



## **Addendum Submission:** Strengthening the General Insurance Code Post-2022 Floods

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## **ACIL's Addendum: The Critical Need for Inquiry Focus on the Code**

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In light of a recent review conducted by ACIL on the General Insurance Code of Practice (the Code), we present this addendum to our earlier submission to further address key issues and insights that have emerged. ACIL believes the Inquiry should place emphasis on the Code as a way of better protecting consumers, and our submission will concentrate on key areas where the Code can be strengthened to ensure uniform application and to further foster trust and confidence in the insurance sector, including at times of major catastrophe events.

This addendum builds on our initial submission and helps provide further context to the issues experienced, with recommendations on how to strengthen the Code to better prepare the industry and consumers for future major events.

ACIL observes that the Code is often leveraged as a marketing tool and as a shield during inquiries to demonstrate good conduct within the industry. While the Code enhances insurers' demonstration of adherence to industry best practices, there is substantial evidence of non-compliance, which is often met with limited consequences.

The current Code of Conduct is riddled with loopholes that insurers have exploited, failing to provide adequate protection for consumers during critical times. This was vividly demonstrated in the aftermath of the 2022 floods, where consumer grievances and the ineffectiveness of the Code were laid bare. The evidence, collected from a wide range of consumer experiences and presented during the flood inquiry, paints a damning picture of the current regulatory measures.

ACIL has formulated a robust set of 52 recommendations aimed at addressing these shortcomings. These recommendations are designed to tighten regulatory oversight, enhance transparency, and bolster consumer protections, ensuring that the Code not only meets but exceeds the expectations of Australian insurance policyholders.

## **Financial Hardship & Consumer Vulnerability**

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We have received mixed feedback from consumer advocates about how insurers recognise financial hardship and consumer vulnerability. While some advocates commend insurers for their responsiveness to these issues, others believe that not all insurers are proactive enough in determining whether a consumer is facing hardship or vulnerable, suggesting that the Code should place greater emphasis on insurers' proactive identification of such vulnerabilities. Part 9 of the Code, which addresses consumer vulnerability, does not impose an obligation on insurers to proactively identify such vulnerabilities, whereas Part 10, dealing with financial hardship, explicitly requires insurers to take proactive measures to recognise financial challenges faced by consumers. Some consumer advocates have reported that certain consumers, aware of the protections provided by the Code, claim to be vulnerable or in hardship despite being in less dire circumstances, while those truly experiencing hardship and vulnerability often do not self-identify as such. Other consumer advocates have suggested that if a customer appears to be pretending to be vulnerable, it is likely an indication that they are trying to address another underlying issue they are experiencing with the insurer, such as inaction or delays.



It is crucial that insurers focus their efforts on genuinely vulnerable consumers and ensure that those not facing serious issues are appropriately distinguished. While the ACIL does not suggest that specific provisions to address this issue be added to the Code, we believe it is imperative that insurers handle these distinctions carefully in their application of the Code. In addressing the issues of financial hardship and consumer vulnerability, it is evident that while there are existing mechanisms within the insurance industry to recognise and respond to these challenges, significant improvements are necessary to enhance their effectiveness and impact. The feedback from consumer advocates and our findings reveal multiple areas where current practices can be better aligned with the needs of consumers, particularly during critical times of distress.



**Fast-Tracking Claims:** Strong criticism targets insurers' typical response to consumers in hardship—referring them to counselling—whereas fast-tracking claims is often the most effective way of addressing their immediate needs and reduces stress.



**Appropriate Referrals:** There is significant criticism regarding the inadequacy of entities to which insurers refer consumers for support. Particularly if the vulnerability the customer is experiencing relates to the claim process or the insurer's conduct, professional consumer advocates with appropriate experience in the management of insurance claims, such as claims advocates, are often most suitable for assisting with claims. ACIL recognises insurers' reluctance to refer consumers to advocates, fearing higher claim payouts. However, if these payments align with policy terms, an advocate can expedite claim resolution, akin to typical expenses like loss adjusting or claims management.



**Compliance with AFSL Obligations:** When referring vulnerable customers to external support services, caution is needed due to recent legal changes restricting claims handling services. Many community organizations, like social workers, could violate financial laws by assisting with insurance claims.



**Empowering Consumers in Support Selection:** Consumers should have the power to choose their support person, rather than the insurer assigning one, respecting consumer autonomy and ensuring tailored support.



**Addressing the Root Causes of Vulnerability:** When a claim exacerbates consumer vulnerability, it is crucial to address the contributing factors, aiming for resolutions that tackle the root causes.



**Efficiency Gap:** Some insurers lack streamlined processes that allow their staff to rapidly and efficiently make decisions that benefit vulnerable consumers, which can lead to delayed assistance and exacerbated hardships for those in need.



**Omission of Claim Circumstances in Defining Vulnerability:** The Code does not currently acknowledge that specific claim circumstances, which are often the most common causes of consumer vulnerability. For example, it is reasonable to assume that a consumer whose house has been flooded, or who has lost a roof in a cyclone, or has sustained a considerable loss should be deemed in the Code as automatically financially vulnerable



**Vulnerability Due to Lower Insurance Literacy:** The Code currently lacks specific protections for less educated consumers, who may struggle to effectively communicate complaints or understand their rights during the claims process. Enhanced measures are necessary to better support and safeguard these individuals.



**Enhancing Training Programs:** The current 30-minute training for staff dealing with vulnerable consumers is deemed inadequate. More in-depth training is essential for effective handling of vulnerable consumers.

## Recommendations

In light of the observed gaps and the feedback received from consumer advocates, the following updates are recommended to ensure that the Code better serves consumers, especially those in vulnerable situations:



**Proactive Identification of Vulnerable Consumers:** Amend Part 9 of the Code to mandate that insurers proactively identify consumers who may be vulnerable.



**Consumer Autonomy in Support Measures:** Modify the Code to allow consumers the right to choose their own support measures, rather than having these decided by insurers.



**Ensuring Appropriate Referrals:** The Code should mandate that insurers refer consumers to the most appropriate professionals and consider those who prioritise consumer interests and needs. This could perhaps be overcome by offering the choice of provider to the consumer or the ICA having a list of accredited Claims Advocates on its website.



