‘HONEST, FAIR, TRANSPARENT AND TIMELY’? EXPERIENCES OF AUSTRALIANS WHO MAKE CLAIMS ON THEIR BUILDING, HOME CONTENTS OR COMPREHENSIVE CAR INSURANCE POLICIES

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In Australia, building, home contents and comprehensive car insurance are regarded as ‘essential’ financial products. Yet the limited research on the experiences of consumers who claim against these policies highlights problems with claims handling by insurers, who are required under the General Insurance Code of Practice (2014) to decide claims in an ‘honest, fair, transparent and timely manner’. These problems are especially apparent in the aftermath of natural disasters, and include inappropriate investigation practices and delays that exacerbate financial hardship for policyholders. In this article, we analyse the findings of our survey of policyholders who recently made claims on building, home contents or comprehensive car insurance policies. We show that while most claims are accepted, excessive resolution times, poor communication and problematic investigation practices by insurers make the claims process burdensome and overwhelming for a significant minority of policyholders. Our findings indicate substantial levels of exposure to financial loss for policyholders who accept cash settlements and problems with transparency surrounding withdrawn or cancelled claims. Our findings highlight issues with compliance with the legal frameworks governing insurance claims, as well as gaps in consumer protection that should be addressed in expectation of more frequent extreme weather events in the coming decades.

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I INTRODUCTION

Building, home contents and comprehensive car insurance are widely regarded as 'essential' financial products in Australia.[1] In recent decades, building and home contents insurance in particular have been put forward by government,[2] industry and others as crucial mechanisms for spreading the costs of recovery from natural disasters and other extreme weather events.[3] Insurance has also been described as having potential to play an important yet currently 'under-utilised' role in climate change adaptation and disaster risk mitigation, alongside land use planning schemes and building regulations.[4] Yet for consumers who purchase building, home contents and car insurance policies, according to the Australian Securities and Investments Commission ('ASIC'),[5] 'the intrinsic value' of these products lies in their 'ability to make a successful claim when an insured event occurs'.[6] The centrality of claims processes for consumers of general insurance is reflected in cl 7.2 of the *General Insurance Code of Practice* ('*2014 Code*'), which requires insurers to 'conduct claims handling in an honest, fair, transparent and timely

1 See, eg, Peter Saunders, *Down and Out: Poverty and Exclusion in Australia* (Policy Press, 2011) ch 5. This study used a survey of clients of welfare services and a broader community survey to identify items that are considered 'essential' to life in Australia, and to measure the extent of deprivation of these items. Home contents and comprehensive car insurance were considered 'essential' by most participants in both surveys: at 99–100. See also the series on financial exclusion in Australia by the Centre for Social Impact, which includes a lack of access to these three general insurance products in its three-part definition of financial exclusion, alongside lack of access to a transaction account and a moderate amount of credit: Chris Connolly, Centre for Social Impact, *Measuring Financial Exclusion in Australia* (Report, June 2013) 6, 48 <https://www.csi.edu.au/media/uploads/Measuring_Financial_Exclusion_in_Australia_-_June_2013.pdf>.

2 See, eg, Department of Transport and Regional Services (Cth), *Natural Disasters in Australia: Reforming Mitigation, Relief and Recovery Arrangements* (Report, August 2002) 76; Council of Australian Governments, *National Strategy for Disaster Resilience* (Report, February 2011) 5 <https://knowledge.aidr.org.au/media/2153/nationalstrategyfordisasterresilience.pdf>; *Natural Disaster Insurance Review: Inquiry into Flood Insurance and Related Matters* (Report, September 2011) 20 <https://treasury.gov.au/sites/default/files/2019-03/p2011-ndir-fr-NDIR_final.pdf> ('*Natural Disaster Insurance Review*'); Senate Environment and Communications References Committee, Parliament of Australia, *Recent Trends in and Preparedness for Extreme Weather Events* (Final Report, August 2013) 70–8 <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Environment_and_Communications/Completed_inquiries/2010-13/extremeweather/report/index>; Department of Health and Human Services (Vic), *Promoting Financial Resilience to Emergencies through Home and Contents Insurance* (Report, December 2017) 1 <https://providers.dhhs.vic.gov.au/sites/default/files/2018-02/promoting%20financial%20resilience%20to%20emergencies%20through%20home%20and%20contents%20insurance%20strategy.pdf> ('*Promoting Financial Resilience*').

3 See, eg, Insurance Council of Australia, *Improving Community Resilience to Extreme Weather Events* (Report, April 2008) 2 <http://www.insurancecouncil.com.au/assets/files/community%20resilience%20policy%20150408.pdf>; Edward Mortimer, Anthony Bergin and Rachel Carter, Australian Strategic Policy Institute, *Sharing Risk: Financing Australia's Disaster Resilience* (Special Report Issue 37, February 2011) 2, 6; Productivity Commission, *Natural Disaster Funding Arrangements* (Inquiry Report No 74, 17 December 2014) vol 2, 413 <https://www.pc.gov.au/inquiries/completed/disaster-funding/report>.

4 Kate Booth and Stewart Williams, 'Is Insurance an Under-Utilised Mechanism in Climate Change Adaptation: The Case of Bushfire Management in Tasmania' (2012) 27(4) *Australian Journal of Emergency Management* 38, 38.

5 The Australian Securities and Investments Commission ('ASIC') is the corporate regulator for Australia's financial services sectors, including insurance.

6 Australian Securities and Investments Commission, *Review of General Insurance Claims Handling and Internal Dispute Resolution Procedures* (Report No 245, August 2011) 4 [1] <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-245-review-of-general-insurance-claims-handling-and-internal-dispute-resolution-procedures/> ('*Review of General Insurance Claims Handling*').

manner',[7] and which was recently replaced by a similar provision in the *General Insurance Code of Practice* (2020) ('*2020 Code*').[8] It is also reflected in s 13 of the *Insurance Contracts Act 1984* (Cth), which provides that at all stages of their relationship including claims handling, the parties to an insurance contract must act towards one another 'with the utmost good faith'.

In 2017–18, Australian general insurers received 4.1 million claims from consumers and small businesses.[9] Just over half of these claims were made against car insurance policies, and a fifth were made against building and home contents insurance policies.[10] The overwhelming majority — 95.7% — of these claims were at least somewhat 'successful', in that they were accepted by the insurer in full or in part.[11] However, while only a small proportion of general insurance claims are formally denied, there are indications that the claims process can be a frustrating and onerous one for policyholders, many of whom are navigating stressful and even traumatic events in their lives. Complaints against general insurers make up the second largest category of consumer complaints received by the Australian Financial Complaints Authority ('AFCA'),[12] which replaced the Financial Ombudsman Service ('FOS'), Credit and Investments Ombudsman and Superannuation Complaints Tribunal as the provider of external dispute resolution services to the financial services sector in 2018. In 2018–19 alone, insurers self-reported 31,186 breaches of the *2014 Code*, up 128% from the previous year, with the General Insurance Code Governance Committee ('Code Governance Committee') attributing the increase to higher claim volumes driven by the impacts of recent natural disasters.[13] The limited empirical research

7 Insurance Council of Australia, *General Insurance Code of Practice* (at 1 July 2014) cl 7.2 <http://codeofpractice.com.au/assets/pdf/Code_of_Practice_2012VF.pdf> ('*2014 Code*').

8 Insurance Council of Australia, *General Insurance Code of Practice* (at 1 January 2020) cl 21 <http://codeofpractice.com.au/2020/10/ICA001_COP_Literature_Code_OnScreen_RGB_DPS_10.2_LR2.pdf> ('*2020 Code*').

9 General Insurance Code Governance Committee, *General Insurance in Australia: 2017–18 and Current Insights* (Report, March 2019) 6 <http://codeofpractice.com.au/assets/General%20Insurance%20in%20Australia%202017-18%20and%20current%20insights%20(March%202019).pdf> ('*General Insurance in Australia 2017–18*').

10 Ibid 28–9. The remaining claims were made against other types of general insurance policies, including personal and domestic property, travel, consumer credit, residential strata and sickness and accident insurance.

11 Ibid 32.

12 'Snapshot of AFCA's First Twelve Months', *Australian Financial Complaints Authority* (Web Page) <https://www.afca.org.au/news/statistics>.

13 General Insurance Code Governance Committee, *Living the Code: Embedding Code Obligations in Compliance Frameworks* (Report, June 2020) 10 <https://www.afca.org.au/news/latest-news/general-insurance-cgc-publishes-living-the-code-report>.

examining consumer experiences of the claims process,[14] and the small number of inquiries by governments, regulators and others that included a focus on claims handling and investigation processes and outcomes,[15] have also shed light on significant problems with claims handling by insurers. These problems include delays that exacerbate financial hardship and inconvenience for policyholders;[16] and inappropriate investigation practices that leave policyholders vulnerable to bullying and harassment by external private investigators.[17] Other issues resulting in unsatisfactory — and at times, financially devastating — outcomes for policyholders include 'underinsurance', where the maximum amount payable under a building insurance policy is insufficient to cover the cost of rebuilding a destroyed home,[18] and unfair contract terms that allow insurers to provide unrealistically low cash settlements instead of repairing or rebuilding the policyholder's property.[19]

Nowhere are problems with claims handling more apparent than in the aftermath of natural disasters and other extreme weather events, when insurers may receive a significant volume of claims within a short period, and when demand may exceed the availability of third-party consultants to provide expert reports as well as tradespeople to conduct repairs. In 2019, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry ('Royal Commission') highlighted cases where insurers subjected policyholders to extended delays in processing claims, providing reimbursement for temporary

14 Such research is limited to one inquiry by ASIC involving the review of claims data and interviews with consumers whose comprehensive car insurance claims were investigated and paid, and a small-scale survey by the Financial Rights Legal Centre, which also had a focus on claim investigations: Australian Securities and Investments Commission, *Roadblocks and Roundabouts: A Review of Car Insurance Claim Investigations* (Report No 621, July 2019) <https://download.asic.gov.au/media/5422526/rep621-published-4july2019.pdf> ('*Roadblocks and Roundabouts*'); Financial Rights Legal Centre, *Guilty until Proven Innocent: Insurance Investigations in Australia* (Report, March 2016) <https://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf> ('*Guilty until Proven Innocent*').

15 *Natural Disaster Insurance Review* (n 2) ch 14; *Review of General Insurance Claims Handling* (n 6); General Insurance Code Governance Committee, *Own Motion Inquiry: Investigation of Claims and Outsourced Services* (Report, 1 May 2017) <http://codeofpractice.com.au/assets/documents/GICGC%20OMI%20on%20Investigation%20of%20Claims%20&%20Outsourced%20Services%20May%202017.pdf> ('*Own Motion Inquiry*').

16 Legal Aid New South Wales, Submission No 57 to House of Representatives Standing Committee on Social Policy and Legal Affairs, Parliament of Australia, *Inquiry into the Operation of the Insurance Industry during Disaster Events* (September 2011) 2, 7, 21 <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0015/10824/Legal-Aid-NSW-Inquiry-into-Insurer-Response-to-natural-disasters.pdf>.

17 See generally *Guilty until Proven Innocent* (n 14).

18 See generally Australian Securities and Investments Commission, *Getting Home Insurance Right: A Report on Home Building Underinsurance* (Report No 54, September 2005) <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-54-getting-home-insurance-right-asics-report-on-home-building-underinsurance/> ('*Getting Home Insurance Right*'); Australian Securities and Investments Commission, *Making Home Insurance Better* (Report No 89, January 2007) <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-89-making-home-insurance-better/>.

19 Consumer Action Law Centre, *Denied: Levelling the Playing Field to Make Insurance Fair* (Report, February 2018) 19–20 <https://consumeraction.org.au/denied-levelling-the-playing-field-to-make-insurance-fair/> ('*Denied*').

accommodation and repairing homes damaged by storms, floods and bushfires.[20] Soon afterwards, in February 2019, severe flooding in Townsville, Queensland, resulted in over 25,000 insurance claims.[21] Six months later, less than half of all homes damaged in the floods had been repaired.[22] Most recently, over the summer of 2019–20, catastrophic bushfires and hailstorms in Victoria, the Australian Capital Territory, New South Wales and Queensland gave rise to over 288,100 claims totaling over $5.19 billion, fewer than half of which were resolved by May 2020.[23] The economic cost of natural disasters in Australia is expected to reach $23 billion per year by 2050 amidst a predicted increase in the frequency and intensity of extreme weather events in the coming decades due to climate change.[24] Given the important role of insurance in reducing disaster recovery costs for governments and emergency relief agencies, it is imperative that we inquire into the efficiency and transparency of claims handling by insurers and the fairness of the outcomes that consumers are receiving through this process.

