arc justice

Parliament of Australia

Insurers' responses to 2022 major floods claims

Inquiry

Submission to the Standing Committee on Economics

OCTOBER 2023

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Acknowledgement

ARC Justice acknowledges Aboriginal Peoples as the traditional and current custodians of the land upon which we work. We respect that this land always was and always will be Aboriginal land. Aboriginal sovereignty has never been ceded. We pay our respect to Elders past and present, as well as all Aboriginal people who have fought, and continue to fight, for equality, self-determination, culture, Country and community.

About ARC Justice

ARC Justice is a rights-based, not-for-profit organisation incorporating the *Loddon Campaspe Community Legal Centre* and *Housing Justice* based in Bendigo, and the *Goulburn Valley Community Legal Centre* based in Shepparton.

Disasters create new legal needs for some community members and exacerbate existing needs for others. Disasters, and responses to them, widen existing inequalities in our communities. Responding to community need in the wake of a disaster is increasingly a core part of our business.

Twelve of the 13 Local Government Areas (LGAs) in ARC Justice's catchment area appear on the Victorian Government's list of Councils affected by the October 2022 floods. Of these, the Shire of Campaspe – which includes the townships of Rochester and Echuca -was the most severely impacted.[1] Major damage was also experienced in Heathcote, Seymour and Shepparton / Mooroopna. ARC Justice had staff on the ground in the immediate aftermath of the floods.

ARC Justice continues to have a regular presence at the recovery hubs in Rochester and Seymour. We are a part of the recovery networks in the LGAs of Central Goldfields, Greater Shepparton, Loddon and Mt Alexander. A year after the disaster, the majority of people we assist are in dispute with their insurers over the settlement of their Home Building insurance claims.[2] We thank you for the opportunity to draw from our experiences to make this submission.

What we have seen and heard

This inquiry has given ARC Justice an invitation to respond to matters relating to insurers' responses to the October 2022 Victorian floods. Based on our experience working in the community, the most common issues that cause community members distress are delays in settling their claims and difficulties communicating with their insurers. The role of technical experts, including assessors, hygienists, engineers, and hydrologists, also contributes to the complexities involved. In addition, people's resources before and during the claims process and their access to support has a direct bearing on the chances of their claim being satisfactorily settled and in the claim's quantum. Available resourcing and support also impact on people's willingness to engage in insurers' internal dispute resolution processes.

Timeframes for resolving claims.

We appreciate that the October 2022 floods in Victoria coincided with extensive flooding in Tasmania and lower New South Wales and followed other disasters, including floods in Queensland and northern NSW. As such, insurers were already managing increased demand. There are also other factors beyond the control of insurers that impede claim settlement. These factors may include difficulties engaging tradespeople and supply chain constraints, although the majority of people we have assisted had not progressed to the rebuilding stage. Ultimately, a year after the floods, much of the responsibility for claims remaining unresolved must now rest squarely with insurers. There are people in

[1] *Measured as both absolute numbers and a proportion of households impacted.*
[2] *In our experience Home Contents claims are settled faster and with fewer disputes than Home Building claims.*

their seventies and eighties living in caravans and families with young children living in sheds. These people have lived through a Victorian winter and are now preparing for summer heat in sub-standard shelter.

Analysis of our data indicates that many of the people we see, 12 months after the disaster, are upset and feel angry and/or helpless about the delays in the settlement of their claim. Claims that are fully declined are much less common than claims that are partially declined. Fully declined claims are usually a result of people not having the appropriate cover. In this instance flood is either specifically excluded or is not included in a policy as a defined event.[3] We note that the distinction between storm and flood damage is not well understood by the general public and left some community members unprepared and uninsured.

The far more common issue is claims that are partially declined. These contribute significantly to the observed delays in resolving claims. The most common reasons for the partial decline[4] of a claim fall into the following broad categories:

- Wear and tear / deferred maintenance;
- Pre-existing issues;
- Soil type, landscaping and trees; and
- Buildings that no longer meet current codes.