**Fact Sheets for Vulnerable Consumers and Financial Hardship:** Require the creation of a comprehensive fact sheet by the Insurance Council of Australia ("ICA") or the Code Governance Committee ("CGC"), providing essential information about vulnerability and financial hardship, rights and protections, available support services, application processes, contact details for support teams, language accessibility options, and relevant Code provisions, ensuring clear and accessible information for all consumers.



**Delegating Appropriate Authority:** Insurers should empower their staff with appropriate authority to make decisions that benefit vulnerable consumers quickly and efficiently.



**Inclusion of Specific Vulnerabilities:** Update point 92 of the Code to include claims circumstances and insurance literacy abilities as recognised forms of vulnerability.

## The Code and the law

In efforts to ensure that the Code is both effective and equitable, the review must consider its interaction with established legal principles and obligations.



**Contra Proferentem:** Contra proferentem, a legal principle interpreting contract ambiguities against the drafter, is vital for consumer protection in insurance. We recommend adding this doctrine to the Code to ensure any contract ambiguities benefit the consumer. For instance, if policy wording differs from the schedule regarding coverage limits, the interpretation should favour the higher amount.



**Meeting the Law:** It is essential that the Code includes commitments that clearly outline the minimum standards insurers agree to uphold to meet legal requirements. This commitment should extend to ensuring compliance with broader consumer laws and regulatory requirements. This not only strengthens the enforceability of the Code but also aligns it more closely with legal standards that protect consumer rights.



**Enhancing the Principle of Utmost Good Faith:** The Code recognises the principle of utmost good faith but needs stronger application. Consumers report unexpected policy cancellations or significant premium increases after filing claims, which is particularly frustrating for those with long-standing, claim-free histories. Furthermore, the Code mandates insurers to explain policy non-renewals, yet some fail even this basic requirement.



**Section 54 Compliance:** Section 54 of the Insurance Contracts Act prevents insurers from refusing to pay claims if the policyholder's act or omission occurred after the contract was entered into and did not contribute to the loss. Common breaches of legislation by insurers include denying claims due to delayed notification by the insured or when consumers discard damaged items after a claim, even though these actions do not increase the insurer's loss or prejudice their position.

## Recommendations

To address these issues effectively, we recommend the following specific amendments to the Code:



**Incorporate Contra Proferentem:** Amend the Code to explicitly include the principle of contra proferentem, stating that any ambiguities in insurance contracts should be resolved in favour of the consumer.



**Explicit Legal Standards Commitment:** Update the Code to include a clear and detailed section outlining the commitments of insurers to meet or exceed legal standards. This should cover all relevant aspects of consumer law, financial services regulations, and other pertinent legal requirements.



**Strengthening Utmost Good Faith Obligations:** Upgrade the Code to include a clear and detailed section outlining the commitments of insurers to meet the Principle of Utmost Good Faith including instances where a policy of insurance might face declinature or substantially increased premiums at renewal.



**Strengthen Section 54 Compliance:** To align with Section 54 of the Insurance Contracts Act, the Code should mandate insurers to demonstrate specific prejudice caused by policyholder actions such as delayed claims notification or disposal of damaged items before denying claims. Additionally, it should enforce flexible evidence standards and require clear, timely communication regarding the status and requirements of claims.

## Standards for Employees and Distributors

In the realm of insurance, the manner in which employees and distributors interact with consumers, can influence their experience. ACIL offers the following comments on this section of the Code.



**Empathy Standard:** Recognising and addressing consumers' emotional and situational needs enhances their experience and reduces conflicts. Incorporating an empathy standard in the Code would ensure that all insurance interactions are conducted with understanding and care. Empathy is vital during crises like property loss or accidents, as it significantly impacts consumer satisfaction and trust. An empathetic approach can turn potentially adversarial situations into supportive experiences, fostering trust and reducing disputes.



**Clarification and Expansion of 'Distributor' Definition:** The growth of specialist underwriting agencies in personal insurance has underscored the need for clearer definitions in the Code. The term "Distributor" is vague and should be expanded to include "Underwriting Agency" for better clarity. Additionally, the current exemption for Distributors with full authority to manage and settle claims compromises consumer protection under the Code, given significant issue we've raised in our submission related to claims handling.

## Recommendations



**Incorporate Empathy Standards into the Code:** Amend the Code to explicitly require that all consumer-facing interactions be conducted with a high standard of empathy, positioning standard as the opposite of adversarial or combative methods. Define what constitutes empathetic communication & set clear expectations for employees to meet this provision.



**Establish Mandatory Empathy Training:** Implement empathy training as a prerequisite for all employees and distributors engaging with consumers.



**Expand the Definition of "Distributor":** Under Code Part 16 Definitions - Expand the definition of "Distributor" to include the term "Underwriting Agency".



**Remove the Claims handling Exemption:** Under Code Part 16 Definitions / Distributor (a) delete the phrase "other than a claims handling and settling service".

# Standards for Insurer Appointed Service Suppliers

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ACIL strongly believes that the handling of issues associated with service suppliers represents the most critical area for change in this Code review. Notably, the "Making Better Claims Decisions" review conducted by the CGC has not led to significant changes, despite clear requirements under the Code. Furthermore, despite ASIC's Regulatory Guide 277, no remediation programs have been established in response to identified issues causing customer loss. Therefore, ACIL advocates for comprehensive enhancements to address both the issues identified in that review and other concerns we have noted.



**Independence and Bias of Reports:** Service suppliers should be mandated to affirm their independence and assert that their opinions are free from bias and have not been unduly influenced by insurers. This includes a requirement for experts to act on behalf of both the insurer and the consumer, with all correspondence to be shared with both parties to maintain transparency. ACIL is aware that some insurers include performance measures in their vendor contracts that incentivise the denial or reduction of claims expenses.



**Undue Influence by Insurers:** ACIL has encountered concerning reports of insurers directing service suppliers on how to assess claims, including a notable instance where a large insurer specifically instructed service suppliers to focus on maintenance issues and wear and tear when assessing water damage assessments. This guidance has resulted in biased outcomes that unfairly disadvantage consumers. There are significant concerns regarding conflicts of interest with service suppliers, who are both paid and chosen by insurers. Questions persist about whether these experts are selected based on their merit or because they tend to provide opinions that favour insurers, potentially leading to adverse consumer outcomes including reduced claims payouts. It is crucial that the Code be amended to explicitly prohibit insurers from unduly influencing the assessments and decisions of service suppliers, ensuring that all expert opinions are conducted impartially and independently.



