# CAXTON LEGAL CENTRE INC.

# SUBMISSION TO QUEENSLAND FLOODS COMMISSION OF INQUIRY

# TERMS OF REFERENCE (B)

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## EXECUTIVE SUMMARY AND RECOMMENDATIONS

I. Many of the problems experienced by the 175 flood affected clients of Caxton Legal Centre Inc. ("Caxton") in their dealings with insurers could have been avoided or mitigated if Australian consumers were better protected by the insurance contracts regulatory regime.

II. The Commonwealth Government is presently considering insurance reform proposals. Caxton supports reforms that:

a. improve disclosure at the time the contract is entered into;

b. provide for a standard definition of 'flood';

c. increase the take up of flood insurance;

d. implement Australian Security and Investment Commission's ("ASIC") 2000 reforms;

e. enact Australian Consumer Law unfair terms legislation for consumers of insurance products;

f. strengthen the protection of consumers in the claims handling and assessment process by developing an Australian Standard for insurance claims; and

g. impose mandatory, enforceable time limits on insurers considering claims and disputes.

III. We refer the Queensland Floods Commission of Inquiry ("the Commission") to the joint submission dated 13 May 2011 made to the Treasury Inquiry *Reforming Flood Insurance: Clearing the Water*, prepared by the Brotherhood of St Laurence, Choice, the Consumer

Action Law Centre, Financial Counselling Australia, Footscray Community Legal Centre, the Insurance Law Service and National Legal Aid. Caxton supports the proposals contained therein and believes that the proposed reforms would prevent a recurrence of many of the problems highlighted in this submission. We have included a copy of this submission as Appendix 1.

IV. Our experience in the claims handling process for 175 clients from the January disaster events, strongly supports the need to bolster the regulatory regime by introducing comprehensive and enforceable requirements for insurers. The General Insurance Code of Practice has proven to be an inadequate vehicle for the protection of our clients, as demonstrated by the case studies in our submission.

V. Briefly, the Caxton experience indicates any Australian Standard should compel insurers to:

a. record all conversations with policyholders, attach all such recordings to customer files and to provide those recordings to the policyholders at request;

b. provide all discoverable documentation to policyholders at request, including expert reports;

c. adequately resource their 'front line' claims handling divisions with staff trained to deal with customers in distress;

d. adequately train their sales staff to ensure product information is timely and accurate;

e. refrain from advising policyholders against making a claim under their insurance policy;

f. undertake the full claims process for every potential claim submitted by a policyholder or enquired about by a policyholder;

g. communicate all decisions about insurance claims in writing, with reasons; and

h. require responses to claims, provision of documents, responses to disputes, and finalisation of internal dispute resolution processes within enforceable time limits;

VI. Caxton suggests that the Commission consider recommending the creation of an adequately resourced permanent insurance law service in either a community legal centre or Legal Aid Commission in each state with a trigger funding mechanism to rapidly expand that service in times of disaster. Legal representation is essential to offset the imbalance of power between the consumer and the insurer, and without which, procedural fairness will not be achieved.

VII. Finally, Caxton suggests that the Commission consider making recommendations regarding the establishment of a publicly funded panel of independent hydrologists to support consumers in both Internal Dispute Resolution ("IDR") and External Dispute Resolution ("EDR") processes following disaster events.

## BACKGROUND

### *About Caxton Legal Centre Inc.*

1. This submission is made by Caxton on request of the Commission.

2. Caxton is the largest and longest running Community Legal Centre (CLC) in Queensland. In operation for over 30 years, Caxton offers free legal advice and social work services, publishes self-help kits and handbooks and undertakes community legal education and law reform activities.

3. Caxton's goals are:

- promoting access to justice;
- free legal advice and information;
- empowering people to address their legal problems;
- increasing community awareness of the law;
- producing plaintiff English publications; and
- working to change unfair laws.

### *Caxton Legal Centre's Flood Response*

4. Caxton was engaged in the immediate flood recovery response offering face to face contact in the Queensland Government Recovery Centres. Initially staff solicitors, staff social workers and volunteer solicitors were rostered to consistently staff two recovery centres for 2 or 3 hours a day, seven days a week. A considerable amount of staff time was dedicated to this project which ran strongly for several weeks and then tapered off as the Recovery Centres began to wind up their work. Training was also provided by Caxton staff and volunteers to broader groups of Queensland Public Interest Clearing House (QPILCH), Caxton and other CLC volunteers who were deployed to recovery centres around Queensland.

5. Caxton also employed an additional lawyer within days of the floods to provide telephone advice to people with urgent flood related problems (tenancy, employment etc). This was initiated without specific funding and it was with good fortune that Caxton was able to engage a barrister who had until recently been a generalist solicitor at Caxton. This lawyer was able to quickly respond to clients' needs and fulfilled a very important role in the weeks immediately following the floods. This lawyer worked two or three days a week for approximately 5 weeks from mid-January 2011.

6. Caxton's generalist social worker spent almost all her time (including a lot of her weekends) for the month following the floods out in recovery centres connecting clients to the legal services on offer and helping people to access information and identify legal issues. It was only in March (two months after the floods) that she was able to redirect some of her time to other work.

7. While the immediate emergency response was underway, Caxton was also engaged in collaborative planning with the Queensland Legal Assistance Forum (QLAF) group to develop a longer term (up to one year) program to meet emerging demand. From the early work it became clear that the main problem in the longer term would be disputes with insurers. Discussions with Legal Aid Queensland (LAQ) led to an arrangement which gave Caxton sufficient funding to employ three additional lawyers to work in a Disaster Recovery Unit.

8. In February 2011 the Consumer Law Service at Caxton began regular (weekly or twice weekly) meetings with the Consumer Protection Unit at LAQ to map out the Caxton Disaster Recovery Unit and to ensure it worked in partnership with the increased Insurance Law programs being offered at LAQ. The experience of both these services was drawn on to make a strategic decision to focus

additional staff resources on the internal review process with insurers.

9. With this funding, Caxton opened its Disaster Recovery Unit. This Unit is run by three lawyers and supervised by the existing Caxton consumer lawyer. The holistic focus at Caxton has meant that this new service has already connected with some of the most vulnerable disaster affected people including via home visits to meet with clients with mobility disabilities. Lawyers from the Disaster Recovery Unit have also visited Grantham, Murphys Creek and Ipswich to provide legal advice via the outreach program.

10. Caxton is now collaborating with Legal Aid New South Wales and the Consumer Credit Legal Centre of New South Wales (which incorporates the Insurance Law Service) as well as LAQ to ensure early and comprehensive help can be provided to the maximum number of clients. These four agencies estimate that, collectively, they will provide approximately 70% of the representation in relation to insurance disputes arising from the disaster events of December 2010 and January 2011. The high level of organisation, coordination and strategic thought being applied to the way these cases are being conducted is designed to ensure that the effects of the work will also be felt in the wider community.

11. The Unit has also been involved in a number of home visits in conjunction with a social worker. This is designed for clients who have physical or emotional mobility issues but who need urgent legal and social work assistance to cope with the post-flood situation.

12. Caxton has also commenced a Saturday morning flood legal help drop-in clinic. This clinic is organised and run by one of the Caxton lawyers and staffed by volunteer lawyers and law students. There is an average of 6 assistance lawyers and law students who see approximately 10 flood affected clients each week. These clients

come from Brisbane, Ipswich and the Lockyer Valley and the clinic provides an opportunity for people who cannot attend services during the week to obtain assistance for their flood related legal issues.

13. Since it opened in March, the Disaster Recovery Unit has taken on over 175 flood and cyclone affected clients and assisted them with a range of legal issues, mainly undertaking internal dispute resolution (IDR) against insurance companies.

14. As at mid-July 2011, Caxton had the following insurance law matters:

| **INSURER** | |
|---|---|
| AAMI | 12 |
| Allianz | 11 |
| APIA | 2 |
| Budget Direct | 6 |
| CGU | 8 |
| CHU | 18 |
| CommInsure | 5 |
| CUNA Mutual Group | 2 |
| Elders | 3 |
| GIO | 1 |
| Lumley Insurance | 1 |
| NRMA | 23 |
| QBE | 14 |
| RACQ | 42 |
| REAL | 3 |
| Strata Unit Underwriters | 4 |
| Suncorp | 4 |
| Westpac | 4 |
| Youi | 2 |
| Zurich | 2 |
| **TOTAL** | 167 |

| **SUBURB** | |
|---|---|
| Barellan Point | 2 |
| Basin Pocket | 2 |
| Bellbird Park | 1 |
| Bellbowrie | 5 |
| Booval | 1 |
| Brassall | 3 |
| Brighton | 1 |
| Brookfield | 2 |
| Burpengary | 2 |
| Chelmer | 4 |
| Corinda | 4 |
| East Ipswich | 2 |
| Emereld | 1 |
| Fairfield | 1 |
| Fernvale | 4 |
| Forest Lake | 1 |
| Gailes | 1 |
| Goodna | 25 |
| Graceville | 5 |
| Heliden | 1 |
| Highgate Hill | 1 |
| Indooroopilly | 6 |
| Ipswich | 4 |
| Jindalee | 17 |
| Karalee | 4 |
| Kenmore | 5 |
| Laidley | 1 |
| Middle Park | 1 |

| | |
|---|---|
| Moggill | 1 |
| Moores Pocket | 2 |
| Morningside | 1 |
| Mt Ommaney | 3 |
| One Mile | 1 |
| Oxley | 3 |
| Raceview | 1 |
| Redbank Plains | 2 |
| Riverhills | 5 |
| Rocklea | 8 |
| Rosewood | 1 |
| Salisbury | 1 |
| Sherwood | 1 |
| Sinnamon Park | 1 |
| Tennyson | 3 |
| Tivoli | 1 |
| Toorbul | 1 |
| Toowong | 1 |
| West End | 3 |
| Westlake | 10 |
| Yamanto | 1 |
| Yeronga | 8 |
| Yerongpilly | 1 |
| **TOTAL** | **167** |

15. The Commission is appointed to inquire into the performance of private insurers in meeting their claims responsibilities. Please note that while we have attempted to provide the above information in the same format as Legal Aid Queensland, our way of recording data is slightly different. Specifically, Legal Aid Queensland has grouped suburbs into areas whereas we have recorded only the actual suburb. We suggest you take this into account if combining the above information with the information provided by Legal Aid Queensland.

## TERMS OF REFERENCE (B)

### *Term of Reference (b)*

16. The Commission is appointed to inquire into the performance of private insurers in meeting their claims responsibilities.

17. Due to the significant number of Caxton clients who need assistance with appeals against insurance company denials, Caxton is in a position to comment on the performance of private insurers in meeting their claims responsibilities.

18. Caxton is primarily engaged in the provision of case work to flood affected individuals. As a consequence these submissions are relatively brief. We are imminently about to embark on a full review of all our open files preparatory to making a submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs. We would welcome the opportunity to provide the Commission with a copy of the submissions when they are completed. The Standing Committee has requested our submissions by 26 August 2011.

19. Additional information on the case studies discussed or references to particular insurers may be provided at the request of the Commission. This information however would be subject to obtaining the permission of the client involved. Many of our clients who have agreed to have their stories used in de-identified case studies are still in ongoing disputes with their insurer and would like to ensure that the resolution of those disputes are not compromised by the making of public statements at a critical stage in the process.

20. It should also be noted that these comments are being made whilst the process is ongoing and therefore are of a preliminary nature. It cannot be overemphasised how changeable the campaign for payment of these claims can be. Insurers who have seemed intractable may all of a sudden agree to pay and insurers who have been actively engaged with us may draw back. The response of an insurance company can also vary significant depending on the individual who is managing the specific claim. Caxton would like the opportunity to provide further submissions as the matters progress.

*Early Response to Terms of Reference (b)*

21. In the Queensland Association of Independent Legal Services (QAILS) submission to the Flood Inquiry, the Terms of Reference (b) issues that were encountered at that point were:

- **Non-insurance, capped payments and under-insurance**, especially in lower socio-economic areas of Brisbane and Queensland.
- **Insurer's delay** - insurers are generally taking significantly longer than average to respond to client questions and claims and organise flood responses, for example organising builders, engineers and loss assessors to attend the affected property. This is leading to significant financial hardship for some clients, such as people who have to cover mortgage and rent payments at the same time.
- **Insurer misrepresentations** – insurance companies representing to clients that they will have the same coverage but for a lower price than competitors, when flood has been removed or limited in the cheaper policy.
- **Discouragement of claims** - CLCs have come across a number of instances where insurance companies have verbally informed clients that they will not be covered by floods and actively discouraged them from putting in a claim.
- A general **lack of understanding of legalistic definitions** and terms as well as unclear disclosure - many clients have assumed that because they had a home and contents insurance policy, they would be covered for floods and storm water inundation.
- **Last-minute policies** - some clients have taken out a last minute insurance policy when the threat of flooding was

imminent but were not told about the relevant time exclusions (which range from 48 hours to 96 hours).

