INSURANCE COUNCIL OF AUSTRALIA

The Hon Bill Shorten MP
Assistant Treasurer and
Minister for Financial Services and Superannuation
PO Box 6022
PARLIAMENT HOUSE ACT 2600

1 March 2012

Dear Minister

The Insurance Council of Australia (Insurance Council) welcomes the opportunity to respond to recommendations of the Natural Disaster Insurance Review (NDIR) in relation to under insurance, claims handling and dispute resolution.

The responses are detailed in the Attachments.

As you are aware the general insurance industry has also made important changes to the Code of Practice. I am pleased that these changes were supported by consumer advocates, the Financial Ombudsman Service (FOS) and ASIC.

The Insurance Council is also participating in a number of other consultation processes relating to the NDIR including:

- Insurance Contracts Act Amendment Bill 2011
- Standard Definition of Flood Regulations
- Regulatory Impact Statement on Unfair Contract Terms
- Reforming Flood Insurance: A Proposal to Improve Availability and Transparency (submission due by 30 March)
- CentrePay Working Group
- Key Facts Sheet (we understand that consultation on the draft regulations will commence shortly).

We have also recently provided submissions to the following inquiries:

- Queensland Flood Commission – draft findings on insurance issues, flood mapping and hydrology reporting used by insurers
- Standing Committee on Social Policy & Legal Affairs inquiry into the operation of the insurance industry during disaster events & residential strata title insurance
- Productivity Commission Climate Change Adaption.

I would be happy to discuss any of our responses further. My contact details are tel: 02 9253- 5150 or email: rwhelan@insurancecouncil.com.au

Yours sincerely

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ATTACHMENT 1

INSURANCE COUNCIL RESPONSE TO THE NATURAL DISASTER INSURANCE REVIEW: Inquiry into Flood and related matters

Chapter 12: Reducing under-insurance of homes

Recommendation 32:
That all home building insurance policies providing sum insured cover be modified by the end of 2014 so as to include replacement value cover in the event of total loss of the home.

That during the transition period insurers consider how the design features of home building replacement value policies should respond following a natural disaster, including the conditions under which cash settlements are to be offered and finalised.

Industry Response:
The Insurance Council does not support this recommendation because the choice of policy type should not be removed from the hands of consumers.

There are a number of reasons for this:

- Sum insured policies have significant benefits for consumers, allowing them to select cover within their budget.
- Choice of product in the market remains of critical importance to competition, without a choice of cover it is likely that non-insurance would increase.
- Average premiums will increase under a Total Replacement Policies (TRP) regime, due to:
  - The need for the implementation of sophisticated technology requiring significantly more information than is traditionally collected to assess total loss exposure.
  - Increased uncertainty, greater risk volatility and uncertainty for insurers to measure and manage aggregate portfolio liabilities.
  - Uncertainty in liabilities impacting on reinsurance purchasing, requiring more conservative settings and therefore increased cost to consumers.

A TRP seeks to guarantee the rebuilding or replacement of a property to an 'as was' condition. This cover is presently available in the market for any consumer who wants to make a purchase, from a number of providers.

However, whilst choice is currently available, the insurance and reinsurance industries cannot be expected to provide a 100% failsafe product to protect policyholders under all contingencies, including those created either by their own inability to select an insurance product, or their inability to select a sum insured appropriate to their needs.

Nor can insurers be expected to manage the impacts where the actual outcome of a loss deviates significantly from the expected outcome, without pricing the risk of that additional uncertainty into insurance contracts.

Benefits of sum insured policies
Sum insured policies provide clarity on insured property values for the consumer. They also limit the insurers' potential loss and keep the exposure definable for reinsurers, therefore keeping insurance policies more affordable for consumers.

Many consumers operate within tight budgets and prefer to purchase insurance with a known sum-insured in order to manage their cash flow and budget. This sum-insured is the total value of the policy and the upper limit of what can be expected to be paid out if there is a total loss. Some products offer additional percentages of cover (+10%, +25% etc) to accommodate policyholder uncertainty.

To assist consumers in determining a reasonable sum-insured to adopt, most insurers offer web-calculators where the consumer can obtain estimates of rebuilding costs for their type of dwelling in that location. To assist with the underinsurance issue some insurers now require that a web calculator be used by the consumer before a quote will be given and some insurers will not provide insurance cover for a sum-insured that falls well outside of a recommended sum-insured band for the building described by the consumer.

