Insurance Council of Australia

7 June 2024

Attention: Review Panel
Helen Rowell, Gerard Brody and Paul Muir
c/- Secretariat to the Review Panel

Sent by email to: secretariat@codeofpracticereview.com.au

Dear Review Panel,

INDEPENDENT REVIEW INITIAL CONSULTATION PAPER

The Insurance Council of Australia (Insurance Council) and its members welcome the independent review of the 2020 General Insurance Code of Practice (Code) and the opportunity to comment on the review's Initial Consultation Paper.[1]

The Insurance Council intends to submit the next version of the Code, developed through the independent review process, to the Australian Securities and Investments Commission (ASIC) for approval.

The Insurance Council is the representative body for the general insurance industry in Australia and represents approximately 89% of private sector general insurers. Our membership is diverse, ranging from large ASX-listed companies to medium and smaller insurers who are mutuals, offer bespoke insurance products, or who are participants in a group structure.

General insurers perform a critical role in the Australian economy, assisting individuals, small business and communities to become more resilient and financially recover from loss or damage to their insured assets (for example car, home and contents, or an investment property). In support of the claims handling service outcomes provided to customers who might make a claim on their policy, general insurers have supply chain networks with builders, car repairers and other service suppliers to be able to offer claims resolution outcomes such as rebuild, replacement, repair or the payment of a cash settlement.

The Code continues to play an important role in setting best practice industry standards that go beyond the law. General insurers commit to the standards in the Code when conducting their business and interacting with customers across the customer experience life-cycle, including at sales and renewal time, when handling claims and complaints, and also when providing extra care and support to vulnerable consumers, including those experiencing financial hardship.

Compared with the 2014 version of the Code, the 2020 Code introduced many new and uplifted Code requirements, including new protections to support customers experiencing vulnerability and strengthened Code protections to support customers in financial hardship and when buying insurance and making a claim. A new Part 13 (*Enforcement, sanctions and compliance*) was also introduced into the Code to promote transparency and awareness of the existence of the Code Governance Committee (CGC), its remit, role and the ability to issue stronger sanctions for Significant Breaches of the Code, including for the first time, a new sanction of a Community Benefit Payment of up to $100,000. These strengthened compliance and enforcement provisions were in response to the

[1] Review Panel, *Independent Review: Initial Consultation Paper* (April 2024)

recommendations of the Financial Services Royal Commission (FSRC), and in preparation for the Insurance Council applying to ASIC for approval of the Code.

As the Code is a key document widely used by a diverse range of stakeholders, it is intended to be accessible and expressed in plain English especially for individual and small business consumers. The Code is not just used by subscribers of the Code, but also other stakeholders, such as consumers and their advocates, and regulators such as ASIC, the Australian Financial Complaints Authority (AFCA) and the CGC (as well as the Code Compliance and Monitoring Team who provides secretariat support to the CGC). With this in mind, it is important that Code commitments are expressed clearly and any areas of ambiguity or uncertainty resolved for accessibility.

To promote accessibility and awareness of the Code, our members support the development of a complementary customer information booklet for consumers and their advocates which covers the general customer protections in the law and commitments in the Code which go beyond the law. Key topics the booklet could range across how to access urgent financial need supports, understanding the difference between intermediated and direct sales channels, protections offered by FSRC laws, such as the protections at point of sale (e.g. add-on insurance and anti-hawking), how to complain, and privacy protections.

Our members support the protections in the Code being enhanced in some areas so that the Code goes beyond the law and overall maintains or strengthens the customer protections in the Code. On behalf of our members, we have suggested some key areas for strengthening the Code, with respect to financial hardship, vulnerability and making a claim. In other areas, where the Code offers limited added value to the overall customer experience journey or outcomes, our submission proposes opportunities to remove or adjust current Code commitments which in our members' experience are adding operational complexity, unnecessary duplication of obligations and compliance costs. For example, our submission recommends the removal of Code paragraph 43 (having a publicly available policy on the development and distribution of products) and Code paragraph 146 (providing progress updates about a complaint every 10 business days).

An operationally efficient and effective Code that delivers good policy outcomes for everyone – consumers (individuals and small business), and the entire business community - contributes to a strong and stable general insurance industry that provides affordable general insurance products. We encourage the Review Panel to carefully consider how changes to the Code can improve operational efficiency, effectiveness and consumer value without unnecessarily adding to claims cost pressures, particularly at a time of sustained cost pressures on insurers, consumers, and a growing insurance protection gap in Australia.[2]

For certain customer protections in the Code, such as those regarding vulnerable customers and financial hardship, it is our members' preference that the Code continue to reflect a principles-based approach and not be made overly prescriptive. This would provide subscribers with the flexibility needed to tailor responses to each customer's unique needs (including unforeseen circumstances) by being able to apply the Code to a diverse range of customer vulnerabilities and circumstances. In turn this will facilitate good customer experience outcomes, especially for those needing extra care and support.

Since the Code commenced, the broader eco-system within which the Code operates has significantly transformed and consumer protections have been uplifted due to the enactment of legislative reforms recommended by the FSRC.[3] These legislative reforms have cumulatively placed a significant burden on insurers and in some instances lead to consumer confusion. We do not consider the Code should be used to correct shortcomings in legislation as it is more appropriate for Government to review the

[2] ICA News Release *Andrew Hall's speech at the National Press Club on the importance of addressing the protection gap* (23 November 2023)

[3] *Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Powers) Act 2019*; *Financial Sector Reform (Hayne Royal Commission Response) Act 2020*; *Financial Sector Reform (Hayne Royal Commission Response No. 2) Act 2021*

efficacy of the newly introduced FSRC laws through a post-implementation review. An example of a topic that would be more appropriate to consider through a FSRC post-implementation review is the types of information general insurers should provide to a customer to assist decision-making about whether to accept a cash settlement offer under the legislated Cash Settlement Fact Sheet (CSFS) requirements. We note that ASIC is presently considering a related matter, namely whether to renew the legislative relief provided by *ASIC Corporations (Cash Settlement Fact Sheet) Instrument 2022/59*[4] which streamlines processes for insurers to provide consumers cash amounts in emergency situations without first providing a CSFS. Consideration of this issue under a FSRC post implementation review would be consistent with ASIC's stated position in its Regulatory Guide 183 that when approving a financial services sector code, ASIC will consider explanations for why a particular consumer issue is not addressed by the Code, including when *an issue is best dealt with in another specified way (e.g. law reform)*.[5] Our submission discusses this in more detail.

Further, we highlight that there are a number of significant legislative reviews presently underway and the subject of inquiries which are not yet complete.[6] It is the preference of the Insurance Council and our members that the Code review not seek to recommend Code changes before the outcomes of these reviews and consequential reform legislation are settled, as these review processes could fundamentally change the customer protections in the *ASIC Act 2001* (ASIC Act), *Corporations Act 2001* (Corporations Act), *Insurance Contracts Act 1984* (Insurance Contracts Act) and *Privacy Act 1988* (Privacy Act). Notwithstanding these possible developments, our submission sets out when we believe it might be possible to make Code adjustments or to take other steps for our sector to improve customer experience outcomes while we wait for the legislative reforms to be implemented, following which further Code changes might be contemplated. It is our view this approach to reviewing the Code would best deliver enhanced consumer protections and operational efficiency and effectiveness at a time when the legislative landscape might undergo significant change.

General insurers acknowledge that since the Code commenced it has been stress-tested by the unprecedented 2022 major floods in New South Wales and Queensland. As part of industry's response to the floods, the Insurance Council commissioned Deloitte to undertake a Review: *The New Benchmark for Catastrophe Preparedness in Australia* (Deloitte Review).[7] The Deloitte Review made a number of findings and recommendations for industry improvement, including that the definition of vulnerability and Extraordinary Catastrophe be reviewed. We look forward to the opportunity to comment on how the definition of Extraordinary Catastrophe in the Code might be modernised to better reflect climate change science and associated considerations as part of the next phase of the review, noting that the Insurance Council and its members may build on or adjust the feedback in this submission as part of our consultation response to the second phase of the Review.

Our submission provides suggestions for improving the definition of vulnerability in the Code and how it might be operationally possible to identify customers experiencing heightened vulnerability during a catastrophe. We note however, that general insurers are different to other financial institutions such as banks, as general insurers do not have the same level of access to day-to-day customer transactions which might provide early indicia of vulnerability, including financial hardship. However, general insurer awareness of financial difficulty in the course of handling a claim, may be especially noticeable when a customer experiences a significant or total 'wipe out' situation of their insured asset such as the family home during a catastrophe. Another indicator may be when a customer fails to pay a premium.

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

[5] ASIC Regulatory Guide 183 *Approval of financial services sector codes of conduct* (March 2013), RG 183.62, page 16

[6] Government Response to the Privacy Act Review Report (28 September 2023) and further targeted consultations currently being undertaken; Parliamentary Inquiry into *Financial Services Regulatory Framework in Relation to Financial Abuse*, Parliamentary Inquiry into wholesale investor and wholesale client tests; Select Committee Inquiry into the *Impact of Climate Risk on Insurance Premiums and availability*

[7] Insurance Council, News Release *Comprehensive review released into insurers' response to 2022 flood Deloitte Review* (31 October 2023); Deloitte Review *The New Benchmark for Catastrophe Preparedness in Australia* (October 2023)

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As part of our sector's responsiveness to the Deloitte Review's findings and recommendations, the Insurance Council has commissioned Deloitte to undertake a follow up review of industry's implementation responses. The follow-up implementation review is scheduled to be completed later this year and we intend to share the findings, as they might assist the Review Panel's thinking.

The Insurance Council and its members also acknowledge the work of the Parliamentary Inquiry into *Insurers' responses to 2022 major floods claims*[8] and we look forward to participating in the second phase of the Code review consultation which will consider the Inquiry Report's findings and recommendations.

We set out in **Annexure 1** to this letter, our detailed feedback and responses to the initial consultation questions. Where possible, we have also provided case studies for illustrative purposes.

We would welcome the opportunity to discuss our submission. If you have any queries, please feel free to contact me, Anne Knight, General Counsel at aknight@insurancecouncil.com.au or Ai-Lin Lee, Senior Policy Advisor, Regulatory and Consumer Policy at alee@insurancecouncil.com.au.

Yours sincerely,

Kylie Macfarlane
Chief Operating Officer

[8] Parliamentary Inquiry into *insurers' responses to 2022 major floods claims*

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ANNEXURE 1: ICA SUBMISSION TO THE INDEPENDENT REVIEW INITIAL CONSULTATION PAPER

1. KEY AREAS TO BE CONSIDERED BY THE REVIEW

Financial hardship

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

For example:

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

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

Response to Question 2.1

The Code's adequacy of protections for customers facing financial difficulties

1.1 The Insurance Council and its members welcome the Review Panel considering enhancements to the Code to support customers experiencing financial difficulty and provide suggestions for how this might be best achieved.

1.2 The Code currently uses three different types of terminology associated with customer financial difficulty:

(a) *financial distress* at paragraph 92(k) in Part 9 of the Code when listing possible factors that might indicate customer vulnerability;

(b) *urgent financial need* at paragraphs 64(b) and 66 at Part 8 (*Making a claim*) and paragraph 106 in Part 10 for fast-tracking urgent claims; and

(c) *financial hardship* in Part 10 of the Code which means *you have difficulty meeting your financial obligations to us* (as defined in Part 16), except in relation to paying an insurance premium, which is excluded from Part 10 by paragraph 108.

1.3 It is the understanding of our members that the term 'financial distress' at paragraph 92(k) was intended to introduce what might be a transient factor that could be an indicia for a customer experiencing vulnerability, while the concept of 'financial hardship' sets the bar at a comparably higher standard.

