9. GENERAL INSURANCE CODE OF PRACTICE

9.1 INTRODUCTION

General insurance refers to a range of non-life insurance products. General insurance consists of two broad types of insurance, commercial and domestic. Commercial insurance is in respect of risks associated with business or corporate structures, whilst domestic insurance covers insurance for an individual's own use.

Domestic insurance is the focus of the general insurance industry's self-regulation. The policies captured by the General Insurance Code of Practice (the Code) are motor vehicle insurance, home contents insurance, home building insurance, personal accident and sickness insurance, travel insurance, consumer credit insurance and other contracts such as movables, valuables, recreational marine craft insurance, caravan insurance and on-site mobile homes insurance.

Self-regulation in the insurance industry has been developed within a legislative framework. This legislative framework has been designed to protect consumers from elements of market failure, including by improving the level of information disclosure to consumers. The incidence of elements of market failure in the general insurance industry — notably information asymmetry — had been identified in reports on the general insurance industry by the Australian Law Reform Commission, including ALRC 20 *Insurance contracts*, (1982) and ALRC 16 *Insurance agents and brokers* (1980). The incidence of market failure in the general insurance industry is discussed further in Section 9.2.3.

The relations between insurers and intermediaries are governed by the *Insurance Contracts Act 1984* and the *Insurance (Agents and Brokers Act 1984).* The Insurance Contracts Act provides the legal framework for the provision of life and general insurance. It covers communication between the insurer and the insured and fairness in relation to insurance contracts.

General insurers are prudentially regulated under the *Insurance Act 1973*, which mandates that companies must be authorised in order to provide general insurance products. However a number of public sector enterprises, not regulated under the Act, also deliver some general insurance services. Under prudential controls, general insurers may be subject to scrutiny by the Australian Prudential Regulation Authority (APRA). These regulations seek to ensure the

solvency of insurers and also protect the public by imposing prudential requirements on insurers.

It is presently an offence for an insurer to carry on business as a general insurer of prescribed policies in the domestic general insurance market if it does not belong to an approved code under the Section 113 of the Insurance Act. At this point in time, the General Insurance Code of Practice is the only approved code in existence. The Code and the two-tier dispute resolution scheme work in combination to provide a framework for consumer protection.

The General Insurance Code of Practice is a general document without significant detail. It is intended to be considered in conjunction with the guidelines to the Code, the Terms of Reference of the dispute resolution scheme, the *Insurance Contracts Act 1984* and the *Insurance (Agents and Brokers) Act 1984*. Self-regulation augments these regulations.

Exposure draft legislation has been released that will affect the status of the General Insurance Code of Practice and the General Insurance Enquiries and Complaints Scheme. The Financial Services Reform Bill, when enacted, will introduce a uniform licensing regime for all financial service providers and, in this context, general insurers would be required to be licensed by ASIC and to belong to an approved alternative dispute resolution scheme.[1] The Australian Securities and Investments Commission (ASIC) is presently responsible for approving dispute schemes and has issued guidelines outlining its expectations of such schemes (ASIC 1999). Guidelines for approving external dispute resolution schemes currently contained in Section 12FA of the ASIC Act will be picked up in regulations to the Financial Services Reform legislation.

ASIC would also play a role in 'approving' industry codes but such approval would be different in nature to the 'approval ' of the general insurance code under existing legislation. In effect, requirements for financial service providers would be set out in the legislation and ASIC will be able to approve industry codes that are consistent with the law.

In addition to the General Insurance Code of Conduct and the GIECS, self-regulatory initiatives in the general insurance industry include:

- the Knock for Knock Agreement applying to motor vehicle insurance claims whereby each insurer agrees to pay the cost of their insured's claim without resorting to legal action. The Agreement aims to reduce costs associated with investigation and litigation

[1] The draft Financial Services Reform Bill is available on the Internet at: http://www.treasury.gov.au/publications/Bills,ActsAndLegislation/CorporateLawEconomicReformProgram/FinancialServicesReformBill/index.asp#Commentary.

and reduce delays in the claims settlement process. Currently around 88 insurers are signatories to the Agreement.

- The General Insurance Information Privacy Principles, which is the privacy code of the general insurance industry launched by the ICA in August 1998. It sets the standards by which the industry collects, uses, stores and disposes of the personal information of its customers; and
- The Insurance Disaster Response Organisation which is a self-regulatory agreement to coordinate the industry's response to the community following a major disaster. The organisations functions include coordinating an efficient industry response to the disaster, providing a single point of contact to assist policyholders, establishing contact with the government, providing accurate information to insurers, assisting the industry to respond to claims and conducting any post disaster review.

9.2 THE MARKET FOR GENERAL INSURANCE

9.2.1 Demand for general insurance

The demand for domestic general insurance stems from consumers' desire to have another party assume and spread various risks they face, including personal accident and sickness, fire, burglary, motor vehicle accident, recreational marine craft accident, and travel related risks. By paying a premium, individuals can enter into an arrangement that provides compensation in the event that they suffer a specified loss or incur liability for damage or injury to third parties.

A large number of individuals and firms in Australia purchase or renew general insurance policies each year. In 1999 there were approximately 39 million general insurance policies in operation in Australia, 28.5 million of these were domestic policies, which are captured by the Code.

In an ideal market consumers will analyse the probability they will experience an adverse event, shop around for the best insurance product to cover that risk and enter into a contract with their preferred insurer by paying an appropriate premium. In practice, however, the purchase of insurance often is not straightforward. It is difficult and costly for individuals to determine the probability that they will experience a particular adverse event. Even if consumers are willing to investigate general insurance products, the market may not make the information available in a form which consumers understand. This factor was a driving force behind the Insurance Contracts Act. Consumers may also have difficulty understanding and

comparing the various terms and conditions in insurance contracts. This can limit the effectiveness of competition between insurers and may place consumers and insurers in an adversarial position in the event of a claim. The Financial Services Reform Bill also seeks to address some of these difficulties.

9.2.2 Supply of general insurance

There are a relatively large number of general insurers operating in Australia. As at 30 June 1998, there were 172 private sector insurers writing commercial and domestic general insurance business in Australia. The industry has in excess of $50 billion in assets (ICA 1997).

The Insurance Council of Australia (ICA) is the peak body for the insurance sector. It has a membership of 123 insurance and reinsurance companies. Its membership accounts for around 90 per cent of general insurance free capital in Australia.