A TRP does not allow the consumer to choose a sum insured that is acceptable to their budget. If consumers cannot afford a TRP and no other choices are available the only choice will be to not purchase insurance at all.

Costs will increase due to a need to introduce sophisticated technology requiring significantly more information than traditionally collected to assess total loss exposure
Accurately assessing and monitoring risk is a critical element in the prudent management of an insurance operation. TRPs by their nature are open limit contracts that require insurers to undertake more detailed evaluation of every policyholders home building to determine the insurers likely maximum liability.

This requires sophisticated technology to determine replacement valuation uniquely relevant to each home. It relies upon both external data and the provision of a higher level of risk information from the insured, that goes beyond the level of information currently requested. This is required at quotation stage to determine a premium for new business, and would be required at renewal time to move policies across to total replacement value.

These measures are not without cost, which would be passed on to the consumer.

Increased Cost due to Increased Uncertainty
Discussion with reinsurers on this issue has indicated that reinsurers are not attracted to products where additional policy benefits provide additional 'bonus' cover under certain contingencies, for example uncapped sum insured covers, safety net covers, and contingent BI covers.

This type of product can transfer up to 100% of the uncertainty of claim outcomes to reinsurers who provide excess of loss reinsurances. For example, once CatXL deductibles are breached in a declared catastrophe event, reinsurers may be required to assume 100% of the additional loss burden and uncertainty.

Reinsurers would find it necessary to charge additional margin for accepting the increased volatility caused by the direct market being required to offer uncapped cover. As the uncertainty surrounding the outcome is high, the additional margin charged by reinsurers is likely to be multiples of the actual risk premium required to fund the uncapped cover portion above a 'suitable' sum insured level.

The insurers, who will then ultimately have to pass the costs back to the policyholder, will pay these additional reinsurance charges. Significant premium increases would be the inevitable result, driving many consumers from the market.

Reinsurers have also advised that they are currently re-assessing whether coverage can continue to be provided on an uncapped sum insured basis, particularly in the critical catastrophe market, following the recent experiences in New Zealand. This may lead to a reduction in available reinsurance capacity and a corresponding increase in cost for both insurers and policyholders.

The Insurance Council's position is that the insurance and reinsurance industries should not (and cannot) be expected to provide a 100% failsafe product to policyholders. Certainty regarding potential losses is necessary for all stakeholders. Without certainty prices will increase. There are a number of key reasons for this:

- Additional premium margin is required to financially manage the policy liability volatility;
- The higher cost of more conservative reinsurance programs, required to risk manage the sum insured uncertainty associated with these contracts;
- Increased cost of delivery systems and the external data required to support the systems;
- The average sum insured in a TRP portfolio is higher because of the eradication of under insurance, and
- The need for consumer friendly sum insured calculators requires conservative calibration, thereby generating higher valuations of each property.
- *The potential loss of reinsurance capacity and resultant higher costs for insurers and policyholders.*

Several insurers have attempted to calculate the average impact on premiums that would occur in the event of a move to total replacement policies – the range of potential increases offered by insurers was 15% to 40%, however insurers were at pains to confirm that the uncertainty in reinsurance outcomes could place increases at even higher levels.

Pressures on the cost of insurance are quite material in the current environment with insurers facing increased catastrophe related claims cost and higher reinsurance costs forcing insurers to pass on increases to consumers. Adding further cost pressures with mandatory TRP products will see cumulative cost increases likely to lead to affordability issues, thereby driving up non insurance. Increased non insurance is clearly contrary to the objectives of the NDIR recommendations for the increased role of insurance in protecting policyholders.

Cash Settlements on Total Replacement Policies
Policyholders making a claim following a disaster event have variable needs. The opportunity for a cash settlement is often something that consumers request, whilst others wish to have building services provided for them. As a consequence there are a range of commercial models at work in the industry, to meet consumer demands.

The ICA supports the retention of choice in this regard and would not support measures that remove choice from the consumer or flexibility from insurers.

INSURANCE COUNCIL OF AUSTRALIA

ATTACHMENT 2

INSURANCE COUNCIL RESPONSE TO THE NATURAL DISASTER INSURANCE REVIEW: Inquiry into Flood and related matters

Chapter 14: Claims handling and dispute resolution

Recommendation 39:
That the Insurance Council of Australia amend the Code of Practice to impose a four month time limit (subject to exceptional circumstances) to make a determination as to liability and the nature of the loss or damage with respect to a claim.

