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ADVOCACY CENTRE

Consultation Draft – Life Insurance Code of Practice

Submission to the Financial Services Council

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Level 5, 175 Liverpool Street, Sydney NSW 2000
Phone: 61 2 8898 6500 • Fax: 61 2 8898 6555 • www.piac.asn.au

About the Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit legal centre based in Sydney.

Established in 1982, PIAC tackles barriers to justice and fairness experienced by people who are vulnerable or facing disadvantage. We ensure basic rights are enjoyed across the community through legal assistance and strategic litigation, public policy development, communication and training.

Our work addresses issues such as:

- Reducing homelessness, through the Homeless Persons' Legal Service
- Access for people with disability to basic services like public transport, financial services, media and digital technologies
- Justice for Aboriginal and Torres Strait Islander people, through our Indigenous Justice Project and Indigenous Child Protection Project
- Access to affordable energy and water (the Energy and Water Consumers Advocacy Program)
- Fair use of police powers
- Rights of people in detention, including equal access to health care for asylum seekers (the Asylum Seeker Health Rights Project)
- Transitional justice
- Government accountability.

Contact

Michelle Cohen
Public Interest Advocacy Centre
Level 5, 175 Liverpool St
Sydney NSW 2000

T: 02 8898 6535
E: mcohen@piac.asn.au

Website: www.piac.asn.au

Public Interest Advocacy Centre

@PIACnews

The Public Interest Advocacy Centre office is located on the land of the Gadigal of the Eora Nation.

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Introduction

1. PIAC welcomes the opportunity to provide comment on the FSC Consultation Draft on the Life Insurance Code of Practice (Consultation Draft Code). This submission focuses on issues relating to discrimination by insurers regarding mental health and builds on the comments provided by PIAC to the FSC during meetings of the the Life Insurance Code of Practice Issues Working Group over the past two years. The purpose of the Working Group has been to discuss how the FSC Code of Practice could better support consumers living with a mental illness. This submission also builds on PIAC's comments in relation to the first iteration of the Life insurnace Code of Practice dated 18 September 2016.

Overall comment on the Consultation Draft Code

2. We acknowledge that effort has been made to expand the extent to which the Code of Practice specifically deals with the way insurers design, price and offer policies and assess claims for people with past or current mental health conditions. However the Consultation Draft Code is overall too general with respect to the obligations of insurers in the area of mental health, and fails to include specific steps which would enhance compliance with the *Disability Discrimination Act 1992* (DDA) and reduce discrimination in the area of mental health. Many of the particular steps which have been omitted from the Consultation Draft Code are also recommendations made by the Parliamentary Joint Committee on Corporations and Financial Services into the Life Insurance Industry, and it is unclear why these recommendations have not been adopted by the members of the FSC.

3. PIAC also remains concerned that the code is not binding and enforceable on FSC members. The Final Report of the Royal Commission (Royal Commission Final Report) recommends that some provisions of industry codes (enforceable code provisions) become provisions in respect of which will constitute a breach of the law. Part 6.2 of the Final Report sets out the limitations and difficulties that result from self-regulation by industry code and Part 6.3 of the Final Report recommends a process for the identification of enforceable code provisions.

4. PIAC supports Recommendation 1.15 of the Final Report along with Recommendation 4.9 which relevantly specifies that the Financial Services Council and ASIC should take all necessary steps, by 30 June 2021, to have the provisions of the Life Insurance Code of Conduct that govern the terms of the contract made or to be made between the insurer and the policyholder designated as 'enforceable code provisions.' Implementation of the Final Report recommendations will result in greater consumer confidence in the Code and increased accountability for insurers. We submit that the Consultation Draft Code should acknowledge, within the body of the Code, the relevant recommendations of the Royal Commission Final Report and require FSC members to engage in the necessary steps to ensure compliance with the recommendations by June 2021.

Discrimination by insurers in the area of mental health

5. One in five Australians will be affected by a mental health condition in any 12-month period and 45% of Australians will experience a mental health condition at some time in their life.[1] It is therefore a matter of significant public interest that insurance providers act fairly and without discrimination, basing their decisions on robust evidence and contemporary understandings of mental illness.

