Submission to Insurance Council of Australia Interim Report on Review of the General Insurance Code of Practice

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Introduction

1. The Public Interest Advocacy Centre (**PIAC**) welcomes the opportunity to provide this submission to the Insurance Council of Australia (**ICA**) on its Interim Report on the Review of the General Insurance Code of Practice (**Interim Report**).

2. This submission builds on our previous submission dated 12 May 2017.

3. Having regard to our experience and case work, the submission addresses some of the questions raised in the Interim Report, adopting the numbering set out in the Report. Where we have not addressed a question, this does not constitute an endorsement or a rejection of the proposal put forward in that question.

Proposal 1: The Code should strengthen standards relating to vulnerable consumers

Question 1. The ICA suggests that the Code could include a new section on vulnerable consumers. The section would begin with a statement acknowledging the diverse needs of vulnerable people and committing to supporting the particular needs of customers where these are identified. Please identify any concerns or suggestions for improvements with this approach.

4. PIAC supports the proposal to include a new section on vulnerable consumers in the Code. Vulnerable consumers, particularly those who have a mental or physical disability, are Aboriginal or Torres Strait Islander, who don't speak English as a first language or who have experienced abuse or trauma should be provided with special protection. Any new section in the Code should include concrete and practical initiatives to improve support for these consumers.

Recommendation 1

The Code should include a new section on vulnerable consumers.

Any new section in the Code should include concrete and practical initiatives to improve support for these consumers.

Question 1.1. It seems reasonable that the Code should require insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from third parties. Please detail any concerns with this suggestion.

5. PIAC supports the proposal to require insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from third parties. The Code should require insurers to identify as early as practicable whether assistance is required and, if it is required, the nature of the assistance required and to take all reasonable steps to accommodate the consumer.

Recommendation 2

The Code should require insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from third parties.

The Code should require insurers to identify as early as practicable whether assistance is required and, if it is required, the nature of the assistance required and to take all reasonable steps to accommodate the consumer.

Question 1.2. The ICA suggests that the Code should require staff to be trained to identify and engage appropriately with vulnerable consumers, and to escalate requirements for additional support. Are there any implementation factors that need to be considered?

6. PIAC supports this proposal. We submit that training should be specifically tailored to address the different functions of staff roles within the organisation. Training programs should also be reviewed annually by insurers to ensure the programs' effectiveness in achieving their objectives and ICA members should be required to report annually to the ICA on the outcome of the review.

Recommendation 3

The Code should require staff to be trained to identify and engage appropriately with vulnerable consumers, and to escalate requirements for additional support.

Training should be specifically tailored to address the different functions of staff roles within the organisation.

Training programs should also be reviewed annually by insurers to ensure the programs' effectiveness in achieving their objectives and ICA members should be required to report annually to the ICA on the outcome of the review.

Question 1.5: Question 1.5: Noting the Commonwealth Ombudsman best-practice principles, and the point raised by some insurers, would the following principles satisfactorily reflect best practice standards for the use of interpreters?

a) Insurers must provide access to an interpreter, either when one is requested by the customer or when a staff member needs one to communicate effectively with a customer (whether formally or informally).
b) Staff must make a record of a customer's interpretation needs and plan ahead to meet these needs. Where an interpreter is offered but declined, staff must also record this.
c) Insurers must provide a direct link on their website to information on interpretation services and any other relevant information for non-English speakers. This includes any product information that insurers have translated into other languages.

Do you have any concerns with this approach or suggestions for improvement?

7. PIAC supports the inclusion of principles to provide people with access to interpreters in accordance with the Commonwealth Ombudsman's best-practice principles.

Recommendation 4

The Code should include commitments to provide people with access to interpreters in accordance with the Commonwealth Ombudsman's best-practice principles.

Proposal 1(B): Providing Code guidance on best practice mental health principles

Question 1.6. The ICA proposes that the mental health best-practice principles (detailed in Appendix 1) should be developed into an ICA guidance document. Do the principles adequately respond to the issues raised by stakeholders? Are there any matters that have not been addressed?

8. PIAC supports the development of the mental health best-practice principles (**Principles**) and commends the ICA for taking this important step to acknowledge and address the systemic issues facing people with mental health conditions in accessing general insurance.

9. PIAC strongly recommends that the Principles form part of the Code for the following reasons:

   a) The enforcement status of the Principles is unclear from the Interim Report. A separate, non-binding document setting out the Principles will not adequately address the systemic issues identified. It is crucial that the Principles are binding and enforceable.

   b) Any breaches of the Principles must be subject to the same monitoring, enforcement and sanction provisions as apply to any other breaches of the Code.

   c) The addition of supplementary material in the form of a guidance document reduces the effectiveness of the Code as a tool for consumers to understand insurers' obligations, one of the key functions of the Code.

10. The Annexure to this submission sets out our recommended amendments to the Principles.

Recommendation 5

The Mental Health Principles should form part of the Code and should be binding and enforceable.

The Annexure to this submission sets out our recommended amendments to the Mental Health Principles.

Question 1.7. The ICA's view is that the Code should not contain guidelines for complying with the DDA. However, the Code could include a statement explaining how underwriting decisions will be made. For example:
a) Decisions will be evidenced based;
b) Underwriting decisions will be regularly reviewed to ensure decision making is not relying on out-of-date information.
Is this a suitable alternative? Are there any issues or concerns with this approach?

11. PIAC does not agree that this is a suitable alternative. While this statement seeks to address some of the requirements of the *Disability Discrimination Act 1992* (Cth) (**DDA**), we are concerned that it introduces new language which does not accurately reflect the language of section 46 of the DDA and which could be confusing for consumers and insurers.

12. PIAC recommends that the Code contain guidance about the *Disability Discrimination Act 1992* (Cth) (**DDA**). We take this position for the following reasons:

    a) The ICA's General Insurance Code of Practice is a crucial instrument by which the general insurance industry sets standards that its members must meet when providing services to their customers. These standards should include minimum guidance for an insurer's legal obligations, particularly where those legal obligations are designed to provide important protections for consumers.

    b) It is clear from PIAC's casework that many general insurers are not aware of their obligations under the DDA and that, as a result, people with mental health conditions continue to experience discrimination when applying for and claiming on general insurance policies. This review of the Code is an important and timely opportunity for the ICA to provide useful and practical guidance to its members to ensure that they understand and comply with their obligations under the DDA.

    c) In our experience, many consumers are not aware that insurers have obligations under the DDA and other disability discrimination laws. Including guidance on the DDA in the Code will serve to enhance and clarify the rights of consumers, a key function of the Code.

13. We note that in the Interim Report, the ICA suggests that the Code should not take an active role in interpreting existing legal requirements. We disagree with this position for the following reasons:

    a) We do not agree that the provision of minimum guidance on what is required by section 46 of the DDA constitutes legal interpretation.

    b) However even if it does, it would be difficult to argue that the guidance PIAC suggested in Recommendation 1 of our previous submission dated 12 May 2017 is in any way controversial. In particular, paragraphs (a) to (c) of Recommendation 1 simply acknowledge the importance of disability discrimination law and restate the content of sections 24 and 46 of the DDA. Paragraphs (d) to (h) are drawn from the Australian Human Rights Commission's *Guidelines for providers of insurance and superannuation under the Disability Discrimination Act 1992 (Cth)* (2016) (**AHRC Guidelines**). This document constitutes authoritative guidance on insurer's obligations under the DDA and is a comprehensive source from which to draw guidance.

    c) Any concerns regarding possible confusion caused by overlap between what is stated in the Code and what is stated in other guidance documents can be easily addressed by ensuring that the restatement of the requirements of the DDA in the Code is consistent with the wording of the DDA (rather than introducing new language in an attempt to interpret the DDA) and by ensuring that the guidance set out in the Code is consistent with the content of the AHRC Guidelines.

    d) As a peak industry body, the ICA should share the responsibility in explaining and clarifying its members' obligations under important pieces of legislation such as the DDA.