Despite the importance of 'honest, fair, transparent and timely' claims processes and outcomes for consumers, there has been little research focusing on the experiences and perceptions of claimants themselves. In order to address this gap in the research, we carried out a study involving a survey of 1,507 Australians who recently made a claim on a building, home contents or comprehensive car insurance policy. In this article, we analyse the findings of this study, which provides insights into multiple aspects of the claims process — including claim resolution times, communication with policyholders and investigation practices

20 *Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry* (Final Report, February 2019) vol 1, 309, vol 2, 415–55 <https://financialservices.royalcommission.gov.au/Pages/reports.html> ('*Royal Commission Final Report*').

21 Insurance Council of Australia, 'Insurance Bill for Summer Catastrophes Passes $2.2 Billion' (Media Release, 26 March 2019) <https://www.insurancecouncil.com.au/media_release/plain/513>. See also Chloe Chomicki and Nathalie Fernbach, 'Townsville Business Owners Stuck in Insurance Standstill after Flood', *ABC News* (online, 25 March 2019) <https://www.abc.net.au/news/2019-03-25/north-qld-floods-ruin-rsl-in-garrison-city/10904848>.

22 Insurance Council of Australia, 'Six Months On, Insurers Making Strong Headway with $1.243B in Townsville Catastrophe Claims' (Media Release, 2 August 2019) <https://www.insurancecouncil.com.au/media_release/plain/534>; Sofie Wainwright, 'Townsville Flood Repair Delays Leave Hundreds Displaced Six Months On', *ABC News* (online, 1 August 2019) <https://www.abc.net.au/news/2019-08-01/townsville-floods-hundreds-displaced-six-months-later/11370062>.

23 Insurance Council of Australia, 'Insurance Bill for Season of Natural Disasters Climbs over $5.19 Billion' (Media Release, 28 May 2020) <https://www.insurancecouncil.com.au/media_release/plain/575>. See also Stuart Marsh, 'Insurance Claims from Australia's Catastrophic Summer Climb over $5.19 Billion', *Nine News* (online, 28 May 2020) <https://www.9news.com.au/national/australia-bushfires-hailstorm-covid19-insurance-claims-hit-more-than-5-billion/6d3530d9-8415-4bae-8773-65ec424578a3>.

24 *Recent Trends in and Preparedness for Extreme Weather Events* (n 2) 58, 63. See also Deloitte Access Economics, *The Economic Cost of the Social Impact of Natural Disasters* (Report, 2 March 2016) 19–20 <http://australianbusinessroundtable.com.au/assets/documents/Report%20-%20Social%20costs/Report%20-%20The%20economic%20cost%20of%20the%20social%20impact%20of%20natural%20disasters.pdf>; Climate Council, *Critical Decade 2017: Accelerating Climate Action* (Report, 2017) 29, 31 <https://www.climatecouncil.org.au/resources/critical-decade-2017/>; Swiss Re Institute, *Natural Catastrophes in Times of Economic Accumulation and Climate Change* (Sigma Report No 2, 2020) 1, 2, 12. An 'extreme weather event' is 'a weather or climate event that is unusually intense or long, occasionally beyond what has been experienced before': Climate Commission, *The Critical Decade 2013: Climate Change Science, Risks and Responses* (Report, June 2013) 52 <https://www.climatecouncil.org.au/uploads/b7e53b20a7d6573e1ab269d36bb9b07c.pdf>.

— as well as the adequacy of cash settlements in the building, home contents and comprehensive car insurance sectors. In Part II of this article, we introduce the legal frameworks that govern insurance claims handling. In Part III, we outline the multi-step process through which insurers assess, investigate and make decisions about claims. In Part IV, we set out the methodology used to carry out our survey, and in Part V, we outline our findings. In Part VI, we discuss the implications of these findings.

Significant proportions of policyholders taking part in our study made their claims in relation to loss or damage caused by a storm, flood, bushfire or another extreme weather event, in circumstances where large claim volumes can amplify problems with claims handling. Our study nonetheless confirms that most home and car insurance claims are accepted, and indicates that for the majority of policyholders, making an insurance claim is an efficient and positively regarded process. However, for a significant minority of policyholders, there are indications of delays, poor communication and problematic investigation practices by insurers that make the process a burdensome and overwhelming one. Moreover, although most policyholders are 'unaware of the potential for out of pocket expenses' when purchasing insurance,[25] significant proportions of those whose claims are resolved by a cash settlement find themselves exposed to repair, rebuilding or replacement costs despite being insured. There are also indications of problems with transparency regarding the circumstances in which claims are withdrawn or cancelled. Finally, a small proportion of policyholders are refused further insurance after they make a claim, while others are effectively prevented from renewing their policies by unaffordable increases in their premiums. Our findings highlight potential problems with compliance with the legal frameworks governing insurance claims — including the requirement for insurers to 'conduct claims handling in an honest, fair, transparent and timely manner' in cl 7.2 of the *2014 Code* — as well as gaps in consumer protection that should be addressed in expectation of more frequent and severe extreme weather events in the coming decades.

II LEGAL FRAMEWORKS GOVERNING INSURANCE CLAIMS

A Insurance Contracts Act 1984 *(Cth)*

Claims made against most types of general insurance policies, including building, home contents and car insurance policies,[26] are covered by the *Insurance Contracts Act 1984* (Cth) ('*ICA*'). While the *ICA* is the primary piece of legislation

25 Effective Disclosure Taskforce, Insurance Council of Australia, *Too Long; Didn't Read: Enhancing General Insurance Disclosure* (Report, October 2015) 39 <https://www.insurancecouncil.com.au/issue-submissions/reports/too-long-didnt-read-enhancing-general-insurance-disclosure> ('*Too Long; Didn't Read*').

26 See *Insurance Contracts Act 1984* (Cth) ss 8–9 ('*ICA*').

governing the relationship between insurers and policyholders, it contains few specific requirements in relation to the claims handling process.

Perhaps the most relevant provision with regard to claims handling is the duty of utmost good faith in pt II of the *ICA*. Section 13(1) states that an insurance contract is 'based on the utmost good faith', meaning that 'there is implied in such a contract a provision requiring each party to it to act towards the other party … with the utmost good faith'. A failure by a party to an insurance contract to comply with the duty constitutes a breach of the Act.[27] A party cannot rely on a term of an insurance contract in a way that constitutes a breach of the duty.[28] While the *ICA* does not define what would amount to a breach of the duty in the context of claims handling, case law indicates that the duty is not limited to an obligation to act honestly, and requires the insurer to consider the legitimate interests of the policyholder,[29] 'consistently with commercial standards of decency and fairness'.[30] The duty requires insurers to follow the rules of procedural fairness when assessing a claim, and to disclose to the policyholder all materials upon which they intend to rely in order to allow them to respond to any adverse material.[31] Insurers are also required to determine claims in a timely manner and without delay.[32] However, drawing upon the findings in *Matton Developments Pty Ltd v CGU Insurance Ltd [No 2]*,[33] Tarr et al conclude that the duty also entitles insurers to:[34]

- a reasonable period of time to make further inquiries of all the circumstances giving rise to a claim, including inquiries of the insured and those involved in its occurrence;
- put an insured to proof if suspicious of the bona fides of the claim; and
- decline indemnity if the circumstances giving rise to the claim fall outside the insurable interest or an exclusion clause is applicable to the circumstances.

For policyholders whose claims have been denied, or been subject to undue delay, the duty of utmost good faith can provide a basis to complain or challenge the insurer's decision. Conduct amounting to a breach of the duty may entitle

27 Ibid s 13(2).

28 Ibid s 14(1).

29 *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1, 12 [15] (Gleeson CJ and Crennan J) ('*CGU Insurance*'), citing *Distillers Co Biochemicals (Australia) Pty Ltd v Ajax Insurance Co Ltd* (1974) 130 CLR 1, 31 (Stephen J).

30 *CGU Insurance* (n 29) 12 [15] (Gleeson CJ and Crennan J), 77–8 [257] (Callinan and Heydon JJ).

31 *Beverley v Tyndall Life Insurance Co Ltd* (1999) 21 WAR 327, 333 [12]–[14] (Malcolm CJ), 348 [93] (Ipp J).

32 *Moss v Sun Alliance Australia Ltd* (1990) 93 ALR 592, 602 (Bollen J).

33 [2015] QSC 72, 69 [247] (Flanagan J) ('*Matton Developments*').

34 Julie-Anne Tarr et al, 'Utmost Good Faith and Accountability in the Spotlight of the Banking Royal Commission: Time to Revisit the Scope, Applicability and Enforcement of the Duty' (2019) 47(3) *Australian Business Law Review* 148, 156 ('Utmost Good Faith and Accountability'), quoting ibid 70 [248].

the policyholder to seek damages for breach of contract;[35] avoid or cancel the contract; or require the insurer to act in a certain way to prevent the duty from being breached. The *ICA* also provides for ASIC to deal with systemic breaches of the duty by exercising its powers under the *Corporations Act 2001* (Cth)[36] to vary, suspend or cancel an insurer's Australian Financial Services Licence.[37] ASIC may also bring representative action on behalf of a policyholder or third party beneficiary against an insurer.[38] In 2019, legislation was passed enabling ASIC to seek civil penalties for breaches of the duty that did not amount to systemic conduct, but that still warranted an enforcement response.[39]

Other relevant provisions of the *ICA* include s 56, which states that an insurer may refuse to pay fraudulent claims, and s 57, which provides for the accrual of interest on claims from the date when it first becomes unreasonable for the insurer to have withheld payment. The *ICA* also contains other provisions that may enable policyholders to seek review of the insurer's decision if their claims are denied. These include s 28 in pt IV of the *ICA*, which limits the remedies that can be sought by an insurer on the basis of precontractual non-disclosure or misrepresentation by the policyholder; s 44 in pt V, which prohibits an insurer from relying on an 'average clause';[40] and s 54 in pt V, which can provide proportional relief when an

35 *Matton Developments* (n 33) 74 [268] (Flanagan J).

36 *Corporations Act 2001* (Cth) ss 764A(1)(d)–(f), 915C(1), 920A(1) ('*Corporations Act*').

37 *ICA* (n 26) s 14A, as inserted by *Insurance Contracts Amendment Act 2013* (Cth) sch 1 pt 1 s 5 ('*Insurance Contracts Amendment Act*'). ASIC has indicated that it would only use its licensing powers to pursue insurers for breaches of the duty of utmost good faith in cases amounting to serious and systemic misconduct: Australian Securities and Investments Commission, *Life Insurance Claims: An Industry Review* (Report No 498, October 2016) 13 [59] <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-498-life-insurance-claims-an-industry-review/>.

38 *ICA* (n 26) s 11F, as inserted by *Insurance Contracts Amendment Act* (n 37) sch 3 s 1, sch 6 pt 5.

39 *ICA* (n 26) s 13(2A), as inserted by *Treasury Laws Amendment (Strengthening Corporate and Financial Sector Penalties) Act 2019* (Cth) sch 4 s 2. Under s 13(2A), a civil penalty of 5,000 penalty units applies if an insurer fails to comply with the duty of utmost good faith set out in s 13(1) of the *ICA*. See also Treasury (Cth), 'ASIC Enforcement Review: Strengthening Penalties for Corporate and Financial Sector Misconduct' (Positions Paper No 7, 2017) 70 <https://treasury.gov.au/sites/default/files/2019-03/c2017-t232150.pdf>.

40 An 'average clause' is a term that 'reduces the amount of a claim that [an] insurer is obliged to pay: the insurer pays not the full insured loss but the amount which is in the same proportion to the full insured loss as the insured loss is to the total value of the same type of property owned by the policyowner. For example, if a policyowner's home contents are valued at $2000 and the policyowner insures the contents for $1000, the insurer pays half of any insured loss': Ian Enright et al, 'General Insurance' (Background Paper No 14, Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, 12 June 2018) 155 <https://financialservices.royalcommission.gov.au/publications/Pages/default.html>.

insurer denies a claim because of post-formation conduct by the policyholder.[41]

B *Financial Services Legislation*

In addition to the insurance-specific provisions of the *ICA*, general insurers are also subject to the regulatory framework governing all financial services, including banking, credit, superannuation and life insurance. This framework comprises the *Corporations Act 2001* (Cth) ('*Corporations Act*'), which sets out a uniform licensing and disclosure regime covering all financial services, and the *Australian Securities and Investments Commission Act 2001* (Cth) ('*ASIC Act*'), pt 2 of which governs 'consumer protection in relation to financial services'.

