28 April 2017

By email: sphillips@insurancecouncil.com.au

Sarah Phillips
Insurance Council of Australia
Level 4, 56 Pitt Street
SYDNEY NSW 1225

Dear Ms Phillips,

Submission: General Insurance Code of Practice 2017 Review

Thank you for the opportunity to make this submission to the Insurance Council of Australia's (**ICA**'s) 2017 review (**Review**) of the General Insurance Code of Practice (the **Code**).

The Code is an important piece of self-regulation, setting out the best practice expected of the industry. Recent inquiries and reviews have ventilated a number of persistent, systemic problems for general insurance customers. This Review is an excellent opportunity for insurers to focus on some of the critical issues for their customers, by:

- addressing unsuitable product design and inappropriate sales practices,
- implementing effective protocols and processes to improve their handling of situations involving family violence, and
- improving the experiences of customers involved in claims, investigations and disputes.

This submission identifies amendments to the Code which could achieve these objectives (under Sections 4, 6, 7, 10 and 14). This submission also comments briefly on the legal effect of the Code and its compliance with Australian Securities and Investments Commission's (**ASIC**'s) *Regulatory Guide 183: Approval of financial sector codes of conduct* (**RG 183**).

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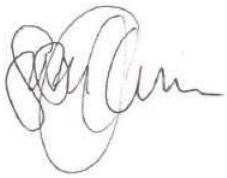
Yours sincerely,

CONSUMER ACTION LAW CENTRE



Gerard Brody
Chief Executive Officer

Susan Quinn
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Attached: Economic Abuse Reference Group, *Family violence and insurance*, 10 April 2017

About Consumer Action

Consumer Action is an independent, not-for profit consumer organisation based in Melbourne. We work to advance fairness in consumer markets, particularly for disadvantaged and vulnerable consumers, through financial counselling, legal advice and representation, and policy work and campaigns. Delivering assistance services to Victorian consumers, we have a national reach through our deep expertise in consumer law and policy and direct knowledge of the consumer experience of modern markets.

Recommendations

Section 4—Buying insurance

1. Section 4 of the Code should be amended to enhance insurers' commitment to sell suitable insurance, by:
   (a) ensuring policies do not contain unfair contract terms,
   (b) only selling policies under which the insured is eligible to claim a benefit,
   (c) comparing policies to standard cover as a benchmark, to clearly show where policies provide less than standard cover,
   (d) ensuring that policy wording reflects the requirements of section 54 of the *Insurance Contracts Act 1984* (Cth) (**Insurance Contracts Act**),
   (e) not unlawfully discriminating through policy wording and underwriting, and at claims time, and
   (f) extending the Code commitment to sell insurance efficiently, honestly, fairly and transparently to all insurance distributors.

2. Amend the Code to include a mandatory seven day delayed opt-in sales model for add-on insurance sold with cars and finance, which separates the sale of the car and/or finance from the sale of the insurance and requires consumers to initiate the insurance purchase.

3. Amend the Code to prevent insurers selling add-on insurance with a financed single premium, and instead require insurers to offer clear, transparent upfront and instalment pricing.

4. The Code should commit insurers to a timeline for implementing appropriate underwriting and cancellation processes and protocols for insurance, to ensure that an abusive partner cannot commit financial abuse through the purchase and/or cancelation of insurance.

Section 5—Employees and Authorised Representatives

5. The Code should be amended to extend the obligations under Section 5 to all insurance distributors in relation training and monitoring of salespeople, notifying insurers of complaints and informing customers of the relevant insurer.

Section 6—Service Suppliers

6. Insurers should commit under the Code to be responsible for the conduct of Service Suppliers they engage, and their approved subcontractors.

7. The definition of 'Service Suppliers' under Section 15 should be expanded to include external experts.

Section 7—Claims

8. In tandem with Recommendation 4, the Code should require insurers to commit to implementing appropriate processes and protocols to improve the experience and outcomes of claims for people who are experiencing family violence. In particular, the Code should confirm that insurers will treat insured people as co-insured to enable partial payment of benefits.

9. The Code should commit insurers to assessing claims consistently with:
    - section 54 of the Insurance Contracts Act, by not denying the claim on the basis of the insured person's actions after the policy was entered into which did not cause or contribute to the loss, and
    - section 46 of the *Disability Discrimination Act 1992* (Cth) (**Disability Discrimination Act**), by not denying a claim on the basis of an exclusion or other term where there is no relevant actuarial or statistical data to support the exclusion.

10. The hardship provisions of the Code should be expanded to include:
    - clear standards for payment of an excess where the customer is in financial hardship, and
    - hardship processes which apply where a consumer has a valid claim by cannot afford to pay the excess.

11. Insurers should develop transparent procedures for responding to financial hardship.

12. The Code should adopt the recommendations of the Financial Rights Legal Centre (Financial Rights) report *Guilty until proven innocent: Insurance investigations in Australia* (March 2016), including:
    - best practice standards for investigations,
    - a statement on diversity and anti-discrimination in the Code,
    - minimum standards for the use of interpreters, and
    - minimum standards for the treatment of people with a mental illness during claims and investigations

Section 10—Complaints and disputes

13. The Code should mandate a one-stage internal dispute resolution (**IDR**) process, to reduce customer confusion and delays, and to reduce the risk of customers dropping out of disputes.

14. Where an insurer has been informed that a customer has representation, the Code should require insurers, their representatives and service suppliers to contact the representative rather than the customer directly. The insurer should only contact the customer directly if there is good reason and the representative agrees.

Section 14—Access to information

15. The Code should specify that insurers will treat a request for personal information according to the Privacy Act, irrespective of whether the consumer specifies that it is such a request.