Recommendation 6

The ICA should set out guidance on the DDA in the Code.

This guidance should be drawn from the Australian Human Rights Commission's Guidelines for providers of insurance and superannuation under the Disability Discrimination Act 1992 (Cth) (2016).

Question 1.8. Should the Code require insurers to provide, on request, a summary of the type of data or a description of the relevant factors relied upon, and why that data or those factors are relevant, when they rely on the DDA to make a decision about the provision of insurance or about a claim? What are the strengths or weaknesses of this approach?

14. PIAC maintains that the Code should require insurers to provide consumers with:

    a) copies of data relied upon in decision making;
    a) plain language summaries of the data to assist consumers to more easily understand the reliance placed on the data by the insurer when making its underwriting decision; and
    b) information about other relevant factors relied upon in decision making.

15. We re-iterate our view that, as well as providing the summaries, insurers should be obliged to provide copies of the statistical or actuarial data itself. Often this data comprises of publicly available medical journal articles or statistical studies which are not readily accessible to consumers.

16. Insurers should only be permitted to decline to provide copies of actuarial or statistical data outside formal complaints processes, where that data is genuinely commercial-in-confidence (noting that, through our case work we have rarely seen insurers rely on statistical or actuarial data that is genuinely commercial-in-confidence) and permission cannot be obtained from the owner of the data (such as a reinsurer) to share it. Wherever an insurer declines to provide copies of actuarial and statistical data on this basis, the insurer should tell the consumer so in writing.

17. The Code should make clear, however, that this does not negate the existing obligation to provide all actuarial or statistical data relied upon, including data that it claims is commercial-in-confidence, once a consumer has made a DDA complaint to a state or federal complaints body.

18. We do not agree that the complexity of some actuarial or statistical data is a valid reason to not provide consumers with the information when requested. Any concerns about the complexity of the documents will be addressed by providing the plain language summary of why the data is relevant.

Recommendation 7

The Code should:

a) require insurers to provide consumers with:

i. *copies of data relied upon in decision making;*
ii. *plain language summaries of the data to assist consumers to more easily understand the reliance placed on the data by the insurer when making its underwriting decision; and*
iii. *information about other relevant factors relied upon in decision making;*

b) *only permit insurers to decline to provide copies of actuarial or statistical data outside formal complaints processes, where that data is genuinely commercial-in-confidence and permission cannot be obtained from the owner of the data to share it;*

c) *wherever an insurer declines to provide copies of actuarial and statistical data on this basis, require the insurer to tell the consumer so in writing; and*

d) *make clear that paragraph (b) does not negate the existing obligation to provide all actuarial or statistical data relied upon, including data that it claims is commercial-in-confidence, once a consumer has made a DDA complaint to a state or federal complaints body.*

Proposal 2: The Code should provide guidance on best practice disclosure principles

Question 2. Do the best practice principles detailed in Appendix 3 adequately address key concerns related to disclosure? Please identify any areas that have not been addressed.

19. PIAC supports the best practice principles set out in Appendix 3. However, we submit that the principles should include more specific requirements regarding the disclosure of exclusions which apply to a product. In our experience, clients are not aware of the exclusions that apply to their policies before they purchase a product and only become aware of the exclusions at claim time, at which point they are often shocked to discover that their claim is not covered by their policy. Burying exclusions in dense and lengthy product disclosure statements is not an adequate solution to this issue.

20. PIAC submits that exclusions which apply to a policy should be clearly brought to a customer's attention in a readily accessible and clear format, prior to the customer entering into the contract.

Recommendation 8

The best practice disclosure principles set out in Appendix 3 should include an additional principle which requires insurers to clearly bring all policy exclusions to a customer's attention in a readily accessible and clear format, prior to the customer entering into the contract.

Question 2.1: Would a new Code requirement that key information must be provided in plain language, and be consumer tested to ensure it is clear and informative enough for a consumer to reasonably assess the suitability of the policy for them, be a sufficient strengthening of the plain language provision? Please advise if you consider an alternative approach more appropriate.

21. The Code should require the use of plain language in all communications with customers not just in the provision of key information.

22. The use of plain language should be consumer tested to ensure its effectiveness.

Recommendation 9

23. The Code should require the use of plain language in all communications with customers and this should be consumer tested to ensure its effectiveness.

Proposal 3: The Code should include product design and distribution principles and provide guidance to insurers

Question 3: Would the inclusion of the following principles in the Code be an effective means of improving product suitability? Are there any other principles to add?

a) Cover must be designed with a clear target market in mind. Equally, it should be clear to insurers and distributors which consumers are not part of the target market.
b) Cover must be designed to meet a genuine need and offer a tangible benefit at reasonable value. This applies to additional as well as core benefits.
c) Insurers must not design products that offer (or are capable of offering) negative or very low value.
d) The product and its features and exclusions must be capable of being communicated to and understood by the target market.
e) When designing products for bundling, insurers must consider how this impacts on the target and non-target market and product value.
f) Insurers must regularly review product performance and act promptly on any identified concerns.

24. PIAC broadly supports the above principles. However, we are concerned that they do not contain any guidelines regarding the requirements of the DDA. We suggest that the following principle is added:

When designing products, insurers must ensure that products:

a) are not designed to automatically decline insurance following disclosure of a mental health condition. Consumers should instead be referred to make an application directly with the insurer so the application can be properly underwritten;
b) do not include blanket mental health exclusions; and
c) do not permit the application of mental health exclusions and/or cover on non-standard terms unless those exclusions and terms comply with section 46 of the DDA.

Recommendation 10

The Code should include the principles set out in question 3 above.

The principles should include the following additional principles:

When designing products, insurers must ensure that products:

a) are not designed to automatically decline insurance following disclosure of a mental health condition. Consumers should instead be referred to make an application directly with the insurer where the application can be properly underwritten;
b) do not include blanket mental health exclusions; and
c) do not permit the application of mental health exclusions and/or cover on non-standard terms unless those exclusions and terms comply with section 46 of the DDA.

Question 3.1: Do the product design considerations attached in Appendix 4 adequately respond to stakeholder concerns? Can the principles be applied to all general insurance products and does the material provide sufficient detail as to how the principles are to be applied?

25. PIAC broadly supports the product design principles and considerations set out in Appendix 4. However, the product design considerations should also include principles regarding the design of the questions in the application form.

26. Under the *Insurance Contracts Act 1984* (Cth) (the **IC Act**), insured persons have a duty of disclosure to an insurer. If an insured person fails to comply with their duty of disclosure or makes a misrepresentation to an insurer prior to entering into the contract, an insurer can exercise certain rights under the IC Act. For general insurance contracts, these rights include the ability of the insurer to void a policy if the failure to disclose was made fraudulently or to have their liability in respect of a claim reduced to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred or the misrepresentation had not been made.