1 Corporations Act 2001 *(Cth)*

As providers of 'financial services'[42] to 'retail clients',[43] insurers are required to hold an Australian Financial Services Licence,[44] and to comply with the general conduct obligations in ch 7 of the *Corporations Act*.[45] These obligations include the requirement to be members of AFCA,[46] and to have in place internal dispute resolution ('IDR') processes that comply with standards and requirements made by ASIC.[47] Insurers are required to 'do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and fairly'.[48] Yet until recently, claims handling and settlement — arguably, the core of the service provided by insurers — was expressly excluded from the definition

41 Also relevant is *ICA* (n 26) s 35, which states that an insurer may not refuse to pay a claim on the basis of policy terms that derogate from standard terms of cover prescribed in the *Insurance Contracts Regulations 2017* (Cth), unless the policyholder was 'clearly informed' of the derogation before the contract was entered into. In the context of building and home contents insurance, these standard terms provide for total replacement cover for loss or damage caused by prescribed events including flood: at ss 19–20, 22–3. However, the majority of insurance policies do in fact derogate from these standard terms of cover — for example, because they do not provide total replacement cover — and in practice, insurers can satisfy the requirement of 'clearly informing' policyholders about derogation from standard cover simply by giving them a copy of the insurance policy terms contained in the Product Disclosure Statement. See Julie-Anne Tarr, 'Disclosure under the Prescribed Insurance Contracts Regime: Section 35 of the Insurance Contracts Act 1984 and Consumer Protection Revisited' (2001) 29(3) *Australian Business Law Review* 198, 204; Australian Securities and Investments Commission, Submission to Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (25 October 2018) 11–12 <https://asic.gov.au/regulatory-resources/find-a-document/asic-submissions/>.

42 A person provides a 'financial service' if they give 'financial product advice' or 'deal in a financial product': *Corporations Act* (n 36) s 766A(1). General insurance policies fall within the definition of a 'financial product' in s 764A(1)(d).

43 A person is a 'retail client' in the context of general insurance only if they are 'an individual' or the product 'is or would be for use in connection with a small business'; and the product is a car, building, home contents, sickness and accident, consumer credit, travel, personal and domestic property, or another kind of general insurance product prescribed by the *Corporations Regulations 2001* (Cth) ('*Corporations Regulations*'): ibid s 761G(5).

44 Ibid s 911A(1).

45 These obligations are set out in ibid ss 912A–F.

46 Ibid s 912A(2)(c).

47 Ibid ss 912A(1)(g), (2)(a).

48 Ibid s 912A(1)(a).

of 'financial service' in s 766A of the *Corporations Act*. As noted by the Royal Commission, this meant that the obligation to ensure that financial services are provided 'efficiently, honestly and fairly' did not govern the ways in which insurers:[49]

- ma[de] decision[s] about a claim, including investigating claims and interpreting policy provisions;
- conduct[ed] negotiations in respect of settlement amounts;
- prepare[d] estimates of loss or damage, or likely repair costs; and
- ma[de] recommendations about mitigation of loss.

In 2020, as part of its move to implement certain recommendations of the Royal Commission,[50] the Federal Government consulted on exposure draft legislation to remove the claims handling exemption and create a new 'financial service' of providing a 'claims handling and settling service' under s 766A of the *Corporations Act*.[51] The resulting legislation was passed in December 2020.[52] According to the definition set out in the legislation,[53] a person will be deemed to be providing a claims handling and settling service if they:[54]

- make a recommendation or state an opinion (i) this is 'in response to an inquiry by or on behalf of another person about an existing or potential [insurance] claim'; and (ii) that 'could reasonably be expected to influence a decision whether to continue with an existing claim or to make [a] potential claim';
- assist or represent another person in making an insurance claim;
- assess whether an insurer is liable under an insurance product;
- make a decision to accept or reject all or part of an insurance claim;
- quantify the extent of an insurer's liability under an insurance product;

49 *Royal Commission Final Report* (n 20) vol 1, 308.

50 See especially ibid 32–3, 308–10.

51 Exposure Draft Financial Sector Reform (Hayne Royal Commission Response — Protecting Consumers (2020 Measures)) Bill 2020: Claims Handling (Cth) cl 5 <https://treasury.gov.au/sites/default/files/2019-11/36687_edl_fsrc_rec_4.8_insurance_claims_handling.pdf> ('Exposure Draft — Financial Sector Reform Bill 2020').

52 *Financial Sector Reform (Hayne Royal Commission Response) Act 2020* (Cth) ('*Financial Sector Reform Act 2020*').

53 This definition for 'claims handling and settling service' captures activities 'from the initial inquiry by an insured before a claim is lodged to the formal lodgement and assessment of a claim': Explanatory Materials, Exposure Draft Financial Sector Reform (Hayne Royal Commission Response — Protecting Consumers (2020 Measures)) Bill 2020 (Cth) 8 [1.8] <https://treasury.gov.au/sites/default/files/2019-11/36687_em_fsrc_rec_4.8_insurance_claims_handling.pdf> ('Exposure Draft Explanatory Materials — Financial Sector Reform Bill 2020').

54 *Corporations Act* (n 36) s 766G, as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cl 10.

- offer to settle all or part of an insurance claim; or
- satisfy a liability of an insurer under an insurance claim.

By including claims handling and settling within the definition of a 'financial service',[55] this legislation enables ASIC to take enforcement action in respect of an insurer's failure to comply with the obligation to provide financial services 'efficiently, honestly and fairly' in the context of claims handling. As a minimum, the obligation to handle and settle claims 'efficiently, honestly and fairly' requires insurers to decide claims 'in a timely way, without undue delay', and to take into account 'the negative effects of delay' on the policyholder.[56] It requires insurers to ensure that any information requests, medical examinations, surveillance and other assessment methods are undertaken 'in the least onerous and intrusive way possible', and only if they are 'strictly relevant to the claim'.[57] It also requires insurers to handle claims 'fairly and transparently, with information about the handling and settling process, the reason for information requests, and reasons for decisions provided to insureds'.[58] Finally, the obligation includes responsibility for ensuring that 'adequate support is provided' to all policyholders and especially 'vulnerable consumers'.[59]

The legislation requires insurers and others who provide claims handling services for insurers (including insurance claims managers,[60] certain tradespeople, certain brokers and certain financial and legal advisers) to hold an Australian Financial Services Licence covering claims handling, or to be authorised by another holder of such a licence.[61] The legislation also excludes certain aspects of an insurer's claims handling role from the additional obligations that apply to 'financial product advice',[62] particularly 'personal advice',[63] under the *Corporations Act*. Financial service providers giving 'personal' advice are required to 'act in the

55 *Corporations Act* (n 36) s 766A(1)(eb), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cl 7.

56 Exposure Draft Explanatory Materials — Financial Sector Reform Bill 2020 (n 53) 11 [1.18].

57 Ibid.

58 Ibid.

59 Ibid.

60 An 'insurance claims manager' is defined as a person who '(a) … carries on a business of providing claims handling and settling services on behalf of one or more insurers; and (b) where the person, as part of that business, also provides goods or other services — providing claims handling and settling services … is the primary part of the business': *Corporations Act* (n 36) s 761DA, as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cl 6.

61 *Corporations Act* (n 36) ss 911A(2)(ek)–(en), 911B(1)(f)–(g), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cls 12, 13. See also Explanatory Memorandum, Financial Sector Reform (Hayne Royal Commission Response) Bill 2020 (Cth) 130–1 [7.9] <https://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r6630_ems_4c5698fa-a114-4687-9843-595e795a64cf/upload_pdf/JC000444.pdf;fileType=application%2Fpdf> ('Explanatory Memorandum, Financial Sector Reform Bill 2020').

62 'Financial product advice' is defined as 'a recommendation or a statement of opinion, or a report of either of those things' that is 'intended to influence', or 'could reasonably be regarded as being intended' to influence, a person in making a decision in relation to a type of financial product: *Corporations Act* (n 36) s 766B(1).

63 Financial product advice is 'personal' if it is given or directed to a person in circumstances where the insurer 'has considered one or more of the person's objectives, financial situation and needs', or 'a reasonable person might expect the [insurer] to have considered one or more of those matters': ibid s 766B(3).

best interests of the client in relation to the advice'.[64] This obligation does not apply to opinions expressed by insurer staff that could reasonably be viewed as a 'necessary part' of providing a claims handling and settlement service,[65] including recommendations regarding:[66]

- The most effective manner of submitting a claim;
- The most effective manner to obtain necessary information as part of submitting a claim;
- The appropriateness of repairing or replacing an item in relation to a claim;
- Ways to mitigate the extent of loss or damage associated with an insurance claim; and
- Ways to 'protect against the same or a similar loss in the future'.

Finally, the legislation requires insurers to provide a Cash Settlement Fact Sheet — a plain English document intended to assist policyholders to 'make an informed decision about whether to accept [an insurer's cash settlement] offer'[67] — if they choose to offer a cash settlement instead of repairing or replacing the policyholder's property.[68] Failure to provide a Cash Settlement Fact Sheet constitutes a strict liability offence attracting civil penalties,[69] similar to failure to provide other important disclosure documents such as Financial Services Guides and Statements of Advice.[70]

2 Australian Securities and Investments Commission Act 2001 *(Cth)*

Under ss 12BF–BM of the *ASIC Act*, consumers of financial products and services are provided with certain protections in relation to unfair contract terms ('UCT'). Section 12BF(1) of that Act states that a term in a 'consumer contract'[71] or 'small business contract'[72] will be void if (a) the term is 'unfair', (b) the contract is a

64 Ibid s 961B(1).

65 Ibid s 766B(7A), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cl 8.

66 Exposure Draft Explanatory Materials — Financial Sector Reform Bill 2020 (n 53) 16 [1.30]. See also Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 143–4 [7.64].

67 Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 140 [7.41].

68 *Corporations Act* (n 36) ss 948B, 948C, as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cl 18.

69 See *Corporations Act* (n 36) s 952C. However, 'the new strict liability offence is not punishable by imprisonment and the penalty is below the maximum penalty unit cap provided for in the Guide to Framing Commonwealth Offences': Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 142 [7.55].

70 Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 141–2 [7.49]–[7.54].

71 *Australian Securities and Investments Commission Act 2001* (Cth) s 12BF(3) ('*ASIC Act*').

72 Ibid s 12BF(4).

'standard form contract',[73] and (c) the contract is either a financial product or a contract for the supply, or possible supply, of financial services. A term will be 'unfair' for the purposes of the UCT regime if it meets three criteria:[74]

(a) it would cause a significant imbalance in the parties' rights and obligations arising under the contract; and

(b) it is not reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term; and

(c) It would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

Until recently, s 15 of the *ICA* excluded general insurance contracts from being the subject of relief under the UCT provisions in the *ASIC Act*. In 2020, following the recommendations of the Royal Commission,[75] legislation was passed to amend s 15 and tailor the UCT regime to accommodate some specific features of insurance contracts.[76] These changes will enable policyholders whose claims are denied on the basis of a term in their policy to challenge their insurer's decision by seeking a declaration that the term is 'unfair'. [77] The policyholder could do this by taking legal action in the courts, or more realistically, through AFCA, which provides its external dispute resolution services free of charge. ASIC can also seek a declaration in the courts for the benefit of consumers who are not themselves parties to the proceedings.[78] If the declaration is made, the unfair term will be void for anyone who would suffer the same detriment,[79] although if the contract is capable of operating without the unfair term, it will continue to bind the parties.[80] In addition to declaring all or part of a contract to be void, a court can make orders to redress loss or damage suffered by non-party consumers, including (a) varying the contract; (b) refusing to enforce all or any of the contract terms; (c) directing the business to refund money to non-party consumers; or (d) directing the business, at their expense, to provide

73 See ibid s 12BK(2) for guidelines that must be taken into account in determining whether a contract is a 'standard form contract'. If a party to a proceeding 'alleges that a contract is a standard form contract, it is presumed to be a standard form contract unless another party to the proceeding proves otherwise': at s 12BK(1).

74 Ibid s 12BG(1).

75 *Royal Commission Final Report* (n 20) vol 1, 32, 303–8.

76 *Financial Sector Reform (Hayne Royal Commission Response — Protecting Consumers (2019 Measures)) Act 2020* (Cth). See also Evgenia Bourova, Ian Ramsay and Paul Ali, 'A "Damaging Loophole" "Long Overdue" for Closing: Extending Consumer Protections against Unfair Contract Terms to Insurance' (2020) 27(3) *Competition & Consumer Law Journal* 264.

