible for insurers to quickly identify and prioritise all customers. The UAC adds that such an approach might lead to unwanted intrusion and increased stress for customers.

The Review Panel considers that insurers should use a "risk factor" approach to identify customer groups that may experience vulnerability, rather than automatically assuming vulnerability. This approach is helpful in identifying those who might be at risk. Insurers should actively engage with customers to assess their needs and determine if any additional support is necessary. As noted, this should be done in a way that supports customer engagement and does not require a customer to identify as vulnerable. For example, insurers should ask customers if they are experiencing difficulties; confirm the customer's understanding; ask customers if they are worried; or ask customers if the insurer has done something wrong or could do something better.

Beyond the additional factors suggested by ICA, Legal Aid Queensland and the CGC suggest adding risk factors relating to cognitive impairment and elder abuse. FC Victoria and the Joint

[9] Victorian Pride Lobby, *Worth the Risk: LGBTIQA+ experiences with insurance providers*, June 2022.
[10] Deloitte, *The new benchmark for catastrophe preparedness in Australia*, October 2023.

Consumer Groups also recommend recent bereavement or separation as an additional factor. Elder abuse and cognitive impairment were included in the equivalent provision of the 2025 Banking Code of Practice following the Australian Law Reform Commission inquiry into Elder Abuse.[11] This inquiry found that financial institutions are in a good position to detect and prevent financial abuse of their older and at-risk customers. As such, the Review Panel supports these factors being added to paragraph 93 of the Code.

Recommendations

23. **The risk factors 'sexual orientation, gender identity and sex characteristics', 'trauma', 'cognitive impairment', 'bereavement' and 'elder abuse' should be added to paragraph 93.**
24. **'Family violence' should be expanded to 'family violence including financial abuse' in paragraph 93.**
25. **Where risk factors are present, insurers should specifically ask consumers about their circumstances and whether any assistance or extra care is required to help them engage with their insurer.**

2.2.4 Training and support

The 2020 Code requires insurers to have internal policies and training relating to customer vulnerability (paragraph 96), and to try to provide customers experiencing vulnerability with additional support and assistance as early as practicable (paragraph 97).

Several submitters emphasise the need for policies and training to promote trauma-informed responses. Trauma-informed responses involve educating staff to understand and recognise the effects of trauma on individuals. These responses ensure that services are provided in a way that is sensitive to the needs of those who have experienced trauma, promoting safety, empowerment, and healing. The goal is to create an environment where vulnerable consumers feel understood and supported, minimising the risk of re-traumatisation, such as having to repeatedly recount the incident that led to their claim in each interaction with the insurer. Given that insurers often deal with customers following catastrophes or personal calamities, the Review Panel believes there is value in expanding the commitment in paragraph 96 to include trauma-informed policies and training.

Since the introduction of the 2020 Code, the Review Panel understands that many insurers have promoted compliance with Part 9 on customer vulnerability by flagging customer accounts, with consent, where vulnerability has been identified. This enables insurers to provide appropriate support to customers and also assists in preventing customers having to repeatedly recount the issue or barrier they experience. The Review Panel considers this is good practice and consider it should be appropriately incorporated into the Code.

In relation to support and assistance, several submitters indicate that the Code could be enhanced by clarifying the nature of support and assistance and requiring that it is provided in a timely way. For example, FC Victoria calls for an expanded definition of ‘extra care’ and suggests that the Code require specific hardship or specialist assistance teams with additional training. It also points to the ‘customer advocate’ model which has been adopted by banks as a support measure which can help promote good responses to customer vulnerability.

[11] Australian Law Reform Commission, *Elder Abuse—A National Legal Response (ALRC Report 131)*, June 2017.

The Review Panel considers that insurers should have flexibility to identify and design additional customer support measures. However, there would be benefit in the Code requiring insurers to set out clearly on their website and in relevant customer communications the types of additional supports they make available. This might include providing additional support through claims processes, paying advance amounts for claims, or helping a customer raise a complaint.

2.2.5

Recommendations

1. **Paragraph 97 should be expanded to include trauma-informed policies and training.**
2. **Insurers should take appropriate steps to record, with consent, personal information to help support people experiencing vulnerability.**
3. **Insurers should set out clearly on their website and in relevant customer communications the types of additional supports they make available to customers experiencing vulnerability.**

Women's financial safety

The 2020 Code requires insurers to publish a family violence policy on their website. This commitment has contributed to much greater insurer awareness and improved responses to customer risks associated with family violence and economic abuse.

Several submitters, however, consider that there are opportunities for the Code to go further. For example, the ICA's *Guide to Helping Customers Affected by Family Violence* includes more specific requirements regarding the protection of private, confidential and personal information; the referring of customers affected by family violence to specialist services; and training to assist insurer staff identify, support and avoid harm to customers affected by family violence.

Currently, the guide is voluntary for insurers. Both the CGC and the Joint Consumer Groups consider that the Code should require compliance with key elements of the ICA's Guide. In short, this would involve the Code enhancing paragraph 95 regarding family violence policies to include some specific minimum standards. A supplementary submission from Financial Rights Legal Centre (FRLC) references recent research, which shows that while there are some improvements in relation to family violence policies, not all family violence policies are meeting the requirements of ICA's Guide, and that some policies have slipped backwards.[12] FRLC suggests that this underscores the need for mandated minimum standards.

The Review Panel considers this would be a sensible evolution of the Code and contribute to it meeting better practice standards. At a minimum, the provisions of the Guide that should become mandatory are:

- Clause 16, which includes a paramount priority that whenever family violence is identified or suspected, the safety of the customer affected by family violence and their family is protected;
- Clause 17 which sets out minimum content for family violence policies; and
- Clauses 27-33 which imposes requirements to protect private and confidential information.

Beyond customer service elements, there is also a growing recognition that insurance policies need to be designed to protect women's financial safety. Several submitters pointed to the recent *Designed to Disrupt* report published by the Centre for Women's Economic Safety which made several relevant recommendations, including:

[12] Financial Rights Legal Centre, *Family Violence and General Insurance: Updated Desktop audit of family violence policies*, August 2024.

- Treating joint insurance policies as composite when advised of separation or divorce—so a perpetrator may not easily remove a victim-survivor from a policy thereby risking coverage. While section 20 of the Insurance Contracts Act enables an insurer to provide benefit to those not named in a policy, clarifying this standard in the Code is likely to lead to greater consistency across the industry;
- If a joint policy is cancelled or not renewed by a perpetrator, leaving a victim-survivor uninsured (especially if the perpetrator then deliberately damages the insured asset), the policy should be reinstated when a claim is made;
- The introduction of 'conduct of other' clauses which allow for property damage because of family violence (and other issues such as mental health) to be paid within the policy, rather than via an ex-gratia payment, avoiding a decline being on the customer's record; and
- Ensuring all parties have access to indemnity where cash settlements are made to co-insureds, and provide mediation where parties are unable to agree.[13]

The Review Panel agrees that the Code would better meet contemporary community expectations regarding risks and harms associated with family violence should the above be incorporated.

In its submission, the ICA warns against the Code being updated in a way that might restrict effective responses to risks and harms associated with family violence. The Review Panel considers that updated commitments can be drafted in a way that allows for flexibility by focusing on the outcomes to be achieved, rather than prescribing how this might be done. The recommendations below provide for a suggested approach.

Recommendations:

4. **The Code should require insurers to comply with key requirements of the ICA guide to helping customers affected by family violence.**
5. **The Code should require insurers to:**
    - **Ensure continuous protection of all insured parties in situations of relationship breakdown, for example by treating joint policies as composite;**
    - **Reinstate policies and provide coverage for claims resulting from deliberate actions by a perpetrator that leave victim-survivors uninsured;**
    - **Ensure policies cover property damage due to family violence within the standard terms; and**
    - **Guarantee fair access to indemnity for all insured parties in the event of cash settlements.**

2.2.6 First Nations customers

Paragraph 100 of the 2020 Code commits insurers to supporting First Nations customers (and others from a non-English speaking background) with identification requirements.

Since that provision was adopted, the Australian Transaction Reports and Analysis Centre (AUSTRAC) has published updated guidance to help financial institutions adopt a flexible approach to assist customers to use alternative methods to verify their identity. For First Nations customers, this may include a referee statement, an indigenous community identity or organisation membership card, or correspondence from a government's authority that shows the customer's name.

The Review Panel considers it would be useful for the Code to specifically mention the AUSTRAC guidance given the pivotal role it plays in customer identification, noting that both

[13] Centre for Women's Economic Safety, *Designed to Disrupt: Reimagining general insurance products to improve financial safety*, March 2024.

the Life Insurance Code of Practice and the Banking Code of Practice specifically mention the AUSTRAC guidance.

As part of its guidance, AUSTRAC also urges financial institutions to provide customers the option to advise if they identify as Aboriginal and Torres Strait peoples. This helps institutions determine whether a flexible approach to identification may be required. The Review Panel considers this could become a commitment in the Code and serve to help insurers understand their customer and provide appropriate services. It may also lead to insurers setting up dedicated call lines or specialist teams to support First Nations customers.

Several submitters consider that the Code could also introduce additional commitments to support First Nations customers. For example, Legal Aid NSW and the CGC suggest insurers commit to cultural awareness training for staff who may assist First Nations customers. The Joint Consumer Groups and the CGC recommend that interpreter services be extended to First Nations customers who do not speak English as their first language. More broadly, there are calls for flexibility for customers living in remote areas who may require additional assistance or time. For example, in its submission, the Joint Consumer Groups identified that First Nations customers in remote areas may need more flexibility for rental cars and repairs. Both the Banking Code of Practice and the Life Insurance Code of Practice include such provisions, and there would be value in the General Insurance Code of Practice having a similar commitment.

Recommendations:

6. **Paragraph 100 of the Code should be updated to reference AUSTRAC guidance regarding customer identification.**
7. **Insurers should ask customers whether they identify as Aboriginal and/or Torres Strait Islander, and seek consent to retain this information, to enable flexible and tailored services.**
8. **Cultural awareness training should be provided for staff who assist First Nations customers.**
9. **Paragraph 103(a) should be updated to clarify that interpreting services includes interpreting for First Nations customers who do not speak English as their first language.**
10. **Insurers should commit to provide additional flexibility and time for customers in remote and regional areas.**

2.2.7 Mental health

Paragraph 104 of the 2020 Code includes specific commitments to support customers who have a past or current mental health condition. These commitments relate to product design and fair treatment. The ICA has also published a *Guide on Mental Health*, which outlines better practices insurers should consider in meeting their Code requirements.

In its submission, Public Interest Advocacy Centre (PIAC) calls for incorporation of the guide into the Code as clear commitments by insurers to adopt practices outlined in the guide. PIAC says that insurers do not consistently follow the ICA's Guide on Mental Health in decisions to decline cover for pre-existing mental health conditions, pointing to research from CHOICE that suggests some insurers may not be complying with requirements when offering travel insurance.[14]

The Review Panel commends the ICA for publishing the Guide on Mental Health, which provides helpful guidance as to how insurers can meet better practice principles to support customers with mental health conditions. However, the Review Panel agrees with PIAC and the Joint Consumer Groups that there is benefit in requiring insurers to comply with the Guide

[14] CHOICE, *Why are travel insurers still denying mental health cover*? (Web Page, 19 December 2023).

through the Code. This would enable the CGC to promote better practice by monitoring compliance more effectively and open the opportunity for sanctions for significant breaches, thereby promoting robust compliance. The Review Panel notes the recommendation from the Victorian Equal Opportunity and Human Rights Commission that compliance with the guide be mandatory and enforceable.[15]

Where an insurer cannot provide cover for a mental health condition, the 2020 Code commits insurers to inform customers about their right to ask for the information relied on when assessing their application. PIAC raises concerns that the information provided is often not sufficient to enable a person to understand whether the decision was reasonable. The Review Panel considers that insurer transparency is essential to building community trust, so agrees that the relevant provision should be amended to require insurers to provide sufficient information to enable a person to understand whether the decision to decline cover or provide cover on non-standard terms is reasonable, such as directly providing the relevant actuarial or statistical data (or a summary thereof) on which the decision was based. This will contribute to transparency and promote community trust that insurers are complying with disability discrimination laws.[16] A related issue is also discussed at section 4.4.10 below.

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[15] VEOHRC, *Fair-minded cover: Investigation into Mental Health Discrimination in Travel Insurance* (Report, June 2019), 12.
[16] The Review Panel notes that section 89 of the *Equal Opportunity Act 1984* (SA) makes it unlawful for an insurer to fail to notify an insured of their ability to request a summary of actuarial or statistical data which forms the basis of discrimination.

This level of transparency may also serve to address concerns raised in submissions about some insurers which decline cover or impose exclusions or premium loadings for people living with blood-borne viruses. The Joint Consumer Groups and the CGC note that such an approach may not be justified, particularly where conditions are being effectively managed through treatment. This issue should be able to be addressed through disability discrimination laws, and barriers to fair treatment may be overcome through improved insurer transparency.

Recommendations:

11. **The Code should require insurers to comply with the ICA Guide on Mental Health.**
12. **Paragraph 104(d) of the Code should be updated to require insurers to provide sufficient information to enable a person to understand whether a decision to decline cover or provide cover on non-standard terms is reasonable, such as directly providing the relevant actuarial or statistical data (or a summary thereof) on which the decision was based.**

2.2.8 Other issues relating to vulnerability

Submissions to the Code Review have highlighted instances where insurer questionnaires or application processes include questions that are potentially irrelevant to the risk being insured. Additionally, they noted that some questions are asked in a manner that lacks compassion, which can lead to stigmatisation.

For example:

- Some insurers ask, as part of financial history information, whether the consumer has experienced a personal insolvency event (such as bankruptcy or debt agreement), where this is unrelated to the risk being insured;
- Some insurers ask seemingly irrelevant questions regarding marital status;
- Some insurers ask questions that may not be inclusive when it comes to sex, gender, and sex characteristics, for example not providing non-binary options for gender and titles; and
- Some insurers ask questions about health conditions, such as Hepatitis C, which demand unreasonably extensive information. This can risk non-disclosure.[17]

Paragraph 45 of the 2020 Code says that when assessing insurance applications, insurers will ask for and rely on information and documents only if they are relevant to their decision. Given the continued asking of potentially irrelevant questions, the Review Panel considers there would be benefit in this provision of the Code being strengthened so that, in questionnaires and applications processes, insurers collect only information that is necessary to assess and insure the risk presented by the customer. Insurers should also ensure that they ask relevant questions sensitively, particularly considering the risk factors relating to vulnerability.

This approach would address the concerns outlined above by setting a principle or norm of conduct, rather than prescribing approaches insurers should take in relation to particular types of questions. It would also show respect for a customer's privacy and circumstances, fostering trust. Additionally, sensitive questioning helps prevent stigmatisation of customers, particularly those who may already be in vulnerable circumstances. Ultimately, this will help the insurer by focusing on relevant information, enabling the streamlining of processes, and enhancing overall customer experience.

[17] Sean Mulcahy et al, *Insurance discrimination and hepatitis C: Recent developments and the need for reforms*, Insurance Law Journal, vol 32, issue 2, November 2022.

Section 2.2.3 above, and recommendation 25 in particular, suggests that insurers should ask customers about their circumstances to identify any need for extra care or support. This should not conflict with the principle that insurers should limit the collection of information to what is necessary for assessing the insured risk. The key distinction lies in the context and intent of the inquiry. When assessing an insurance application or issuing a questionnaire, insurers should focus on gathering information strictly relevant to the insured risk. However, once a customer has been identified as potentially vulnerable—whether through self-identification or the recognition of risk factors—it is appropriate for insurers to inquire more deeply into the customer's situation to offer the necessary support, which will generally occur when they are already a customer and in relation to claims. These inquiries should be voluntary and carried out with sensitivity, ensuring that customers are not compelled to disclose more information than they are comfortable with.

