An aid
supporting
Fairness in Insurance: – A Challenge to Boards of Insurance Companies

This Aid summarises the challenge questions set out in the Paper, and is intended to facilitate a discussion. Full explanations and background thinking are set out in the Paper itself.

Drivers of Community Views

Key Points	Questions for the Board
There are multiple examples of public criticism of insurers and their treatment of customers. **Appendix A of the Paper provides some details.** All of these matters are potential triggers for community unease. From the insurer's perspective there may be a rational explanation for some; however, they have all contributed to consumer concerns. And, of course, even when there is a reasonable explanation for the insurer, the view of the customer may be quite different.	☐ Does the Board regularly and systematically consider the issue of fairness? For example, does it have a standing item on the Board agenda? Does it expect commentary on the impact of fairness in all relevant Board papers? ☐ When considering matters of fairness, does the insurer consider all of the relevant contemporary areas of community concern, as set out in Appendix A (such as pricing for new customers relative to existing customers, or the appropriate use of customer data)? ☐ Does the Board have a stance on each of these areas of concern? ☐ Does the Board consider the harmony of the various matters addressed in this paper with each other and with community expectations?

Fairness – the Insurance System & Externalities

Key Points	Questions for the Board
There are two primary parties to an insurance contract – the insurer and the customer. Considerations of fairness start with those two parties. However, there are others affected by insurance arrangements between the two primary parties. For example, society has an interest in properties being insured against natural catastrophes, since wider society often will be called on to help those impacted by a major catastrophe, and insurance will help maintain the economy to the benefit of all. And a third party might suffer damage or loss (for example, in a car accident) with compensation dependent on insurance held by the primary party.	☐ Does the insurer consider these various interests in the context of fairness? ☐ Does the insurer have a formal stance on how third-party interests should be considered by management? How does that stance sit with the insurer's corporate values and environmental, social and governance (ESG) stance? ☐ Does the insurer discuss these various interests in its communications with customers and with society?

Obligations of Insurers and Customers

Key Points

There are multiple obligations placed on insurers to treat their customers fairly in insurance laws, other legislation, regulations, guidance from regulators and codes of conduct.

Appendix C of the Paper provides a summary.

At the same time, there are significant obligations in legislation placed on the customer. This starts with the principle of Utmost Good Faith. That Act also imposes a duty on the customer to take reasonable care not to make a misrepresentation to the insurer.

Questions for the Board

- ☐ Does the insurer systematically consider each of the formal obligations in Appendix C in any changes to product or practices?
- ☐ Does the Board seek positive assurance from management (rather than limited or negative assurance) of compliance with fairness obligations from time to time?
- ☐ As a matter of course, does the insurer filter products and practices through the notions of unfairness set out in the Competition and Consumer Act?
- ☐ Does the insurer recognise its significantly superior knowledge and understanding of its products in its customer communications, handling of claims and in training of staff?
- ☐ In its consideration of matters involving product design, pricing, claims management, etc., does the insurer give consideration to its position of trust in society and its obligations under its 'social licence'?

Purpose and Principles of Insurance

Key Points

The purpose of insurance lays the foundation for what is fair or unfair.

That purpose basically is to protect the customer against financial loss from one or more specific contingencies – for example, the loss of property due to fire.

To help ensure the integrity of the process supporting that purpose, an insurer should have in place a set of *insurance principles* to guide them in their decision making. Principles to support fairness might address matters such as these:

- Indemnity
- Utmost Good Faith
- Objectivity

Questions for the Board

- ☐ Does the insurer have a set of clearly articulated and diligently followed insurance principles to guide management in decision-making?
- ☐ Does the Board pay attention to the application of Utmost Good Faith by the insurer?
- ☐ Is Utmost Good Faith captured in the insurer's corporate values?

Financial Inclusion

Key Points

Financial inclusion "refers to efforts to make financial products and services accessible and affordable to all individuals and businesses, regardless of their personal net worth."

