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General Insurance Code Governance Committee

Dear Committee

General Insurance Code Governance Committee 2024-25 monitoring priorities

Thank you for the opportunity to respond to the General Insurance Code Governance Committee's (Committee) consultation on monitoring and compliance priorities for the 2024-2025 year. This is a joint submission from **Consumer Action Law Centre** and **WEstJustice**.

Consumer Action is an independent, not-for profit consumer organisation with deep expertise in consumer and consumer credit laws, policy and direct knowledge of people's experience of modern markets. We work for a just marketplace, where people have power and business plays fair. We make life easier for people experiencing vulnerability and disadvantage in Australia, through financial counselling, legal advice, legal representation, policy work and campaigns. Based in Melbourne, our direct services assist Victorians and our advocacy supports a just marketplace for all Australians.

WEstjustice provides free legal services and financial counselling to people who live, work, or studying in the cities of Wyndham, Maribyrnong and Hobsons Bay, in Melbourne's western suburbs. We have offices in Werribee and Footscray, as well as youth legal branch in Sunshine, and outreach across the west. Our services include: legal information, advice and casework, duty lawyer services, community legal education, community projects, and law reform and advocacy.

Together, Consumer Action and WEstJustice recommend that the Committee consider the following areas for monitoring or compliance work, based on trends we see in our casework relating to general insurance products.

Claims handling misconduct

We note the Committee intends to commence or progress targeted investigations in claims handling for the rest of the financial year. We encourage the Committee to continue this important work into 2024-2025. Claims handling misconduct is systemic and multifaceted. It has a significant impact on a consumer's journey to seek redress. Poor claims handling leads to poor claims decisions – policy holders are prevented from fully engaging in the process and frequently accept outcomes that are less than they deserve.

<u>Failing to provide interpreters – Paragraph 101 of the General Insurance Code of Practice</u>

Westjustice's 2023 response to the Committee's monitoring and compliance priorities for 2023-24 noted a number of issues associated with the failure to provide interpreters where a General Insurance Code of Practice (**Code**) Subscriber is unable to otherwise effectively communicate with the client, in breach of Paragraph 101 of the Code. We have unfortunately continued to see clients not being provided with interpreters, particularly at the crucial stage of needing to make a claim. This has resulted in a client being unable to clearly convey the information and the circumstances of the claim (potentially exposing them to the accusation that they have not been accurate or honest in their dealings with the insurer) or are simply unable to make a claim at all.

We believe an investigation into Subscribers compliance with this obligation would be a valuable opportunity to identify recurring issues (and also good practice) in the insurance industry with interpreter access, including the conduct of service suppliers.

Issues with accepting authorities – Paragraph 98 of the Code

Increasingly we encounter fundamental issues with Subscribers accepting our authorities as lawyers and financial counsellors. This causes unacceptable delay and confusion for our clients, particularly as the majority have multiple vulnerabilities and do not have the capacity to advocate for themselves. Subscribers are committed to ensuring their processes are flexible to recognise the authority of a lawyer, consumer advocate, interpreter or friend in Paragraph 98 of the Code. In our casework, this is frequently not what occurs.

We have encountered frustrating instances such as:

- Authorities on file are not accessible by the insurer or their third-party contractor – for example, when our services call through to the insurer's call centre, who are unable to confirm the authority of the caller and consequently refuse to progress our client's claim;
- Inappropriate requirements that an authority is for an individual lawyer or financial counsellor rather than the common practice of an organisation (including demands that the caseworkers supply their personal information (including individual lawyer's date of birth) and/or identity documents);
- Refusing to accept our standard authorities and requiring bespoke forms to be completed, including by clients who do not have access to a computer or printer.

In contrast, we query whether insurers even request authority forms from private law firms representing their insureds. For years consumer advocates have persistently raised concerns about these issues with senior executives of Subscribers, however we have seen little to no improvement in our day-to-day dealings. All of the above draw out the process of a claim and lead to worse outcomes for consumers.