- **Lack of communication** from insurers - some insurers have been difficult for clients to contact. This issue is compounded by the fact that many clients have lost their home phone lines and waiting on hold for long periods of time on a mobile phone is cost prohibitive. Insurers should also ensure that 1300 or 1800 numbers are also free from mobiles.
- **Insurers not informing clients of outcomes in writing** - some insurers have been rejecting clients' claims or paying limited claims verbally and not providing written rejection letters. This makes internal and external dispute processes significantly more difficult as the basis of the rejection is often unclear.
- **Inappropriate communication** - insurers are providing information in a wordy, formal and legalistic manner. This is inappropriate, especially given the emotional distress that the clients are experiencing.
- **Inappropriate oral communication** - some insurers have been rejecting clients' claims or paying limited claims verbally and not providing written rejection letters. This makes internal and external dispute processes significantly more difficult as the basis of the rejection is often unclear.
- **Insurance brokers and agent misrepresentations** - some clients have received incorrect or misleading advice from insurance brokers regarding what is and is not covered by the insurance policy.
- **Postal delay** - in some of the badly affected flood areas, there are significant delays between when the insurer sends notices and information to clients and when the clients are receiving them in the post. This could have a significant impact on time limits for internal and external reviews.

## *Current Issues related to Terms of Reference (b)*

22. A majority of the issues previously discussed remain problematic and new issues have arisen. Each will be discussed in more depth below.

### Procedural fairness

23. There is a significant power imbalance between insurance companies and their policyholders. For example, when appealing against an insurance company denial, policyholders need to obtain information (such as telephone conversation transcripts, hydrology information, policy wording etc.) from the insurance company in support of their appeal.

24. Policyholders need to request this information from the insurance company to determine their grounds of appeal. There are procedures in place for this to happen under the General Insurance Code of Practice. In our experience however, insurers are frequently unwilling, and sometimes entirely refuse, to provide the relevant material. This means that individuals can easily become victims of procedural unfairness and have little ability to take any action against the insurance companies when this occurs. The only remedy available is to lodge a dispute with the FOS; this can take many months for a successful review and determination in the client's favour, if one is obtained at all.

25. Ensuring procedural fairness is an important aspect of the IDR process. It counterbalances the significant power imbalance and ensures that policy holders can appeal against insurance company denials with adequate information. Procedural fairness is an overall issue that is relevant to a number of other issues discussed below.

## Lack of Engagement with the IDR Submissions

26. One of the main problems Caxton has experienced is a lack of engagement by insurers with our clients' IDR submissions. This shows that some insurance companies are not substantively considering the submissions put forward by Caxton and treating the IDR stage as a 'tick a box' process. Examples of this include:

- Caxton have received a large number of **Insurance Company EE** responses to IDR submissions. We have included an example IDR response from Insurance Company EE as Appendix 2, which has been de-identified to protect the client's personal details. The responses seem to be perfunctory and not tailored to the specific submissions that have been provided by Caxton. For example, the standard Insurance Company EE response to a misrepresentation submission is:

*"We have investigated the statements alleged to have been made to your client. We do not accept that the statements were in fact made, or that if any statements were made they were reasonably relied on by your client. Our standard policy is for customer service operators to tell insureds that their policy automatically covers Flash flood [sic] and stormwater run-off, and that if they would like more comprehensive coverage against flood they would have to apply for it separately".*

No reference to the exact circumstances or discussion about what was specifically stated to the client are included. This appears to indicate that Insurance Company EE has not actually investigated the issue in-depth and has assumed that the standard procedure was followed.

- Caxton has witnessed instances of **Insurance Company CC** submissions where the wrong name has been stated in the documents. For example, one lawyer requested IDRs for two clients at similar times. The responses received from Insurance Company CC were very similar and in some instances one client's name had been used on both of the submissions. This seems to indicate that Insurance Company CC had undertaken a 'copy and paste' approach to their responses.

- The responses from **Insurance Company AA** also appear to be very pro forma and not tailored to the specific submissions provided by Caxton. We have included an example IDR response from Insurance Company AA as Appendix 3, which has been de-identified to protect the client's personal details.

**Case Study 1 - Lack of Engagement**

The client is with **Insurance Company AA.** Their claim was denied but they have a ground of appeal on the hydrology aspect of their matter. The IDR provided in-depth submissions showing that there was significant rainwater inundation (which is covered by the policy) prior to riverine flooding.

Considerable evidence was provided supporting this argument, including weather data, maps showing the proximity to stormwater drains and the policyholder's recollection of events. The IDR submission also analysed the hydrology information provided in-depth and highlighted a number of significant problems with the report, including rainwater data, delay in undertaking a review and the time difference between the initial damage and the riverine flooding. The IDR submissions were 14 pages in total.

The response Insurance Company AA provided for these in-depth submissions stated:

*"We acknowledge your comments that* [redacted] *has failed to articulated [sic] any grounds for denying [your client's] claim for loss or damage caused by storm or a sudden, excessive run-off of water as a direct result of a storm. We refer you to the Brisbane and Ipswich (ICA) [sic] Hydrology report and the individual property hydrology report from WorleyParsons Services Pty Ltd (WorleyParsons) which confirmed the nature and cause was flooding".*

This response appears to indicate that Insurance Company AA has not engaged with the detailed submissions or provided any response to the evidence of significant rainwater inundation. It did not provide any evidence that would support its version of events and it failed to address significant problems raised in relation to the hydrology report. The response merely reaffirmed the conclusion of the original hydrology report.

27. These examples indicate that some insurance companies are not engaging with the IDR process. This means that policyholders are not being afforded with procedural fairness and are very unlikely to have their decision effectively reviewed at this stage, thereby forcing them to go to the FOS to obtain a remedy.

28. It is unclear as to whether this results from:

a. a strategic decision to delay the resolution of claims and therefore the incursion of claims payments;
b. a strategic decision designed to minimise successful claims by the attrition of exhausted claimants (see Case Study 2 below); or

c. the unintentional effect of not having sufficient staff to process claims.

29. If an Australian Standard is implemented, it should ensure that insurance companies have sufficient staff to deal with claims or they may be subject to financial penalties.

**Case Study 2 - Attrition of Exhausted Claimants**

Flood victims are starting to exhibit signs of exhaustion and fatigue and no longer want to proceed with their insurance claim. This is exacerbated by the fact that a number of clients have obtained Premier's Relief Fund payments which provides up to 50% of the rebuilding costs.

The client is with **Insurance Company BB** and their claim has been denied. The client however has a strong misrepresentation ground of appeal. Caxton drafted submissions outlining the ground of appeal and sent it to the client. As it is over six months since the flood and the client has received a part payment from the Premier's Relief Fund, the client decided that they just wanted to "get on with their life" and did not want to proceed with the appeal.

If the insurance appeal was successful, the client would obtain a complete payout of their insurance claim as opposed to a part payment under the Premier's Relief Fund. This would also mean that there is more money in the Fund to distribute to the Queenslanders who need it.

## Obtaining Documents from Insurance Companies

30. Caxton has been requesting these documents on behalf of the policyholders and have found significant issues. Some examples of this are:

- **Insurance Company CC** are refusing to provide any documents, including hydrology, policy documents and transcripts, to the policy holders during the IDR process. This means that Caxton has immense difficulty providing IDR submissions and is required to go directly to the FOS to obtain the relevant documents.

- **Insurance Company DD** have a complicated customer complaints / dispute resolution departmental structure. Policyholders are required to make a request for IDR to one department, but contact a different department to ask for any required documents. Unfortunately this requirement is not clear. This means that Caxton sent request for documents letters to the department referred to on the insurance refusal letter. This department does not hold the relevant information and therefore the documents were rarely received. The lawyer is then required to undertake follow-up communication to obtain the document and the entire process is significantly delayed. This means that policyholders had to wait longer to proceed with their appeal and Caxton lawyer has to spend significant amounts of time attempting to obtain these documents from various departments.

- A significant number of Caxton's clients are with **Insurance Company EE** and it is one of the major insurers in Queensland. Until recently Insurance Company EE refused to provide any policyholders or solicitors with the hydrology information it used to determine claims. This information was withheld on the grounds of legal professional privilege. Within a week of the writing of this submission, some 6 months after the relevant

events, that insurer agreed to provide some of the requested information. This is an extraordinary delay in the provision of critical information. Once again the power imbalance is an important issue for policyholders as it is extremely difficult for individuals to dispute legalistic arguments without proper representation and a significant amount of time in which to properly ventilate the dispute, whether in FOS or the Queensland Supreme Court.

- **Insurance Company BB** should be commended on their approach to the obtaining documents. The initial difficulties obtaining documents were overcome by contacting the complaints officer who was listed on the FOS website. This complaints officer was quick to answer the phone, able to make a decision and produce the required documents efficiently. We believe that the difference was due to the fact that there was a personal name and phone number rather than a generic call centre.

**Obtaining Transcripts from Insurance Companies**

31. Misrepresentations during the sales process is one of the biggest grounds of appeal against insurance companies' denials of claims for flood damage. Unfortunately, the best source of information about the contents of a conversation must be obtained from the insurance companies which have access to the telephone transcripts (if transcripts exist for the relevant policy) or information in another format, such as phone recordings or policy notes. We are unaware of any legal obligation which requires insurance companies to record telephone conversations.

32. Caxton's standard policy is to request a transcript of the telephone conversation in our initial letter to the insurance company. Of the 175 clients we assist, we have only obtained transcripts for a

handful of matters. Without this transcript it is difficult to provide accurate submissions on any misrepresentation that may have been made to the client. **Insurance Company FF** should be commended as the only insurance company which is providing copies of the requested transcripts.

33. We are uncertain why transcripts are not being provided by the insurance companies. In some instances it could be because the telephone conversation was not recorded and therefore no transcript exists. However, the insurance companies are not providing reasons why the transcript is not provided; they are merely not providing them.

34. The problem of the lack of provision of the transcripts is exacerbated by the general approach by insurance companies of discounting policyholders' recollections without corroborating written evidence. In addition, FOS finds itself unable to test evidence on oath and is, therefore, also generally reluctant to credit evidence provided by individuals where that evidence is contentious and there is not documentary support. This means that clients with misrepresentation aspects to their dispute may need to consider taking their further action in a court which will accept oral evidence and also provide for proper disclosure processes. This seems an extraordinarily onerous process for obtaining a document or recording that is relatively simple for the insurer to find and provide.

35. **Insurance Company GG** should also be commended for their approach to this issue. If a transcript cannot be obtained because no recording was made, Insurance Company GG is asking clients for a statutory declaration of the telephone conversation. We are not aware of any other insurer that is taking this approach.

## Delay in Responses to IDR Submissions

36. Under the General Insurance Code of Practice, insurance companies are required to respond to IDR submissions within 15 business days. In addition to this, the FOS Terms of Reference and ASIC Regulatory Guide 165 provide a 45 day period to respond to IDR submissions.

37. We understand that insurance companies are receiving unprecedented numbers of IDR submissions and therefore may have difficulties responding within the required time. Insurance companies' responses to these issues have however been very varied.

**Case Study 3 - Delay**

The client is with **Insurance Company AA.** Their claim has been denied and Caxton appealed against the decision. It took Insurance Company AA eight weeks to provide a response to IDR submissions.

The lawyer involved in the matter attempted to contact the relevant case manager by telephone on a number of instances without any success. It was only when the lawyer contacted the head of the Customer Relations Department and made a complaint about the delay did anything occur on this matter.

- **Insurance Company GG** should be commended for their approach to this issue. Insurance Company GG have contacted the relevant lawyer on each of the relevant files every 10 business days to provide an update on the appeals process and explain any delays that are being experienced.

**Case Study 4 - Delay**

The client is with **Insurance Company EE.** Their claim has been denied and Caxton sent submissions on behalf of the client on 24 May 2011. At the time of writing, this matter remained unresolved. The lawyer on this file has attempted to contact the insurance company's solicitor on numerous occasions by telephone and email for a number of weeks, but no response was received.