16. The Code should require insurers to provide customers with access to personal information within 14 days of a request by a customer.

Legal status of the Code

17. The Code should be enforceable as a term of all insurance contracts covered by the Code.

18. There should be penalties for breach of the Code.

Compliance with ASIC Regulatory Guide 183

19. The Code should be amended to comply with the requirements of RG 183 that an industry code be independently reviewed at least every three years.

Section 4—Buying insurance

Section 4 provides minimal assurances for people who are looking to buy or cancel insurance. In our view Section 4 could be improved on a number of counts, including:

- stronger guarantees that insurers will only sell suitable insurance,
- changes to the sales process and pricing of add-on insurance, and
- better protocols and protections where a customer is experiencing family violence.

A commitment to sell suitable insurance

We note that insurers currently do not have any legal obligation to ensure that the products they sell are suitable for the people who buy them. The lack of any suitability obligation contrasts with the responsible lending obligations on credit providers, which require that finance is 'not unsuitable' for the customer in question.

Sales of insurance which do not meet the needs of people who have bought them are widespread. For example, home insurance policies with flood exclusions have been sold to people who live in a flood zone, and add-on Consumer Credit insurance (**CCI**) has been sold to people who are employed casually and ineligible to claim benefits if they become unemployed.

The forthcoming Product Design and Disclosure Obligations (**DADO**s) will require insurers to define target and non-target markets for their products, and to ensure that insurers select the appropriate distribution channels for the target market.[1]

However, this Review is an opportunity for insurers to make a head start in addressing this systemic problem. Insurers' can accept the onus for selling suitable insurance, which will improve claims data and trust in the industry.

In our view, the following are necessary features of a suitable insurance policy.

No unfair contract terms

The recent Australian Consumer Law Review Final Report proposed an end to insurers' exemption from the unfair contract terms regime for standard form consumer contracts.[2] We support the proposal, and the Report's assessment that:

> *The current exclusion… is at odds with the underlying intention that the ACL operate as a generic, economy-wide law that minimises exemptions where possible, particularly where those exemptions are no longer considered appropriate or in the public interest.*[3]

[1] See Consumer Action's submission to the Treasury
[2] Consumer Affairs Australia and New Zealand (CAANZ), *Australian Consumer Law Review: Final Report*, April 2017, p 53.
[3] CAANZ, *ACL Review Final Report*, p 53.

The report also noted that:

- the current duty of utmost good faith and disclosure requirements for insurers 'have not been shown to provide equal or greater consumer protection' to unfair contract terms laws, and
- the harm caused by unfair contract terms in general insurance may be worse than previously estimated.[4]

The Financial Ombudsman Service (FOS) does not, under existing laws, decide whether or not a term is 'unfair'. Consumer Action has reviewed FOS determinations in recent years where the duty of utmost good faith (**DUGF**) was considered.[5]

We found that:

- In 83% of cases, the insurer argued a breach by the consumer, alleging the consumer had been fraudulent, misleading or untruthful, breached the duty of disclosure or failed to co-operate with the claims process.
- In 66% of cases, FOS found no breach of the duty by either party.
- FOS found that the consumer breached the duty in approximately 40% of cases where it was argued by the insurer.
- FOS found the insurer had breached the DUGF in only 4% of cases where the consumer argued a breach. Where the insurer did not breach the duty, it was commonly because the dispute concerned underinsurance or exclusions.

Our analysis shows that the DUGF is primarily used by insurers to deny claims on the basis of fraud or the consumer's conduct during the claims process. It does not provide any recourse for someone who has been sold a policy which they argue is unsuitable or unfair.

Below are two examples of terms which we believe could be 'unfair' if the unfair contract terms regime applied to insurance contracts. We also outlined this issue in our submission to the Senate Economics References Committee inquiry into Australia's general insurance industry.[6]

Example: Motor Vehicle Insurance—Uninsured Motorist Extension

[The insurer will cover you if] Your vehicle is damaged in a collision with another vehicle driven by an uninsured driver, but only if:

— *we agree you are not at fault and*
— *you give us the name and address of the uninsured driver and*
— *registration details of the vehicle.*[7]

[4] CAANZ, *ACL Review Final Report*, March 2017, p 53. The ineffectiveness of disclosure was reported in the ICA's commissioned report *Consumer Research on General Insurance Product Disclosures: Research findings report*, February 2017.
[5] Consumer Action review of 137 FOS determinations from July 2013 to March 2017.
[6] Consumer Action, *Submission: Senate Standing Committee on Economics inquiry into Australia's general insurance industry*, 10 February 2017.
[7] Suncorp, *Motor Vehicle Insurance Product Disclosure Statement*, 28 May 2010.

Case study: Uninsured Motorist Extension

Ruby (not her real name) was hit by a car while riding her motorcycle. The car driver fled the scene.

Ruby's insurance policy included an Uninsured Motorist Extension clause which said that the insurer would pay up to $3,000 for damage to the bike if the insurer thought the accident was caused by an uninsured driver or rider.

The insurer declined Ruby's claim because she did not have the details of the other driver. Consumer Action assisted Ruby to lodge a dispute through the FOS. The insurer then agreed to pay Ruby's claim.