77 See *ASIC Act* (n 71) s 12GND(1)(a). Certain terms are excluded from being the subject of review under these provisions, including terms that (a) define the main subject matter of the contract; (b) set the upfront price payable under the contract; or (c) are required, or expressly permitted, by law: at s 12BI.

78 Ibid ss 12GNB(1), 12GND(1)(b).

79 Ibid s 12BF(1).

80 Ibid s 12BF(2).

specified services to non-party consumers.[81] In 2020, following a consultation process commenced in 2019,[82] consumer affairs ministers from the Federal, State and Territory Governments reached an agreement regarding proposed reforms that would include making UCT illegal and allowing ASIC to impose civil penalties on insurers who include and rely on UCT in their contracts.[83] Treasury is expected to develop exposure draft legislation implementing these reforms in 2021.

C *General Insurance Code of Practice (2014)*

As shown in Parts II(A) and (B) of this article, general insurance is covered by an intersecting framework of insurance-specific legislation as well as legislation governing financial services generally. However, until 2020, the primary source of specific obligations in relation to claims handling was the *2014 Code* — a voluntary code of practice covering most types of general insurance.[84] By adopting the Code, an insurer enters into a contract with the Insurance Council of Australia to abide by its provisions.[85] Clause 7.2 of the *2014 Code* requires insurers to 'conduct claims handling in an honest, fair, transparent and timely manner'. In early 2020, after conducting a review of the *2014 Code*,[86] the Insurance Council of Australia launched a new version of the Code, being the *2020 Code*.[87] The *2020 Code* took effect on 1 January 2020.[88] Because our study was carried out in 2019, throughout this article, we will primarily refer to the provisions of the *2014 Code*.

While the *2020 Code* retains the majority of the standards contained in the previous Code, it also incorporates some significant changes. First, it extends the obligation in cl 7.2 of the *2014 Code* to all dealings between insurers and

81 Ibid s 12GNC.

82 See Treasury (Cth), 'Enhancements to Unfair Contract Term Protections: Consultation Regulation Impact Statement' (Consultation Paper, December 2019) <https://consult.treasury.gov.au/consumer-and-corporations-policy-division/enhancements-to-unfair-contract-term-protections/>.

83 Treasury (Cth), 'Enhancements to Unfair Contract Term Protections: Regulation Impact Statement for Decision' (Report, September 2020) <https://ris.pmc.gov.au/sites/default/files/posts/2020/11/enhancements_to_unfair_contract_term_protections_-_decision_ris.pdf>.

84 *2014 Code* (n 7) cl 3.5.

85 Ibid cl 1.5.

86 Insurance Council of Australia, *Review of the General Insurance Code of Practice* (Final Report, June 2018) <http://codeofpracticereview.com.au/assets/Final%20Report/250618_ICA%20Code%20Review_Final%20Report.pdf> ('*Review of the General Insurance Code of Practice*').

87 See *2020 Code* (n 8).

88 Ibid cl 7. The *2020 Code* is being adopted in stages. In order to support consumers affected by COVID-19, implementation of its provisions for customers experiencing vulnerability and financial hardship was brought forward to 1 July 2020. By this date, insurers were also required to introduce a policy to support customers affected by family violence. The remainder of the Code must be adopted by 1 July 2021: Insurance Council of Australia, 'Insurance Council Fast-Tracks New Code of Practice Vulnerability and Hardship Provisions' (Media Release, 7 May 2020) <https://www.insurancecouncil.com.au/media_release/plain/570>.

policyholders, stating 'We, our Distributors and our Service Suppliers' — which include investigators, loss assessors, loss adjusters and other third-party service providers — 'will be honest, efficient, fair, transparent and timely in our dealings with you'.[89] Secondly, the *2020 Code* requires insurers to provide consumers with information regarding cash settlements and scope of works if these are offered or needed in relation to a building insurance claim.[90] Thirdly, it contains new provisions for supporting policyholders experiencing vulnerability (for example, due to disability, family violence, language or literacy barriers, or financial distress),[91] and enhanced protections for customers in financial hardship.[92] Fourthly, it introduces mandatory standards for claim investigations.[93]

Finally, the *2020 Code* expands the powers of the Code Governance Committee to impose sanctions for breaches of its provisions.[94] This is in response to concerns about the limited mechanisms for enforcing compliance with self-regulatory codes,[95] as a result of which the code regime was 'widely considered insufficient, lacking regulatory oversight and limiting consumer confidence in the sector'.[96] Compliance with the Code is monitored and enforced by the Code Governance Committee.[97] Policyholders can report alleged breaches of the Code to the Committee,[98] and AFCA can report potential breaches arising in disputes between insurers and policyholders.[99] Insurers themselves are required to report 'Significant Breach[es]' to the Committee within 10 business days.[100] However, while over 13,000 breaches of the *2014 Code* were self-reported by insurers between 2014 and 2018, and a further 689 breaches were conceded in the course of an investigation, the Code Governance Committee did not impose sanctions in respect of any of these breaches,[101] its powers being activated only when an insurer had already 'failed to correct' a breach.[102] There was also a lack of clarity as to whether sanctions for breaches could include compensation for

89 *2020 Code* (n 8) cl 21.

90 Ibid cls 61, 79.

91 Ibid pt 9.

92 Ibid pt 10.

93 Ibid pt 15.

94 Ibid pt 13.

95 See *Royal Commission Final Report* (n 20) vol 1, 104–8, 310–11, citing Witness Statement of Lynelle Briggs, 14 September 2018, 4 [17], 7 [18], 32 [180].

96 ASIC Enforcement Review Taskforce, *ASIC Enforcement Review Taskforce Report* (Report, December 2017) 31 <https://treasury.gov.au/sites/default/files/2019-03/ASIC-Enforcement-Review-Report.pdf>.

97 *2014 Code* (n 7) cl 12.1.

98 Ibid cl 13.1.

99 Ibid cl 13.17.

100 Ibid cl 13.3.

101 *Royal Commission Final Report* (n 20) vol 1, 315, citing Witness Statement of Lynelle Briggs, 14 September 2018, 4 [17], 7 [18], 32 [180].

102 See *2014 Code* (n 7) cl 13.11.

financial loss caused to individual policyholders.[103] In response to these concerns, the *2020 Code* gives the Code Governance Committee a broader power to impose sanctions in circumstances that are not limited to an insurer's failure to remedy a breach.[104] The *2020 Code* also sets out 'additional sanctions' for 'Significant Breaches', which may include compensation for any direct financial loss caused to an individual, publication of the breach, or the payment of a community benefit of up to $100,000.[105] The Committee is required to report Significant Breaches or serious misconduct to ASIC.[106]

These changes went some way towards addressing concerns about the mechanisms for incentivising compliance with the Code. However, they did not address what the Royal Commission described as ongoing uncertainty over which provisions of the Code may actually be relied upon and enforced by individual policyholders.[107] Unlike the Australian Banking Association's *Banking Code of Practice* (2020),[108] the *2014 Code* does not form part of the individual contract between insurer and policyholder, preventing policyholders from seeking contractual remedies for breaches of its provisions.[109] To enable policyholders to enforce breaches through insurers' IDR processes, AFCA or the courts,[110] the Royal Commission recommended amendments to the *Corporations Act* to enable the identification of 'enforceable code provisions', a contravention of which would constitute a breach of the Act.[111] It also recommended that the Insurance Council of Australia and ASIC take 'all necessary steps' to have Code provisions governing 'the terms of the contract made or to be made' between insurers and policyholders designated as 'enforceable' by 30 June 2021.[112] Following a consultation process conducted

103 *Review of the General Insurance Code of Practice* (n 86) 68; *Royal Commission Final Report* (n 20) vol 1, 105–6.

104 See *2020 Code* (n 8) cl 170. Sanctions for breaches may include requiring the insurer to take rectification steps within a set timeframe, audit their compliance with the Code at their own cost, or advertise to correct an issue flagged by the Code Governance Committee: at cl 173.

105 Ibid cl 174.

106 Ibid cl 176.

107 *Royal Commission Final Report* (n 20) vol 1, 106, 311.

108 See Australian Banking Association, *Banking Code of Practice* (at 1 March 2020) cl 2. For examples of cases where it was held that certain provisions of the Australian Bankers' Association's *Code of Banking Practice* (at 2013) — the predecessor to the current banking code — formed part of the contract between the financial service provider and the customer, see *Doggett v Commonwealth Bank of Australia* (2015) 47 VR 302, 326 [95]–[96], 337 [139] (McLeish JA); *National Australia Bank Ltd v Rice* [2015] VSC 10, 2 [4] (Elliott J); *Commonwealth Bank of Australia v Wood* [2016] VSC 264, 18 [79] (Elliott J).

109 See Consumers' Federation of Australia et al, Submission to Insurance Council of Australia, *General Insurance Code of Practice 2017 Review: Interim Report* (January 2018) 105–6 <http://codeofpracticereview.com.au/submissions>, quoting Ian Enright, *General Insurance Code of Practice Independent Review 2012–2013* (Final Report, May 2013) 102 [9.120] <https://www.insurancecouncil.com.au/for-consumers/code-of-practice/2012-review>.

110 *Royal Commission Final Report* (n 20) vol 1, 109–11, 312.

111 Ibid 24, 112.

112 Ibid 33, 316.

in 2020,[113] legislation was passed implementing these proposals,[114] upon the basis that designating certain code provisions as 'enforceable' would allow industry 'to be held accountable for breaches of the code'.[115] This legislation enables ASIC to identify code provisions as enforceable where the provision:[116]

> (a) represents a commitment to a person by a subscriber to the code relating to transactions or dealings performed for, on behalf of or in relation to the person; and
>
> (b) a breach of the provision is likely to result in significant and direct detriment to the person; and
>
> (c) additional criteria prescribed by the regulations for the purposes of this paragraph (if any) are satisfied; and
>
> (d) it is appropriate to identify the provision of the code as an enforceable code provision.

Whether it is appropriate to identify a provision as an enforceable code provision will depend upon factors including whether the code imposes a 'more onerous' level of obligation than that imposed by other laws under which ASIC has regulatory responsibility';[117] and 'whether the obligations of subscribers to the code are capable of being enforced'.[118] Civil penalties of up to 300 penalty units may apply for breaches of an enforceable code provision by a person who 'holds out that they comply with an approved code of conduct'.[119] The legislation also establishes a framework for certain codes of conduct to be declared mandatory codes of conduct under the regulations. Civil penalties of up to 1,000 penalty units may apply for a breach of a provision of a mandatory code of conduct that has been designated a civil penalty provision.[120] ASIC also has the power to 'issue an infringement notice if it believes on reasonable grounds that a person has contravened an enforceable code provision in an approved code of conduct or a

113 See Exposure Draft Financial Sector Reform (Hayne Royal Commission Response — Protecting Consumers (2020 Measures)) Bill 2020: FSRC Rec 1.15 (Enforceable Code Provisions) (Cth) <https://treasury.gov.au/sites/default/files/2020-01/c2020-48919f-exposure-draft-20200130.pdf>;Explanatory Materials, Exposure Draft Financial Sector Reform (Hayne Royal Commission Response — Protecting Consumers (2020 Measures)) Bill 2020: FSRC Rec 1.15 (Enforceable Code Provisions) (Cth) <https://treasury.gov.au/sites/default/files/2020-01/c2020-48919f-explanatory_memorandum.pdf>.

114 *Financial Sector Reform Act 2020* (n 52) sch 1.

115 Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 26 [1.73].

116 *Corporations Act* (n 36) s 1101A(2), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4.

117 *Corporations Act* (n 36) s 1101A(3)(a), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4. See also Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 22 [1.42]–[1.44].

118 *Corporations Act* (n 36) s 1101A(3)(c)(i), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4. See also Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 23–4 [1.54]–[1.57].

119 *Corporations Act* (n 36) s 1101AC, as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4.