An email was then sent to a different person, and a response was received stating that further time was needed to review the claim.

At the time of writing, the client has been waiting over 10 weeks for a response to the IDR submissions.

**Inappropriate / Insensitive Comments from Insurance Companies**

38. Caxton has a number of clients who have been subject to inappropriate and/or insensitive comments from insurance company employees during the claims process. This is concerning, especially given the trauma that they have already experienced. These types of comments could have a significant impact on the client's wellbeing, including discouraging them from proceeding with the insurance claim.

39. Caxton has also received reports of offensive, insulting comments being made to clients during the claims process. They have come from a variety of insurance companies and it appears to be an industry-wide issue.

**Case Study 5 - Insensitive Comments**

Caxton has various complaints about one case manager with **Insurance Company AA.** We have been informed that this case manager is very intimidating throughout the claim process. Our clients believe that this approach is designed to make them back down about their claim.

An example of insensitive behaviour occurred when an Insurance Company AA client was discussing potential rainwater run-off issues. The claims manager made a joke stated "maybe your neighbour left the garden hose running". Complaints have been made to Insurance Company AA about this case manager, but we are unaware of any steps being taken to correct these types of actions.

**Case Study 6 - Insensitive Comments**

The client is with **Insurance Company HH.** The contacted the insurance company to make a claim against their policy. When the client discussed the potential for storm damage, the sales consultant said words to the effect "have you been living under a rock, it wasn't raining".

**Discouragement of Claims**

40. Caxton has received a high number of reports of policyholders being overtly discouraged from placing an insurance claim on the grounds that flood is excluded in their insurance policy. For example, when some clients have called to put in a claim, they have received

responses such as "your policy does not include flood and therefore you are not covered". After receiving this information, clients are not proceeding with the claim. Another example is when a client contacted to make a claim under a landlords insurance policy. The employee stated words to the effect "You didn't have a tenant, therefore you will not be covered".

41. It will be nearly impossible to determine the number of people who have not proceeded with a claim because of verbal discouragement from the insurance company. Considering the anecdotal evidence we have obtained on this practice and the large number of people affected by the floods, it is likely that the number is very high. These people are also unlikely to seek legal assistance about their claim and therefore have been denied the opportunity to have their claim properly assessed and appeal any unfair or incorrect decisions.

42. It is important that all potential claims go through the full assessment and claims process, which usually includes a review of the policy, loss assessment and hydrology. This reduces the possibility that claims are unduly denied. It also ensures that policyholders who may have a claim on a ground other than flood (for example, initial inundation by stormwater) will be able to receive their entitled payout.

43. Caxton submits that this is an important issue as the discouragement of potential claims is a denial of procedural fairness to policyholders. Insurance companies should therefore be prevented from discouraging any claims and be required to undertake the full claims process for every potential claim submitted by policyholders.

44. All decisions on insurance claims need to be provided in writing to the policyholders, providing reasons for the decision and information on the relevant appeals process.

**Case Study 7 - Discouragement of Claims**

The client is with **Insurance Company BB.** Their client contacted the Call Centre to make a claim against her policy. The employee quickly responded "That's flooding, you're not covered". She then quickly listed the complicated definition of flood and asked for the postcode of the property. When the employee heard that it was an Ipswich postcode, she confirmed that it was a flood and stated that the policy would not cover the damage.

If the client did not talk to another employee about this matter, she would not have proceeded with her claim. After seeking advice from Caxton, the client has a strong case for misrepresentation and hopefully will have a successful appeal against the decision.

**Insurance Brokers and Agent Misrepresentations**

45. Caxton has a number of clients who have been subject to misrepresentations from insurance brokers or authorised representatives of insurance companies. We believe that insurance companies should be liable for any comments made by these people and pay out the insurance claims of policyholders who have been subject to these misrepresentations.

46. Caxton has submitted a number of IDRs for these matters, but have not yet received any responses from insurers. We are therefore unsure how insurance companies are going to react to these issues and whether they will take responsibility for any misrepresentations made by agents and brokers.

### *Issues No Longer Prevalent to Insurance Claims*

47. As a vast majority of insurance claims have already been submitted, some of the previous issues are no longer prevalent problems.

48. **Lack of communication** is not an ongoing issue as most insurance companies no longer have long waiting periods for telephone communications. This was, however, a significant cause of anger and distress in the weeks following the relevant events. It needs to be recognised that after a disaster, mobile telephones are both the only way to communicate and also a lifeline. Caxton received reports of mobile phone 'credit' being expired waiting for insurers to answer calls and consider that in such an event this is highly undesirable and very unfortunate. Insurers should be required to have 1300 and 1800 numbers that are free from mobiles.

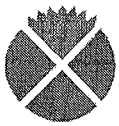
49. **Insurers not informing clients of outcomes in writing** - we still have a number of clients who have not received their insurance outcomes in writing. This makes it difficult for clients to appeal decisions. This issue will largely be resolved by the implementation of an Australian Standard.

50. **Inappropriate communication** to policyholders is no longer a predominant issue for our clients as Caxton receives the correspondence on behalf of our clients.

51. As postal service has returned to almost all of the flood affected areas, **postal delay** is no longer a significant issue.

52. We note that these issues are no longer predominant due to the passing of time and the fact that almost all the insurance claims have been submitted. The problems have not been resolved and could arise again if a similar natural disaster arises in the future. It is therefore worth considering these issues for potential law reform.

Appendix 1: Joint submission to Reforming Flood Insurance: *Clearing the Waters discussion paper*



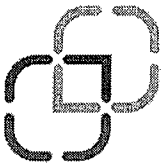
Brotherhood of St Laurence
Working for an Australia free of poverty

choice

financial counselling australia

Footscray
Community Legal Centre Inc

Insurance Law Service



National Legal Aid

consumer action law centre

13 May 2011

**By email: icareview@treasury.gov.au**

Flood Insurance: Proposed Reforms
c/- Insurance Contracts Act Review
The Treasury
Langton Crescent
PARKES ACT 2600

Dear Sir/Madam

**Joint submission to *Reforming Flood Insurance: Clearing the Waters* discussion paper**

The following is a joint consumer submission in response to the *Clearing the Waters* discussion paper (the discussion paper) released by the Australian Government on 5 April 2011. The Brotherhood of St Laurence, Choice, Consumer Action Law Centre, Financial Counselling Australia, Footscray Community Legal Centre, Insurance Law Service at Consumer Credit Legal Centre NSW and National Legal Aid have all contributed to this submission. We welcome the opportunity to comment on the discussion paper. Background on each of the contributors can be found in the Appendix.

We generally welcome the reforms proposed by the discussion paper, subject to the remarks made on each proposal below. In addition, we have suggested further reforms which were not canvassed by the discussion paper but which we think are nonetheless required to achieve a comprehensive response to issues around flood insurance. We expect that such reforms will also be considered through the Government's Natural Disaster Insurance Review.

In brief, this submission addresses:

- The proposed standard definition of flood
- the proposed key facts statement
- time limits for claims handling
- Centrepay processing for premium payments
- Further reforms

## Standard definition of flood

*Introductory Remarks*

We support the proposed definition of flood as outlined on page five of the discussion paper.

The proposed definition is reasonably clear and, subject to our comments below, should go some of the way to meeting the objective outlined by Treasury at paragraph 23 of the discussion paper, of providing consumers with a better understanding of whether an insurance policy includes cover for flood.

Whilst we support the proposed definition of flood, it is important to note that developing a standard definition of flood is only one in a series of tasks that will be necessary in order to reduce consumer confusion about flood cover. This is discussed further at the end of the paper.

*Answers to consultation questions*

*Are the concerns noted [in the discussion paper] regarding consumer confusion about flood cover still valid?*

Yes. As early as 2000, ASIC identified In ASIC Report No 7 into Consumer Understanding of Flood Insurance[1], a series of concerns with the state of consumer awareness in the Australian insurance market on their level of cover for flood.

As ASIC correctly noted, the consumer consequences of consumer confusion about flood are typically more serious than they might be for most other issues arising under house and contents insurance policies because of the potentially devastating effect of floods. [2]

Amongst other things, ASIC recommended a common definition for flood. However, it warned that a holistic approach to flood issues needs to be adopted to address consumer confusion in this area. ASIC found that[3]:

- Insurance sales representatives may not be adequately trained to provide information or answer consumer queries about the availability and nature of flood cover;
- Because home and contents insurance documents are often difficult to understand on the issue of flood insurance, consumers may not be aware whether they are covered for flood and, if they are, about the importance of the distinction between flood and other storm damage; and
- The process for assessing flood insurance claims is usually complex and may be confusing for consumers. For example, insurance companies may use a hydrologist to determine the primary cause of water inundation.

[1] ASIC, *Consumer Understanding of Flood insurance*, Report 7, June 2000.
[2] As above at p 3.
[3] As above at pp 2-3.

As is outlined below, ASIC's concerns from 2000 have been mirrored in our casework experience from the recent Qld floods.

ASIC made recommendations[4] in 2000 that improvements could be made in three key areas: education, sales processes and disclosure.

With regards to **education**, ASIC found that consumers need to be aware that they should consider the risk of flood when purchasing a house and contents insurance policy, or when reviewing the level of cover provided under an existing policy. Therefore, ASIC recommended that consumers ask the following questions when purchasing or reviewing a house and contents insurance policy:

- Do I need to obtain cover for flood damage?
- What policy is available that will provide me with this cover? and
- Does my current policy cover flood?

Regarding **sales processes**, ASIC recommended that insurers prompt consumers to consider the risk of flood prior to taking out a home and contents insurance policy, particularly where the consumers are located in an area known to be flood prone.

Insurance sales representatives, including telephone-sales staff, should also be adequately trained so that they are able to effectively explain the availability of flood insurance to consumers. ASIC recommended that this should include the ability to explain the difference between damage caused by storm water (which is generally covered) and damage caused by flood (which is generally not covered).

Finally, with regard to **disclosure**, ASIC specifically recommended that:

1. The standard use of key common terms should be explored;
2. The distinction between flood, storm and rainwater needs to be clear and consistent;
3. The concept of proximate damage needs to be made clear;
4. The distinction between "all in cover" and "defined event" policies should be clear; and
5. Information about cover for flood should be given where possible at renewal.

Unfortunately, the ASIC recommendations have not been heeded by industry over the last decade. Generally speaking, reforms were not made in the manner outlined above, apart from a failed attempt in 2008 to implement a sweeping, flawed and voluntary common definition of flood[5].

The consequence of that inertia from 2000 to date has been a market failure to adequately respond to significant natural disaster events. Our recent casework experience in respect of the Queensland flood disaster and elsewhere has been that:

- The marketplace features various different definitions of flood, usually relied upon as an exclusion clause, rather than as part of cover[6]: For example, National Legal Aid came

[4] As above.
[5] See 2008 ICA application to ACCC for common definition of flood, www.accc.gov.au/content/index.phtml/itemId/841725.
[6] Though we do note that market trend in the last few years is to slowly move toward cover. However, in the Queensland flood of the 25 insurers who offered home and contents insurance, only three insurers provided full cover for their consumers.

across 11 different definitions of flood in its work in the Wagga flood and 18 different definitions in the Queensland floods;

- The definitions of flood were in fact a confusing mixture of definitions that included all three of the ICA's broad categories for inundation - stormwater/rainfall run off, riverine/inland flooding/flooding and actions of the sea/sea level rise/ storm surge;

- Consumers who have had their claims refused have expressed widespread confusion and concern that they thought they were covered for flood when in fact they were not;

- Much of that consumer confusion and concern related to misrepresentations at that time of sale of cover over the phone including:

    - Failing to advise consumers of a 72 hour waiting period after taking out the policy before cover applies

    - Advising people their policies would provide the equivalent level of cover to rival policies when in fact it did not

    - Giving consumers the impression that flood cover was automatic and uncapped

    - Not advising of sum insured amounts - which leave consumers effectively unaware that they are underinsured

    - Insurance being sold in person or on the phone by frontline Bank staff as agents of the insurer who do not have an appropriate understanding of Insurance to allow them to answer basic features of the product

    - Statements being made like "*You are covered for all you need.*"

    - Consumers in Queensland given information relevant only to NSW policies

- Many consumers were unaware that they only had limited cover for flood, and that:

    - The only time they became aware of their level of cover for flood was when they came to make a claim and their insurer advised them that the limitation was in their Product Disclosure Statement (PDS)

    - To understand their level of cover involved reading various technical definitions within the PDS and then piecing together the legal implications of the limits of cover

- The reality for many Australians who lost their homes or property is that their insurance did not indemnify them for the most significant insurance event of their lives:

    - Whilst the majority of claims were paid in Qld floods, the refusal rate for this disaster event was significantly higher than industry average[7]

    - A significant number of Australians were not indemnified for their significant loss

[7] On average, insurers pay out on 98% of insurance claims (ICA website – Myths about General Insurance ica.com.au). In relation to the flood disaster, insurers paid out on approximately 85% of claims: Courier Mail, 8 April 2011. Given the 49,400 claims in respect of Qld floods, 7410 claims have been rejected.