Example: Travel insurance—Unsupervised Luggage

To the extent permitted by law, we will not pay a claim in relation to your luggage and personal effects if:
…

l] the luggage and personal effects were left ***unsupervised*** *in a* ***public place****;*
…

Public place *means any place that the public has access to, including but not limited to planes, trains, cruise ships, taxis, buses, air or bus terminals, stations, wharves, streets, shops, museums, galleries, hotels, hotel foyers and grounds, beaches, restaurants, private car parks, public toilets and general access areas.*
…

Unsupervised *means leaving your luggage and personal effects:*

- *with a person who is not named on your Certificate of Insurance or who is not a travelling companion or who is not a relative; or*
- *with a person who is named on your Certificate of Insurance or who is a travelling companion or who is a relative but who fails to keep your luggage and personal effects under close supervision; or*
- *where they can be taken without your knowledge; or*
- *at such a distance from you that you are unable to prevent them being taken; and*

includes forgetting or misplacing items of your luggage and personal effects, leaving them behind or walking away from them.

FOS Determination 348812, 24 August 2014

A customer stowed his camera bag in the overhead locker of a plane on an overnight flight from Brisbane to Kuala Lumpur. The bag was stolen, and he claimed on the travel insurance held by his credit card provider.

FOS found that the customer did not take adequate precautions, considering the value and size of the stolen items. FOS she he could have stored the bag under the seat in front of him, and that this would have been taking adequate precautions in view of the value of the bag and its contents. The insurer could therefore deny the claim.

Outcomes like this, where a common practice by customers can lead to a claim decline, show that policy wording can heavily advantage an insurer over a customer without there being any test of whether the insurer's legitimate interest is being protected.

While the unfair contract terms laws for insurance will now need to be formulated, and their scope is still unknown, the Code could require insurers to proactively review policies for what would be 'unfair' contract terms according to current unfair contract term legislation applying to all other consumer contracts.[8]

The Code could also set out how the unfair contract regime and its exemptions applies to insurance contracts, for example, the 'main subject matter' of a contract, and terms that are reasonably necessary to protect the advantaged party's legitimate interests. This would only be appropriate, however, if there was agreement among insurers, consumer groups, dispute resolution bodies and government officials about the form of these exemptions.

The Code could also set out examples of unfair terms in the insurance contract that could not be relied upon by insurers.

Consumer is eligible to claim

People covered by a policy should, as a very basic principle, be eligible to make a claim under that policy. We have seen countless examples of people being sold insurance under which they could not make a claim, particularly add-on insurance sold through car yards or with loans and credit cards.

Jake's story

Jake (not his real name) was 19 years old when he got his first casual job and bought his first car.

[8] *Australian Securities and Investments Commission Act 2001* (Cth) section 12BG.

Jake got finance through the car yard. The salesperson visited him at his home and advised him to get loan protection insurance because he was young and therefore more likely to lose his job. He purchased disability cover.

Jake had pre-existing mental illness, so the disability cover was of limited value to him. The salesperson also added Guaranteed Asset Protection (**GAP**) insurance to the loan, which Jake didn't realise until we brought it to his attention later. He did not know what GAP insurance was.

When Jake became unable to work due to mental illness, his mother asked the insurer about making a claim. She was told it only covered very serious conditions such as cancer.

John's story

John* got a loan for a modest run-about car and also bought a Walkaway Insurance policy. John says he was told that the insurance would kick in if he became unable to work because of illness. He thought it sounded like a sensible thing to buy.

John was diagnosed with a mental illness and lost his job. Relieved he had bought the insurance, John contacted his insurer. He says he was then told that the insurance did not cover claims for mental illness and would only kick in if he surrendered his car. He was not aware of either of these limitations.

John eventually lost his car when it was repossessed.

The Code could mandate a basic commitment that insurers will not sell consumers insurance under which they are ineligible to claim a benefit. This should include bundled products (such as add-on CCI) under which a consumer cannot claim on one or more components. For example, an unemployed customer should not be required to pay premiums for the unemployment component(s) in a CCI or loan protection policy.

Alex's story

Alex (not her real name) took out mortgage protection insurance with life, trauma, disablement and unemployment cover with her home loan. Just one month after she moved into her new home, Alex was made redundant. There is a two-month waiting period for claims under the policy, so Alex was ineligible to claim on her unemployment cover. She was not advised about the waiting period before she took out the insurance.

Alex is still unemployed. She wants to continue her mortgage protection insurance but will have to pay the full premium, even though she will never be able to claim on the unemployment component of the policy.

Comparison to standard cover

The general insurance standard cover regime under the *Insurance Contracts Regulations 1985* (Cth) (the **Insurance Contracts Regulations**) has, until recently, been extremely low-profile. This is because insurers can comply with it by simply providing a Product Disclosure Statement (**PDS**), which, as noted above, is a weak consumer protection.

Consumer Action's research has found that, of the thousands of FOS domestic insurance determinations between July 2013 and early 2017:

- standard cover was considered in just 27 determinations,
- standard cover was found to apply in 44% of those cases, and
- the insurer had not provided a PDS in 83% of cases where standard cover applied.

Standard cover clearly does not give consumers any assurance of a minimum level of cover under an insurance policy, nor does it enable them to assess a policy against any standard or benchmark.

There is now public discussion about how the standard cover regime could be revived to provide some value to consumers, including in the Senate Economics References Committee current inquiry into Australia's general insurance industry.[9] That inquiry is keenly focused on transparency and comparability of policies, and standard cover is one mechanism by which those two aspects could be improved.

Consumer Action recommended to the Senate inquiry that standard cover could operate as a minimum standard or benchmark for insurance, in conjunction with a star rating and warning system.[10]

For example, a policy which meets all elements of standard cover could have a one-star rating, with policies exceeding standard cover receiving higher ratings. A policy which does not meet standard cover should receive no star rating and should come with a very clear warning that it falls short of the benchmark. Claims experiences may also form part of the star rating, but price would not. This model would have the additional advantage of encouraging people to shift their focus away from price only and towards policy features and claims processes.