The ICA, in its submission, suggests an addition to paragraph 45 of the Code to allow insurers to also ask for information about the customer's asset or risk to assist insurers to improve their products and services. The ICA considers that adjusting Code paragraph 45 in this way would enable insurers to innovate and uplift the design and development of general insurance products so they continue to evolve to reflect developing risks as a result of changing consumer behaviours.

The Review Panel considers there is a balance between requesting relevant information to enable an insurer to assess an insurance application and placing onerous obligations on consumers to provide such information.

While the Review Panel considers there is some merit in ICA's submission, the Panel recommends that paragraph 45 is not amended in this manner. The Review Panel further notes that claims and complaints data that is likely to be readily available should assist insurers in ensuring general insurance products continue to meet the needs and financial requirements of consumers.

Recommendations:

13. **Paragraph 45 of the Code should be updated to require insurers, in questionnaires and application processes, to only collect information that is necessary to assess and insure the risk presented by the customer.**
14. **The Code should require insurers, in questionnaires and application processes, to ensure sensitivity and avoid stigmatisation.**

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3. The Code and the law

The Initial Consultation Paper outlined a number of issues on which views were sought in relation to the interaction of the Code and the law, given the material legislative changes that have been made since the finalisation of the 2020 Code. This section addresses the following:

- How the Code works with the law;
- How the Code can clarify and go beyond the law; and
- Application of the Code to retail and wholesale insurance and customers.

3.1 How the Code works with the law

The Code is designed to work with laws applying to the general insurance industry, specifically financial service laws. If there is any conflict or inconsistency between the Code and any law, then that law prevails.

Paragraphs 18-20 of the Code provide a framework for how the Code is designed to work with the law.

Since the introduction of the 2020 Code, there has been substantial regulatory change impacting the general insurance sector. The Review Panel viewed that, to ensure the Code remained relevant, it was appropriate to consider whether certain paragraphs of the Code impacted by regulatory changes required amendment.

Submissions generally consider that the Code should continue to work with the law, rather than be silent on areas where the law and the Code interact.

There was also broad support that the Code should go beyond the law in areas where such measures provide the greatest benefit to consumers, including detailing the minimum standards that insurers will undertake to meet the requirements of the law or to provide clarification (refer in particular to the submissions from Legal Aid Queensland and the Joint Consumer Groups).

The ICA notes in its submission that inconsistencies between the Code and the law may contribute to operational complexity because the Code commitment might be expressed in a slightly different way to the law.

In their submissions, both AFCA and the CGC point out that altering the Code to remove overlap with the law could unintentionally lead to a narrower mandate for the CGC and limit AFCA's ability to consider the standards set in the Code when resolving complaints.

The Review Panel’s view is that the Code should continue to promote good industry practice by exceeding legal requirements where there is consumer benefit to do so and providing clarity about how insurers should meet legal requirements. In particular, paragraph 18 could be framed to provide guidance on how the Code works with the law to avoid operational inefficiencies and inconsistency. Any consideration of removing a Code provision to avoid duplication with the law must be balanced against the ability of the CGC, AFCA and others to perform their role and the overarching Objectives of the Code.

3.2 How the Code clarifies or goes beyond the law

The Review Panel has considered the paragraphs covered below that have been impacted by recent changes to the law.

In addition, Part 11 of the Code (Complaints) and paragraph 79 (Cash Settlements) are considered in sections 4.4.5 and 4.4.10 respectively, of this report.

3.2.1 Core obligation: paragraphs 21 and 22

Paragraph 21 requires Code subscribers, their Distributors and Service Suppliers to be honest, efficient, fair, transparent and timely in their dealings with customers.

Several submissions note the importance of paragraph 21. The CGC advised that paragraph 21, from the commencement of the 2020 Code until 30 April 2024, accounted for 43 percent of all significant breaches of the Code.

Some submissions consider that paragraph 21 duplicates the Australian Financial Services Licensee (AFSL) general obligation 'to do all things necessary to ensure that financial services are provided efficiently, honestly and fairly' and should be removed. The Review Panel does not share this view and notes in INFO Sheet 253 *Claims handling and settling: How to comply with your AFS licence obligations* (INFO 253), ASIC states 'Although not mandatory, subscribing to and complying with a relevant industry code of practice, where available, is a strong indicator of your commitment to raised standards that complement the legislative requirements.'[18]

The Review Panel considers paragraph 21 is an important overarching obligation and should be retained in the Code. Other paragraphs of the Code set standards at certain stages of the customer interaction or based on specific activities. The Review Panel considers that an overarching obligation complements these specific requirements and clarifies the standard required in all dealings with customers, including customers experiencing vulnerability.

Paragraph 22 of the Code sets out how subscribers will meet the obligation in paragraph 21. In early consultations, some of those consulted indicated that paragraph 22 is ambiguous. For example, on one interpretation, paragraph 22 may be viewed as restricting the operation of paragraph 21. The Review Panel does not consider that this is the intent and suggests that paragraph 22 be amended to make that clearer.

Recommendations:

40. **Paragraph 21 should be retained and amended to clarify that it operates alongside other Code paragraphs.**
41. **Paragraph 22 should be clarified to make it clear that it does not limit the general obligation in paragraph 21.**

3.2.2 Standards for distributors and employees

Paragraphs 28 and 38 of the Code contain education and training requirements for Distributors and Service Suppliers, respectively. Paragraph 28 includes similar requirements for Employees involved in distribution.

The Code is not prescriptive in the training required but rather says 'appropriate education and training'.

The CGC, Queensland Small Business Commissioner, Legal Aid Queensland, FC Victoria and the Joint Consumer Groups called for specific training to be prescribed, especially in respect

[18] ASIC, INFO 253 *Claims handling and settling: How to comply with your AFS licence obligations* (6 May 2021)

of consumers experiencing vulnerability and trauma. This was noted as a particular area where consumer complaints often arise and that consumer experiences could be improved through more specific training obligations in the Code.

Suncorp, in its submission, observed that paragraphs 28 and 38 are more specific than the law, and explicitly require Code training.

The Review Panel notes that representatives of AFSLs must be adequately trained and competent to provide financial services. Nevertheless, the Review Panel considers that there is benefit in the Code setting out additional education and training requirements, while not being overly prescriptive in relation to the nature and scope of training that may be appropriate.

Where Distributors and Service Suppliers are part of a trade or professional association, there is merit in the Code requiring such suppliers to meet educational standards relevant to their association. For example, the Australian Institute of Chartered Loss Adjusters referred to the education requirements for loss adjusters in its submission.

Recommendations:

42. **The Code should include an overarching obligation for education and training requirements for all Code Subscriber Employees, Distributors and Service Suppliers.**
43. **The requirements should stipulate that education and training must include:**
    - **the Code;**
    - **the products and services provided by the Code Subscriber;**
    - **dealing with customers experiencing vulnerability, including trauma-based training (also see recommendation 26); and**
    - **complaint management, including more advanced training for Employees in specialised internal dispute resolution or external dispute resolution roles.**
44. **In addition, the Code should require that Distributors and Service Suppliers receive education and training to a standard that is considered relevant to the trade or profession that they operate within and in accordance with the requirements of any relevant industry body.**

3.2.3 Claims handling as a financial service

The Review Panel notes that the *Corporations Act 2001 (Cth) (*Corporations Act) has been amended to include the provision of claims handling and settling services as a financial service. At the time of the amendment, ASIC issued INFO 253 for anyone who provides claims handling and settling services for insurance products regulated by ASIC. The Review Panel has considered Part 5 of the Code in respect of this regulatory change and INFO 253 and is of the view that the Code will complement the changes to the law, particularly should other recommendations of the Review Panel be adopted.

3.2.4 Design and distribution

Paragraph 43 of the 2020 Code requires insurers to have a publicly availably policy on their approach to the development and distribution of products for appropriate target markets. This requirement was adopted prior to the enactment of DDO in the Corporations Act.

The ICA consider that paragraph 43 should be removed as it may be overlapping and create compliance complexity. However, the Review Panel consider that there would be benefit in the requirement in the Code being revised to elaborate on how insurers could meet the statutory requirements. This would ensure the provision is not duplicative, but rather can be drafted so as to help insurers meet or exceed the regulatory requirements.

For example, Legal Aid NSW recommend that the Code could require insurers to regularly obtain customer feedback and conduct product testing to ensure products continue to meet the needs of retail clients. Such an approach would provide robust commitments and help

insurers meet requirements relating to the review of target market determinations under section 994C of the Corporations Act.

Similarly, the Code could set consistent review triggers for particular classes of insurance. ASIC's Regulatory Guide 274 identifies that review triggers relevant for insurance include product claim ratios; the number, nature and magnitude of paid, denied and withdrawn claims; the number of policies sold, including penetration rates; policy lapse or cancellation rates; average claim duration; and the nature and number of complaints and complaint trends. Given public concern about insurance claims delays, the Code could, for example, set a benchmark for average claims duration that require insurers to trigger target market reviews should the benchmark be exceeded. The Code could also commit insurers to a specific timeframe for product reviews, noting that the legislation only requires firms to review products periodically or in response to review triggers.

Noting earlier Review Panel recommendations for insurers to adopt inclusive service standards, paragraph 43 could also be adapted to commit insurers to design products so that they are inclusive of people experiencing vulnerability. This aligns with ASIC guidance in relation to DDO which refers to how consumer vulnerabilities should be considered in product design (RG 247.47). A specific Code commitment to incorporate the inclusive service standards into product design would build on the legislative requirement.

Recommendations:

45. **Paragraph 43 should be adapted to help insurers meet Design and Distribution Obligations, including for example through:**
    - **incorporating inclusive service standards into product design requirements;**
    - **requiring insurers to regularly obtain customer feedback as part of product reviews; and**
    - **setting a benchmark for average claims durations which would trigger target market reviews should the benchmark be exceeded.**

3.2.5 Consumer credit insurance

Paragraphs 52, 53 and 54 of the Code impose requirements on insurers who provide Consumer Credit Insurance. These requirements create a 4-day deferred sales period within which insurers will not sell a Consumer Credit Insurance product. The obligations also apply to any intermediary, acting on behalf of an insurer, who offers Consumer Credit Insurance for credit cards, home loans or personal loans.

The ICA notes that paragraphs 52, 53 and 54 have been superseded by Part 2, Division 2, Sub-Division DA of the *Australian Securities and Investments Commission Act 2001 and* should be deleted. The Review Panel agrees with this position, given the new law provides for a comprehensive set of consumer protections that promotes informed purchasing decisions by consumers of add-on insurance, including consumer credit insurance.

Recommendations:

46. **Paragraphs 52, 53 and 54 should be removed as they duplicate the requirements of the *Australian Securities and Investments Commission Act 2001* for *Deferred sales for add-on insurance products*.**

3.3 Application of the Code to retail and wholesale insurance and customers

3.3.1 The Code and wholesale insurance

The Code distinguishes between retail and wholesale insurance by referencing the definitions of retail client and wholesale client in section 761G of the Corporations Act. The Corporations Act defines 'general insurance products provided to retail clients', in subsection (5)(b) of section 761G and in *Corporation Regulations 2001* 7.1.11 - 7.1.17A.

The Corporations Act includes small business within the definition of a retail client, but only where the insurance is or would be for use in connection with a small business and is a general insurance product, as defined by the Corporations Act. A small business is defined in the Corporations Act as a business employing less than 100 people if the business is or includes the manufacture of goods, or otherwise 20 people.

The Corporations Act defines a wholesale client as any person other than a retail client.

The practical application of the Corporations Act is that in certain circumstances, general insurance products are provided to individuals or small business as a wholesale client.

The following parts of the Code do not apply to wholesale insurance:

- Part 5 — Standards for our Service Suppliers;
- Part 6 — Buying insurance;
- Part 7 — Cancelling an insurance policy;
- Part 8 — Making a claim;
- Part 9 — Supporting customers experiencing vulnerability; and
- Part 11 — Complaints (except in limited circumstances).

Most submissions support that all provisions of the Code should apply to small business. The Australian Small Business and Family Enterprise Ombudsman note 'as with households, most small businesses do not have the in-house expertise to understand complex insurance products, and given other cost pressures, may not have the resources to seek professional assistance regarding their insurance needs.' The Queensland Small Business Commissioner strongly supported protections in the Code being extended to small business, calling existing definitions 'arbitrary'. The CGC confirms that the reliance on definitions in the Corporations Act relating to 'retail' and 'wholesale' insurance leaves many small businesses with reduced safeguards. The CGC further note that small business do not have the size, complexity, resources, capability, and business acumen of larger enterprises, and operate on small budgets with limited resources and personnel. Generally, they lack the expertise and risk management capabilities of larger corporations.

National Insurance Brokers Association of Australia (NIBA) did not support changing the current approach in the Code of categorising insurance customers into retail or wholesale clients in accordance with the definitions outlined in the Corporations Act. NIBA considered that any changes to this approach would likely introduce increased administrative complexity and necessitate significant changes to insurers' systems. These changes would incur costs, which are ultimately passed on to consumers. Suncorp, in its submission supported the NIBA position and requested the Review Panel consider the complexity in the wholesale market, and the unintended consequences that can result from drafting obligations without thorough consideration of whether they can practically apply to wholesale clients.

The Review Panel notes that small and medium-sized enterprises (SMEs) are often not sophisticated purchasers of general insurance policies and also often do not have a professional intermediary, such as an insurance broker, acting on their behalf. The Review Panel, on balance, recommends that the Code fully applies to small business.

3.3.2 The definition of small business

The Review Panel sought views on whether the definition of a small business should be amended to be aligned with the definition of a small business in the AFCA Rules, that is, less than 100 employees.

Submissions from the Joint Consumer Groups and the Australian Small Business and Family Enterprise Ombudsman observe that this would reduce inconsistency and confusion in the current Code and dispute resolution systems.

To the contrary, the ICA considers that changing the definition of small business to AFCA's definition could introduce greater compliance complexity, as AFCA's remit does not presently cover all types of general insurance policies an SME might purchase. The ICA further noted that the classes of SME businesses are typically more complex and involve a few different parties. Often claims are made by third parties who are not the insurer's customers. The Review Panel also notes the view of NIBA and Suncorp in respect of removing the Corporations Act distinctions between retail client and wholesale client from the Code as outlined above.

The Review Panel, on balance, considers that the definition of small business should be aligned to the AFCA Rules and that references to retail and wholesale be removed from the Code. Insurance policies for small businesses are often not wholesale, in the way that the term is generally understood. Limiting the definition of small business to less than 100 employees will assist in addressing the wholesale client complexity issues raised by ICA, NIBA and Suncorp. We also note that the new Banking Code of Practice defines small business without relying on legislative definitions, also adopting the 100 employee criterion.

3.3.3 General insurance products

The Review Panel notes that the description of general insurance products for retail clients (as defined in the Corporations Act) is based upon a traditional view of general insurance products. The Review Panel considers that the Code should be decoupled from the legal definition of a retail client, enabling the Code to be more flexible and respond to new and innovative general insurance products designed to manage new and emerging risks that threaten individuals and small business. Cyber risk and associated cyber risk insurance policies are a case in point.

3.3.4 Consumers who engage an intermediary to act on their behalf

The Review Panel also sought views on whether the Code should 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. NIBA, in its submission, did not support such a differentiation on the basis that all consumers are entitled to receive equal protection under the Code. The ICA notes the unnecessary complexity that this differentiation would introduce. The Joint Consumer Groups also did not support this approach.

The Review Panel notes that NIBA members are bound by the Insurance Brokers Code of Practice however, not all insurance brokers are NIBA members. Further, no submissions supported there be a different approach to Code commitments where consumers engage an intermediary.