120 *Corporations Act* (n 36) ss 1101AE(3), 1101AF, as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4.

civil penalty provision in a mandatory code of conduct'.[121]

III OUTLINE OF THE CLAIMS PROCESS

A *After a Claim is Made*

According to the Financial Rights Legal Centre, the process through which insurers make decisions to accept or deny claims can 'vary greatly' depending on the insurer's internal procedures, 'the circumstances of each case', and the 'individual behaviour' of third-party service providers such as investigators, loss assessors and loss adjusters.[122] This process is activated when, 'as soon as is reasonably practicable'[123] after an event resulting in loss or damage to their property, the policyholder notifies the insurer of their intention to make a claim.[124] The insurer must then assess the claim to determine what loss or damage was suffered, and whether the circumstances of the loss qualify as an insurable event under the policy. The policyholder may be required to provide evidence of the extent of their loss — such as receipts, police reports, valuation reports and photographs of property — although the insurer must only request and rely on such information that is relevant to their decision.[125] The policyholder may also be required to pay an excess.[126]

For claims that do not require any further assessment or investigation, the insurer must accept or deny the claim and notify the policyholder within 10 business days.[127] The insurer may be required to 'fast-track the assessment and decision process' and 'make an advance payment' if the policyholder demonstrates urgent financial need of the benefits to which they are entitled under the policy.[128] When responding to an event that the Insurance Council of Australia declares to be a 'Catastrophe' (typically a natural disaster or other extreme weather event resulting in a large number of claims),[129] the insurer is required to handle claims in an

121 Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 35 [1.138].

122 *Guilty until Proven Innocent* (n 14) 18.

123 Enright et al (n 40) 133.

124 The policyholder may do this by telephone, online, by completing a claim form, or by communicating with their broker: ibid 132.

125 *2014 Code* (n 7) cl 7.3.

126 Excesses payable under an insurance policy may include a standard excess (the level of which can typically be increased in return for a decreased premium), an additional excess (for example, for drivers under 25 years of age, or for theft or other non-collision incidents), or a special or imposed excess (for example, where a policyholder's driving record or claims history suggests additional risk): *Review of General Insurance Claims Handling* (n 6) 41 [232]–[234].

127 *2014 Code* (n 7) cl 7.9.

128 Ibid cl 7.7.

129 Ibid pt 15 (definition of 'Catastrophe').

'efficient, professional and practical way, and in a compassionate manner'.[130] This is in addition to the general requirement in cl 7.2 of the *2014 Code* to 'conduct claims handling in an honest, fair, transparent and timely manner'.

B *Claim Investigations*

Most claims are decided within the 10-business-day timeframe prescribed by cl 7.9 of the *2014 Code*.[131] In some cases, the decision is made at initial contact by frontline staff taking telephone calls from policyholders.[132] However, if the insurer identifies 'anomalies' or 'red flags' indicating that the claim has a risk of being fraudulent,[133] they may apply an internal 'triage process' to determine whether the claim requires investigation.[134] In the majority of cases, if the insurer determines that the claim should be investigated further, the claim will be referred to an external private investigator.[135] The insurer is required to notify the policyholder within five business days of appointing an investigator.[136] The insurer may also appoint other third-party service providers such as loss assessors or loss adjusters to assess the extent of the loss or damage. They may in turn arrange for specialists such as engineers or tradespeople to provide expert reports and repair or rebuilding quotes.

Importantly, the appointment of a third-party service provider to assess or investigate the claim extends the timeframe within which the insurer must make a decision. Where an investigator, loss assessor or loss adjuster is appointed, the insurer must accept or deny the claim within four months of receiving it,[137] unless 'Exceptional Circumstances' apply, in which case the decision must be made within 12 months.[138] 'Exceptional Circumstances' include cases where the insurer 'reasonably suspect[s] fraud'.[139] An exception from these timeframes is where the cause of any noncompliance is 'a delay in the supply' of an expert report and

130 Ibid cl 9.2.

131 *Guilty until Proven Innocent* (n 14) 15.

132 *Review of General Insurance Claims Handling* (n 6) 24 [123]–[124]. However, the authorisation of frontline staff to make claims decisions at initial contact typically extends only to approving claims. Where frontline staff are permitted to decide to deny a claim, that decision will typically be 'reviewed by a claims specialist before being confirmed in writing': at 6 [21], 24 [124].

133 Such indicators may concern the nature of the claim (for example, fire, theft); if the claim is made a short time after the policy began, or after an increase in cover; inconsistency between the nature of the claim and the loss; a history of similar claims, declined claims or fraudulent claims; a history of queries about coverage in circumstances similar to the claim; 'inconsistencies or discrepancies' in the policyholder's statements; 'evasive, hostile, uncooperative, vague or dismissive behaviour'; and the policyholder's financial situation: *Own Motion Inquiry* (n 15) 17–18. See also *Guilty until Proven Innocent* (n 14) 15.

134 *Own Motion Inquiry* (n 15) 16–18.

135 Ibid 20.

136 *2014 Code* (n 7) cl 7.12.

137 Ibid cl 7.17.

138 Ibid cl 7.18.

139 Ibid pt 15 (definition of 'Exceptional Circumstances').

the insurer had used their 'best endeavours to obtain the report in time'.[140] The insurer must keep the policyholder informed about the progress of the claim at least every 20 business days,[141] and respond to requests made by the policyholder regarding the claim within 10 business days.[142]

An investigation usually involves one or more interviews with the policyholder. Typically, interviews are held at the policyholder's home, although they may also be held at the insurer's branch office, at a neutral location such as a café, or over the phone.[143] The policyholder may be asked open-ended questions about 'what happened', or direct questions to 'clarify [any] discrepancies' in their narrative.[144] At the end of the interview, the policyholder is asked to sign an authority to access their records.[145] The investigator may then verify the policyholder's version of events by contacting witnesses or third parties, or evaluating evidence including their insurance history, social media communications and independent forensic reports.[146] Upon concluding the investigation, the investigator provides a report to the insurer.[147] Once they 'have all relevant information and have completed all enquiries', the insurer must accept or deny the claim and notify the policyholder within 10 business days.[148]

C *Making a Decision*

If the claim is accepted, the insurer will notify the policyholder of their decision and make an assessment of the extent of the loss or damage that they will compensate by repairing, rebuilding or replacing the property, or by providing the policyholder with a cash settlement. In many cases, the insurer's assessment of the loss or damage is different to that of the policyholder, meaning that only part of their claim is paid out. If the insurer decides to repair or rebuild the policyholder's property, they may select their own contractor to do this,[149] or allow the policyholder to choose their own repairer. Delays sometimes occur at this point if the insurer's authorised repairer fails to complete the works within a reasonable period, or if they have difficulty obtaining replacement car parts. If

140 Ibid cl 7.21.

141 Ibid cl 7.13.

142 Ibid cl 7.14.

143 *Guilty until Proven Innocent* (n 14) 16.

144 Ibid.

145 For example, 'criminal records, bank and phone records and any other documents relevant to the investigation': ibid 17.

146 Ibid.

147 An external service provider or expert must provide their report within 12 weeks; however, if they fail to do so, the insurer may simply inform the policyholder that the report is not complete, and comply with the requirements for keeping the policyholder informed of the progress of the claim: *2014 Code* (n 7) cl 7.15.

148 Ibid cl 7.16.

149 If repairs are performed by a person selected and authorised by the insurer, the insurer will be responsible for any faulty or incomplete repairs: ibid cl 7.20.

the insurer denies the claim, they must give the policyholder written reasons for the decision and inform them of their right to receive copies of the information relied upon to assess their claim.[150] The insurer must also inform the policyholder of their right to seek review of the decision through their IDR process.[151]

IV METHODOLOGY

In this part of the article, we introduce our study, which used an online survey to investigate the experiences of Australians who had recently made claims on a building, home contents, or comprehensive car insurance policy. The survey was delivered through the research company Pureprofile, which maintains a database of panelists who complete online surveys in return for a cash payment.

The survey comprised 107 questions. The survey began with a series of screener questions to ensure that it was only completed by people who (a) had, within the previous three years, made a claim on a building, home contents, or comprehensive car insurance policy,[152] (b) were aged over 18,[153] and (c) had sole or joint responsibility for making insurance decisions in their household.[154] After their eligibility to participate was confirmed, respondents were asked if they consented to have their comments quoted directly, to which 91.5% gave their consent. Following a series of demographic questions, the survey asked respondents about the incident that led to them making a claim, and the extent of the loss or damage to their property. The survey asked respondents about their experience of the claims process and the outcome of their claim. Certain questions were programmed so as to be visible only to those respondents who had experienced certain stages of the claims process (such as a claim investigation); or those who selected particular claim outcomes (such as 'claim denied', or 'claim accepted'). While most questions were multiple choice, at various points in the survey, open-ended questions invited respondents to provide qualitative comments about particular aspects of the claims process.

150 Ibid cl 7.19(a)–(c).

151 Ibid cl 7.19(d). A policyholder has the right to make a complaint to their insurer's IDR process about any aspect of their relationship: at cl 10.3.

152 Question 1 asked respondents if their home contents were covered by home contents insurance. Question 2 asked if they had, within the previous three years, made a claim on their home contents insurance policy. The survey was programmed so that respondents who answered 'yes' to both of these questions would proceed to the main survey and would answer subsequent sections in relation to home contents insurance only. Respondents who answered 'no' to either question would proceed to Question 3, which asked if their home was covered by building insurance; and Question 4, which asked if they had, within the previous three years, made a claim on their building insurance policy. The same approach was taken in relation to comprehensive car insurance. Those who did not have building, home contents or comprehensive car insurance — or who had not claimed on any of these types of insurance — were not permitted to complete the survey.

153 Question 10 asked respondents to select their age. Those aged under 18 were not permitted to complete the survey.

154 Question 8 asked respondents if they had any responsibility for making decisions about insurance in their household. Those who indicated that such decisions were made by 'someone else' — for example, a parent or a partner — were not permitted to complete the survey.

In order to compare respondents' experiences by type of insurance product, we delivered the survey in three waves. We asked Pureprofile to obtain quotas of 500 completed surveys from people who had, within the previous three years, made a claim on a home contents insurance policy (Wave 1); a building insurance policy (Wave 2); and a comprehensive car insurance policy (Wave 3).[155] We asked Pureprofile to impose quotas based on Australian Census data so that our results were representative of the population in terms of age, gender and geographic location. Ethics approval for the study was granted on 12 July 2019. The survey was launched between August and September 2019.[156] A total of 1,507 completed responses were obtained.

The survey data was analysed by a statistician. Differences in sample means and proportions between various sub-groups within the total sample (n = 1,507) were tested using t-tests and chi-square tests of independence to determine whether these differences were statistically significant. The three sub-groups compared in this article are respondents who took part in Wave 1 (n = 498) ('home contents insurance respondents'); Wave 2 (n = 500) ('building insurance respondents'); and Wave 3 (n = 509) ('car insurance respondents').

V OUR FINDINGS

In this part of the article, we set out the findings of our survey. Unless otherwise specified, all references to 'the respondents' refer to our total sample (n = 1,507). When comparing the results from Waves 1, 2 and 3, we refer to proportions of home contents insurance respondents, building insurance respondents and car insurance respondents respectively.

A *Respondent Demographics*

The respondents consisted of 1,507 members of the Pureprofile panel. Just over half (52.6%) of respondents were female; 47.4% were male; and 0.1% described their gender as 'other'. Nine per cent were aged 18–24 years; 24.6% were aged 25–34 years; 21.0% were aged 35–44 years; 15.0% were aged 45–54 years; 14.1% were aged 55–64 years; and 16.3% were aged over 65 years. The majority (79.9%) of respondents were born in Australia. Most identified their highest level of education completed as a Bachelor Degree at university (31.8%); a TAFE diploma

155 We decided to deliver the survey in this way based on the expectation that without the use of quotas, our sample would consist overwhelmingly of car insurance policy claimants, as car insurance is the more commonly held and claimed upon insurance product in Australia. See Connolly (n 1) 26; *General Insurance in Australia 2017–18* (n 9) 28–9.

156 Wave 1 was launched on 12 August and closed on 28 August 2019. Wave 2 was launched on 28 August and closed on 18 September 2019. Wave 3 was launched on 16 September and closed on 26 September 2019. In order to test the survey, as part of every wave, 50 responses were collected and data collection paused to allow the results to be reviewed.

(25.0%); or a postgraduate degree (19.8%).[157] Smaller proportions identified their highest level of education as Year 12 (13.1%); Year 11 (3.8%); or Year 10 or less (6.5%).[158]

The largest proportion of respondents (32.5%) were living in New South Wales, followed by Victoria (26.2%); Queensland (20.9%); Western Australia (9.7%); South Australia (7.4%); Tasmania (1.7%); the Australian Capital Territory (1.4%); and the Northern Territory (0.4%). Most respondents (72.2%) were living in major cities, with smaller proportions living in inner regional areas (17.1%); outer regional areas (9.3%); and remote areas (1.4%).[159] The majority of respondents were homeowners. Forty-three per cent had a mortgage over their home, and 35.9% owned their home outright. Only 15.1% were renting from a landlord or real estate agent, and small proportions were renting in public or community housing (2.5%) or living rent-free with family or friends (3.1%).