**Expert Report Concerns:** In 2023, ACIL conducted an investigation into expert reports, the findings of which were shared with both ASIC and the GGC. The investigation identified several specific issues:

- **Insufficient Evidence:** Some reports lack the necessary evidence to support their findings, leaving consumers vulnerable to claim denials and disputes.
- **Misinterpretation of Regulations:** Errors in citing building codes, standards and regulations, including those that were in force after the property was built.
- **Overlooking Certified Solutions:** Incorrectly stating a property was defective due to the expert neglecting to explore prior performance solutions signed off by a certifier.
- **Inadequate Investigations:** Some reports fail to conduct proper investigations or on-site visits, leading to potential of erroneous findings and unfair consequences for consumers.
- **Further Investigation:** Failing to specify additional investigations that can provide a more accurate understanding of the cause, leaving consumers with unanswered questions.
- **Inconclusive Findings:** In cases where the findings are inconclusive, some reports mention only excluded causes for damage, neglecting to explore other potential factors that could be relevant and covered by the policy.

- **Echoing Insurer Exclusions:** Reports mirroring insurer exclusions word for word.
- **Exaggerating Remediation Work:** Overstating required remediation work places unnecessary burdens on policyholders and complicates the claims process.



**Handling Concerns and Complaints About Service Suppliers:** The current process for disputing an expert opinion often places a financial burden on consumers, who must pay for an alternative expert to challenge the findings. This creates a power imbalance, as some consumers are either unable or unwilling to take the risk of incurring substantial costs to dispute a finding. To rectify this imbalance, insurers should be required to provide a second opinion from a new, independently appointed service supplier at no cost to the consumer in cases where there is a dispute over an opinion or work of a service supplier. Advocates report that when consumers raise misconduct, providers often review their own work, leading to conflicts of interest and significant consumer harm.



**Qualifications and Transparency:** Concerns have been raised about individuals, such as internal assessors, providing opinions on matters for which they are not qualified, such as tasks that should be performed by qualified engineers. Additionally, there are issues with reports failing to identify the individuals who conducted site visits or their qualifications, leading to a lack of transparency. This makes it challenging to verify whether these individuals possess the appropriate qualifications or expertise for their assigned tasks.



**Independence and Objectivity in Multi-Service Firms:** Firms offering multiple services, such as assessments, building, engineering, and restoration, must maintain strict independence between their divisions to prevent conflicts of interest. Concerns have been identified when second opinions are sourced from within the same business, raising apprehensions about whether the internal party is supporting their colleague rather than providing a genuine, unbiased second opinion. To avoid such perceived conflicts, it is essential that alternate opinions be obtained from independent, external sources and not subject to internal review. Furthermore, contracts should be awarded based on merit rather than internal preferences. Insurers must be mandated to oversee contract authorisation and actively manage any perceived conflicts of interest to ensure fairness and integrity.



**Right to Choose Experts:** To mitigate perceived conflicts of interest, it is essential that consumers be granted the right to select their expert from a panel pre-approved by the ICA, especially if they are dissatisfied with the expert initially chosen by their insurer. This measure ensures that consumers have confidence in the impartiality of the assessments and the integrity of the claims process.



**Expert Willingness to Serve Both Parties:** We have concerns about experts who primarily serve insurers and may avoid working with consumers due to fears of providing opinions that could adversely affect their main client base (i.e. insurers). To uphold the integrity of their assessments, experts should be mandated to base their opinions solely on factual observations, uninfluenced by their relationships with insurers. Additionally, it is essential that experts demonstrate a willingness to act for both insurers and consumers. This approach will help eliminate any perception of bias and ensure fairness in all assessments.



**Definition and Coverage of Service Suppliers:** The current Code does not adequately encompass all types of service suppliers that Part 5 should apply to, notably omitting builders including those who provide both expert opinion and undertake the work. and other external parties who provide expert opinions on claims. Additionally, internal assessors perform functions similar to those covered under this section. ACIL believe both external and internal assessors should be subject to the same provisions and standards.



## Recommendations



**Preventing conflicts of Interest:** Part 5 of the Code should contain a new section which discusses managing conflicts of interest with the following provisions:

- **Independence:** Service suppliers who provide expert opinions must declare their independence and confirm that their opinions are unbiased and not influenced by insurers.
- **Prohibit Directive Guidance:** The Code should be amended to explicitly prohibit insurers from providing directive guidance to service suppliers on how to assess claims. This includes specific instructions that may bias the evaluation of claims.
- **Selection of Services Suppliers:** Insurers must select service suppliers based on their professional merit and qualifications, refraining from choosing suppliers solely because they produce outcomes favourable to insurers.
- **Objectivity in Multi-Service Firms:** The Code should require that any second opinions be obtained from external, independent sources, particularly in disputes or significant claim assessments. Alternatively, Insurers must be mandated to oversee contract authorisation and actively manage any conflicts of interest to ensure fairness and integrity.
- **Willingness to Serve Both Parties:** The Code should require that all service suppliers engaged in insurance assessments demonstrate a willingness to act impartially for both insurers and consumers.



**Recommendation for Ensuring Fair and Honest Expert Opinions:** The Code should be amended to include specific requirements for those providing expert opinions, to enhance the credibility and fairness of their findings. These requirements should include compel experts to:

- **Evidence-Based Findings:** Provide sufficient evidence to substantiate their conclusions, ensuring their opinions are well-supported and verifiable.
- **Adherence to Standards:** Accurately cite and apply the correct building codes, standards, and regulations relevant to each case.
- **Exploration of Performance Solutions:** When reporting on defects consider whether there are performance solutions previously certified.
- **Thorough Investigations:** Conduct proper and comprehensive investigations relevant to the issues they are assessing. This includes identifying and undertaking additional investigations that could provide a clearer understanding of the issues, especially in complex cases where initial findings might be prone to inaccuracies.
- **Transparency in Findings:** If findings are inconclusive, experts should clearly state this in their reports and avoid limiting their opinions to interpretations that might favour the insurer, such as exclusively identifying excluded causes for damage.
- **Independence from Policy Influence:** Expert opinions should not mirror an insurer's policy wording or be influenced to align with insurance exclusions, particularly when they are word-for-word.