Delays in claims handling and communication

2022 was a 'disaster year' for insurance and we acknowledge the huge impact on the insurance industry from an unprecedented number of claims. The evidence presented to the House Economics Committee's inquiry into the 2022 floods clearly demonstrated this fact.[1]

WestJustice and Consumer Action continue to assist clients who have not recovered from events in 2022 due to extended processing in claims handling.

We often see communications with policy holders that are automated and do not provide meaningful updates about their claims, or the steps they need to progress. These are particularly difficult for consumers who are recently arrived or from culturally and linguistically diverse backgrounds.

One client with a contents claim received communications that requested further information each time – multiple lists of items that were damaged; then lists of items which were not damaged; then photos; then quotes for replacements. If the full information had been requested from the outset the client would have been able to finalise the process much faster.

Issues with claims outcomes

Reliance on broad exclusions

[1] Please refer to the Hansard record of the hearings on 31 January 2024

The use of pre-existing damage, inadequate maintenance or wear and tear exclusions by insurers has been well-discussed by consumer groups,[2] ASIC,[3] the Deloitte report,[4] and by the Committee.[5] We believe the over-reliance of these exclusions may be in breach of Code paragraphs 21 and 81 and we encourage the Committee to continue investigating this issue. This over-reliance on exclusions causes direct harm to policy holders, who generally have to source their own expert reports at significant cost and grapple with complex factual circumstances to resolve this issue.

This issue arises particularly in relation to property claims. We have seen insurers identify pre-existing damage that appears unrelated to the actual claim, or significantly overstate their likely contribution to the overall damage.

We note that the issues presenting when these exclusions are relied on contribute to the above issues of **communication and claims handling delays**.

Failing to offer uplift payments

Many of the clients who contacted Consumer Action following the 2022 floods were offered a cash settlement from their insurer. Paragraph 79 of the Code includes a commitment to providing policy holder information about how settlements work.

A cash settlement transfers all the risk of rebuilding onto a client, as well as the labour involved in managing a rebuild. An insurer has access to economies of scale and a stronger bargaining position that are not available to policy holders. Clients who have been offered these settlements are typically experiencing a crisis, living in temporary accommodation, financially stretched, and are unlikely to have the skills and knowledge to manage a rebuild. AFCA typically awards uplift payments to recognise the increased cost to the policy holder, however we frequently see cash settlements that include no uplift payment or any indication that the risk to the consumer has been priced into the offer.

We feel that not including uplift payments in recognition of the increased cost and difficulty to an insured falls well short of best practice and may amount to a breach of the Code in some circumstances.

Emerging innovations

Collecting money

Our services are identifying concerning conduct in seeking recoveries against uninsured third parties for costs that are not fair and reasonable. We consider this conduct may amount to a breach of Paragraph 133 and 'Standards for collecting money' in the Code in many circumstances. A detailed study of a typical and concerning case is included in **Appendix A**.

In these cases, we see insurers:

- Not providing the totality of relevant evidence used to calculate the amount they are seeking to recover;
- Seeking to recover more than the reasonable costs of repairs (i.e. where a repair has been poorly done so that it increases the overall costs).

Uninsured consumers are at a significant disadvantage when engaging with an insurer recovering on behalf of a policyholder. They are also typically uninsured because they could not afford the relevant cover, which means they are likely vulnerable in other ways due to their income or visa status for example. Without resource-intensive advocacy from a free service on their behalf, they end up paying a significant and unjust amount.

Other emerging areas

[2] CHOICE, Weathering the Storm: Insurance in a changing climate
[3] ASIC, Rep 768 Navigating the storm: ASIC's review of home insurance claims
[4] Insurance Council of Australia, The New Benchmark for Catastrophe Preparedness in Australia
[5] CGC Thematic Inquiry: Oversight of External Experts

We refer to WestJustice's submission to the 2023-2024 consultation and note several non-code specific industry issues continue to impact our clients at both services. Particularly:

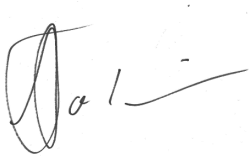
- "Carnapping" behaviour, which can interact with the legitimate insurance market insofar as insured parties are being misled into commencing repair or recovery actions without a claim being properly notified to the insurer;
- "Self-insured" car or fleet rental companies for personal or small business use by lessors, which often operates to the detriment of the lessor and undermines industry standards.