Most general insurance services in Australia are provided by companies that have one of three corporate forms — capital stock companies, mutual organisations owned by members and state government owned insurance businesses. At least in the past there has been a pronounced difference between government and other insurers in terms of commercial orientations and cost structures (IC 1997). Profit maximisation is usually not the sole objective for government insurers and mutuals. Recent moves towards demutualisation by some insurers suggest that the disadvantages of a mutual structure may outweigh the advantages, at least for larger mutual companies. This move, combined with privatisation of government owned insurers has placed a greater proportion of general insurers on a similar footing and has increased the intensity of competition in the general insurance market.

Insurance companies set premiums with a view to recouping claim and administrative costs and earning a commercial return on their assets. In practice, this is a complicated and information intensive exercise. Insurers need to be well informed about the risks being indemnified to enable them to tailor premiums to the risks associated with insuring different individuals or firms (or groups of individuals or firms). Many insurers incur underwriting losses, that is, the cost associated with claims exceed premium income. However, they make a profit by investing premium income and reserves.

It is common for insurers to reduce their underwriting risk by reinsuring their risks with other insurers, known as reinsurers. This usually takes the form of an agreement whereby the insurance company pays a specified premium to have the reinsurer pay a designated proportion of an insurer's liability or all outlays above a stated level should events prescribed in the agreement occur. Reinsurance is more common for classes of general insurance which

are susceptible to unforeseen events with the potential for large-scale losses such as natural disasters.

General insurance is usually sold directly by insurance companies or through intermediaries (ie agents and brokers). The Insurance (Agents and Brokers) Act applies to insurance brokers and agents. Insurance brokers are persons who arrange insurance contracts as an agent for policyholders and intending policyholders. Brokers can also be involved in the preparation and presentation of claims. Some brokers charge their client a fee and receive a commission payment from the insurer. Insurance agents, on the other hand, generally are remunerated by way of commission. Brokers and agents allow insurers to extend their geographical coverage without expanding their network of offices. Some of the larger general insurers tend not to use agents or brokers as their network is already extensive in the geographical areas where they wish to provide a service.

Most 'retail' general insurance policies offer similar cover. However, there is some product differentiation. For example motor vehicle insurance policies differ in terms of write-off value (eg market value or agreed value), choice of repairer and additional benefits such as accommodation and travel expenses incurred following an accident, short term provision of a replacement vehicle after an accident or theft, compensation for personal property losses and provision for damage to a towed trailer (IC 1995).

In addition to product differentiation, there can be significant differences between insurers in terms of distribution channels, claims assessment practices, warranties and internal dispute resolution. There also are differences between insurers in the way insurance claims are assessed. Most require policyholders to obtain more than one quote in the event of a claim. Some insurers have preferred supplier arrangements with firms who repair or replace damaged property. All general insurers make use of loss assessors to:

- assess the extent of benefit to be supplied in the event of a claim;
- determine the accuracy of quotations submitted by firms who replace or repair property in the event of a claim; and
- authorise repairs, replacements and other actions on behalf of insurers.

In some cases, assessors are employed directly by the insurer. In other cases, assessors are contracted from an independent company. There is some concern among firms who provide services to the general insurance industry that loss assessors are actually “adjustors” with an overriding concern to minimise costs, often at the expense of quality (IC 1997).

Most insurance companies offer some form of warranty. However, in practice it usually is the firm providing a repair, replacement or other service to the insurance company that bears the risk because they can be held legally responsible for the work they carry out.

Although there are a large number of general insurers in Australia, many have a relatively small share of their product market and many do not operate nationally. For most general insurance products, a relatively small number of large insurers supply the majority of the market. For example, 1995 ISC data shows that the top 5 motor vehicle insurers in New South Wales and Victoria account for 86 per cent and 73 per cent of the volume of premiums, respectively. In some rural markets, the number of suppliers may be less and industry concentration could be higher. However, the Industry Commission (IC) found that at least in the major metropolitan motor vehicle and recreational marine craft insurance markets, there is fierce competition on price, in the nature of products provided and on service quality (IC 1997). The ISC submitted to the IC that there are "quite active levels" of price and product competition in all of the key classes of general insurance industry business.

Increasing competitive pressures associated with the privatisation and demutualisation of some insurers and the breaking down of some traditional market boundaries has increased the incentive for insurers to improve performance and become more customer focused. In the last decade or so new products have been introduced to the market (eg no claim bonuses and bonus protection) and some new services have been added (eg accommodation expenses in the event of a motor vehicle accident). There also has been some evolution in business practices. For example more business is now conducted over the telephone.

9.2.3 Nature of market failure(s)

Information asymmetry

One of the key reasons why insurance markets do not operate efficiently is due to asymmetric information between consumers and insurers. Information asymmetries manifest in this market in several ways.

An example of asymmetric information is where individuals who seek to insure against future possible states of the world possess information that the insurers do not. The insured person can exploit this informational advantage when dealing with insurers. This problem can manifest itself in the form of either moral hazard or adverse selection. Section 21 of the Insurance Contracts Act addresses this information asymmetry by imposing a duty of disclosure.

Moral hazard occurs where the insured can influence the probability of an adverse event occurring, or the magnitude of the loss, without the insurer's knowledge (eg by not locking their house, driving in a reckless manner, etc). If the insurer cannot enforce the amount of preventative action the insured takes there will be no incentive for people to be careful and minimise the risk of accident. To help reduce moral hazard problems, insurers can use excesses and no claim bonuses to share claim costs with insureds and create an incentive for them to minimise the probability of a claim. Notwithstanding this, the insurance industry is affected by significant levels of fraudulent claims, especially in relation to motor vehicle insurance. This leads to higher insurance premiums for policyholders. Due to information asymmetries, it can be difficult for insurance companies to detect whether a claim is fraudulent.

To assist in the reduction of moral hazard problems insurers will also rely on the customers claim history, as required under the duty of disclosure. Insurers, by denying claims for breaches of the duty of disclosure (as it relates to moral hazard questions) create an understanding or expectation within the community that a failure to satisfactorily answer such moral hazard questions may result in an insurer's refusal to indemnify.