While this and various options have been canvassed in recent discussions, at minimum a consumer should be able to ascertain how a policy they are considering purchasing compares to standard cover. This would provide a benchmark and prevent consumers falling into the trap of comparing policies predominantly on price.

While standard cover laws currently fall short of providing transparency in policy features, the Code could require insurers to clearly compare their policies against standard cover, and

[9] *Proof Committee Hansard: Senate Economics References Committee—Australia's General Insurance Industry (Public)*, Sydney, 12 April 2017 and Melbourne, Thursday 13 April 2017. See also Consumer Action, *Submission: Senate Standing Committee on Economics inquiry into Australia's general insurance industry*, 10 February 2017, pp 6-10.
[10] *Proof Committee Hansard: Senate Economics References Committee—Australia's General Insurance Industry (Public)*, Melbourne, Thursday 13 April 2017.

clearly point out where a policy falls short. Adopting a star rating system based on features and claims data and experiences, rather than price, would be another step towards better product transparency.

Complies with section 54 of the Insurance Contracts Act

Section 54 of the *Insurance Contracts Act 1984* (Cth) (the **Insurance Contracts Act**) provides that an insurer may not refuse to pay a claim, either in whole or part, on the basis of an act or omission after the insurance contract was entered into, unless the act 'could reasonably be regarded as being capable of causing or contributing to' the relevant loss covered by the policy.

We have seen policy wording which directly contradicts section 54.

Example: Home Building Insurance—Excess payment requirement[11]

When you make a claim we will choose whether to deduct the applicable excesses from the amount we pay you or direct you to pay the excesses to us or to the appointed repairer or supplier. ***We may require you to pay the excesses in full before we pay your claim or provide any benefits under your policy****. The fact we have asked for payment of your excess does not of itself mean that your claim has or will be accepted by us either in whole or in part. [Emphasis added]*

In our view, a clause of this kind may not only be contrary to law, but also contrary to the hardship provisions under Section 7.7 of the Code.

Although insurers may read and apply policies according to section 54, if the policy wording is not consistent with section 54, it may mislead a consumer as to their rights and position when making a claim. It can even deter people from lodging claims.

The Code could commit insurers to ensuring that their policy wording is consistent with section 54, that is, if policies refer to a person's actions after the policy is entered into, it should state that insurers will only deny claims or pay a reduced amount if those actions caused or contributed to the loss.

Does not unlawfully discriminate

Insurance policies routinely discriminate against people with illnesses, including pre-existing medical conditions and mental illnesses.

Discrimination of this kind may be legal if it complies with the *Disability Discrimination Act 1992* (Cth) (the **Disability Discrimination Act**) requirement for relevant actuarial or statistical

[11] AAMI, *Home Building Insurance: Product Disclosure Statement*, 1 October 2013, p 44.

data.[12] However, it appears that there has been systematic discrimination in travel insurance policies (as well as life insurance policies) over a long period of time which does not comply with the Disability Discrimination Act. FOS recently determined that a blanket mental health exclusion was unreasonable in the absence of any data to justify the exclusion.

FOS Determination 428120, 31 March 2017

The customer suffered a manic episode for the first time while he was overseas, and was hospitalised. He made a claim on his travel insurance policy. The insurer denied his claim on the basis of a blanket exclusion for claims arising from or in any way related to depression, anxiety, stress, mental or nervous conditions.

FOS found that the customer had a disability under the Disability Discrimination Act, and that the insurer had discriminated against the customer in the policy terms and conditions and the manner in which it made the services available. The blanket exclusion relating to mental illness was therefore unlawful.

FOS then determined that the insurer had not established it would suffer unjustifiable hardship if it covered mental illness arising for the first time during the policy, nor did it show that any exemptions under section 46 applied. The insurer also could not provide relevant actuarial data and could not that show it relied on any such data when it introduced the blanket exclusion. The insurer only provided information about general mental health studies and the prevalence of the customer's condition.

Therefore, the insurer could not refuse payment of most of the claim.

The Code should confirm that insurers will not sell policies with exclusions or other terms which discriminate against an insured person contrary to the Disability Discrimination Act. Any exclusions of this kind should only be made on the basis of publicly available data. In addition to this, insurers should review their underwriting practices to ensure that they are not underwriting in a way that is contrary to section 46. This would be an important step to improve the low trust customers have in insurers when it comes to medical definitions and exclusions.

Efficient, honest, fair and transparent sales by all distributors

Section 4.4 is a commitment from insurers that the sales process and services of Employees and Authorised Representatives will be 'conducted in an efficient, honest, fair and transparent manner'. Section 4.4 often arises in disputes where consumers have been mis-sold insurance.

However, the Section 4.4 obligation does not extend to other distributors, such as Financial Services Providers (**FSP**s) which sell insurance under their own Australian Financial Services Licences (**AFSL**s). While there may be some instances where Section 4.4 does extend to

[12] Discrimination Act section 46.

FSPs (for example it will apply to employees of a bank where the bank is a 'related entity' of an insurer), this is a significant gap in the Code.

Addressing this gap would ensure that all distributors of insurance are bound by the overarching obligation to use appropriate sales practices. This would make Section 4 of the Code a more robust and practical commitment from the insurance industry.

Recommendation 1

Section 4 of the Code should be amended to enhance insurers' commitment to sell suitable insurance, by:

(a) ensuring policies do not contain unfair contract terms,
(b) only selling policies under which the insured is eligible to claim a benefit,
(c) comparing policies to standard cover as a benchmark, to clearly show where policies provide less than standard cover,
(d) ensuring that policy wording reflects the requirements of section 54 of the Insurance Contracts Act,
(e) not unlawfully discriminating through policy wording and underwriting, and at claims time, and
(f) extending the Code commitment to sell insurance efficiently, honestly, fairly and transparently to all insurance distributors.