- Many consumers were the victims of poor claims handling by insurers which included, amongst other things:

    - Serious delays in processing and confirming in writing of refused insurance claims

    - Insurers advising consumers on the phone *"You're not covered for flood – you can't make a claim"*

    - Insurers advising consumers at an early stage after the floods that they would be indemnified - but then consumers still waiting some four months after the floods for the insurer to know whether the insurer is going to pay the claim

    - Insurers pressuring consumers into accepting a limited settlement of their claim

    - Insurers engaging contractors that provide low-end quotes and incomplete scopes of works before making a low lump sum payment offer

    - Insurers requiring consumers to provided itemised lists of contents lost, including getting quotes from suppliers for each item and calculating depreciation on each item – even in situations of total loss on a sum insured policy where there is no allegation or evidence of fraud

    - Insurers outsourcing significant quantity of their claims work to private solicitors - who used legal concepts like "legal professional privilege" as a basis for not providing hydrology reports they have relied upon to refuse claims

Resolving these issues will require a broader range of reform than envisaged by the discussion paper. Some further reforms we suggest - unfair contract terms protection for insurance consumers and an Australian Standard for claims handling and assessment - are discussed at the end of this submission.

*Is the proposed wording of the standard definition appropriate?*

We support the proposed definition of flood as outlined on page five of the discussion paper. It represents a significant improvement on the last attempt[8] to devise a common definition of flood. We do not propose at this stage any different wordings or approaches for the standard definition of flood.

*Should water escaping from water channels constructed within natural watercourses be treated in the same way as water escaping from natural watercourses?*

And

*Does the language in proposed paragraph (a) [of the standard definition of flood] cover those water channels and, if not, would it be appropriate to add some further elements to paragraph (a) or (b) to ensure that such water channels are included?*

Water escaping from water channels is already accommodated to the appropriate degree in the proposed standard definition wording in the discussion paper, and should not be given its own additional reference within the standard definition of flood. This is because:

1. Water channels constructed within natural watercourses will naturally fit within the existing proposed definition - as natural watercourses that have been altered or

[8] See 2008 ICA application to ACCC for common definition of flood.

modified. Water escaping from water channels within natural watercourses fits with what a consumer would reasonably or ordinarily understand to be flooding; and

2. Water channels which are not constructed within a natural watercourse should not be considered as part of the flood definition, as they contain a meaning more ordinarily associated with storm (including storm water channels), not flood. For this reason, including these kind of water channels would offend key guiding principles of a common definition including that the definition should align with the natural ordinary meaning of flood, and the definition should give proper disclosure of risk.

*Implementation of a standard definition*

We support the implementation of a standard definition of flood through separate provisions within the *Insurance Contracts Act*.

We note and agree with the analysis in the discussion paper that there may be limitations in using the standard cover regime of s 35 Insurance Contracts Act as a vehicle for these reforms, including that s 35 would not prevent insurers from modifying the standard definition, undermining the purpose of the reform to provide for one standard definition of flood, and that s 35 does not ensure consumers are effectively advised of what matters are excluded from cover.[9] The new regime should set higher standard of disclosure than s 35.

However, the definition of flood for the purposes of standard cover should be aligned with the standard definition of flood.

*To what types of insurance policies should the proposed new rules apply?*

A broader category of policy holders including body corporate/strata insurance and small business insurance would benefit from a standard definition of flood. As stated above, a new regime proposed under the *Insurance Contracts Act* for a standard definition of flood should align with but take precedence over existing provisions of s 35, thus they can be drafted to cover a broader category of insurance policies than home and contents policies.

It is our casework experience from the Queensland floods that a great many people living in body corporate/strata units were not covered for flood by the body corporate/strata insurance. As noted by the paper, this proposal would not force insurers to offer flood cover to bodies corporate or small businesses, but it would help these consumers to understand the cover offered by their insurance policy and to consider what risks they need cover for.

*Are there cases of consumer confusion with other categories of inundation risk?*

Yes. Some policies on the market contain unfair or unusual definitions of storm or flash flood as a basis for limiting cover, so providing a standard definition for flood may not protect such consumers from unfair or unusual definitions for other categories of inundation. For example, one policy we have seen confuses rainwater and runoff with flood. Another turns rainwater into flood the minute the rainwater hits the ground.

We are aware of cases in the Qld floods, where consumers have had their claims denied or reduced dramatically based on unusual definitions of water inundation.

Company A, for example, excludes cover for flood, and then caps cover for flash flood and storm water run off at 50% of the value of the policy. The policy states that it covers damage for storm but not for rain after it hits the ground.

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[9] See for instance *Hams v Anor v CGU Insurance Limited* (2002) 12 ANZ Insurance cases 61-525, where provision of PDS was sufficient compliance with requirements on clearly informing of derogation from standard cover.

*Are there possible advantages of standardising a broader spectrum of inundation risk?*

We do not at this point have a firm position on whether standard definitions for other categories of inundation risk are required. However, it is clear from the example immediately above that confusing and unfair definitions currently exist.

If consumers were afforded the protection of unfair contract terms regulation for insurance at the same level of protection in the Australian Consumer Law, this would help to address unfairness in the drafting of terms relating to other forms of inundation risk, without the need to prescribe standard definitions. This is the solution we recommend at this stage.

## Key Facts Statement

*Introductory remarks*

We support the introduction of key facts statements for three main reasons:

- **Comprehension:** key facts statements will give consumers a better understanding of what their policy covers and what it does not, accepting the reality that very few people read and understand their PDS;
- **Comparison:** key facts statements will help consumers shop around for insurance by allowing easy comparison between competing policies, improving competition; and
- **Product safety warning:** key facts statements will give consumers important information relating to under-insurance, which is a serious and endemic problem in Australia – consumers must be warned as to whether a home building policy is sum insured or total replacement, and that purchasing a sum insured policy comes with considerable risk of not having sufficient cover to indemnify for loss.

Our suggestions below should be seen in light of these objectives.

We agree with the sentiment in the discussion paper that key facts statements should not be a substitute for Product Disclosure Statements (PDS) (paragraph 48), which contain the full terms and conditions relating to an insurance policy. However, we accept the reality that most consumers do not read their PDS, probably because they are discouraged by their length and complexity. When people do not read their PDS they cannot fully understand their policy, which can have terrible consequences. Further, even if a consumer does read the PDS, they might not understand it or become overwhelmed by detail. As we saw in January's floods, many people affected simply were not aware that their policy did not cover them for the damage they endured. In addition to enormous personal hardship, this increased the financial burden of reconstruction on the broader public.

A key facts statement does not replace a PDS because it cannot provide the same level of detail, but this is as much a strength as a weakness. The lack of detail in a key facts statement enables it to set out the most important points of the policy clearly and simply in a way that a PDS cannot. By providing for the two documents to be given to consumers (we recommend at different stages in the transaction - see below), we retain detail but improve clarity and accessibility. This will help consumers make better decisions about insurance coverage, which is good for consumers, the industry and the community at large.

A key facts statement will also encourage competition between insurers as it will allow consumers to compare key elements of two or more policies easily - so long as it is made

available at the shopping around and insurance quote stages. In the context of flood insurance, for example, key facts statements will quickly tell consumers in flood prone areas which policies provide flood cover and which do not. This kind of comparison is much more difficult and time consuming to do using a PDS alone. A population with a clearer idea about which policies include flood cover (and of the price of flood cover) will send clearer demand signals to providers, improving the range of products on offer.

We also support the Government's intention to subject a revised key facts sheet to consumer testing on its content and layout before the requirements are finalised (paragraph 55). Testing will be critical to ensure that the key facts statements ultimately required to be produced are, in practice, able to be used effectively by consumers.

*Responses to consultation questions*

*Are there any disadvantages with a combined key facts statements where a PDS is also combined?*

We do not support allowing for a combined key facts statement for a home building policy and a home contents policy simply because an insurer chooses to issue a single PDS covering these products.

Home building and home contents insurance are, quite clearly, different products. The purpose of the key facts statement must be to allow for simple and easy comprehension and to facilitate easy comparison with like policies offered by other insurers, facilitating competition *on both products*. Consumers may, but also may not, purchase both types of policies together. First, any insured home that is rented will be subject to policies covering the building and the contents that are shopped for, purchased and held by different parties. Secondly, even owner-occupiers often shop for and purchase the two policies from different insurers.

A combined key facts statement will make it harder for the consumer to compare either the home building or the home contents policy with other home building or home contents policies - and each policy *should* be separately considered and compared. A review of recent CHOICE reports on home building and home contents insurance policies reveals that the insurers with the best buys for home building policies do not necessarily provide the best buys for home contents policies.[10]

Insurers have an interest in bundling these products to increase sales and dampen the incentive for consumers to properly compare each policy. This sort of bundling can potentially save consumers money in the form of a discount for holding more than one policy with an insurer, but it can also cost consumers money if it dampens competition in one or both of the policy types. Thus, while insurers should of course be allowed to continue to offer packages or incentives to consumers to purchase both policies with the one insurer, to drive better outcomes overall this must be balanced by facilitating consumers shopping around on both policies, not merely on one with the other choice following automatically. Without this, insurers would also be encouraged to, in a sense, "loss lead" to some extent with one type of policy.

We also believe that combining a key facts statement for the two types of policies will make it harder for the consumer to notice and understand the most important features of each policy.

[10] CHOICE, *Home and contents insurance comparison and review*, updated 14 January 2011, www.choice.com.au.

For example, whether a policy is sum insured or total replacement is only relevant to home building policies. Exclusions or damage types covered must be set out for both policy types, increasing the clutter on the page if combined - and it is not only the amount and type of the content in the key facts sheet that will be important to its ease of reading and comprehension, but also its layout and elements such as the amount of "white space". Further, we suggest that special benefit limits might also be treated differently in the key facts statements for the two different policies (see below).

These issues could be further investigated during product testing.

*Is the proposed treatment of policy type [discussed at paragraphs 58-60] appropriate?*

We agree with the Government that the type of policy - sum insured or replacement cover - is one of the most important features that consumers should be aware of when considering a home building policy. We strongly support the proposal to require the type of policy to be disclosed in a simple and clear fashion toward the top of the statement.

We also agree that simply stating the type of policy alone will not be sufficient, because most consumers will be unaware of the meaning and difference between the policy types. However, we do not believe that the proposed description of 'covered amount' alone will address this problem, because it is not directly related to the policy type section. A generic description of the policy types on the reverse side of the statement is even more unlikely to be read or considered by most consumers (and if online, will appear further down the page in a larger section of text, thus again is unlikely to be considered by readers).

We suggest adding a very brief definition of each option in the 'policy type' section itself. As well as giving consumers a better idea of what each policy type is, this section should be used to encourage consumers to consider the merits of total replacement policies. This might look something like:

| Description of your home insurance policy | | | |
|---|---|---|---|
| Policy name | XYZ Home Building Classic | | |
| Policy type | ☑ Sum insured | ☐ Sum insured plus margin | ☐ Total replacement cost |
| | ### | ### | ### |

The discussion paper at paragraph 59 states that a sum insured policy set at too low an amount "is a potential cause of underinsurance". We do not think this puts the case strongly enough. As ASIC's reports into this issue indicate,[11] sum insured policies are the most common and natural cause of underinsurance because most consumers are simply not in a position to accurately predict the cost of replacing their home and contents, and many rely on insurers to estimate these costs. This is particularly a problem after a large event like a natural disaster, when costs of repairing and rebuilding increase. Essentially, the decision between a sum insured policy or a total replacement policy is a matter of which party bears the risk of the costs of under (or over) insurance, as explained by ASIC:

[11] ASIC, *Getting home insurance right: A report on home building underinsurance*, Report 54, September 2005; ASIC, Making home insurance better, Report 89, January 2007.