6. Systemic problems exist in the way insurers design, price and offer policies and assess claims for people with past or current mental health conditions. These problems arise in both general and life insurance for products such as travel, income protection, total and permanent disability and death insurance. This submission sets out the range of systemic issues that PIAC's work has revealed and provides case studies from our work.

7. In PIAC's experience, too many insurers are unreasonably denying cover and applying broad, blanket mental health exclusions that are not supported by evidence and do not reflect the risk posed by the applicant to the insurer. PIAC has also observed insurers cancelling policies and refusing to pay claims on the basis of imputed mental health conditions.

8. As a result of these practices, it can be extremely difficult for individuals with mental health conditions to obtain insurance with mental health cover, to obtain insurance at all or to have their claims paid. This includes people who:

    a. had a mental health condition many years ago but no longer have a mental health condition;
    b. have a mild mental health condition which has been well-managed for many years; or
    c. have never been clinically diagnosed with a mental health condition but have shown symptoms of a mental health condition.

9. These practices are unfair and may be discriminatory. They fall well below community standards and expectations.

10. For further details regarding the systemic issues relating to mental health and insurance, please review PIAC's submission to the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (**PIAC's submission to the Royal Commission**), which can be found here: https://www.piac.asn.au/2018/04/26/submission-to-the-royal-commission-into-misconduct-in-the-banking-superannuation-and-financial-services-industry/

11. We also note PIAC's Submission in response to policy questions arising from Module 6 of the Royal Commission dated 25 Octobr 2018, which is publically available.

[1] Australian Bureau of Statistics (ABS), *National survey of mental health and wellbeing: summary of results, Australia*, 2007. ABS cat. no. 4326.0, available http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features12007?OpenDocument.

Scope of Chapter 1 of the Code

Clause 2.13

12. PIAC has repeatedly[2] maintained that the Life Insurance Codes of Practice should:

    a. be binding and enforceable;
    b. be approved by ASIC in accordance with ASIC Regulatory Guide 183 "Approval of Financial Services Sector Codes of Conduct"; and
    c. set out guidance about insurers' obligations under the DDA. This guidance should be drawn from the Australian Human Rights Commission (**AHRC**) has issued 'Guidelines for Providers of Insurance and Superannuation under the *Disability Discrimination Act 1992* (Cth) (**DDA**)'[3].

13. As set out in our introductory paragraphs 3 and 4 in the introduction of this submission, PIAC submits that the Consultation Draft Code should acknowledge, within the body of the Code, the relevant recommendations of the Royal Commission Final Report and require FSC members to engage in the necessary steps to ensure compliance with the recommendations by June 2021.

Policy design and disclosure

Clause 3.1

14. Clause 3.1 of the FSC Code does not go far enough in protecting consumers in the design process. Clause 3.1 of the FSC Code should be amended to require insurers to ensure that when designing policies the terms are based on up to date, relevant and reasonable actuarial or statistical data, and where such data is not available that the terms of policies are based on other relevant factors.

15. This language should be uncontroversial to insurers. It is also consistent with existing obligations under the *Disability Discrimination Act 1992* (Cth) (**DDA**), which prohibit insurers from discriminating against a person on the basis of mental health, including past, present, future and imputed mental health conditions, or symptoms of mental health conditions, unless the discrimination is:

    a. based on actuarial or statistical data that is reasonable for the insurer to rely on; and
    b. the discrimination is reasonable having regard to that data and all 'other relevant factors'[4].

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[2] See for example PIAC's previous submissions to the Royal Commission and the Parliamentary Joint Committee into the Life Insurance Industry.

[3] https://www.humanrights.gov.au/sites/default/files/AHRC_DDA_Guidelines_Insurance_Superannuation2016.pdf

[4] Section 46 of the *Disability Discrimination Act 1992* (Cth) (**DDA**). Similar provisions can be found in state anti-discrimination legislation. For example, see *Anti-Discrimination Act 1977* (NSW) s 49QX and *Equal Opportunity Act 2010* (Vic) s 47X which each provide a similar exemption for insurers in the area of disability discrimination.