On balance, the Review Panel does not consider that the Code should differentiate between consumers who deal directly with insurers and those who engage an intermediary to act on their behalf.

Recommendations:

47. **All parts of the Code should apply to small business.**
48. **The definition of small business should be aligned to the definition in the AFCA Rules.**
49. **The Code should be:**
    - **decoupled from the legislated definitions of retail client, wholesale client and general insurance products; and**
    - **apply to individuals and small business and not be limited to the nature of general insurance products other than statutory insurances (Code paragraph 10).**

4. Other parts of the Code

The Initial Consultation Paper canvassed issues related to various other sections of the Code that may require review or updating in light of developments since and experience with the implementation of the 2020 Code. These are addressed in this chapter, and include the following:

- Standards for Employees and Distributor;
- Standards for Service Suppliers;
- Buying and cancelling an insurance policy;
- Claims handling;
- Complaints; and
- Other feedback.

4.1 Standards for Employees and Distributors

This Report has outlined in section 3.2.2 observations and recommendations in relation to the training requirements for Employees and Distributors.

In addition to training requirements, the Code imposes minimum standards of conduct for Employees and Distributors to:

- conduct sales appropriately; and
- prevent unacceptable sales practices.

The Code provides mechanisms and requirements for insurers to deal with concerns about Employees and Distributors.

The CGC, AFCA, Legal Aid Queensland, the Joint Consumer Groups and the Australian Consumer Insurance Lobby (ACIL) submitted that the Code should apply to any distributor acting on behalf of the insurer. The Review Panel supports this position.

The purpose of Part 4 of the Code is to manage conduct risk. Conduct risk is broadly the action of a firm or its representative that leads to customer detriment. An insurer can distribute its products through employees, authorised representatives, AFSLs such as banks or underwriting agencies or through non-financial service firms such as real estate agents, travel agents and property managers, whether under an ASIC instrument or otherwise.

The Code should provide minimum requirements for standards of conduct of Distributors when acting on behalf of insurers and require monitoring of all Employees and Distributors by insurers. This is broadly consistent with the obligations on insurers under the Financial Accountability Regime[19] and APRA's *Prudential Standard CPS 230 Operational Risk Management*,[20] both taking effect during 2025.

Recommendations:

50. The definition of Distributor should be sufficiently wide to include any person acting on behalf of the insurer to distribute general insurance products.

51. The Code should require that insurers have effective systems to monitor the conduct of all Distributors who act on their behalf.

[19] *Financial Accountability Regime Act 2023* (Cth)

[20] Banking, Insurance, Life Insurance, Health Insurance and Superannuation (prudential standard) determination No. 2 of 2023 (Prudential Standard CPS 230 Operational Risk Management)

4.2 Standards for Service Suppliers

This Report has outlined in section 3.2.2 observations and recommendations in relation to the training requirements for service suppliers.

In addition to training requirements, the Code:

- imposes minimum standards of conduct for Service Suppliers;
- requires insurers to have measures in place to appoint and monitor service suppliers; and
- requires insurers to deal with concerns about Service Suppliers.

4.2.1 Definition of service suppliers

The Code defines a Service Supplier to include an Investigator, Loss Assessor or Loss Adjuster, Collection Agent, or a person, company or entity who is not an employee of the insurer but is contracted to manage claims on behalf of an insurer such as an insurance claims manager.

The Code elsewhere refers to External Experts and repairers (also known as insurance fulfilment providers under the claims handling and settling provisions of the Corporations Act).

The CGC noted that the separate Code definitions create unnecessary complexity and may act to limit the protection afforded to consumers under the Code. AFCA, in its submission, supported the extension of Service Suppliers to include External Experts.

The Review Panel agrees that insurers are responsible for the training, appointment, conduct and monitoring of Service Suppliers acting on their behalf. A single definition of Service Supplier will ensure a consistent approach to the management of Service Suppliers by insurers and reduce Code complexity.

4.2.2 Monitoring of service suppliers

Paragraphs 38, 39 and 40 of the Code are captured under the heading of '*Appointing and monitoring service suppliers'.* However, none of these paragraphs explicitly require insurers to monitor the ongoing performance of Service Suppliers. The Review Panel considers that monitoring of any service provider is essential to maintaining appropriate standards of conduct and performance.

Recommendations:

52. **A single Code definition should be adopted for all claim services provided by a third-party supplier acting on behalf of, or appointed by, an insurer.**
53. **The Code should require that insurers must have effective systems to monitor the conduct of all claim service suppliers who are appointed by the insurer or who act on their behalf.**

4.3 Buying and cancelling an insurance policy

Part 6 and Part 7 of the Code provides standards and requirements for selling, underwriting and cancelling an insurance policy.

4.3.1 Sales practices

Paragraph 44 of the Code prohibits pressure selling. Pressure selling is defined in Part 16 of the Code. Pressure selling may result in consumers being provided with general insurance products that do not meet their financial objectives and needs, leading to significant harm or detriment. This was the case, for example, with some forms of 'add-on' insurance.

The Code currently requires insurers to make it clear to their Employees and Distributors that pressure selling is prohibited.

The CGC in its submission supports the view that the Code 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.

The Joint Consumer Groups noted an example of a customer completing an online insurance application being contacted by phone by a representative of the insurer shortly after completing the online application. The Joint Consumer Groups commented that the insurer effectively usurped the communication choice of the consumer and placed them in a more pressured environment. The Review Panel considers that consumers should be free to choose how they wish to engage with insurers.

The Review Panel considers that paragraph 44 should be amended to require insurers to monitor Employees and Distributors to ensure they are not engaging in pressure selling. This is consistent with the Review Panel's recommendation for insurers to have effective systems to monitor Employees, Distributors and claim service suppliers under Parts 4 and 5 of the Code.

4.3.2 Sum insured calculators

Paragraph 48 of the Code requires insurers to provide consumers with access to a home building sum insured calculator, and to periodically review and update the calculator, to assist consumers to estimate their sum insured.

The Review Panel notes that underinsurance continues to be an issue for consumers and the industry. Several submissions proposed enhancements to paragraph 48 to better manage the risk of underinsurance.

- The CGC proposes that insurers should be required to use an up-to-date calculator for home and building insurance and proactively inform customers if they appear underinsured at policy inception and renewal.
- The ACCC notes in its *Northern Australia Insurance Inquiry Final Report* that the results from building sum insured calculators could vary significantly (despite a near universal reliance on the Cordell calculator) and that this could confuse consumers. [21] The ACCC proposes that insurers should be required to estimate an updated sum insured for their home insurance customers and advise them of this estimate on their renewal notice. This estimate should note when the information used by the insurer to form the estimate was last updated by the consumer and direct the consumer to contact the insurer if renovations/alterations to their home have occurred since then. The ACCC further propose that, where the sum insured estimate is materially higher than provided for under the policy, the renewal notice should also include a warning to the customer about the dangers of their property being underinsured.
- Legal Aid Queensland recommends that insurers should commit to:
  - warn consumers if they are underinsured at policy renewal and inception;
  - provide an estimated updated sum insured at renewal; and
  - debris removal and architects' fees being benefits covered under the policy over and above the sum insured.

[21] ACCC, *Northern Australia Insurance Inquiry—final report*, December 2020.

- The Joint Consumer Groups propose similar recommendations to Legal Aid Queensland and ACCC.

The Review Panel considers that paragraph 48 of the Code should place a requirement on the insurer to ensure that the sum insured calculator is accurate and up to date.

4.3.3 Sum insured

The Joint Consumer Groups notes that almost the entire onus for setting a sum insured is on the consumer and indicated that this has left consumers underinsured at claims time and contributed to a spate of underinsurance. They identify several reasons why, including one related to the costs of debris removal. Such costs are generally treated as a part of the sum insured, rather than paid in addition to it, thereby eating into the total amount available for a rebuild. The Joint Consumer Groups note that consumers do not always appreciate this distinction and generally underestimate or do not allow for the likely cost of professional clean up services when determining the sum insured they need.

The Review Panel supports the proposition that unanticipated additional costs such as debris removal should not be included in the sum insured for repair/rebuild but provided as a benefit over and above the sum insured. It would also be desirable if there were additional transparency for consumers about the components of the insured cover, and in particular what is included as part of the sum insured and what may be paid by the insurer in addition to that amount. This would assist consumers to determine the amount of sum insured required and reduce the extent of (unintended) underinsurance.

4.3.4 Renewals

Paragraph 49 of the Code imposes requirements on insurers in relation to insurance that automatically renews.

The CGC, Legal Aid Queensland and Joint Consumer Groups submissions recommend that renewal notices should be provided at least 28 days before renewal, with a reminder notice provided at least 7 days before renewal. The CGC submission limits its recommendation to automatic renewals.

The Insurance Contracts Act requires a renewal notice to be provided 14 days prior to renewal. This timeframe has remained unchanged since the Insurance Contracts Act came into effect, whereas consumer protection laws have been significantly enhanced since that time. Across other industries it is not uncommon that a payment notice is received a month before the payment is due, with a subsequent reminder notice prior to the due date. This extended period provides the consumer with sufficient time, for example, to research alternative arrangements or arrange to make the payment.

The Review Panel agrees that renewal notices should be provided at least 28 days before renewal, with a further reminder notice provided at least 7 days before renewal. The Review Panel does not see any reason why this requirement should be restricted to automatic renewals or specific types of general insurance products.

4.3.5 Cancelling an insurance policy

Part 7 of the Code deals with cancelling an insurance policy and comprises three relatively short paragraphs, possibly because cancellation of general insurance policies is regulated by the Insurance Contracts Act.

AFCA, in its submission, comments that insurers are not always clear in their communication with consumers about the basis for cancellation and/or the person's right to dispute the cancellation through the internal dispute resolution (IDR) process.

The Review Panel notes that in other paragraphs of the Code, insurers are required to advise the consumer of their right to IDR. Refer, for example, to Code paragraphs 33 (remedies for poor conduct of Employees or Distributors), 63 (issues with a claim) and 77 (delays in claim decisions). It is therefore not inconsistent that insurers should be required to inform consumers of their right to IDR for cancellation of an insurance policy.

The ICA also notes the proposed phasing out of cheques by 2028 and suggest that this requires amendment to paragraph 55 which provides for insurers to refund premiums where a customer elects to cancel coverage. The ICA suggests that the requirement to return the refund within 15 days should be amended so that this period should start from when the customer provides a valid payment method rather than the date of cancellation. The Review Panel appreciates the ICA's concern and considers that insurers should either provide the refund using the payment mechanism used by the policyholder when they initially paid for the policy or ask customers who cancel their policy whether they would prefer an alternative payment method. However, the Review Panel considers that the 15 days should still begin from when the customer cancels the policy, which allows the insurer sufficient time to ask and obtain a valid payment method. The Review Panel notes that a key benefit of electronic payments is that transactions can be facilitated much more quickly compared to cheques.

Recommendations:

54. **Paragraph 44 of the Code should be strengthened to require insurers to prevent pressure-selling through robust frameworks, systems, processes, training, and monitoring.**
55. **Insurers should be required to respect consumer communication preferences, so that for example where a consumer makes an application online, then communication should be online unless the customer provides a specific request to be contacted via another method.**
56. **Paragraph 48 should be strengthened to require insurers to ensure that sum insured calculators are accurate and up to date.**
57. **Unanticipated additional costs (debris removal and architectural fees) should not be included in the sum insured for repair/rebuild but provided as benefits over and above the sum insured. Further, insurers should be required to clearly communicate to consumers what is included as part of the sum insured and what may be paid by the insurer in addition to that amount.**
58. **Renewal notices should be provided at least 28 days before renewal, and a further reminder notice provided at least 7 days before renewal.**
59. **Part 7 of the Code should be amended so that insurers are required to clearly inform a customer about the basis for cancellation of an insurance policy and the customer's right to make a complaint through the insurer's internal dispute resolution process.**
60. **Paragraph 55 of the Code should be amended so that insurers commit to either returning any refund using the payment mechanism used by the customer when they initially paid for the policy or asking customers who cancel their policy about their preferred payment mechanism for the policy refund.**

4.4 Claims handling

Part 8 of the 2020 Code outlines a series of important standards for claims handling. Despite these standards, significant weaknesses in how insurers handle claims have been identified. This is evident, for example, from two key reports: the Deloitte Report[22], which examined the industry's response to the 2022 floods in Queensland and New South Wales, and ASIC's

[22] See above n 10.

Navigating the Storm: ASIC's Review of Home Insurance Claims (Report 768)[23], which evaluated claims handling since it became subject to financial services laws.

The Review Panel is particularly concerned about delays in claims handling, which contributes to consumer complaints as well as reduces trust and confidence in the industry. AFCA reports that delay in claims handling accounted for almost one quarter of general insurer complaints between 2019 and 2024. The CGC's *General Insurance Data and Compliance Report 2022-23* also identified delays and failures to meet timeframes as contributing to rises in Code breaches. [24]

Given this, the Review Panel's recommendations relating to claims handling respond to this primary issue of timely and effective claims handling. Insurers being able to resolve complaints sooner, particularly long tail complaints that persist many months if not years after the claim, should reduce community concerns about insurer practices.

As noted, since the 2020 Code came into effect, claims handling has been recognised as a financial service.[25] In regulatory guidance, ASIC has indicated that, to meet regulatory obligations claims handling should be conducted in a timely, fair and transparent manner. The Review Panel's recommendations seek to help insurers meet and exceed regulatory obligations in the following areas:

- Insurer preparedness;
- Claim lodgement;
- Timeframes and communications;
- Claim decision-making;
- Use of experts; and
- Cash settlements.

4.4.1 Insurer preparedness

Both the ACIL and Joint Consumer Groups call for the Code to mandate that insurers demonstrate preparedness for disaster and catastrophe events. Given that disasters and catastrophes are occurring more frequently, with greater severity, and sometimes overlapping, it is increasingly important to ensure that insurers' catastrophe planning is effective.

This aligns with findings of the Deloitte Report, which recommended insurers establish catastrophe response plans. ASIC has also called for insurers to develop comprehensive severe weather event response plans addressing assessment, assistance, and emergency repairs for claimants.[26]

The Review Panel notes that it is not standard practice for industry codes of practice to deal with operational planning issues like preparedness for catastrophes. Industry codes of practice primarily deal with how firms deal with consumers. Nevertheless, the Review Panel supports the recommendations from Deloitte and ASIC for such plans to be developed. Providing transparency of these plans will contribute to community confidence in insurers, particularly during a time when claims related to catastrophes are increasing in frequency and severity due to climate change.

[23] ASIC, *REP768—Navigating the storm: ASIC's Review of Home Insurance Claims*, August 2023.
[24] Code Governance Committee, *General Insurance Data and Compliance Report 2022-23*, May 2024.
[25] Financial Sector Reform (Hayne Royal Commission Response) Act 2020, Schedule 7.
[26] See above n 23.

4.4.2 Claim lodgement

Paragraphs 58 and 59 of the 2020 Code relate to making a claim.

The ICA suggest that paragraph 58 may be enhanced by allowing insurers to inform customers that they may not have cover if their excess is higher than the amount they intend to claim, before the claim is lodged. Paragraph 58 does not prevent an insurer from doing this, and the Review Panel considers that the existing commitment not to discourage a consumer from making a claim is important.

Legal Aid Queensland considers that these provisions can be improved by requiring insurers to inform consumers about items they can claim. ASIC's Report 768 identified this as a good industry practice and noted the benefits of insurers proactively informing consumers about claimable items they might not be aware of. For instance, during power outages, consumers might claim for appliance failure but may not realise that food spoilage is also covered without requiring an excess payment. The Review Panel supports this suggestion.