> The most common home building insurance policy in Australia (known as a sum insured policy) places the risk of an incorrect estimate on the consumer... Under total replacement policies, the insurer accepts responsibility for estimating rebuilding costs.[12]

We are of the firm view that a greater take-up of total replacement policies will significantly reduce the underinsurance problem in Australia. For this reason, we feel that any description of each policy type should be specifically designed to encourage demand for total replacement policies. Descriptions could be along the lines of the following:

> **Warning:** Sum insured: "the policy will only cover you up to a fixed amount"
> Total replacement: "the policy will cover all repairs or replacement, whatever the cost"

Under the "covered amount" section where there is more space to describe policy types, the statement should go into more detail. For example, for a sum insured policy we suggest something like:

> This policy is a sum insured policy, which will only cover you up to a fixed amount, agreed by you. This could mean that you do not have enough insurance coverage to repair or rebuild your home. You should consider whether a total replacement policy is better for your needs.

This approach is attractive because it facilitates a market solution to the problem of underinsurance. It avoids prescriptive requirements on insurers to offer particular insurance products, which may unnecessarily increase costs to consumers if these products are not wanted by all consumers. However, it provides consumers with the information they need to make an informed choice between sum insured and total replacement cover, sending more accurate signals to insurers about consumer preferences regarding how the risk of underinsurance should be covered.

*Should the wording of a note on how to use the statement be prescribed?*

A note referring consumers to the full PDS may be useful, so long as it is simple and clear and is standardised so that its wording and placement in the key facts statement do not detract from the key facts statement's overall effectiveness. In our view, the key facts statement should be standardised as much as possible.

Perhaps a better option would be to design the key facts statement so that important information was accompanied by a reference directing the consumer to the specific relevant clause(s) in the full PDS for more details. This can be done in a format that does not detract from overall ease of reading - for example, see the key facts statements for loan products tested in the March 2010 report on disclosure simplification produced by Uniquest for the Standing Committee of Officials of Consumer Affairs.[13]

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[12] ASIC, *Getting home insurance right: A report on home building underinsurance*, Report 54, September 2005, p 20.

[13] Paul O'Shea, *Simplification of Disclosure Regulation for the Consumer Credit Code: Empirical Research and Redesign - Final Report*, Prepared for the Standing Committee of Officials of Consumer Affairs by Uniquest Pty Limited,12 March 2010.

*What advantages and disadvantages would there be in prescribing events that should be addressed in the 'what is covered' list?*

We strongly recommend that, if the format on page 11 of the discussion paper is chosen, the list of events to be listed on the key facts sheet must be prescribed to ensure clarity about what is and is not covered by the policy, and to allow easier comparison between products. However, this does not only apply to the 'what is covered' list. If an event is prescribed that event must be listed on the key facts statement whether covered or not. In other words, if the format on page 11 is used, all prescribed events would need be listed either on the 'what is covered' or on the 'what is NOT covered' lists.

Prescribing the events covered will ensure that exclusions for key events will be made clearer. Where a list of events is not prescribed, insurers may simply avoid mentioning events that they do not cover but that are not required to be listed in the 'what is NOT covered' section. This would be a poor outcome for consumers, who need to know whether a policy covers a particular risk in order to make an informed choice about which policy to buy. It would also be directly contrary to the discussion paper's objective for the key facts statement "to allow consumers to quickly and easily check the basic terms of the insurance policy, including the nature of cover and any key exclusions" (paragraph 47).

Prescribing a list of events will also ensure that consumers are aware that similar types of events may be covered differently by the same insurer. Even with a standard flood definition, many consumers will not be aware that their insurance policy insures flood, storm and sea surge damage differently. For example, assume a policy covers storm damage but not flood damage and that a list of events is not prescribed. If the insurer includes 'storm' as an event that is covered but doesn't list 'flood' on the statement at all, consumers may reasonably assume that a flood following a storm will be covered under their policy (as was the case in Queensland's recent floods). Where all three risks are listed, a consumer can clearly see that storm is covered but flood is not.

We also believe that prescribing a list of events is important to, conversely, limit the additional matters that insurers might otherwise choose to include in the 'what is covered' list but that are not essential to the consumer's understanding of the most important features of the product. There is a risk that, without a prescribed list, insurers would choose to list a number of matters on the key facts statement to make the policy appear more comprehensive and attractive, for example component parts of events that would ordinarily be considered one item or other standard elements of insurance policies. This would clutter up the statement, making it harder for consumers to read it and identify the most important elements, and potentially turn the statement into more of a marketing or promotional document, undermining the purpose of this reform.

An arguable disadvantage of prescribing the list may be that insurers offering cover for events not on the prescribed list will not be able to promote those differences through the key facts statement, however, as noted above the greater risk is precisely that insurers would choose to list too many things on the statement. If insurance changes over time and different events emerge that are of genuinely more interest to consumers, the regulations can be changed to allow other events onto the key facts statement. In addition, insurers will still be free and able to mention other types of cover or features through their promotional material.

*Is the list of prescribed events in the standard cover regulations suitable for that purpose?*

Broadly speaking, yes. The existing list of events prescribed in the regulations is intended to reflect the most important events consumers would typically expect to be covered for under these policies, thus it would be sensible to use the same list to determine the events most relevant for inclusion in a key facts statement. Using the existing list will also be administratively efficient and avoid delay in determining a new list.

We note however that the prescribed standard cover events for home buildings and home contents insurance are set out in a list that has some events in groups (for example storm, tempest, flood, action of the sea, land slide) that should be separately set out in a key facts statement, and uses some terminology that could be simplified. We therefore suggest that the list of 'what is covered' events prescribed for the key facts statement be based on, but a clearer version of, the list of events in the standard cover regulations. These would also require a list of over 15 events. This may mean the key facts statement needs to be re-formatted to fit a larger table.

*If an order of events were to be prescribed, what is an appropriate way to determine the order?*

We believe the order of events should be prescribed to make the key facts statements as standardised as possible. While we have no view on the specific order, we suggest that events that are similar (for example, storm, flood and sea surge) need to be listed separately but follow one another in the order to ensure consumers understand that they are separate risks and may be treated differently under the policy.

*Should there be any prescription of how the covered event is described in the list? What sort of rule could be appropriate?*

Wherever possible, events should be described as a single word or phrase accompanied by a short sentence description, as in the Fire example in the consultation draft on page 11. A sentence gives a better understanding of the risk that is covered than a single word (even though the single words will still be accompanied by a list of exclusions in the 'what is NOT covered' section). For example, the word 'flood' would be construed broadly by many consumers, but adding a short sentence (based on the proposed standard definition) would give a more accurate impression. For example:

> **Flood:** the covering of normally dry land by water escaped from lakes, rivers, reservoirs, canals or dams. (refer to paragraph x.yz in your PDS)

As noted above, referring consumers to the relevant section in the PDS (along with general statements about how the key facts statement is to be used) will help consumers to find the complete definition and not assume the definition on the statement is the contractual definition. However, a reference to the PDS definition is recommended regardless of whether the event is described in a sentence or a single word.

We note that a lack of space on the key facts statement may mean it is not possible to describe each event, particularly if insurers are required to list 15 or more events. We suggest this be considered during product testing.

*If a covered event is subject to a special benefit limit, should that limit be disclosed together with the covered event, in the adjacent 'what is not covered' space, or otherwise?*

We agree that special benefit limits must be disclosed in the key facts statement. If the format proposed on page 11 of the discussion paper is used, we currently have no strong preference in relation to home building policies, as long as such limits are clear and unambiguous (but see our response below regarding the proposed format at section 69 of the discussion paper).

In relation to home contents policies, there may be a range of actual goods (or content types) that may be subject to benefit limits, for example jewellery or electronics. This can be contrasted with benefit limits in relation to the cause of the damage, for example damage caused by flood. Key facts statements for home content policies do not need a "policy type" section towards the top of the statement because the sum insured versus total replacement issue is not relevant - instead, below the list of events covered and not covered, we submit that the statement should include a section that requires specific contents subject to a special benefit limit to be listed along with the amount of the limit.

More generally, we suggest that how best to disclose special benefit limits could be investigated during product testing - we would choose the options that lead to the most consumers understanding and recalling any such limits.

*Is it feasible, in a single page format, to require all derogations from standard cover to be mentioned in the 'what is NOT covered' list?*

Any wholesale derogations from standard cover, for example an exclusion for flood damage, an exclusion for damage from actions of the sea or an exclusion for damage caused by the escape of liquid, should be required to be included in the 'what is NOT covered' list.

However, there may also be a number of partial derogations from standard cover events under a policy, for example, damage caused by the slow escape of liquid as opposed to any escaping liquid is a partial derogation. It may not be possible to list all partial derogations from standard cover on the key facts statement if they are too numerous, and indeed listing every exclusion in detail could make the key facts statement less accessible and so less useful. However, where it is not practical to list all derogations, those listed should be the most significant derogations (for example, exclusions of more common scenarios, or exclusions which, as the discussion paper suggests, cause most confusion for that type of policy - this should be determined by looking to the reasonable expectations of an insured about that type of cover as a guide).

In addition, the consumer should be put in a position where they can easily find the other exclusions in their PDS. For example, after listing all exclusions as is practical for a particular event, text such as the following could be inserted:

> Other exclusions such as [example] and [example] also apply. Please see paragraphs 2.42, 2.77 and 4.15 of your PDS for details.

*What other exclusions/conditions should be required to be included on the 'What is NOT covered' list?*

As discussed immediately above, all exclusions (whether derogations from standard cover or not) should be listed if at all practical. Where not practical, consumers should be made aware that other exceptions exist and directed to the relevant paragraphs of the PDS.

*Is it feasible to summarise the key elements of home buildings and home contents policies in [the format proposed at paragraph 69]?*

And

*Would a list of prescribed events/risks in [the format proposed at paragraph 69] provide advantages, for comparison of policies or otherwise, compared to the 'what is covered' and 'what is NOT covered' lists set out in the draft sample key facts statement?*

With some modifications, this format could provide some advantages over the format at page 11 of the discussion paper.

The format currently proposed at paragraph 69 is not suitable, mostly because the meanings of the tick symbol and the word 'partial' are overlapping and unclear. For example, on the example at paragraph 69, the tick symbol is both used to signify that an event is covered with no exclusions (storm and flood) and also that an event is covered, but with some exclusions (fire, theft, sudden escape of liquid). The example then uses the word 'partial' to signify that an item is covered up to a certain amount. In effect then, the tick symbol can actually mean 'partial' (because coverage for the risk is partially excluded), and 'partial' actually means 'up to a certain amount'. It is also unclear whether a tick or the word 'partial' would be used to signify an event that is covered up to a certain amount, with some exclusions.

We suggest a modified version of the format below is a better option than either of the proposals in the discussion paper:

| Event/Risk | Is it covered? | Main Limitations / Exclusions |
|---|---|---|
| **Fire or explosion** (see PDS paragraph x.yz) | √ | Damage from ash or soot if there is no fire in your home is excluded (see PDS paragraph x.yz) |
| **Stormwater/rainfall runoff** (see PDS paragraph x.yz) | √ | None |
| **Flood** (see PDS paragraph x.yz) | √ | None |
| **Tsunami/action of the sea** (see PDS paragraph x.yz) | x | |
| **Theft** (see PDS paragraph x.yz) | √ | Theft by persons living with you is excluded (see PDS paragraph x.yz) |
| **Accidental glass breakage** (see PDS paragraph x.yz) | Up to $750 | Maximum payment for each event is $750 (see PDS paragraph x.yz) |
| **Sudden escape of liquid** (see PDS paragraph x.yz) | √ | Damage from liquid escaping slowly is excluded (see PDS paragraph x.yz) |

The advantages of this format are:

- It allows all prescribed events/risks to be listed in the table at the same place on all key facts statements, that is, in the left hand column in a standard order. Where the left hand column is headed 'What is covered' (as in the example on page 11) some insurers would list a risk in the left hand column and some in the right, depending on whether they covered it or not;
- it allows the right hand column to purely list limitations/exclusions of coverage of an event which is covered, making a cleaner, more easily understood table. In the model on page 11 (assuming a list of events was prescribed), some entries in the right hand column ('what is NOT covered') would be wholesale exclusions of events, and other entries would be limitations on events covered.
- it adopts the tick or cross system of the example at paragraph 69, but removes the confusion caused by the use both of the tick symbol and the term 'partial';
- It clearly states if there are no exclusions to the cover of a particular risk. Where the 'exclusions' field is left blank, consumers may be unsure whether this means there are no exclusions, or simply that the exclusions are not listed.