16. If there is no statistical or actuarial data available or reasonably obtainable to assess the risk, an insurer may justify its discrimination by relying solely on all 'other relevant factors'. The reference to the discrimination being 'based' on statistical or actuarial data means that the insurer must have actually based its decision on that data and the data must have been in existence at that time a policy is developed or a decision in relation to an insurance application or claim is being made[5].

Clause 3.2

17. PIAC recommends that this provision be amended to require reviews of medical definitions at least every three years, or 'otherwise whenever we become aware that a medical definition may no longer be current'.

18. As set out in PIAC's response to policy questions arising from Module 6 of the Royal Commission, Module 6 of the Royal Commission received evidence about outdated definitions (the CommInsure case study) which further shows the need for standardised definitions, and regular review and upgrades of defintions to align with current medical knowledge.

19. The amendments we propose to Clause 3.2 are also consistent with Recommendation 10.3 of the Parliamentary Joint Committee Inquiry into the Life Insurance Industry, that life insurers must regularly update all definitions in policies to align with current medical knowledge and research, standardise definitions, use clear and simple language in definitions and clearly explain which associate definitions that arise from the initial condition, including mental illness, are covered by a policy.

Clause 3.4

20. Clause 3.4 should be amended to expressly state that insurers will provide prospective purchasers of a life insurance policy with definitions of key terms and concepts and plain English examples of their operation. For example, if a threshold to obtaining a TPD payment is that the claimant is "incapable" of obtaining work, this should be clearly defined and explained upfront, with practical examples. The "general description" referred to in subsection (f) does not go far enough in this respect.

21. Clause 3.4 should also be amended to require insurers to provide information to consumers through a range of methods and mediums, so that consumers can select a method of receiving that information that best suits them and their needs. As set out in Clause 3.1 the Code should require insurers to test these methods on consumers before they are implemented and constantly reviewed to ensure language is simple, clear and understandable.

22. To assist a consumer's understanding of the specific events they are not insured for (exclusions and/or limitations as set out at Clause 3.4(e)), insurers should be required to provide examples of the types of claims that will and will not be covered under its policies. These examples should be set out in short, simple case studies that are intended to be illustrative of the application of the policy terms in practice.

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[5] *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 193, para 117.

Exclusion clauses in standard terms and conditions

Clause 3.5

23. Clause 3.5 should be amended to specify that an exclusion clause will only be placed on a policy where an insurer:

    a. has relied upon relevant and up to date actuarial or statistical data; and
    b. has considered all other relevant factors, including the particular circumstances of the applicant.

24. To assist a consumer's understanding of the specific events they are not insured for, insurers should be required to provide examples of the types of claims that will and will not be covered under its policies. These examples should be set out in short, simple case studies that are intended to be illustrative of the application of the policy terms in practice.

Clause 3.5A

25. Clause 3.5A(a) states "If we do this, we will ask you to agree to the changes. If you take out the policy, we will take this as your agreement to the changes".

26. There is a risk that FSC members will read these words in Clause 3.5A as providing FSC members with rights against consumers that will be inconsistent with the law. The objective of the Code is to set out the life insurance industry's key commitments and obligations to consumers, not to create binding or mutual obligations. These words should therefore be deleted.

27. The practical difficulty of the inclusion of these words is highlighted by the following example. An applicant makes minor disclosures about anxiety in an application for insurance and the insurer offers a policy with a blanket mental health exclusion. The insurer intends that the exclusion clause will exclude claims for all mental health conditions, not just an anxiety. The applicant reads the exclusion but, given its breadth, assumes it will operate on a more limited basis, to exclude only those claims arising from anxiety. The applicant agrees to the exclusion on the basis of their narrower interpretation of the clause.

28. In this example, the consumer's agreement to an exclusion imposed by the insurer does not render lawful what is otherwise likely to be discriminatory clause under Federal and State anti-discrimination legislation.

29. Clause 3.5A should also be amended to ensure that further specific information is provided in the event of a non-standard term such as a higher premium, exclusion or other limitation on the policy.