**Equitable Dispute Resolution of Service Supplier:** In cases where there is a dispute over the opinion or work of a service supplier, insurers should be required to provide a second opinion from an independently appointed service supplier at no cost to the consumer.



**Qualifications and Transparency:** The Code should require that all service suppliers, including internal assessors, are appropriately qualified for the specific tasks they perform. Moreover, the Code should mandate that all reports clearly identify the personnel who conducted site visits or provided an expert opinion, along with their qualifications.



**Consumer Choice of Service Supplier:** The Code should be amended to grant consumers the right to select their expert from a panel that has been pre-approved by the ICA. This right should be explicitly available to consumers particularly when they express dissatisfaction with the expert initially provided by their insurer.



**Service Supplier Definition:** The Code should be amended to include a broader and more inclusive definition of 'Service Supplier.' This updated definition should explicitly encompass builders, internal loss assessors, and any other parties that provide expert opinions relevant to insurance claims, without exclusion or limitation. Furthermore, the provisions that apply to external service suppliers should also be extended to internal loss assessors, given the similarities in the services they provide.

## **Buying and cancelling an insurance policy**

In the insurance sector, the acts of buying and cancelling policies are pivotal for consumer protection and trust. This section highlights these key issues and offers recommendations for enhancing the Code to ensure fairer and more transparent interactions between insurers and consumers.



**Shifting the Onus of Underinsurance:** Insurers possess greater knowledge of rebuild costs than consumers and should therefore bear a greater responsibility for highlighting underinsurance. It is particularly crucial for insurers to take a proactive role in ensuring adequate coverage levels, especially when they are aware that the policy is being issued may be insufficient for the consumer's needs.



**Preventing Predatory Pricing in Monopoly Markets:** There have been perceptions of predatory pricing by insurers, particularly when they are the sole providers of insurance for specific consumers, such as buildings with defects or located in high-risk areas. Insurers with monopolies over certain clients or markets must avoid engaging in such practices.



**Fair Administration Fees for Policy Cancellation:** It is essential that any administrative fees charged upon policy cancellation accurately reflect the actual amount of work involved. To protect consumers from excessive fees, the Code should mandate that all cancellation fees be strictly proportional to the administrative services provided.

## Recommendations



**Proactive Underinsurance Management:** The Code should require insurers to proactively notify consumers of potential underinsurance at both policy inception and renewal. Alternatively, insurers should provide an updated estimated sum insured for home insurance customers and clearly communicate this estimate and consequences of underinsurance in their renewal notices.



**Preventing Predatory Pricing:** The Code should include a firm commitment that insurers will not engage in predatory pricing, especially in instances where they hold a monopoly over certain markets or client segments.



**Fair Cancellation Fees:** To safeguard consumers from excessive administrative fees, the Code should mandate that all cancellation fees be strictly proportional to the actual administrative work performed.

## Claims Handling

The claims handling process is a critical juncture in the insurance lifecycle where consumer satisfaction and trust are most vulnerable. This section outlines key improvements needed to ensure that claims are processed efficiently, transparently, and with the utmost respect for consumer rights, reinforcing the insurance industry's commitment to integrity and consumer protection.



**Enhancing Consumer Experience in Claims Handling:** The manner in which insurers handle claims has a profound impact on consumers, particularly during vulnerable times. It is essential that the claims process be managed empathetically, fairly, and professionally. This ensures that consumers receive not only the financial support they need but also the respect and understanding they deserve, significantly enhancing their overall experience during critical moments.



**Catastrophe Claim Turnaround Times:** The current timeframe of up to 12 months for insurers to accept or decline catastrophe-related claims is excessively long and does not meet reasonable consumer expectations, particularly in light of the policy limitations applied to temporary accommodation or loss of rent or business interruption which often do not exceed a 12 month period, or may have a conservative financial limit applied. Additionally, clear consequences should be established for insurers who fail to meet these timelines, ensuring prompt and efficient handling of claims during critical times.



**Preparedness:** In the wake of the 2022 major floods, the readiness and response of insurers came under scrutiny as they grappled with the unprecedented scale and impact of the flooding events. Insurers were faced with a formidable challenge, one that revealed both strengths and areas in need of enhancement. Insurers are not required demonstrate their capability to effectively support clients during major catastrophe events. Currently, insurers are not obligated to demonstrate their capability to effectively support clients during major catastrophe events. This is particularly crucial in scenarios such as the La Niña season, where the potential for large claims is known well in advance of the storm season. It is essential that the Code mandates insurers to show preparedness for these events to ensure they can provide timely and adequate support when disasters strike.



**Dedicated Case Officers:** A frequent criticism has been consumers' having to repeatedly explain their claims circumstances to different insurer personnel each time they make contact. While we respect multiple claims handlers is appropriate for low value claims the Code should reflect a commitment to, dedicated "case officers" should be the touch point on larger claims or identified vulnerable consumers.



**Addressing Insurer Gaslighting in Claims Handling:** A significant factor contributing to mental health issues, frustration, and unmet expectations during the claims process is gaslighting by insurers. This behaviour includes failing to respond to consumer inquiries, promising actions without follow-through, delay tactics, providing incorrect or misleading information, failing or refusing to acknowledge errors, or to appropriately address the impacts of errors when they are admitted, or making consumers feel unheard and invalidated. Such practices not only deteriorate trust but also significantly impact the emotional well-being of consumers. It is crucial for the Code to explicitly prohibit these practices and ensure that insurers engage in transparent, responsive, and respectful communication with claimants.



**Transparency in Claim Inspections:** Insurers should be required to clearly communicate the purpose of sending representatives for inspections to consumers. If the inspection involves assessing issues unrelated to the primary claim, such as identifying unrelated maintenance concerns, the insurer must clearly communicate this intention to the consumer beforehand. Such transparency will reduce unnecessary burdens on consumers and ensure they are adequately informed about the scope and reasons for any assessments conducted. When insurers or experts obtain evidence outside of the agreed scope, it should be excluded from the consideration of the claim.