There is a concept known as the "poverty premium", which is the phenomenon of poorer members of the community paying higher prices or carrying greater risk than others, because of their disadvantaged position.

Questions for the Board

- ☐ Does the insurer systematically consider how suitable their products may be for poorer members of the community?
- ☐ Does the insurer have a corporate policy on this? How does this fit with the insurer's corporate values and ESG stance?
- ☐ Does the insurer analyse their products and pricing models to understand how they may be inadvertently excluding poorer members of the community, and adjust their models accordingly?

Cross-subsidies

Key Points	Questions for the Board
Cross-subsidies are something of a vexed, but very important issue when fairness is considered. **Appendix D of the Paper provides detailed comments on cross-subsidies.** In a sophisticated system of risk pooling, each participant would pay according to the risk being insured – that is, participants would contribute to the pool according to their particular detailed circumstances. However, in practice cross-subsidies emerge in various ways: in pricing, product terms and conditions, underwriting, and claims management. Some are by design; some are a compromise; some are accidental. Some are even legislated – for example, health insurance has heavy cross-subsidies mandated (with some offsetting tax incentives), as does CTP insurance.	☐ Does the insurer have a clear policy on cross-subsidies, which considers matters such as strategy, competition, risk management, corporate values, laws and regulations, and community expectations? ☐ Does the insurer actively monitor and manage sources and levels of cross-subsidy (including those mandated by government), analyse the marketing and profitability implications, and report the position to the Board systematically? ☐ Is it clear who has authority to determine acceptable cross-subsidies?

Product Philosophy

Key Points	Questions for the Board
The product philosophy would address matters such as: • constraints (if any) on target market segments for each product line • clarity of language and transparency of intent in all material • simplicity vs complexity of product, including possibility of alternative products, and aids to affordability, such as ability for customer to restrict cover • the sustainability of the product, in the sense of product features that should not need significant change over time (particularly relevant for long-term life insurance) • minimum claims payout ratio – noting that low ratios can be due to excessive profit margins or high expenses, but in either event may produce poor value for customers • meeting community expectations, including "can we" vs. "should we", and offsets to the benefits from social security and other insurance • responding to corporate values • assessing the risks of the product against risk appetite.	☐ Does the insurer have a formal product philosophy? ☐ Does the Board review and sign off the product philosophy? ☐ Does it address all of the points listed to the left and/or is there a considered reason for not doing so? ☐ Does the Board review compliance with the spirit of the product philosophy? ☐ Would the Board be comfortable if the product philosophy were inadvertently published?

Pricing Philosophy

Key Points	Questions for the Board
The pricing philosophy would address matters such as: • technical pricing and market pricing • what account may be taken of the matter of social licence and trust mentioned in section 2.3, and the implications of this for profitability targets, including fair profit margin targets • use of loss leadership – including intention for future profitability of loss leaders • the sustainability of the pricing, in the sense that it should not need significant change over time (particularly relevant for long-term life insurance) • recovery of past losses from existing and future customers (again, particularly important for life insurance) • communication of likely price increases at the time of purchase • pricing for new customers versus established customers • approach to cross-subsidies in pricing • aids to affordability, such as monthly payments and associated loadings • minimum premiums • responding to corporate values • assessing pricing risk against risk appetite	☐ Does the insurer have a formal pricing philosophy? ☐ Does the Board review and sign off on the pricing philosophy? ☐ Does it address all of the points listed to the left and/or is there a considered reason for not doing so? ☐ Does the Board review compliance with the spirit of the pricing philosophy? ☐ Would the Board be comfortable if the pricing philosophy were inadvertently published?