Address problematic add-on insurance sales and pricing

The problems with add-on insurance are long-standing and well-documented.

Three ASIC reports in 2016 found that the car yard add-on market is 'failing consumers', driven by reverse competition and high commissions, and providing very poor value products.[13] ASIC's 2011 report on add-on insurance sold by authorised deposit-taking institutions found high claims decline rates and relatively low claims ratios.[14]

Consumer Action's DemandARefund.com website has enabled more than 260 people to write letters of demand claiming over $570,000 in refunds on add-on insurance. Based on what users of DemandARefund.com have reported:

- one-in-five people did not know they had bought add-on insurance,
- more than one-in-four people thought the add-on insurance was mandatory, and

[13] ASIC, *Report 470: Buying add-on insurance in car yards: Why it can be hard to say no*, February 2016; *Report 471: The sale of life insurance through car dealers: Taking consumers for a ride*, February 2016; *Report 492: A market that is failing consumers: The sale of add-on insurance through car dealers*, September 2016. Add-on insurance sold in car yards had an overall claims ratio of just 9%, compared with home insurance at 55% and car insurance at 85%: ASIC Report 492, para 48.
[14] ASIC, *Report 256: Consumer credit insurance: A review of sales practices by authorised deposit-taking institutions*, October 2011, p 5.

- one-in-three people felt pressured or rushed into buying add-on insurance.

There is ample evidence that something has to change—significantly and fast.

Disappointingly, we are unaware of anything that has been done to effectively and proportionately address this systemic problem. The application to the Australian Competition and Consumer Commission (**ACCC**) to approve a 20% cap on commissions paid to car dealers was unsuccessful. However, in our view it would not have had a meaningful impact. ASIC found that CCI claims ratios were a mere 5%[15]—an indication that CCI is even lower value than other add-on insurance products, despite the fact that CCI commissions are currently capped at 20%.[16]

While 75% of add-on insurance is sold in car dealerships, the problems obviously extend beyond the yard.

In his recent *Independent Review of Code of Banking Practice*, Phil Khoury said that there was no banking industry data to show whether sales practices had moderated in response to the recommendations of the 2011 ASIC report.[17] Khoury recommended that to address the add-on insurance problem, among other things banks should introduce a one-day delayed opt-in sales model which requires the consumer to proactively contact the bank.[18] This was rejected by the banks.[19]

Callum's story

Callum (not his real name) was 19 when he went to buy his first car. He picked out a car and the car dealer said he just had to sign some papers, then it would be his. The car dealer added CCI, GAP insurance and an extended warranty totalling $6,350 to Callum's car loan. Callum did not know that the insurance and warranty were optional. The dealer just said 'this is everything that comes with the car' and gave Callum the total amount.

Callum felt rushed and pressured. He says: '*I was very overwhelmed as this was my first car and I was 19 and only went with my girlfriend who doesn't know anything about cars so I had no idea of the process of buying a car.*'

After two years, Callum was struggling to make his car repayments and was in arrears. With the help of a financial counsellor, he claimed a refund on the insurance and warranty through Consumer Action's DemandARefund.com. He received a $4,900 refund for the insurance.

Callum has now paid off the loan arrears and can keep his car. It means he can keep his job and continue to provide for his girlfriend and their baby.

[15] ASIC, Report 492, para 45.
[16] Under the National Credit Code section 145.
[17] Khoury, *Independent Review of Code of Banking Practice*, January 2017, p 159.
[18] Khoury, *Independent Review of Code of Banking Practice*, Recommendation 67.
[19] Australian Bankers' Association, *Code of Banking Practice: Response by Australian Bankers' Association to Review Final Recommendations*, 28 March 2017, p 25.

Another side to the add-on problem is financed single premiums. This significantly inflates and obscures the total cost of insurance for consumers.

Bob's story

Bob (not his real name) bought his new 'dream' car for $48,700 and arranged finance through the car dealer. He was very excited that he had been approved for finance. Without Bob knowing, the car dealer added CCI and GAP insurance totalling $19,200 to Bob's loan.

Interest on the insurance alone would have been close to $10,000 over the course of the loan, meaning Bob would have spent almost $30,000 on add-on insurance he did not know he had bought.

Consumer Action assisted Bob to get a refund on the insurance.

The widespread consumer harm caused by add-on insurance will continue for as long as insurers, banks and car dealers are inactive in stepping up to address the problem.

This Review is a clear opportunity to take effective action by introducing a delayed opt-in sales model and banning financed single premium pricing.

Recommendation 2

Amend the Code to include a mandatory seven day delayed opt-in sales model for add-on insurance sold with cars and finance, which separates the sale of the car and/or finance from the sale of the insurance and requires consumers to initiate the insurance purchase.

Recommendation 3

Amend the Code to prevent insurers selling add-on insurance with a financed single premium, and instead require insurers to offer clear, transparent upfront and instalment pricing.

Appropriate handling of family violence situations

The Victorian Economic Abuse Reference Group (**EARG**) is a group of community organisations tasked with reducing the financial impacts of family violence. The EARG has published a paper on the problems experienced by people in family violence situations in

relation to the purchase and cancellation of insurance.[20] We have previously provided this paper to the ICA, and **attach** it to this submission.

Family violence issues arise most commonly in relation to home building insurance, although also in home contents and car insurance. Consumer representatives have raised the issues covered by the paper with the ICA, and understand that the ICA is in the preliminary stages of addressing internal protocols and processes.