**Addressing Power Imbalance in Settlements:** Consumers often experience a significant power imbalance during the claims process, especially when dealing with unliveable property conditions and waiting for insurer responses. This urgency can pressure consumers into accepting settlements that are neither fair nor satisfactory because they lack the time or resources to contest them. Additionally, the practice by some insurers of requiring consumers to sign release forms before offering a settlement raises concerns. If settlements are truly fair and reasonable, consumers should not need to waive their rights beforehand; instead, they should retain the right to dispute the settlement even after receiving it.



**Improving Communication Requirements in the Code:** The current requirement in the Code for insurers to communicate every 20 business days often falls short of providing real value to consumers, particularly when advocates report insurers issuing automated standard templates with no substantial updates, leading to a mere box-ticking exercise. This approach can increase consumer anxiety rather than alleviate it.



**Establishing Defined Timelines for Claim Resolution:** Currently, there is no standard timeframe within the Code for resolving a claim, lacking any binding commitment to timely closure. This often leads to prolonged claim processes without clear expectations. The Code should be amended to include more robust and enforceable time limits for each step of the claims process, including initial assessments, make-safe procedures, indemnity decisions, scope of work determinations, and the commencement of repairs or issuance of cash settlements. Instituting these specific timelines will ensure a more efficient and predictable process, significantly enhancing the overall consumer experience and satisfaction.



**Exploring independent claims advocates:** The insurance claims process is often fraught with disputes, leading to consumer dissatisfaction and resource-intensive resolutions. ACIL recognises the potential value of independent claims advocates in the claims process, particularly in reducing disputes within IDR and AFCA, and enhancing consumer and insurer outcomes. Benefits include Perception of fairness, Effective Dispute Communication, independent management of cases with unrealistic consumer expectation, Objective Claim Assessment, Reduction in Dispute Escalations, Shortened Claim Processing Times, Enhanced Support for Vulnerable Consumers.





**Challenges with Cash Settlement Processes:** ACIL has identified multiple issues with how cash settlements are handled:

- Insurers often base cash settlements on what it costs them, not what the repair would realistically cost the consumer in the market. Insurers should be mandated to base their offers on genuine repair quotes that reflect reasonable market values.
- Insurers sometimes insist on cash settlements, which may be appropriate in certain circumstances, but they sometimes base the settlement on liability quotes that do not accurately reflect the actual repair costs, often resulting in settlements based on underestimated values.
- There are cases where cash settlements are perceived as full and final resolutions even when they only cover a portion of the claim.
- Cash settlements often fail to include contingencies for unforeseen issues or allowances for variations, and they typically do not compensate for the transfer of risk, such as losing the insurer's lifetime warranty on repairs.
- Many consumers accept cash settlements without fully understanding the implications. ACIL recommends that for claims above a certain threshold, consumers should be advised to obtain professional advice regarding the settlement terms or, at the very least, be given the option to consult with an expert at the insurers expense.
- It is crucial to ensure that the scope of work is complete, correct, and appropriately detailed, including allowances for reasonable variations. Claims consultants we work with have indicated that this continues to be a significant issue for many consumers.
- Vulnerable consumers are at significant risk of accepting unfair cash settlements due to factors like limited knowledge, financial and emotional stress, fear of claim denial, complexity of insurance documents, and lack of access to professional advice. These factors can lead them to hastily accept offers that may not fully compensate them for their losses.



**Extending Loss of Rent and Accommodation Benefits:** It is inherently unjust for consumers to face undue penalties solely due to delays in claim finalisation by insurers or their contractors. Current policy conditions, such as limiting loss of rent and accommodation benefits to 12 months or 10% of the policy value, can prove inadequate, particularly when insurers take up to 12 months to determine their position on indemnity. This frequently leads to consumers exhausting their entitled benefits solely during the prolonged assessment or rebuild period.



**Mandatory Short-Term Accommodation Provision:** In cases where consumers are left vulnerable due to uninhabitable property conditions while insurers are still making decisions on claims that may potentially be denied (such as flood claims), it is crucial for their immediate needs to be addressed. Although many insurers voluntarily provide such support, the Code should explicitly require insurers to offer short-term accommodation while they are determining indemnity. This provision should be clearly linked to specific timeframes, ensuring that consumers have access to necessary housing during the decision-making period.



**Inadequate Scope of Works:** Consumer advocates are concerned about the adequacy of the scope of works provided by insurers because it often underestimates the repairs needed, leading to insufficient settlement amounts at cash settlement or and potentially substandard restoration. Additionally, insurers should be required to provide customers with all valid scopes and quotes when settling, not just their preferred one. For example, if an insurer obtains two quotes from different builders and chooses the lower one, both quotes should be provided to the client.



**Addressing Mistakes:** The current Code does not address situations where customers incur losses exceeding policy limits or outside policy terms due to insurer or provider mistakes. For instance, if insurer negligence leads to a total loss of contents, the insurer should not simply apply the policy limit. Similarly, if a vendor's error causes damage not covered by the policy, such as painting a garage and damaging a customer's boat, the insurer should still be liable.



**Provision of Information:** Noticeable inconsistencies exist in the process and level of information different insurers provide. While the current Code requires insurers to make available the documents they rely on for making decisions, we believe this does not go far enough. Insurance companies should be obligated to provide any information they hold regarding a claim upon request, except in cases where sensitive issues justify withholding certain documents. Such actions would exemplify a commitment to enhanced transparency throughout the claims process. Additionally, there are concerns about insurers failing to inform consumers about documents relevant to their claims.



**Proactive Disclosure of Policy Benefits:** Insurers often fail to proactively offer all applicable benefits during the claim assessment process. For instance, consumers might not be informed about specific policy benefits, such as reletting expenses following a rental loss event, unless they explicitly ask for them. To address this issue, the Code should impose a greater obligation on insurers to clearly outline all applicable policy benefits to consumers at the start of the claims process. This could be facilitated by providing a detailed fact sheet listing all potential benefits relevant to the claim, ensuring that consumers are fully aware of their entitlements and can make informed decisions about their claims.