Nearly half (46.6%) of respondents were employed on a permanent full-time basis. Smaller proportions were employed on a permanent part-time basis (12.9%); employed on a casual basis (9.5%); or self-employed or working in a family business (5.9%). A further 16.9% were retired and 4.7% were studying. Small proportions were engaged in home duties (5.4%); caring for a child or another person (3.5%); or looking for work or extra work (1.7%), while 0.7% selected 'none of the above'. When asked to estimate their annual household income before tax,[160] 10.6% of respondents selected '$150,000 or more'; 11.4% said '$125,000 – $149,999'; 14.9% said '$100,000 – $124,999'; 17.7% said '$75,000 – $99,999'; 14.9% said '$50,000 – $74,999'; 18.2% said '$25,000 – $49,999'; and 7.0% said 'less than $25,000', while 5.4% said 'do not know or prefer not to say'.

B *Insurance Claims*

All respondents were asked about the type of incident that led to them making

157 People with higher levels of educational attainment were somewhat over-represented in our sample. Figures published by the Australian Bureau of Statistics ('ABS') in 2019 showed that 27.2% of the Australian population identified their level of highest educational attainment as a TAFE diploma or certificate, while only 18.6% had completed a Bachelor degree at university; 6.8% had a postgraduate degree; and 3.0% had a graduate diploma or graduate certificate: Australian Bureau of Statistics, *Education and Work, Australia, May 2019* (Catalogue No 6227.0, 13 November 2019) tbl 9 <https://www.abs.gov.au/ausstats/abs@.nsf/mf/6227.0/>.

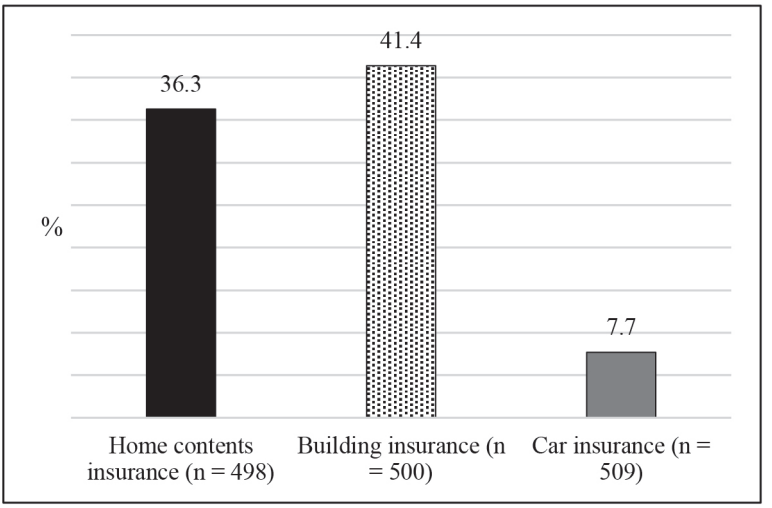
158 By comparison, higher proportions of the Australian population identified their levels of highest educational attainment as Year 12 or equivalent (18.3%); Year 11 (5.3%); and Year 10 or less (17.7%): ibid.

159 These categories are based upon the *Accessibility and Remoteness Index of Australia* utilised by the ABS: see Australian Bureau of Statistics, *Australian Statistical Geography Standard (ASGS*): *Volume 5 — Remoteness Structure, July 2016* (Catalogue No 1270.0.55.005, 16 March 2018) <https://www.abs.gov.au/ausstats/abs@.nsf/mf/1270.0.55.005>. The category 'major cities' includes all Australian capital cities except for Hobart and Darwin, which are classified as 'inner regional' and 'outer regional' respectively. The categories 'remote' and 'very remote' have been combined into a single category for the purposes of this article, as the proportion of respondents living in these areas was very small.

160 Respondents were asked to include in their estimate all sources of income such as wages, Centrelink payments and child support.

a claim, and the extent of the loss or damage to their property.[161] As shown in Figure 1, significant proportions of claims in our sample were made in relation to loss or damage caused by a storm, flood, bushfire or another extreme weather event.

Figure 1: Proportion of Claims Made in Relation to Natural Disasters and Other Extreme Weather Events



1 *Home Contents Insurance*

When asked about the type of incident that made them make a claim, 17.7% of home contents insurance respondents (n = 498) selected 'storm damage', while the same proportion selected 'accidental breakage', and 17.5% selected 'burst or leaking pipes'. Twelve per cent selected 'break in, burglary or vandalism', followed by 'flood' (10.4%); 'house fire' (7.2%); 'bushfire' (5.4%); or 'another extreme weather event (for example, a cyclone)' (2.8%). Just over 9% selected 'other'. When asked to estimate the extent of the damage to their home contents, 33.3% of home contents insurance respondents said their claim related to 'minor damage totaling less than $1,000'. Forty-three per cent selected 'moderate damage totaling $1,000 to $4,999', while 19.9% selected 'major damage totaling $5,000 or more'. Two per cent selected 'total loss' (meaning their home contents had to be fully replaced), and 1.8% said 'can't recall'.

161 If they had made multiple claims on this policy within the previous three years, respondents were asked to consider their most recent claim.

2 *Building Insurance*

The largest proportion (27.4%) of building insurance respondents said their claim related to 'storm damage', followed by 'burst or leaking pipes' (18.6%); 'accidental breakage' (15.0%); 'house fire' (9.6%); 'flood' (7.4%); 'break-in, burglary or vandalism' (6.6%); 'bushfire' (3.4%); or 'another extreme weather event' (3.2%), with 8.8% selecting 'other'. Over half (56.6%) of building insurance respondents said their claim related to 'minor damage totaling less than $5,000'. Smaller proportions selected 'moderate damage totaling $5,000 to $14,999' (29.2%); 'major damage totaling $15,000 or more' (10.0%); 'total loss' (meaning their home had to be fully rebuilt) (2.2%); and 'can't recall' (2.0%).

3 *Car Insurance*

The majority (75.8%) of car insurance respondents said their claim related to a 'car accident'.[162] A further 9.4% selected 'theft of my car'; 7.7% selected 'an extreme weather event (for example, a flood, storm, bushfire or cyclone)'; and 7.1% said 'other'. Nearly half (47.7%) of car insurance respondents said their claim related to 'moderate damage totaling $1,000 to $4,999'. Smaller proportions selected 'minor damage totaling less than $1,000' (28.1%); 'major damage totaling $5,000 or more' (12.0%); 'total loss' (meaning their car was written off) (9.2%); and 'can't recall' (2.9%).

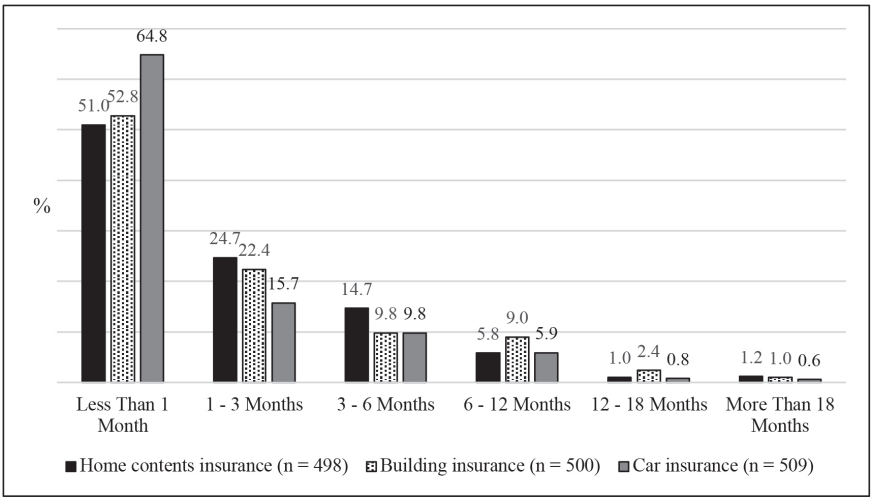
C *Claims Handling Experiences*

1 *Claim Resolution Times*

All respondents were asked how long it took their insurer to make a decision on their claim. Across Waves 1, 2 and 3, 56.3% of respondents selected 'less than 1 month', and 20.9% selected '1–3 months'. Smaller proportions said '3–6 months' (11.4%); '6–12 months' (6.9%); '12–18 months' (1.4%); or 'more than 18 months' (0.9%), while 2.2% said 'can't recall'. A comparison of claim resolution times for respondents from Waves 1, 2 and 3 is set out in Figure 2. Only 7.3% of car insurance respondents said their claims took six months or more to resolve, compared to 8.0% of home contents insurance respondents and 12.4% of building insurance respondents.

162 It should be noted that the category 'car accident' included both collisions between vehicles as well as accidents involving only the policyholder's vehicle (for example, driving into a garage wall).

Figure 2: Claim Resolution Times across the Home Contents, Building and Car Insurance Sectors



2 *Insurance Investigations*

All respondents were asked about the cause of any delays in the processing of their claims. Twenty-eight per cent said the insurer conducted an investigation into their claim; 13.5% found additional damage after making their claim; 20.4% cited delays by third parties (for example, loss assessors, engineers, builders or investigators); 4.5% had engaged a claims servicing company;[163] and 47.0% said 'none of the above'.

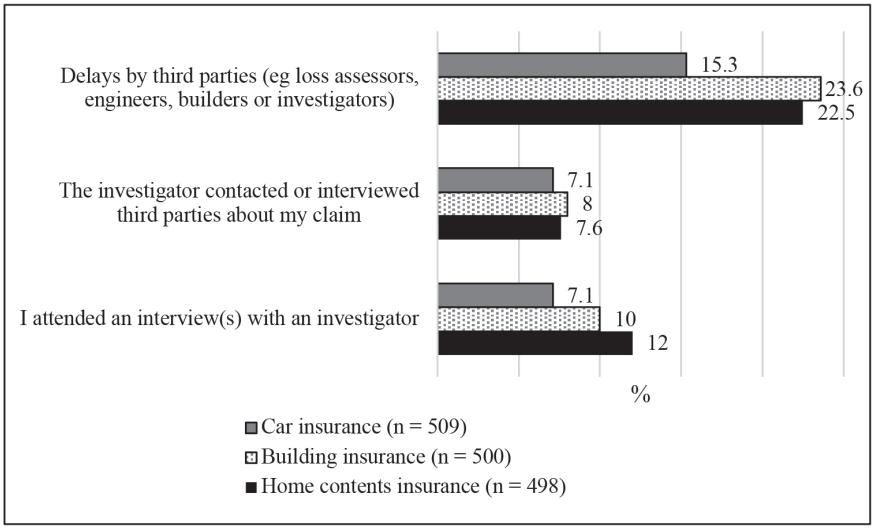
Of those respondents who said their claims had been investigated by the insurer (n = 422), only 34.6% — or 9.7% of our total sample — said they attended an interview (or multiple interviews) with a private investigator. Just over 51% — or 14.4% of our sample — had to provide documents (for example, bank statements, telephone records, driving history) upon request. Twenty-seven per cent — or 7.6% of our sample — said the investigator contacted or interviewed third parties (for example, family, business contacts or neighbours) about their claim, while 10.9% said 'can't recall'. Just under 38% of respondents whose claims had been

163 Claims servicing companies or claims management services are for-profit businesses that represent policyholders through the claims process for a percentage of any cash settlement offered by the insurer. According to consumer groups, engaging these services — which are currently unregulated and are not required to be members of AFCA — poses a number of risks for policyholders. In particular, such services seek to have the claim resolved by way of a cash settlement even where it would be in the policyholder's best interests to have the insurer complete the works themselves. See, eg, Consumer Action Law Centre, 'Government Must Regulate Exploitative Insurance Claims Managers in Wake of Bushfires' (Media Release, 13 January 2020) <https://consumeraction.org.au/claims-managers-in-wake-of-bushfires/> ('Government Must Regulate Exploitative Insurance Claims'); Financial Rights Legal Centre, 'Insurance Claims Management Services', *Insurance Law* (Fact Sheet) <https://insurancelaw.org.au/factsheets/insurance-claims-management-services/>.

investigated were asked to pay fees or costs relating to the investigation or had investigation fees taken out of their settlement.

A comparison of the proportions of all respondents from Waves 1, 2 and 3 who experienced specific sources of delay relating to the investigation of their claim is shown in Figure 3. As can be seen from this figure, 23.6% of building insurance respondents experienced delays due to conduct by third-party service providers including investigators. Home contents insurance respondents reported the highest rate of interviews with private investigators, with 12.0% saying they had been interviewed, compared to 10.0% of building insurance respondents and 7.1% of car insurance respondents.