30. In relation to additional premiums, the following words should be inserted into Clause 3.5A: "If you are being charged a higher premium as a result of a disclosure you have made, you will receive information as to the difference in cost and an explanation as to why the additional cost is being charged".

31. In relation to additional premiums, exclusions or limitations on the policy, Clause 3.5A should be amended to require that an explanation will be provided in plain English of:

    a. the effect of those non-standard terms,
    b. how long those non-standard terms will apply,
    c. the process for removing those non-standard terms and
    d. the criteria that would be needed to be satisfied to remove those non-standard terms.

Blanket exclusion clauses

32. Insurance products that apply blanket mental health exclusion clauses are likely to be in breach of anti-discrimination laws and should not be sold. Accordingly a provision should be added to the Consultation Draft Code clearly stating that life insurance policies should not contain blanket mental health insurance clauses as standard terms and that a broad exclusion should only be included as a non-standard term where the exclusion is supported by reasonable actuarial and statistical data and is reasonable according to the particular circumstances of the applicant.

33. We note that it has long been PIAC's view that blanket mental health exclusions are unlikely to be supported by reasonable actuarial and statistical data and are therefore unlawful. As stated as paragraphs 48-58 of PIAC's Submission to the Royal Commission, some life insurers are unreasonably denying cover and applying broad, blanket mental health exclusion clauses that are not supported by evidence, and do not reflect the risk posed by an individual applicant.

Questions in the application process

34. Our comments in relation to the use of plain language and the methods of providing information to consumers set out above in Clause 3.4 also apply to each part of Clause 5. We do not repeat these points below.

Clause 5.3A

35. The additions of clauses 5.3A to 5.3D in the code are positive, however the requirements are far too general and do not provide enough specific guidance on how insurers should comply with the processes proposed to avoid discrimination to insureds.

36. Clause 5.3A requires life insurers, when asking questions in the application process, to ensure those questions are easy to understand and not ambiguous, 'noting that we expect you to have a reasonable understanding of your health, lifestyle and financial situation'.

37. PIAC submits that the words 'noting that we expect you to have a reasonable understanding of your health, lifestyle and financial situation' should be removed. This phrase is not properly defined, and it is unclear what the 'reasonable understanding' standard is, or how such a standard interacts with the duty of disclosure as set out in the ICA. Further, as noted earlier in this submission, the purpose of the Code is to set out the obligations and requirements of insurers, not consumers, and the inclusion of these words is not consistent with the overall purpose of the Code.

Example 10

38. Example 10 provides an example of the where confusing questions may be asked but provides no guidance on how the insurer can be "clear about what needs to be disclosed" (as the title suggests).

39. As PIAC has previously recommended, examples in relation to mental health could address the following terms commonly included in life insurance application forms but not defined:

    a. "episodes". An example could demonstrate what the insurer means by a question like "how many episodes have you had of the mental health condition?"
    b. "stress". An example could demonstrate what the insurer means by a question like "have you had symptoms of, been diagnosed with or received medical treatment for stress?".

40. Consistent with our earlier recommendations above, terms such as "episodes" and "stress" should also be defined using plain English. "Stress" in particular has the potential to surprise a significant number of consumers who have, most likely, disclosed at some point in their lives, periods of stress to their GP in the course of standard appointments, and assume that such disclosures are not caught by questions by insurers about their mental health history.

41. PIAC supports the Joint Submission of the Financial Rights Legal Centre, Financial Counselling Australia and Redfern Legal Centre which recommend that draft clauses 5.3A(a) should be expanded to clarify that preventative mental health measures not be included within the questions that an insurer asks as a Life Code commitment.

Clause 5.3D

42. Clause 5.3D should be amended to make it clear to a consumer that life insurers will not automatically decline an application (whether for initial cover or extension of cover) for a life insurance product where the application reveals a past or current mental health condition or symptoms of a mental health condition.