**Partnering with Consumers in Claims:** Insurers often overlook consumers' ability to use their own resources to expedite claims, such as sourcing repair quotes from local contacts or utilising the Alternate Premises benefit. Instead of supporting solutions like staying with family or friends, insurers typically insist on commercial rentals, leading to quickly depleted benefits and financial stress for consumers. Adopting a partnership philosophy could benefit both consumers and insurers, particularly during catastrophe events.

## Recommendations



**Core Principle for Claims Handling:** Part 8 of the Code should open with a clear statement mandating that all claims be handled with a high degree of empathy, fairness, and professionalism.



**Catastrophe Claim Turnaround Times:** The Code should be amended to reduce the standard turnaround time for catastrophe claims from 12 months to a variable timeframe, starting at four months. This timeframe should be adjustable by the CGC, upon application by the ICA or subscribers, based on factors such as the scale of the event, availability of experts or repairers, and historical data from prior similar events. Consideration should be given to the explicit extension of temporary accommodation and loss of rent timeframes to allow for these extended decision-making timeframe.



**Establishing Clear Consequences for Timeline Non-compliance:** The Code should be amended to include explicit consequences for insurers who fail to meet established claims handling timelines.



**Dedicated Claims Officers:** The Code should reflect a commitment to, dedicated "case officers" to be the touch point on larger claims or identified vulnerable consumers.



**Mandatory Catastrophe-Ready Plans for Insurers:** The Code should mandate that all insurers develop and maintain a catastrophe-ready plan that adheres to a-set criteria.



**Enhanced Transparency for Claim Inspections:** The Code should require insurers to clearly communicate the purpose of sending representatives for inspections to consumers. Specifically, if the inspection assesses issues unrelated to the primary claim, this intention must be explicitly stated to the consumer in advance.



**Settlement Releases:** Where a settlement offered is wholly in line with the customer's common law or policy entitlements, (i.e. it does not include any ex-gratia component), the Code should prohibit the practice of requiring consumers to sign release forms before a settlement offer is made, allowing for a consumer to enter dispute resolution on a settlement made by an insurer.



**Right to Appoint Independent Claims Advocate:** Consumers should have the right to appoint their own claims preparer or advocate from an ICA-accredited list immediately after filing a significant claim (e.g., \$50,000 or 2.5% of the Sum Insured) on an owner-occupied dwelling. The insurer should cover a portion of the claims preparation fee, which must be specified in the home insurance policy wording.



**Establishing Defined Time Limits for Claims Processing Steps:** The Code should be amended to set specific time limits for each critical step in the claims handling process. For example, in a property damage claim this could include time frames for initial assessments, implementing make-safe measures, determining indemnity, finalising the scope of work, and commencing repairs or issuing cash settlements. Similar provisions should apply to other claims such as motor claims.



**Fair and Accurate Cash Settlements:** The Code should mandate that cash settlements be based on the reasonable cost of repairs, supported by genuine and verifiable repair quotes. Cash settlements should also comprehensively account for contingencies, unforeseen issues, and variations, and compensate for the transfer of risk, such as the loss of an insurer's lifetime warranty on repairs.



**Expert Consultation for Large Claims & Vulnerable Consumers:** ACIL recommends that the Code mandate insurers to advise consumers to obtain professional advice for claims exceeding a specified threshold or in cases where a consumer is identified as vulnerable. At a minimum, consumers should be given the option to consult with an independent expert at the insurers cost, to ensure that settlement terms are fair and fully understood.



**Scope of Works:** The Code should require insurers to commit to ensuring that all scope of works are complete, correct, and detailed, including allowances for reasonable variations.



**Prohibition of Consumer Penalties Due to Insurer Delays:** Amend the code so consumers do not lose policy benefits such as loss of rent or temporary accommodation benefits due to unreasonable delays caused by insurers or their service suppliers. Furthermore, consideration must be given for consumers disputing a claim given AFCA timeframes.



**Transparency and Documentation Accessibility:** Insurance companies should be obligated to provide all information they hold regarding a claim upon consumer request, with the exception of sensitive issues, which may warrant withholding certain information. Furthermore, insurers should be required to provide a comprehensive list of all documents available pertaining to the claim upon request by consumers.



**Benefit Fact Sheet Requirement:** The Code should require insurers to provide a comprehensive fact sheet detailing all potential benefits pertinent to the claim.



**Develop an Insurer-Consumer Partnership Philosophy.** The Code should require insurers to note that insurers will proactively seek to ascertain and support appropriate Consumer capacity and desire to provide practical applications to the Claims Process, especially post Catastrophic Events.



**Redress for Losses from Insurer or Provider Mistakes:** Amend the Code to specify that when insurer or provider mistakes cause additional losses, customers should be entitled to claim for these losses even if they exceed policy limits or fall outside policy terms.

## Other parts of the Code

During our consultations with claims advocates and various stakeholders, we have identified several issues with the current Code that warrant attention and highlight the need for comprehensive revisions.



**Heavy-Handed & Intimidating Investigation Tactics:** Claims advocates have reported that some insurers use overly aggressive and intimidating tactics during fraud investigations. Specific concerning behaviours include:

- Labelling investigations as fraud inquiries to consumers.
- Engaging global security firms whose services go beyond private investigations and may convey an intimidating presence.
- Requesting information beyond what is essential for the investigation.
- Failing to engage in a discussion with consumers before initiating investigations.



**Tenant Protections:** Despite a prior pledge, insurers lack formal commitments in the Code to not pursue tenants for recovery of claims. ACIL believes it's crucial to enshrine this stance in the General Insurance Code.

## Recommendations



**Fair Investigation Processes:** The Code should be amended to include specific provisions that ensure investigations are conducted fairly and respectfully. Recommended updates include:

- Insurers should be required to take reasonable steps to gather essential information about a consumer before deciding on whether to commence a fraud investigation.
- It should be mandated that insurers and their investigators treat consumers with respect throughout the investigative process. Investigators should approach each case with an open mind, avoiding tactics that might intimidate or exert undue pressure on consumers.
- Face-to-face interviews be conducted only when necessary, and only if the required information cannot be effectively obtained through less intrusive methods.



