GENERAL INSURANCE
Code Governance Committee

PO Box 14240
Melbourne Mailing Centre
MELBOURNE VIC 8001
Phone: 1800 931 678
Email: info@codecompliance.org.au

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Mr Lachlan Wilson
Committee Secretary
Standing Committee on Economics
PO Box 6021
Parliament House
Canberra ACT 2600

By email: floodinsurance.reps@aph.gov.au

Code Governance Committee submission - Inquiry into insurers' responses to the 2022 major floods claims

As the General Insurance Code Governance Committee (CGC), we welcome the opportunity to contribute to the inquiry by the House of Representatives Standing Committee on Economics on insurers' responses to 2022 major floods claims.

The role of the General Insurance Code Governance Committee

We are an independent body that monitors compliance with the General Insurance Code of Practice (the Code).

By monitoring compliance with the Code, we aim to improve standards of service in the Australian insurance industry and promote best practices to, ultimately, help insurers to create a better experience for customers.

Our work involves:

- examining insurers' practices
- identifying current and emerging industry-wide problems
- monitoring the effectiveness of customer remediation
- recommending improvements to practices
- applying sanctions to insurers when necessary, and
- consulting with stakeholders and the public on issues and keeping them informed.

Although our funding comes from the industry, we operate independently of the industry. Our operations are carried out by an independent secretariat service that sits within the Australian Financial Complaints Authority (AFCA).

Our role is not to oversee insurers' compliance with the law. It is to oversee their compliance with the General Insurance Code of Practice.

Codes of practice are an important part of a broad consumer protection environment. When implemented well and supported by the industry, codes of practices are an effective layer of consumer protection beyond the minimum requirements of the law.

Monitoring compliance with the Code

We draw on a wide range of data and information to identify potential areas of non-compliance with the Code.

Our sources of data and information include:

- Annual data collection from insurers that subscribe to the Code
- Notifications of significant breaches from insurers
- Inquiries we conduct into insurers' compliance with certain Code obligations
- External dispute resolution data from AFCA
- Consumer groups and other key stakeholders.

This allows us to identify issues and trends across the industry and work to promote better practices.

The Code has several obligations relevant to claims-handling which provide important protections to customers, particularly people affected by catastrophes or experiencing other forms of vulnerability.

Our submission draws on the insights from our monitoring work and the observations of the impacts of Code breaches.

Key points

1. Breaches of obligations in the Code related to claims-handling increased, in particular for timeframes and communication, as insurers' systems, processes and capabilities were challenged by volumes following extreme weather events.

2. Insurers should improve preparedness for and capacity to deal with extreme weather events by:

    a. Ensuring permanent sufficient staffing levels to manage increases in claims following an extreme weather event.
    b. Providing better training to staff on claims-handling for extreme weather events.
    c. Automating processes for claims-handling and communications on claims where possible.
    d. Enhancing the content and timeliness of communications with customers on claims.
    e. Using technology to identify areas from which claims are likely to come following an extreme weather event.

3. The upcoming review of the Code of Practice must retain consumer protections, and the existing requirements on timeframes for claims-handling should be upheld.

4. The Code review should allow the CGC to name insurers in reporting on breaches to strengthen compliance with the Code of Practice.

Overarching observations

Insurers have improved their practices for identifying and reporting breaches in recent years, but an overall increase in breaches indicates that they must do more to improve compliance with the Code.

Contributing to the breaches has been the increased volume of claims following extreme weather events; many insurers' systems, processes and practices were incapable of managing the volume effectively.

Extreme weather events can no longer be regarded as anomalous. Their frequency means that, in planning, insurers must consider such events to be part of business as usual, and operations must reflect this.

The frequency of extreme weather events also means that insurance is now essential for many people. Insurers must ensure that customers understand the level of cover with each policy product and must ensure that, for a policyholder, making a claim is efficient and comes with clear communication and compassionate support.

While we have seen examples of good practice from insurers, we have also seen some struggle to cope with claims in the aftermath of an extreme weather event.

Our data shows that in the two years leading up to the 2022 fiscal year, the industry had downsized from a workforce of 118,000 in 2019-20 to 87,000 in 2021-22, a five-year low.

We accept that there were factors in the operating context beyond the control of insurers. For example, some of the downsizing was, in part, due to challenges brought on by COVID.

The ramifications of this, however, almost certainly affected the industry's ability to cope with the surge in claims from the 2022 major floods. Our monitoring has identified a range of areas in which insurers could have performed better, more effectively alleviating customer stress and delivering better outcomes to customers.

We have several remediation audits and investigations in progress, and are considering further action, including sanctions where appropriate.

Our approach is to work with insurers to understand the root causes of non-compliance with the Code and to monitor remediation. We work to ensure insurers adequately address the issues they identify and implement improvements to deliver sustained compliance.

Internal dispute resolution

Insurers receive more complaints following extreme weather events, which subsequently lead to an increase in disputes referred to AFCA.

In July 2023, we published an inquiry report, 'Making Better Claims Decisions',[1] which examined how insurers use their data to gain insights into the decisions to deny claims that were subsequently overturned following a complaint from a customer.