27. In PIAC's experience, insurance application forms often ask unclear or open-ended questions which are misunderstood by applicants. If applicants misinterpret a question because it is vague or unclear, at claim time, this gives rise to the risk that an applicant could be accused of failing to comply with their duty of disclosure or of making a misrepresentation. This creates a great deal of contractual uncertainty for customers and the risk that their policy may provide little or no cover.

28. For example, an applicant might disclose that they have depression and a follow up question might then ask "how many episodes of depression have you had". This question is difficult for applicants to answer as it is not always possible to categorise a person's experience of depression into one or more "episodes". There is also often no explanation of what is meant by the term "episode".

29. PIAC submits that the product design principles in Appendix 4 must provide guidance on the structure and content of application forms. In particular, we recommend that principles should require insurers to:

a) develop standardised application forms for insurance; and
b) ensure that the questions in the application forms:
    i. are simple, clear and specific;

ii. ask only one question at a time and not bundle several questions together at once;
iii. not ask questions requiring knowledge which the applicant could not reasonably be expected to possess;
iv. are accompanied by examples of the type of information that is sought where possible; and
v. provide sufficient opportunity for an applicant to provide more detailed answers where necessary.

Recommendation 11

The product design principles and considerations set out in Appendix 4 should include the following additional principles:

Insurers must:

a) develop standardised application forms for insurance; and
b) ensure that the questions in the application forms:
i. are simple, clear and specific;
ii. ask only one question at a time and not bundle several questions together at once;
iii. not ask questions requiring knowledge which the applicant could not reasonably be expected to possess;
iv. are accompanied by examples of the type of information that is sought where possible; and
v. provide sufficient opportunity for an applicant to provide more detailed answers where necessary.

Proposal 8: The revised Code should meet the requirements for ASIC approval

Question 8: What issues should be taken into account if the Code were to make it explicitly clear that Code standards are enforceable through the Code Subscribers' EDR scheme?

30. PIAC submits that the ICA should seek ASIC approval of the Code.

31. There can be no doubt that consumer confidence in the insurance industry is low. Poor practices, the glacial pace of change and the overall absence of a genuine commitment to change across the sector has contributed to such declining levels of consumer confidence. An ASIC approved Code will establish an industry wide commitment to deliver a certain standard of practice, raise industry standards, complement legislative requirements and encourage consumer confidence.

32. The ICA notes that "*[…] the benefit of keeping the Code standards part of standalone self-regulatory model is that it allows the Code to contain principles and flexibility. […] If Code Subscribers are required to make the Code enforceable at law, that flexibility could well end up being stripped out and the Code reduced to base-level, prescriptive service standards*".

33. We do not accept this reasoning as a sensible basis to refuse to make the Code enforceable at law. As ASIC notes, experience has shown that community confidence in the effectiveness of industry codes is reliant on consumers being able to seek redress under the code and, further,

that the code is seen to be enforced against non-compliant subscribers.[1] A well-evolved and flexible Code is of limited utility if it is not capable of effective enforcement by consumers.

34. Real enforcement of the Code is lacking in the ICA's current self-regulatory model. The Code does not create any legal rights for consumers and the Code Governance Committee (**CGC**) has a discretion about whether or not to investigate complaints.

35. PIAC submits that all necessary steps should be taken to ensure that the Code meets the enforceability requirements of RG 183, including in particular that insurers agree to be contractually bound by the Code.

36. Further, the process of seeking ASIC approval for the Code should not jeopardise or water down the progressive content of the Code. The ICA and its members should continue to demonstrate leadership to ensure that the Code evolves in a timely manner to respond to emerging issues facing consumers.

Recommendation 12

The ICA should seek ASIC approval of the Code.

All necessary steps should be taken to ensure that the Code meets the enforceability requirements of RG 183, including, in particular, that insurers agree to be contractually bound by the Code.

The ICA and its members should continue to demonstrate leadership to ensure that the Code evolves in a timely manner to respond to emerging issues facing consumers.

Question 8.1: Are there any factors to consider if the Code required the CGC to report systemic code breaches and serious misconduct to ASIC?

37. PIAC supports the proposal to require the CGC to report systemic Code breaches and serious misconduct to ASIC.

38. PIAC recommends that systemic breaches should include Code breaches that have implications beyond the immediate actions and parties affected by the breach. This definition is consistent with the definition of "systemic issue" in FOS's terms of reference i.e. "an issue that will have an effect on people beyond the parties to a dispute".

39. The CGC should be required to report the breach/conduct as soon as practicable, and within ten business days of becoming aware of the breach/conduct.

Recommendation 13

The CGC should be required to report systemic Code breaches and serious misconduct to ASIC.

Systemic breaches should include Code breaches that have implications beyond the immediate actions and parties affected by the Code breach.

[1] ASIC Regulatory Guide, paragraph 183.26.

The CGC should be required to report the breach/conduct as soon as practicable, and within ten business days of becoming aware of the breach/conduct.

Question 8.3: Given the apparent lack of clarity around the operation of the remedies and sanctions in the Code, would this be addressed if the available Code sanctions mirrored those recommended by ASIC RG 183:

a) Compensation for any direct financial loss or damage caused to an individual
b) Binding non-monetary orders obliging the subscriber to take (or not take) a particular course of action to resolve the breach
c) Formal warnings
d) Public naming of the non-complying organisations
e) Corrective advertising orders
f) Fines
g) Suspension or expulsion from the ICA
h) Suspension or termination of Code subscription

Are there any other factors that need to be considered with this approach?

40. The limited range of sanctions in the Code has long been a weakness in the enforcement provisions of the Code. PIAC therefore supports the inclusion of Code sanctions which mirror those recommended by ASIC RG 183.

Recommendation 14

Code sanctions should mirror those recommended by ASIC RG 183 as follows:

a) compensation for any direct financial loss or damage caused to an individual;
b) binding non-monetary orders obliging the subscriber to take (or not take) a particular course of action to resolve the breach;
c) formal warnings;
d) public naming of the non-complying organisations;
e) corrective advertising orders;
f) fines;
g) suspension or expulsion from the ICA; and
h) suspension or termination of Code subscription.

Additional Code Review Themes

(i) Claims

Discussion Point 1: What issues should be taken into account if the Code were to require the following:
a) provide a claimant with contact details they can use to get information about the claim
b) explain to the claimant why particular information is being requested
c) where possible, request all required information early and in one request, rather than in multiple information requests.

41. PIAC supports this proposal. For travel insurance claims in particular, customers or their family members are often in distressing situations. Family members are sometimes travelling to be with the insured person because of a health-related emergency. This is an extremely stressful time which is often compounded by the difficulties people face in the claim process. It can be particularly frustrating where an insured person or their family member do not have one point of contact with the insurer for their claim and are forced to re-explain their situation every time they contact the insurer. The Code should also include a requirement that an insured person and any person assisting them is provided with one consistent point of contact whom they can contact throughout the claims process.