***That, should a claimant not receive a determination within the four month period, the claim be automatically escalated to an internal dispute resolution complaint and the insurer notify the Code Compliance Committee of the breach of the Code*.**

Industry Response
The Insurance Council Board has considered this recommendation and approved a clear four month time frame for claims handling in the Code. A breach of the Code will occur if a decision on a claim has not been made after four months.

The Code has been amended, with insurer compliance due by 1 July 2012, to require (unless exceptional circumstances apply in relation to 'specified classes' - motor vehicle, home building, home contents, sickness and accident, consumer credit and travel insurance policies), a decision to be made within 4 months of receipt of the claim.

If the insurer does not make a decision, it will be a breach of the Code and the insurer will be obliged to inform the insured in writing of the insured's right to:
a. access the insurer's internal dispute resolution process (IDR), and
b. take any complaint in relation to the handling of the claim to an external dispute resolution scheme, if the insured so chooses.

The Code has not been amended to provide for automatic escalation to IDR at four months as this option assumes the insured is dissatisfied and a dispute exists. If the insured is satisfied with the actions of the insurer, despite a determination on the claim not having been made within four months, there would be no relevant dispute to consider at IDR. It would be inappropriate therefore to utilise IDR as a claims determination mechanism, rather than a mechanism to review a claim determination. The changes to the Code maintain the right of the insured to proceed to IDR where a claim has not been determined within four months whilst retaining the insured's autonomy to consider their own circumstances. It should also be understood that an insured can access IDR at any point in time should they not be satisfied with the actions of the insurer and make a complaint (RG165.83).

In addition to the four month timeframe, a 12 month timeframe has been inserted into the Code for decisions on claims covered by exceptional circumstances.
'Exceptional circumstance' in the Code means:
a. the claim arises from an **extraordinary** (our emphasis) catastrophe or disaster as declared by the Board of the Insurance Council of Australia;
b. the claim is fraudulent or the insurer suspects fraud;
c. there is a failure by the insured to respond to the insurer's reasonable inquiries or requests for documents or information concerning your claim;

d. there are difficulties in communicating with the insured in relation to the claim due to circumstances beyond the insurer's control; or
e. the insured requests a delay in the claims process.

We note the recommendation that should a claimant not receive a determination within the four month period, the claim be automatically escalated to an internal dispute resolution complaint and the insurer notify the CCC of a breach of the Code.

For the reasons described above, the Insurance Council does not support automatic escalation to IDR.

The Insurance Council also does not consider it is necessary for an insurer to notify the CCC immediately of a breach of the Code if a claim is not determined within 4 months. There are obligations in the Code for insurers to provide annual reports to FOS on their compliance with the Code and significant breaches need to be notified to FOS within ten business days. For example, in FOS's *General Insurance Code of Practice – Overview of the Year 2009 – 2010*, insurers provided data and FOS reported on breaches identified through insurers' internal breach reporting and monitoring programmes. FOS is required under the Code to report significant breaches to the CCC.

A number of additional improvements to the Code have been made consistent with the Code's objectives to:

- promote better, more informed relations between insurers and customers;
- improve consumer confidence in the general insurance industry;
- provide better mechanisms for the resolution of complaints and disputes between insurers and their customers; and
- commit insurers and the professionals they rely upon to higher standards of customer service.

A 'right to claim' provision to provide that if an insured asks whether a policy provides cover for a loss suffered, the insurer will:

a) ask whether the insured would like to lodge a claim,
b) explain that if the claim is lodged, the question of coverage will be fully assessed, and
c) the insurer will not discourage the insured from lodging a claim even if it is of the view that it is unlikely to be accepted.

A time frame of twelve weeks for the provision of external expert reports to insurers has been inserted.

Hydrology and other external expert reports used for claim determination are to be made available to the customer within ten business days of request by the insured.

Insurers will also be obliged to:

- inform insureds they can ask for copies of information relied upon in denying a claim; and
- inform insureds of their right to request a review if the insurer declines to provide those copies.

In line with member practice, the Code has also been amended to make clear insurer staff are required to be trained to deal professionally with policyholders during a catastrophe. Training covers understanding the consumer situation "particularly in a catastrophe or disaster".

Recommendation 40:
That the Insurance Council of Australia repeal clauses 4.3 and 4.4 of the General Insurance Code of Practice, so that claims arising from natural disasters are subject to the same minimum standards as other claims — including the four month time limit for a determination on liability and the nature of the loss/damage with respect to the claim.