Several submitters also made proposals regarding the upfront information provided by insurers when a claim is made. Improved information upfront can help the efficiency and effectiveness of claims processes, by improving consumer understanding of their entitlements and any necessary steps. Key suggestions, including from the ACCC, Legal Aid Queensland and the ACIL, relate to who will manage the claim (contact details) and the right to make a complaint. Issues that arise when claimants have to deal with multiple different contacts and retell details about their claim/circumstances were also raised in submissions and could be addressed through insurers seeking to provide a single contact point for claimants. The Review Panel supports amendments to the Code to reflect these suggestions.

Recommendations:

61. **Insurers should be required to inform consumers about claimable items and the consumer's right to make a complaint at the point of claim.**
62. **Insurers should commit to providing a single contact point, including contact details, so claimants have a primary contact point throughout the claims process.**

4.4.3 Timeframes and communication

Submissions to the Initial Consultation Paper universally raise concerns about the Code's provisions relating to timeframes. The relevant provisions are:

- Paragraph 70: Insurers must provide an update on the progress of a claim at least every 20 days;
- Paragraph 71: Insurers must respond to routine inquiries about a claim within 10 days;
- Paragraph 76: Insurers must decide whether to accept or deny a claim and communicate this to the customer within 10 days of receiving all relevant information and completing all inquiries;
- Paragraph 77: Insurers must make a decision on a claim within 4 months of receiving it, unless an exception applies;
- Paragraph 78: Specifies exceptions that can extend the timeframe to make and communicate a decision on the claim up to 12 months after receiving the claim;
- Paragraph 83: If any timeframes in Part 8 are impractical, insurers must agree on a reasonable alternative timetable with the consumer; and
- Paragraph 84: Allows further avoidance of timeframe obligations if an alternative timetable is agreed upon with the customer, if the insurer's conduct and the actual timeframe were reasonable under the circumstances, or if the delay was caused by an external expert despite the insurer's best efforts to obtain the report in time.

As noted, a key goal is to reduce the overall length of claims handling processes. The Review Panel recognise that delayed claims, sometimes taking more than a year, are a minority of

claims and most claims are resolved within a reasonable timeframe. However, the few very delayed claims create overall trust and confidence issues for the insurance industry.

Paragraph 78: 12-month final deadline for claims decisions

In its submission, Uniting recommends that the Code should contain a provision that if the insurer has not made a decision to accept or decline a claim within 12 months, then the claim should be deemed to be accepted. It points to appropriate exemptions, such as if a complaint to AFCA is on foot or if the delay was caused by the consumer. The Review Panel considers that this measure would promote compliance with the existing commitment in paragraph 78 of the Code and encourage insurers not to unduly delay the claim assessment process.

In addition, the Review Panel supports there being greater transparency about claims which take longer than 12 months. Transparency about insurance claims lasting more than 12 months would be beneficial because it would enhance accountability, promote timely resolution for policyholders, and build trust by encouraging industry to provide reasons for any delays. While the CGC's annual data and compliance report reveals the number of breaches of paragraph 78, it does not disclose the total number of claims that take longer than 12 months to resolve. To achieve this, the report should include information not only the breaches of paragraph 78 but also on claims where paragraph 78 has been complied with, that is, statistical reporting by each insurer about how many claims take more than 12 months to resolve. The CGC could then issue a league table to provide appropriate transparency about insurance performance with respect to these very long claims.

Paragraph 77 and 78: exceptions to commitment to make claim decision within 4 months

More broadly, several submitters raise concerns regarding the exceptions in paragraph 78. The Deloitte Report recommends that ‘Extraordinary Catastrophe’ in paragraph 78(a) be ‘redefined’. The Review Panel notes that the ICA has never declared an Extraordinary Catastrophe for the purposes of this paragraph, as it ‘would not improve outcomes for policyholders’.[27] It is hard to imagine how reducing insurer commitments during a catastrophe meets community expectations, and the Review Panel considers that this exception should be removed.

The Joint Consumer Groups also suggest that the exception in paragraph 78(d) be removed. This exception applies where the insurer has difficulty communicating with a customer due to circumstances beyond their control. The concern raised is that it is unclear what sorts of circumstances are beyond an insurer’s control. Paragraph 78(c) already provides for an exception where the customer does not respond to reasonable inquiries or requests for documents or information about the claim, so this would appear to deal with insurer difficulties caused by customer engagement. The Review Panel agrees that this paragraph should be removed.

The Joint Consumer Groups raise an additional concern regarding the application of paragraphs 77 and 78 when an Investigator is appointed pursuant to Part 15 of the Code. While the Code is not clear on this point, it appears to be interpreted by some insurers as displacing the requirements of paragraphs 77 and 78. The Review Panel notes that if an Investigator is appointed, the claims process can become elongated. But it would be absurd for the Code to mean that, should an Investigator be appointed, the claims decision timeframes do not apply at all. The Review Panel notes that paragraph 78(b) provides for an exemption to the four-month timeframe where the insurer reasonably suspect that a claim is fraudulent. This provides flexibility for an insurer to lengthen the claims decision timeframe for

[27] ICA submission to Floods Inquiry.

a maximum of 12 months where an Investigator is appointed following a reasonable suspicion of fraud. This would appear to provide sufficient flexibility for insurers, and it is unnecessary for the provision to be rendered ineffective due to Part 15 of the Code.

Paragraph 70: communicating claim progress every 20 days

The ICA raises several concerns regarding paragraph 70, fundamentally that it inhibits insurers communicating meaningfully with their customers about the progress of the claim. This is the most breached provision of the Code.

The ICA's concern appears to emanate from the implementation of the requirement which has focused on insurer systems to provide automated updates every 20 days, but that these updates do not necessarily provide meaningful information to the consumer. Suncorp refers to this as 'tick box' compliance. The ICA suggests that the Code could instead allow progress updates that are focused on event-based updates as a better way to keep customers updated.

Other submissions oppose removing the time-based requirement in paragraph 70. For example, the CGC, NIBA and Legal Aid NSW consider 20 business days to be a reasonable expectation for an insurer to provide updates on claims. Legal Aid NSW note that consumers expect delays after a catastrophe, but they also expect regular updates for certainty that they have not been forgotten.

The Review Panel agrees that, to be effective, progress updates need to be both meaningful and regular. We support the suggestion from NIBA that updates be meaningful and provided at least every 20 business days, unless insurers have agreed an alternate timeframe with their customer (which is already allowed via paragraph 83). This would enable some flexibility for insurers. UAC supports progress updates being 'meaningful and clear', noting that this can be implemented practically. While the Review Panel does not think it necessary to define 'meaningful', it is important to clarify that even if a claim has not progressed from the previous update, there is still opportunity for a meaningful update to be provided. For example, the update could explain that the claim has not been forgotten and that the insurer is progressing it subject to certain events it is awaiting (for example, finalisation of an expert report).

The ICA supports the requirement for progress updates to be 'meaningful' but also call for the Code to allow updates to be provided in operationally expedient ways. The Review Panel supports changes that would allow insurers to meet the requirement by, for example, sending a SMS reminder to the customer that invites them to check their self-service portal or app for their latest progress update. This would be appropriate where the customer has indicated a preference to receive updates this way when they made their claim.

The ICA and Suncorp also propose limiting the application of paragraph 70 to the 'claims assessment' stage of the claim, and not during the rebuild or repair stage. This approach does not appear to be consumer-centric, given from the consumer's perspective the claim is not finalised until any rebuild or repair is finalised. However, noting the 20 business days can be amended to enable insurers to agree with the customer an alternative timeframe, insurers appear to have sufficient flexibility in this regard. At the point of a decision on the indemnity, insurers could agree on a timeframe for repair and rebuild including timing for progress updates.

Paragraph 71: responding to routine inquiries

Several submitters consider the requirement on insurers to respond to inquiries within 10 business days is insufficient and does not meet community expectations. Legal Aid Queensland suggests that the requirement be that an insurer make contact within 48 hours of the customer making an inquiry, while NIBA suggests it should be reduced to 5 days. The Review Panel considers 3 days would be an appropriate benchmark. The 2018 ISO

complaints management standard requires complaints to be acknowledged within 3 days.[28] While responding to an inquiry is different to acknowledging a complaint, an aligned benchmark should be operationally possible.

Paragraph 84

The Joint Consumer Groups, FC Victoria and the CGC consider the broad discretion not to comply with the timeframe requirements in paragraph 84 should be removed. As noted, the discretion arises where the insurer's conduct was reasonable under the circumstances, or if the delay was caused by an external expert despite the insurer's best efforts to obtain the report in time. The CGC claims that this exemption conceals the true extent of non-compliance with Code obligations.

The Review Panel notes the expectations of ASIC that, in order to meet legislative obligations, insurers should be better resourcing claims handling, including anticipating resource surge requirements to respond to disasters and catastrophes.[29] In the light of these expectations, the Review Panel does not consider that the Code should allow insurers to resource in a way to avoid timeframe obligations. To put it another way, it does not seem reasonable for insurers not to meet the timeframe obligations merely because there has been a disaster or catastrophe.

In relation to delays caused by external experts, the Review Panel appreciates that there can be delays associated with specialists at a time of high demand for those experts. However, where this occurs, it would be more appropriate for the insurer to engage with their customer and come to an agreement as to an alternative timeframe in line with paragraph 83. This would improve the customer experience by providing them with information and agency. The Review Panel considers that a blanket exemption from the timeframe obligations where an expert is appointed is not reasonable.

Recommendations:

63. **Where the insurer has not made a decision on a claim within 12 months, and the delay is not due to the consumer or other reasons beyond the control of the insurer (such as a complaint having been lodged with AFCA), the Code should require the claim to be accepted.**
64. **Insurers should report to the CGC the number of claims that take longer than 12 months to resolve, and the CGC should report on timeframes to resolve claims transparently by individual insurer.**
65. **The exceptions in paragraph 78(a) relating to Extraordinary Catastrophes and 78(d) relating to delays in customer communication should be removed.**
66. **Paragraph 70 should be updated to require insurers to provide meaningful progress updates every 20 business days. This paragraph should also be clarified to enable insurers to provide updates via SMS or in-app alerts, where this is the customer's communication preference.**
67. **Paragraph 71 should be updated to require insurers to respond to routine inquiries within 3 business days.**
68. **The exceptions in paragraphs 84 should be removed.**

4.4.4 Temporary accommodation

A temporary accommodation benefit under an insurance policy provides coverage for the cost of alternative living arrangements if the insured property is uninhabitable due to a covered event, such as fire, storm, or flood. This benefit ensures that policyholders have financial support for reasonable living expenses while their home is being repaired or rebuilt.

[28] AS 10002:2022 Guidelines for complaints management in organisations, clause 8.6
[29] ASIC, *ASIC's expectations of general insurers: Insurance claims and severe weather events*, November 2022.

The 2020 Code does not specifically deal with temporary accommodation benefits, but several submissions consider that it should. The CGC, the Joint Consumer Groups, Legal Aid Queensland and the ACIL all call for improvements, focusing on transparency and extending benefits where appropriate.

To encourage swift claims handling, the Review Panel recommends that the Code require temporary accommodation benefits to extend until the insured property is fully repaired or rebuilt. This would provide policyholders with comprehensive financial protection and stability, allowing them to focus on recovery without worrying about housing costs during the repair period. Additionally, it would incentivise insurers to manage claims more effectively by offering appropriate accommodation for the entire claim duration upfront, rather than multiple short-term arrangements that require frequent moves, extensions or renewals. To manage financial risks to customers, the Review Panel considers that this change should require temporary accommodation benefits to extend for a minimum of 12 months In addition, insurers should be required to contact customers about temporary accommodation benefits ceasing at least three months before the benefits are set to conclude, including advising whether or not any extension of the benefits is available if the repair or rebuild is not completed.

Recommendation:

69. **The Code should require temporary accommodation benefits to extend until the property is fully repaired or rebuilt, up to a cap of 12 months. Insurers should also be required to contact customers at least three months before the benefits are set to conclude, and advise whether any extension of the benefits is available if the repair or rebuild is not completed.**

4.4.5 Cash settlements

Paragraph 79 of the 2020 Code requires information to be provided if a cash settlement is offered under a home building policy, to help the customer understand how cash settlements work and how decisions are made on cash settlements. The ICA has issued an information sheet to support paragraph 79 that gives common reasons for when a cash settlement should be considered.[30]

The Initial Consultation Paper triggered significant responses on the issue of cash settlements. Several submissions from consumer groups confirmed that cash settlement is a common issue raised by consumers when seeking advice and support, and that one in five clients raise an issue with cash settlement.

There are several issues relating to cash settlement:

- The decision to offer cash settlement;
- Information provided upon cash settlement offer;
- Cash settlement amounts, and the basis of the offer;
- Review rights in relation to cash settlement; and
- Cash settlement beyond home building policies

Decision to cash settle

Some submissions raise concerns that the decision to offer a cash settlement lays with the insurer and may be offered where a claim becomes difficult or complex. Further, many consumers do not understand all of the implications of cash settlement, despite efforts to improve consumer understanding through paragraph 79 as well as the Cash Settlement Fact

[30] ICA, *Cash Settlements under a home building policy*, July 2021.

Sheet.[31] This is not surprising, given the well understood limits of information as a form of consumer protection.

Where a consumer accepts an offer of cash settlement, they will bear risk associated with managing the rebuild or repair. While some consumers may be able to manage this risk, many may not, particularly those experiencing vulnerability. Where rebuild or repair requirements are substantial, the consumer may be required to contract a project manager to assist.

Many home building insurance policies state that the insurer will arrange repair or rebuild in the first instance. However, policies may allow insurers to offer cash settlement in certain circumstances. There may be value in bringing consistency to the insurer decision to offer cash settlement, to address the concern about cash settlement being offered inappropriately. At the very least, the Review Panel considers insurers should be required to clearly state the circumstances in which they consider it reasonable to offer cash settlement, on the basis that the insurer will explore all options to undertake the works itself in the first instance. Where the decision to offer cash settlement is on the basis that the insurer cannot source builders or trades, for example, it may be considered unreasonable to offer cash settlement as the consumer will be similarly constrained. In these circumstances it is likely to be preferable that insurers hold repairs until the needed services are available.

Currently, the ICA Information Sheet references the core reasons for cash settlement, including where it is unsafe to repair or rebuild; where the local authority will not allow repair or rebuild; where the insurer only partially accepts the claim; or where the insurance does not cover the amount of money it will take to repair or rebuild a home to present day building standards. This suggests that the industry can bring a level of consistency to the decision to offer cash settlement, reducing the risk that cash settlement is offered inappropriately. Suncorp notes that the Code should provide direct reference to the ICA Information Sheet.

The CGC specifically recommends that, in considering an offer of cash settlement, an insurer should be required to consider the consumer's individual circumstances to determine whether they can carry out the required repairs. The Review Panel agrees that this would be an appropriate requirement, noting it is particularly relevant for consumers experiencing vulnerability. It would be inappropriate to propose that a very elderly customer, for example, be provided a cash settlement to manage an entire rebuild where they lack the capacity to do so. Such a requirement would support the more general obligations relating to vulnerability, set out in the Code and suggested in section 2.2 of this report.

Finally, the Review Panel notes that Suncorp opposes Code changes to the decision to offer cash settlement, noting that any undue influence can be addressed through existing laws. The approach suggested by the Review Panel is not prescriptive but seeks to promote the offering of cash settlements when it is reasonable and appropriate to the consumer, rather than only remediating any inappropriate offers after the event.

Information provided when offering cash settlement

Several submissions consider there would be benefit in improving or enhancing the information provided to consumers when the insurer offers cash settlement.