*Should the wording of [the 'need to consider risks'] statement be prescribed?*

In our view, this kind of statement is of very little use to consumers and need not be included at all. If this text refers to risks which are listed in the table of events, a consumer does not need to be notified about those risks - the table has already done so. If the text refers to risks not included in the event table, few consumers will know how to check whether their policy covers the risk or not, so the warning is of no use.

If it is decided to retain this statement it is important that if the statement advises consumers to consider a particular risk that the consumer can use the key facts sheet to find out whether they are covered for that risk. The example on page 11 recommends people consider whether their policy covers "land slippage" though this risk is not included on the risk of events in the table above.

*Should the wording of [the statement regarding cooling-off rights] be prescribed?*

Yes. In our view, the statement should be standardised as much as possible to facilitate easy comparisons. Information about the consumer's cooling off rights is very important, and the only way to ensure it is properly and clearly presented is to prescribe requirements for this information. This would be consistent with the new Australian Consumer Law approach to cooling off rights - it also prescribes certain requirements for the giving of information about the consumer's right to terminate an unsolicited consumer agreement within the termination period. We also suggest that the wording include not only a statement about the existence of cooling off rights but a simple sentence explaining how the consumer can exercise these cooling off rights if they wish to do so.

*Is it feasible to require that a standard excess be disclosed (in dollar value), and a note to the effect that it may be varied (if applicable)?*

Yes. The amount of any excess is likely to be an important consideration for consumers. While we accept that an exact dollar value cannot be provided in all cases, we think it is quite feasible

for insurers to provide an indication of the excess payable. This could be expressed as a figure "between $x and $y" or "up to $x".

We also note that the wording in the consultation draft on page 11 describes the excess as: 'An excess may be payable if a claim is made', but recent case law confirms that an excess should not be a barrier to a consumer's claim being made or paid, rather, it may be deducted from the claim paid. It is very important that consumers are not wrongly told they cannot make or obtain a claim until they have paid an excess - this has been a significant concern in some of our insurance casework involving lower income consumers, where these consumers have been prevented from obtaining a claim that is otherwise payable because they cannot afford to pay the excess as a lump sum upfront payment but the insurer refuses to pay the claim until the excess is paid.

We therefore strongly recommend that standardised wording be required and that it describe the excess as an amount that may be borne by the consumer (whether paid at the time of the claim or deducted from the claim amount).

*If there is a reference to the PDS, is it feasible to refer to specific pages/paragraphs, rather than to the PDS generally?*

Yes. It should be mandatory for all references to the PDS on the key facts statement to specify the relevant pages or paragraphs. As we have already argued, many consumers do not read their PDS because they find them confusing and daunting. This being so, simply referring a consumer to the PDS is little better than saying nothing at all, as the consumer is still unlikely to find or read the relevant section.

In addition, in our experience it is not unusual for a PDS to refer to the same topic at different points in the PDS (for example, a discussion about the coverage of a particular event is discussed in one section, and the discussion about exclusions from that coverage in another). This increases the likelihood that a customer looking for particular details of their cover will receive an incomplete picture. Referring the consumer to all relevant paragraphs will make it more likely the consumer will read all relevant parts and properly understand their policy.

*Are the [matters described at paragraph 76] suitable to prescribe for inclusion on a generic reverse side?*

Each of the matters described at paragraph 76 is potentially important information for consumers considering the purchase of a home insurance policy.

However, we simply do not believe that a reverse side of key facts statements is likely to be noticed, read or used by the large majority of consumers, particularly if it merely contains generic information found on all statements - this information will become like "white noise", ignored by consumers. Consumer testing may reveal otherwise, however, until such proof emerges we suggest it is much safer to use the assumption that consumers will not pay much attention to a generic reverse side.

If the decision is made to include generic information on the reverse of the statement, we recommend that an assessment should be made about how important the matters at paragraph 76 (or any other matters) are for inclusion. Any matters that are considered critical for the key facts statements should be included on the front page in relevant places and in a way that

enhances, rather than detracts from, the comprehensibility and usability of the statements. Other less important elements can be included on the reverse.

Some specific comments on some of the matters listed at paragraph 76 are below.

**Explanation of policy types:** As discussed in detail above, we recommend that a very brief description of each policy type be included in the 'policy type' section itself. A slightly more detailed explanation could then be included at the 'covered amount' section, still on the front page. As well as explaining the different policy types, this statement should specifically encourage consumers to consider buying a total replacement policy.

**Statements encouraging consumers to consider carefully whether the policy adequately covers the risks that are faced by their property:** As discussed above, we note that if such a statement is to be included, it should be standardised and any risks listed should also be required to be listed in the what is covered and not covered table of the key facts statement, so that consumers can see whether the policy covers the risks being warned about.

**Statements encouraging consumers to consider other policies:** A statement encouraging consumers to shop around and look over key facts statements from other insurers would be useful. The Treasury's draft mortgage key facts sheet[14] is an example of how this could work.

*What other matters could be mentioned as part of such generic information?*

As discussed above, we advise against including too much generic information. However, if the decision is made to include generic information on the reverse of the sheet, advice for how to make claims, how to make a complaint or appeal a decision of the insurer should be included. This could address:

- How a consumer can make a claim, state clearly that they can make a claim even if they are not sure whether their policy covers the event in question, and that their rights under the policy (for example, rights to appeal a decision or action of the insurer with relation to cover for an event) are not triggered until they do make a claim;
- Explain their rights to appeal decisions made by the insurer through internal dispute resolution, which is free of charge; and
- Explain that, if they are not satisfied with the outcome of the internal dispute resolution process, they can appeal to external dispute resolution service, which is free of charge. The name and contact number of the relevant EDR scheme should be noted.

*When should a key facts statement be required to be provided, including for telephone/internet sales?*

In general, key facts statements should be available at all times to consumers who are shopping around for a policy, not just to those consumers who formally approach an insurer (for example to request a quote). This is to ensure statements can be used to compare different policies, not

[14] See http://www.treasury.gov.au/banking/content/mortgage_key_facts_sheet.htm

just to inform consumers about a policy they have already decided to buy. This will also ensure comparison websites can link to fact statements of different providers.

We do not see why key facts statements cannot be made available to consumers at all points mentioned at paragraph 78. At a minimum, insurers should be required proactively to provide the key facts statement when a consumer is obtaining a quote - whether written or online. However, we also believe the statements should be clearly accessible on insurer websites at the pages where consumers are reading about the policies, before they go through the quote process.

We also suggest insurers be required to advise consumers to look at relevant key facts statements when enquiries are made about insurance products, and advise where the statement can be found or offer to send them a copy. Key facts sheets should also accompany any PDS sent to a consumer, but it is much more important that key facts statements are also provided earlier in the process.

As they would be standard documents and easy to supply, we also strongly support key facts statements accompanying renewal notices. This would help to prompt consumers to consider whether their insurance policy continues to meet their needs before they simply renew the policy.

*Could the document be incorporated into the PDS? Should this be required?*

The key facts statement should not be incorporated into the PDS, although it could generally be provided alongside the PDS. In our experience, many customers never even open their PDS, so an incorporated key facts statement will often be unseen by consumers. In addition, key facts statements should be available quickly and easily, including online. Including facts sheets inside a PDS will make the facts sheet a larger document and so less accessible to consumers who wish to download, print and compare different policies at home.

*What are the main advantages and disadvantages associated with the various options?*

As discussed above, we believe key facts statements should be available to consumers at all times. Advantages of providing key facts statements at the points mentioned in paragraph 78 are:

> **In conjunction with a written quote:** A quote is virtually meaningless unless the consumer understands the features of the policy they are paying for, and both the insurance industry and consumer advocates regularly warn of the dangers of selecting insurance cover on the basis of price alone. Providing key facts statements at this point will increase the likelihood that decisions are made on a more balanced understanding of the policy's merits.
>
> **During the cooling-off period:** As above, the cooling-off period has little value unless consumers can use the period to consider whether the policy they have bought is right for them. A key facts statement will help inform that consideration.
>
> **With a renewal notice:** this will be particularly important for consumers who have a pre-existing insurance policy. Many consumers will stay with the same policy for many years, at least partly because of inertia - choosing a different policy requires a considerable amount of time and effort. Key facts statements will not prompt consumers to leave their current provider if their policy meets their needs, if nothing else because of

the effort involved in finding a new policy. However if a policy does not meet the consumer's needs, the key facts statement will help bring this to the consumer's attention and assist them to find a better product.

*What is the appropriate sanction/remedy if an insurer:*

A. *fails to provide the key facts statement at the appropriate time; or*

B. *provides a key facts statement which is non-compliant with the requirements*

The sanctions and remedies should be similar to those for failing to provide a PDS at required times or providing a non-compliant PDS. There are also key parts of the statement that should also have an impact on the cover itself. We do not suggest that if a generic warning is incorrect in some manner, this should prevent an insurer from relying on exclusions in the policy. However, in particular, if a prescribed event was incorrectly listed on the key facts statement as covered or was missing from the not covered section, this should affect whether the insurer is permitted to rely on an exclusion of that event in the policy.

*Is there any need to clarify or prescribe the legal status of the key facts statement — in particular its relationship to the policy terms and conditions in the PDS?*

Yes. We note that the 'How to use this statement' section on the front of the key facts statement covers some of this ground. This statement will need to include words to the effect that information on the statement is a summary only and consumers need to refer to their PDS for full details. We reiterate that this kind of statement will only be effective if the front of the key facts statement refers consumers to specific paragraphs/pages of the PDS that relate to particular events and exclusions. However, as above, we equally note that the key facts statement will be relied upon by many consumers to inform them of their rights, as intended by the reform, thus insurers should be legally bound to the most important representations made in such statements, especially regarding prescribed events to be listed.

*Should there be prescribed in detail the format (for example, font size) for various items, or is it preferable to leave some flexibility in presentation?*

We strongly recommend that the details of format be prescribed. The purpose of the key facts statements are to convey information simply and clearly to consumers. Once a format has been developed to do so, we do not see a need for flexibility. On the contrary, allowing flexibility in presentation may make comparison of different products more difficult. Insurers remain free to develop any marketing materials that they like and will continue to do so, and they have full flexibility in that space. Key facts statements, on the other hand, are not intended to constitute insurer marketing.

If not all details are prescribed, at the very least insurers should be required to list exclusions at least as prominently as descriptions of what is covered.

## Time limits for claims handling

*Introductory Remarks*

As noted in the discussion paper, the Insurance Council of Australia (ICA) has agreed to consider amending the General Insurance Code of Practice to limit the time insurers have to make a decision on claims. We welcome this, subject to the remarks below.

*Imposing time limits through code or regulation*

Although unstated, the proposal to amend the General Insurance Code of Practice is put forward as an alternative to regulatory change by Government through amendments to the *Insurance Contracts Act 1984* or the ASIC Regulatory Guide 165.

In our view, the changes should be imposed by way of regulatory change. We believe that there are at least three reasons to question whether reliance on the non-regulatory Code will achieve the desired outcomes:

1. The recent history of the Code is poor – there have been problems with the governance and funding of the monitoring committee and staff. There has been a lack of transparency in Code monitoring and it is unclear as to whether the industry has been compliant with the Code of Practice.

2. The ICA has yet to commit to the monitoring of the Code through the Financial Ombudsman Service or any alternative body. This indicates a serious lack of commitment to the Code at the very time the industry is suggesting that Code amendments will lead to change within the industry.

3. The existing section of the Code on Claims Handling has been in place for around ten years and has not resolved these issues. In particular, Section 3.2.3 of the Code requires insurers to update consumers on the status of unpaid claims every 20 days. In our experience this clause has been ineffective and unworkable.

Real change is more likely to occur if the change is imposed by regulation through ASIC Regulatory Guide 165, where reporting can also be monitored on an ongoing basis by the regulator. We have no objection to the proposed changes being included in the Code of Practice but submit that inclusion in the Regulatory Guide is more likely to be effective in ensuring compliance by industry.

*Operation of the time limit*

We submit that the rule be explicitly stated as one which requires insurers to make a decision regarding a claim within six months from receiving it, unless exceptional circumstances exist.

If a decision has not been made within four months of receiving the claim, we recommend that insurers be required to refer the claim to their internal dispute resolution (IDR) process. The automatic referral after four months will require the insurer to make a decision within 45 days. The insurer will also have to send the insured a letter setting out the circumstances of the referral and the right of the insured to seek a review at EDR if dissatisfied with the IDR decision. Where no decision has been made after four months, the insured must be given written details of their right to both IDR and external dispute resolution (EDR).