42. The stress of situations in which claims are made also means that claimants or the people assisting them are often not in a position to sit down and read through the intricacies of a lengthy product disclosure statement to understand the claims process. We note that section 8.3 of the Life Insurance Code of Practice includes the following requirement:

    Within ten business days of being notified about your claim, we will explain to you your cover and the claim process, including why we request certain information from you and any waiting period before payments will be made. We will give you contact details that you can use to get information about your claim.

43. PIAC submits that the Code should include a similar obligation requiring insurers to provide written advice to claimants and the people assisting them which explains the claim process, the type of cover the claimant holds, any pre-requisites for making a claim, any waiting periods, any excess amounts and any other relevant information applicable to the policy.

Recommendation 15

The Code should require insurers to do the following:

a) *provide a claimant and any person assisting them with one consistent point of contact whom they can contact throughout the claims process;*
b) *explain to the claimant and any person assisting them why particular information is being requested;*
c) *where possible, request all required information early and in one request, rather than in multiple information requests;*
d) *within five business days of being advised of a claim, provide advice to claimants and the people assisting them which explains the claim process, the type of cover the claimant holds, any pre-requisites for making a claim, any waiting periods, any excess amounts and any other relevant information applicable to the policy.*

Discussion Point 1.2: There is strong support for better data collection of withdrawn claims. The ICA notes that this could involve extensive system changes for some insurers. Taking this into consideration, would an appropriate middle ground be for the Code to require that when a claim is withdrawn, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish? Please identify any concerns with this approach or alternative options.

44. PIAC supports this proposal. Insurers should be required to ask claimants why they have withdrawn their claims and this information should be recorded. In situations where an insurer has not been formally advised by a claimant that a claim is being withdrawn but the claim appears to have been abandoned, insurers should be obliged to follow up with the claimant to determine if the claim has in fact been withdrawn and if so, to ask the claimant their reasons for doing so.

45. Once an insurer becomes aware that a claim has been withdrawn, they should be required to inform the claimant of the insurer's complaints process.

Recommendation 16

Insurers should be required to ask claimants why they have withdrawn their claims and this information should be recorded where provided.

In situations where an insurer has not been formally advised by a claimant that a claim is being withdrawn but the claim appears to have been abandoned, insurers should be obliged to follow up with the claimant to determine if the claim has in fact been withdrawn and if so, to ask the claimant their reasons for doing so.

Once an insurer becomes aware that a claim has been withdrawn, they should be required to inform the claimant of the insurer's complaints process.

Discussion Point 1.3: What factors should be taken into account if the Code were to require regular updates to be given to a claimant every 10 business days (which can be provided via text, email or mobile phone), with responses to routine queries given within five business days?

46. PIAC supports Legal Aid NSW's submission that the timeframe for deciding a claim should be reduced from four months to two months before a claimant is referred to internal and external dispute resolution processes and that consumers should be referred to mandatory internal dispute resolution where a claim has not been determined within four months of lodgment.

47. Insurance provides consumers with financial protection. This protection is undermined if claims are not processed expeditiously to ease a customer's financial strain. Four months is simply too long to decide a claim and such delays risk forcing claimants into precarious financial circumstances.

48. PIAC supports the ICA's proposal to require insurers to provide regular updates to a claimant every ten business days, with responses to routine queries given within five business days.

Recommendation 17

The Code should require insurers to:

a) *notify claimants of their right to engage in internal or external dispute resolution if their claim is not determined within two months of lodgement;*
b) *refer claimants for mandatory internal dispute resolution if their claim has not been determined within four months of lodgement; and*

c) *provide regular updates to a claimant every ten business days and responses to routine queries within five business days.*

(d) Claims denials and partial denials

Discussion Point 1.4: Are there any matters that would have to be resolved if the Code were to require that, where a claim is partially accepted, this should be confirmed in writing? The written confirmation could include:
a) which aspects of the claim have not been accepted and the reasons for this
b) the consumer's right to access information relied on to make the decision
c) information about the insurer's complaints process

49. PIAC supports the Code requiring, where a claim is partially accepted, written confirmation to be provided, including information about which aspects of the claim have not been accepted and reasons for this, the consumer's right to access information relied on to make the decision and information about the insurer's complaints process.

Recommendation 18

The Code should require, where a claim is partially accepted that written confirmation is provided and that written confirmation should include:

a) *information about which aspects of the claim have not been accepted and reasons for this;*
b) *the consumer's right to access information relied on to make the decision; and*
c) *information about the insurer's complaints process.*

Discussion Point 1.5: Would a satisfactory Code improvement be for clause 7.19 to make it clear that all of the information provided when a claim is denied is required to be in writing, not just the reasons for the denial in (a)? Is there an alternative approach?

50. PIAC supports the Code requiring that all information provided when a claim is denied be put in writing.

Recommendation 19

The Code should require that all information provided when a claim is denied be put in writing.

Discussion Point 1.6: Are there any issues to be considered if the Code required insurers to record the reasons for claim denials?

51. PIAC supports this proposal. In addition, we recommend that the obligation include a requirement to record, where cover is offered on non-standard terms (including with an exclusion or with a premium loading), the reasons why cover has been offered on non-standard terms.

52. As noted in our response to Discussion Point 7 below, insurers should be obliged as a matter of practice to provide their reasons in writing for not providing insurance or for providing cover

on non-standard terms. An internal requirement to record these reasons will facilitate the provision of reasons to customers.

Recommendation 20

The Code should require insurers to record the reasons for claim denials and the reason why cover is offered on non-standard terms.

(j) Provision of documents

Discussion Point 1.15: The Access to Information section of the Code could be updated to clarify that insurers will provide the following information on request (subject to any special circumstances where information cannot be provided under clause 14.4):

a) information and documents relied on to deny a claim
b) copies of the PDS and insurance certificate
c) copies of any expert or assessment reports relied on
d) copies of any recordings or available transcripts of the sale of insurance

Would this be a suitable improvement or are there alternative documents that should be specified?

53. PIAC supports this addition to the Access to Information section of the Code subject to the following amendments:

a) The paragraph should be prefaced with the following chapeau to reflect the scenarios set out in section 75 of the IC Act:

Where we:

i. refuse to enter into a contract of insurance with you;
ii. deny your claim on a contract of insurance;
iii. cancel your contract of insurance;
iv. indicate to you that we do not propose to renew your cover under your insurance contract; or
v. offer you insurance cover on non-standard terms,

we will provide the following information on request:

b) Sub-paragraph (c) should be amended to reflect the requirements of section 46 of the DDA and should read "any statistical data, actuarial data, expert or assessment reports relied upon".
c) Another sub-paragraph should be added to reflect the proposal in question 1.8 of the Interim Report and should read "a summary of the type of data relied upon, a description of the relevant factors relied upon and an explanation as to why that data or those factors were considered relevant".
d) Sub-paragraph (d) should not be limited to recordings and transcripts of the sale of the policy. The sub-paragraph should be amended to include "any recordings and available transcripts between you and us".

Recommendation 21

The Access to Information section of the Code should be updated to include the following requirement:

Where we:

a) refuse to enter into a contract of insurance with you;
b) deny your claim on a contract of insurance;
c) cancel your contract of insurance;
d) indicate to you that we do not propose to renew your cover under your insurance contract; or
e) offer you insurance cover on non-standard terms,

we will provide the following information on request:

f) information and documents relied upon to deny a claim;
g) copies of the PDS and insurance certificate;
h) copies of any statistical data, actuarial data, expert or assessment reports relied upon;
i) a summary of the type of data relied upon, a description of the relevant factors relied upon and an explanation as to why that data or those factors were considered relevant; and
j) copies of any recordings and available transcripts between you and us.