For example, the UAC considers that the Code can mandate a more detailed explanation of the insured's legal rights, instead of the insurer recommending that the insured seek their own legal advice (as per the ICA Information Sheet). The CGC, FC Victoria, Legal Aid Queensland and the Joint Consumer Groups all make recommendations to enhance the information

[31] *Corporations Act 2001 (Cth),* Division 3A, Chapter 7.

provided. NIBA makes recommendations about the content of the Cash Settlement Fact Sheet.

The ICA opposes changes to the information provided when offering cash settlement at this time, noting that it would prefer a post-implementation review of the Cash Settlement Fact Sheet and that ASIC is considering its relief which allows for streamlined processes in emergency situations.[32] The Review Panel acknowledges that it cannot facilitate changes to the Cash Settlement Fact Sheet process, and changes to the information provided would be better suited to legislative review. Moreover, information remedies are not always effective and there is a need for the Code to respond through other measures.

That said, the ICA Information Sheet on cash settlement contains valuable information that is not included in the Cash Settlement Fact Sheet. For instance, it advises consumers to consult their mortgage lender, as the lender might require that any cash settlement be used to pay down the mortgage or approve any repair or rebuild. It is also clearer about the risks that the consumer bears should they accept a cash settlement. The Review Panel considers that legislative review of the Cash Settlement Fact Sheet should consider how information in the ICA Information Sheet can be incorporated into the legislated requirements.

Cash settlement amounts, and the basis of cash settlement offers

Several submitters propose that the Code should impose requirements relating to the amount of cash settlement offers.

For example, Legal Aid Queensland and the Joint Consumer Groups propose that cash settlement offers should be based on what it would cost the consumer (rather than the insurer) to repair or rebuild the property. The ACIL agrees, noting that this should be supported by genuine and verifiable repair quotes.

Others, such as the CGC, AFCA, UAC, Uniting and the Joint Consumer Groups call for quotes to be actionable by the customer. The ICA agrees that Code requirements regarding an 'actionable quote' would improve the customer experience journey. Scopes of work are discussed further below.

Several submitters propose that cash settlements should provide for contingency uplifts, to account for unforeseen risks and variations and to compensate for the transfer of risk, such as the loss of an insurer's lifetime warranty on repairs. Cash settlements can also be limited and require an uplift where the costs of re-building have increased, or there is a need to 'build back better' to reduce future risk. Suggested amounts of contingency uplift vary, from 10 percent to 25 percent. Both the CGC and AFCA suggest that cash settlements should include other policy benefits that are likely to be triggered by the repairs (e.g., temporary accommodation, removal and storage of contents, professional fees etc).

KPMG opposes to cash settlements attracting contingency uplifts, as this could create a preference to cash settle as opposed to leveraging the supply chain model, which is designed to drive the most appropriate consumer outcomes. The Review Panel understands this concern, however we consider that our recommendations (below) requiring insurers to explore all options to arrange the rebuild or repair themselves would substantially mitigate this risk.

NIBA also raises concerns with contingency uplifts, as it may create moral hazard by incentivising policyholders to underinsure their risks. The ICA suggests that industry consistency regarding contingency uplift should be left to the development of a forthcoming AFCA Approach on cash settlements.

[32] *ASIC Corporations (Cash Settlement Fact Sheet) Instrument 2022/59*

The Review Panel consider that if there were clearer, consistent upfront standards regarding cash settlements, this would aid efficiency in claims handling and improve customer experience. We consider an outcomes-focused (rather than prescriptive) approach to such standards would also contribute to insurers meeting regulatory requirements to ensure claims handling is conducted in a fair and transparent manner. As such, the Review Panel considers the Code could require:

- Cash settlement offers to provide for actionable quotes, and be based on the cost to the consumer to undertake the rebuild or repair;
- Cash settlements offers should demonstrate how they reflect unforeseen risks and variations and compensate for the transfer of risk to the consumer; and
- Cash settlement offers should include all policy benefits that are otherwise applicable.

Cash settlement review rights

Several submitters recommend that the Code could be enhanced by clarifying rights to review of cash settlements. For example, the ICA proposes the Code include a commitment for insurers to consider customer requests for reviews of cash settlement amounts within 12 months of the payment if the customer discovers the amount is insufficient. The ICA also proposes an amendment to paragraph 90 of the Code, to extend review rights provided by this paragraph to all home building claims, not just where the loss was caused by a catastrophe.

The Joint Consumer Groups, Legal Aid Queensland and the CGC also propose that if a consumer cash settles, they should have 12 months in which to ask the insurer to review the amount of the cash settlement if the amount is inadequate due to circumstances which were unforeseen at the time of the settlement. Uniting makes a similar proposal, that where a cash settlement is discovered to be insufficient, then the consumer should contact the insurer and the insurer will reopen the claims file.

The Review Panel endorses this approach and considers that the review rights should enable a consumer to seek review of a property claim cash settlement within 12 months from the date of finalisation of the claim. This could be implemented by updating paragraph 90 to apply more broadly than catastrophes, and to not be limited to claims finalised within 1 month.

Cash settlement beyond home building policies

The Initial Consultation Paper asked whether paragraph 79 should be extended to all cash settlements, noting that it is currently limited to home building policies. Most submissions agreed that the primary concerns relating to cash settlements arise in the context of home building, noting that this is a consumer's primary asset and home. It would seem unnecessary to impose additional requirements regarding insurer cash settlement involving a personal property theft claim, for example.

The Joint Consumer Groups recommend that paragraph 79 should, however, be extended to motor vehicle insurance. The submission notes that consumers regularly raise questions and concerns regarding the circumstances of a motor vehicle being written off, and there may be benefit in extending the information requirements to this type of claim.

The Review Panel considers that, before recommending new information requirements, it would be necessary to investigate further and consider whether this would aid consumer understanding. Particularly following motor vehicle accidents, consumers may be stressed and additional information at the point of claim may not aid effective decision-making. In the first instance, the Review Panel recommends that consumer groups and the ICA consider this issue further.

Recommendations:

70. **The Code should require the insurer to explore all options to arrange rebuild or repair themselves and provide clarity about under what limited circumstances the insurer will offer cash settlement when it is reasonable to do so.**
71. **Before offering a cash settlement, the Code should require insurers to consider a consumer's individual circumstances to determine whether they are likely to be able to carry out the repairs.**
72. **Cash settlement offers should:**
    - **provide for actionable quotes, and be based on the cost to the consumer to undertake the rebuild or repair**
    - **demonstrate how the cash settlement offer reflects unforeseen risks and variations and compensates for the transfer of risk to the consumer**
    - **include all policy benefits that are otherwise applicable.**
73. **If a consumer opts for a cash settlement for a property claim, they should have a 12-month period to request a review if the settlement amount turns out to be insufficient due to unforeseen circumstances at the time of settlement.**

4.4.6 Scope of works

Paragraph 61 of the 2020 Code provides that if a scope of works is needed for a home building claim, the insurer will provide information to help customers understand how scope of works operate, its purpose and the process involved.

Several submissions raise concerns about scope of works. For example, FC Victoria raised concerns about 'bare bones' scope of works being provided after initial assessments, and that these can require substantial amendment and variation. The Joint Consumer Groups point to scopes of works that are redacted, impeding consumer understanding and diminishing trust. Moreover, submitters raise concerns about scope of works not containing a full breakdown of costs, and being written in a way that may help builders source trades and materials, but not in a way that aids consumer understanding.

The Review Panel considers that the Code should be amended to address these concerns, requiring scope of works to provide a full breakdown of works and costs, as well as meeting a standard form to ensure it is correct and appropriately detailed. This would support the previous recommendation that quotes should be actionable.

Recommendations:

74. **The Code should require Scopes of Work to be clear, standardised, and provide a full description of work and costs.**

4.4.7 External experts and reports

Paragraphs 74 and 75 of the 2020 Code address the use of external experts. According to these paragraphs, if an insurer hires an external expert for a report, they must request the report within 12 weeks and inform the claimant if there are any delays. Additionally, insurers commit to engaging only experts who have the appropriate expertise and comply with relevant regulations. Paragraph 82 provides consumers with a right to seek a copy of an expert report relied upon and commits insurers to providing it within 10 business days of the request.

Many submitters express concerns about the adequacy of these requirements, an issue also examined by the Flood Inquiry. The main issues raised include ambiguities and incorrect interpretations in expert reports, as well as inconsistent formats. FC Victoria note that expert reports often fail to clearly demonstrate causation and are presented as conclusive rather than opinion-based, making them difficult to challenge.

To address concerns, several submitters consider that the Code should require minimum standards for the use of experts, including that:

- Expert reports should include clear facts and evidence in plain English to support expert opinions;
- When expert opinions address 'wear and tear' exemptions and 'reasonable maintenance' requirements, they should clearly explain how the consumer's failure to maintain the property significantly contributed to the resulting loss or damage;
- Expert reports should be in a standardised format to improve consumer accessibility and understanding; and
- Insurers should ensure experts respectfully and constructively engage with consumers when collecting information for their assessments.

It has been suggested in the Review Panel's consultation with stakeholders that 'wear and tear' and 'reasonable maintenance' exemptions should be limited to observable maintenance or—at a principle level—must be related to something the consumer can control. The Review Panel suggests this proposal has merit and should be explored further by the ICA, in consultation with other stakeholders.

AFCA, in its submission and through other mechanisms, has expressed concerns about the quality of and reliance on experts reports in external dispute resolution.

The UAC, in contrast, considers that the Code should not mandate a specific format for expert reports, as this could make them longer and less useful. The ICA, however, are supportive of better practice standards being developed for the use of external expert reports and has developed, with stakeholder consultation, and recently published the *Use of Expert Reports: Industry Best Practice Standard*. The Review Panel welcomes this Standard and agrees that compliance with it should be mandated in the Code.

Given the weight of submissions on this topic, the Review Panel considers that there is benefit in the Code setting out minimum expectations for expert reports. The Review Panel also considers that it would aid understanding about the role of the expert reports if the Code clearly articulated their purpose. For example, the expert should not be deciding whether indemnity is provided, as that decision is for the insurer. Rather, the purpose of the expert report is to provide an independent, detailed, and professional assessment of the cause and extent of damage or loss.

In terms of professionalism and independence of experts, the Review Panel considers that the Code can be strengthened. As noted, paragraph 75 says insurers will only use experts whom they *believe* have appropriate expertise. Insurers should have systems to *ensure* that experts meet relevant professional standards and are appropriately independent.

The Review Panel notes that expert reports may be considered less than independent, as the expert is working for the insurer. Moreover, there will be occasions where it is appropriate for the insured to have the benefit of a more independently appointed expert, for example, in the case of a protracted dispute. In its submission, AFCA provides some detail about its approach in considering whether to rely on expert reports in the determination of disputes. The Review Panel understands that, when implementing its approach, AFCA can require additional independent expert reports.

Recommendations:

75. **The Code should state the purpose of the appointment of experts, being to provide independent, detailed, and professional assessments of the cause and extent of damage and loss.**
76. **The Code should require insurers to ensure the expertise, professionalism and independence of experts appointed by them and apply the other provisions recommended in relation to service providers as outlined above.**
77. **The Code should set out minimum standards for experts:**
    - **Expert reports should include clear facts and evidence in plain English to support expert opinions;**
    - **Expert reports should be clear regarding when the cause or extent of loss is not able to be definitively determined;**
    - **When expert opinions address 'wear and tear' exemptions and 'reasonable maintenance' requirements, they should clearly explain how the consumer's failure to maintain the property significantly contributed to the resulting loss or damage;**
    - **Expert reports should be in a standardised format to improve consumer accessibility and understanding; and**
    - **Insurers should ensure experts respectfully and constructively engage with consumers when collecting information for their assessments.**
78. **The Code should mandate compliance with ICA Standard 'Use of Expert Reports: Industry Best Practice Standard'.**

4.4.8 Claims decisions

The ICA considers that the Code could be updated to improve how claims outcomes are communicated. Paragraph 76 of the 2020 Code does not seem to be entirely consistent with paragraphs 77, 78 and 81 which require claims decisions to be communicated in writing. The Review Panel agrees that the Code should be clarified to address this.

Legal Aid Queensland considers that paragraph 81, which addresses partial acceptance or claim denials, should be strengthened. The paragraph should clearly state which aspects of the claim are accepted and provide clear reasons for denials, linked to policy terms. Additionally, communications should appropriately reference expert opinions, rather than just generally referring to an attached expert report. The CGC makes similar observations, noting that insurers should provide detailed reasons in plain English, and not simply note an exclusion in the product disclosure statement.

The Review Panel agrees that providing clear detail about claim decisions that enable consumers to understand the outcome of their claim is essential.

Recommendations:

79. **Paragraph 76 should be amended to require the claim decision to be provided in writing.**
80. **Paragraph 81 should be updated to require insurers to communicate in plain English and to:**
    - **State clearly aspects of the claim which are accepted, and which are denied;**
    - **Provide reasons that enable consumers to understand the outcome of the claim; and**
    - **Appropriately reference policy terms and attach any expert reports relied upon.**

4.4.9 Complaints

Complaints about general insurance have grown. Data published by AFCA shows that general insurance complaints to it increased from between 17,000 and 19,000 in 2019-20, 2020-21 and 2021-22 to 27,924 in 2022-23, a jump of fifty percent.[33] For the six months to December 2023 (the latest data published), complaints have grown from the prior year.[34] There is not currently publicly available data about complaints that are not referred to AFCA (and under IDR) however ASIC has indicated that it will soon be publishing this information.

As noted in the Initial Consultation Paper, since the 2020 Code came into force, there are new ASIC-mandated internal complaints handling standards. Regulatory Guide 271 on IDR provides for the definition of a complaint, sets maximum timeframes for IDR responses, and makes standards covering the design, implementation and ongoing improvement of dispute resolution processes. [35]

In its submission, the ICA calls for Part 11 of the 2020 Code to be updated in light of the new IDR requirements. It points to paragraph 147 which commits to insurers to make a decision about a complaint within 30 days and, if this is not met, to explain the reason for the delay and inform the customer of their right to progress the complaint to AFCA. ASIC's regulatory requirements also impose this requirement, and state that a decision does not have to meet the 30-day timeframe where the complaint is complex or there are circumstances beyond the firm's control. The firm still must inform the consumer about their right to progress the complaint to AFCA and provide AFCA's contact details.[36] The ICA notes that this additional detail is not in the Code and may contribute to complaints resolution teams not understanding the requirements, thus impacting the quality of dispute resolution responses.

The Review Panel agrees that paragraph 147 should be updated to align with the ASIC IDR requirements.

The Review Panel disagrees with significantly reducing Part 11 due to the new mandatory IDR requirements. Although it is important for the Code to align with and not contradict ASIC's requirements, there are reasons to keep key obligations in the Code. First, a number of stakeholders have indicated to the Review Panel that the Code serves as a useful plain English summary of requirements, avoiding the complexity of directing readers to more complicated regulatory guides or legislation. In this respect, the Code including the timeframes for complaints in paragraphs 147 to 151 is particularly useful. Second, the Code offers an opportunity to exceed legal requirements and explains how insurers will meet these obligations.

There are several provisions of the Code that should be maintained in this regard:

- The commitment to provide the name and contact details of the person assigned to liaise about a complaint in paragraph 143 (this is not an ASIC requirement);
- The commitment that the complaint will be handled by a person who was not involved in the decision or conduct complained about in paragraph 144 (the ASIC guide does not require this for small firms); and
- The requirement to keep complainants informed about the progress of complaints at least every 10 business days in paragraph 146 (this is not an ASIC requirement).

[33] AFCA, *Annual Review 2022-23, General Insurance Complaints.* October 2023.
[34] AFCA Data cube.
[35] ASIC, *Regulatory Guide 271: Internal dispute resolution*, September 2021.
[36] As above, RG 271.64 – 271.68

Several submitters, such as NIBA and the UAC, consider no specific changes are required to Part 11 in light of ASIC's regulatory requirements. However, others point to several ways in which the Code commitments may be enhanced, either to exceed or explain how insurers can meet complaint standards.