1.4 While our members have trained their staff to understand the different terminology for financial difficulty in Parts 9 and 10 in this way, our members suggest there could be benefits for all stakeholders and not just subscribers, in terms of improved accessibility, ease of understanding and therefore consistency of application if Part 16 of the Code were to also include definitions for the meaning of 'financial distress' and 'urgent financial need'. Definitions would also assist with delineations between the three different concepts.

1.5 We note that relevant to the concept of 'urgent financial need', the Insurance Council and its members worked with ASIC to obtain legislative relief from having to provide a CSFS when making emergency payments to customers of $5,000 or less.[9] A review of ASIC's relief instrument is currently underway. The emergency payments covered by the relief are intended to

[9] As above for note 4

assist the customer purchase essential items such as food or clothing following a break-in or catastrophe such as a bushfire or flood.[10] The legislative instrument refers to immediate need as being when *the customer expressly instructs the insurer they are in immediate need of a cash payment because of an insurable event the subject of the claim*.[11]

1.6 Our members suggest there could be greater prominence in the Code at paragraph 64 or in supporting guidance to the Code and in the customer information booklet discussed at paragraph 4.2 of this Annexure 1, to assist consumer awareness of the types of circumstances when a customer may request their insurer provide urgent financial assistance. For example, in addition to providing assistance with purchasing essential items such as food and clothing, urgent financial assistance might also respond to temporary accommodation needs,[12] or urgent medical needs, such as when a customer is a diabetic and their medicine needs to be stored in a fridge, thereby also covering financial assistance for a fridge.

1.7 Our members tell us there may also be a need for general insurers to provide urgent financial assistance for farming small business customers in remote locations to be able to obtain a generator, especially if electrical power might not be reinstated for an extended period of time following a catastrophe.

1.8 We suggest the cross-reference at Code paragraph 65 in Part 8 that refers to applying for Financial Hardship support in Part 10 be removed. Our members advise us this cross-reference may create customer confusion as it is not necessary for a customer to apply for financial hardship support under Part 10 to be able to receive assistance for urgent financial need.

1.9 As the commitments in Part 10 of the Code were originally designed to support customers at the later claims handling stage, and in the context of general insurers writing off a customer's debt, the processes for requesting, assessing and deciding to grant financial hardship relief are formal processes. The 2020 Code at paragraph 123 also introduced new options for relief so that customers would not be disadvantaged if they could not first pay their excess, to receive the benefit of a claims resolution outcome.[13]

1.10 Our members suggest there could be opportunities to improve the processes in Part 10, so hardship requests can be considered and granted more quickly at the later claims handling stage leading to an enhanced customer experience. Code paragraph 111 refers to what happens if a person tells an insurer they are experiencing financial hardship and that the insurer will provide a form for the person to apply for financial hardship support. Our members advise us that they may not always need the applicant to complete a form if they are an existing customer, however completing a form may be useful if the applicant is a third party beneficiary or an at fault individual against whom the insurer seeks to recover and their details are not already on file. The hardship application experience could be further enhanced if the Code were to allow for technologically neutral methods of applying for financial hardship (e.g. by using an app or conversation over the phone). Presently the term in 'writing' as defined in Part 16 is limited and excludes some methods of communication. These changes would enhance general insurers' ability to expeditiously support customers who may be experiencing financial hardship especially if they have experienced a significant or total 'wipe out' situation of their insured asset such as the family home during a catastrophe.

Adopting ASIC's expectations

1.11 During COVID-19, the Insurance Council engaged with its members to explore how insurers could better support customers, and a number of general insurers decided to voluntarily offer

[10] Explanatory Memorandum to ASIC Corporations (Cash Settlement Fact Sheet) Instrument 2022/59
[11] As above for note 4, ASIC Corporations (Cash Settlement Fact Sheet) Instrument 2022/59, paragraph 5
[12] ASIC Report 768 *Navigating the storm: ASIC's Review of home insurance claims* (August 2023), page 12
[13] Insurance Council Final Report *Review of the General Insurance Code of Practice* (June 2018), recommendation 3, pages 6-7 and 20-22

premium relief options to existing customers on a discretionary basis, over and above the commitments in Part 10 of the Code. This was to minimise customer detriment by assisting customers to remain insured at a critical point in time when their income might have been significantly reduced due to COVID-19 State and Territory stay at home orders, notwithstanding Government financial support payments. The COVID-19 situation led to ASIC undertaking a review of general insurers' hardship practices, and ASIC writing to all general insurers to recommend the short-term financial hardship initiatives offered on a voluntary and discretionary basis be carried forward longer term and offered by all insurers.[14]

1.12 We highlight that ASIC's expectations did not apply to new customers and our members are of the view it would not be appropriate to expect that new customers can access these discretionary supports.

1.13 Our members wish to draw to the Review Panel's attention to potential legal and operational considerations that might pose barriers to all general insurers', and especially the ability of smaller general insurers to meet certain ASIC expectations regarding hardship practices if they were to be introduced into the Code.

1.14 It may be challenging for general insurers to:

(a) *proactively communicate financial hardship information to assist a customer maintain cover* as general insurers do not have line of sight into an existing customer's income and have limited information that might provide early indicia the customer is experiencing financial difficulty, unless the customer (or their financial counsellor or other consumer advocate, such as a Legal Aid lawyer, acting on the customer's behalf) actively notifies the general insurer. For example, general insurers may only be able to actively identify the customer is potentially experiencing financial difficulty if they miss a monthly payment under a monthly instalment policy or tell the insurer they are unable to pay their excess; and

(b) *collect and monitor data on hardship requests and outcomes to inform the financial hardship support options provided* as any customer data collection would need to comply with the Privacy Act and Australian Privacy Principles and be balanced against the potential risk of identification of the individual customer in the event of a cyber security incident. Further, it may be that some customers may not consent to their personal data being collected, and it may not be possible to pin-point with accuracy through data alone whether a customer might be experiencing financial hardship, as general insurers who have a larger data capacity (due to having a larger customer-base) might have different insights to those who do not. It may be possible for some larger insurers to collect and review data at a very high level or at the portfolio level (e.g. in relation to home, contents or motor policies), to better understand the kinds of hardship relief being granted to support regular reviews of practices and policies for continuous improvement and enhanced customer experience outcomes. However smaller insurers may have more limited capacity for data collection and review, and building systems changes.

1.15 Further considerations might apply if the Code were to be updated for the premium relief support options in ASIC's letter of 22 April 2021. We discuss these below at paragraphs 1.16–1.19.

Premium relief support options

1.16 Our members inform us that not all general insurers, especially smaller general insurers, would be able to offer premium relief support options to existing customers on a discretionary basis. This is supported by the CGC's review of hardship information on Code subscriber's websites which found that a very small number of Code subscriber websites (11) mentioned the availability

[14] ASIC letter to Directors of general insurers, *ASIC's expectations of general insurers: responding to consumers in financial hardship* (22 April 2021)

of this option.[15] Premium relief also needs to be considered in the context of a premium usually being in respect of a one year contract (unlike other types of financial products) and the need for insurers to appropriately price for risk associated with insuring a particular asset. It is also important to remember that insurers have certain prudential obligations. While COVID-19 gave rise to highly exceptional circumstances and support to customers including by way of premium relief, this is not an option that would necessarily be sustainable or appropriate in all circumstances given the nature of the risks that insurers are taking on and in the context of insurers' prudential obligations.

1.17 In light of this, our members prefer a principles-based approach for how this discretionary support might be offered. It is our members' preference that these discretionary support options be left to general insurers and whether they are available will continue to be published on a general insurer's websites in line with Code paragraph 105 which provides: *We will have information about applying for Financial Hardship support on our website. The information will set out the types of support options that may be available, and how you can access Financial Hardship support*.

1.18 In the event the Review Panel wishes to update the Code to include this and the other discretionary support options suggested by ASIC to help an existing customer maintain their insurance cover,[16] the drafting in the Code would need to make it clear these are discretionary support options and are suggestions for general insurers' consideration when offering support to existing customers who might be experiencing short-term financial hardship. This would mean there could be no Code breach consequence if the Code subscriber in its discretion determined not to provide such options.

1.19 Further, if these discretionary support options were to be introduced into the Code, our members identify there may need to be other changes to support good customer experience responses for existing customers in short-term financial hardship. These might include:

(a) *an agreed definition of what temporary and short-term financial hardship means*: Our members suggest that the inclusion of a definition of temporary and short-term financial hardship for accessibility, ease of understanding and consistency of application, would be needed. Such a definition could be: 'temporary and short-term financial hardship' means *when the general insurer reasonably assesses the customer would experience financial hardship for no longer than 12 calendar weeks (or 3 months)*;

(b) *relaxed processes:* This would allow for general insurers to be able to flexibly and expeditiously consider and grant premium support options to existing customer policy holders, and at the later claims handling stages on a discretionary basis, but not in relation to debt recovery actions. This would be needed so general insurers can responsively assist the customer. Further there might need to be relaxed processes to accommodate pay by the month administration which may typically involve arrangements for direct debit payments; and

(c) *complaints handling:* Our members identify there may need to be consideration of the complaints handling avenues available to the customer if a customer does not accept the general insurer's response to their hardship request, and whether adjustments are necessary to Part 11 (*Complaints*) of the Code. Currently, complaints about the level of a premium are generally outside AFCA's remit in recognition that premium pricing is risk-

[15] CGC Thematic Inquiry Report *Information about Financial hardship support on Insurer's websites* (June 2023), page 11
[16] As above for note 14, ASIC's letter, expectation 1 (page 4)

based.[17] Our members would not support AFCA becoming a premium pricing regulator by being able to consider complaints about the level at which the price of a premium is set.

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

Response to Question 2.2

1.20 The Code already provides adequate obligations for third party debt collectors. Our members are of the view there is no need for the Code to go further in this area, given the strengthened regulation arising from APRA CPS 230 which may go some way to improving oversight.[18]

1.21 The Insurance Council in its submission to the CGC's monitoring priorities consultation 2024-25,[19] encouraged the CGC to complete the second part of its Thematic Inquiry into insurer's end-to-end processes for providing financial hardship support to customers. Such a Thematic Inquiry could review third party debt-collection processes. CGC Thematic Inquiries provide important insights into Code subscribers' performance against certain Code provisions and usually result in findings of best practice and recommendations to encourage continuous improvement.

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

Response to Question 2.3

Guide covering discretionary short-term hardship relief options for existing customers

1.22 In the event the Review Panel considers something more is needed than insurers providing information on their website about the discretionary premium relief support options available, we suggest that instead of updating the Code, an accompanying Guide to support the Code could be developed. This could provide value for customers without unnecessarily adding to compliance costs, by minimising the need to extensively rewrite Part 10 of the Code. Such a guide could be developed in consultation with relevant stakeholders including support agencies.

Customer vulnerability

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

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

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

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

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[17] AFCA Rules, Rule C.1.2 (7 March 2024), page 123: *AFCA must exclude: a) a complaint about the level of a fee, premium, charge, rebate or interest rate – unless: (i) the complaint concerns non-disclosure, misrepresentation or incorrect application of the fee, premium, charge or interest rate by the Financial Firm having regard to any scale or practices generally applied by that Financial Firm or agreed with that Complainant*

[18] APRA Prudential Standard CPS 230 *Operational Risk Management* (July 2025)

[19] Insurance Council, submission to *CGC Monitoring Priorities Consultation 2024-25* (5 February 2024)

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

Response to Question 2.4

Improving the Code in line with community expectations

1.23 For the first time, the 2020 Code referred to the concept of customer vulnerability and that these customers might be offered extra care and support. Part 9 *Supporting customers experiencing vulnerability* in the Code has been transformative for the general insurance industry. Many of our members restructured their businesses to set up specialist 'high care' customer support teams, trained customer-facing staff to identify and support vulnerable customers and changed systems and processes to have in place a Family Violence Policy about how the business would support victim-survivors.