It is our experience that where a decision has not been made after four months, a referral to IDR or even denial of the claim is preferable to no decision at all.

Where an insurer wishes to claim that a decision could not be made within six months because of exceptional circumstances, the onus should rest with the insurer to establish those circumstances exist and explain the failure to make a decision. The alternative, that the failure to

make a decision can be considered to be due to unusual or exceptional circumstances unless challenged by the insured, is unacceptable.

To ensure the rule is being properly complied with and to gauge the level of consumer detriment in claims handling delays, insurers should provide ongoing reporting to ASIC, particularly on:

- The number of matters in which the insurer has not made a decision within four months and has referred the consumer to IDR; and
- The number of matters where "exceptional circumstances" have resulted in insurers not complying with the requirement to make a decision within six months.

Providing for these obligations in a regulatory guide rather than the Code would allow for this important reporting requirement. If these proposals are adopted, it is also essential that the ICA, ASIC or FOS conduct shadow shopping exercises to monitor compliance with the changes.

## Centrepay processing for premium payments

We strongly support the decision to include home and contents and motor vehicle insurance premiums amongst the types of expenses that can be paid using Centrepay. Previous research with low income households suggests strong interest in Centrepay being available to pay insurance premiums given that most low-income households budget fortnightly (Sheehan & Renouf 2006). Recent quantitative research supports this, with over 30 per cent of surveyed low income households showing interest in making insurance premium payments via Centrepay (Collins, forthcoming).

The experience of other consumer industries suggests that making Centrepay available can be of benefit to both low income consumers and businesses. This is because it will be more likely that the payment will be made if a Centrepay arrangement is set up and less likely that payments will be missed. This is of particular concern in relation to insurance contracts where policies which allow for periodic payment of premiums can be cancelled for non-payment.

Pursuant to the *Insurance Contracts Act 1984* (Cth), insurers can cancel an insurance contract due to an unpaid periodic premium payment where at least one instalment has remained unpaid for a period of at least one month and, before the contract was entered into, the insurer clearly informed the consumer in writing of the effect of the provision. Even where an insurance contract hasn't been cancelled by the insurer, an insurer can deny a claim where at least one instalment has remained unpaid for a period of at least 14 days and, before the contract was entered into, the insurer clearly informed the consumer in writing of the effect of the provision. Insurers are not obligated to consider financial hardship or difficulty when cancelling a policy or denying a claim on these grounds.

As such, there are significant risks that a consumer will have their contract cancelled or be denied a claim where a period payment of an insurance premium is unpaid, perhaps because a direct debit arrangement broke down or the consumer had insufficient funds to cover a direct debit payment. We recommend the Government reviews these sections of the *Insurance Contracts Act*.

One of the advantages of using Centrepay is that premiums will be paid directly from Centrelink to the service provider (and not via the recipient of the Centrelink benefit). This may reduce the

risk of insurance contracts being cancelled for non-payment of instalments compared to regular direct debit arrangements.

However, we are concerned that the Government approach of simply allowing insurance premiums to be paid through Centrepay will not mean that insurers will actually offer Centrepay as a payment method. Despite insurers knowing of the benefits and operation of Centrepay for some years, to our knowledge not one insurer has made an application to join the scheme. Should insurers not offer Centrepay for basic contents policies for renters and basic motor vehicle insurance policies, the Government should take further steps to require insurers to offer Centrepay.

Finally, we are also concerned that Centrepay's requirement that deductions be at least $10 per fortnight will prevent some consumers from using Centrepay to pay premium instalments. A $10 fortnightly payment may be more than some insurance contracts would require, especially products designed for low income Australians. Given the essential role insurance plays in protecting assets and livelihoods, the government should review the appropriateness of Centrepay's $10 minimum payment.

We are aware that some have suggested this issue could be addressed by allowing consumers to pay $10 per fortnight until the yearly premium is paid, at which point deductions cease until the following year when they re-commence. However, we feel consumers will better be able to manage their budgets if outgoings for expenses such as insurance are consistent across the year. In our view, it would administratively simpler for both consumers and insurers to allow Centrepay to process payments of less than $10 per fortnight.

To summarise this section, we recommend that:

- should insurers not offer Centrepay as a payment method for basic contents policies for renters and basic motor vehicle insurance policies, the Government should take further steps to require insurers to offer Centrepay either through legislation or the General Insurance Code of Practice;
- the *Insurance Contracts Act* be reviewed so that a consumer who pays a premium in instalments does not have their contract cancelled or a claim denied where non-payment of an instalment is due to financial hardship or through no fault of their own; and
- Centrepay accept fortnightly payments of less than $10.

## Recommendation to commit to comprehensive set of reforms

While we welcome the reforms envisaged by the discussion paper, we believe a still more comprehensive set of reforms is also required.

First, in our view much of the recent consumer confusion around flood cover could have been avoided by implementing ASIC's 2000 recommendations on improving disclosure, sales processes and education, discussed in detail above in relation to consumer confusion about flood cover.

Accordingly, we recommend that the Government commit to implement the full suite of ASIC's 2000 recommendations regarding improving disclosure, sales processes and education listed earlier (which included but were not limited to a standard definition for flood).

Secondly, in addition to the ASIC recommendations, we recommend that the Australian Government:

1. Enact Australian Consumer Law unfair terms legislation for consumers of insurance products[15]

Unfair terms provisions will, amongst other things, obligate insurers to draft their flood exclusion clauses according to a minimum standard of (objective) fairness.

2. Support the development of an Australian Standard for general insurance claims handling and assessment

There is a long and documented history in this country of consumer concerns regarding claims handling and assessment in the area of general insurance.[16] There is also significant experience within insurers and within the Financial Ombudsman Service's (FOS) general insurance area regarding what constitutes best practice in the steps that make up the process of receiving, handling and assessing general insurance claims, but this experience has not been extended in any systematic way to standards across the industry more generally.

Existing regulation or standards relating to claims handling, as set out in the General Insurance Code of Practice and ASIC Regulatory Guides 165 & 139, are limited in scope and coverage of this area, with a much greater focus placed on the standards for complaint handling and dispute resolution (also important) than on the handling and assessment of claims up to the point that the insurer makes a determination. Consequently, they do not adequately protect consumers from unfair claims handling and assessment practices including:

- Misinformation about a consumer's right to lodge a claim;
- Failure to process claims without delay;
- Poor practices with regard to the collection and use of evidence, including technical evidence such as hydrologists and lay evidence such as eye witness accounts;
- Failure to provide refusal of claims without delay including proper reasons for refusal; and
- Failure to adequately inform consumers of their rights to IDR & EDR in relation to refused claims or claims-related complaints.

[15] It is on the public record in various consumer submissions on unfair terms legislation, that this legislation is a vital piece of consumer protection, given the limitations of disclosure and education programs. See for instance National Legal Aid submission to Inquiry into Trade Practices Amendment (ACL), Senate Economics Legislation Committee, 2009 on Australian Consumer Law; National Legal Aid Submission to Options Paper on Unfair Terms, Treasury, 2010; Consumer Action Law Centre submission to Inquiry into Trade Practices Amendment (ACL), Senate Economics Legislation Committee, 2009 on Australian Consumer Law

[16] See for instance Insurance Law Service submission to the 2009 Review of General Insurance Code of Practice; Joint Consumer Submissions to the FOS Terms of Reference, Joint Consumer Submission to Review of ASIC RG 165 & 139; Legal Aid NSW submission to the Review of IOS (2005); National Legal Aid submission to Inquiry into Trade Practices Amendment (ACL), Senate Economics Legislation Committee, 2009 on Australian Consumer Law; National Legal Aid Submission to Options Paper on Unfair Terms, Treasury, 2010; Consumer Action Law Centre submission to Inquiry into Trade Practices Amendment (ACL), Senate Economics Legislation Committee, 2009 on Australian Consumer Law

Consumers should be entitled to minimum standards of fairness and timeliness in the handling of their claims, including in the legal and technical assessment of the claim by the insurer.

While there is a need for some detail on best practice in these areas, this may be better suited to the nature of a technical standard, developed in consultation with all stakeholders, than higher-level legislation or regulation that does not typically go into such detail but can call up technical standards if required. This is the way in which complaints handling and dispute resolution is now addressed - an Australian Standard on complaints handling has been developed which contains details on best practice, and this standard has then been called up as a regulatory requirement for financial services licensees under ASIC's regulatory guides (as well as being available more generally as a best practice guide to other industries).

We submit that a new type of standard needs to be developed in Australia which will address longstanding consumer concerns with claims handling and will encourage best practice claims assessment by insurers. Such a standard would also help to guide FOS and its general insurance panel in reviewing insurer-consumer disputes regarding claims handling. We submit that the time has come for the Government to encourage and support the development, most likely through Standards Australia, of an Australian Standard for claims handling and assessment in general insurance.

Finally, we support the Government's decision to undertake a more comprehensive Natural Disaster Insurance Review, as a full investigation of current problems in the insurance area and possible solutions is required, including how best to address under-insurance and non-insurance for natural disasters. We submit that our recommendations above could be considered as part of this Review, but we also note that it is important the Review consider and recommend additional reforms.

Thank you for the opportunity to comment on these proposals. Please contact us if you have any questions about this submission - our contact details are set out in the Appendix.

Yours sincerely

Gerard Brody, Senior Manager Financial Inclusion
Brotherhood of St Laurence

Nick Stace, CEO
CHOICE

Catriona Lowe, co-CEO
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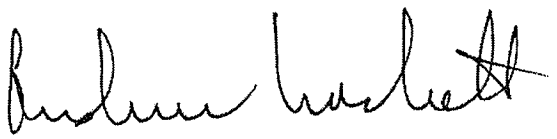
Fiona Guthrie, Executive Director
Financial Counselling Australia

Denis Nelthorpe, Manager
Footscray Community Legal Centre

Katherine Lane, Principal Solicitor
Insurance Law Service



Andrew Crockett, Chairperson
National Legal Aid

## Appendix - About the Contributors

### Brotherhood of St Laurence

The Brotherhood of St Laurence is an independent non-government organisation with strong community links that has been working to reduce poverty in Australia since the 1930s. Based in Melbourne, but with a national profile, the Brotherhood continues to fight for an Australia free of poverty, guided by principles of advocacy, innovation and sustainability. Our work includes direct service provision to people in need, the development of social enterprises to address inequality, research to better understand the causes and effects of poverty in Australia, and the development of policy solutions at both national and local levels.

Contact: Gerard Brody, Senior Manager Financial Inclusion, 03 9445 2425 or gbrody@bsl.org.au

### CHOICE

CHOICE exists to unlock the power of consumers. Our vision is for Australians to be the most savvy and active consumers in the world.

As a social enterprise we do this by providing clear information, advice and support on consumer goods and services; by taking action with consumers against bad practice wherever it may exist; and by fearlessly speaking out to promote consumers' interests – ensuring the consumer voice is heard clearly, loudly and cogently in corporations and in governments.

Contact: Katrina Lee, Strategic Policy Adviser, 02 9577 3347 or klee@choice.com.au

### Consumer Action Law Centre

Consumer Action is an independent, not-for-profit, campaign-focused casework and policy organisation. Consumer Action provides free legal advice and representation to vulnerable and disadvantaged consumers across Victoria, and is the largest specialist consumer legal practice in Australia. Consumer Action is also a nationally-recognised and influential policy and research body, pursuing a law reform agenda across a range of important consumer issues at a governmental level, in the media, and in the community directly.

Since September 2009 we have also operated a new service, MoneyHelp, a not-for-profit financial counselling service funded by the Victorian Government to provide free, confidential and independent financial advice to Victorians with changed financial circumstances due to job loss or reduction in working hours, or experiencing mortgage or rental stress as a result of the current economic climate.

Contact: David Leermakers, Policy Officer, 03 9670 5088 or david@consumeraction.org.au

### Financial Counselling Australia

Financial Counselling Australia is the peak body for financial counsellors. Financial counsellors help consumers in financial difficulty by providing information, support and advocacy. Their services are free, confidential and independent.

Contact: Fiona Guthrie, Executive Director, 0402 426 835 or fiona.guthrie@afccra.org

**Footscray Community Legal Centre**

Footscray Community Legal Centre and Financial Counselling Service is a non-profit, community managed incorporated association. The Centre has a Legal Service and a Financial Counselling Service. Our purpose is to address systemic injustice by providing free legal and financial counselling services on an individual level and more broadly through community education, law reform and advocacy. We assist people who live, work or study in the City or Maribyrnong. Our service gives priority to those who cannot afford a private lawyer and/or do not qualify for Legal Aid.