Insurer's opinions are often presented as facts and refuting them is difficult for community members unfamiliar with the policies, processes and language used. Where wear and tear/deferred maintenance is used by insurers to partially decline a claim they must demonstrate the link they believe exists between the observed damage and the deferred maintenance. They often fail to do this. Wear and tear is used as a blanket reason to refuse to pay for damage. Where wear and tear is detected, its impact is often inflated so, for example, deterioration in one wooden window frame is used to refuse to cover damage to all of the window frames. In events as major as the 2022 floods it often tests credibility to believe that any level of maintenance would have made a difference to the outcome.

In our experience, insurers refusing to remediate damage because it pre-dates the floods often relates to stumping – and the resultant damage to flooring. Insurers regularly say that stumps were not damaged by fast paced flood water running under homes – even in cases where they have paid for damaged fences on either side of the house.

> Jan's house was uninhabitable following the floods. She and her husband are still living in temporary accommodation. She is her husband's primary carer. He is not well enough to help her negotiate with their insurers. Their insurer has declined to pay for the damaged stump subflooring. They argue damage to the stumps was not caused by the floods. Jan's home was re-stumped in 2011.

We are seeing claims being partially declined when reports from engineers refer to homes being on highly reactive soils – a measure of the degree to which they shrink or swell when exposed to moisture.[5] People are then advised by their insurer that flood repair work will not begin until the insured pays to have that remediated – an expensive process usually involving retro-fitting drainage. These are not isolated examples and occur across geographically disparate areas in our catchment. We have instances of insurers using dated images from Google Maps or real estate websites to partially decline claims saying that trees visible on the property have contributed to the damage apparent after the floods.

Finally, claims are partially declined because the home doesn't meet current building codes. Community members find this difficult to comprehend. They understand that building codes have changed over time but, where their home was originally code compliant, they expect the damage to that home to be covered in full following a disaster.

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[3] Depending on the type of policy the insured has.
[4] A partial decline occurs when insurers agree to pay for or remediate some part of the damage caused by the event but decline to cover the full cost.
[5] Victorian Building Authority (2023) Minimising Foundation Movement

When a claim is partially declined, community members have to pay for a proportion of the repair costs before an insurer will begin any repairs. Where they don't have the money needed to do this, they often forgo part of the repairs[6] or accept a cash settlement. Community members frequently tell us they feel pressured into accepting cash settlements; an outcome that they do not want. There are multiple instances where people have told us they have accepted a settlement out of fatigue. Cash settlements come with identified problems[7] including the shifting of the risk of cost escalation and project management from insurers to community members and the loss of insurance backed warranties on repairs.

> An engineering report on Graham's home identified that the stumps were not 'to code'. He disputes that there were any problems with the stumps before the floods.
>
> The insurer accepts that, above the flooring, there was damage to the home which is covered by the insurance policy. They offered him a cash settlement, insisting that the stumps must be rectified before other repairs can commence.
>
> Graham declined the offer and the claim was reassessed.
>
> The insurer has now made three offers of cash settlement, each for a larger sum. Graham believes that the insurance company makes offers hoping people will give up and that he was only offered more because he 'pushed back'.

The onus of proof to demonstrate that an exclusion applies, or that factors other than the insured event contributed to the damage, rests with insurers. However, this is an area where the power imbalance between community members and insurance companies is clearly displayed. Companies partially decline a claim and community members have little recourse other than finding and paying an expert to challenge the assessment. Insurers have frequently declined claims on advice contained in a single report from a builder, assessor or engineer. Community members do not always realise insurers must prove an exclusion applies and many have accepted sub-standard offers without challenging a decision.