1.24 With the Code commitments in Part 9 stress tested during the 2022 major floods, we recognise further work is needed to improve the customer experience and advance a more sophisticated and nuanced approach to recognising and responding to customer vulnerability, especially during a catastrophe event (and if an Extraordinary Catastrophe is declared, under a new definition to take into account climate change science).

1.25 We welcome the independent review of the Code assisting our sector to respond to the Deloitte Review's recommendations relevant to vulnerability. These involve reviewing:

(a) for effectiveness, the definition, identification and support of vulnerable customers during catastrophes, including how to identify and support customers experiencing heightened vulnerability, such as those arising from family violence;[20] and

(b) the minimum commitments general insurers would be expected to meet to prioritise vulnerable customers as part of reviewing the definition of 'Extraordinary Catastrophe' and the types of relief that would be afforded to general insurers once declared.[21]

1.26 For greatest operational efficiency and effectiveness, we encourage any Code changes to be aligned with other best practice standards such as the ISO Vulnerability Standard, and for the Code commitments to be scalable so they are capable of being implemented by large and small general insurance businesses without having a disproportionate impact on the latter.

1.27 General insurers would like to see Code commitments that are not overly prescriptive, and that allow sufficient flexibility so general insurers can offer tailored solutions for optimal customer experience outcomes to best suit a customer's particular vulnerability and the unique scenario their circumstances might present.

1.28 This could best be achieved by the Code being updated by the inclusion of a modernised definition of vulnerability, a shared understanding of what vulnerability means for the purposes of general insurance, and a continuation of the principles-based approach for enhanced general insurer identification and triaging of support to those who need it most.

1.29 It is our preference that any supporting considerations for particular vulnerabilities be set out in supporting Guidance to the Code, instead of being included in the Code. This would allow for flexibility and evolution through piloting, testing and further improvement as the sector's knowledge and understanding grows.

1.30 Our members encourage the Review Panel to explore whether there might be more appropriate terminology that could be inserted in the Code instead of 'vulnerability' as our members advise us there may be certain cohorts of customers who may find the term offensive, and do not wish to be labelled as 'vulnerable' because they associate this term with stigmatisation. The Insurance

[20] As above for note 7, Finding 8.10 and recommendation 2.3, pages 30, 37, 97-98, 117
[21] As above for note 7, Finding 9.2 and Recommendation 7, pages 34, 41, 110 and 121

Council and our members do not wish for customers to feel stigmatised. Our members suggest possible alternative language such as supporting customers 'requiring extra care or additional support'.

1.31 In further support of this, Code paragraph 93 could be updated 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 – otherwise, there is a risk that we may not find out.*

Inquiry into financial abuse

1.32 We draw the Review Panel's attention to the Federal Inquiry into *Financial Services Regulatory Framework in Relation to Financial Abuse* announced on 2 April 2024.[22] This Inquiry will consider the effectiveness of existing legislation (i.e. the Insurance Contracts Act, Privacy Act, ASIC Act), other potential areas for reform (including prevention, protection, proactive systems and employee training), as well as steps that might be taken to support financial institutions to better detect and respond to financial abuse. The Inquiry has invited submissions by 14 June 2024 and proposes to report to Parliament by October 2024.

1.33 As the Inquiry could transform the broader legislative framework against which the Code would operate, we suggest the Inquiry's Report is likely to be of great interest to the Review Panel.

1.34 The Insurance Council intends to coordinate an industry submission to the Inquiry. We would be happy to share a copy of our submission with the Review Panel.

Inclusive product and service design

1.35 Many of our larger members have independently developed Financial Inclusion Action Plans for their business, that are publicly available on their websites.[23]

1.36 Separate to these, the Insurance Council has engaged KPMG to develop an industry Financial Inclusion Blueprint in consultation with members, and other key stakeholders such as consumer advocates represented on the Insurance Council's Consumer Advisory Committee (CAC) as part of the Insurance Council's 2024 work program. The Blueprint will support the general insurance industry's customer inclusion work program, by having regard to consumer vulnerabilities, and also potentially consider what financial abuse means in the general insurance context, for a shared understanding across the industry.

1.37 The Insurance Council and its members are supportive of the Code being more explicit in its articulation of general insurers providing inclusive and accessible general insurance products by a customer being able to access a support person such as a lawyer, consumer advocate, interpreter or friend (paragraphs 97-98), identification (paragraph 100) and by the general insurer arranging for the use of an interpreter or translations in other languages (Code paragraphs 101-103).

1.38 While these Code commitments are already included in Part 9 of the Code, our members suggest there could be drafting enhancements to modernise and refine the commitments to take into account recent developments. The drafting enhancements could also assist consumer and consumer advocates' understanding of what the Code obliges an insurer to do. For example, in relation to:

(a) *identification*: general insurers support the new AUSTRAC guidance for flexible forms of ID,[24] and also broader considerations associated with the possible introduction of an economy-wide digital ID for customers; and[25]

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[22] Parliamentary Inquiry *Financial Services Regulatory Framework in Relation to Financial Abuse*
[23] For example: Suncorp FIAP 2022-25, Allianz FIAP 2021-22, IAG FIAP 2020-21, QBE FIAP 2019-2020
[24] AUSTRAC Guidance *Assisting customers who don't have standard forms of identification* (17 Jan 2024)
[25] *Digital ID Bill 2024*

(b) *insurers arranging for access to an interpreter or publishing translated information on the insurer's website*: in our members' experience, it may not always be well understood that there may be practical limitations for insurers, especially smaller general insurers, when some languages are not commonly spoken and it is not possible to find a qualified interpreter or translator.

1.39 Our members would be supportive of new best practice guidance being developed to support the Code regarding a new high level and aspirational statement, that general insurers will endeavour to consider and review how the design of their products and processes might be improved for greater customer inclusion. Our members are of the view it would not be feasible to include this aspirational statement in the Code at this time.

1.40 An aspirational statement in supporting guidance to the Code would allow the Insurance Council and general insurers sufficient time to carefully consider the further work that can be done to support customers experiencing family violence and financial abuse, taking into account the recent calls to action in the *National Plan to End Violence Against Women and Children 2022-2032* to make general insurance products and processes safer for victim-survivors,[26] the recommendations in the Centre for Women's Economic Safety (CWES) Discussion Paper 2[27] and the legislative and other developments that might flow from the Inquiry into financial abuse.[28] The Insurance Council and its members appreciate that developing appropriate and best practice industry responses to financial abuse is a complex and highly nuanced problem to solve and we would not want to see unintended poor consequences for victim-survivors, by the Code being updated in a way that might not allow flexibility for general insurers to sufficiently respond to the full range of circumstances that might arise. We encourage the Review Panel to adopt an approach that recognises that responses to financial abuse will be a longer-term journey of continuous improvement for our sector, and that different general insurers may be at different stages of the journey.

1.41 Once the Financial Inclusion Blueprint is developed, the Insurance Council intends to work with its members and other key stakeholders to review and update our current *Guide to helping customers affected by family violence*[29] to expand on the best practice extra care supports that might be available to customers experiencing financial abuse and what financial abuse means in the general insurance context. As part of this process, there may be opportunities to also consider inclusive product design and process features.

1.42 Another recent example of focus where the Insurance Council and general insurers have been working on improved products and processes for enhanced customer inclusion is in response to the InsurePride *Worth the Risk* Report and its best practice inclusive design recommendations for LGBTIQA+ customers.[30]

1.43 As the InsurePride Report was acknowledged by consumer advocates represented on the Insurance Council's CAC, which recently reported the work the general insurance industry had done on this topic in the Insurance Council's Annual Report 2023:[31] *The CAC drew to a close in 2023 its priority issue focused on customer inclusivity of LGBTIQA+ customers, noting the general insurance sector had made considerable progress in responding to the best-practice recommendations in the InsurePride Worth the Risk Report. The Committee acknowledged that while general insurers are at different stages of the journey, the general insurance sector would continue to work towards further improvement.*

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[26] Department of Social Services *National Plan to End Violence against Women and Children 2022-2032* (17 October 2022), pages 18, 96-97 and 105
[27] CWES, Discussion Paper 2 *Designed to Disrupt: Reimagining general insurance products to improve financial safety*
[28] As above for note 22
[29] Insurance Council *Guide to helping customers affected by family violence* (1 July 2021)
[30] InsurePride Report *Worth the Risk* (28 June 2022)
[31] Insurance Council *Annual Report 2023*, page 15

Modernised definition of vulnerability in the Code

1.44 The Insurance Council and its members support updating the definition of vulnerability at paragraph 92 of the Code to include two new factors and expand one factor to improve customer experience outcomes so the Code is modernised to better align with community expectations and learnings following the 2022 major floods.

1.45 Our members are supportive of Code paragraph 92 being updated to:

(a) add two new factors:

- sexual orientation, gender identity and sex characteristics;
- trauma; and

(b) expand the existing factor at paragraph 92(e) for family violence to explicitly mention financial abuse as a type of family violence.

1.46 We support the Review Panel considering these changes to the definition of vulnerability at paragraph 92 because:

(a) the new factors of sexual orientation, gender identity and sex characteristics would respond to the suggestion in the InsurePride Report;[32]

(b) the new factor of trauma would recognise that trauma may arise as a result of a customer surviving a catastrophe (whether in relation to a flood, hailstorm, bushfire or cyclone, or an extreme weather event) or other situation, or perhaps due to other vicissitudes of life (for example, the possible scenarios provided in the initial consultation paper);[33] and

(c) explicitly including financial abuse as a type of family violence, 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.[34]

1.47 Our members are of the view that other than these factors, there are no other types of vulnerability or disadvantage that require explicit mention in the Code.

1.48 With respect to the factor for trauma, our members suggest that this would be most relevant to identifying whether the extra care and support for the customer would need to be delivered by general insurer staff who have been appropriately trained to provide trauma-informed responses.

Early identification and triage of vulnerable customers and promoting enhanced responses to customers experiencing heightened vulnerability during a catastrophe

1.49 Our members highlight that general insurance may be sold through insurance brokers, or directly to the customer and increasingly online. In this respect, general insurance is different to other financial services, because general insurers may not necessarily have face-to-face customer interactions, nor line of sight into a customer's vulnerability until claims time. Even if a general insurer may become aware of indications of possible vulnerability when the customer calls the general insurer, it may be the case that the customer does not wish to be identified as vulnerable, nor consent to being flagged as vulnerable on the general insurer's system, perhaps because they might think that others might be more vulnerable than them.

1.50 Our members would not wish to see the introduction of a requirement in the Code that subscribers must enquire of each customer at the buying and renewal stage (e.g. using a tick the box question for the Code's vulnerability factors) to gauge whether the customer self-identifies as vulnerable. We anticipate that even if permitted by privacy laws, this could be perceived by customers to be a personally intrusive question and could also generate complaints about

[32] As above for note 30, InsurePride Report, page 3
[33] As above for note 1, page 12
[34] As above for note 26, pages 52-53

whether the insurer is engaging in unfair trading practices when deciding whether or not to insure the customer. Current questions asked of customers at the buying and renewal stage respond to policy underwriting questions and inform whether the customer is within the risk-tolerance for the general insurer to provide cover. When responding to questions at point of sale and renewal time, customers have a duty not to misrepresent, otherwise there may be implications for their cover including that the policy may be avoided by an insurer (treated as if it never existed) or result in a claim being declined or a benefit being reduced. Further, expanding the reach of policy underwriting questions to gauge whether a customer is vulnerable and their type of vulnerability, could potentially result in customers losing access to general insurance products altogether if the customer were to be found outside risk-tolerance levels. This would generally only be a potential risk in respect of physical health matters which are relevant for certain products. Our members wish to highlight these possible unintended consequences if the Code were to be updated to adopt this approach. Further, it is the view of our members it would not be operationally efficient nor effective to identify vulnerable customers at this early stage of the customer experience journey, especially as vulnerability may be temporary and not necessarily enduring, depending on a person's particular life circumstances. Vulnerability may also be different at the claims handling stage and not all customers who purchase or renew insurance may necessarily make a claim on their policy. To require the capture of this type of data at this stage of the customer experience journey, would impose significant compliance costs associated with systems and process changes and training staff, without providing any consumer value.