We encourage the Committee to consider how they can guide industry in responding to this concerning conduct. Further details are contained in parts 5 and 6 of Westjustice's previous submission (**Appendix B**). We are able to provide recent client stories to the Committee on request.

Thank you again for the opportunity to respond to this consultation. Please contact Rose Bruce-Smith at [redacted] or on [redacted] or Joseph Nunweek at [redacted] if you have any questions about this submission.

Yours sincerely

CONSUMER ACTION LAW CENTRE



Stephanie Tonkin
Chief Executive Officer
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WEstJustice

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APPENDIX A – ALI'S STORY

Ali (name changed), a recently arrived refugee who speaks limited English, was involved in a minor car accident in which he scraped the side of a stationary vehicle parked next to in a car park. Ali, who was uninsured, was contacted several months later by the insurer of the damaged vehicle. The insurer's debt collection correspondence demanded a payment of more than $12,000 from Ali. Ali was shocked by this figure, as the damage to the other car was only a small scratch. The photographs of the damaged vehicle that the insurer sent to Ali were consistent with the scratch being very small. Ali, who fled an authoritarian regime, was very frightened of the prospect of going to court, which was threatened in the debt collection correspondence. Ali earned only a low wage in unskilled employment and had no capacity to pay the alleged debt.

On Ali's request, the insurer sent Ali documents which the insurer claimed substantiated the $12,000 quantum. The documents consisted of repair receipts from two different mechanics, which listed items replaced and repaired plus labour costs on two different occasions. The 'first' mechanical repair invoice was for a figure of less than $1,500. The second invoice was for a figure of more than $11,000. An invoice for a period of car hire which appeared to correlate to the 'second' repair was also provided.

Westjustice assisted Ali to write to the insurer asking for an explanation as to why the Vehicle had been repaired by two separate mechanics, noting that several items that invoiced for repair were to parts of the vehicle that seemed to be unrelated to the scratched panel, and that there appeared to be duplication in the itemised repairs performed by the 'first' mechanic in the invoice of the 'second' mechanic. Westjustice asked the insurer to specify how it alleged the invoiced repairs related to the damage caused by Ali. The insurer responded to Westjustice by claiming that the existence of the invoices was evidence that the repairs were necessary. The insurer declined to explain how these repairs were alleged to have been required due to Ali's accident.

Westjustice then assisted Ali to engage an independent mechanic to review the repair receipts and provide an opinion on whether the repairs invoiced reasonably arose from Ali's accident. Ali had to pay around $450 for this independent review.

In investigating the matter, the independent expert spoke to the 'second' mechanic, who confirmed that they had been engaged by the insurer to repair damage to the vehicle that had been caused by the 'first' mechanic in its attempted repairs. The independent expert produced a report of their findings, which Westjustice sent to the insurer. Westjustice argued that Ali's liability should be limited to the quote provided by the first mechanic, which had been accepted by the insurer, and that Ali should not be liable for extra repairs that were required because of damage caused by the first mechanic.

On receiving the expert report, the insurer agreed to settle the case for by accepting a sum of less than $2,000: less than 20% of the original quantum sought. Ali agreed to this offer as he wanted the case finished. He had found the matter very stressful and wanted to be sure of avoiding any risk of going to court. Ali was still left out of pocket $450 for the independent expert report he had to commission. The insurer has never explained to Ali or Westjustice why it was that it attempted to recover the cost of repairs conducted by the second mechanic from Ali.

Appendix B

Submission to the General Insurance Code Governance Committee - Monitoring Priorities Consultation

14 February 2023

About Westjustice

Westjustice is a Community Legal Centre that provides free legal advice and financial counselling to people who live, work or study in the cities of Wyndham, Maribyrnong, and Hobsons Bay, in Melbourne's western suburbs. We have offices in Werribee and Footscray, a youth legal branch in Sunshine, and outreach across the West. Our services include legal information, advice and casework, duty lawyer services, community legal education, community projects, law reform, and advocacy. Westjustice has also been at the forefront of developing and trialling innovative, integrated, place-based partnerships.