Figure 3: Proportions of Respondents Who Experienced Delays Relating to an Investigation



Of those respondents who attended an interview (or multiple interviews) with an investigator (n = 146), 65.7% said their interviews had taken up to two hours in total; and 26.0% said two to three hours. A small proportion (7.5%) were interviewed for three to four hours, while 0.7% said 'can't recall'. Thirty-seven per cent were not offered a choice of location for the interview, and 29.5% were not offered any breaks.

Respondents who attended an interview were asked to what extent they agreed with two statements about the conduct of the interview.[164] Nearly half of this group (48.6%) said they 'strongly agree' or 'agree' with the statement 'I felt

164 Respondents were able to respond in the format of a Likert scale, with possible responses being 'Strongly disagree', 'Disagree', 'Neither agree or disagree', 'Agree', 'Strongly agree' and 'N/A'.

intimidated, bullied or harassed during my interview', while 13.7% said 'neither agree nor disagree', and 37.6% said 'disagree' or 'strongly disagree'. A slightly smaller proportion (43.8%) said they 'strongly agree' or 'agree' with the statement 'I was treated like a criminal or guilty of fraud', while 17.1% said 'neither agree nor disagree', and 39.0% said 'disagree' or 'strongly disagree'.

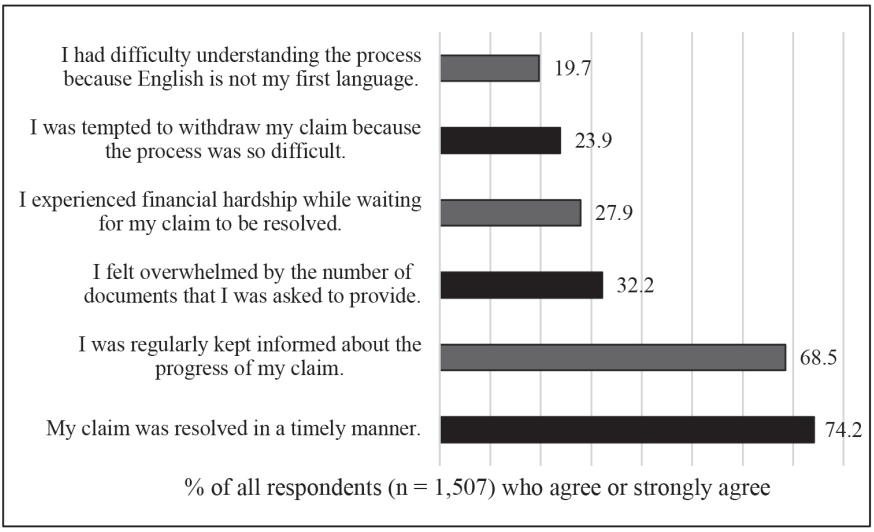
3 *Overall Claims Experience*

All respondents were asked to what extent they agreed with six statements about the handling of their claim.[165] The proportions of respondents who answered 'agree' or 'strongly agree' to these statements are shown in Figure 4. As shown in this figure, 74.2% of respondents said they 'agree' or 'strongly agree' with the statement 'My claim was resolved in a timely manner', while 12.8% selected 'disagree' or 'strongly disagree', and 13.0% selected 'neither agree nor disagree'. A smaller proportion (68.5%) said they 'agree' or 'strongly agree' with the statement 'I was regularly kept informed about the progress of my claim (i.e. at least every 20 days)', while 14.2% selected 'disagree' or 'strongly disagree' and 17.3% selected 'neither agree nor disagree'. Just over 32% answered 'agree' or 'strongly agree' to the statement 'I felt overwhelmed by the number of documents that I was asked to provide'; 44.9% selected 'disagree' or 'strongly disagree'; and 22.9% selected 'neither agree nor disagree'.

Nearly 28% of respondents said they 'agree' or 'strongly agree' with the statement 'I experienced financial hardship while waiting for my claim to be resolved', while 54.7% selected 'disagree' or 'strongly disagree', and 17.4% selected 'neither agree nor disagree'. Just under 24% said they 'agree' or 'strongly agree' with the statement 'I was tempted to withdraw my claim because the process was so difficult', while 61.9% selected 'disagree' or 'strongly disagree', and 14.3% selected 'neither agree nor disagree'. Nearly 20% said they 'agree' or 'strongly agree' with the statement 'I had difficulty understanding the process because English is not my first language', while 68.6% selected 'disagree' or 'strongly disagree', and 11.8% selected 'neither agree nor disagree'.

165 Respondents were able to respond in the format of a Likert scale, with possible responses being 'Strongly disagree', 'Disagree', 'Neither agree or disagree', 'Agree', 'Strongly agree' and 'N/A'.

Figure 4: Agreement with Statements about Overall Claims Experience



In their qualitative comments, numerous respondents described their insurer's claims process positively, saying 'it was quick and efficient', and '[I w]as completely satisfied with [the] service from our insurer, which is why we have been with them for over 40 years'. One building insurance respondent described a 'positive experience after a burst pipe in the kitchen ruined the bamboo flooring', saying '[i]t was handled professionally and eased our stress'. One car insurance respondent praised the handling of their claim for similar reasons, describing it as 'a simple process': 'I made a claim, sent photos, they gave me providers that would manage my repairs and then I went from there.'

By contrast, respondents who experienced lengthy delays in the processing of their claim expressed frustration with the process, particularly in cases involving a lack of communication by the insurer. One car insurance respondent said, 'all actions were taken only when I phoned to seek updates on the status of the claim'. Some building insurance respondents felt their claims should have been expedited due to the essential nature of the repairs in their home, with one saying, 'I haven't been able to use my bathroom since the beginning of January. It's September next week …'. Another said that delays in the resolution of their claim:

> caused inconvenience because we had no access to a bathroom whilst the claim was being processed — four weeks without a bath or shower. … We had to shower with a bucket of hot water outside.

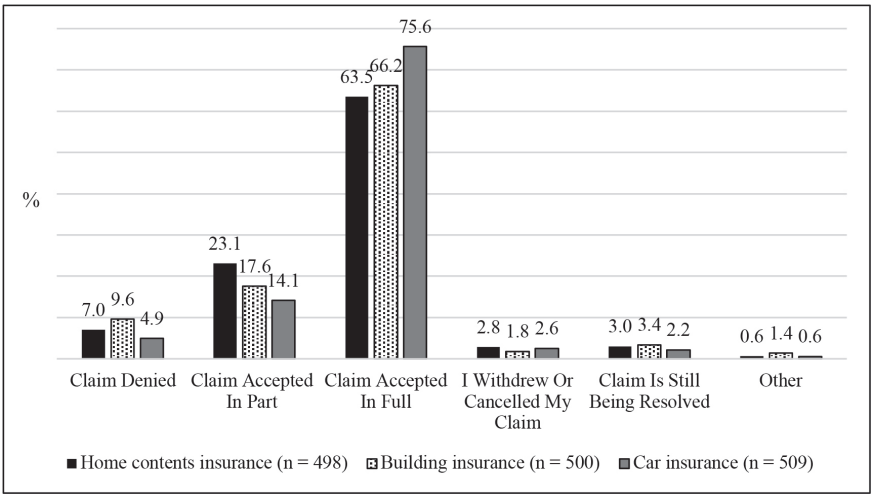
A number of building insurance respondents felt that the involvement of loss assessors and other third-party service providers contributed to these delays. Several respondents were satisfied with the claims handling process generally but

were unhappy with the work carried out by the insurer's preferred repairers. One respondent described their insurer's repairer as 'slow' and 'difficult to work with', saying they 'didn't want to do repairs to an adequate standard'.

D *Claim Outcomes*

Across Waves 1, 2 and 3, the majority (86.7%) of all claims were accepted. Most respondents (68.5%) said their claim was accepted in full, meaning their insurer arranged all necessary repairs or paid out the full amount they were claiming, while 18.2% said their claim was accepted in part. Only 7.2% said their claim was denied; 2.4% withdrew or cancelled their claim; 2.9% said their claim was still being resolved; and 0.9% selected 'other'. A comparison of claim outcomes for respondents from Waves 1, 2 and 3 is set out in Figure 5, which shows that the highest proportion of claims accepted in full (75.6%) was reported by car insurance respondents, while the highest proportion of denied claims (9.6%) was reported by building insurance respondents.

Figure 5: Claim Outcomes across the Home Contents, Building and Car Insurance Sectors



All respondents were asked whether they had renewed their policy with the same insurer after their claim was decided. The majority (75.4%) renewed their policy with the same insurer; 9.8% chose to switch to a new insurer; 9.1% said their insurer declined to provide them with future insurance, or to renew their policy; and 5.8% said 'none of the above'. The highest proportion of refusals to provide future cover was reported by home contents insurance respondents (12.2%), followed by building insurance respondents (9.6%) and car insurance respondents (5.5%). In their qualitative comments, one home contents insurance

respondent said, '[a]fter our claim was finalised and our insurance was up for renewal we were sent a letter saying we would no longer be offered insurance due to our claims history'. Other respondents found themselves facing substantial increases in their insurance premiums after they made a claim. As one home contents insurance respondent commented:

> Our insurance increased [by] $200 from last year for no discernable reason … Paying for home insurance is becoming exceedingly stressful … Also, we were forced to have a minimum of $90,000 coverage for contents, yet every calculation I have done for our needs comes up as not even half of that … Greater transparency on how the price is calculated plus some flexibility [on] the level of cover from our existing provider would be nice!

1 *Claims Accepted in Full or in Part*

(a) *Home Contents Insurance*

Respondents whose home contents insurance claims had been accepted (n = 431) were asked how the amount of their insurance payout or cash settlement compared with the total cost of repairing or replacing their lost or damaged property. Of this group, 63.1% said their cash settlement 'fully covered' their repair or replacement costs, and 8.6% said their insurer did not provide a cash settlement, but rather 'arranged the necessary repairs' to their property. However, 21.8% said their settlement was 'less' than their repair or replacement costs, and 4.2% said it was 'significantly less', while 2.3% selected 'can't recall'.

Home contents insurance respondents whose cash settlement was 'less' or 'significantly less' than the cost of repairing or replacing lost or damaged items in their home (n = 112) were asked if they had to employ any of a number of strategies to cover this cost. While 17.9% said 'none of the above', 18.4% borrowed from a mainstream lender (for example, a bank, credit union or building society); 17.9% had to seek assistance from an emergency relief organisation or charity; 12.3% took out a short-term loan (for example, from a payday lender); 5.6% borrowed money from family or friends; and 6.7% went without because they could not afford to replace damaged goods.

(b) *Building Insurance*

Respondents whose building insurance claims had been accepted in full or in part (n = 419) were asked how the amount of their insurance payout or cash settlement compared with the total cost of repairing or rebuilding their home. Fifty-eight per cent said their cash settlement 'fully covered the cost of repairs or rebuilding', and 13.1% said their insurer did not provide a cash settlement, but rather 'arranged the necessary repairs' to their property. However, 22.7% said their cash settlement

was 'less' than the cost of repairs or rebuilding, and 4.3% said it was 'significantly less', while 1.9% selected 'can't recall'.

Respondents whose cash settlement was 'less' or 'significantly less' than the cost of repairing or rebuilding their home (n = 113) were asked if they were still able to rebuild or carry out the necessary repairs to their property. While 51.3% said 'Yes – similar size/quality home as before', and 15.9% said 'Yes – larger/higher quality home than before', 14.2% said 'Yes – but smaller/lower quality home than before'. A small minority (3.5%) said they 'could not rebuild due to inadequate payout'. Fifteen per cent said 'none of the above'.

Respondents whose cash settlement was 'less' or 'significantly less' than the cost of repairing or rebuilding their home were asked to identify the main reason for the gap between these costs and the amount of their settlement. Of this group, 36.3% said 'I underestimated the cost of repairs/rebuilding when deciding on a level of cover'. Smaller proportions said 'I chose to rebuild a larger/higher quality home than before' (15.9%); 'I did not update my level of cover to account for rising repair/rebuilding costs' (11.5%); 'I chose not to use the insurer's repairer' (10.6%); and 'I received incorrect advice about the right level of cover for me' (3.5%). A further 22.1% selected 'none of the above'.

While 58.5% of respondents whose building insurance claims had been accepted (n = 419) did not require alternative accommodation while repair or rebuilding works were under way, 24.1% said their insurer covered the cost of temporary accommodation for them and their families, while 17.4% said these costs had not been covered by the insurer.