Adverse selection occurs where there may be several risk categories of people in the market but either the purchaser or seller cannot distinguish between them. For example, an insurer may not be able to distinguish between careful and reckless drivers except on the basis of very imperfect categorisation such as age, sex and area of residence. This could disadvantage careful drivers (particularly younger males) and may lead to them withdrawing from the market. If insurance companies' information bases do not allow them to adequately differentiate between high risk and low risk individuals and firms, low risk individuals may face premiums that are higher than their risk profile deserves. These people may choose not to insure. Ultimately, this could lead to only relatively high-risk individuals seeking insurance. Unless premium levels are adjusted accordingly, this can expose insurers to significant losses.

Another example of asymmetric information is that consumers may not know all the financial and other implications associated with the purchase of a particular insurance product. For instance, many insureds believe their home building and contents insurance covers them against losses incurred during a flood when in many cases it does not. In other cases, consumers may not be able to determine differences in the quality of competing insurance products. Often this information asymmetry arises due to the complex nature of insurance contracts which makes it difficult to fully understand the risks covered and excluded under an insurance contract or to make comparisons across competing firms offering a similar product.

Where there is information asymmetry, the people that lack the information will usually act conservatively and may assume the worst about the good or service on offer. This prevents sellers of better goods and services obtaining a return for their better quality products and may lead to them also withdrawing from the market.

Property rights

The potential for adversarial relationships within general insurance markets can add significantly to transaction costs incurred by market participants, including insurers, agents, consumers and repairers. Some degree of tension between buyers and sellers is inevitable in any insurance market, due to a fundamental conflict of interest. Insurers wish to minimise their expenses by keeping claim costs (ie benefits) to a minimum, while consumers seek to maximise the benefit associated with their claim. The large disparity in the size of insurers relative to consumers adds to the tension. This factor was also influential in the development of the Insurance Contracts Act.

The time and resources required to resolve disputes between insurers and consumers can impose considerable costs on both parties. Where disputes reach the court system they can also impose costs on the community in general. For this reason it is important that processes are in place that encourage parties to settle disputes between themselves and as early as possible, using the court system only as a last resort.

When the level of conflict becomes sufficiently great that it impacts on the effectiveness of communication between the two parties, the industry's performance is adversely affected. Insurance companies have a commercial incentive to promote effective communication with consumers, up to a point. However, where there is inertia on the part of insurance companies, co-regulation can help to reduce the level of conflict.

Most general insurance customer complaints are about the quantum of insurance payouts or about insurers denying liability. There also are complaints about the standard of repairs or replacement goods or services. Generally, more disputes arose over motor vehicle insurance than any other form of general insurance (IEC 1999). In part this is because there are more motor policies issued than any other form of general insurance.

The role for regulation

Against this background, there is a role for regulatory intervention (regulation, industry self-regulation, or a combination of the two) to strengthen market operation by making market

participants better informed and thereby providing the fundamental conditions necessary for markets to work efficiently. Such intervention can address information market failure by:

- directly providing information that informs market participants about the risk of an adverse event occurring (eg campaigns advising of the damage caused by bushfires and the benefits of valuing home and contents appropriately to avoid being left out of pocket);
- establishing standards for good insurance products and business practices for insurers to adhere (including standards for information provision, training of employees and handling of disputes); and
- introducing a scheme to provide a dispute resolution service at low cost to consumers.

9.3 THE PRESENT SYSTEM OF SELF-REGULATION

9.3.1 Background

The development of a dispute resolution scheme preceded the development of a code of practice in the general insurance industry.

Dispute resolution scheme

Prior to 1990, general insurers tended to handle complaints by their policyholders themselves. As competition in the industry increased there was pressure to cut costs in order to lower premiums and capture greater market share. General insurers were inclined not to give the customer the benefit of doubt because this had adverse implications for the company profits. In response to growing concerns expressed by the consumer movement the Insurance Council of Australia (ICA) began employing consumer officers to assist consumers with an enquiry or a complaint against their insurer. These consumer officers could only negotiate and conciliate in disputes. Less assistance was given to consumers where their insurer was not a member of the association. Further pressure from consumer groups and government, combined with a desire within industry to provide a better service to consumers, led to the development of a more formal alternative dispute resolution scheme.

In 1991 the ICA established the General Insurance Claims Review Panel (CRP) to provide consumers with a free and formal non-litigious dispute resolution scheme. It was able to make decisions about disputed claims that were binding on the insurer, but not binding on the consumer. The Panel was made up of an independent chairperson, a representative with insurance industry expertise and a representative with consumer affairs expertise.

The ICA initially considered an Ombudsman model to deal with consumer complaints, however this was rejected in favour of the Panel approach because they believed the Panel would be more visible and could be perceived to be more independent than an Ombudsman as it provided for consumer representation.

Following an independent review of the dispute resolution scheme in 1993, the ICA established Insurance Enquiries and Complaints Ltd (IEC) to take over the administration of the Panel to increase its independence from member insurers. Several companies who were not members of the ICA joined the new independent General Insurance Enquiries and Complaints Scheme. In 1994, the jurisdiction of the dispute resolution scheme was expanded — procedures were introduced to deal specifically with disputes involving fraud. In addition, the dispute resolution process was made available to certain small businesses and residential strata title policyholders.

Since 1 January 2000, the CRP Scheme has also provided access to uninsured third parties who are ‘natural persons’ (that is, not a corporation) and who are having a dispute with insurers in relation to motor vehicle property damage. Such a dispute is limited to an amount not exceeding $3,000. The uninsured third party complainant is required to contribute to the insurance pool through the payment of a $150 administrative fee. The uninsured third party process will be reviewed after 12 months operation.

Code of Practice

During the late 1980s and early 1990s consumers and government became concerned about standards of practice and service in the insurance industry. In 1993 the Commonwealth Government announced that it was intending to introduce a compulsory code of practice for the general and life insurance industry.

According to Hamilton (1995) one of the reasons behind the desire to introduce the Code was the belief that not all of the legislative reforms introduced under the Insurance Contracts Act had produced the intended results. For example, the Act included a requirement that insurers provide insureds with written notice advising them of the insured's duty to disclose. The Insurance and Superannuation Commission (1993) noted that many aspects of insurance contracts were not well understood by insureds and that one of the least understood areas was the nature and extent of the duty of disclosure. Hamilton argues that insureds may have understood the duty to answer questions asked by insurers in application forms, but many were not aware of their duty to declare any other information affecting the probability they would make a claim.