Our insurance practice

We assist clients with insurance matters, particularly motor vehicle and home and contents insurance matters, through our:

- Motor Vehicle Accident Clinic
- Consumer Law Clinic
- Settlement Justice Partnership ('SJP'), which assists people who are recently-arrived in Australia, in partnership with settlement agencies
- Tenancy Advocacy and Assistance Program ('TAAP').

We thank the General Insurance Code Governance Committee ('CGC') for the opportunity to contribute to this consultation.

Submissions

Over the past 12 months, Westjustice has continued to encounter concerning trends in our insurance casework, particularly in our consumer, motor vehicle accident and tenancy practices. Some of these matters do not fall within the CGC's remit, particularly where an issue requires a government response, but we have included them to provide the CGC with a full picture of the issues we have observed over this period.

1. Motor vehicle accident claims where the driver is not the policyholder

It is common for people to share motor vehicles among family, friends and community members, particularly within newly-arrived communities. Clients have sought our assistance when they were in a motor vehicle accident while driving another person's motor vehicle, or when they had lent their car to another person who was in a motor vehicle accident.

Some owners did not have motor vehicle accident insurance or had only third-party cover, which left them liable for damages when they or the driver of the vehicle were at fault or unable to meet the costs of repairing their vehicle. Others paid for their own repairs because they did not know they could, or did not know how to, report an accident to their insurer. This reflects

broader concerns about underinsurance and limited understanding of insurance policies and processes, particularly among people who have recently arrived in Australia.

Even when owners had comprehensive motor vehicle insurance, we received inconsistent responses, or in some cases no response, from insurers when trying to assist third party beneficiaries under insurance policies, such as drivers who were not the policyholder. It is unclear how a claim should be lodged or processed in such matters, while some insurance policies and Product Disclosure Statements ('PDS') have ambiguous clauses about the application of excess. Some insurers also would not provide us with key documents relating to the claim or policy, so that we could properly advise and assist our clients.

We recommend that the CGC develop a guidance note to assist insurers to appropriately navigate these matters.

2. *Failure to use interpreters*

Some of our clients, particularly in the SJP and Consumer Law Clinics, cannot speak or read English and may be unable to read or write in their own languages.

Insurers have access to interpreters and requirements under the *General Insurance Code of Practice* for appropriate use of interpreters,[1] but have frequently failed to offer, or declined access to, interpreters for our clients. Among other things, a lack of access to interpreters resulted in:

- clients being confused and distressed;
- clients not understanding the exclusions relevant to their policies, including options to purchase additional cover for major events such as flood and fire;
- clients failing to understand the insurance claims process, their rights; and obligations under their insurance policies;
- outcomes of claims not being communicated to clients within the timeframes set out in the Code; and
- delays in resolving insurance claims.

Large corporate service providers, including insurers and debt collectors, sometimes relied on family members to interpret, especially children. It is inappropriate and distressing for minors to be used as interpreters, particularly in debt collection or other matters where they might be asked to convey threats of litigation to their parents. There is a high risk that a child may not properly interpret unfamiliar financial concepts, such as insurance exclusions, and children should not have to advocate for their parents regarding traumatic experiences of family violence or ill-health.

The practice also creates a considerable risk of elder abuse.[2] In one SJP matter, an insurer used an adult child to interpret a discussion about a claim where the child's interests were at odds with the policyholder parent for whom they were interpreting, in circumstances where the insurer was on notice of this conflict.

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[1] Part 9 of the General Insurance Code of Practice.
[2] Bourova, E, Ramsey, I and Ali, P, '*It's Easy to say 'Don't sign anything': debt problems among recent migrants from a non-English- speaking background',* Alternative Law Journal, Vol 44, No. 2, 2019, p 127. Accessed at https://journals.sagepub.com/doi/epub/10.1177/1037969X18817875 on 17 January 2023.

Case study: failure to advise of claim outcome

Our client Lisa* (name changed) is a refugee and cannot read or write English. She made a claim for storm damage in January 2022 after a storm had caused water ingress in her balcony, resulting in a metre length hole in her roof. The claim was made in January, however our client only became aware that the claim was denied in July when our legal centre intervened. When asked why our client never received a formal letter outlining the decline, we were advised by the insurer it was because she was illiterate. We note no other means of communication were used to convey this information to our client. As a result, our client had to live with a hole in her roof during the extreme storm events across the winter of 2022. To date, the hole has not been repaired and the insurer is now denying the claim on the basis of structural damage.