1.51 Our members do not support a default presumption of vulnerability for customers who may be experiencing trauma because it would not be operationally possible for general insurers to be able to quickly identify and triage those customers experiencing heightened vulnerability, especially victim survivors of family violence or financial abuse, during a catastrophe.

1.52 The findings of the Deloitte review and the evidence of lived experience being presented to the Parliamentary Inquiry into *Insurers' responses to 2022 major floods claims*[35] indicates that in a catastrophe situation of the scale and impact of the 2022 floods, any person who has survived would have likely be experiencing trauma to some degree. As a result, the focus instead needs to be on discerning those experiencing elevated levels of vulnerability and we suggest this could be by focusing on those at greatest risk of harm.

1.53 Instead, our members welcome the Review Panel considering whether the Code could be updated to provide that general insurers will identify and triage those customers at greatest risk of 'harm' which is a consideration reflected in the ISO Vulnerability Standard and was also applied by ASIC when granting general insurers relief from having to provide a CSFS to protect victim survivors of family violence.[36] The concept of 'at greatest risk of harm' and what it might mean in practice, could be elaborated in best practice supporting guidance to the Code. This would assist general insurers with a categorisation of possible indicia to identify and triage the greatest harms and those impacting customers during a declared catastrophe or Extraordinary Catastrophe.

1.54 Further, a consideration of 'at greatest risk of harm' would be sufficiently flexible, adaptable and scalable to allow extra care responses for a diverse range of customer vulnerabilities and circumstances.

1.55 Our members identify there may be an extensive range of extra care responses that might be offered to vulnerable customers by general insurers but what this might be is dependent on the general insurer, scalable across large and smaller general insurers, and informed by commercial considerations relevant to each insurer. With this in mind, we do not think it desirable to prescribe the nature of the responses that should be offered in the Code. However possible de-

[35] As above for note 8

[36] ASIC Media Release (22-26MR) *ASIC helps insurers to response to family violence* (28 September 2022); ASIC Corporations (Cash Settlement Fact Sheet and Confirming Transactions) Instrument 2022/809

identified customer experience examples could be canvassed for illustrative purposes and to enhance customer awareness.

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

Response to Question 2.5

1.56 The vulnerability commitments in Part 9 of the Code have only been in place for a relatively short period of time.

1.57 The Insurance Council has established mechanisms to obtain feedback about emerging consumer vulnerability issues and how the general insurance industry can improve its support for customers experiencing vulnerability. This has been through regular engagement with key stakeholders such as AFCA, ASIC, the CGC (Code Team) and consumer advocates represented on the Insurance Council's CAC. Additional insights have been derived from AFCA determinations in accordance with its rules. When resolving a complaint, AFCA is to consider what is fair in all the circumstances, having regard to the legal principles, industry best practice and applicable industry Codes or guidance.[37] Further, AFCA, members of the public and consumer advocates can directly report to the CGC a breach of the Code under Code paragraph 164. From time to time, the CGC provides insights into this mechanism being actively used by a range of stakeholders to report Code breaches and whether the information provided led to CGC investigations.[38]

1.58 We highlight the Reviews and Thematic Inquiries undertaken by the CGC into vulnerability and financial hardship which have encouraged industry compliance and offer best practice improvement recommendations to assist general insurers.[39]

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

Response to Question 2.6

Other mechanisms

1.59 The Financial Inclusion Action Plans of each general insurer and the Insurance Council's Financial Inclusion Blueprint would complement the Code's vulnerability support provisions.

The Code and the law

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

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

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

Response to Question 2.7

Areas for improvement when the Code interacts with the law

[37] As above for note 17, AFCA Rule A.14.2
[38] CGC Annual Report 2021-22, page 13
[39] CGC Report *Assessment of Compliance with new provision on family violence policy* (March 2021); CGC Report *Parts 9 and 10 of the Code - Review of subscribers' implementation of vulnerability and financial hardship obligations* (November 2021); CGC Thematic Inquiry Report *Information about Financial Hardship support on Insurers' websites* (June 2023);

1.60 Our members are of the view that Code paragraphs 18 – 20 do not adequately resolve conflicts or inconsistencies between the Code and the law.

1.61 Our members encourage consideration of improving accessibility and simplification of the Code, especially when duplication and overlap between the Code and the law are contributing to operational complexity because the Code commitment might be expressed in a slightly different way. Minor differences in drafting between an overlapping Code and legal requirement can contribute to compliance complexity, creates uncertainty as to the standard of compliance that needs to be met and may detract from general insurers being able to focus on providing good customer experience outcomes.

1.62 Our members welcome the Review Panel considering the removal of the following Code paragraphs which were introduced prior to the introduction of the laws implemented following the recommendations of the FSRC. As these Code commitments have now been superseded by the laws passed following the recommendations of the FSRC, and are duplicative. They do not add considerable value or benefit to the customer experience journey or consumer outcomes and our members suggest they be removed in order that compliance efforts and resourcing may be devoted to those Code protections that go beyond the law. Further, our members consider that there is a stronger argument for removal of these paragraphs, if the Review Panel is not inclined to adopt our suggestions in paragraphs 4.23–4.24 below to address the compliance burden associated with duplicative reporting to the CGC and ASIC:

(a) Code paragraph 43: *We will have a publicly available policy on our approach to the development and distribution of our products for appropriate target markets. This policy will be published on our website.* Our further reasons for suggesting this paragraph be removed are detailed below in response to Question 3.8 at paragraphs 2.19–2.21 below.

(b) Code paragraph 44 about pressure sales has been superseded by the Corporations Act anti-hawking obligations.

(c) Code paragraphs 52 – 53 regarding sale of Consumer Credit Insurance. These Code commitments have been superseded by the new provisions in the Corporations Act in respect of the deferred sales model for add-on sales.

1.63 Our members would welcome reconsideration of the need for Code paragraph 79: *If we offer a cash settlement under a home building policy, we will provide you with information to help you understand how they work and how decisions are made on cash settlements.* The law on CSFS covers in detail when and how general insurers must offer specific information to customers to assist their decision about whether to accept a cash settlement offer. The CSFS requirements in the law apply more broadly to all cash settlements (unless ASIC has provided an exemption), regardless as to whether or not such a settlement is offered in relation to a home building policy. We recognise that if a post-FSRC implementation review covering CSFS were to be undertaken, it could adjust the legislative framework for CSFS and this may inform any proposal for change to Code paragraph 79.

1.64 If these Code paragraphs were to be removed from the Code, customer awareness of these legal protections could instead be promoted by referring to them in the customer information booklet proposed at paragraph 4.2 of this Annexure 1.

1.65 Our members would also welcome a review of the operational efficiency and effectiveness of Part 11 (*Complaints*) given new legislative complaints handling requirements in ASIC Regulatory Guide 271 *Internal Dispute Resolution*.[40] Our reasons for recommending this are provided below in response to Questions 3.13–3.14 at paragraphs 2.58–2.63 of this Annexure 1. We also refer to

[40] ASIC Regulatory Guide 271 *Internal Dispute Resolution* (September 2021); ASIC Corporations, Credit and Superannuation (Internal Dispute Resolution) Instrument 2020/98

our recommendation that the Review Panel consider removing the duplication with the Privacy Act that is contained in paragraphs of 2.72-2.74 of this Annexure.

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

For example:

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

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

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

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

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

Response to Question 2.8

How the Code can go beyond the law

1.66 The Insurance Council and its members are of the view the Code goes beyond the law and provides the greatest value to consumers with respect to the Code commitments in Part 9 (*Supporting customers experiencing vulnerability*) and with respect to supporting customers in urgent financial need (Code paragraph 64) and in financial hardship under Part 10.

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

Response to Question 2.9

1.67 We are of the view that any best practice guidance for how Code subscribers may comply with the law be documented in an accompanying guide to the Code and not in the Code itself.

Retail insurance and wholesale insurance

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

Response to Question 2.10

Review the application of the Code to retail and wholesale insurance

1.68 Our members support the Code continuing to apply to wholesale insurance, as it currently does, and welcome a review of the application of the Code to retail as distinct from wholesale insurance to ensure the Code is accessible and easy to apply. Some members consider the distinction between a retail and wholesale product in the Code is not entirely clear and potentially the Code could develop a different categorisation based on product.

1.69 We draw to the Review Panel's attention, the current Parliamentary Joint Committee Inquiry into *Wholesale investor and wholesale client tests* which will re-examine the definition in the Corporations Act.[41] The Inquiry has invited submissions by 15 May 2024 and proposes to report to Parliament by the end of 2024.

1.70 As the Inquiry may shift the delineation between a retail and wholesale client in the law and transform the broader legislative framework against which the Code would operate, the Inquiry's

[41] Parliamentary Joint Committee Inquiry into *Wholesale investor and wholesale client tests*

Report might be of interest to the Review Panel. Members consider the distinction between a retail and wholesale product in the Code is not clear and believe it would benefit from further clarification.

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

Response to Question 2.11

1.71 Notwithstanding the Parliamentary Joint Committee Inquiry may recommend changes to the broader legislation framework against which the Code operates, our members are not supportive of this proposed change and are of the view 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. This is in recognition that some SME products are highly complex and it is not appropriate for AFCA to handle certain types of complaints. Further, the classes of SME businesses are typically more complex and involve a number of different parties. Often claims are made by third parties who are not the insurer's customers.

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

Response to Question 2.12

1.72 Our members do not support updating the processes in the Code to distinguish between direct and intermediated insurance broker services as this would introduce unnecessary complexity.

1.73 Intermediated sales have been highly scrutinised by the FSRC, leading to new legislative requirements for add-on sales commissions, and also for insurance brokers.

1.74 As insurance brokers are not members of the Insurance Council, and also not subscribers to the General Insurance Code of Practice, the General Insurance CGC has no remit to oversee nor sanction the compliance performance of insurance brokers with respect to the Code. Instead, insurance brokers have their own Insurance Brokers Code of Practice[42] administered by the National Insurance Brokers Association (NIBA) and overseen by the Insurance Brokers Code Compliance Committee (IBCCC).

1.75 Even though the Code focuses on direct sales, the Insurance Council and its members are supportive of promoting greater customer awareness of the different types of sales channels (e.g. distributors and agents) that might apply even though the Code focuses on direct sales. Customer awareness could be promoted through the customer information booklet discussed at paragraph 4.2 in this Annexure 1. The customer information booklet could highlight some typical customer scenarios, for example if a refund is provided under Code paragraph 55 due to cancellation of the insurance policy, the general insurer would refund the insurance broker within the Code's timeframe, and the broker would then pass on the refund to the intermediated customer.

[42] NIBA, *National Insurance Brokers Code of Practice* (2022)

2. OTHER PARTS OF THE CODE

Key obligation – honest, efficient, fair, timely and transparent

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

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

Response to Questions 3.1 and 3.2

Improving the operational effectiveness of Code paragraphs 21 and 22

2.1 Our members support an efficient and effective Code that does not unintentionally create customer confusion. Our members encourage the Review Panel to consider deleting Code paragraphs 21 and 22 given the principles that underpin the Code at page 4 already cover the same principles. We are aware the principles are used by the CGC to guide interpretation of the Code in a manner the CGC often describes as the 'spirit and intent' of the Code. Alternatively, 'honest, efficient, fair, transparent and timely' could be added to the objectives in Part 1 of the Code.