By September 1994, following extensive lobbying by general insurers, the Commonwealth announced that it would not proceed with a statutory code for the general insurance industry. Instead it allowed that industry to develop a self-regulatory code. The industry argued that self-regulation would be more effective than a statutory code because the industry would 'own' it. Notwithstanding this, there appears to have been significant government involvement in the development of the Code. For example, in May 1994 the Insurance and Superannuation Commission recommended that the draft code should provide for a specific client guide to be provided to insureds at the point of sale including an explanation of the nature and extent of the duty to disclose and the consequences of failing to comply. The ISC also recommended that the customer be reminded of that duty and the consequences of failing to comply in any subsequent cover note, policy variation or renewal notice issued to the insured.

The General Insurance Code of Practice was finalised in December 1994 after extensive consultation between the Government, consumer representatives and the general insurance industry. Responsibility for its implementation and administration was vested with IEC, the organisation originally established to administer the dispute resolution scheme. The code was officially launched on 1 July 1995, following approval by the Insurance and Superannuation Commission. At this time the Australian Insurance Institute, with the support of the ICA, conducted a large training exercise involving thousands of insurance industry employees. The Institute also produced a range of training materials, promotional items and information brochures and implemented an image advertising program to promote the Code to the community. After a one-year implementation phase, full implementation occurred from July 1 1996. At this time compliance became mandatory for all members of the ICA ie around 85 to 90 per cent of general insurers. Insurers who were not members of the ICA were encouraged to subscribe to the Code. The Code, in turn, requires insurers to belong to the dispute resolution scheme.

In late 1997, following concern that some non-ICA member general insurers had not subscribed to the Code, legislative changes were introduced to the Insurance Act 1973 making it a condition of registration for general insurers to belong to an approved code.

9.3.2 Objectives of the Code

The General Insurance Code of Practice aims to:

- improve customer service standards across the industry;
- promote good relations between insurers, agents and consumers;

- reduce the number of disputes; and
- provide for a non-litigious low cost mechanism for consumer redress.

The Code seeks to raise industry standards by making policy documents more user friendly and improving claims and complaints handling. It also encourages insurers to train and supervise their employees and agents (including brokers who act as agents), investigators, loss assessors and adjusters. Following the launch of the Code, hundreds of insurance employees attended a range of seminars to build their understanding of the Code; provisions and ensure companies had adequate systems in place. The Financial Services Reform Bill proposes a legislative framework for the supervision by insurers of their employees and agents.

The Code sets out standards of practice for insurers. It is not intended to provide a bare minimum nor is it best practice. The IEC claims that insurers can and do compete on the basis of service offered that is higher than the Code standard (IEC 1999).

To date, the ICA has intended that the Code be used as a device to ensure the industry stays aligned with the needs of its clients (ICA 1996). The code is intended by the ICA to be a “living code”, that is, one which is progressively developed over time after consultation with stakeholders including government and other interested groups such as consumer groups. It also is intended to be capable of adaptation to the legislative framework, changing market conditions and consumer expectations over time.

9.3.3 Code coverage

The main features of the Code are a dispute resolution scheme; strong enforcement powers, which allow the ICA to impose fines for non-compliance on its members; and a list of practice standards in respect of the relationship of insurers and their agents and employees to the policy holders and in respect of policy documentation and claims handling procedures.

The code covers all products covered by the Insurance Contracts Act 1984. It establishes minimum standards with which insurers and intermediaries need to comply. For example, it:

- describes standards of good practice and service to be met by participating insurers;
- seeks to promote disclosure of information relevant and useful to consumers to allow them to make an informed choice and compare one product with another;
- facilitates the education of consumers about their rights and obligations under insurance contracts;

- seeks to promote informed and effective relationships between consumers, insurers and agents;
- requires insurers to have fair procedures for resolution of disputes between consumers, insurers and agents. Although no specific consumer redress is provided by the Code, it requires participating insurers to establish internal and external dispute handling procedures; and
- provides for consumer representation in the administration and development of the Code.

9.3.4 Overview of the Code

The Code of Practice imposes rules or standards for general insurers of domestic policies in relation to:

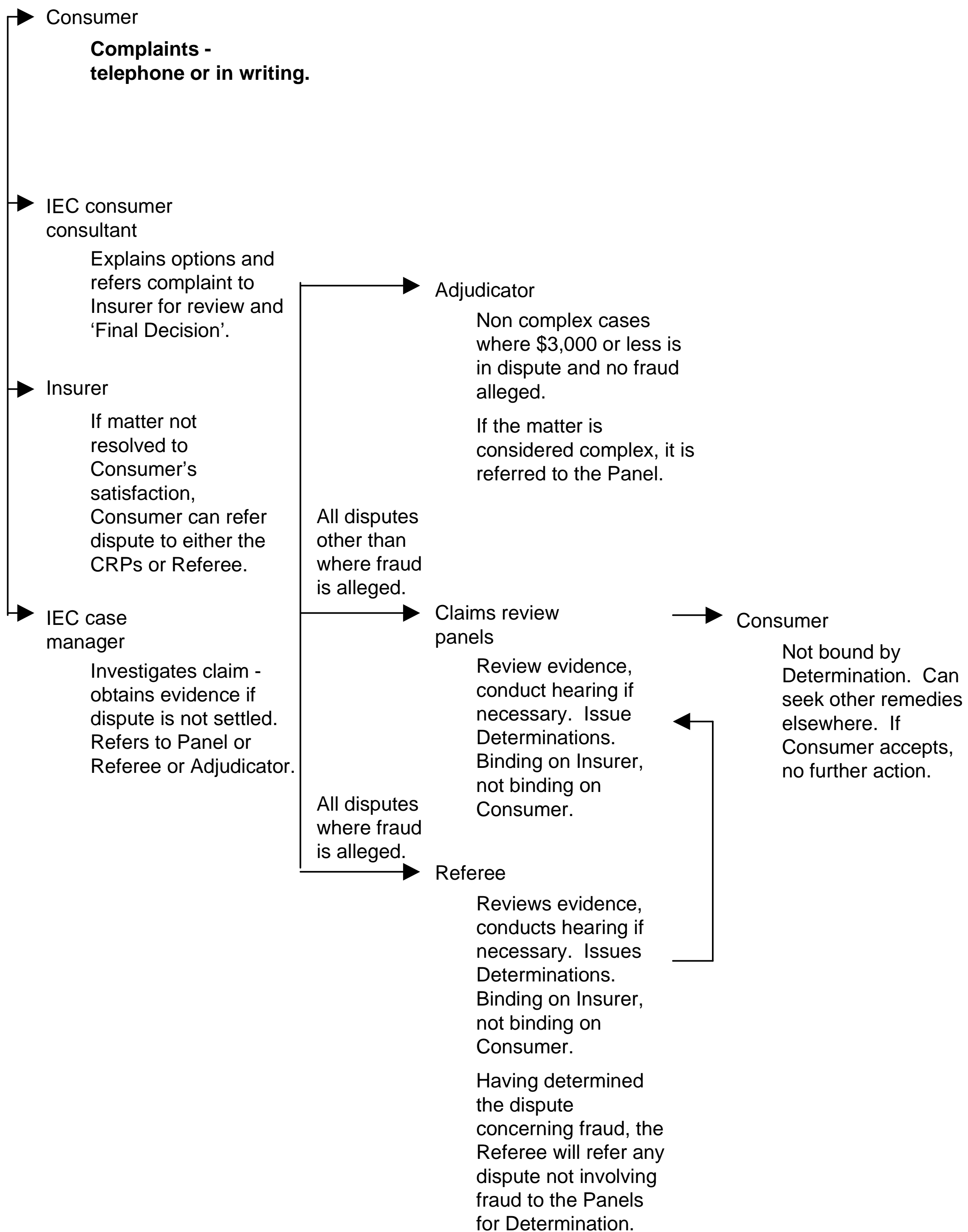
- insurers' relations with agents and employees — the Code has provisions relating to supervision of agents, authority to arrange insurance, agent training, agent record keeping, employee skills and training;
- policy documentation — the Code requires that insurers make provision for insurance policy documentation to be in plain language and designed and presented to assist comprehension by consumers. It also requires insurers to make copies of the policy available to consumers at inception. The insurers must also make available with policy documentation advice that the documents should be read carefully and provide information about the Code and availability of internal and external dispute resolution processes. Insurers should inform the consumer of their duty to disclose and identify all information ordinarily required to be disclosed prior to providing cover. The duty of disclosure also requires information to be given on the consequence of non-disclosure;
- claims handing — the Code sets out principles for good claims handling practice including requirement that insurers: make claims forms readily available to claimants; explain the procedure for making a claim in plain language; promptly respond to claimants requests for assistance; keep insurers informed about the progress of their claim; and advise the claimant of the reasons for any decision to reject a claim;
- dispute resolution — the Code requires insurers to have a fully documented internal process for resolving disputes with a requirement that this process should be readily accessible by consumers without charge. There is also a requirement that internal processes should be fair and timely. The Code also requires that each insurer shall participate in the Claims Review Panel Scheme operated by the IEC;

- responsibility, review and sanctions — the Code requires that insurers implement appropriate systems and documentation to comply with the Code and prepares an annual report to the IEC on the operation and compliance with the Code. The IEC may review compliance of the Code by any insurer from time to time and in the event of a breach by the insurer. Insurers are required to cooperate with the Code Compliance Committee and IEC staff. In the event of a material breach of the Code by an insurer, and the insurer not taking all reasonable steps to ensure that procedures are established to prevent the breach recurring, the Code Compliance Committee may notify the insurer that it proposes to impose sanctions. The insurer has an opportunity to make representations to the Code Compliance Committee. Ultimately the Committee may require the insurer to take steps to rectify according to a specified timetable, require that a compliance audit be undertaken, implement corrective advertising and/or recommend to the IEC board that the insurer be named in the annual report.

The dispute resolution scheme is a national two tiered service (see Figure 3). The first tier is an enquiry and advisory service performed by consumer consultants who receive calls from consumers and policyholders and liaise with insurers to resolve disputes. If a claims dispute is unresolved after review by the insurer through its internal dispute resolution process (which insurers are required to have under the Code), it is referred by the policyholder to a second tier for determination by the Claims Review Panel, Referee or Adjudicator. The Panel Chair, Referee and Adjudicator are appointed by the IEC Board following nomination by the ICA. The ICA is required to consult with the Federal Minister responsible for Consumer Affairs and ASIC. The ICA appoints the industry representative and the Minister appoints the consumer representative. Each panel member is appointed for a period of one year, with possible re-appointment periods of one year.

The scheme provides a free dispute handling process with industry wide coverage. It issues determinations which are binding on member companies but not on consumers, who have recourse to the legal system if they are dissatisfied with the Panel's, Referee's or Adjudicator's decision. Some consumer groups feel that scheme could be more transparent. The ICA commented in discussions with the consultant that they are looking at ways to make the process more visible so that consumer organisations can have more confidence in the scheme.

Figure 3: **The Dispute Resolution Scheme – Flow Chart**



Note: Alleged breaches of the Code are resolved by the National Code of Practice Manager. The Code Compliance Committee may assist with resolution. The Privacy compliance Committee resolves complaints, disputes and alleged breaches relating to the Privacy Principles.

Source: IEC (1999)

The Code and the scheme are reviewed periodically which provides scope to ensure they meet the needs of a changing market place. Since their inception, both the Code and the dispute resolution scheme have been improved over time and the jurisdiction has been expanded. For example, in 1998 a one person Adjudicator process was introduced to enable the dispute resolution scheme to deal more efficiently with low value, non-complex disputes. The first tier of the scheme has been expanded to handle compulsory third party insurance enquiries from New South Wales.

9.3.5 Operation of the Code

In 1998-99 some 56,909 enquiries were made to the IEC. This represents a substantial increase since the Code was officially launched on 1 July 1995 — in 1995-96 the IEC received 37,895 enquiries (IEC 1999). However, the number of policies issued and the number of claims made have also increased considerably over that period. There also is anecdotal evidence that some of the increase in the number of enquiries is due to a greater awareness of the scheme among consumers. The educative role performed via IEC publications, talks, conferences etc. has contributed to consumers' greater awareness of the Code and the dispute resolution procedures.

The Code requires participating insurers to establish both internal and external dispute handling procedures. As outlined above, if a claims dispute falling within the scope of the Terms of Reference of the scheme remains unresolved after review by the insurer through its internal dispute resolution process it is referred by the policyholder to the second external tier for determination. Binding determinations can be made on participating insurers by an Adjudicator for amounts not exceeding $3,000 and by a Panel or Referee for amounts not exceeding $120,000. A Panel or Referee may also make recommendations for an amount greater than $120,000 but not exceeding $290,000.