43. Further to the above the Code should establish processes for life insurers to adhere to when considering life insurance applications that reveal a mental health condition. In accordance with recommendation 10.7 of the Parliamentary Joint Committee Inquiry into the Life Insurance Industry, clause 5.3D needs to include the following additional explicit commitments:

    a. refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter; and
    b. give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;
    c. where an insurer offers insurance on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium), the Code should require insurers to specify:
        i. how long it is intended that the exclusion/higher premium will apply to the policy.

ii. the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced.
iii. the process for removing or amending of the exclusion/premium; and
iv. to develop, implement and maintain policies that reflect the above practices.

44. Inclusion of the above step will assist to ensure the Code accurately reflects the requirement to ensure decisions relating to insurance are based on actuarial or statistical data that is reasonable to rely on, or other relevant factors.

Example 11

45. PIAC recommends the deletion of the words 'as they have had no recurrence and the normal grief cycle has passed' in Example 11. PIAC is concerned that these words encourage insurers to form their own views about what is a "normal grief cycle" when that should be a matter of medical opinion. It should be sufficient that a doctor has formed the view that the applicant does not have a mental health condition.

Clause 5.5

46. Where additional information or reports from a third party are required to assess an application in accordance with clauses 5.6, 8.6A and 19.7 of the Consultation Draft Code an insurer should provide clear written information to the consumer as soon as practical precisely identifying what further information is required, and why. Embedding this additional step within the Code is important to assist compliance with the DDA, by prompting insurers to justify why they need further information from consumers. It will also assist consumers to identify why they have received a request for further information, and avoid an additional step of the consumer having to reapproach an insurer to ask why further information is required.

Clause 5.6

47. We support the ALA's submission which suggests that this clause should provide that FSC members will, where possible, provide a list of three independent service providers, from which the consumer may nominate one.

Clause 5.14

48. This provision should specifically set out what information insurers should provide consumers in circumstances where they are offered an insurance policy on non-standard terms. As such, an in accordance with Recommendation 10.7 of the Parliamentary Joint Committee on Corporations and Financial Services into the Life Insurance Industry and our submissions in relation to Clause 5.3D above, we suggest this provision be redrafted to require insurers to specify:

    a. how long it is intended that the non standard term will apply to the policy;
    b. the criteria the insured would be required to satisfy to have the non standard term amended or removed eg the exclusion removed or premium reduced;
    c. the process for removing or amending the non standard term; and
    d. to develop, implement and maintain policies that reflect the above practices.

Clause 5.14A

49. In accordance with our comments regarding Clause 3.5A(a), we suggest the sentence 'If you do then buy the policy, we will take this as your agreement to the revised terms', be deleted.

Clause 5.17

50. While the acknowledgement in clause 5.17 is important, it should do more than simply re-state the law[6] but also provide a framework within which compliance with the law can be tested.

51. As PIAC has previously submitted, it is extremely difficult for consumers to gain access to the data relied upon by insurers in decisions that affect them to test compliance with anti discrimination legislation. Insurers rarely provide such data unless compelled by formal complaints or court processes.

52. For many individuals the only way to test whether an insurer has satisfied the insurance exemption in the DDA is for an individual to pursue a legal complaint at a court or tribunal, using compulsory document production processes to access the actuarial and statistical data and other reasons for insurers decisions. This places an unrealistic and unfair burden on vulnerable individuals who suspect an insurer has unlawfully discriminated against them and pursuing a legal complaint is arduous, time consuming and expensive.

53. This clause should be amended to also require insurers to provide applicants with detailed written reasons when they refuse to provide insurance of offer cover on non-standard terms (with an exclusion or a premium loading), which at a minimum refers to the specific grounds on which the decision was made having regard to the disclosures made during the application process and the risk according to actuarial and statistical data that was relied on to make the decision.

54. This part of the Code should be require insurers to report pubilically and annually (for example, in an annual report) on the number of times they have declined to provide insurance or offered insurance on non-standard terms on the ground of disability. This information should specify whether the insurer has relied on actuarial or statistical data in making their decision and the type of disability invoked by the insurance exemption. Such obligations would increase transparency and accountability to the community and assist insurers to comply with the provisions of the DDA.