- The CGC considers that paragraph 146 can be strengthened so that insurers are required, when updating complainants about the progress of complaints, to provide a level of detail and contact details for further information; and
- The ACIL considers that IDR staff should speak with the customer before issuing decisions.

Several suggestions are also made in relation to the provision of the Code relating to AFCA.

- The ACIL considers that the Code could require insurers to engage directly with complainants that have made an AFCA complaint, rather than await the AFCA process. This would enhance efficiency in complaint resolution.
- The CGC considers that paragraph 156 which confirms that AFCA decisions are binding on insurers could be enhanced by committing insurers to complying with AFCA decisions within a particular timeframe.

The one area where there was most support for improvements relates to resourcing and expertise of complaints resolution teams. General insurers are, by virtue of general licensing obligations, required to have adequate procedures and resources including in relation to dispute resolution. However, ASIC's Report 768 called for improvements in how insurers respond to expressions of dissatisfaction (including through staff training) and comply with their obligations for resourcing and resolving complaints. The Joint Consumer Groups, Legal Aid Queensland, and the ACIL all make recommendations to improve resourcing and ensure complaints staff are adequately trained to identify expressions of dissatisfaction as complaints.

Given the substantial changes in regulatory expectations in relation to complaints handling over the last few years, the Review Panel is not minded to recommend wide-ranging changes to Part 11 at this time. However, the Review Panel does consider that the Code should be amended to respond to concerns about resourcing and training of complaint resolution teams, particularly given the substantial increase in complaints over recent times. As such, the Review Panel considers Part 11 should be amended to include a provision that commits insurers to adequately resource and train complaints handling staff. This should include insurers being ready to implement surge responses should there be an increase in complaints following an event.

Recommendations:

81. **Paragraph 147 should be amended to align with the ASIC internal dispute resolution requirements.**
82. **Part 11 should include commitments for insurers to adequately resource and train complaint resolution teams, including considering surge capacity that may be needed following an event.**

4.4.10 Other feedback

Privacy, access to information, and technology developments

Part 12 of the 2020 Code deals with privacy and commits insurers to comply with privacy laws. The Code extends insurers' obligations by committing insurers to provide, free of charge, access to information relied upon by the insurer in assessing an application, managing a claim, or responding to a complaint.

The ICA considers that Part 12 should be removed from the Code (along with paragraph 47(b) which provides for a consumer right to ask for information relied upon when assessing an application), considering the current economy-wide review of privacy law.

The Joint Consumer Groups, in contrast, consider that Part 12 can be extended to improve the processes and standard forms, including plain English explanations, in relation to actioning and fulfilling consumer data access requests. It also echoes an ACCC recommendation that insurers provide a clear and prominent notice to inform consumers that they can obtain information held about them and contact details for doing so.[37] The Joint Consumer Groups point to reports which indicate poor compliance with data access requirements, and that these requirements would improve insurer compliance with their obligations.[38]

An individual submission from Chris Dolman also raises concerns with Code compliance, in that some insurers use ambiguity in the Code's provisions to deny access to information used to quote premiums. Mr Dolman's submission does not seek access to insurer proprietary pricing information, but rather seeks access to data used to generate prices, so that consumers can check to determine accuracy and, if not, have it corrected (for example, insurer data about type of house construction materials).

The Review Panel considers that, given the current review of privacy legislation, no substantial changes should be made to Part 12 at this time. The Review Panel notes that several proposals from the Privacy Act Review report respond to privacy policies and collection notices, including standardised templates and layouts, as well as improved rights of access to, and explanation about, their personal information.[39] Given that changes will apply economy-wide, it makes sense for a future review of the Code to consider whether specific additions are required for general insurance. Further, when the new laws are clear, the Code can be updated to account for any inconsistencies that might give rise to operational complexity.

However, the Review Panel agrees that Part 12 should enable consumers to access personal information that is used by the insurer in assessing applications, including pricing decisions. The Code, specifically paragraph 163(a), does not appear to allow insurers to decline access to information however it should be amended to make the intent of the Code clear.

Separate from privacy requirements, KPMG also notes the impact of new technology, including artificial intelligence, in the context of claims processing and complaints management. It calls for the Code to include minimum requirements for change control activities related to the consideration of customer impact, noting that regulatory focus is largely limited to security and data requirements.

Similarly, Uniting references the 'explosion' of new technology across the insurance value chain, from pricing algorithms to the denial or acceptance of claims. Uniting refers to a guide published by the Actuaries Institute and the Australian Human Rights Commission that helps insurers comply with federal anti-discrimination legislation when using artificial intelligence in pricing and underwriting insurance policies.[40] Uniting recommends insurers adopt this guidance and also publish their own Data Ethics Principles on their websites. The Joint

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[37] ACCC, see note 21, recommendation 18.2.y
[38] Financial Rights Legal Centre, *Privacy practices in the general insurance industry*, April 2022; Financial Rights Legal Centre, *Automating General Insurance Disclosure*, October 2021.
[39] Attorney-General's Department, *Privacy Act Review Report*, 2022.
[40] Actuaries Institute and AHRC, *Guidance Resource: Artificial intelligence and discrimination in insurance pricing and underwriting*, December 2022.

Consumer Groups also recommend the Code require insurers to meet artificial intelligence ethics principles to ensure that the use of artificial intelligence is safe.

The Review Panel recognises that technology and artificial intelligence is changing business practices rapidly, and that risks relating to automation, algorithmic bias, and discrimination are real. The Review Panel thus agrees that there is benefit in requiring insurers to publish their own data ethics principles, so that they can demonstrate to their customers and communities that they are addressing risks appropriately.

Recommendations:

83. **The Code should require that insurers provide to consumers personal information that is used by the insurer in assessing applications, including where information is not provided by the consumer.**
84. **Insurers should be required to publish data ethics principles that set out how they address risks associated with artificial intelligence and discrimination.**

Investigations

The Review Panel notes that Part 15 of the Code was first included in the 2020 Code, adopting a more prescriptive approach to claim investigations including requirements before, during and after a formal interview. In addition, the 2020 Code prescribed requirements regarding the appointment and conduct of external investigators and the use of surveillance.

The Joint Consumer Groups noted in respect of Part 15 of the 2020 Code: 'Commitments regarding investigations have been a positive addition to the Code with improved consumer outcomes and, anecdotally at least, fewer complaints regarding investigations reaching our lines.'

Notwithstanding the improvements to the 2020 Code, the Joint Consumer Groups referenced ASIC's *Roadblocks and roundabouts: A review of car insurance claim investigations* (Report 621), noting that a number of recommendations have yet to be taken up by insurers in the Code. [41] The Joint Consumer Groups called for these recommendations to be included in the Code. Legal Aid Queensland submission did not reference ASIC's Report 621, however the submission contained recommendations similar to those in Report 621.

Consistent with an overarching obligation to manage claims efficiently, honestly and fairly, the Review Panel recommends that the following principle-based proposals in Report 621 are included in Part 15 of the Code.

Recommendations:

85. **Insurers and Investigators should treat consumers respectfully, approach investigations with an open mind, and avoid acting in ways that are likely to intimidate or unduly pressure consumers.**
86. **Insurers should request information only if it is strictly relevant to the claim, avoid multiple requests, and clearly communicate why each item of information is necessary and relevant.**
87. **Face-to-face interviews should only occur if the information cannot be obtained in a less intrusive way.**

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[41] ASIC, *REP621 Roadblocks and roundabouts: A review of car insurance claim investigations*, July 2019.

5. Emerging Issues

5.1 Affordability

The Initial Consultation Paper sought views on whether it is appropriate for the Code to address certain affordability issues, noting that insurance price inflation is a significant community concern.

Several submissions, including those from the UAC, NIBA, and KPMG, consider that product affordability should not fall under the remit of the Code. The ICA considers that the most important way in which the Code can contribute to improved affordability is by removing friction points in the Code that add unnecessary compliance complexity and costs. The ICA also notes that there are a range of other sector and government initiatives underway or planned that are designed to address affordability.

Other submissions, however, point to measures through which the Code can promote affordability. The Review Panel notes that in considering these measures, it is not intended that the Code should facilitate pricing coordination. Rather, the intent is to look at an insurer conduct relating to pricing representations and consumer impacts. Indeed, the Code already deals with such issues, for example paragraph 50 on premium comparison and paragraph 51 on ‘no claims discounts’.

A key issue raised relates to insurance pricing differentials between new and renewing customers. The CGC considers that pricing should be based on risk, not the loyalty of the customer or their likelihood to shop around for more reasonable offers. The ACCC, in its *Northern Australia Insurance Inquiry Final Report*, identified that renewing customers paid between 7 and 24 percent more than new customers depending on the region in 2018-19.[42] The Joint Consumer Groups consider that insurers should only offer a renewal price that is no greater than the equivalent new business price that it would offer a new customer. The Review Panel notes regulatory reform in the UK that requires that renewal quotes for home and motor insurance consumers are not more expensive than those for new customers.[43] Given there is a community expectation in this regard, and the likelihood that there will be legislative change if the industry does not address the concern, the Review Panel considers it would be appropriate for insurers to commit in the Code to meeting an obligation consistent with the new UK obligation.

Another pricing issue highlighted in submissions involves additional surcharges sometimes applied to premium instalments. According to Uniting, customers facing financial difficulties are more likely to opt for instalment payments to manage their expenses. However, these customers are the least capable of handling extra surcharges, which means that insurers are effectively discriminating against them based on their income.

Both the ACCC and the CGC believe that this issue should be resolved through better disclosure. They suggest that insurance quotes and renewal notices should clearly show the cost difference, in dollars, between paying premiums annually and in instalments. They point out that the lack of transparency from some insurers about these additional costs makes it difficult for customers to understand their premiums and find ways to save money. Uniting considers the cost differential should be capped, essentially to the transaction cost and any additional risk associated with payment by instalment. The Joint Consumer Groups, the

[42] ACCC, *Northern Australia Insurance Inquiry – final report*, 30 November 2020, p.247
[43] UK FCA, *FCA confirms measures to protect customers from the loyalty penalty in home and motor insurance markets*, 28 May 2021

Queensland Small Business Commissioner, Legal Aid NSW and Legal Aid Queensland consider that the Code could go further and should require insurers to not charge more for paying by instalment.

The Review Panel has considered this issue and believes that the latter position is preferred for several reasons. First, the Review Panel is concerned that insurance affordability is a widespread issue, affecting not only lower income households but people across the income spectrum—evidence shows that tight cashflow households cancel or do not renew insurance cover, affecting household resilience.[44] Given instalment payments can make insurance premiums more manageable, there is an urgent need to promote this method. Removing additional costs is an important way to do that. Second, there is some evidence that disclosing additional fees for paying by instalment may actually reduce take up of insurance by lower income households, as it contributes to lack of trust and perceptions of poor value for money.[45] Transparency, on its own, may not have the desired effect of improving consumer choices and promoting uptake in insurance coverage.

A third pricing issue raised in submissions relates to pricing offers and promises. As noted in the Initial Consultation Paper, a 2023 ASIC report identified a range of 'pricing failures' primarily related to insurers' internal systems and processes, and recommended improvements required to fix them.[46] Many of these pricing concerns related to poor description of discounts, benefits or rewards, including multi-policy discounts, 'no claims discounts' and loyalty discounts. Paragraph 51 of the Code requires insurers to explain how 'no claims discounts' work. The Review Panel considers that the concerns identified by ASIC could be addressed by paragraph 51 being extended to other types of discounts (multi-policy, loyalty etc) and requiring insurers to proactively determine eligibility for such offers. Compliance with such a provision would reduce the likelihood that the industry has to remediate customers in the future.

Finally, the Review Panel considers that, subject to financial advice law, insurers should be required to provide appropriate information to consumers on options that an insurer has available that would assist them with managing the cost of their insurance. This might include information on changes to policy settings that the consumer can select (such as excess amounts) or alternative types of policies or cover that the insurer may offer (for example with flood exclusions). Any such information should also clearly set out for the consumer the implications of taking up those options (for example, that they would have to pay a higher amount when they make a claim, or that they would not then have cover for a claim that was due to flooding).

Recommendations:

88. **The Code should require renewal quotes for home and motor insurance consumers to not be more expensive than those for new customers.**
89. **The Code should ensure that home and motor insurance policies do not charge more for instalment payments.**
90. **Paragraph 51 should be expanded to apply to multi-policy, loyalty and other types of discounts and offers, and require insurers to proactively determine consumer eligibility for discounts and pricing offers.**
91. **Subject to financial advice law, insurers should be required to provide appropriate information to consumers on options that an insurer has available that would assist them with managing the cost of their insurance.**

[44] Antonia Settle and Maxim Ananyev, '*Household insurance and financial stress: do households maintain coverage on their most important assets?*', Melbourne Institute Working Paper No 24/23, November 2023.
[45] Social Market Foundation, *Insurance and the poverty premium—summary*, March 2023.
[46] ASIC, Media Release 23-169MR *General insurers to repay consumers $815 million for broken pricing promises* (23 June 2023)

5.2 Helping reduce risks

Submissions to the Review Paper highlight that insurers often focus on risk management and mitigation to address insurance affordability but fail to offer financial benefits to customers who implement these risk reduction measures. As noted in the Initial Consultation Paper, several insurers do now offer programs that incentivise structural resilience of homes in exchange for premium discounts. The Initial Consultation Paper sought views on whether the Code could include provisions that encourage or require insurers to respond to consumers' risk-mitigation efforts.

In its *Northern Australia Insurance Inquiry Final Report*, the ACCC recommended that insurance quotes and renewal notices should include a schedule of mitigation measures that could improve a property's risk rating. Additionally, insurers should be required to show any discounts applied due to the mitigation measures undertaken by the customer. The ACCC's recommendation, or similar measures, are supported by various submitters. Many submissions suggest that the Code should require insurers to consider individual risk mitigation. Supporters of this position include AFCA, the CGC, the Australian Small Business and Family Enterprise Ombudsman, NIBA, and the Queensland Small Business Commissioner. Consumer group submissions support this as well.

Several submissions oppose the Code dealing with this issue. For example, Insurtech Australia consider that measures taken by insurers to reduce risks should occur on a commercial basis given the sophistication of multi-factor pricing models. Similarly, the UAC considers that any Code requirement regarding consumer risk mitigation would be difficult to practically apply.

The ICA similarly cautions against any new measures in the Code, 'as this could have the unintended consequence of authorising the CGC to become a pricing regulator, when this is completely outside the scope of their remit and expertise'. The ICA also points to broader initiatives underway to address some of these issues (for example, the work of the Hazards Insurance Partnership and the National Emergency Management Authority's mitigation knowledge database). The ICA considers it is more appropriate that these initiatives continue to progress given the complexities involved before consideration is given to including new Code commitments. In contrast, while Suncorp considers that the Code should not mandate specific processes or baselines for customer self-mitigation, if insurers provide information on potential premium benefits from self-mitigation, then the Code should require the stated benefits should be reasonably achievable by most customers

The Review Panel acknowledges and accepts the concerns of the industry but believes that amendments to the Code can support consumer risk mitigation without leading to price regulation or disrupting sophisticated pricing models. The Code could adopt a principles-based approach, requiring insurers to be transparent with consumers about the types of risk-mitigation activities that will result in a pricing benefit. This approach does not require standardisation of pricing models across insurers or involve the CGC setting premium components or prices. Compliance would be assessed by examining whether insurers are providing transparency in line with the Code requirements.