(iv) Complaints and disputes

Discussion Point 4: Insurers have suggested that moving to a one-tier complaints process would be difficult to manage. Noting the issues outlined above, are there other suggestions for improving the internal complaints process? Are there any concerns with waiting until after AFCA is established before implementing changes?

54. PIAC supports the proposal to move to a one-tier complaints process. In practice, it is our experience that general insurers do not follow the two-tier process in any case. In our experience, the process is usually as follows:

    a) the customer makes a claim;
    b) the claim is denied;
    c) the claimant is then advised of their right to seek an internal review and does so;
    d) if the outcome of the internal review is negative, the claimant is then advised about the external dispute resolution options and no further internal review opportunity is provided.

55. The current two stage process set out in the Code provides, in the first stage, for someone close to the complaint to conduct an initial review. We see no value in retaining this process. The rule against bias is one of the pillars of procedural fairness and requires decision-makers to approach matters with an open mind, free of prejudgment and prejudice. The risk of apprehended or actual bias is inevitably increased if a decision-maker is permitted to review his or her own decision or someone close to him or her is permitted to do so.

56. Section 10.4 of the Code commits insurers to handling complaints in a fair, transparent and timely manner. However, the inclusion of the first stage of the complaints process only serves to slow down the internal review process and in turn encourages inertia on the part of complainants.

57. PIAC recommends that the Code should implement a one-tier internal dispute resolution process with a 45-day time limit for making decisions. If a decision is not made within 45 days, the complainant should be referred to the insurer's external dispute resolution processes.

58. We see no reason why the ICA should wait until after AFCA is established before making changes to the complaint process for the following reasons:

    a) It is not known how long it will take to establish AFCA. It could take several years before it is operational.
    b) The external dispute resolution to be provided by AFCA operates independently of the internal dispute resolution provided by insurers. We do not see how the move from a two-tier complaints process to a one-tier complaints process should affect how AFCA operates.
    c) Once AFCA is established, any further changes to the Code which are required can be addressed in the next Code review process.

Recommendation 22

The Code should implement a one-tier internal dispute resolution process with a 45-day time limit for making decisions.

If a decision is not made within 45 days, the complainant should be referred to external dispute resolution processes.

Discussion Point 4.1: Would a satisfactory improvement be for the Code to require that insurers and Service Suppliers contact a customer through their representative when this has been requested by the customer?

59. PIAC supports this proposal. Consumers, particularly vulnerable insurers, should be able to appoint a non-legal representative to act on their behalf. This can assist in reducing a consumer's distress and facilitate the early resolution of a matter.

60. We also note that PIAC has experienced a number of instances where general insurers have contacted consumers directly despite the fact that the insurer was informed that the customer is legally represented. In addition to causing confusion for the consumer, it is highly inappropriate for insurers to contact consumers directly about a complaint when the consumer is legally represented in that complaint.

Recommendation 23

The Code should require insurers and Service Suppliers to contact a customer through their representative when this has been requested by the customer.

(vii) Customer communications

Discussion Point 7: To address the concerns raised above, is a satisfactory solution for clause 4.8(b) in the current Code to be amended to state "*we will inform you of your right to ask for the information that we have relied on in assessing your application and, if you request it, we will supply it in accordance with Section 14 of this Code.*" Please identify any concerns with this approach.

61. PIAC does not agree that this is a satisfactory solution to the concern that there is a lack of transparency surrounding the decisions made by insurers.

62. Insurers should be obliged as a matter of practice to provide their reasons for not providing insurance or for providing cover on non-standard terms in writing.

63. In the course of applying for insurance, customers provide insurers with a significant amount of personal information. When an application is declined or cover is provided with premium loadings or exclusions, it is often not obvious why this decision was made.

64. The practice of not automatically providing reasons for why an underwriting decision was made only serves to hide and protect potentially discriminatory conduct by insurers. Without knowing the reasons why an application was rejected, a customer with a potential discrimination claim may never become aware of that claim unless they agitate the issue with the insurer. This practice operates to reinforce discrimination against people who may have a claim.

65. In our experience, insurers are extremely reluctant to articulate why precisely an application was rejected. Even after a formal request for reasons has been made, insurers' responses are often generic and unhelpful. For example, insurers often simply state that an application was rejected "due to your medical history".

66. These practices must stop. The burden should not be on the customer to chase insurers for the reasons why they have made a particular decision. The insurer is the one who has made the decision so they should have systems and processes in place to record why that decision was made so the provision of reasons should not be difficult.

67. PIAC recommends that if an application is rejected or cover is provided on non-standard terms, insurers must provide the applicant with written reasons for their decision without the applicant having to make a request for the reasons.

Recommendation 24

If an application is rejected or cover is provided on non-standard terms, the Code should require insurers to provide the applicant with written reasons for their decision without the applicant having to make a request for the reasons.

(vii) Monitoring, enforcement and sanctions

Discussion Point 8: Would a redrafting of Clause 13.1 of the Code to read "*Anyone can report alleged breaches of this Code to the CGC*" sufficiently address the issue noted above? Is an alternative solution needed?

68. PIAC supports this proposal. We recommend that it should also be clarified that "Anyone can report alleged breaches of this Code to the CGC at any time".

Recommendation 25

The Code should state that anyone can report alleged breaches of this Code to the CGC at any time.

Discussion Point 8.1: The ICA suggest that provisions such as honest, fair and timely should operate in relation to the standards in each section. Is there a way for these terms to be appropriately defined if this approach is not taken?

69. PIAC supports the CGC's submission that sections 4.4, 6.2, 7.2, and 10.4 of the Code be amended by removing the words "...in accordance with this section...", so that it is clear that the principles of efficiency, honesty, fairness and transparency contained in these subsections operate as stand-alone provisions.

70. The application of the principles of efficiency, honesty, fairness and transparency would be severely curtailed if they only applied to inform the interpretation of the other sections of the Code in which they are located. If these principles were to be read down in this way, the obligations of insurers in these sections would be reduced to the specific wording of the other sections. If this is the case, it is unclear then what meaningful utility the principles of efficiency, honesty fairness and transparency necessarily add to the interpretation.

71. Reading the Code in this way runs counter to the purpose of the Code as stated in sections 1.3 and 2.1, namely:

> *1.3 The terms of this Code require us to be open, fair and honest in our dealings with you.*
>
> *[…]*
>
> *2.1 The objectives of this Code are:*
> *(a) to commit us to high standards of service;*
> *(b) to promote better, more informed relations between us and you;*
> *(c) to maintain and promote trust and con dence in the general insurance industry;*
> *(d) to provide fair and effective mechanisms for the resolution of Complaints and disputes between us and you; and*
> *(e) to promote continuous improvement of the general insurance industry through education and training.*

Recommendation 26

Sections 4.4, 6.2, 7.2, and 10.4 of the Code should be amended to remove the words "...in accordance with this section..."

Discussion Point 8.2: What would be the advantages or challenges if the CGC were to regularly publish its decisions on a de-identified basis?