**Non-Recovery from Tenants for Unintentional Damages:** Update the Code to explicitly state that insurers should not pursue tenants for the recovery of claims related to unintentional damage, aligning with insurers' public commitments and protecting tenants from undue financial burdens.

## Complaints

The effectiveness and integrity of the Internal Dispute Resolution (IDR) process within the insurance sector is a topic ACIL believes should be included as part of this submission. Feedback from some claims advocates indicates substantial room for improvement in this area, which is vital for maintaining consumer trust and ensuring fair outcomes.



**Perceived Inefficacy of the IDR Process:** There is a prevalent sentiment among some claims advocates ACIL spoke to that the current IDR process often serves as a perfunctory step, merely reaffirming initial dispute decisions rather than genuinely reassessing the cases. This perception devalues the IDR's role and diminishes its credibility. ACIL is concerned that numerous customers with legitimate disputes do not escalate their issues to AFCA, resulting in their acceptance of incorrect decisions. AFCA itself has publicly stated that it suspects some insurers' IDR systems are almost a rubber stamp, basically outsourcing their consumer complaints to AFCA.





**Contrast with External Dispute Resolution (EDR) Outcomes:** A notable observation is that when disputes are escalated to the Australian Financial Complaints Authority (AFCA), a different case manager within the same insurance company often overturns the IDR decision shortly after lodgement. This trend is particularly concerning in instances where the dispute submission remains largely unchanged, yet the outcome differs significantly. This inconsistency creates a perception among consumers and consumer advocates that the Internal Dispute Resolution (IDR) process may not be the effective avenue for achieving a fair resolution. Such a perception severely undermines the integrity of the IDR process.



**Identifying Underlying Issues in IDR:** Several factors contribute to the perceived inadequacy of the IDR process, including:

- Greater authority and decision-making power vested in insurer's EDR case managers.
- Once a complaint reaches AFCA, insurers face increased pressure to make correct decisions, as opposed to the IDR process where there are fewer consequences for errors.
- Lower experience levels among IDR team members.
- Potential overburdening of IDR case managers with higher caseloads.
- A lack of independence between the Claims and IDR functions.
- Rushed responses to complex complaints due to time constraints, evidenced by the bulk of them being delivered on the 30th day of the mandated response period.
- Inadequate communication efforts with consumers to fully comprehend their issues before delivering their final decision.
- Concerns exist about insurers potentially using the IDR process to test if consumers will escalate their complaints.
- A lack of direct communication from IDR teams with customers or advocates directly.

## Recommendations



**Commitment to Resource and Expertise:** The Code should require insurers to commit to properly resourcing their dispute resolutions teams. This includes providing sufficient staffing to handle caseloads effectively, ensuring team members have the necessary expertise to assess and resolve disputes accurately, and offering ongoing training to keep pace with changes in the industry and regulatory environment.



**Direct Communication for Dispute Resolution:** IDR decision-makers should be required to offer to speak with the customer or their representatives prior to making a decision. Additionally, EDR teams should actively engage in direct discussions to resolve disputes, rather than waiting for formal AFCA processes, to expedite the resolution of claims and reduce unnecessary delays.

# Affordability

We believe insurers have a moral obligation to ensure insurance is accessible and affordable for all consumers. Generally, insurers meet this obligation adequately, but there have been notable exceptions. For instance, in January 2024, ACIL, along with the Owners Corporation Network of Australia, Unit Owners Association of QLD, and NQ Strata Action Group (collectively, the Consumer Alliance), raised concerns about insurers' refusal to offer insurance in Northern Australia. This refusal persists despite the availability of the Cyclone Reinsurance Pool, which mitigates the primary risk of concern for insurers —cyclones. We believe insurers could leverage this pool to address severe affordability issues and the lack of available insurance (market failure) in northern Australia.

Additionally, the tendency of insurers to select only 'good risks' particularly in hardening markets contributes to this issue. If all insurers committed to making insurance affordable and available to everyone, not just selecting 'good risks,' it would significantly address affordability issues, especially in cases of market failure. Such a commitment across the industry would ensure a more equitable distribution of insurance coverage, helping to stabilise markets and support consumers who face the greatest challenges in obtaining necessary insurance.

## Recommendations



**Accessibility Mandate:** The Code should mandate that insurers take all reasonable measures to prevent market failure, reflecting their commitment to making insurance universally affordable and accessible and affirming their societal role.

## Helping reduce risks

Incorporating risk reduction measures into the Code would be advantageous for insurers. A primary challenge with insurer-led mitigation efforts is that those who invest in such practices often face a competitive disadvantage, as they may not retain clients after spending on these measures. By mandating all insurers to implement risk reduction strategies, the Code would ensure that no insurer is placed at a competitive disadvantage for risk mitigation. This approach would level the playing field and promote a more comprehensive commitment to risk management across the industry.



**Mandatory Mitigation Measures in Claims Handling:** ACIL advocates for the integration of mitigation measures as a fundamental component of reducing risk within the insurance industry. While the responsibility for funding these measures often falls to the government, we believe that insurers should also contribute to mitigation efforts during the claims process. By incorporating mitigation considerations and expenses into claims repairs and cash settlements, insurers can play a critical role in reducing overall risk and future claims. To this end, it would be advantageous for the Code to mandate mitigation spending for all member insurers during the claims process. Although the specifics of the amount and allocation have not been considered by ACIL, including such provisions in the Code would undoubtedly benefit both consumers and insurers by fostering a proactive approach to risk management.



**Periodic Risk Surveys with Government Support:** ACIL supports the implementation of risk surveys on properties every 3-5 years, under the condition that these inspections do not negatively impact consumers by affecting their affordability or insurability. While these surveys could enhance risk assessment and potentially limit insurers' ability to deny claims based on maintenance exclusions, we recognise that the financial burden of such a program might be significant for individual consumers. Therefore, we propose that this initiative should be complemented by government funding aimed at bolstering individual consumer resilience to insurance risks.

# Code Governance and Compliance

As we seek to enhance the effectiveness and integrity of the insurance industry's regulatory framework, it is essential to address the current gaps in Code governance and compliance. Strengthening these areas is crucial for ensuring that insurers not only adhere to established standards but also engage in practices that genuinely protect and benefit consumers. Below are key concerns and recommendations aimed at improving the governance and compliance mechanisms within the Code.