Industry Response
The Insurance Council Board has agreed to repeal clauses 4.3 and 4.4 of the Code. The declaration of an extraordinary catastrophe does not remove the obligations of insurers to meet the standards that apply to all claims and time frames to keep insureds informed as to the progress of a claim and respond to requests for information.

Recommendation 41:
That the Insurance Council of Australia amend clause 4.5 of the General Insurance Code of Practice to extend the time within which claimants in natural disasters have the right to make further claims or lodge reviews after the finalisation of an initial claim to seven months from the date of the relevant natural disaster, regardless of when the initial claim was finalised.

Industry Response
The Insurance Council is unclear as to the reasons for this recommendation as any difficulties with this clause have not otherwise been raised. We therefore propose to seek further background on this issue and have it considered as part of the independent review of the Code to be conducted in 2012.

Recommendation 42:
That the Insurance Council of Australia amend the General Insurance Code of Practice to require that:

a) internal dispute resolution processes be independent of the claims handling department and the internal dispute resolution officers have the authority to overturn the original decisions and to accept claims;

Industry Response
Insurance Council members advise that it is normal practice that an IDR committee or officer has the authority to overturn a decision and accept a claim. ASIC Regulatory Guide (RG) 165 Guiding Principle 4.5 (Objectivity) provides that wherever possible a complaint or dispute should be investigated by staff not involved in the subject matter of the complaint or dispute.

The Insurance Council is not aware of complaints from insureds in relation to the authority of IDR officers within particular insurers to reconsider a claims decision.

We therefore intend that this recommendation should be addressed as part of the independent review of the Code to be conducted in 2012.

b) internal dispute resolution complaints be finalised within an aggregate of 45 days and if this time limit is not met, the insurer to advise the claimant of his or her right to lodge an external dispute resolution complaint with the Financial Ombudsman Service (if applicable) and to seek independent legal advice;

Both the Code of Practice and ASIC RG 165 require an insurer to finalise IDR processes within 45 days. Under the Code, where this timeframe is not met, the insurer is obliged, before the end of 45 days, to advise the claimant of their right to lodge a complaint with an External Dispute Resolution scheme.

There is no requirement for a complainant to have legal representation when bringing a dispute before FOS, with the processes designed to encourage easy access without legal representation. An insurer is not obliged either under RG 165 or the Code to inform the complainant that they have a right to seek legal advice. Consequently, if FOS is available to the insured, there should not be a requirement to advise an insured to seek independent legal advice. Where FOS is not available, there are already obligations existing in the Code:

> 6.14. Where FOS Terms of Reference do not extend to you or your dispute, we will advise you to seek independent legal advice or give you information about other external dispute resolution options (if any) that may be available to you.

The Insurance Council considers no change is required to the Code.

c) time limits on internal dispute resolution complaints commence immediately after a policyholder notifies the insurer of a complaint, whether verbally or in writing; and

The Insurance Council submits this is industry practice and is clearly set out in the Operation Guidelines to the FOS Terms of Reference (page 52):

> "Where the Applicant requested the FSP to remedy the issues in dispute before lodging a Dispute with FOS, the IDR period commences on the date of the expression of dissatisfaction to the FSP, whether in writing or by any other means. This will usually be the date when the Applicant contacts the FSP outlining the issues in dispute."

AS ISO 10002-2006 which is the basis for RG 165 explicitly states that a complaint or dispute does not need to be made in writing. A complaint made verbally or in writing is treated equally.

The Insurance Council considers therefore that no Code change is necessary.

d) *a general fairness test be applied to claims and complaints handling.*

The concept of fairness in claims and complaints processing is strongly entrenched in the Code, as well as the principle of utmost good faith in respect of any matter arising under the policy. Part 1.20 of the Code states:

"This Code requires us to be open, fair and honest in our dealings with customers and commits us to high standards of service when selling insurance, dealing with claims, responding to catastrophes and disasters and handling complaints."

The Insurance Contracts Act 1984 also imposes a duty of the utmost good faith on general insurers in relation to all aspects of an insurance contract. The High Court has held that the duty of utmost good faith includes an obligation on both parties to an insurance contract to treat each other fairly.

Furthermore as financial services licensees, general insurers also have a licence obligation to provide financial services "Fairly, honestly and efficiently".