We also refer to:

- the EARG's recent *Good Practice Industry Guideline for Addressing the Financial Impacts of Family Violence*, and
- the submissions of other consumer representatives to this Review which comment on this issue in detail.

We encourage the ICA to consider these informed and thoughtful perspectives in developing the industry's processes and protocols for the purchase and cancellation of insurance (see further below our related recommendations regarding claims handling).

Recommendation 4

The Code should commit insurers to a timeline for implementing appropriate underwriting and cancellation processes and protocols for insurance, to ensure that an abusive partner cannot commit financial abuse through the purchase and/or cancelation of insurance.

[20] EARG, *Insurance and Family Violence*, 10 April 2017.

Section 5—Employees and Authorised Representatives

The Section 5 commitments regarding insurers' Employees and Authorised Representatives could be strengthened.

Section 5 does not cover all insurance distributors. The obligations under Sections 5.1, 5.2 and 5.3 do not extend to FSPs such as insurance brokers, banks (if they are not related entities) and credit unions which sell general insurance. We are also unsure if all car dealers selling add-on insurance are Authorised Representatives. If they are not, a significant and highly problematic segment of general insurance distributors is not adequately addressed by this important Section of the Code.

A customer with a complaint against an insurance distributor which is not an Employee or Authorised Representative has limited recourse under Section 5.5.

In our view, this is a large gap in the Code. It significantly limits which salespeople the Code applies to, with arbitrary reasons from a consumer's perspective.

The broader obligations under Sections 5.1, 5.2 and 5.3 should extend to all insurance distributors, to ensure that:

- all salespeople are appropriately trained and educated, their conduct is monitored and any problems with their conduct are addressed,
- distributors must notify insurers of any complaints, and
- distributors must tell customers the identity of the relevant insurer.

Recommendation 5

The Code should be amended to extend the obligations under Section 5 to all insurance distributors in relation training and monitoring of salespeople, notifying insurers of complaints and informing customers of the relevant insurer.

Section 6—Service suppliers

Many of the problems we have seen in claims investigations, interviews and surveillance are the result of the conduct of third parties contracted by insurers.

For example, women who have been the victims of family violence have been interviewed by male interviewers for many hours, and have been asked about highly personal and traumatic details of their experiences and their partners or ex-partners.[21]

Section 6 of the Code is currently unclear as to what extent insurers are responsible for the conduct of third parties. Section 6 puts in place general obligations for Service Suppliers, but does not state that insurers will be responsible for the conduct of Service Suppliers they engage. This contrasts with, for example, Section 7.20, which stipulates that insurers will accept responsibility for the work of authorised repairers.

'Service Suppliers' also does not include external experts, such as building experts and medical specialists. Claims disputes regularly arise due to decisions made by insurers on the basis of experts reports. While experts have their own professional obligations, they should be brought within the scope of 'Service Suppliers', and the Code should set out how insurers will engage experts and the level of responsibility insurers have for the conduct of experts they engage.

Recommendation 6

Insurers should commit under the Code to be responsible for the conduct of Service Suppliers they engage, and their approved subcontractors.

Recommendation 7

The definition of 'Service Suppliers' under Section 15 should be expanded to include external experts.

[21] See further EARG, *Insurance and Family Violence*, 10 April 2017.

Section 7—Claims

Section 7 is critical to consumers, as it sets out the commitment of insurers at a time when people are at their most vulnerable.

There are several improvements which could be made to Section 7. These includes commitments when handling claims to appropriately handle family violence situations, assess consistently with the law, respond to financial hardship and appropriately manage investigations, interviews and surveillance.

Commitments when deciding claims

Handling family violence situations

People who are victims or survivors of family violence can face significant difficulties when making claims. These include:

- being unable to access information about the insurance or make a claim, if it is in the abusive partner or ex-partners name,
- inappropriate conduct by claims assessor, investigators and others, for example, lengthy interviews by a male which goes into details about the perpetrator's behaviour,
- the insurer paying a benefit to the perpetrator alone, and
- claims for property damage or theft by the perpetrator being denied because the policy has exclusions for where the perpetrator was 'invited' into the home, or the perpetrator is a co-insured.

The ERAG paper notes the options for addressing these problems, including treating insured people as co-insureds who can claim their portion (for example 50%) of the benefit if their abusive partner/ex-partner commits the property theft or damage.

Recommendation 8

In tandem with Recommendation 4, the Code should require insurers to commit to implementing appropriate processes and protocols to improve the experience and outcomes of claims for people who are experiencing family violence. In particular, the Code should confirm that insurers will treat insured people as co-insured to enable partial payment of benefits.

Consistency with the law

A noted under Section 4, we have seen significant problems with policies not reading consistently with section 54 of the Insurance Contracts Act and section 46 of the Disability Discrimination Act.

This is also a problem at claim time, when people are unclear as to whether they should dispute the denial of their claim, or even whether they should make a claim in the first place.

The recent FOS decision on a blanket mental health exclusion (above) also exemplifies what we see as a systemic issue of claims outcomes being inconsistent with the legal obligations of insurers. While this a bigger issue than the Code alone can grapple with, an acknowledgement of the basic responsibilities of insurers to claimants would be a significant improvement on the status quo.

Recommendation 9

The Code should commit insurers to assessing claims consistently with:

- section 54 of the Insurance Contracts Act, by not denying the claim on the basis of the insured person's actions after the policy was entered into which did not cause or contribute to the loss, and
- section 46 of the Disability Discrimination Act, by not denying a claim on the basis of an exclusion or other term where there is no relevant actuarial or statistical data to support the exclusion.