[1] See 'Making Better Claims Decisions' available at https://insurancecode.org.au/app/uploads/2023/07/CGC-Thematic-Inquiry-into-Making-Better-Claims-Decisions.pdf

We examined the practices of six insurers and found that all needed to improve their practices for denying claims.

In 2021-22, a quarter of denied home claims proceeded through to the internal dispute resolution functions of the six insurers we examined. This was nearly 11,000 complaints, with nearly half later overturned in favour of the customer. This was a significant overturn rate and raised questions about the quality of the decision-making by insurers.

In an environment of increasing extreme weather events, it is crucial that insurers understand the importance of quality claims-handling and the impact of a denied claim. All must strive to ensure claims are handled efficiently, fairly and transparently.

Data from complaints is a rich source of insights and it is incumbent on every insurer to use their data to make improvements to the claims-handling process. Doing so can enhance customer experiences and outcomes and can act as an early warning signal for systemic issues.

Expert Reports

Our inquiry into claims decisions set out to investigate how insurers used complaints data to gain insights into decisions to deny claims. But in investigating this, we found a concerning trend in the number of claims denied because of maintenance or wear-and-tear exclusions.

Claim denials based on such exclusions are commonly associated with extreme weather events. Research by the Financial Rights Legal Centre[2] found that denials based on wear and tear to be consistently in the top five of all complaints in extreme weather events, including floods.

Our inquiry found:

- More than half of the decisions to deny claims were based on maintenance or wear-and-tear policy exclusions
- Insurers overturned almost half of their decisions to deny on review after a complaint from a policyholder
- The expert evidence that insurers relied on to deny claims was of poor quality
- A lack of adequate quality control for the expert reports.

We saw instances of neighbouring properties with the same type of cover from the same insurer receiving different outcomes for their claims.

It was clear that insurers were getting many initial decisions on claims incorrect. This resulted in customers going through the complaints process, which creates unnecessary stress in the aftermath of an extreme weather event.

Furthermore, we are left with questions about the quantity of claims that were incorrectly denied but did not result in a complaint because the customer, in the circumstances, was unwilling or incapable of undertaking that effort. Under AFCA's rules, insurers may be required to reimburse a customer for obtaining their own expert report; however, many customers may not be able to afford the upfront costs.

[2] See 'Exposed: Insurance problems after extreme weather events' available at https://financialrights.org.au/wp-content/uploads/2021/07/Financial-Rights-Exposed-Report_FINAL.pdf

We expect insurers to address the flaws in systems, processes and practices that led to these failings and improve outcomes. We will monitor their responses. The insurers that were not examined in this inquiry have been asked to review their data on overturned claims and address these issues.

As a result of this inquiry, we have several investigations underway and have commenced an inquiry into insurer oversight of external experts.

Resolving claims: timeliness and communication

The Code of Practice sets out the timeframes that insurers are expected to meet when handling a claim. It details the requirements for assessing claims, fast-tracking urgent claims, making a claims decision and, handling claims in the aftermath of an extreme weather event.

Handling and resolving claims efficiently is important for affected consumers because it is the start of their recovery.

For many people, uncertainty about a claim outcome is stressful. Delays can force people into temporary accommodation for extended periods of time, and even threaten homelessness, adding to the emotional and financial shock and distress of the instigating event.

Challenges for insurers are exacerbated when high demand for trades, expert consultants and loss assessors cause shortages and prolong the claims assessment process.

Making a decision in a timely manner

The Code requires insurers to make a decision within four months of receiving a claim under normal circumstances and in the absence of suspected fraud or where the consumer is unresponsive to the insurer's requests for information about their claim (paragraph 77).

In 2021-22, insurers reported 1,114 breaches of this obligation – the highest level in the past five years. In 2022-23, insurers reported 709 breaches of the obligation.

The Code also requires insurers to communicate their decision to accept or deny a claim within 10 business days of making that decision.

In 2021-22, insurers reported 7,810 breaches of this obligation – the highest in the past 5 years. In the same period, customers lodged 4,375,045 retail claims, an increase of more than 470,000 on the previous year.

In 2022-23, breaches of this obligation fell to 4,781 despite retail claims increasing further to 4,619,370. This reflects efforts to improve claims-handling across the industry.

In both 2021-22 and 2022-23, insurers attributed most of the breaches of these obligations to failing to follow processes and procedures and too few staff. System failures was also cited as a reason in 2021-22.

Through our analysis and engagement with insurers to address breaches, we identified key contributing factors:

- Relying too much on manual processes and individual staff to meet timeframes.
- Too few staff to manage the volume of claims.

Insurers often reported that missed timeframes were the result of staff not following processes and procedures. Too often insurers told us that they missed timeframes because a staff member was away, or they were dealing with staff under-performance.

Relying solely on the performance of individual claims assessors is not in line with contemporary practice.

Insurers must maintain adequate staffing levels to be able to effectively manage surges in volume from extreme weather events. This includes effective training to increase the speed to competency for new staff.