The Review Panel notes that consumer groups support broader reforms requiring insurance premiums to be broken down into component parts. For example, a premium quote or renewal notice could include a breakdown of controllable risks, non-controllable risks, and statutory charges. However, the Review Panel is concerned that component pricing alone may complicate pricing and potentially be confusing for consumers. Research shows that when

prices are separated into multiple fees, consumers may end up paying more.[47] Nonetheless, the goal of component pricing—providing transparency to help consumers reduce their risks and premiums—can be achieved through the Review Panel's recommendation. Insurers can improve consumer understanding of their premiums by being transparent about the types of risk-mitigation activities that result in a pricing benefit.

Recommendation:

92. **Subject to financial advice law, the Code should require insurers to provide transparency about the types of consumer risk-mitigation activities that result in a pricing benefit.**

[47] Consumer Financial Protection Bureau, *CFPB publishes research finding higher price complexity leads consumers to paying more*, 30 April 2024.

6. Code structure, enforceability and governance

The Initial Consultation Paper covered a number of areas related to the structure, enforceability and governance of the Code and these are addressed in this chapter.

6.1 Structure of the Code

The Initial Consultation Paper sought views on the audience of the Code, and whether any amendments to its structure may assist with stakeholder communication and understanding.

Submissions suggest that there are different views about the audience of the Code. The ICA considers that the primary audience are consumers and their representatives. Others consider that insurers and their staff, AFCA and regulators are also key audiences.

ICA also proposes the development of a complementary customer-facing document to aid consumer understanding. AFCA specifically oppose restructuring the Code or separating the Code so there is another consumer-facing document, stating that this will result in confusion, poorer understanding of rights, and potentially a loss in consumer protection. The Joint Consumer Groups and Legal Aid Queensland specifically state that the length of the Code should not be a concern, noting it may need to be expanded to address consumer concerns.

Several submissions consider that there is benefit in the approach taken by Part 15 of the 2020 Code. That is, providing more detailed guidelines for insurers where clarity and precision are essential for compliance and implementation. The ICA, however, oppose such a change, noting that the focus of this review should not add to compliance costs without consequent benefit.

What unites all submissions, however, is a view that the Code should not be substantially re-written. There are concerns that this will be costly and time consuming. Rather, it seems appropriate that any new Code commitments are clear, noting Code paragraphs should avoid multiple commitments in one paragraph.

Given this, the Review Panel does not support a substantial re-write to the Code but encourages any response to this review to ensure Code commitments are clear so as to promote effective compliance. The Review Panel notes that this aligns with the requirements of section 1101A(3)(c)(i) of the Corporations Act, which requires ASIC, when approving the Code, to have regard to whether code obligations are capable of being enforced. ASIC approval is discussed further in section 6.3.

Recommendations:

93. **The drafting of the Code should ensure code commitments are clear, so as to promote effective compliance.**

6.2 Code governance and compliance

The Initial Consultation Paper asked a range of questions regarding Code governance and compliance. The responses from submissions can be categorised as follows:

- Sanctions;
- Transparency;
- CGC operations; and
- Administrative arrangements.

6.2.1 Sanctions

The 2020 Code provides that the CGC may impose one or more sanctions on a subscriber for a breach of the Code or for a significant breach of the Code. Sanctions for Code breach include rectification, auditing of compliance, or advertising corrections (paragraph 173). Where the Code breach is significant, sanctions can require compensation to affected customers, payment of a community benefit payment of up to $100,000, and/or publishing the fact of significant breach (paragraph 174).

Several submissions identify that the level of sanctions does not effectively promote compliance. For example, the ACIL considers the $100,000 is not sufficient and KPMG support greater financial consequences for significant breaches that have a customer impact. The Review Panel agrees that the maximum community benefit payment should be materially increased, and suggests doubling the maximum amount. It should also be indexed annually, to ensure that it maintains value. As stated by KPMG, the sanction should not be seen as a cost to comply as opposed to a deterrent.

Both ICA and the CGC provide feedback about the factors to be considered when determining sanctions. The CGC considers that the factors in paragraph 170 are ‘largely backward looking’ and could be adapted to a principles-based approach which is more in line with contemporary practices. The ICA consider that the CGC should consider additional factors, such as the broader industry implications or customer impacts of a sanction. The ICA also suggest that the CGC should issue a guidance note as to how it is likely to use its sanctions for a significant breach of the Code. The Review Panel notes that the CGC has already issued guidance in this regard, so is not certain what additional guidance is required.[48] The Review Panel agrees that as a matter of good regulatory practice, this guide should be regularly reviewed including through consultation with industry.

Submissions also raised concerns around the definition of ‘significant breach’. Concerns related not only to when sanctions are available, but also reporting, noting paragraph 181 requires subscribers to report significant breaches to the CGC. The ICA would like to see alignment in the reporting requirements with the ASIC reportable situations regime. The ICA indicate that this would allow trivial breaches not to be reported and improve efficiency in operations. The CGC, on the other hand, note that there may be some overlap in reporting requirements but that reporting to it serves a different purpose to reporting to ASIC. The Joint Consumer Groups suggest that any overlap in reporting requirements can be dealt with through an agreed alignment of processes and information/data standards between insurers, ASIC and the CGC.

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[48] Code Governance Committee, *Operational Guidance—Imposing sanctions under the 2020 General Insurance Code of Practice*.

The Review Panel considers that there is benefit in efforts to improve the effectiveness and efficiency of breach reporting processes. Before changing definitions of significant breach in the Code, however, the Review Panel considers that a specific, external review of the CGC and its processes are warranted. This could consider opportunities to enhance efficiency and effectiveness of reporting arrangements and look at opportunities for operational improvements. The Review Panel notes that, unlike the charter for the Banking Code Compliance Committee, the charter for the CGC does not require it to be regularly reviewed. The Review Panel considers this should change, so that a more effective review of its operations, including data requirements, can be regularly undertaken.

Recommendations:

94. **The Code Governance Committee should be subject to regular review, including its data collection requirements and operational effectiveness.**
95. **The maximum Community Benefit Payment in paragraph 174(c) should be doubled to $200,000 and indexed annually.**

6.2.3 Transparency

The Initial Consultation Paper sought views on whether Code compliance should facilitate greater transparency, including whether the CGC should be able to name subscribers that commit a substantial breach.

Many submissions supported greater transparency. For example, FC Victoria, KPMG, Legal Aid Queensland and the Queensland Small Business Commission all supported regular public reporting about which insurers commit substantial breaches.

The UAC opposes additional public reporting, while ICA did not support public reporting of significant breaches that focus on worst performer at the top of the leaderboard. The ICA does, however, support greater public transparency through a leader board approach that focuses on positive Code compliance performance metrics.

The Review Panel notes that the 2021 review of the Banking Code Compliance Committee recommended that the BCCC transition to public reporting of compliance statements, which include breaches. The Australian Banking Association supported this recommendation. The Review Panel considers that there is merit in aligning processes in this regard.

The Review Panel considers that the CGC should commit to greater transparency when undertaking thematic inquiries. These inquiries could adopt the approach suggested by the ICA in producing leader board information that demonstrates both better compliance practices, as well as where improvement is needed.

There may also be merit in considering whether there should be periodic reviews of Code compliance undertaken by insurers, that are provided to the CGC to inform and support their oversight of Code compliance.

Recommendations:

96. **The CGC should publish insurer names in regular compliance and data reports.**
97. **The CGC should produce leader board information at an individual insurer level when undertaking thematic reviews, to provide additional transparency on both better compliance practices and where improvement is needed.**

6.2.4 CGC membership and administrative arrangements

The Australian Small Business and Family Enterprise Ombudsman submits that the membership of the CGC should be expanded to include small business representation. The Review Panel considers that there is merit in this, or alternatively that other mechanisms to ensure advice on small business matters is available to the CGC.

Both the ICA and CGC identify improvements that can be made to Code governance administrative arrangements. Currently, the Code Governance Association is an independent association responsible for appointing the members of the CGC and establishing its charter and budget. It is suggested that this could be abolished, and the arrangements aligned with the other codes administered by AFCA. This would involve CGC members having contractual arrangements with AFCA directly, and would appear to reduce administration. The Review Panel agrees this is sensible.

Both the CGC and Joint Consumer Groups consider that the Code governance budget approval process should remain as it is now, as it demonstrates better practice and involves consumer representatives. The Review Panel agrees.

Recommendations:

98. **The Code Governance Association should be abolished and arrangements for Code management aligned with that of other financial services codes managed by AFCA. Consumer representative involvement in the annual budget approval process should be maintained.**
99. **The addition of a small business representative to the CGC should be considered, or an alternative mechanism for ensuring advice on small business matters is available to the CGC.**

6.2.5 Enforceability of the code

The ICA has indicated its intention to submit the revised code to ASIC for approval. Section 1101A of the Corporations Act allows ASIC to approve a code of conduct and designate certain provisions as enforceable code provisions. The Review Panel welcomes ICA's proposal, noting that approval of a voluntary code of conduct signals to consumers that the Code is trustworthy and taken seriously by insurers.

The terms of reference for the Code Review asks the Review Panel to identify possible Code commitments for designation as an enforceable code provision as part of ICA's application for Code approval by ASIC. Pursuant to the legislation, a code provision can be identified as an enforceable code provision if:

- it represents a commitment to a customer—this includes direct and specific commitments, not broad aspirational commitments to the public at large; and
- where breached, it causes significant and direct detriment to consumers—more than an inconvenience, it could include economic and non-economic loss that is direct and substantial.[49]

Before approving enforceable code provisions, ASIC must be satisfied that these provisions have been agreed upon with the applicant and are legally effective.[50] The explanatory memorandum clarifies that legally effective means these provisions can be relied upon by consumers and regulators for enforcement. The Review Panel must consider these legislative requirements when addressing enforceable code provisions.

Some submissions suggested specific provisions be designated as enforceable, such as FC Victoria's suggestions on cash settlements, care for vulnerable consumers, and claims handling. Others, like AFCA, propose that enforceable code provisions be clear obligations or commitments rather than aspirational terms to ensure they are enforceable. Legal Aid Queensland and the Joint Consumer Groups believe the entire Code of Practice should be enforceable but have reservations about the enforceable code regime's design.

[49] *Corporations Act 2001 (Cth)*, section 1101A(2).
[50] *Corporations Act 2001 (Cth)*, section 1101A(3)(b).

Both the CGC and ICA express concerns about the enforceable code provision scheme. ICA notes that designating some provisions as enforceable creates a two-tiered Code, complicating consumer understanding. The CGC worries that the regime might lead the industry to focus on minimum legal standards rather than striving for higher standards. Suncorp suggests that identifying enforceable code provisions should wait until after the Code Review when new provisions are drafted.

The Review Panel shares concerns about the enforceable code provision regime and does not recommend identifying any provisions as enforceable through the ASIC approval process for several reasons:

- Enforceable code provisions must be agreed upon with the applicant. No other industry association has agreed to this. For instance, the recently approved Banking Code of Practice did not include any enforceable provisions, indicating little incentive for associations to adopt the regime;
- Industry participants may be discouraged from adopting robust consumer protections as enforceable due to the potential for increased regulatory scrutiny and civil penalties for non-compliance. Although the regime aims to enhance consumer protection and accountability, its practical implementation remains limited; and
- Breaching an enforceable code provision allows ASIC to seek civil penalties up to $93,900, which is less than the current maximum $100,000 sanction that the CGC can apply for significant breaches. This discrepancy offers little deterrence against breaching enforceable provisions.

The Review Panel considers that, in the absence of reform to the enforceable code provision regime to make it more effective, better outcomes can be achieved through alternative enforcement mechanisms. When approving an industry code (separately to considering enforceable code provisions), ASIC must have regard to whether the obligations in the Code are capable of being enforced. One effective method is for Code signatories to include the Code of Practice in their contractual agreements with customers, as is the case with the Banking Code of Practice. This practice promotes compliance by providing consumers with contractual enforcement options alongside internal or external dispute resolution mechanisms.

Recommendations:

100. **The ICA should seek ASIC approval of its Code, but not seek designation of enforceable code provisions.**
101. **The Code should be incorporated into customer contracts so that commitments are contractually enforceable.**

Appendices

Appendix 1 – List of recommendations

Financial hardship

1. Paragraph 107 should be expanded to require insurers to provide financial hardship support to all customers who require it, including people who need help maintaining premium payments.
2. The Code should define financial hardship broadly to include where someone is unable to pay what they owe, where they expect to be unable to pay upcoming obligations or they are experiencing difficulties meeting obligations.
3. Paragraph 65 regarding the fast-tracking of urgent claims, including making an advance payment to help ease an urgent financial need, should be extended to small business insureds.
4. The Code should provide a comprehensive list of potential support options that insurers may consider offering (expanded as outlined above).
5. The Code should commit insurers to adopting some of the listed options and being transparent about the options that they make available.
6. The Code should clarify that claims cannot be denied solely because of unpaid excesses. The Code should also expand on the options to pay an excess when the claimant is experiencing financial hardship, including deducting the excess from claim payments, waiving the excess entirely or partially, or allowing the excess to be paid in instalments.
7. The Code should adopt a minimum definition for 'urgent financial need' focused on emergency payments to customers to meet an immediate need for essential items.
8. The Code should require insurers to make information about financial hardship support, including the types of support options available and how to access support, visible, easy to find, and prominent through a range of customer service channels (website, apps, renewal notices etc).
9. The Code should require insurers to provide information about financial hardship support on relevant pieces of insurer correspondence, such as notices of non-payment of instalment or notices of cancellation.
10. The Code should allow for requests for hardship support to be made flexibly, including online, via phone and other customer service channels.
11. Paragraph 115 should be amended to require insurers to not request unnecessary documentation or information as part of providing hardship support.
12. The Code should commit insurers to engage with a consumer before the conclusion of hardship support to consider whether assistance has been effective or whether further assistance is required.
13. The Code should require insurers to have in place effective systems that monitor and ensure compliance of third-party agents and collectors with insurers' financial hardship commitments.
14. The Code should specifically require insurers not to utilise their right of subrogation over a tenant where a potential liability has arisen from a landlord or strata policy unless malicious damage was involved.
15. The Code should clarify that Part 10 applies to insurers that provide lenders mortgage insurers. LMI insurers should provide consumers with information about financial hardship support in any communication that seeks recovery.
16. The Code should require insurers to seek recovery from employers where an employee causes loss in the course of employment. The ICA, through the Code or an industry guideline, should articulate standards of proof should there be disputes about the standard of employment and/or link to an event in the course of employment.
17. The Code should require insurers to have quality assurance systems in place regarding the effectiveness of their hardship support. Such systems should be overseen by senior management.