72. PIAC supports the proposal to publish CGC decisions. We see no reason why insurers should not be identified in the decisions.

Recommendation 27

The CGC should regularly publish its decisions and should include the names of insurers who were parties to the dispute.

Discussion Point 8.3: Are there any issues that need to be taken into account if the Code were to require that, where a CGC decision has a significant and/or broad industry impact, there is an ability to appeal? Should the industry be able to provide a collective submission on Code interpretation?

73. PIAC opposes this proposal. CGC decisions should be final and binding. The CGC is responsible for the independent administration and enforcement of the Code. It should be free to carry out this function with authority and without the risk of insurers challenging its decisions. An appeals process risks undermining the objectivity of the CGC and overall compliance with the Code.

74. Insurers already have significant control over the drafting of the Code and have agreed to the appointment of the CGC as the independent monitoring and enforcement body. They should not also be provided with an opportunity to challenge the terms of the Code and the decisions of the independent body they have appointed.

75. Any concerns of insurers are already adequately covered by the ability of insurers to make complaints about the CGC under section 7 of the CGC Code Governance Committee Charter.

Recommendation 28

The Code should not permit an appeals process for CGC decisions or for industry to provide collective submissions on Code interpretation.

(x) Code scope

Discussion Point 10: The ICA's view is that the Code should not contain a specific provision relating to corporate culture. Please advise any concerns with this perspective. How can culture be adequately monitored and measured?

76. PIAC disagrees with the ICA's view that the Code should not contain a specific provision relating to corporate culture.

77. In our experience, poor corporate culture is one of the key impediments to reform in the insurance industry, particularly with regard to discrimination.

78. Corporate culture is a key focus for ASIC. As former ASIC Chairman, Greg Medcraft has pointed out:

> *ASIC is interested in corporate culture, because culture is a driver of conduct. And a poor corporate culture can be a driver of misconduct. Conversely, a good corporate culture can be a driver of best practice, or ethical conduct. Ethical conduct can help organisations move beyond minimum standards and 'tick a box' compliance practices to best practice standards and compliance practices that protect stakeholders and which are commercially valuable.*[2]

79. While we accept that corporate culture is complex and cannot be measured in the same way as other requirements in the Code, it is important for the Code to acknowledge the importance of corporate culture and to spell out certain steps insurers should be taking to improve culture.

80. PIAC recommends that the Code include provisions which require Code subscribers to:
    a) develop firm values;
    b) ensure that corporate culture is a regular feature on board and audit committee agendas;
    c) develop policies and processes for;
        i. ensuring that firm values are implemented within business practices; and
        ii. gathering data on key indicators for the implementation of firm values such as employee surveys and customer complaints; and
    d) put in place a recruitment, training and reward structure that is aligned to and reinforces good corporate culture.

81. PIAC considers that a robust corporate culture is in the best interest of insurers. As ASIC Commissioner, John Price stated:

> *Companies should also be interested in culture because many studies have found that good culture is good for business and generating long-term shareholder value. Good culture enhances brand loyalty and bolsters reputation, which has a very real financial impact.*[3]

Recommendation 29

82. The Code should include provisions which require Code subscribers to:

a) develop firm values;
b) ensure that corporate culture is a regular feature on board and audit committee agendas;
c) develop policies and processes for:
    i. ensuring that firm values are implemented within business practices; and
    ii. gathering data on key indicators for the implementation of firm values such as employee surveys and customer complaints; and
d) put in place a recruitment, training and reward structure that is aligned to and reinforces good corporate culture.

Discussion Point 10.3: Do you agree with the ICA's view that the Code should not restate and provide guidelines on existing legal requirements? If not, noting the concerns raised,

[2] http://download.asic.gov.au/media/3951997/greg-medcraft-speech-launch-of-governance-institute-inaugural-ethics index-20-july-2016.pdf
[3] http://download.asic.gov.au/media/4393665/john-price-speech-aicd-regulator-insights-on-risk-culture-published-20-july-2017.pdf

how could the Code effectively provide guidance on existing legal requirements without cutting across regulatory frameworks?

83. See our response to question 1.7 above.

Annexure – Mental Health Principles

Introduction

1. PIAC commends the ICA for preparing the draft Principles and acknowledging the systemic issues faced by people with mental health conditions when they seek to access general insurance.

2. We set out below our recommended changes to the draft Principles. We submit that the ICA should engage in further specific consultation on the form and content of the Principles and invite feedback from consumer and mental health stakeholders on the next draft.

Principles should be binding and enforceable

3. As noted above, PIAC is of the view that the Principles should be binding and enforceable on the ICA's members. The time for aspirational, best practice principles has long since passed. Consumers deserve committed change from the insurance industry. We therefore recommend that the title of the Principles should be changed to "Mental Health Principles" and where appropriate, the use of the word "should" should be replaced with "must" throughout the Principles.

The Preamble

4. Paragraph 2 of the Preamble states:

> *Individuals with mental illness have experienced challenges at times in accessing some general insurance products. Some products provide limited underwriting of mental illness, due to the increased risk from higher levels of morbidity and mortality for consumers with a mental illness compared to consumers without a mental illness.*

5. The first sentence should be amended to include individuals with a past or current mental health condition. The paragraph should also include a reference to the use of blanket mental health exclusions.

6. The assertion that limited underwriting is available due to the "increased risk from higher levels of morbidity and mortality for consumers with a mental illness" is a generalisation. It lumps all mental health conditions together and assumes that the underwriting outcomes will be the same for everyone with a mental health condition, regardless of the nature of the condition or the individual circumstances of the applicant. It is such generalisations that the DDA is designed to address.

7. We recommend that paragraph 2 is therefore amended to read as follows:

> *Individuals with a past or current mental ~~illness~~ health condition have experienced challenges at times in accessing some general insurance products. Some products provide limited underwriting ~~of mental illness, due to the increased risk from higher levels of morbidity and mortality~~ for consumers with a past or current mental ~~illness~~ health condition compared to consumers without a mental ~~illness~~ health condition. Some products also include blanket mental health exclusions which exclude claims arising from a mental health condition.*

8. Paragraph 3 of the Preamble refers to the exemption for insurers in section 46 of the DDA. It states:

   The exemption only enables discrimination if it is based on actuarial or statistical data, or if no actuarial or statistical data is available, the discrimination is reasonable having regard to any other relevant factors.

9. PIAC is concerned that this summary of section 46 does not accurately reflect the wording of the legislation. In particular, it does not specify that:

   a. it must be reasonable for the insurer to rely on the actuarial or statistical data;
   b. the discrimination must be reasonable having regard to the matter of the data and other relevant factors;
   c. if no actuarial or statistical data is available and cannot reasonably be obtained, the discrimination must be reasonable having regard to any other relevant factors.

10. To avoid any confusion, we recommend that the above summary is replaced with the actual wording of section 46 of the DDA.

11. Paragraph 4 of the Preamble states:

    With increasing awareness and better understanding of mental illness, there is a growing community expectation that insurance products should evolve to better meet the needs of consumers suffering from a mental illness.

12. This sentence does not refer to underwriting practices and it also suggests that products should only evolve as awareness of mental illness improves. We recommend that that this sentence is amended to read as follows:

    ~~With increasing awareness and better understanding of mental illness, there is a growing community expectation that I~~ Insurance products and underwriting practices ~~should~~ must evolve to better meet the needs of consumers with past or current ~~suffering from a~~ mental ~~illness~~ health conditions.