2.2 The principles of 'honest, efficient, fair, transparent and timely' dealings in paragraph 21 were moved to in the front section of the 2020 Code as a standalone overarching obligation, instead of being replicated at each section as was the case in the 2014 Code, in response to stakeholder feedback from consumer advocates and the CGC.[43]

2.3 Code paragraph 21 goes beyond the law in section 912A(1)(a) of the Corporations Act by adding the terms transparent and timely to 'honest, efficient, fair'. However, while the wording of paragraph 21 would appear to draw from the language in section 912A(1)(a), the interpretation of Code paragraph 21 by the CGC has moved in a different direction to the body of case law which has developed by the courts in respect of section 912A(1)(a). This is creating a parallel Code compliance regime that does not add considerable consumer value.

2.4 When drafted, it was intended that Code paragraph 21 would be read in conjunction with Code paragraph 22, to distinguish that the role of the CGC is to monitor the compliance performance of Code subscribers against the obligations in the Code, and not in law. Further, the specific ways in which Code subscribers could demonstrate they are meeting the overarching principles expressed in Code paragraph 21 would be through their compliance with the specific commitments in the rest of the Code.

2.5 It was not envisaged at the time that Code breaches would have to be separately reported against Code paragraph 21, even though this is the direction the CGC (and Code Team) have taken with the administration of the Code.

2.6 As illustrated by scenarios A and B, our members highlight that Code paragraph 21 can unnecessarily raise customer expectations about how general insurers will treat customers in accordance with the Code, resulting in complaints.

Scenario A: ***Code paragraph 21 and privacy***

The customer raised concerns with the general insurer about how the insurer was handling their personal information in relation to privacy laws and Part 12 (*Your access to information*) of the Code. Notwithstanding the customer lodging a complaint with the Office of Information Commissioner (OAIC) and the OAIC finding the general insurer had met all privacy requirements,

[43] As above for note 13, Final Report, recommendation 26, pages 11, 68-70

the customer continued to complain about the insurer's practices citing the insurer had not treated the customer fairly as required by Code paragraph 21.

Scenario B: *Code paragraphs 21 and 70 and timeliness*

The Code subscriber failed to provide the customer with an update within 20 business days as required by paragraph 70 of the Code, but did so within 23 business days. Although this is a breach of Code paragraph 70 and in most instances is not a significant difference, the customer sought to rely on Code paragraph 21 claiming the Code subscriber failed to deal with them in a timely manner and made a complaint.

Standards for employees and distributors

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

Response to Question 3.3

2.7 Refer to our response to Question 3.15 below from paragraph 2.67 of this Annexure 1.

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

Response to Question 3.4

2.8 No Code changes are required given sections 912A(1)(ca) and (f) of the Corporations Act, ASIC Regulatory Guide 146 *Licensing: Training of financial product advisors* and CPS 230 require general insurers to ensure their representatives comply with the financial services laws, are adequately trained and competent to provide financial services.

Standards for service suppliers

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

Response to Question 3.5

2.9 Our members suggest that a definition of 'manage a claim' be included in Part 16 of the Code for accessibility, operational efficiency and effectiveness, as well as for consistency of application. Our members suggest the definition could identify that a substantive aspect of management of a claim involves control of the claim and this threshold would need to be met before a supplier could be considered to be 'managing the claim'. Some members have also expressed concern about the meaning of the word 'subcontracting' in paragraph 40 of the Code and the practical difficulties in a Service Supplier obtaining an insurer's approval before subcontracting any services. In particular this requirement would cause delays if there is an emergency during the night or over a weekend. In addition the insurer relies upon the recommendation of the Service Supplier as regards the subcontractor and an insurer would rarely have any information to make its own assessment or be in a position to suggest another subcontractor.

Question 3.6: *The provision of Claims handling and settling services for insurance products is now included in the definition of a 'financial service' in the Corporations Act 2001. What impact has this had, if any, on the operation of Part 5? Does Part 5 need to be amended given the changes to the law and if so, how?*

Insurance Council of Australia

Response to Question 3.6

2.10 The Insurance Council and its members are of the view no changes are required to Part 5 of the Code.

Buying and cancelling an insurance policy

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

Response to Question 3.7

Feedback about the practical operation of Parts 6 and 7

2.11 Our members would be amenable to consideration of the Code offering extended renewal period timeframes than those timeframes required by the Insurance Contracts Act[44] so as to allow individual and small business customers additional time to shop around for a better deal.

2.12 As discussed above in response to Question 2.7 at paragraph 1.62 of this Annexure 1, our members would welcome consideration of the removal of Code paragraphs 43, 44 and 52–55 to respond to compliance complexity caused by duplicative and overlapping legal and Code protections.

2.13 Our members also would welcome adjustment to Code paragraph 45 so it is updated to state *If we are assessing your application for insurance, then we will ask for information and documents only if they are relevant to our decision or if we need further details about your asset or risk to assist us to improve our products and services.*

2.14 Adjusting Code paragraph 45 in this way will enable our members 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 instead of choosing not to offer general insurance products due to the 'unknown' or insufficient level of available data to be able to appropriately design and develop general insurance products.

2.15 An illustrative example of the type of enquiries that might be made under updated Code paragraph 45 would be to ask the customer whether they typically work from home some days of the week, which might indicate for a car insurance policy that the customer should be assessed at a lower level of risk given the customer's car is not being driven daily to commute to work. Similarly for a home insurance policy, this might indicate there is a lower risk of theft due to the home being occupied for the days the customer is working from home. This may in turn lead to general insurers being able to develop more affordable and appropriately designed general insurance products for customers.

2.16 Our members consider that there would be appropriate checks and balances in the Privacy Act, Australian Privacy Principles and Insurance Contracts Act to ensure general insurers would only be asking reasonable and fair questions. Further, there would be no intention for general insurers to be asking any questions to gauge vulnerability for the reasons already provided above at paragraph 1.50 of this Annexure 1.

2.17 The Insurance Council would welcome an adjustment to Code paragraph 47(c) so the referral pathway to the Insurance Council is removed when a Code subscriber does not offer the particular type of insurance cover a customer is seeking. The Code subscriber would still be able to refer the customer to NIBA to be able to find an insurer that offers the designed cover. We consider this could enhance the customer experience, as NIBA has the appropriate expertise to quickly connect a customer with alternative insurance providers that might best respond to the customer's needs.

[44] *Insurance Contracts Act 1984*, section 58

An example of this might be if the customer is looking for insurance cover for the sex work profession, as this is only sold through the insurance broker distribution channel.

2.18 Our members caution against the Review Panel considering changes to the Code, especially regarding component pricing disclosure in renewal notices, or requirements that respond to mitigations at the individual household level, 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. We note there are already broader initiatives underway to address some of these issues (for e.g. the work of the Hazards Insurance Partnership and the National Emergency Management Authority's mitigation knowledge database). We consider it is more appropriate that these initiatives continue to progress given the complexities involved before consideration is given to including new Code commitments.

Question 3.8: *What has been the interaction between the Code commitments and recent law reforms, such as the Design and Distribution Obligation and the deferred sales model for add-on insurance? What changes or clarifications to the Code would be helpful, including to deal with the phasing out of cheques?*

Response to Question 3.8

Code changes needed to respond to the DDO and deferred sales model for add-on insurance

2.19 When the 2020 Code was under development, it was recommended that Code paragraph 43 be introduced even though the Design and Distribution Obligation (DDO) legislation had not yet been enacted.

2.20 The intention was that Code paragraph 43 could reflect the general insurance industry's commitment to good practices for product design and distribution, by requiring insurers to have a policy in place for product design and distribution, which could for example explain:[45]

(a) how the insurer designs its products;

(b) how the insurer ensures the design of a product meets consumer needs, and the metrics used to assess this occurs in practice;

(c) how the insurer distributes its products;

(d) the insurer's controls over the design and distribution process, taking into account a product's particular risk profile;

(e) what the insurer considers to be good sales practices, and what constitutes unacceptable sales practices; and

(f) how it makes clear to customers who the product has been designed for.

2.21 As Code paragraph 43 replicates the DDO regime and the disclosures that are required to be included in an insurer's Target Market Determination, our members are of the view that having a separate product design and distribution policy on their website provides limited additional benefits to consumers and this Code commitment could be removed.

2.22 In relation to the deferred sales model for add-on insurance, as discussed above at our response to Question 2.7 at paragraph 1.62 of this Annexure 1, our members are of the view that as Code paragraphs 52-54 for Consumer Credit Insurance have been superseded by the legislation passed following the FSRC, there is no need to have duplicative commitments in the Code.

2.23 In anticipation of the FSRC legislative reforms for add-on insurance commencing, the Insurance Council developed *Guide for the design and distribution of add-on insurance distributed through*

[45] As above at note 13, recommendation 14, pages 8 and 41 – 43

motor dealer intermediaries.[46] The Guide supports the Code and provides best practice principles to assist Code subscribers develop internal processes, procedures and policies to design sales practices of motor insurance policies through motor dealerships when a car is sold for good customer outcomes. With the FSRC add-on insurance laws having commenced, we consider there is no longer a need to maintain this Guide. We propose to retire this Guide and instead suggest that information to promote customer awareness of the add-on insurance laws be included in the customer information booklet referred to at paragraph 4.2 of this Annexure 1.

Code changes needed to respond to the phasing out of cheques

2.24 Due to a declining use of cheques, on 7 June 2023 the Australian Government announced[47] it would be phasing out cheques from the payment system by 2030, with Government agencies phasing out its use of cheques by 2028. We are aware that almost all major banks have already commenced the phasing out of cheques.[48]

2.25 In preparation for this change, general insurers are already looking for safe and secure alternative payment methods to cheques, such as electronic bank transfers, to be able to refund a customer when their policy is cancelled under Part 7 of the Code.

2.26 As general insurers need to obtain these details from the customer and customers are exercising heightened levels of caution due to recent cyber incidents and greater consumer awareness of scams, it may take some time for general insurers to receive banking transfer details to be able to transact a refund.

2.27 Our members propose this issue could be addressed by making an adjustment to Code paragraph 56 such that it states: *If you are entitled to a refund and you cancel your policy, then we will return the amount within 15 days of you providing a valid payment method to us.* Our members suggest for expediency, it could be beneficial for similar adjustments to be made to Code paragraph 64(b) for fast-tracking urgent claims so that it would read we will… *pay you an advance amount to help ease your urgent financial need – we will do this within 5 Business Days after you demonstrate your urgent financial need and have provided a valid payment method to us.*

2.28 Given this is an active issue, our members welcome the Review Panel considering whether these changes might be made expeditiously.

Claims handling: cash settlements, expert reports and timeframes

Claims handling

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

Response to Question 3.9

Improvements that could be made Part 8 (Making a Claim)

2.29 The operation of Part 8 of the Code has been significantly stress-tested by COVID-19 and the 2022 major floods and there are a number of Code protections the Insurance Council and its members suggest could be strengthened and enhanced for an improved customer experience journey and better customer outcomes.