Contact: Denis Nelthorpe, Manager, 0414 545 290 or denis.nelthorpe@iinet.net.au

**Insurance Law Service**

The Consumer Credit Legal Centre is a community legal centre that also maintains a project called the Insurance Law Service ("ILS"). The ILS is funded by the Legal Aid Commission of NSW and the Commonwealth Attorney-General's Department through the Community Legal Services Program. The ILS is a national service and has provided telephone advice in the course of over 5,000 calls since its inception in mid 2007 and finalised more than 260 casework files. Advice is provided free of charge on a 1300 number available throughout Australia. 28% of calls in 2010/11 financial year to date came from Qld and 16% from Victoria, many involving consumers affected by the recent storms and floods. ILS is actively involved in representing consumers affected by the Queensland floods and previously acted for a number of consumers affected by other natural disasters.

Contact: Katherine Lane, Principal Solicitor, 02 8204 1350 or kat.lane@cclcnsw.org.au

**National Legal Aid**

National Legal Aid (NLA) represents the Directors of the eight State and Territory Legal Aid Commissions (Commissions) in Australia. The Commissions are independent statutory authorities established under respective State or Territory enabling legislation. They are funded by State or Territory and Commonwealth governments to provide legal assistance to disadvantaged people.

NLA aims to ensure that the protection or assertion of the legal rights and interests of people are not prejudiced by reason of their inability to:

- Obtain access to independent legal advice;
- Afford the appropriate cost of legal representation;
- Obtain access to the Federal and State and Territory legal systems; or
- Obtain adequate information about access to the law and the legal system.

Contact: Louise Smith, Executive Officer, 0419 350 065 or louise.smith@legalaid.tas.gov.au

Appendix 2: Example Response from Insurance Company EE

[redacted]

6 July 2011

[redacted]
C/o Jodi Gardner
Caxton Legal Centre Inc.
1 Manning Street
SOUTH BRISBANE QLD 4101

Dear Ms Gardner,

**Re:** **Claim Number –** [redacted]
**Your reference:** [redacted]

We refer to your letter dated 14th June 2011.

The IDR manager has reviewed your client's submissions and decided to confirm the decision to decline your client's claim.

The reasons for that decision are as follows:

**Provision of Product Disclosure Statement (PDS)**

We have investigated your client's allegations that they did not receive a Product Disclosure Statement.

It is [redacted]nsurance's position that a copy of the PDS was sent to your client, along with the certificate of insurance, within 14 days of the date the policy was entered into and thereafter prior to each subsequent renewal invitation and before your client's loss arose. This is sufficient to "clearly inform" your client for the purposes of section 35 *Insurance Contracts Act 1984* (Cth).

We do not accept your client's comments that they did not received a Product Disclosure Statement. Product Disclosure Statements are automatically sent along with the Certificate of Insurance at the time of inception. Furthermore, each year your client would have received policy renewal documents which would include any updated PDS or SPDS documentation. We do not understand how your client could have received the documents relating to renewal of the policy without also receiving these other documents.

**Statements allegedly relied on by your client**

We have investigated the statements alleged to have been made by your client at the time their policy was taken out.

We do not accept that the statements were in fact made, or that if any statements were made they were reasonably relied upon by your client.

Our standard procedure is for customer service operators to tell insureds that their policy automatically covers Flash flood and stormwater run-off, and that if they would like more comprehensive cover against flood they would need to apply for it separately.

**Flood definition**

We do not agree with your comments about the definition of "Flood".



[redacted]

[redacted]

When the definitions of "Flood" and "Flash flood and stormwater run-off" are read together, the different between the two is clear. "Flash flood and stormwater run-off" is a particular category of flood – namely, a sudden flood caused by rain that fell not more than 24 hours earlier. The policy makes clear that this is the only type of flood which is covered, and that any other kind of flood is not covered.

[redacted] Insurance's position is that your client was clearly informed about the scope of the flood coverage.

**Hydrology Issues**

There is no evidence that the inundation of your client's property falls within the definition of "Flash flood and stormwater run-off".

The evidence relied upon by your client is basically to the effect that there was rain or a storm on 11 January 2011. Your client's submissions do not state what date it is claimed that the property was inundated, but we assume your client claims the property was inundated on 12 January 2011. That evidence is not sufficient to show any connection between the rain that fell on 11 January 2011 and the inundation of your client's property (the fact that one occurred after the other does not show that one was caused by the other.)

We note your client has not sought to rely upon hydrological evidence.

The fact that there was local rainfall before the inundation does not mean that the inundation was "Flash flood or stormwater run-off". It is not sufficient, to satisfy the definition, to show that there was rain within 24 hours of your client's property being inundated. Your client must show that the rain which fell within 24 hours was what caused the inundation. The evidence relied upon by your client does not establish this.

Your client's submissions have not attempted to address the other possible causes of inundation, particularly, the effect of water (which had fallen in the Wivenhoe Dam catchment from around 9 January 2011) which was released from Wivenhoe Dam.

Overall, we do not believe that the inundation of your client's property meets the definition of "Flash flood or stormwater run-off".

**Alleged breach of the Code**

We do not agree with your comments regarding your client's access to information pursuant to clause 3.4.3 of the General Insurance Code of Practice.

Clause 3.4.3 clearly states that "In special circumstances or where a claim is being or has been investigated, we may decline to release information and reports but we will not do so unreasonably." This includes "where information is subject to privacy laws, where information is protected from disclosure by law, or where the release of the information may be prejudicial to us in relation to a dispute about your claim."

As previously indicated, it is [redacted]Insurance's position that the hydrology report is subject to legal professional privilege and contains private information of other customers which we are required to protect, therefore, we are not obliged to release this information under clause 3.4.3 of the Code.

**Loss adjustors report**

We do not agree with your comments regarding the loss adjustor's report. The statement in the loss adjustor's report which you have referred to was simply a report by the loss adjustor of the matters alleged by your clients. It does not indicate

[redacted]

[redacted]

a view formed by the loss adjustor on the cause of the inundation of your client's property (and indeed a loss adjustor is not qualified to form such an opinion).

In any event the report, on page 2, clearly states under the heading "Caused by" "Flood-River". This is consistent with the conclusions in the [redacted] Insurance information sheet provided to your client, in particular, that your client's property was inundated as a result of the release of water from Wivenhoe Dam that followed the rainfall in the Brisbane River catchment that commenced on 9 January 2011.

**Information relied upon**

The information we relied upon in making a decision on your client's claim includes:

- Your client's IDR submissions;
- Your client's certificate of insurance;
- Your client's PDS documentation; and
- [redacted] information sheet – Ipswich (Approaching the Bremer River and Brisbane River junction)

We have also relied upon a hydrology report relating to Ipswich provided by Water Technology Pty Ltd. We are not in a position to release that hydrology report to you because the report contains personal details of a number of customers which we are required to protect, and the report is also subject to legal professional privilege.

The information sheet is attached and explains in detail the conclusions we have formed following our hydrological investigations.

We also do not propose to release legal advice we have received in relation to your client's claim on the basis that it is subject to legal professional privilege.

The decision by the IDR Manager is the final step in this stage of your appeal process. If you are unhappy with our internal dispute resolution (IDR) decision you may refer your dispute to the Financial Ombudsman Service Limited (FOS) who can advise you whether your dispute is one which falls within their Terms of Reference.

The FOS provides a free and independent dispute resolution service for consumers who have general insurance disputes that are covered by its Terms of Reference. If you wish for the FOS to consider whether the dispute falls within their Terms of Reference, you must refer your dispute to FOS within two years of the date of the IDR decision. You can do this by contacting FOS at:

Financial Ombudsman Service Limited
GPO Box 3
Melbourne, Vic 3001

1300 78 08 08 (National toll free)
Tel: (03) 9613 6300 Fax: (03) 9613 6399
Email: info@fos.org.au
Website: www.fos.org.au

Yours faithfully

[redacted]

[redacted]

## Appendix 3: Example Response from Insurance Company AA

[redacted]

19 July 2011

[redacted]

Caxton Legal Centre Inc
Att: Jodie Gardner
1 Manning Street
South Brisbane QLD 4101

Dear Jodie,

**Our Reference:** [redacted]
**Our Insured:**
**Situation Address:**

We refer to our final decision letter dated 18 April 2011 and your correspondence dated 24 May 2011, requesting we review this matter further.

**Provision of the Product Disclosure Statement**

We have considered your suggestion that [redacted] misinformed you and/or failed to advise you that flood was excluded from cover when you incepted the policy over the telephone. We have fully investigated this and confirm that at no stage were you advised that you were covered for flood.

More importantly, the details of your policy coverage, including any exclusions, are set out in the PDS most recently sent to you with your Certificate of Insurance on 18 December 2005. The policy coverage has not changed since that time and, unfortunately, does not include cover for flood.

Therefore, as we cannot identify any error on the part of [redacted] Insurance, and confirm that the correct copy of the PDS was sent to you, we maintain our position that [redacted] has complied with Section 35 of the *Insurance Contracts Act 1984* and clearly advised you of the relevant policy conditions in writing.

Therefore, as we cannot identify any error on the part of [redacted] nsurance, we restate our previous decision that [redacted] will not be indemnifying you for this matter.

[redacted] **Misrepresentations as to coverage**

Although we acknowledge the unfortunate nature of your loss and the difficulties faced as a result of the flooding to your property, as per your client's advice that he was informed that he was covered for flood, in order fo[redacted] to carry out additional enquiries, you need to provide us with the following details:

- Which [redacted] Department did you speak to? i.e. Teleclaims? Home Claims? Customer Service?
- If possible, what was the consultant's name?
- What was discussed?
- Provide details of the telephone number from which the call was made from.

Please note if you are unable to provide [redacted] with the abovementioned details we will not be able to carry out any additional enquiries in this regard and our final decision will remain unchanged.

**Hydrology Issues**

We acknowledge your comments that [redacted] has failed to articulated any grounds for denying [redacted] claim for loss or damage caused by storm or a sudden, excessive run-off of water as a direct result of a storm.

We refer you to the Brisbane and Ipswich Hydrology report, the Insurance Council of Australia (ICA) Hydrology report and the individual property hydrology report from WorleyParsons Services Pty Ltd (WorleyParsons) which confirmed the nature and cause was flooding.

In part Worley Parsons conclude :

*"In our opinion, inundation of the property at* [redacted] *was caused by flood water escaping from the normal confines of the Brisbane River and backing up into the area along Jindalee Creek and the Golf Course."*

Please find attached is a copy of WorleyParsons report for your perusal.

**Request for information relied upon to make our final decision**

We have enclosed a copy of the [redacted] PDS which sets out the terms and conditions of the cover we provide, as well as, a copy of the WorleyParsons report dated 17 February 2011, which sets out the cause of the flooding in the Brisbane and Ipswich area on 12 and 13 January 2011.

Accordingly, we have provided you with any/all information we have relied upon in order to make our final decision.

Please note the Insurance Council of Australia (ICA) has established a 'Hydrology Panel' to assess and report on the nature and causes of flooding in various localities across Queensland. You may choose to reference their website for any relevant information, (http://www.insurancecouncil.com.au/).

After further review of your claim, we reiterate our decision as contained in my letter dated 18 April 2011. We remain of the view that the damages to your client's property was **not** as a result of any storm or any other insurable event covered under the [redacted] Insurance policy.

We do value your client's ongoing association with our organisation and are confident we provide our customers with a competitive product delivering value for money, superior

service and peace of mind in the event they need to lodge a claim. It is because of this that we have, over the years, earned the loyalty of the customers we serve.

As part of this, of course, we have a responsibility to all our policy holders to ensure the coverage we provide when a claim is made is in accordance with the Contract we have entered into. However, we appreciate disputes sometimes arise and so have a robust Internal Disputes Resolution process to ensure any decision a customer is dissatisfied with can be reviewed.

With regard to your request for the transcript of the proposal for insurance and record of this claim, please find attached a copy of the Personal Information Access Request form. Please forward the completed form, for access to this information.

Please accept this letter as our final decision. Should you not accept this decision, you may wish to pursue this further and your options are now external to [redacted] Insurance and include:

- Financial Ombudsman Service
  GPO Box 3,
  Melbourne Victoria 3001
  Ph: 1300 780 808
  www.fos.org.au
  *Please note that this matter must be pursued within 2 years from the date of this letter.*

- Alternative legal options.

Yours sincerely,