Furthermore, insurers must invest in systems and tools to better track timeframes, notify staff and assist in providing accurate and timely communications to customers. Relying on individual manual intervention is not a sustainable strategy and insurers must explore emerging technologies to help them improve in this area.

Communication from insurers

A key obligation in the Code promises that communication from insurers will be clear, transparent, fair and timely.

The most common reported breaches of the Code consistently relate to communications:

- Informing customers of the progress of a claim at least every 20 business days (paragraph 70)
- Responding to routine inquiries about a claim's progress within 10 business days (paragraph 71).

We have seen insurers struggle to meet these obligations.

In 2022-23, there were 28,189 breaches of the obligation to tell a customer about the progress of a claim at least every 20 business days. This was a 60% increase on the previous year, and almost five times higher than in 2019-2020 (5,723 breaches).

In 2021-22, there were 5,578 breaches of the obligations to respond to routine enquiries about a claim's progress within 10 business days. While this was a 47% increase on the 2020-21 reporting year, these breaches fell to 3,253 in 2022-23.

Most breaches reported in 2022-23 that related to these obligations were attributed to staff not following processes and procedures. Pressure on staff from the large volume of claims may be a contributing factor.

Inadequate staffing levels saw insurers move experienced staff from regular claims into catastrophe claims, resulting in a need to backfill the regular positions with new recruitment.

This process took time and insurers reported a range of challenges exacerbated by COVID-induced labour shortages and logistics troubles. Once recruited, new staff needed significant time for induction and training.

Delays with communications also led to more complaints for some insurers, which subsequently caused delays in complaints-handling and further contributed to breaches.

Clear communication is also essential. This is necessary before, during and after an extreme weather event to manage the expectations of customers. We have heard about instances of unclear communication leading to confusion and exacerbating stress and anxiety among customers in the aftermath of an extreme weather event.

Insurers still have much work to do improving communications with customers. It is important that they remind customers of policy coverage and exclusions, including the benefits and limits of the policy. When managing a claim, insurers must explain the loss assessment process clearly and be proactive in sharing information with consumers to help manage their expectations.

A crucial element of communications is ensuring proper oversight when delegating messages on claims to a third party. Insurers must know precisely what information its third-party contractor tells a customer about a claim.

Many of the issues related to communication can be alleviated with more staff and better training. However, we believe that insurers should invest in technology and automation more widely to help improve communication.

This may involve staff notifications and reminders for contacting a customer, automating simple administration tasks to allow staff to focus on the more complex aspects of a claims process, and customer portals that allow customers to track the status of claims in real time.

Insurer preparedness for future flood events

Our submission has noted that insurers attributed most breaches regarding claims-handling to staff not following processes and procedures.

This suggests a lack of preparedness from insurers to deal with high levels of claims and inquiries in the aftermath of extreme weather events.

Insurers must do more to prepare for what is becoming a regular occurrence. They must invest in the staff, systems and processes required to adequately deal with surges in demand.

Insurers should develop plans and test staff, systems and processes to manage significant surges in claims. Such surges need to be factored into regular business planning so that insurers are capable of responding and delivering better outcomes for customers.

Adequate preparedness requires sufficient investment in technology and automation.

We are aware of insurers that have used geospatial mapping and macrolevel data to identify customers who may be affected by certain extreme weather events and are likely to make claims. Insurers should consider adopting such technology as best practice and we encourage its widespread uptake.

Furthermore, insurers can proactively provide education to customers in the lead-up to seasons with higher chances of extreme weather events, such as floods and bushfires.

Review of the Code of Practice

The Insurance Council of Australia (ICA) will shortly commence an independent review of the Code.

We see this as an important opportunity for the ICA and the industry to demonstrate and reinforce commitment to better practices that protect customers, especially in the aftermath of an extreme weather event.

It is vital that the existing protections in the Code are not only retained but strengthened in the review. The Code must continue to set standards for customer protection above and

beyond minimum legal requirements and provide confidence that insurers will treat customers with fairness, respect and compassion.

This is essential if the Code is to continue to be a progressive conduct model and a benchmark for self-regulation in the financial services sector.

As part of the review process, we will recommend that we be allowed to name insurers in our reporting on breaches.

Naming insurers is a vital element of enhancing compliance with the Code of Practice. It provides transparency which helps customers make informed decisions and increases accountability which creates additional motivation for insurers to address issues with compliance.

Currently, our Charter prevents us from naming subscribers in our annual data reports; we can only name an insurer that has breached the Code if we impose a naming sanction.

We note that the Australian Banking Association has accepted a recommendation for banks to be named in breach reporting. The Banking Code Compliance Committee (BCCC) will implement this improved approach when the new Banking Code comes into effect.

Thank you for the opportunity to share our insights to this inquiry. If you have any questions in relation to our submission, please contact Joanna Ifield, Senior Manager Code Compliance, at info@codecompliance.org.au.

Yours sincerely,

Veronique Ingram PSM
Independent Chair

General Insurance Code Governance Committee
info@codecompliance.org.au