Clause 5.20

55. There are clear and persuasive public interest reasons to limit insurers' ability to avoid policies for non-disclosure of an unrelated condition to cases of fraud. Module 6 of the Royal Commission hearings included case studies that showed a practice of insurers unfairly and unnecessarily avoiding insurance policies to avoid paying legitimate, reasonable claims.

56. Recommendation 4.6 of the Royal Commission Final Report is that section 29(3) of the *Insurance Contracts Act* 1984 (Cth) (**ICA**) be amended so that an insurer can only cancel an insurance policy on the basis of non-disclosure or misrepresentation if it can show that it would not have entered into a contract on any terms. The recommendation closes a loophole

[6] This is consistent with ASIC's RG183.30 which states that 'a code must do more than restate the law'.

that insurers have relied on to cancel policies for innocent non-disclosure of a mental health history in circumstances where that history is entirely unrelated to the illness that is the subject of an insurance claim.

57. Clause 5.20 of the Consultation Draft Code states "Unless you acted fraudulently, we will try to change life insurance to the same terms, if any, that we would have offered had the error or omission not occurred". We recommend that Clause 5.20 goes further to insert the words "wherever possible" before the words we will try to change…" to make it clear that variation of the policy (in. accordance with section 29(6) of the ICA) will be the preferred approach.

58. Further the Code should provide that an insurer will only deny a claim or avoid a policy on the basis of a pre-existing condition if that have obtained an independent medical opinion which establishes a direct medical connection between the prognosis of a pre-existing condition and the claim. In communicating this decision to the consumer the Code should require the insurer to provider the consumer with the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in plain language, to support their decision.

59. The Code should also include guidance notes providing examples to show how variation rather than avoidance of a policy may occur, including where the insured has made a claim on their policy for an illness or condition that is unrelated to the illness or condition that it is alleged was required to have been disclosed during the application process.

60. Our submissions regarding clause 5.20 also apply to clause 8.5A and 8.8A of the Code.

Making a claim

Clause 8.10(b)

61. We support the ALA's submission which suggests that this clause should provide that FSC members will, where possible, provide a list of three independent service providers, from which the consumer may nominate one.

Clause 8.11

62. We recommend that the information sheet referred to in clause 8.11 is provided in advance of an interview being scheduled.

Clause 8.12

63. The Code should specifically prohibit surveillance of by an insurer of a person who has a diagnosed mental health condition or who is making a claim based on a mental health condition.

64. Round 6 of the Royal Commission heard damning evidence in relation to TAL's use of surveillance techniques on an insured with a mental health condition and the serious personal consequences experienced by the insured, including an exacerbation of her mental health condition.

65. A consumer's mental health cannot be known by surveillance. The only relevant factor is the opinion of the consumer's treating medical practitioner.

Code Governance, Sanctions and Definitions

Clause 25.11

66. Recommendation 4.10 of the Royal Commission Final Report states that section 13.10 of the Life Insurance Code of Practice should be amended to empower the Life Code Compliance Committee to impose sanctions on a subscriber that has breached the applicable Code. As no legislative or other regulatory change is required to implement this recommendation clause 25.11 of the Consultation Draft Code should be amended to ensure that the next version of the Code complies with this recommendation in the Final Report.

Clause 25.15

67. Clause 25.15 does not comply with ASIC Regulatory Guide 183, in so far that it allows for discretion in the imposition of sanctions for breach of the Code.

68. As set out in PIAC's Submission to the Royal Commission, we are of the view that Code should be approved by ASIC in accordance with ASIC Regulatory Guide 183 'Approval of Financial Services Sector Codes of Conduct'.

69. There is currently no specified process for the approval of Code, once in final form. ASIC Regulatory Guide 183 provides a more stringent and uniform process for code development and approval, requiring codes to meet certain threshold and statutory criteria to meet approval. Importantly these criteria include ensuring codes are drafted in plain language, that a genuine consultative process was undertaken for code development and incudes amongst over things, are requirement that there be effective and independent code administration, that a code is enforceable against subscribes, that compliance is monitored and enforced and appropriate remedies and sanctions exist for breach of a code. Each of these factors would serve to engender consumer confidence in the operation and enforcement of the Code.