We acknowledge it can be difficult for staff to identify when a customer requires an interpreter, particularly as we move away from face-to-face consumer interaction, and some may hesitate to assume a person's language ability is limited to avoid offence or discrimination. Reliance on customer identification of need is also problematic, as many customers are not aware that interpreting services are available for free, or at all. However, we encourage insurers to provide interpreting services as an option as a means of dismantling the accessibility barriers for non-English speakers.

3. Rejection of authorities from lawyers and financial counsellors

We experienced recurring issues with insurers rejecting authorities from lawyers or financial counsellors acting on a customer's behalf and failing to respond promptly to requests for basic information, such as claim records or a contract of insurance, even when our client was the policyholder. In some matters, we have been forced to apply to the Australian Financial Complaints Authority ('AFCA') to obtain these basic documents. This has caused extensive delays, exacerbated our clients' financial hardship and distress, and unnecessarily increased AFCA's workload.

4. Claims handling in home insurance matters

We have experienced issues with claims handling in home insurance matters which has been further exacerbated by major weather events including the 2021 Mansfield Earthquake and the 2022 Maribyrnong Floods. Some key issues include:

- insurer delays in responding to and assessing claims;
- failure of insurers to communicate the decision or outcome of the claim within the timeframes set out in the Code;
- reliance on broad general exclusions in denying claims, in particular the exclusion of 'pre-existing structural damage', requiring clients to source expensive expert reports to refute;
- reliance on broad general exclusions which are not adequately defined, or defined contrary to relevant legislation;
- the rejection of claims that appear to stem from mistakes in claims processing – for example, an insurer relying on reports about a building not subject to the claim and disputing insurable events that were matters of historical record, such as earthquakes.

In one SJP matter, an insurer's customer service representative gave our client and their settlement worker information about their rights that contravened the wording of the client's policy, in a situation where they had been without their car for over three months.

Case study: insurer reliance on erroneous assessor report

Our Consumer Clinic advised Nayfa* (name changed) who made a storm damage claim following heavy rains in Melbourne. The insurer sought to deny her claim on the basis that the water ingress that caused a hole in her garage ceiling was caused due to structurally defective roofing tiles which would be excluded under her policy. Upon review of the assessor's report and a photo of our client's property, it was clear that there was no roof over the garage ceiling and that the area above the garage ceiling was in fact a balcony. It appeared that the report in all likelihood pertained to a different building. In this case, it was concerning to see the insurer's reliance on an assessor's report that was plainly wrong and that no further enquiries (such as a simple Google search of the property) were made prior to declining the claim. We also note the privacy ramifications where assessments of another customer's building are sent to an unrelated party.

Case study: denial of earthquake event despite evidence to the contrary

Our Consumer Clinic has been representing a client whose claim for damage from the 2021 Mansfield Earthquake claim was denied on the basis that, amongst other things, the geotech's findings that it was unlikely the 2021 Mansfield earthquake would have been felt as far as the Western suburbs of Melbourne despite contemporary news reports and accounts that the quake could be felt across the city and even interstate as far as Adelaide and Launceton. This report was used to support the insurer's denial of the loss and damage to the client's property that arose directly after the earthquake event. The matter is now set for AFCA determination.

It was our experience that clients' in the SJP and clients from non-English speaking backgrounds who attended our Consumer Law Clinic typically did not under understand that their home and contents policy would not cover damage to their property without limitation.