We are disappointed by the dismissive way that the structural assessment reports, organised and funded by Emergency Recovery Victoria (ERV), are regarded by insurance companies. We are aware of a number of cases where the insurer refuses to include these reports in their assessment decision at all or fail to explain differences between their expert's opinion and those in the ERV report. This is despite ERV saying, 'you can use your structural assessment as part of your insurance claim'.[8]

The partial denial of claims, based on the issues discussed above, is widespread. When they sell an insurance policy companies know, or could reasonably be expected to know, a great deal about the property including its age, construction material and location. This information and their actuarial expertise allow them to set a premium that reflects their risk. To subsequently deny claims based on a location's soil type or the proximity of trees to a home appears to consumers as unreasonable and manifestly unfair. In our opinion this behaviour fails to meet the commitment that 'every contract of insurance is a contract based on the utmost good faith'.[9]

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[6] *For example, they may not get a verandah or shed rebuilt or the new fittings in the bathroom or kitchen are not of a similar quality to the old ones.*
[7] *Financial Rights Legal Centre (2021) Exposed: Insurance problems after extreme weather events.*
[8] *Emergency Recovery Victoria Registering for a Structural Assessment.*
[9] *Insurance Council of Australia (2023) General Insurance Code of Practice Part1:2.*

A Scope of Works (SoW) is a critical document that describes what damage is going to be covered by an insurer and its quantum. It is usually prepared by an assessor, acting for an insurer.[10] We understand that preparing a SoW can be an iterative process as the finer points of the repairs are worked out. However, we have seen far too many examples, even months after the disaster, where the SoW is very inaccurate – including major fittings or whole rooms that have not been included.

> A year after the flood, Kay and Sam are still living with Kay's 80-year-old mother as they wait for repairs to their home to begin. They have spent twelve months trying to manage the claim themselves. They are negotiating their SoW, received December 2022. It is still not adequate to restore their home. In July 2023 a friend who is a builder went through the SoW with them to identify incorrect or missing items. There are scores of errors – it is missing doors, external cladding, power points and a toilet. The claim is still in dispute as the insurers decide which of the items misrepresented on the SoW they will accept. Kay has recently sent more photos in support of their claim. She has now had 122 contacts trying to get their claim settled. She has to fit this around her full-time job. Sam struggles to comprehend a situation that feels really unfair. He has 'kept his end of the bargain' by paying his premium for decades – why won't the insurer keep theirs?

Errors and omissions in SoW contribute significantly to delays in settling peoples claims. They also add to the trauma people are experiencing. We find that insurance staff can be dismissive of people's concerns and their attention to detail. Does it matter if the SoW says 'painted' where it was 'stained', 'plaster' where it was 'wood panelling' or 'hollow core door' when it was 'solid core door'? It most certainly does. Staff need to remember these are people's homes and they have an emotional as well as a financial investment in them.

We are now seeing new issues emerging as a result of these delays. Mould is a significant problem with recognised health and structural concerns. In some cases, insurers are responding appropriately. However, we are concerned about cases that have come to our attention where insurers say mould is a new and unrelated issue and that people must lodge a new claim. The implications of this may include customers being liable for a new excess or, more importantly, a claim for mould being declined because it is not a defined event within the terms of an insurance policy.

> Repairs to Helen and Mike's flood damaged home were completed mid-2023. They subsequently discovered evidence of mould in the corner of the ceiling. They advised their insurer in August. The insurance company have declined to remediate the issue arguing the mould issue was due to the roof that was replaced five years ago. Helen and Mike don't think this is fair. Prior to the floods they had never experienced an issue with mould in their home.

RECOMMENDATIONS:

1. *Insurers maintain an expanded pool of qualified assessors and other necessary workforce to provide surge capacity in anticipation of disasters occurring with increased frequency and severity given our changing climate.*
2. *Where flood is excluded from a policy, a separate document is supplied to policy holders in addition to the product disclosure statement explaining the difference between storms and floods and the limits of the exclusion.*
3. *Insurers specify and explain the reason for denying a claim (either in part or in total) and provide a copy of the evidence relied upon to the policy holder.*
4. *An assessment of reasonable maintenance must be relative to the age of a home and the building standards applicable at the time of construction or issuing of a certificate permitting occupancy. If insurers are to rely on*

[10] *Insurance Council of Australia (undated) Info on Scope of Works.*

reasonable maintenance as being defined by current building standards, the insurer must be responsible for informing consumers of the standards applicable at the time of contract.