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[46] Insurance Council, *Guide to the design and distribution of add-on insurance distributed through motor dealer intermediaries* (1 July 2021)
[47] Federal Treasury, Media Release *Modernising payments infrastructure by phasing out cheques* (7 June 2023)
[48] For example: NAB from 3 March 2023, Commbank from 3 June 2023, Macquarie from 20 May 2024, ANZ from 16 June 2024

2.30 Possible opportunities for strengthening the Code commitments include:

(a) the application of Code paragraph 90 to provide for a review of all home building claims regardless of whether the customer's loss was caused by a catastrophe. This would recognise that home building claims involve a customer's major life asset, and as claims may potentially be higher value and complex they warrant a stronger customer protection. Customers could seek a review if it is found the scope of works might need to be revised due to more damage being discovered or the settlement payment is insufficient to respond to the scope of works;

(b) introduce a new Code commitment that general insurers will consider customer requests for reviews of cash settlement amounts sought within 12 months of the payment if the customer discovers the amount insufficient. Our members consider that situations which would not be eligible for such a review would be when the general insurer has an actionable quote and has offered to repair or rebuild, but the customer instead chooses a cash settlement. This should be made clear in any new Code commitment.

2.31 Our members suggest the following Code revisions could also be considered by the Review Panel because they would provide value to customers without unnecessarily adding to claims costs pressures:

(a) update Code paragraph 58 to allow subscribers to inform customers they may not have cover if their excess is higher than the amount they intend to claim before the claim is lodged. The objective would be to provide clarification upfront to minimise customer disappointment, while not discouraging the customer from making a claim;

(b) update how claims outcomes should be communicated. The obligations in Part 8 (e.g. Code paragraphs 76-78 and 81) apply different requirements for how claims outcomes should be communicated, whether in writing or otherwise. Consideration could be given to taking a more consistent and structured approach for all claims outcomes, for example that written information about approved claims could also be provided;

(c) update the claims handling progress update requirements in Code paragraphs 70 and 71 so meaningful status updates can be provided to customers in operationally expedient ways. We suggest options for improvement below at our response to Question 3.12 at paragraphs 2.42–2.53 of this Annexure 1.

Cash settlements

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

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

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

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

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

Response to Question 3.10

Information for customers about cash settlements

2.32 Our response above to Question 2.7 about the Code and the law at paragraph 1.79 of this Annexure 1 recommends re-consideration of the need for Code paragraph 79. Code paragraph 79

complements the CSFS requirements, which apply to cash settlements offered across all types of general insurance policies.

2.33 We do not consider the Code should be used to correct shortcomings in legislation as it is more appropriate for Government to review the efficacy of the newly introduced FSRC laws through a post-implementation review. An example of a topic that would be more appropriate to consider through an FSRC post-implementation review is the types of information general insurers ought to provide a customer to assist decision-making about whether to accept a cash settlement offer under the legislated CSFS requirements.

2.34 We highlight that ASIC is presently considering a related matter namely whether to renew the legislative relief provided by *ASIC Corporations (Cash Settlement Fact Sheet) Instrument 2022/59* which streamlines processes for insurers to provide consumers cash amounts in emergency situations without first providing a CSFS.[49] ASIC has also granted legislative relief so victim-survivors of family violence are not put at risk of harm by the CSFS requirements.[50]

2.35 Consideration through a FSRC post implementation review would be consistent with ASIC's stated position in its Regulatory Guide 183 that when approving a financial services sector code, ASIC will consider explanations for why a particular consumer issue is not addressed by the Code, including when *an issue is best dealt with in another specified way (e.g. law reform)*.[51]

2.36 We note that the CSFS legislative requirements already prescribe the types of information that must be set out in writing in a CSFS, including a statement that the customer *should consider obtaining independent legal or financial advice before settling*.[52]

2.37 We note that the legislation permits a CSFS to include *other information.*[53] In support of smaller general insurers being able to operationalise Code paragraph 79, the Insurance Council consulted with its members and consumer advocates represented on the Insurance Council's CAC to develop a sample information sheet[54] that Code subscribers could adapt to the language of their brand or use without change, with the added assurance that consumer advocates had endorsed the key messaging. We consider the messaging may be useful to assist consumer understanding and awareness of why a cash settlement is being offered instead of repair or rebuild and what things to keep in mind when considering a cash settlement. Our members tell us they may provide the key messages in the sample information sheet when giving a CSFS and this could continue in line with the legislation without the need for the Code to introduce a duplicative requirement.

2.38 To promote simplification and better consumer outcomes, it may be more efficient and effective for customer information messages to be considered as part of the FSRC post-implementation review.

2.39 We recognise that if a post-FSRC implementation review covering CSFS were to be undertaken, it could adjust the legislative framework for CSFS and this may inform any proposal for change to Code paragraph 79.

Actionable quotes instead of cash settlement uplifts

2.40 Our members highlight that as part of its 2024 work program, AFCA has advised the Insurance Council and its members it will be developing a new AFCA approach to general insurance cash settlements. The Approach will be developed in consultation with the Insurance Council, general insurers and other key stakeholders.

2.41 We understand the AFCA Approach will likely consider the AFCA Determinations providing an uplift on cash settlement amounts to establish greater consistency across AFCA's fairness

[49] As above for note 4
[50] As above for note 36
[51] ASIC Regulatory Guide 183 *Approval of financial services sector codes of conduct* (March 2013), RG 183.62, page 16
[52] *Corporations Act 2001,* section 948F(1)(d)
[53] *Corporations Act 2001,* section 948F(4)
[54] Sample information sheet *Cash settlements under a home building policy*

decision-making and also assist general insurers with greater predictability as to AFCA's likely approach to an appropriate offer of settlement. Our submission to AFCA's consultation about its recent Rules changes identified variations in the amounts of uplifts applied by AFCA decision-makers and welcomed the development of an AFCA Approach.[55]

2.42 We suggest it is more appropriate for this topic to be dealt with through the development of an AFCA Approach than through the Code. This is because introducing a new requirement to provide an uplift on cash settlement amounts in the Code would be based on assumptions regarding certain prevailing market conditions, which might change in future.

2.43 It is important that the Code remain future-proofed and capable of allowing insurers to respond fairly and adaptably across changing market conditions. In line with standard approaches to best practice, our members would apply the AFCA Approach to all complaints (once finalised), including those handled by the Internal Dispute Resolution (IDR) process.

2.44 Our members suggest there might be greater customer benefit if the Review Panel were to instead consider the consumer rights and protections associated with an 'actionable quote' to improve the customer experience journey.

Expert reports

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

Response to Question 3.11

Improving the quality of external expert reports

2.45 Our members note the CGC is undertaking a follow up Thematic Inquiry into oversight of external experts[56] and the findings of that Inquiry may provide valuable insights into best practice standards that might be considered by the review.

2.46 Our members are supportive of best practice standards being developed for the use of external expert reports.

Timeframes

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

Response to Question 3.12

Meaningful progress updates about a claim

2.47 Our members are of the view that the policy intention of the progress update provisions in the Code have not been able to be realised, especially in relation to Code paragraph 70 *We will tell you about the progress of your claim at least every 20 Business days*; and Code paragraph 71 *We will respond to your routine enquiries about your claim's progress within 10 Business Days.*

2.48 When the 2020 Code was under development, the Insurance Council sought to improve transparency and timeliness through communication updates about the progress of a claim.

2.49 The frequency of updates was set at 20 Business Days on the understanding this would provide *a reasonable balance between meeting the claimants' need to be kept informed and administrative burden. Insurers requested that the Code recognise technology where the claimant could access*

[55] Insurance Council Submission to AFCA consultation on changes to AFCA rules and operational guidelines (22 May 2023)
[56] CGC Thematic Inquiry Oversight of external experts (13 December 2023)

the status of their claim at any time through a mobile application or other online media, and that this should satisfy the customer contact requirement.[57]

2.50 The Deloitte Review found a record number of breaches of these Code commitments during the 2022 major floods,[58] and notwithstanding improved performance in claims timeframe compliance, the CGC recently reported that Code paragraph 70 continues to be the most breached Code commitment.[59]

2.51 Our members appreciate the importance of customers receiving timely and meaningful communication updates about the progress of their claim.

2.52 When the CGC (and Code Team) were consulting on the development of its Guidance Note 3 *Varying claims handling timeframes – Subsection 7.21 of the 2014 Code and Paragraph 84 of the 2020 Code*,[60] the Insurance Council coordinated an industry submission seeking clarification that insurers would be able to adjust communication timeframes by using Code paragraph 84 so that customers would receive meaningful progress updates in operationally efficient and effective ways, especially during a large scale catastrophe.

2.53 The Insurance Council sought clarification that Code subscribers would be able to communicate with customers in the way proposed by Scenario C (see below). Unfortunately, due to the CGC requiring that paragraph 84 be used *rarely and judiciously and assess each instance individually* and on a *case-by-case basis*[61] Code subscribers have not been able to communicate with customers in the way proposed by Scenario C.

Scenario C: *A group of customer claims are impacted similarly*

General insurers might experience delays at a portfolio level in obtaining a necessary car part to repair a vehicle due to the impacts of COVID-19 on the international supply chain.

A group of customers might be similarly impacted by this if they have taken out a car policy with the same Code subscriber, and it would be more efficient and expeditious for the Code subscriber to communicate with the group of impacted customers within the portfolio in the same way and obtain each customer's agreement that they only be contacted again once the car part is available.

In these circumstances, it is the experience of our members that some customers might not wish to receive progress updates every 20 business days and might only ask to be contacted once the car part is available.

2.54 Our members would welcome the Review Panel considering whether the Code could be changed to allow progress updates that are focused on event-based updates as a better way to keep customers updated. Scenario D below illustrates how an event-based approach to updates could improve the customer experience and add value to customer outcomes without unnecessarily adding to claims cost pressures.

Scenario D: *Possible event-based approach to progress updates for a car repair claim*

In respect of a claim involving the repair of a damaged car, the Code subscriber accepted the claim and booked the car in for repair in three months' time.

This was the earliest available time the car could be booked for repair and the customer requested the booking be made.

[57] As above for note 13, Final Report, recommendations 22-23, pages 10, 57-58.
[58] As above for note 7, Findings 5.2 and 8.7, pages 26, 30, 78 and 96
[59] CGC General Insurance Industry Data and Compliance Report FY2022-23, pages 7, 10 and 12
[60] CGC Guidance Note 3 *Varying claims handling timeframes – Subsection 7.21 of the 2014 Code and Paragraph 84 of the 2020 Code* (June 2022)
[61] As above for note 60, paragraphs 7 and 14

As the CGC Guidance Note limits a Code subscriber's ability to ask whether the customer would like to receive an update if anything changes, the insurer is required to continue to update the customer for the intervening months every 20 days even though there is no substantive update that could be provided other than 'your car is still booked in for repair'.

2.55 Our members would also welcome the Review Panel considering whether the Code could be updated to allow for digital self-service progress updates to customers. Scenario E below illustrates how this might operate in practice and illustrates the current obstacles to providing progress updates through a digital interface.

Scenario E: digital self-service progress updates

The Code subscriber has developed an app or self-service platform for active engagement between the insurer and a customer about the progress of their claim.

However, to meet Code paragraph 70, the Code subscriber must actively update the customer about the progress of their claim. The insurer cannot SMS the customer to invite them to check their self-service portal or app for their latest progress update, as the customer might not do so within the 20 business days.

2.56 Further matters where our members seek clarification on the operation of Code paragraph 70 is:

(a) whether progress updates continue to be required when the customer has made a complaint about the handling of their claim to AFCA and the matter is under consideration with AFCA;

(b) whether the 20-day progress update requirement continues for the lifecycle of the claim or stops after the claims decision is made. Even though Code paragraph 70 falls under the heading 'Assessing your Claim' and therefore suggests that progress updates would be expected to continue until a claim decision is made, the CGC has set out its expectations that in line with the 'spirit and intent' of the Code, progress updates should be provided to a customer until the claim is fully finalised and resolved. Our members suggest it would provide better customer value and be more efficient and effective if the Code were to instead require 20-day progress updates until the claim decision is made. Thereafter for rebuild or repairs, progress updates be either events-based updates (e.g. when a spare part for the car has been able to be sourced; or when the relevant materials to rebuild the home kitchen have been found) or if there is no event-based progress update, an update every 2 months so the customer knows their claim is still in-progress, whichever is the sooner, until the claim is fully finalised. This will ensure the customer receives meaningful updates at a frequency that is operationally efficient and effective once the claim decision is made;

(c) its applicability to third party liability motor insurance claims. Our members suggest that as paragraph 70 also applies to third party liability motor vehicle insurance claims, it would be desirable to exclude these from the application of paragraph 70 so progress updates along the lines of *We are waiting for the third party to provide us with information* is not required.