Claims Philosophy

Key Points	Questions for the Board
The claims philosophy would address matters such as: • communication, including with claimants with non-English-speaking backgrounds • meeting community expectations, including "could we" vs. "should we" • consideration of corporate values • passive vs. active assistance to claimants – that is, is the insurer's starting position that a claim is valid, or that it should be denied until proven valid • approach regarding potential fraudulent claims • promptness of claims finalisation • operational preparedness for mass claims events (e.g., following a natural catastrophe) and messaging to customers • responding to corporate values.	☐ Does the insurer have a formal claims philosophy? ☐ Does it avoid platitudes such as "We pay all valid claims"? ☐ Does it address all of the points listed to the left and/or is there a considered reason for not doing so? ☐ Does the Board review and sign off on the claims philosophy? ☐ Does the Board review compliance with the claims philosophy in practice and in spirit? ☐ Has the Board satisfied itself that the claims philosophy will be honoured in the event of a mass claims event (e.g., following a natural catastrophe)? ☐ Would the Board be comfortable if the claims philosophy were inadvertently published?

Individual Customer Disputes

Key Points

There are various areas of insurance arrangements where misunderstandings or disagreements can emerge with individual customers. They include:

- the scope of coverage – for example, whether a free-standing garage is covered against fire under the home insurance policy;
- the wording of policies – for example, how a definition of disability may be interpreted. This can lead to disputes over eligibility for a claim;
- the pricing model used by the insurer – for example, this model could produce markedly different premium rates for risks that, to the layperson, appear similar;
- reasons for increases in premiums – for example, why life insurance premiums may have increased so much in recent years;
- customers seeking payments that are not technically covered by the policy, though they think they should be; and
- fraudulent claims.

Concerns of this nature, particularly if numbers are high, may indicate some underlying unfairness. Analysis of complaints information from multiple sources (internal records, Australian Financial Complaints Authority (AFCA) records, surveys of complainants, surveys of intermediaries, etc.) will provide useful insights.

Questions for the Board

- ☐ Does the Board regularly review underlying reasons for complaints to gain insights into fairness?
- ☐ Does the Board draw on multiple sources of information to gain those insights and do they go as deep as they should in order to understand fairness?

Quality of Customer Relationships

Key Points

Most insurers will assess the relationship they have with customers and other interested parties. Typically, the Board will be provided periodically with a summary. That summary may include, for example, Net Promoter Scores for various segments of customers, including those making claims.

A significant failing of typical methods is that they rely on averages. That is, they provide an average score. The Royal Commission showed that, even when average experience seems reasonable, those who have a poor experience can have a very poor experience indeed. This can be lost in average scores, and the lessons missed accordingly.

One relatively simple way of dealing with this is to analyse the views of people in the "tail" – that is, those who have had poor experiences. So, for example, analysis of the end-to-end experience of customers who have complained through the insurer's internal complaints resolution process or to the Australian Financial Complaints Authority (AFCA).

Questions for the Board

- ☐ Does the Board regularly review the quality of customer relationships?
- ☐ Is the methodology used a simple one, based on averages, or does it use sophisticated analysis to provide deep insights and nuances, especially concerning those customers who have been treated poorly, those who have complained and/or those given ex-gratia payments?
- ☐ Does the insurer assess the fair treatment of customers by intermediaries, and consider the implications for the insurer?

Agency Risk, Incentives and Culture

Key Points	Questions for the Board
Any business is exposed to the risk of management making decisions – deliberately or otherwise – in their own interests, rather than in the interests of shareholders and/or policyholders as needed. This is known as agency risk. In the case of insurance companies, there is also the risk of management not giving due consideration to the interests of customers, and indeed, the community. Remuneration, incentives and recognition could all encourage behaviour and decision-making which could lead to unfairness. Culture, and its cousin, risk culture, are equally critical in maintaining fairness over time. Attitudes to fairness in staff and management should be considered in any assessment of culture. Under the Financial Accountability Regime (to apply from March 2025) it would be helpful if fairness were specifically addressed in Accountability Statements.	☐ Does the Board apply a customer fairness filter when setting and assessing remuneration, incentives and recognition? ☐ Does the Board formally assess agency risk, and is it included in its Risk Appetite Statement? ☐ Does the Board specifically assess culture against its fairness expectations? For example, does it assess attitudes and behaviours concerning respect for customers? ☐ Do Accountability Statements clearly address fairness?