**Enhanced Penalties to Support Vulnerable Consumers:** ACIL believes the current \$100,000 community benefit payment penalty is insufficient to deter non-compliance among insurers. Despite widespread non-adherence, no insurer has faced or expects to face this penalty. To foster better compliance, ACIL proposes the implementation of a robust market mechanism tied to adherence levels. Given that no insurer currently fully complies with the Code, all insurers should anticipate being required to make payments based on their compliance levels. We recommend that the CGC issue an annual compliance scorecard for each insurer, evaluating factors such as egregious individual breaches, systemic breaches, self-reported breaches, AFCA complaint statistics, overall compliance culture, and support for vulnerable consumers. Based on this scorecard, insurers should be required to contribute financially in an amount that reflects their level of compliance, with higher penalties for greater infractions. Proceeds from these payments should be allocated to a fund dedicated to supporting vulnerable consumers and those facing financial hardship. This approach not only incentivises adherence to the Code through financial implications but also directly aids in addressing the needs of the most vulnerable customers, thereby resolving two significant issues within the industry.



**Enhancing CGC Enforceability:** Consumer advocates have expressed concerns regarding the CGC's approach to handling reported breaches. Currently, upon reporting a breach, consumers often receive a standard response indicating that the CGC focuses only on systemic breaches, not individual instances. To strengthen trust and accountability, the CGC should also consider individual cases, especially those involving egregious or serious breaches. Additionally, the CGC should investigate individual complaints that may suggest systemic issues, even if the complainant lacks proof, to ensure thorough oversight and enforcement.



**Lack of Individual Case Rights in Breach Handling:** There is currently no provision within the Code that grants consumers specific rights when individual breaches occur. This gap in the policy prevents effective recourse for consumers affected by isolated incidents. It is crucial to establish mechanisms within the Code that empower consumers to seek redress or intervention on an individual basis, ensuring their rights are protected even in non-systemic breach scenarios.



**Inconsistencies in Breach Reporting:** Inconsistencies observed in the Code monitoring reports from insurers reveal that some insurers are not adequately complying with the requirements to report breaches. This lack of compliance undermines the effectiveness of regulatory oversight and compromises the integrity of the insurance industry's self-regulatory framework.



**Compliance Culture:** In our consultations it was expressed that significant variations exist in the culture of Code compliance among different insurers. Claims advocates we spoke to have noted that a culture of compliance serves as a reliable indicator of adherence to the Code. Insurers with a strong compliance culture tend to exhibit better Code compliance.



**Reducing Over-Reliance on Frontline Staff for Code Compliance:** A key concern ACIL have is the dependence on frontline staff for adherence to the Code, rather than integrating systematic processes to guarantee compliance or provide better oversight for insurers. Examples include the failure to provide essential documents like Cash Settlement Fact Sheets to consumers when offering a cash settlement, providing regular updates, correcting mistakes/errors and inadequate acknowledgment of complaints and expressions of dissatisfaction.



**Clarifying Code Compliance Standards:** The current Code contains ambiguities regarding what it means to "adopt and comply with" its provisions. To prevent insurers from merely claiming adherence without substantive compliance, the Code should be revised to include precise definitions and detailed criteria that outline what true adoption and compliance entail, ensuring that all insurers meet a standardised level of practice. Furthermore, the term "competent" lacks a clear definition, leaving room for interpretation on the expected standards of practice.

## Recommendations



**Introduction of a Graduated Penalty System:** ACIL recommends that the current penalty system be overhauled to introduce a graduated penalty mechanism that is closely tied to insurers' compliance levels. The CGC should issue an annual compliance scorecard for each insurer, ensuring that penalties are accurately aligned with the insurers' adherence to the Code. The financial penalties collected should be directed into a fund specifically established to support vulnerable consumers and those facing financial hardship.



**Broadened Scope of CGC Investigations:** The Code should be revised to mandate that the CGC not only focuses on systemic breaches but also gives due consideration to individual cases, particularly those that involve egregious or serious breaches.



**Establishment of Individual Redress Mechanisms:** The Code should be amended to incorporate specific provisions that explicitly grant consumers rights in cases of individual breaches, with the facilitation of these provisions potentially being handled by the CGC or AFCA.



**Promoting Compliance Culture in the Code:** The Code should be revised to explicitly require all subscribers to foster and maintain a strong culture of compliance. This inclusion should detail the expectations for developing, promoting, and sustaining an environment where adherence to the Code's standards is a central tenet of operational practices.



**Integration of Systematic Compliance Frameworks:** The Code should mandate that all insurers develop and integrate systematic processes designed to guarantee compliance with its provisions.





**Specify Compliance Standards:** The Code should be revised to clearly define what it means to "adopt and comply with" the code, including precise definitions and detailed criteria for true adoption and compliance such as the requirement for preventative and detective controls, quality assurance programs, adequate staffing levels, training requirements.



**Define 'Competent':** The Code should explicitly define "competent" to clarify the expected standards of knowledge and practice, ensuring consistent interpretation and application across all insurers.

## Fostering Integrity through Insurance Code Reforms

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Meaningful and substantive amendments to the Code are crucial, not only for enhancing trust and confidence in the insurance industry but also for addressing the specific, particularly in the context of the ongoing Inquiry into insurers' responses to the 2022 major floods claims. These changes are essential to ensure that all consumers, especially the most vulnerable, are robustly protected and supported during such critical events. It is imperative that these enhancements transcend superficial adjustments and lead to significant improvements in how consumer grievances are handled during disasters. The recommendations put forth in this submission are designed to elevate consumer trust and compel insurers to adhere to higher standards of operation and accountability. We strongly advocate for the Inquiry to focus on the Code of Conduct as a crucial framework for compelling insurers to meet and exceed consumer expectations, particularly in times of major catastrophes. This focus will confirm the Code as not just a guideline, but as a robust standard of accountability and consumer protection when it is most needed.



**Email: [info@acilobby.org.au](mailto:info@acilobby.org.au)**

**Website: [www.acilobby.org.au](http://www.acilobby.org.au)**