2.57 Our members are firmly of the view that if greater flexibility could be afforded to how Code subscribers may communicate meaningfully with their customers about the progress of their claim, the resources focused on responding to Code paragraph 70, and the customer complaints that might follow, could be reallocated to other activities that could contribute to enhanced claims customer experience outcomes.

Complaints

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

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

Response to Questions 3.13 and 3.14

Feedback about the practical operation of Part 11

2.58 As mentioned above in response to Question 2.7 at paragraph 1.65 of this Annexure 1, we welcome a review of the operational efficiency and effectiveness of Part 11 (*Complaints*) given new legislative complaints handling requirements in ASIC Regulatory Guide 271 *Internal Dispute Resolution*[62] to streamline complaints handling.

2.59 Our members are of the view that ASIC Regulatory Guide 271 provides a high standard of customer protection and additional Code obligations such as every 10 business day progress updates in Code paragraph 146 may not add particular value to the customer experience journey.

2.60 While Part 11 acknowledges at paragraph 141 *Our Complaints process will comply with the Australian Securities and Investments Commission's guidelines,* the drafting of particular Code paragraphs may provide a different standard for compliance compared with ASIC's requirements.

2.61 An illustrative example is Code paragraph 147 which does not provide the permissible exceptions to the 30-calendar day timeframe for making a decision about a complaint that are available at IDR in ASIC's Regulatory Guide 271.[63] This can present operational compliance complexity and challenges for managing customer expectations, especially when a customer points to Code paragraph 147, but may not be familiar with ASIC's regulatory requirements in RG 271. Our members further advise that the lack of clarity in the Code is putting pressure on complaints resolution teams and potentially impacting the quality of IDR responses, which may contribute to customer dissatisfaction and an increased number of complaints escalated to AFCA, which is not the policy intent of RG 271.

2.62 Our members suggest Part 11 could be simplified by removing duplication to focus on those Code paragraphs which improve the customer experience journey and add value to customer experience outcomes beyond RG 271 requirements. For example, the Review Panel could consider retaining the complementary Code commitments in Parts 4 and 5 of the Code which ensure that general insurers are aware of complaints about their Distributors and Service Suppliers.

2.63 General information about a customer's rights to complain through IDR processes and AFCA could be included in the customer information booklet developed to accompany the Code, as discussed below at paragraph 4.2 of this Annexure 1.

Definition of 'uninsured person'

2.64 When the 2020 Code was under development, it was recommended that the Code be updated to clarify uninsured third parties have access to both the financial hardship supports in Part 10 and also access to complaints processes in Part 11.[64] During the drafting process, it seems that Part 10 has been drafted quite specifically to support a *Third Party Beneficiary* as defined in Part 16 and also an at-fault individual against whom the general insurer seeks to recover for damage or loss to the insured or *Third Party Beneficiary* at Code paragraph 107.

2.65 This is in contrast to Part 11 which talks about an 'uninsured person' who may have access to the complaints handling processes under the Code (and also claims handling process under

[62] ASIC Regulatory Guide 271 *Internal Dispute Resolution* (September 2021); ASIC Corporations, Credit and Superannuation (Internal Dispute Resolution) Instrument 2020/98
[63] As above for note 62, RG 271.64 – RG271.68
[64] As above for note 13, pages 20-21 and 26

paragraph 60 at Part 8 (*Making a Claim*)). Given the policy intention behind the 2020 changes, our members would welcome a definition of 'uninsured person' being included at Part 16 of the Code for enhanced accessibility, ease of understanding and consistency.

2.66 It would seem that a definition of an 'uninsured person' aligned to the types of persons who can access financial hardship supports, who can make a claim under the motor vehicle policy of a customer of the insurer,[65] and who can also access the Uninsured Motor Vehicle complaints jurisdiction at AFCA[66] was intended.

2.67 Currently, in the absence of a definition, it would seem that general insurers might be obliged to handle complaints made by individuals who are the customer of another insurer, but had their claim declined or who do not wish to claim on their own policy.

Complaints about wholesale financial hardship support

2.68 Our members encourage the Review Panel to consider whether adjustments are needed to Part 11 for complaints about wholesale insurance products where the customer is entitled to financial hardship support under paragraph 107(b). It may not result in a good customer experience if Code subscribers are obliged to inform these customers about their right to complain to AFCA and the customer finds they cannot access AFCA due to the limits of AFCA's jurisdiction.

Other feedback

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

Response to Question 3.15

A technologically neutral Code

2.69 As Code subscribers are increasingly considering technological solutions to deliver an improved customer experience, especially with respect to progress updates, it would be desirable to review the Code to ensure the Code's obligations are capable of operating in a technologically neutral manner.

Counting timeframes under the Code

2.70 The calculation of timeframes could be made clearer under the Code noting that both the terms of Business Days and calendar days are used. Our members highlight there may also be differences between the Code and RG 271. This is because RG 271 provides that section 36 of the *Acts Interpretations Act 1901* is to be applied when calculating timeframes. This means that the day on which a complaint is received is counted as day zero and if the 30th calendar day falls on a weekend or national public holiday, the IDR response would be required on the next Business Day.

2.71 Our members further highlight that with respect to Distributors and Service Suppliers telling the Code subscriber about a complaint within 2 Business Days under Code paragraphs 26 and 36, it is not entirely clear when a Business Day starts. If a complaint is received by email at 11pm, the Code could be read that this is the day the timeframe starts, even though the Distributor or Service Supplier would be unlikely to be reading their emails.

Privacy

2.72 Part 12 (*Your access to information*) of the Code reiterates a general insurer's obligation to comply with the Privacy Act and Australian Privacy Principles. As the Federal Attorney-General's Department is undertaking a major economy-wide review of federal privacy legislation, our members suggest Part 12 be removed to future-proof the Code.

[65] Code paragraph 60
[66] As above for note 17, AFCA Rule B.2.1(f)

2.73 Consideration might also be given to whether the cross-reference at Code paragraph 47(b) should also be removed.

2.74 Instead, general information about a customer's rights under privacy laws could be included in the customer information booklet developed to accompany the Code, as discussed below at paragraph 4.2 of this Annexure 1.

3. EMERGING ISSUES

Affordability

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

Response to Question 4.1

3.1 An operationally efficient and effective Code that delivers good policy outcomes for everyone – consumers (individuals and small business) and the entire business community - contributes to a strong and stable general insurance industry that provides affordable general insurance products. We encourage the Review Panel to carefully consider how the Review Panel's recommendations for the Code can improve operational efficiency, effectiveness and consumer value without unnecessarily adding to claims cost pressures, particularly at a time of sustained cost pressures on insurers and a growing insurance protection gap in Australia. Consideration should also be given by the Review Panel of the global context in that insurers in Australia are already subject to a regulatory framework for consumer protection and a self-regulatory framework that are more complex and stricter than many other comparable jurisdictions. Consumers in Australia are also able to access a broader general insurance coverage and it is the practice of Australian insurers to undertake to rebuild and guarantee work whereas in other jurisdictions cash settlements is the preferred option for settlement of an insurance claim. All these factors indicate that there are already many benefits and additional protections for consumers in the Australian market in comparison to other foreign markets.

3.2 The most important way in which the Review Panel can contribute to improved affordability of general insurance products is by removing the friction points in the Code that are adding unnecessary compliance complexity and duplication of obligations that already exist under the law which all add to the costs of doing business, without significantly enhancing value to the customer experience or contributing to improved consumer outcomes.

3.3 We draw to the Review Panel's attention, the establishment of the *Select Committee* on 16 May 2024 to inquire into the *Impact of Climate Risk on Insurance Premiums and availability*.[67] The Select Committee Inquiry will consider the affordability and availability of insurance in some regions due to climate-drive disasters, the underlying causes and impacts of increases in insurance premiums, the extent to which climate risk is priced into insurance premiums, the distributional impact of increases in insurance premiums across communities, demographics and regions and the role of governments to implement climate adaptation and resilience measures to reduce risks and the cost of insurance. The Select Committee is to present its report to Parliament by 19 November 2024.

3.4 The Select Committee Inquiry Report is likely to be of interest to the Review Panel.

3.5 There are a number of other initiatives in progress seeking to address affordability issues. On 14 May 2024 as part of the Budget the Treasurer announced that the Department of Prime Minister and Cabinet would establish an Insurance Affordability and Natural Hazard Risk Reduction

[67] As above for note 6

Taskforce. In addition in March 2024 Treasury issued a consultation paper on Standardising natural hazard definitions and reviewing standard cover for insurance. Mention has already been made to the current work of the Hazards Insurance Partnership at paragraph 2.18 above.

3.6 Our members have previously considered whether premiums could be paid by the Centrepay system and until the Centrepay system is modernised, it would not be feasible for general insurers to consider this payment option more broadly.

Helping reduce risks

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

Response to Question 4.2

3.7 Our members are of the view the Code is not the appropriate mechanism to require insurers to respond to individual consumer risk-mitigation efforts. Also see our comments above at paragraph 2.18 regarding other current initiatives in this area.

4. CODE STRUCTURE, ENFORCEABILITY AND GOVERNANCE

Code structure

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

Response to Question 5.1

The intended audience for the Code

4.1 The intended audience for the Code is primarily consumers and their advocates. Others who may use and read the Code include not just subscribers of the Code, but also other stakeholders, such as members of the public and regulators such as ASIC, AFCA and the CGC (as well as the Code Compliance and Monitoring Team who provides secretariat support to the CGC). With this in mind our members are of the view it is crucial that the Code remain accessible and easy to understand.

4.2 To promote accessibility and awareness of the Code amongst consumers, our members support the development of a complementary customer information booklet for consumers and their advocates which covers the general customer protections in the law, including any that may be designated as an Enforceable Code Provision (ECP), and the other commitments in the Code which go beyond the law. The booklet could also cover information for customers:

(a) about how to access certain supports such as urgent financial need assistance discussed above at paragraph 1.6 of this Annexure 1;

(b) about the prohibition of pressure sales tactics, Consumer Credit Insurance and CSFS protections discussed above at paragraph 1.62 of this Annexure 1;

(c) to promote general awareness about intermediated sales as distinct from direct sales discussed above at paragraph 1.75 of this Annexure 1;

(d) to promote general awareness about add-on insurance law protections discussed above at paragraphs 2.23 of this Annexure 1;

(e) about the ability to complain through IDR and AFCA discussed above from paragraph 2.58 to 2.63 of this Annexure 1; and

(f) about privacy law rights and access to information as discussed above at paragraphs 2.72–2.74 of this Annexure 1.

Focus on building on the existing structure and drafting of the 2020 Code instead of a comprehensive rewrite

4.3 We are not supportive of a complete restructure and rewrite of the Code as part of the independent review process. This is because subscribers of the Code have already invested heavily in implementing changes to train their staff, update their systems and processes, and report to the CGC to implement the 2020 Code.

4.4 The Insurance Council and our members suggest that any revisions or redrafts to the Code through the review process should ideally focus on building on the existing Code structure and drafting style. This is because the provisions of various Code Parts and paragraph numbers are already well known and a complete restructure and rewrite of the Code would necessitate a fundamental 'root and branch' implementation review for subscribers and the CGC (as well as the Code Team), which would introduce unnecessary compliance costs into the system.