Customer vulnerability

18. In redrafting the Code, language which requires consumers to identify as being in vulnerable circumstances to access support should be avoided.
19. Paragraph 93 should be redrafted to state: *We encourage you to tell us about your circumstances so that we can work with you to arrange the support you might need.*
20. The Code should adopt a broad definition of vulnerability: where someone who, due to their personal circumstances and market practices, is especially susceptible to harm.
21. Paragraph 91 should be amended to require insurers to comply with ISO 22458.
22. Alternatively, the Code should require insurers to demonstrate organisational commitment to improving outcomes for consumers in vulnerable circumstances by following the key principles in ISO 22458, including:
    a. Requiring insurers to design customer service and claims processes to be inclusive; and
    b. Requiring insurers to have a range of free, easy-to-access contact channels so that consumers can choose their preferred method of communication for enquiries and complaints.
23. The risk factors 'sexual orientation, gender identity and sex characteristics', 'trauma', 'cognitive impairment', 'bereavement' and 'elder abuse' should be added to paragraph 93.
24. 'Family violence' should be expanded to 'family violence including financial abuse' in paragraph 93.
25. Where risk factors are present, insurers should specifically ask consumers about their circumstances and whether any assistance or extra care is required to help them engage with their insurer.
26. Paragraph 97 be expanded to include trauma-informed policies and training.
27. Insurers should take appropriate steps to record, with consent, personal information to help support people experiencing vulnerability.
28. Insurers should set out clearly on their website and in relevant customer communications the types of additional supports they make available to customers experiencing vulnerability.
29. The Code should require insurers to comply with key requirements of the ICA guide to helping customers affected by family violence.
30. The Code should require insurers to:
    a. Ensure continuous protection of all insured parties in situations of relationship breakdown, for example by treating joint policies as composite;
    b. Reinstate policies and provide coverage for claims resulting from deliberate actions by a perpetrator that leave victim-survivors uninsured;
    c. Ensure policies cover property damage due to family violence within the standard terms; and
    d. Guarantee fair access to indemnity for all insured parties in the event of cash settlements.
31. Paragraph 100 of the Code should be updated to reference AUSTRAC guidance regarding customer identification.
32. Insurers should ask customers whether they identify as Aboriginal and/or Torres Strait Islander, and seek consent to retain this information, to enable flexible and tailored services.
33. Cultural awareness training should be provided for staff who assist First Nations customers.
34. Paragraph 103(a) should be updated to clarify that interpreting services includes interpreting for First Nations customers who do not speak English as their first language.
35. Insurers should commit to provide additional flexibility and time for customers in remote and regional areas.
36. The Code should require insurers to comply with the ICA Guide on Mental Health.
37. Paragraph 104(d) of the Code should be updated to require insurers to provide sufficient information to enable a person to understand whether a decision to decline cover or provide cover on non-standard terms is reasonable, such as directly providing the relevant actuarial or statistical data (or a summary thereof) on which the decision was based.
38. Paragraph 45 of the Code should be updated to require insurers, in questionnaires and application processes, to only collect information that is necessary to assess and insure the risk presented by the customer.

39. The Code should require insurers, in questionnaires and application processes, to ensure sensitivity and avoid stigmatisation.

The Code and the law

40. Paragraph 21 should be retained and amended to clarify that it operates alongside other Code paragraphs.
41. Paragraph 22 should be clarified to make it clear that it does not limit the general obligation in paragraph 21.
42. The Code should include an overarching obligation for education and training requirements for all Code Subscriber Employees, Distributors and Service Suppliers.
43. The requirements should stipulate that education and training must include:
    - the Code;
    - the products and services provided by the Code Subscriber;
    - dealing with customers experiencing vulnerability, including trauma-based training (also see recommendation 26); and
    - complaint management, including more advanced training for Employees in specialised internal dispute resolution or external dispute resolution roles.
44. In addition, the Code should require that Distributors and Service Suppliers receive education and training to a standard that is considered relevant to the trade or profession that they operate within and in accordance with the requirements of any relevant industry body.
45. Paragraph 43 should be adapted to help insurers meet Design and Distribution Obligations, including for example through:
    - incorporating inclusive service standards into product design requirements;
    - requiring insurers to regularly obtain customer feedback as part of product reviews; and
    - setting a benchmark for average claims durations which would trigger target market reviews should the benchmark be exceeded.
46. Paragraphs 52, 53 and 54 should be removed as they duplicate the requirements of the *Australian Securities and Investments Commission Act 2001* for *Deferred sales for add-on insurance products*.
47. All parts of the Code should apply to small business.
48. The definition of small business should be aligned to the definition in the AFCA Rules.
49. The Code should be:
    - decoupled from the legislated definitions of retail client, wholesale client and general insurance products; and
    - apply to individuals and small business and not be limited to the nature of general insurance products other than statutory insurances (Code paragraph 10)

Other parts of the Code

50. The definition of Distributor should be sufficiently wide to include any person acting on behalf of the insurer to distribute general insurance products.
51. The Code should require that insurers have effective systems to monitor the conduct of all Distributors who act on their behalf.
52. A single Code definition be adopted for all claim services provided by a third-party supplier acting on behalf of, or appointed by, an insurer.
53. The Code should require that insurers must have effective systems to monitor the conduct of all claim service suppliers who are appointed by the insurer or who act on their behalf.
54. Paragraph 44 of the Code should be strengthened to require insurers to prevent pressure-selling through robust frameworks, systems, processes, training, and monitoring.

55. Insurers should be required to respect consumer communication preferences, so that for example where a consumer makes an application online, then communication should be online unless the customer provides a specific request to be contacted via another method.
56. Paragraph 48 should be strengthened to require insurers to ensure that sum insured calculators are accurate and up to date.
57. Unanticipated additional costs (debris removal and architectural fees) should not be included in the sum insured for repair/rebuild but provided as benefits over and above the sum insured. Further, insurers should be required to clearly communicate to consumers what is included as part of the sum insured and what may be paid by the insurer in addition to that amount.
58. Renewal notices should be provided at least 28 days before renewal, and a further reminder notice provided at least 7 days before renewal.
59. Part 7 of the Code should be amended so that insurers are required to clearly inform a customer about the basis for cancellation of an insurance policy and the customer's right to make a complaint through the insurer's internal dispute resolution process.
60. Paragraph 55 of the Code should be amended so that insurers commit to either returning any refund using the payment mechanism used by the customer when they initially paid for the policy from or asking customers who cancel their policy about their preferred payment mechanism for the policy refund.
61. Insurers should be required to inform consumers about claimable items and the consumer's right to make a complaint at the point of claim.
62. Insurers should commit to providing a single contact point, including contact details, so claimants have a primary contact point through the claims process.
63. Where the insurer has not made a decision on the claim within 12 months, and the delay is not due to the consumer or other reasons beyond the control of the insurer (such as a complaint having been lodged with AFCA), the Code should require the claim to be accepted.
64. Insurers should report to the CGC the number of claims that take longer than 12 months to resolve, and the CGC should report on these numbers transparently by individual insurer.
65. The exceptions in paragraph 78(a) relating to Extraordinary Catastrophes and 78(d) relating to delays in customer communication should be removed.
66. Paragraph 70 should be updated to require insurers to provide meaningful progress updates every 20 business days. This paragraph should also be clarified to enable insurers to provide updates via SMS or in-app alerts, where this is the customer's communication preference.
67. Paragraph 71 should be updated to require insurers to respond to routine inquiries within 3 business days.
68. The exceptions in paragraphs 84 should be removed.
69. The Code should require temporary accommodation benefits to extend until the property is fully repaired or rebuilt, up to a cap of 12 months. Insurers should also be required to contact customers at least three months before the benefits are set to conclude and advise whether any extension of the benefits is available if the repair or rebuild is not completed.
70. The Code should require the insurer to explore all options to arrange rebuild or repair themselves and provide clarity about under what limited circumstances it will offer cash settlement when it is reasonable to do so.
71. Before offering a cash settlement, the Code should require insurers to consider a consumer's individual circumstances to determine whether they are likely to be able to carry out the repairs.
72. Cash settlement offers should:
    - provide for actionable quotes, and be based on the cost to the consumer to undertake the rebuild or repair;
    - demonstrate how the cash settlement offer reflects unforeseen risks and variations and compensate for the transfer of risk to the consumer; and
    - include all policy benefits that are otherwise applicable.
73. If a consumer opts for a cash settlement for a property claim, they should have a 12-month period to request a review if the settlement amount turns out to be insufficient due to unforeseen circumstances at the time of settlement.
74. The Code should require Scopes of Work to be clear, standardised, and provide a full description of

work and costs.

75. The Code should state the purpose of the appointment of experts, being to provide independent, detailed, and professional assessments of the cause and extent of damage and loss.
76. The Code should require insurers to ensure the expertise, professionalism and independence of experts appointed by them and apply the other provisions recommended in relation to service providers as outlined above.
77. The Code should set out minimum standards for experts:
    - Expert reports should include clear facts and evidence in plain English to support expert opinions;
    - Expert reports should be clear regarding when the cause or extent of loss is not able to be definitively determined;
    - When expert opinions address 'wear and tear' exemptions and 'reasonable maintenance' requirements, they should clearly explain how the consumer's failure to maintain the property significantly contributed to the resulting loss or damage;
    - Expert reports should be in a standardised format to improve consumer accessibility and understanding; and
    - Insurers should ensure experts respectfully and constructively engage with consumers when collecting information for their assessments.
78. The Code should mandate compliance with ICA Standard 'Use of Expert Reports: Industry Best Practice Standard'.
79. Paragraph 76 should be amended to require the claim decision to be provided in writing.
80. Paragraph 81 should be updated to require insurers to communicate in plain English and to:
    - State clearly aspects of the claim which are accepted, and which are denied;
    - Provide reasons that enable consumers to understand the outcome of the claim; and
    - Appropriately reference policy terms and attach any expert reports relied upon
81. Paragraph 147 should be amended to align with the ASIC internal dispute resolution requirements.
82. Part 11 should include commitments for insurers to adequately resource and train complaint resolution teams, including considering surge capacity that may be needed following an event.
83. The Code should require that insurers provide to consumers personal information that is used by the insurer in assessing applications, including where information is not provided by the consumer.
84. Insurers should be required to publish data ethics principles that set out how they address risks associated with artificial intelligence and discrimination.
85. Insurers and Investigators should treat consumers respectfully, approach investigations with an open mind, and avoid acting in ways that are likely to intimidate or unduly pressure consumers.
86. Insurers should request information only if it is strictly relevant to the claim, avoid multiple requests, and clearly communicate why each item of information is necessary and relevant.
87. Face-to-face interviews should only occur if the information cannot be obtained in a less intrusive way.

Emerging issues

88. The Code should require renewal quotes for home and motor insurance consumers to be not more expensive than those for new customers.
89. The Code should ensure that home and motor insurance policies do not charge more for instalment payments.
90. Paragraph 51 should be expanded to apply to multi-policy, loyalty and other types of discounts and offers, and require insurers to proactively determine consumer eligibility for discounts and pricing offers.
91. Subject to financial advice law, insurers should be required to provide appropriate information to consumers on options that an insurer has available that would assist them with managing the cost of their insurance.
92. Subject to financial advice law, the Code should require insurers to provide transparency about the

types of consumer risk-mitigation activities that result in a pricing benefit.

Code structure, enforceability and governance

93. The drafting of the Code should ensure code commitments are clear, so as to promote effective compliance.
94. The Code Governance Committee should be subject to regular review, including its data collection requirements and operational effectiveness.
95. The maximum Community Benefit Payment in paragraph 174(c) should be doubled to $200,000 and indexed annually.
96. The CGC should publish insurer names in regular compliance and data reports.
97. The CGC should produce leader board information at an individual insurer level when undertaking thematic reviews, to provide additional transparency on both better compliance practices and where improvement is needed.
98. The Code Governance Association should be abolished and arrangements for Code management aligned with that of other financial services codes managed by AFCA. Consumer representative involvement in the annual budget approval process should be maintained.
99. The addition of a small business representative to the CGC should be considered, or an alternative mechanism for ensuring advice on small business matters is available to the CGC.
100. The ICA should seek ASIC approval of its Code, but not seek designation of enforceable code provisions.
101. The Code should be incorporated into customer contracts so that commitments are contractually enforceable.

Appendix 2 – Review Terms of Reference

GENERAL INSURANCE CODE OF PRACTICE

INDEPENDENT REVIEW TERMS OF REFERENCE

Background

The General Insurance Code of Practice was introduced in 1994 by the Insurance Council of Australia (ICA) as a voluntary Code and it has been regularly reviewed and updated, most recently in 2020.

It sets out the standards that general insurers must meet when providing services to their customers, such as being open, fair and honest.

The Code is intended to be a positive influence across all aspects of the general insurance industry including product disclosure, claims handling and investigations, relationships with people who are experiencing vulnerability and reporting obligations.

The 2020 General Insurance Code of Practice (2020 Code) is due for a formal independent review this year as part of the regular 3 year cycle for continuously improving the Code. It is the intention of the ICA to apply to ASIC for approval of the new Code under the Corporations Act and having regard to ASIC Regulatory Guide 183.

Guiding principles for the review

The review's overarching principle will be to overall, maintain or enhance consumer protections.

In seeking to achieve the overarching principle, the review will also take into account the guiding principles of:

1. ***modernisation*** by being progressive and keeping up to date with contemporary developments;
2. ***enhancement of the customer experience journey*** when interacting with general insurers for example when buying insurance or at claim or complaints time;
3. ***accessibility*** in terms of clarity, enhanced understanding and simplification without losing meaning;
4. ***effectiveness and efficiency*** in terms of a positive customer experience and also operationally for general insurers, the Code Governance Committee, consumers and other stakeholders; and
5. ***providing consumer value without unnecessarily adding to claims cost pressures*** which may also take into account the weighing of broader cost-benefit considerations.

Independent review

In line with our sector's commitment to continuously improve the Code through formal independent reviews at least every three years, the ICA has appointed a three person Review Panel to conduct the review. The Review Panel will comprise of Helen Rowell (Chair), Paul Muir (industry expert) and Gerard Brody (consumer expert).

Scope of the review

The review will focus on the practical operation of the 2020 Code and relevant external developments including:

1. catastrophe response – taking into account the learnings and opportunities for Code improvement arising from the 2022 floods including the findings of both the Deloitte review and the Federal Parliamentary Inquiry into the general insurance industry's response to the 2022 floods as well as the COVID-19 pandemic;
2. support for customers and third-party beneficiaries in urgent financial need or experiencing financial hardship especially having regard to a catastrophe context. The review might also take into account any relevant ASIC good practice findings for the general insurance sector, the ACCC's recommendations in its Final Report *Northern Australia Insurance Inquiry* and any relevant Code Governance Committee recommendations;
3. whether the Code or its accompanying guidance for Part 9 of the Code (which deals with supporting vulnerable customers) continues to meet community standards in light of new and emerging best practice approaches for extra care, customers experiencing vulnerability, and the *National Plan to End Violence Against Women and Children 2022-2032*;
4. the interaction of the Code with existing laws and whether advancements or clarifications are needed having regard to the Financial Services Royal Commission reforms such as the new product Design and Distribution obligations, the inclusion of claims handling as a Financial Service, the deferred sales model for add-on insurance and the phasing out of cheques by 2030;
5. identifying the possible Code commitments which might be advanced for designation as an enforceable Code provision as part of any application for Code approval to ASIC.

The Review Panel will also consider if any enhancements are necessary to the Code's underlying governance arrangements to appropriately support the work of the Code Governance Committee. Adjustments may be necessary to advance an application for Code approval to ASIC which will include identification of enforceable Code provisions.

Timing of the review

The review will commence on Tuesday 14 November 2023, with the Review Panel to conduct the review in two phases.

The first phase will focus on consulting on topics that are unrelated to the floods (i.e. topics 2. – 5. and the governance arrangements to support the Code Governance Committee) towards delivering initial findings and recommendations of the first phase of the review in a Report by no later than 30 June 2024.

The second phase will focus on consulting on flood related topics to deliver findings and recommendations (and also confirm whether there might be any adjustments to the review's first phase findings and recommendations) in a Report by no later than 30 June 2025.

Both reports will contain findings and recommendations as to changes that may improve the operation and effectiveness of the Code taking into account the views expressed to the Review Panel during the

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consultations and having regard to the guiding principles for the review. However the reports will be framed according to the opinions of the individual members of the Review Panel. Whilst the ICA and its members will appoint the Review Panel and fund the review and the ICA will provide secretariat support, the Review Panel will act independently.

The ICA and its members remain committed to continuously improving the Code and will consider each report to determine what appropriate changes should be made to the Code.

Consultation

The Review Panel will consult key stakeholders, including the general insurance industry – the ICA and its members, ASIC, APRA, the General Insurance Code Governance Committee (CGC), Code Monitoring Team, AFCA and consumer representatives.

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