Internal Dispute Resolution

Under the present complaints handling system the consumer is initially referred to the insurer's own Internal Dispute Resolution process. The insurer will then attempt to resolve the dispute internally. However, if it is not resolved to the consumer's satisfaction then the consumer can refer to complaint to the IEC for adjudication.

As a result of the Code every company has a formal internal dispute resolution arrangement for customers which is documented, free and forms the precursor to access to the Claims Review Panel system. Industry employees and agents receive formal training in the Code.

The Australian Insurance Institute is continually developing programs to meet the industry's education needs.

In 1999, general insurers' in-house dispute resolution units handled 12,007 complaints. Of these 3,980 (around 33 per cent) were decided in favour of the consumer. This is around the same number of complaints as the previous year, however the total number of policies increased by 3 per cent and the number of claims increased by 10 per cent over the same period.

Second Tier Dispute Resolution

In 1998-99 2,102 disputes were referred to the IEC for determination, this represents a 14 per cent increase on the previous year. By contrast in 1995-96, the first financial year after the Code's launch, 931 disputes were referred to the IEC.

Once the complaint reaches the IEC, a case manager investigates the claim and refers the complaint to the Adjudicator, Claims Review Panel, or the Referee for appropriate action. In 1998-99, these three bodies determined 2,188 disputes (IEC 1999). Unlike the insurer, claimants are not bound by any determination and retain their rights to legal action or other forms of redress in the event of being dissatisfied with a determination.

The Claims Review Panel

It is the role of the Panel to provide the insurer and the complainant with an impartial and authoritative alternative to litigation, although it is bound to operate within its Terms of Reference. All participating insurers sign an Agreement signifying their compliance with the Terms of Reference, including the procedures which must be followed to resolve disputes within the periods set down in the Terms of Reference. The Agreement also means that the insurers undertake to comply with the binding determinations of the Panel up to the $120,000 limit outlined above.

The Panels will not consider a complaint if the Chair of the Panel is convinced that:

- the complaint is statute barred or otherwise unable to be determined by the courts;
- there have been allegations of fraud (in which case the complaint will be referred to the Referee);
- the complainant is a corporation and not a natural person as defined by the Code; or
- where an insurer was not a member of the scheme prior to 31 December 1993 and has already made a decision on the matter prior to this date.

In 1998-99, 1,292 disputes directed to the Panel were completed (IEC 1999). Of these 284 were decided in favour of the consumer and 774 in favour of the insurer. The remaining complaints did not require a decision to be made by the Panel for various reasons, including outside settlement and complaint withdrawal. The vast majority of complaints dealt with by the Panel (that is, 86.2 per cent) were resolved within 120 days (IEC 1999).

The Adjudicator

The Adjudicator process was introduced in 1998 for the purpose of fast tracking disputes of a non-complex nature where those disputes involve a sum of money valued at less than $3,000. According to the IEC, the Adjudicator's introduction has enabled the Claims Review Panel to concentrate on more complex matters, thus resulting in a more effective and efficient process of dispute resolution.

In 1998-99, the Adjudicator determined 532 complaints; another 91 complaints before the adjudicator were settled and 5 were withdrawn. Of those complaints subject to determination, 8 were dismissed, 104 were decided in favour of the consumer, with the remaining 420 decided in favour of the insurer (IEC 1999). These statistics demonstrate that approximately 19.5 per cent of insurer decisions were over-turned by the Adjudicator.

The Referee

Where a participating insurer alleges fraud in respect of non-disclosure, misrepresentation or in the claim, IEC shall refer the dispute to a Referee for determination or recommendation. The Referee is an independent person appointed by the Board and nominated by the ICA, after the ICA has consulted with the Federal Minister responsible for Consumer Affairs and with ASIC. The Referee's appointment lasts for two years with the possibility of re-appointment for further terms, each not exceeding two years. Like the Panel, the Referee can issue binding decisions on insurers for payments totalling $120,000.

In 1998-99 242 disputes considered by the Referee were completed, 165 of which were settled within the first 150 days of receiving the complaint. Of these completed complaints, 50 were decided in favour of the consumer, 143 were not to be decided (that is, ruled in favour of the insurer), with the remaining cases withdrawn, settled or referred to the Panel for adjudication (IEC 1999).

9.3.6 Administration of the Code

The Insurance Enquiries and Complaints Limited (IEC) is responsible for implementing and administering the Code. The IEC is also responsible for the administration of the Claims Review Panel Scheme (CRP) established by the insurance industry. The IEC Board of

Directors includes an independent Chair, three participating general insurance company members, the ICA Chief Executive, and three members with experience in consumer affairs. Responsibilities of the Board include:

- Overseeing and monitoring the activity of the Scheme and ensuring the independence of the dispute resolution process.
- Effecting changes to the Terms of Reference following consultation with the Federal Minister responsible for Consumer Affairs.
- Appointing the Chair of the Panels, the Referee and the Adjudicator.
- Ensuring that the Panels, the Referee and the Adjudicator adhere to the Terms of Reference, but in so doing, the Board shall have no power to overturn any decision of those review bodies.
- Analysing statistical information on the Scheme.
- Analysing an annual review of the scheme from the General Manager and making its own comments therein as appropriate.
- Satisfying itself that the promotional programs/projects of the Scheme are adequately funded.

The Scheme is fully funded by participating insurers, including provision of all administrative, research and secretarial resources and facilities to assist complainants to formulate complaints and reduce them to writing. Approximately 60 per cent of the IEC budget is met by a levy upon the personal lines premium income of member companies. Companies either pay the minimum levy of $1,600 or a levy based on their proportion of personal lines premium income. The other 40 per cent of the budget is met by a fee per case payment (IEC 1999). Access to the dispute resolution scheme is free to all consumers, except uninsured third parties who have not contributed through insurance premiums to the funding of the scheme.

The code was formally reviewed two years after it became fully operational by Mr George Pooley, a former ISC Commissioner. The Pooley report was published in October 1998 following the receipt of 23 submissions and discussions and forums with the IEC, consumer representatives, insurers and government agencies. The report included 28 recommendations, which have subsequently been considered by the ICA but have yet to be incorporated into the Code. Having accepted a number of these recommendations in principle the ICA has submitted the final report to ASIC for approval. ASIC took over responsibility for consumer protection in the insurance industry from ISC in July 1998, with APRA assuming

responsibility for prudential regulation of the industry. ASIC is yet to approve the Code amendments. It is seeking to strengthen reporting obligations on the industry, so that it receives performance information as well as the IEC. In future, the Code will be reviewed at three-year intervals.