Finally, the concept of fairness is applied by FOS when deciding a dispute. The FOS Terms of Reference provide that in dispute resolution FOS will do what in its opinion is fair in all the circumstances.

The Insurance Council therefore considers no further regulation on this point is required.

Recommendation 43:
That the Insurance Council of Australia amend the General Insurance Code of Practice such that the General Insurance Code Compliance Committee:

a) be appointed in the same manner as FOS Panels, with the independent chair and the consumer and industry representatives to be appointed in the same manner as the ombudsman and panel members are appointed under the FOS rules;

Industry Response
The composition of the CCC and FOS panels are already very similar. Both have a consumer representative, an industry representative and an independent Chair.

Given the CCC's role in a self regulatory initiative by the general insurance industry, it is not apparent why the FOS Board should determine its composition. The appointment process for the CCC already provides for input from relevant stakeholders.

The Insurance Council considers therefore that no Code change is necessary.

b) have the authority and resources to record all breaches of the Code reported to it, to investigate breaches of the Code where appropriate and to conduct regular audits of insurance companies for compliance with the Code;

Part 7 of the Code details FOS's responsibilities in relation to Code Monitoring and Enforcement, and allows the CCC to concentrate on the policy aspects of the Code's operation. We note that FOS has recently established a separate entity to its dispute resolution functions to undertake the compliance monitoring for the General Insurance, Banking and Credit Mutuals Codes

The Insurance Council does not consider a change to the Code as recommended is necessary.

c) report serious or systemic breaches of the Code directly to ASIC; and

d) publicly release annual reports as to Code compliance and breaches, with insurers to be identified in the reports.

As required by its Terms of Reference (reflecting ASIC's RG 139.129), FOS is required to report serious or systemic breaches of the financial services regime to ASIC. Given that the Code is a self regulatory instrument, it is appropriate that FOS reports significant breaches of the Code to the CCC rather than ASIC.

We note in relation to recommendation 43 (c) Minister Shorten said that when consulting on this matter the Government would take into consideration the existing role of the FOS in reporting breaches of the Code of Practice.

The Insurance Council Board has agreed to the release of the CCC reports, to be made available on the Insurance Council website to improve transparency of member compliance with the Code and FOS's active monitoring of the Code. However, given a range of matters may lead to a Code breach being recorded, it is appropriate that the CCC have discretion as to whether an insurer be named in the CCC reports, which is currently reserved as an option for serious Code breaches.

Recommendation 44:
That ASIC conduct a review of the General Insurance Code of Practice three years after the amendments recommended to the Code in this Review are implemented, in order to assess the effectiveness of the Code with a view to determining whether an ASIC Regulatory Guide for claims handling should then be introduced.

In the event that amendments are made to the Code of Practice in response to the recommendations of the Review, the Government will consider the need to undertake an assessment of the effectiveness of the revised Code.

Industry Response
As the Code is a self regulatory instrument for the general insurance industry, it would be inappropriate for ASIC to review its operation. We note that this view is consistent with the following from ASIC's RG 183: Approval of financial services sector codes of conduct:

> RG183.78 "In rare instances, there may be a role of ASIC in administering and/or monitoring the code (e.g. where the code is a functional code that covers a range of industries and providers). We will consider this on a case by case basis."

The Code already has provisions for an independent review of its operations to take place every three years. ASIC and a wide range of stakeholders such as consumer advocates are consulted as a matter of course as part of each review.

The Insurance Council intends to proceed with an independent review of the Code, commencing in 2012. We are aware that the independence of the Reviewer will be essential for the credibility of the Review and have assured consumer advocates and ASIC that the Insurance Council will consult relevant stakeholders on the person to be chosen as Reviewer.

In view of ASIC's standing as the corporate regulator, the Insurance Council is pleased to advise it intends to seek ASIC approval of the Code following finalisation of the outcomes of the forthcoming independent Code review. We anticipate that one of ASIC's major considerations when deciding whether to approve the Code will be how thoroughly the Review took account of stakeholder, particularly consumer, concerns with the Code's operations.

Recognising that the focus of Recommendation 44 is on improvements to claims handling in light of changes made to the Code since the catastrophes, particularly those stemming from the NDIR recommendations, the Insurance Council would welcome ASIC undertaking a review of the industry's claims handling practices in home and home contents policies in the second half of 2015. This would be three years after the implementation of the significant changes recently made to the Code.