5. *Cash settlements accepted by policy holders, where the damage relates to a disaster, should be subject to a minimum 30 day cooling off period, without limiting the current rights to have a claim re-opened. The policy holder must also be advised that they should seek independent legal or financial counselling advice and of their rights to re-open a claim when provided with a settlement offer.*

Insurers communication with policyholders

Poor communication from insurers contributes to people's distress over the time it is taking to have their claims settled. Good practice would be providing people with multiple avenues to engage with their insurers – including face-to-face, telephone and online. Directing people via email or text message to 'log-on' to check the progress of their claim is not suitable for all community members nor ideal when a disaster means people are no longer living in their own homes.

Auspiced by the Insurance Council of Australia, a number of insurance companies have attended the Recovery Hub in Rochester on multiple occasions. They have also attended a community venue in Shepparton. Community members have been able to make appointments and meet claims settlement teams in person, but these opportunities are not consistent across insurers, nor sufficiently frequent. However, in our experience when face to face meetings are available people feel they have been seen and listened to. This opportunity has been highly valued by people – even in situations where an insurer's decision they were unhappy with was upheld.

Most insurers have a system where claims are handled by a team of people. They would argue this provides continuity of service. This may be the case in the early period following a disaster where most claims follow a similar pathway and the questions being asked by customers are comparatively straight-forward and often similar. However, after a certain point, claims should be moved to a case management arrangement because the delay is a problem in itself or it indicates an issue in dispute. Case management would mean customers deal with one or two people and they are given the opportunity to develop a relationship with staff, providing a more trauma-informed experience. This might also increase staff levels of empathy, customer service skills and job satisfaction.

We often contact insurers on behalf of community members, our firsthand experience of frequently occurring issues includes:

- Telephone wait times that are very long;
- There is a dedicated claims telephone number but reaching the correct person managing a claim is difficult;
- Calls are not returned / messages are not responded to;
- A telephone system with no facility to leave a message (it simply rings and cuts off).

The General Insurance Code of Practice (COP) is generous in its timeframe for responding to client queries – 10 working days for a routine enquiry about a claim and the provision of a claim progress report every 20 working days.[11] This has not been the experience of many people we work with. We are concerned by examples we see of practices that meet the 'letter' of the COP but miss the 'spirit'. We have helped community members who receive automatically generated letters or emails month after month – typically they say:

> *We note from our records that we are due to provide you with an update on the progress of your claim. The current status of your claim is:* [redacted] ***is awaiting information to make a decision on whether the claim is accepted.*** *We will continue to keep you informed of the status of your claim, at least every 20 business days.*

[11] *Insurance Council of Australia (2021) General Insurance Code of Practice, Sect. 70 & 71.*

Insurers must routinely provide clients with information they are entitled to. We are working with community members who, many months after the floods, needed our assistance before they were provided with a scope of works for repairs or other relevant information. We have had people told of a claim being declined by an assessor or over the phone. This information should come directly from the insurer and, in most cases, a telephone call with immediate written confirmation is best practice.

These unacceptable delays and poor communication practices are well within the control of insurers. Insurers could more fully recognise the trauma experienced by our communities in the way they communicate with them.

RECOMMENDATIONS:

6. *Insurers to accommodate the preferred communication mode nominated by a policy holder during the claim processing period.*
7. *Complex claim applications or claim processes unresolved after a reasonable period to move to a case-management system. The period to be clearly defined in the In General Insurance Code of Practice.*
8. *Progress reports to be issued regularly and provide genuine information specific to the policy holder's claim. This should include an outline of the claim process, indicating steps that have been resolved and the anticipated timeframe before the next step is complete. If the insurer is unable to meet their own nominated date for progress, this should trigger an internal escalation process.*
9. *When a claim is made, the insurer is to provide a plain English written explanation of the claims process. This will make clear to the policy holder that any information provided by assessors or other third parties is their opinion for their insurer's consideration.*
10. *Important information relating to a claim being accepted or declined (whether in part or in total) to be communicated to a policy holder by the insurer, verbally and in writing.*

The role of technical experts

The accessibility and affordability of expert opinion, including hydrology and engineering reports is another area where the financial and power differential between large insurance companies and community members is obvious. Insurers employ costly experts in hydrology, soil sciences and structural engineering. Families, dealing with this in isolation often think their situation is unique. They don't have the resources to gather their own expert opinion to challenge an insurer's decision to decline or partially decline their claim.