13. The last sentence of the Preamble states:

    The Principles are intended to be aspirational and encourage continuous progress by industry in meeting the highest standards with regards to the provision of products to consumers with a mental illness.

14. The reference that the Principles "are intended to be aspirational and" should be deleted.

The Principles

15. Principle 1 states:

Through each stage of the life cycle for relevant insurance products, the recognition and management of mental illness should be commensurate with other medical conditions, with documented rates of prevalence, morbidity and mortality.

16. The language of this sentence is a little unclear. We suggest that it should be amended as follows:

    Through each stage of the life cycle for relevant insurance products, ~~the recognition and management of~~ mental ~~illness~~ health conditions must ~~should~~ be treated in the same way as any ~~commensurate with~~ other medical condition~~s~~ ~~with~~ and have regard to documented rates of prevalence, morbidity and mortality.

17. PIAC supports Principle 1.1.

18. Principle 1.2 states:

    For some mental illnesses, the documented rates of prevalence, morbidity and mortality could be less than actual rates. When taking account of this, the risk assessment of mental illnesses should be centred on reliable evidence-based data and objective assessment.

19. No evidence to support the first sentence in this Principle has been provided. Even if evidence were provided, it is an inappropriate statement and undermines the aim of the principles to improve the treatment by insurers of people with mental health conditions. We recommend that Principle 1.2 is amended as follows:

    ~~For some mental illnesses, the documented rates of prevalence, morbidity and mortality could be less than actual rates. When taking account of this,~~ ~~t~~ The risk assessment of a person with a past or current mental ~~illnesses~~ health condition must ~~should~~ be centred on reliable ~~evidence-based~~ statistical or actuarial data and objective assessment.

20. Principle 2 states:

    In designing general insurance products, the needs of those who have a mental illness should be considered.

21. This Principle should be amended to take into account people with current or past mental health conditions. It should read:

    In designing general insurance products, the needs of those who have a past or current mental ~~illness~~ health condition must ~~should~~ be considered.

22. The first sentence of Principle 2.1 states:

    Premiums for covers related to mental health illness will be influenced by an insurer's risk appetite.

23. This sentence suggests that if insurers have a low risk appetite, they will be justified in not providing cover to persons with a past or current mental health condition. This is legally incorrect. Under the DDA, premiums for cover related to past or current mental health

conditions must be based on statistical or actuarial data on which it is reasonable for the insurer to rely and must be reasonable having regard to the matter of the data and other relevant factors. Even aside from the legal inaccuracy of this sentence, it detracts from the overall purpose of the Principles and we recommend that it is deleted. Principle 2.1 should be amended to read:

> ~~*Premiums for covers related to mental health illness will be influenced by an insurer's risk appetite.*~~ *Where possible, insurers should* ~~*seek to*~~ *provide cover to persons with a past or current mental health condition and manage risk through policy pricing, exclusions, limits and caps based on actuarial and statistical data and other relevant factors rather than not provide cover at all.*

24. Principle 2.2 states:

> *When setting premiums for covers related to mental health illness, the pricing of the offered products should reflect the increased associated morbidity, mortality and other risks.*

25. This Principle assumes that the pricing for a product which covers mental health conditions or which provides cover to a person with a past or current mental health condition will always be increased. No evidence has been provided to justify this broad assumption. While there may be risks concerning a product that covers mental health conditions or cover for a person with a past or current mental health condition, risk assessments must be carried out on a case by case basis having regard to statistical or actuarial data on which it is reasonable to rely. We recommend that this Principle is therefore amended as follows:

> *As with all health conditions,* ~~*W*~~ *when setting premiums for* ~~*covers related to mental health illness*~~ *products that cover mental health conditions or for cover for a person with a past or current mental health condition, the pricing of the offered products or cover* ~~*should reflect the increased associated morbidity, mortality and other risks*~~ *must comply with the requirements set out in section 46 of the Disability Discrimination Act 1992 (Cth).*

26. Principle 2.3 states:

> *Insurers should aim to apply narrower exclusions as data becomes more available over time to reflect a better understanding of mental illness. Where possible, insurers should move away from the application of blanket-based exclusions.*

27. PIAC commends the ICA for the second sentence in this Principle. However, we are concerned that the first sentence fails to account for the requirements of the DDA. If insurers do not have statistical or actuarial data on which it is reasonable to rely to justify a mental health exclusion in a policy, then that exclusion will constitute unlawful disability discrimination. It is not a question of more data becoming available over time. If the data does not exist at the time the product is designed or at the time an individual underwriting decision is made, then the exclusion is discriminatory. This sentence also suggests that insurers are not responsible for obtaining data and can take a passive role in that process. This is again contrary to the requirements of the DDA. We recommend that this Principle is amended as follows:

> *Insurers should aim to apply narrower exclusions and must ensure that any exclusions or premium loadings comply with the requirements set out in section 46 of the Disability*

Discrimination Act 1992 (Cth). ~~*as data becomes more available over time to reflect a better understanding of mental illness.*~~ *Where possible, insurers should move away from the application of blanket-based exclusions.*

28. PIAC welcomes and supports Principles 2,4, 2.5, 2.6 and 3 and recommends the following amendments:

    2.5 Insurers must ~~*should*~~ *work collaboratively with stakeholders such as consumers, mental health professionals and consumer advocates to improve the provision of products and services to consumers with a past or current mental* ~~*illness*~~ *health condition.*

    2.6 Insurers must ~~*should*~~ *co-operate with the Insurance Council in ongoing research endeavours that have the aim of improving the provision of products and services to individuals with a past or current mental* ~~*illness*~~ *health condition.*

    3. Consumers who have a past or current mental ~~*illness*~~ *health condition must* ~~*should*~~ *be treated fairly and with dignity.*

29. Principle 3.1 states:

    At the point of sale, insurers should act in a transparent manner in determining the risk of applicants who have been previously diagnosed with a mental illness that is still part of the current commonly accepted professional standards.

30. PIAC supports the intent of this Principle however we suggest it is unnecessary to include the words "*that is still part of the current commonly accepted professional standards"* as these words duplicate Principle 1.1 which states that "*Mental illnesses should be categorised according to current commonly accepted professional standards*". The focus of Principle 3.1 should be the requirement to act in a transparent manner.

31. In the context of the application process, PIAC is concerned that some insurers have application processes which are designed to automatically decline an applicant when they disclose a past or current mental health condition without providing the applicant with the opportunity to provide further information regarding their specific risk profile. These practices are discriminatory unless insurers can provide statistical or actuarial data on which they can reasonably rely to show why the risk of those applicants is so high to justify an automatic decline.

32. PIAC submits that insurers should not automatically decline applications from people who disclose a past or current mental health condition and should provide those applicants with the opportunity to provide further information regarding their specific circumstances. We recommend that this section of the Principles include an additional Principle to this effect.

33. In the context of transparency, one of the systemic issues facing people with a past or current mental health condition is that where insurers offer a policy on non-standard terms, the insured person is not always told in what circumstances the non-standard terms will be removed. Some insurers appear to provide this information as a matter of practice whereas others do not. In PIAC's view, this is a matter of basic fairness and transparency and should be a standard requirement for all insurers.