4.5 We encourage the Review Panel to have regard to the guiding principles for decision-making in the Review's Terms of Reference, including whether the value to customers would outweigh the costs of a complete Code restructure and rewrite, especially when the Review Panel also invites stakeholder's views on affordability issues.

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

Response to Question 5.2

4.6 Our members do not support other sections of the Code being written in a detailed way similar to Part 15 of the Code for the same reasons provided above at paragraphs 4.3–4.5 of this Annexure 1.

Code governance and compliance

Question 5.3: *What measures would improve governance of the Code and promote enhanced compliance with Code commitments? In particular:*

(a) Are the sanctions in Part 13 a sufficient deterrent to misconduct. Should they be strengthened? If so, how?

(b) A number of the sanctions available to the Code Governance Committee are restricted to a significant breach of the Code (defined in Part 16). Should the additional sanctions in paragraph 174 apply to any breach of the Code?

(c) Should the Code definition of 'significant breach' be aligned to the ASIC reportable situations regime, in RG 78 and if so, how?

(d) The CGC is only able to require a Code subscriber to publish the fact that the subscriber has committed a significant breach of the Code. Should the CGC be able to name subscribers that commit a substantial breach? Should this additional sanction apply to all Code breaches? What other transparency mechanisms may better promote Code compliance?

Response to Question 5.3

Measures to improve supporting governance arrangements of the Code

4.7 The Insurance Council encourages the Review Panel to consider the need for the CGC to be a committee of an incorporated association, namely the Code Governance Committee Association

Inc (CGCA), which is an incorporated association registered under the *Association Incorporation Act 2009 (NSW)*.[68] We consider this structure of an incorporated association may be confusing for stakeholders and involves additional governance and compliance requirements which are not necessary to ensure independence of the CGC compared with other options, such as the CGC being directly appointed as a standalone Committee by representatives of industry and consumers.

4.8 The additional governance and compliance requirements associated with an association structure, include the need to have a Public Officer, financial reporting and having to register any changes to the CGCA's Constitution (including the CGC Charter) with the NSW Office of Fair Trading.

4.9 We suggest the CGCA could be wound up and the three persons appointed to the CGC (Independent Chair, industry expert and consumer expert) could instead be employed directly by the Code administration function that sits within AFCA. This is in line with other financial services sector code governance committees; no other has an incorporated association such as the CGCA. Other features of the CGCA could be retained to ensure the independence of the CGC, for example a continuing mechanism for the consideration of consumer advocate input when setting the CGC's annual work program and compliance monitoring priorities.

The Insurance Council and its members welcome a regular independent review of the CGC's effectiveness and performance that could coincide with the 5-yearly independent review of the Code. The 5-yearly independent review of the Code is now a requirement under section 1101AB of the Corporations Act for financial service sector Codes approved by ASIC and reflects the approaches of other financial service sector Codes.

Adequacy of the sanctions in Part 13 of the Code

4.10 The additional sanctions in Code paragraph 174 for Significant Breaches of the Code do not currently apply to standard Code breaches because they are serious sanctions reserved for more serious levels of Code non-compliance. The 2020 Code introduced for the first time, a Community Benefit Payment of up to $100,000 as a sanction for a Significant Breach of the Code.

4.11 Our members suggest it would be desirable for the CGC to develop a guidance note regarding how it would likely use its sanctions for a Significant Breach of the Code for procedural fairness to Code subscribers. The guidance could also enhance understanding of the CGC's approach to issuing sanctions, especially when the CGC might have other powers the CGC could utilise, such as identifying areas for industry improvement or providing guidance regarding the Code's interpretation.

4.12 Our members suggest that there are additional considerations the CGC should turn its mind to when imposing a sanction at Code paragraph 170, such as taking into account:

(a) any broader industry implications if the sanction was to be imposed; and

(b) any broader customer experience or customer outcome impacts if the sanction was to be imposed.

4.13 Presently, the CGC is missing the ability to encourage or reward Code subscribers who are high performers in terms of Code compliance performance from its tool-kit.

Alignment of the definition of 'Significant Breach' in the Code with ASIC reportable situations regime

4.14 The Insurance Council and its members welcome alignment of the definition of 'Significant Breach' in the Code with the ASIC reportable situations regime in RG 78.[69]

[68] Constitution of Code Governance Committee Association Inc (version 2) effective from 1 July 2021
[69] ASIC Regulatory Guide 78 *Breach reporting by AFS licensees and credit licensees* (19 December 2023)

4.15 This would adjust the trigger and timeframe for reporting to be 'within 30 business days from when the subscriber discovers the Significant Breach' instead of 'within 10 business days of identifying the Significant Breach' under Code paragraph 181.

4.16 Alignment would also introduce an appropriate materiality threshold for when a breach of the Code achieves a sufficient level of significance to be reportable to the CGC, and would exclude the reporting of trivial matters.

4.17 It would also mean that there would be no Significant Breach that would need to be reportable to the CGC if the relevant breach:

(a) only impacts one person, or if it relates to a financial product that is or proposed to be held jointly by more than one person, those persons;

(b) not result in, and be unlikely to result in, any financial loss or damage to any person (regardless of whether that loss or damage has been, will be, or may be, remediated); and

(c) not give rise, and be unlikely to give rise, to any other Code breach.

4.18 A CGC approach that is aligned with ASIC reporting minimises complexity in the reporting system, especially when the CGC expects Code subscribers will identify whether there is a Significant Breach of the Code when identifying whether there is a reportable situation to ASIC.

CGC power to name Code subscribers

4.19 The Insurance Council and its members do not consider it is appropriate to grant the CGC the power to publish the fact a subscriber has committed a Significant Breach of the Code in the CGC's Annual Report as this could have the practical effect of unfairly punishing a subscriber for a point-in-time Significant Breach in perpetuity.

4.20 General insurers also do not support the CGC being granted the power to publish the names of Code subscribers who have breached the Code in Annual Reporting. The current reporting approach adopted by the CGC is to publish on a de-identified basis, a leaderboard of Code subscribers with the worst performer at the top of the leaderboard in terms of the subscriber with the most self-reported Code breaches and contextualised by 10,000 policies to indicate the worst Code compliance performance by market share.[70] If this style of leaderboard reporting were to name each Code subscriber, it may have the unintended consequence of incentivising under-reporting of Code breaches by subscribers when there is currently high rates of self-reporting. In addition as each Code subscriber has different product offerings and product configurations, this may result in different levels of performance. There would need a way to take into account this differential for calibrated reporting of comparative or 'apples-with-apples' Code subscribers.

4.21 Our members might be amenable to the CGC having the power to name subscribers in Annual Reporting if the CGC's approach to leaderboard reporting were transformed to rank at the top of the leaderboard, the Code subscriber who performed the best in terms of clear and demonstrable positive Code compliance performance metrics. The metrics used would need careful consideration and consultation to ensure they would truly demonstrate 'good compliance performance'. The metrics would also need to take into account the different levels of performance that might arise from the different offering and product configurations Code subscribers offer for fair and comparable reporting. Naming Code subscribers in this way could provide transparency for customers to be able to make informed choices about the subscribers who have the best Code compliance performance. It could also provide a positive incentive for Code subscribers to reduce the number of their Code breaches year-on-year.

Question 5.4: *Does the requirement to report significant breaches of the Code to the CGC duplicate or create inefficiencies related to the obligation on AFS Licensees to report reportable*

[70] As above for note 59, pages 29-30

situations to ASIC? If so, how should this be managed given the role of the CGC in monitoring and enforcing the Code?

Response to Question 5.4

Minimising double-handling

4.22 Our members advise us there is presently double-handling with Code subscribers reporting the same circumstances to both ASIC as a breach of the law and the CGC as a breach of the Code. Further, we are aware that in accordance with Code paragraph 176,[71] the CGC on-reports to ASIC all reports of Significant Breaches of the Code it receives from Code subscribers.[72] Similarly where reportable situations reported to ASIC are also breaches of the Code, this information is shared by ASIC with the CGC as part of the annual data collection process.

4.23 While Part 13 of the Code seeks to minimise inefficiencies and double handling by the CGC (see for example Code paragraph 169(c)), the Code could be enhanced further to minimise unnecessary double-handling by introducing a similar provision to that in the Life Code,[73] that if a matter has already been reported to ASIC by a Code subscriber it does not need to also be reported to the CGC as a Significant Breach. This would provide considerable efficiencies and benefits, especially when ASIC is currently restricted by law from sharing confidential information with the CGC (and Code Team),[74] including when ASIC might be investigating conduct that might also be the subject of a CGC investigation.

Enforceable Code Provisions

Question 5.5: *Which provisions of the Code could be considered for designation as Enforceable Code Provisions and what changes to the Code would be needed to support that?* (Question 5.5)

Response to Question 5.5

Possible provisions that might be considered for designation as an Enforceable Code Provision

4.24 The Insurance Council and its members are of the view that the process of applying for and receiving ASIC approval of the Code in accordance with section 1101A of the Corporations Act in and of itself represents an elevated status of enforceability of a Code, compared with a Code that has not otherwise been approved by ASIC. This is because approval by ASIC of the Code represents to the general public that ASIC is supportive of all the Code protections set out in the Code, as well as the CGC being the independent compliance and enforcement body for the Code.

4.25 If the Code were to include a number of Code commitments that are designated as an Enforceable Code Provision (ECP), thereby elevating those commitments to the standing of law and attracting any of the sanctions ASIC may impose, this could create a two-tiered Code. A two-tiered Code could become challenging for consumers to read and understand, especially if designated ECPs are drafted more technically than other Code commitments to be sufficiently capable of being enforced by ASIC.

4.26 In the absence of an updated ASIC Regulatory Guide 183 to confirm ASIC's approach to enforcement of designated ECPs in financial services sector codes, it is not entirely clear to the Insurance Council and its members how ASIC intends to administer its role as compliance enforcer across all financial sector codes that might be approved with designated ECPs and how this would interact with the role of the CGC.

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[71] CGC Operational Guidance on Paragraph 176 (October 2022)
[72] CGC Annual Report 2022-23, page 10
[73] CALI *Life Code*, clause 8.13
[74] ASIC Act 2001, section 127

4.27 Presently, the legislative framework does not permit ASIC to share confidential information with the CGC (and Code Team) about potential breaches of the law ASIC is investigating. Until this is changed, we suggest it might be more administratively efficient and effective for a reporting pathway directly to ASIC about possible breaches of designated ECPs.

4.28 In the event the Review Panel would like to recommend a Code commitment for possible designation as an ECP, the Insurance Council and its members are of the view that vulnerability or financial hardship might be possible areas for consideration as they may meet the eligibility criteria under the legislation governing ECPs.

4.29 Our members do not support a Code commitment about making a claim (under Part 8) becoming a designated ECP because it does not meet the threshold criteria given claims handling has become a financial service under the Corporations Act.

Other changes that would be needed to the Code to support Enforceable Code Provisions

4.30 The Insurance Council considers that a designated ECP may need to be written differently to other Code commitments because they must be drafted in a way to be sufficiently capable of being enforced as a designated ECP.

4.31 As a designated ECP in the Code would achieve the status of law, there would need to be some explanation in the Code so consumers and other stakeholders are able to distinguish a designated ECP from other commitments in the Code dealing with the following matters:

(a) there would be a breach reporting pathway directly to ASIC and not via the CGC;

(b) responsibility for compliance and enforcement of the designated ECP would be with ASIC and not the CGC;

(c) the sanctions that might apply for non-compliance would be the enforcement powers available to ASIC and not the CGC; and

(d) breaches of ECPs would not be included in the CGC Annual Reporting for the Code.