We have some concerns about the behaviour of experts and believe there is more they could do to demonstrate true independence. Where they make recommendations to insurers about the relationship between the observed damage and the event, we see significant variation in the quality of their reports. Assessors present themselves as independent and impartial, but we wonder about the extent to which this is credible given the bulk of their business comes from the major insurance companies. When policy holders need to source reports from experts to provide evidence refuting that of the insurer, it can be difficult to find an expert who does not provide services to their insurer.

Insurers rightly rely on the opinions of experts. However, in their dealing with clients they ought to be explicit that the insurance contract is between the insurer and the insured. We often work with people who are unhappy with an engineer's report, or an assessor's attitude or a tradesperson's work. They feel left to manage these issues alone when actually the insurers should be addressing them.

Simon's house was inundated to a height of 1.2 metres with flood water that didn't dissipate for several days. The assessor told him his house was a total loss and he would get a full cash payout. His insurer subsequently claimed much of the damage, including cracking in the walls, pre-dates the flood. They offered him a cash settlement of approximately half his home's sum insured. After months in dispute, Simon is being helped by a friend to make a complaint to the Australian Financial Complaints Authority.

RECOMMENDATIONS:

11. *In the aftermath of a disaster, government funded or employed experts to independently assess damage to private property.*

Advocacy, support and internal dispute resolution

We have been involved in, and heard about, cases where community members were able to successfully challenge an insurer's decision. In some cases, a previously declined claim has been accepted. More frequently settlement offers have been increased. This happens when cash settlements have been based on SoW that are demonstrably inadequate. While we are pleased for the individuals who have been successful, we are concerned about people who have accepted their insurance company's preliminary decisions without question. This is particularly pertinent given the number of instances where claims are rejected based on exclusions related to pre-existing conditions or homes not up to code.

We have spoken to a number of people who are reluctant to make a complaint about the management of their claim or challenge an insurers decision. Whilst some people simply don't know they can challenge a decision, others are reluctant to, fearing consequences including slowing the settlement process down, having an offer withdrawn or 'getting on the insurer's bad side'. People's lack of access to resources and support magnifies inequitable outcomes in the claim settlement process.

The system requires that people traumatised by disaster, and with an unresolved claim, navigate a complaints process with very little assistance. We encourage people to complain in writing, rather than over the phone. This gives them a chance to articulate their concerns and provides them with a written record of their complaint. We provide them with the correct contact details to ensure their complaint doesn't simply end up being reviewed by the initial claims handler. We are concerned that this happens at times. Community members tell us that they are casually asked "would you like to complain?" when they raise issues with claims staff. They are then encouraged to complain in that instant. This serves to circumvent the established IDR process.

Seven months after the flood Vicky, her partner and their children were still living in a shed and caravan on their property. Their claim was in dispute. An assessor inspected the property in the first week after the flood and said it would "be a write-off". Their sum insured is just under $500,000. The first SoW had a $90,000 total. Vicky rejected it as clearly inadequate.

A second SoW, completed by another builder at the end of March, had a $300,000 total. They rejected this also because it is not enough to repair the house.

There was then a six-week delay – with each of the third parties blaming the other. Vicky believes the insurer is slowing the process down in the hope that she will take a cash settlement.

RECOMMENDATIONS:

12. *Place-based community legal centres and financial counsellors to be provided with ongoing, adequate funding to engage and inform community members about their rights in relation to insurance policies in preparation for, and in response to, disasters.*

The insurance system, as it is currently organised, does not work in the interest of consumers following a disaster. This magnifies existing inequities in and between communities. This is an issue of justice.

Thank you for this opportunity to share our communities' experiences. We would welcome further discussion and an opportunity to appear before the Committee. We look forward to the recommendations of the Committee.