34. Similarly, as noted in paragraphs 61 to 67 above, when an insurer refuses to provide cover or provides cover on non-standard terms, they should be required, as a matter of practice to provide reasons for that decision.

35. We recommend that Principle 3.1 is therefore amended as follows:

> *At the point of sale, insurers ~~should~~ must act in a transparent manner in determining the risk of applicants with a past or current mental health condition ~~who have been previously diagnosed with a mental illness that is still part of the current commonly accepted professional standards~~.*

And the following additional principles should be included:

> *Insurers must not automatically decline an application for insurance where an applicant discloses a past or current mental health condition but rather must obtain further information from the applicant to assist in the proper assessment of their application.*
>
> *Where cover is refused or provided on non-standard terms, insurers must:*
>
> a) *provide the applicant with a statement of written reasons setting out why they refused to enter into a contract with the applicant or why they offered cover on non-standard terms; and*
> b) *advise the applicant:*
> a. *how long it is intended that the terms will apply to the policy;*
> b. *what criteria they would need to satisfy to have the terms removed; and*
> c. *of the process for removing or amending the terms.*

36. PIAC supports Principle 3.2 subject to the following amendments:

> *Insurers, their authorised representatives and agents ~~should~~ must adopt a respectful and positive approach towards consumers with a past or current mental ~~illness~~ health condition in their sales and claims processes. Insurers ~~should~~ must develop and implement policies and procedures that support this approach.*

37. PIAC welcomes and supports Principle 3.3. We suggest that a cross reference to the Claims Investigation Standards in Appendix 5 of the Interim Report is included. A reference to the treatment needs of customers with a mental health condition should also be included. We recommend that the Principle is amended as follows:

> *Claims involving mental ~~illness~~ health conditions ~~should~~ must be processed sensitively having regard to the customer's ongoing medical treatment needs, and where possible, using the least intrusive methods of investigation.*

38. Principle 3.4 states:

> *Claims need to use standard diagnoses, established using evidence-based techniques and information.*

39. We suggest that the words “established using evidence-based techniques and information” be replaced with language that is consistent with Principle 1.1 and should read:

> *Claims ~~need to use~~ should be assessed according to current, commonly accepted professional standards and diagnoses~~, established using evidence-based techniques and information~~.*

40. Principle 4 states:

> *The risk assessment of mental illnesses should be centred on reliable, evidence-based data.*

41. PIAC welcomes and supports this Principle. However, we recommend that the language be amended to reflect the actual requirements of section 46 of the DDA. It should read:

> *Insurers must comply with the Disability Discrimination Act 1992 (Cth). Section 46 of the Disability Discrimination Act 1992 (Cth) requires that ~~T~~ the risk assessment of people with a past or current mental ~~illnesses~~ health condition must ~~should~~ be centred on ~~reliable, evidence- based~~ statistical or actuarial data on which it is reasonable for an insurer to rely and the risk assessment must be reasonable having regard to the matter of the data and other relevant factors.*

42. Principle 4.1 states:

> *Exclusions for pre-existing mental illnesses should only apply where there is evidence that an applicant has, or is at risk of a recurrence of, a mental illness and the covered event relates to the pre-existing mental illness.*

43. We support the intent of this Principle. However, we think that the Principle should be broken down into three sections and it should be made clear that exclusion clauses must comply with section 46 of the DDA. We recommend that the Principle be amended as follows:

> *Exclusions for pre-existing mental ~~illnesses~~ health conditions should only apply where there is evidence that an applicant has, or is at risk of a recurrence of~~,~~ a past mental ~~illness~~ health condition and the exclusion complies with section 46 of the Disability Discrimination Act 1992 (Cth). ~~and the covered event relates to the pre-existing mental illness~~.*
>
> *Where a consumer makes a claim against an existing policy, the claim should not be denied on the basis of a pre-existing mental health condition where the covered event does not relate to the pre-existing mental health condition.*
>
> *The scope of mental health exclusion clauses must comply with section 46 of the Disability Discrimination Act 1992 (Cth).*

44. Principle 4.2 states:

> *Where loadings are applied to insurance products and services, these should be quantified based on reasonable data or opinions.*

45. We also support the intent of this Principle. However, we are concerned that the requirement that loadings be "based on reasonable data or opinions" does not satisfy the requirements of section 46 of the DDA. We recommend that the Principle is amended as follows:

> ~~*Where*~~ *Any loadings* ~~*are*~~ *applied to insurance products and services must comply with section 46 of the Disability Discrimination Act 1992 (Cth).~~ ~~, these should be quantified based on reasonable data or opinions.~~

46. There is some overlap between Principles 4, 4.1 and 4.2 and Principle 1.2. If Principles 4, 4.1 and 4.2 are included in the form recommended above, we suggest that Principle 1.2 can be deleted. There is also likely to be some scope for consolidation of Principles 4, 4.1 and 4.2 and Principles 2.2 and 2.3. Given the importance of the issue of compliance with the DDA in the risk assessment process, we recommend that Principles 4, 4.1 and 4.2 be moved up and appear after section 1.

47. We support Principles 5, 5.1 and 5.2 subject to the following amendments:

> *5. Staff, authorised representatives and agents working with consumers with mental* ~~*illness*~~ *health conditions* ~~*should*~~ *must be appropriately trained and supported.*
>
> *5.1. Training* ~~*should*~~ *must increase awareness and understanding of common causes, signs and symptoms of mental* ~~*illnesses*~~ *health conditions in the community.*
>
> *5.2. Training* ~~*should*~~ *must develop communication skills for interacting with consumers who have, or show signs of having, a mental* ~~*illness*~~ *health condition.*
>
> *5.3 Training must cover the requirements of section 46 of the Disability Discrimination Act 1992 (Cth).*
>
> *5.4 Training programmes must be reviewed annually by insurers to ensure the programmes are effective in achieving the objectives set out in Principles 5.1, 5.2 and 5.3 above and insurers must report to the ICA on the outcome of those reports.*

48. We support Principle 6.

49. Principle 6.1 states:

> *6.1. Insurers should aim to regularly review their progress towards the effective implementation of these Principles.*

50. PIAC is concerned that this Principle does not place any positive obligations on insurers to ensure that they are complying with the Code. There is also no oversight of insurers' compliance with the Principles.

51. We recommend that this Principle is amended as follows:

> *6.1. Insurers* ~~*should aim to*~~ *must regularly review their* ~~*progress towards the effective implementation of*~~ *compliance with these Principles and must report to the CGC on their compliance every three years.*

52. PIAC reiterates our previous submission that, where insurers rely on the exemption contained in section 46 of the DDA, they should keep accurate records of the actuarial or statistical data they have relied upon to do so. An additional Principle should be added to this effect.

53. A cross reference should be included to PIAC's recommendation in response to question 3.1. above, namely, insurers must:

    a) develop standardised application forms for insurance; and
    b) ensure that the questions in the application forms:
        i. are simple, clear and specific;
        ii. ask only one question at a time and not bundle several questions together at once;
        iii. not ask questions requiring knowledge which the applicant could not reasonably be expected to possess;
        iv. are accompanied by examples of the type of information that is sought where possible; and
        v. provide sufficient opportunity for an applicant to provide more detailed answers where necessary.

Public Interest Advocacy Centre
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