Responding to financial hardship

In our experience, Section 7.7 has provided some relief for people who are in dire financial situations when they make an insurance claim. However, there is room for improvement, particularly when it comes to payment of excesses.

As noted above under Section 4, some insurance policies require payment of an excess before the benefit is paid. Insurers should review these types of clauses in policies in light of the financial hardship requirements under the Code. There should be provision for people who cannot afford to pay an excess. Insurers should also develop transparent procedures for responding to financial hardship. For example, IDR and hardship information could be included on debt recovery letters, rather than this information only being given to customers who request financial hardship.

Recommendation 10

The hardship provisions of the Code should be expanded to include:

- clear standards for payment of an excess where the customer is in financial hardship, and
- hardship processes which apply where a consumer has a valid claim by cannot afford to pay the excess.

Recommendation 11

Insurers should develop transparent procedures for responding to financial hardship.

Protecting customers in investigations, interviews and surveillance

The Financial Rights report *Guilty until proven innocent: Insurance investigations in Australia* (March 2016) pointed to significant problems with the conduct of insurance investigations. Consumer representatives have raised these issues with the ICA.

The report detailed the experiences of dozens of people involved in claims investigations. The major problems experienced by these people included:

- being subjected to long and repeated interviews, with questions that are irrelevant and relate to highly sensitive issues,
- feeling bullied, harassed, threatened and intimidated and 'treated like a criminal' by investigators,
- racial profiling,
- not providing people with low English skills with translators, and not providing consumers with mental health problems with access to a support person.
- being given little or no explanation of the investigation process and no mention of any rights or standards,
- being asked to sign unexplained documents,
- being asked to provide personal and sensitive documents without warning or reason, and
- having neighbours, family, friends, business associates and clients questioned without the insured person knowing.

The Financial Rights report found that the investigations process led many people to withdraw their claims because the process is too difficult and/or invasive (see further the comments on Section 10 below).

The FRLC report recommended a raft of changes, including changes to ICA practices, law reform and amendments to the Code, to improve the experience of people subjected to investigations.

The Code should adopt the report's evidence-based recommendations as a priority first step, to set a strong standard for an aspect of claims that require robust protections for people who are vulnerable. This would include standards for investigations generally, as well as the use of interpreters and the treatment of people with a mental illness. It would also include a clear statement on insurers' commitment to anti-discrimination.

Recommendation 12

The Code should adopt the recommendations of the Financial Rights report Guilty until proven innocent: Insurance investigations in Australia, including:

- best practice standards for investigations,
- a statement on diversity and anti-discrimination in the Code,
- minimum standards for the use of interpreters, and
- minimum standards for the treatment of people with a mental illness during claims and investigations

Section 10—Complaints and disputes

We note that the recent Code Governance Committee report on claims and dispute data for 2015-16 showed a spike in claims denials and withdrawals on the previous year.[22] This is an extremely disappointing state of affairs, considering the potential of IDR to deliver positive and timely consumer outcomes.

In particular, the marked increase in claims withdrawals is concerning in light of insurers' commitment under Section 7.8 of the Code to not discourage people from lodging a claim. While claims are relatively flat, the increase in withdrawals may be due in part to people being encouraged to withdraw claims, or feeling that the claims process is too difficult to pursue, particularly, as noted above, where claims are investigated. In short, withdrawals may be a symptom of poor claims handling. We have seen multiple instances of this, for example, when a person has made a small claim on their car insurance and is encouraged to withdraw the claim and pay for the repairs instead. This could progress to a claim denial and dispute, but instead results in a withdrawal. Our clients' experience gives some insight into the reasons people may withdraw a claim.

Rose's story

Rose used Consumer Action's website DemandARefund.com to write a letter to her insurer requesting a refund for two insurance policies that were added to her car loan by her car dealer. She sent the letter to the insurer in early August 2016. In the letter, Rose explained that she had approached the car dealer about making a claim when she lost her job and was told the policy only covered medical expenses, which is clearly incorrect.

The insurer responded asking seven very detailed questions, one of which asked Rose why she asked the car dealer (the insurer's authorised representative) about making a claim and not the insurer.

Rose responded promptly and answered all of the questions clearly and articulately. 20 days after the original complaint, the insurer denied Rose's request for a full refund. The dispute was handled by the insurer's customer service team.

Rose was fatigued by the process.

After 60 days following the original complaint:

- the insurer had not advised her about her right to take the dispute to FOS,
- the insurer had not corrected or apologised for the incorrect information provided to her by its authorised representative.
- the insurer had not advised that she may make a claim under the policy.

[22] General Insurance Code Governance Committee, *General Insurance Code of Practice Industry Data Report 2015-16*, March 2017.

We routinely see significant delays in IDR. For example, we are currently assisting someone whose claim was denied and who had been stuck in the IDR process for five months when she came to us for help. Her dispute is still ongoing.

Systemic failures in complaints handling and IDR are a critical problem, which we expect to be a focus for the industry in the immediate term. Several aspects of the problem are relevant to the Code.

One-stage internal dispute resolution

In our view, the two-stage IDR process under the Code provides no advantages to consumers. Consumers are often confused as to which stage of a claim or dispute they are at, and it leads to considerable delays in the process.

Abdul's story

In November 2015, Consumer Action wrote to an insurer on Abdul's behalf requesting a refund of the premiums for two add-on insurance policies together with interest on the basis that both policies were mis-sold to Abdul.

The insurer responded in late November denying any breaches (the first IDR response). This letter did not advise Abdul about his option to take his dispute to external dispute resolution at FOS.