9.4 FEATURES OF THE MARKET THAT MAKE SELF REGULATION MOST OR LEAST EFFECTIVE

9.4.1 Overall effectiveness in addressing market failure(s)

As noted in Section 9.2.3, the existence of asymmetric information can reduce the efficiency with which the market for general insurance operates. Insurers are likely to have better information about the risks covered by insurance products and the likelihood of a claim than consumers. Although there is some commercial incentive for them to supply consumers with information about insurance products, the nature and level of information is not necessarily what consumers would prefer. Consumers, on the other hand, can influence the probability of a claim through their own action or inaction.

In a market such as general insurance where self-regulation complements government regulation, it is difficult to definitely assess the effectiveness of the General Insurance Code of Practice (in particular) in addressing market failures.

Notwithstanding this, several stakeholders believe that the Code and accompanying two-tier dispute resolution scheme have been effective. For example, the Department of Industry, Science and Tourism considered that the Code has been “quite effective” in its submission to the 1998 Pooley Review of the Code. The Pooley Review also found that the Code was effective (Pooley 1998).

The ICA — admittedly, not an independent commentator on the Code’s effectiveness — claims the Code and dispute resolution scheme are successful due to the IEC’s understanding of the Codes procedures and aspirations combined with a good knowledge of the industry’s internal workings (ICA 1997).

Consumer groups acknowledge that the Code and two tier dispute resolution scheme have facilitated an improvement in industry practices such as provision of information and handling of disputes, although many argue there is still a way to go. Many would prefer that self-regulation be given greater legislative backing. To some extent, this is proposed under the Financial Services Reform legislation. The code and accompanying two-tier dispute

resolution scheme does help to overcome information asymmetry related problems and property right related market failures.

In terms of information asymmetry, the Code requires insurers to provide easily understood information to consumers about:

- the sorts of information they need to disclose to allow the insurer to calculate their risk profile;
- the risks that are covered by the general insurance product;
- the risks that are not covered by the general insurance product;
- their recourse to internal and external dispute resolution schemes; and
- how they can make a claim and how the insurer will process a claim.

The code also addresses information asymmetry between employer and employee by making provision for ongoing training of industry employees.

The IEC has advised Tasman that, following the introduction of the Code, the plain language requirement resulted in an improvement in policy wordings. Furthermore, due to the existence of standard policy wordings, (Insurance Contracts Regulations), competition has driven insurers to achieve greater market share by offering additional cover, better service and improved plain English policy wording.

In terms of addressing property right market failures, the Code and associated dispute resolution scheme have demonstrably reduced the transaction costs associated with disputes for both insurers and consumers, since it largely avoids the need to proceed with costly litigation. The dispute resolution scheme:

- is highly accessible in the sense that it is readily available to all customers, fairly well advertised, and involves no cost to consumers, except in the case of third party claims;
- is independent in the sense that the scheme is administered by a separate company, rather than the insurance companies or their industry association;
- promotes fair decision making by requiring the Panel, Referee and Adjudicator to follow explicit procedures based on a Terms of Reference and to base decisions on information before them;
- is efficient in the sense that it keeps track of complaints and also ensures that complaints are dealt with by the appropriate process and handled in a timely fashion;

- is periodically subject to independent review so that it may be updated in line with changed market conditions and consumer expectations. This provides flexibility to broaden the charter of the scheme as the need arises;
- is accountable in the sense that the IEC publicly accounts for its operations by publishing its determinations and information about complaints and highlighting any systemic, industry-wide problems;
- discourages frivolous or vexatious complaints; and
- is mandatory for all general insurers so that consumers do not experience difficulty accessing a low cost dispute resolution mechanism because their insurer is not a party to the Code or scheme.

Insurers have an incentive to resolve many complaints in-house using frontline staff. If a matter cannot be settled by frontline counter staff, it can progress to the insurer's in-house dispute resolution section. All general insurers are required to have a separate section dealing specifically with consumer complaints under the Code. The NRMA submitted to the IC that the benefits associated with running an internal customer complaints department far outweigh the costs. The benefits include retaining business, reducing negative word of mouth advertising, saving management time and providing insurers with information about areas of their business which require improvement.

In-house schemes are low cost and easily accessible, but they are not independent and may not be regarded by consumers with confidence. This does not limit effectiveness in the case of general insurance because consumers have recourse to other complaint resolution options under a multi-tiered system. And, as a last resort, they have recourse to the legal system through the courts.

9.4.2 Product related factors influencing effectiveness

Although general insurance products are relatively homogeneous they are not perfectly so. The general insurance products of the different suppliers are highly substitutable within particular product categories. Consumers can and do shop around for the general insurance product that meets their requirements. Many customers review their choice of insurer and insurance product each year when their insurance policies fall due for renewal.

Some domestic general insurance products compete with self-provision of insurance. That is, some individuals are willing to accept liability in the event that they cause damage to another person's property or their own property. Some people do this because they know they do not have sufficient wealth to meet the cost of damage they cause to others and they do not have

significant assets themselves to damage. It is for this reason that governments regulate that motor vehicle owners must purchase third party cover for bodily injury they cause to others so that the injured party can be compensated.

The cost of switching between close substitutes is very low for consumers. The presence of low switching costs and availability of close substitutes may limit the scope for market failure in general insurance markets. That is, it can provide insurers with an incentive to reveal to consumers as much information as consumers feel necessary. If insurers do not, their policyholders may switch to another insurer offering a similar priced product but better provision of information. Notwithstanding this, self-regulation can be effective where it reduces the extent to which market failure distorts consumer choice between products that are close substitutes.

Demand for general insurance is likely to be relatively price inelastic (ie unresponsive to a small change in price) because it is difficult for consumers to pool risk without it. However, the demand for a particular general insurance product offered by an individual insurer may be highly price elastic (ie highly responsive to a small change in price). Anecdotal evidence from insurers suggests consumers may be willing to change insurer for a $5 difference in premium. Self-regulation tends to be effective in this kind of environment because brand name image and customer loyalty are important determinants of market share and insurer profitability. Damage to brand reputation through non-compliance with the Code can be very costly to restore.