Case study: failure to properly define 'boarding house' exclusion

We represented Peter* in the Australian Financial Complaints Authority after his insurer refused his claim for accidental escape of liquid, causing loss and damage to his home. The denial was on the basis that he was operating a 'boarding house'. The insurer's definition of 'boarding house' was contrary to the equivalent legislative and regulatory definitions in Victoria and appeared to capture house-share situations where an owner-occupier lived with friends. At the time, Peter had been residing at the property and letting out one of his rooms to a friend in order to make the mortgage repayments which was a common arrangement throughout the pandemic. AFCA determined that the insurer was not entitled to deny the claim because they continued to offer him insurance notwithstanding his disclosure that he was letting his room to others and that the boarding house exclusion had not been defined within the PDS. AFCA awarded a further $1000 in non-financial loss as the insurer cancelled Peter's policy without any basis during the AFCA complaint process. See further: **AFCA Determination 810049.**

This reflects the concerns we raised earlier in our submission about limited understanding of insurance policies and processes, particularly among people who are recently-arrived in Australia and/or from non-English speaking backgrounds. It also emphasises the need for insurers to use interpreters at all stages of the insurance process, including the sales process.

5. 'Car napping'

We have seen an increase in matters involving 'car napping' across both the SJP and our general access Motor Vehicle Accident Clinic. 'Car napping' describes a co-ordinated practice orchestrated by unscrupulous businesses – at various times involving car hire, smash repairs and tow truck companies, and debt recovery lawyers ('legal recoveries firms') – which takes advantage of drivers' limited legal, insurance, and mechanical knowledge following motor vehicle accidents.

A typical 'car napping' matter involves roadside referral by an attending tow truck driver directing the 'not-at-fault' driver to specific car hire, smash repairs, and recoveries firms. The driver often signs documents at the scene of the accident when they are stressed. For not-at-fault drivers with comprehensive insurance, or where the at-fault driver was insured, there is arguably no value in these services, which prolong disputes by claiming disproportionate repair, storage and car hire costs from the at-fault driver or their insurer. Individuals generally mistakenly, or are misled to, believe the carnapper is liaising with their insurer.

Some uninsured clients who were at-fault in an accident where the not-at-fault 'other driver' was represented by a legal recoveries firm also received damages claims that dramatically exceeded the market value of the damaged vehicle. In one SJP client's case, the costs were calculated without any physical inspection of the damaged vehicle.

Disputing quantum of loss following motor vehicle accidents is arduous, requiring inspection of the other driver's car by an independent expert and the production of a 'court standard' expert report. Typically, the costs of such a report would exceed $2,000 as a legal disbursement. Unlike a dispute with an insurer of another driver, no industry ombudsman scheme exists, and matters that are not resolved by negotiation must be settled in court.

There is little incentive for a legal recoveries firm, whose business model is premised on recovering court costs from the opposing party, to settle such disputes out of court. Accordingly, affected drivers – both at-fault and not-at-fault – experience undue stress as they are pulled into a protracted litigation, and the court system must expend considerable resources for these matters to progress.

Insurers cannot address car-napping alone but should have clear and consistent procedures for when their customers fall victim to it. We recommend that that the CGC develop a guidance note would assist the insurance industry and consumers to navigate these issues.

6. Car rental businesses claiming to offer comprehensive insurance

Our Motor Vehicle Accident Clinic has assisted clients who have leased cars from businesses, particularly commercial passenger vehicles, who claim to offer comprehensive motor vehicle insurance in promotional material or terms and conditions but are self-insured at best. Drivers

are then unable to lodge a claim with these companies after an accident and are pursued for the cost of all damage.

These companies are rarely, if ever, AFCA members or Insurance Council of Australia ('ICA') members, but we raise this issue to alert the CGC and ICA to a pressing regulatory gap that disadvantages both consumers and general insurers.

7. Insurers pursuing renters under landlord insurance policies

Insurers continue to pursue renters for costs under rights of subrogation, following claims by residential rental providers under their landlord insurance policies. These claims occurred where neither the rental provider nor the insurer had a legal basis for pursuing the renter or had established the renter's liability. Some of our cases involved insurers:

- pursuing renters for rent arrears where the renter had not accrued those arrears
- alleging renters were liable for rent as compensation for breaking their lease agreement when the renter had lawfully ended their tenancy
- pursuing renters for damage they are not legally liable for, such as fair wear and tear or other damage to the property that the renter did not cause.

We note that these practices continue despite undertakings from the insurance sector in late 2021 that these practices would cease following a campaign by Choice and WEstjustice.