In early December 2015, Consumer Action responded in writing to the insurer disputing its position. The insurer responded in mid-December, again denying liability and again failing to provide EDR information (the second IDR response). Around this time, Consumer Action advised the insurer that Abdul's loan account was to close shortly and requested that any insurance premium be refunded directly to him. Consumer Action mentioned this again by email in late January 2016.

In mid-January 2016, Consumer Action asked the insurer to confirm that the second IDR response from mid-December was its final IDR response, with a view to lodging a complaint with FOS. The insurer responded stating that it was not its final response, and that Abdul would now have to seek an independent 'IDR review'. By this point, 61 days had passed since the initial complaint, well in excess of the 45-day timeframe provided for by ASIC's *Regulatory Guide 165: Licensing: Internal and external dispute resolution*.

At no point did the insurer provide information about FOS.

The joint consumer submission to Ian Ramsay's recent External Dispute Resolution Review commented that multi-tiered IDR is poor practice, and recommended that insurers' IDR processes be simplified.[23] We reiterate this position.

Recommendation 13

The Code should mandate a one-stage IDR process, to reduce customer confusion and delays, and to reduce the risk of customers dropping out of disputes.

Dealing with representatives

On a number of occasions, insurers have directly contacted people who we are representing in claims or disputes, instead of contacting us as their representatives. This can cause significant confusion and stress for our clients. It happens despite the fact that the insurer has been informed by us and/or the customer that they are represented.

When an insurer has been informed that a customer is represented, either by a financial counsellor or a lawyer, it is appropriate for insurers and their representatives and service suppliers to deal with a customer's representative only.

Recommendation 14

Where an insurer has been informed that a customer has representation, the Code should require insurers, their representatives and service suppliers to contact the representative rather than the customer directly. The insurer should only contact the customer directly if there is good reason and the representative agrees.

[23] *Joint consumer submission: Review of the Financial System Dispute Resolution Framework (Review)—Issues Paper*, 10 October 2016.
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Section 14—Access to information

Procedure and hard timelines for personal information requests

A customer will often require access to their personal information held by an insurer when making a claim or pursuing a dispute. Often delays or difficulties with accessing information and documents can have a significant impact on someone at an already stressful and time-sensitive stage.

In addition to this, our experience has been that insurers treat a request for personal information according to the principles under the *Privacy Act 1988* (Cth) (**Privacy Act**) only where the customer specifies that it is a request under the Privacy Act. This provides little assurance to consumers, who are largely unaware of the Privacy Act and what it requires.

The Code should lift the standards of insurers and provide an assurance to consumers that insurers will provide information and documents quickly. This should enable claims and disputes to progress in a fair and timely way.

Recommendation 15

The Code should specify that insurers will treat a request for personal information according to the Privacy Act, irrespective of whether the consumer specifies that it is such a request.

Recommendation 16

The Code should require insurers to provide customers with access to personal information within 14 days of a request by a customer.

Legal status of the Code

There is increasing concern to ensure that industry codes of conduct have legal consequences and are enforceable. For example, the Minister for Financial Services publicly stated her expectation that the Life Insurance Code of Practice be enforceable,[24] and has subsequently asked the ASIC Enforcement Review Taskforce to consider the enforceability of codes.[25]

An appropriate way to ensure legal force of the Code is to make it a term of the insurance contract. Precedents for this approach already exist in the Code of Banking Practice and the Mutual Banking Code of Practice. The decision to make the Code a term of the insurance contract sends a clear message to the public that the insurance industry stands behind the Code and takes the terms of the Code as seriously as a contract of insurance. A decision not to include the Code as a term of the insurance contract would send the opposite message, that is, that the Code is weak and unenforceable, and that the Code is not as effective as the Code of Banking Practice and the Mutual Banking Code of Practice. ASIC's RG 183 also suggests that making a code enforceable as a term of the contracts with customers is the preferable way to ensure a code is enforceable for the purposes of ASIC approval.[26]

A further way to ensure public confidence in the insurer promises in the Code would be to incorporate a penalty regime as part of the Code administration. This would mean that insurers would be prepared to pay some compensation for failure to comply with the code. Any decision on the compensation would need to be made by the Code Governance Committee.

By way of comparison, under the Insurance Council of New Zealand's (**ICNZ**'s) *Fair Insurance Code 2016*, insurers can be reprimanded, fined or expelled from the ICNZ by its Board if they breach the code.[27] The ICNZ has agreed to fines of up to $100,000 for breach of their code.[28]

Recommendation 17

The Code should be enforceable as a term of all insurance contracts covered by the Code.

Recommendation 18

There should be penalties for breach of the Code.

[24] The Hon Kelly O'Dwyer MP, *Media release: Release of ASIC report on claims handling in life insurance industry*, 12 October 2016.
[25] The Hon Kelly O'Dwyer MP, *Media release: ASIC Enforcement Review Taskforce*, 19 October 2017.
[26] ASIC, RG 183, para RG 183.27.
[27] ICNZ, *Fair Insurance Code 2016*, para 49.
[28] ICNZ, *Press release: Insurers agree $100k fine for Fair Insurance Code breach*, 10 June 2015.

Compliance with ASIC Regulatory Guide 183

While we have not commented in detail on the Code's likely compliance with ASIC's RG 183, we note that the Code currently does not comply with the requirement of RG 183 that industry codes be independently reviewed at least every three years.[29]

Recommendation 19

The Code should be amended to comply with the requirements of RG 183 that an industry code be independently reviewed at least every three years.

[29] Requirement under para RG 183.82. The Code complied with RG 183.82 until the Code was amended after the 2012-13 review—see former para 1.14 of the Code.