The complexity of the general insurance product also has important implications for the effectiveness of self-regulation. This is because the greater the product complexity, the greater the potential for information asymmetry between insurers and consumers about the product, and the greater the risk that consumers will not fully understand the characteristics of the insurance product they purchase. In this environment there is an incentive for insurers to abide by self-regulation to foster consumer confidence in their products.

9.4.3 Impact of nature and extent of competition between firms on effectiveness

The nature and extent of competition in the general insurance market can also influence the effectiveness of self-regulation because it affects the ability of firms to develop, implement and maintain self-regulation.

There currently is strong competition in the general insurance market between a significant number of industry participants. Around 110 general insurers compete with each other to provide relatively homogenous products. Notwithstanding this, a group of around 5 large

insurance companies tend to dominate most general insurance product markets. Nonetheless, there is vigorous competition between even the largest insurers for market share.

The competitiveness of the general insurance industry is influenced by barriers to entry and exit. The greater the freedom to enter a market, the greater is the pressure on firms to minimise costs and price efficiently. If they do not, profit opportunities emerge for new entrants to take advantage of. If barriers to market entry are low, even a large insurer may have little market power.

It would appear that barriers to entry and exit in general insurance are not high and are likely to be reducing due to the adoption of low-cost technologies. Significant levels of entry to the general insurance industry over recent years, suggests that barriers to entry are not high. New entrants may face problems in obtaining all of the relevant information about the risks they wish to insure. However, risk profiles can be inferred from the premiums charged by other insurers. This information is sometimes publicly available or can be collected at relatively low cost. New entrants also face costs associated with developing the business to a scale where it can be viable and compete with the premiums offered by competitors. The Industry Commission found that firms wishing to enter most industries face similar problems and it is doubtful whether such costs can be considered as significant entry barriers (IC 1995).

Competition in the general insurance industry is becoming more intense as technology allows the development of new distribution channels such as e-commerce. There also has been a breakdown of market barriers to entry in general insurance. For example, it is now easier for insurers to operate across several states. In recent years many of the largest general insurers such as NRMA and Suncorp have extended their operations into other states.

Competition also is increasing because some large financial institutions (eg banks, credit unions and building societies) that have traditionally not offered an insurance product are now extending their operations into general insurance markets. This financial sector convergence (ie the increasing tendency for a variety of financial products to be produced by the same company) is occurring now due to the removal of restrictions on the lines of business in which insurers and other financial organisations may engage. The underlying information processing and risk management technologies used by banks and insurance companies are essentially similar. This gives rise to economies of scope in the joint production of banking and insurance products.

A high degree of competition creates an incentive to use adherence to the Code of Practice as a marketing tool. As noted by the NRMA (1999) in their submission to the taskforce, competition creates a strong incentive for insurers to comply with and in some cases exceed,

the levels of customer service and other conditions specified in the Code. This is because non-compliance by a particular company could see it lose market share to competitors.

The degree of dynamism within the market also can influence the effectiveness of self-regulation. The industry is continually seeking new ways to deal with new risks and better ways of dealing with old risks. General insurance products and distribution channels also are continually changing to meet consumers' changing needs and preferences. New products are emerging and new technologies pave the way for new distribution opportunities.

At the same time, regulation and industry self-regulation need to be more flexible and responsive to keep pace with the market. The Financial Services Reform Bill has been drafted to provide for in-built flexibility in dealing with innovation in financial service delivery. Self-regulation can be particularly flexible where it is allowed to evolve over time and is subject to periodic independent review, as is the case for the General Insurance Code of Practice.

9.4.4 Commonality of producer and consumer interests and effectiveness

Self-regulation tends to be more effective in markets where consumers and producers share a similar interest in addressing a market failure.

There is a high degree of similarity of consumer interests in the general insurance industry. Many consumers experience difficulty making a decision about their preferred insurer and insurance product due to the complexity of information. Information problems exist not only at the time of purchase but also when consumers seek to lodge a claim with an insurer. Consumers may be unaware of how to lodge a claim and may not have information to determine whether the insurance companies settlement offer is appropriate. Where they wish to dispute an insurer's decision, many consumers would not be prepared to take their claim to the courts due to high transaction costs and (usually) relatively low quantum in dispute. Thus, most consumers share a common interest in making sure insurance companies provide relevant information that is easily understood and also provide recourse to a low cost non-litigious dispute resolution service in the first instance.

Similarly, there is a high degree of similarity of producer interests in the general insurance industry. Most insurers use similar inputs and production technologies to produce relatively homogeneous general insurance products that are highly substitutable. Where production processes and inputs are similar across insurers, standards of good practice (eg training standards, dispute handling standards, plain English contracting standards) contained in a self-regulatory code can be highly relevant to each insurer. This helps to ensure that the Code is widely accepted and adhered to by insurers.

The high degree of similarity of producer interests in the general insurance market has helped to build a relatively strong industry association in the ICA. Insurance companies in the pursuit of similar strategic goals have clubbed together to jointly undertake and fund various functions including industry training initiatives, lobbying of government, public relations exercises and the collection of industry statistics. The ICA was instrumental to the development of the Code and liaised with insurers to reconcile any differences. Although code administration has been handed over to the more independent IEC, the ICA maintains a strong interest in the continuation of the Code.

The effectiveness of the General Insurance Code of Practice and accompanying two-tier dispute resolution scheme is greatly enhanced by the fact that they have nation wide support from the industry. The industry backs the Code and IEC processes both financially and through its compliance. With few exceptions, general insurers have shown a willingness to accept determinations made by the Claims Review Panel. To date, there have been only two examples where insurance companies have refused to abide by the rules of the Scheme. The first involved an insurer who refused to comply with the determination of the Panel. This was one reason why the Federal Government amended the *Insurance Act 1973* to mandate insurers abide by an approved code. The second involved an insurer that refused to provide timely information to the IEC.

The effectiveness of general insurance industry self-regulation is also enhanced by the fact that the Code and the dispute resolution scheme encourage individual insurers to shoulder much of the responsibility for improving their training, claims handing and dispute resolution practices. For example, the NRMA noted in its submission to the Taskforce that self-regulation is enhanced when a specialised unit is established within the company to deal with code compliance and address customer concerns. This is required under the Code. This arrangement helps to ensure that all customer concerns are given priority, are managed by the appropriate business unit, and are addressed in a consistent and timely manner.