(c) *Car Insurance*

Car insurance respondents whose claims had been accepted in full or in part (n = 457) were asked how the amount of their insurance payout or cash settlement compared with the total cost of repairing or replacing their car. Of this group, 55.6% said their cash settlement 'fully covered' their repair or replacement costs, and 18.6% said their insurer did not provide a cash settlement, but rather 'arranged the necessary repairs'. However, 17.1% said their cash settlement was 'less' than their repair or replacement costs, and 5.3% said their payout was 'significantly less', while 3.5% selected 'can't recall'.

Car insurance respondents whose cash settlement was 'less' or 'significantly less' than the cost of repairing or replacing their car (n = 102) were asked if they had to employ any of a number of strategies to cover this cost. While 29.4% said 'none of the above', 25.5% had to borrow money from family or friends; 25.5% borrowed from a mainstream lender; 19.6% sought assistance from an emergency relief organisation or charity; 11.8% went without a car because they could not afford to

repair or replace it; and 10.8% took out a short-term loan.

While 26.9% of car insurance respondents whose claims had been accepted (n = 457) did not need a hire car while their own car was being repaired or replaced, 35.7% said their insurer provided or covered the cost of a hire car for as long as they needed it, while 37.4% said that their insurer did not do so.

2 *Denied Claims*

Respondents whose claims had been denied (n = 108) were asked how they had been informed about the outcome of their claim. The majority (68.5%) said their insurer informed them in writing (for example, by mail or email); 29.6% were informed over the phone, and 1.9% selected 'other'.

Respondents whose claims had been denied were asked to identify one or more reasons that their insurer gave for their decision to deny the claim. Of this group, 26.9% said 'my claim was made too long after the event'; 24.1% said 'insufficient evidence or information'; 22.2% said 'an exclusion in my policy (pre-existing defect)'; 20.4% said 'an exclusion in my policy (wear and tear)'; 13.0% said 'non-disclosure or misrepresentation (for example, failing to disclose relevant information when first purchasing the policy)'; 13.0% said 'an exclusion in my policy (flood)'; and 13.0% said 'an exclusion in my policy (other)'. Smaller proportions said 'an exclusion in my policy (unlisted or restricted driver)' (10.2%); 'my policy had lapsed' (9.3%); 'breach of the conditions of my policy' (4.6%); 'failure to maintain my property' (4.6%); 'failure or inability to pay excess' (3.7%); and 'fraud' (1.9%). Only 2.8% said 'insurer did not explain why they denied my claim'. Respondents whose claims were denied as a result of an exclusion in their policy (n = 69) were asked whether they had been aware of this exclusion when they purchased the policy. The majority (62.3%) of these respondents had been aware of the exclusion; however, 37.7% had not been aware of the exclusion.

In their qualitative comments, some respondents were unsurprised by their insurer's decision to deny their claim, with one home contents insurance respondent saying, 'I understood … why my claim was invalid'. However, other respondents expressed frustration because their claims were denied for reasons they did not expect, such as exclusions that were 'too hard to interpret', or their inability to locate the driver at fault following a hit-and-run incident. One home contents insurance respondent 'had to borrow money from relatives to fix the issues' and said the experience made them 'very cynical about the "benefits" of insurance'. Another was surprised to learn that their claim was affected by flood exclusions:

> I was not happy as we live in a flood-prone area and had read all the paperwork involved. It seems our council upgraded the flood zones mid-contract with my

> insurer and we had no coverage because of this. I spoke at length but got nowhere … [N]o other insurer would touch us, we [later] sold up and moved …

Others were surprised to hear that their claim was denied due to pre-existing damage of which they had been unaware. As one building insurance respondent said:

> Claim was denied due to the insurer's insistence that we should have been aware of the pre-existing damage which was actually moisture inside an internal wall and under carpet underlay. [Given] that no one in my family has x-ray glasses and cannot see under carpet or through walls, it was impossible to have been aware of such damage.

VI IMPLICATIONS FOR CLAIMS HANDLING BY INSURERS

Our study provides insights into consumer experiences of the claims process and allows for a comparison of claims handling practices and outcomes in the building, home contents and comprehensive car insurance sectors. Significant proportions of building and home contents insurance respondents taking part in our study made their claims in relation to loss or damage caused by a storm, flood, bushfire or another extreme weather event, in circumstances where large claim volumes can amplify problems with claims handling. Yet as shown in Part V(C) of this article, for most of our respondents, the handling of their claims was an efficient process that they regarded positively. However, for a significant minority of policyholders, there were indications of delays and poor communication and investigation practices by insurers that made the process a burdensome and overwhelming one. Moreover, while most claims were accepted, as outlined in Part V(D), significant proportions of respondents found themselves exposed to out-of-pocket costs not covered by their cash settlement or payout. There were also indications of problems with transparency regarding the circumstances in which claims were withdrawn or cancelled. Finally, a small proportion of respondents were refused further insurance after making a claim, while others were effectively prevented from renewing their policies by unaffordable increases in their premiums. In this part of the article, we analyse the implications of these findings, particularly insofar as they highlight potential problems with compliance with the legal frameworks outlined in Parts II and III of this article — including the requirement for insurers to 'conduct claims handling in an honest, fair, transparent and timely manner' in cl 7.2 of the *2014 Code* — as well as gaps in consumer protection that should be addressed in expectation of more frequent and severe extreme weather events in the coming decades.

A *Problems with Claims Handling*

1 *Claim Resolution Times and Impacts on Policyholders*

As outlined in Part III of this article, the *2014 Code* requires claims that do not require further assessment or investigation to be resolved in 10 business days.[166] Claims that require assessment or investigation must be decided within four months, or 12 months in 'Exceptional Circumstances'[167] (such as where the claim relates to an event declared a 'Catastrophe', or where the insurer 'reasonably suspect[s] fraud'[168]). The Code Governance Committee identified these timeframes as a major source of breaches of the *2014 Code* in 2017–18.[169] Yet not all delays in claims handling will be in breach of the Code, which provides an exemption from these timeframes, including the maximum 12-month limit, if complying with them is 'not practical' for the insurer (for example, due to delays in obtaining an expert's report).[170]

As shown in Part V(C) of this article, our study found that while the maximum 12-month limit in the *2014 Code* was only exceeded in 2.3% of claims, a significant minority of claims — and between 12.4% and 22.2% of building insurance claims — were not resolved within the four-month timeframe prescribed for all but 'Exceptional Circumstances'. Claim resolution times were shortest in the car insurance sector and longest in the building insurance sector, where 9.8% of claims were resolved in three to six months and 12.4% took six months or more to resolve. The difference between the claim resolution times reported by building and home contents insurance respondents and car insurance respondents may partially be attributable to the fact that — as shown in Figure 1 — significant proportions of building and home contents insurance claims related to loss or damage caused by a storm, flood, bushfire or another extreme weather event. As highlighted by Treasury in its 2011 review of natural disaster insurance in the wake of severe flooding in Queensland, delays are especially common in the context of extreme weather events, when insurers may receive a significant volume of claims within a short period.[171] In such cases, the reliance upon third-party consultants to provide experts' reports can prolong claim resolution times,[172] particularly where hydrologists are needed to determine whether property damage is caused

166 *2014 Code* (n 7) cl 7.9.

167 Ibid cls 7.17–7.18. These timeframes are retained in *2020 Code* (n 8) cls 76–8.

168 *2014 Code* (n 7) pt 15 (definition of 'Exceptional Circumstances').

169 *General Insurance in Australia 2017–18* (n 9) 41.

170 *2014 Code* (n 7) cls 7.5, 7.21. This exemption is retained in *2020 Code* (n 8) cl 84.

171 *Natural Disaster Insurance Review* (n 2) 24–5, 44, 110.

172 Consumers' Federation of Australia et al (n 109) 117.

by storm or flood.[173] Delays may also ensue when demand exceeds the availability of tradespeople to conduct repairs.[174]

In addition to indicating problems with compliance — both with the timeframes in Part 7 of the *2014 Code* and the requirement in cl 7.2 to conduct claims handling in a 'timely manner' — delays create financial and logistical difficulties for policyholders. As shown in Part V(C)(3) of this article, 27.9% of our respondents agreed with the statement 'I experienced financial hardship while waiting for my claim to be resolved', and a concerningly large proportion — 23.9% — agreed with the statement 'I was tempted to withdraw my claim because the process was so difficult'. Respondents' qualitative comments also showed that delays caused significant inconvenience for those forced to get by without a car, or unable to complete essential repairs in their home. Similarly, policyholders surveyed by ASIC in 2019 reported difficulties supporting their families and attending work while awaiting the outcome of their claims, especially where the insurer had not provided a hire car, or had provided a car for a few weeks only.[175] According to Legal Aid New South Wales, delays are most harmful precisely when they are most difficult for insurers to avoid — in the aftermath of natural disasters: [176]

> When a family has lost everything they own in a disaster event, the time that it can take for insurers to process claims … becomes a matter of financial survival for many families. Mortgages and [ordinary] costs of living still continue despite the fact that consumers may not have a house to live in.

For policyholders affected by natural disasters, these difficulties may be alleviated through Code provisions allowing them to apply for their claims to be fast-tracked where they are in 'urgent financial need' of the benefits to which they are entitled under the policy.[177] For those whose claim is subject to delays, the primary avenue for seeking recourse continues to be making a complaint through their insurer's IDR process, and if that is not resolved to their satisfaction within

173 The distinction between damage caused by storm and flood is 'technical', yet significant. While building and home contents insurance policies in Australia have historically covered loss or damage caused by storm water — as well as bushfire and other extreme weather events — many have excluded flood cover, or allowed policyholders to opt out of coverage for flood: *Natural Disaster Insurance Review* (n 2) 131. The lack of flood cover for many policyholders in areas affected by severe flooding in Queensland in 2010–11 was the 'primary stimulus' for Treasury's 2011 review of natural disaster insurance: at 1. However, the Federal Government rejected the review's recommendation for the inclusion of mandatory flood cover in all building insurance policies. While according to the Insurance Council of Australia, around 94% of building and home contents insurance policies purchased in 2019 included flood cover, policyholders are still able to opt out of flood cover at the time of purchase, or purchase policies that exclude flood cover: Insurance Council of Australia, 'Townsville Catastrophe Insurance Claims Rising By the Hour' (Media Release, 5 February 2019) <https://www.insurancecouncil.com.au/media_release/plain/498>.

174 *Natural Disaster Insurance Review* (n 2) 111.

175 *Roadblocks and Roundabouts* (n 14) 4–5.

176 Legal Aid New South Wales (n 16) 17.

177 *2014 Code* (n 7) cl 7.7; *2020 Code* (n 8) cl 64.

45 days,[178] lodging a dispute with AFCA.[179] Furthermore, under the *2020 Code*, anyone may report potential breaches of its provisions to the Code Governance Committee,[180] which may require the insurer to 'take particular rectification steps within a set timeframe',[181] or order 'additional sanctions' such as compensation to individuals, publication of the breach, or the payment of a community benefit.[182] Yet these 'additional sanctions' may only be ordered in respect of breaches deemed 'significant' by reference to factors including 'the number and frequency of similar … breaches', their impact and duration, and 'the actual, or potential, financial losses caused [to policyholders]'.[183] It remains to be seen how frequently this power would be exercised, and therefore to what extent it will provide an incentive for insurers to ensure that claims are resolved in a 'timely manner' in accordance with cl 7.2 of the *2014 Code* (or cl 21 of the *2020 Code*). The same could be said of the recent incorporation of claims handling and settling into the definition of a 'financial service' under the *Corporations Act*, which is discussed in Part II(B)(1) and which could potentially enable ASIC to take action in respect of an insurer's failure to decide claims 'in a timely way'.[184]

The passing of legislation enabling ASIC to designate certain provisions of codes of practice as 'enforceable code provisions' — discussed in Part II(C) of this article — may enhance the enforceability of the timeframes contained in pt 8 of the *2020 Code*. As this legislation was only passed in December 2020, ASIC has not yet designated these timeframes — or any other provisions in the *2020 Code* — as 'enforceable code provisions'. Yet by contrast with provisions 'that are broader in their nature and seek to make general, in-principle commitments regarding industry practices or aspirational targets',[185] these timeframes are likely to satisfy one of the key requirements for being identified as an 'enforceable code provision', being that the provision represents a 'direct and specific'[186] 'commitment to a person by a subscriber to the code relating to transactions or

178 *2014 Code* (n 7) cl 10.22.

179 In deciding the dispute, AFCA will consider whether the insurer has taken any measures to expedite the resolution of the claim and minimise inconvenience to the policyholder (for example, by providing a hire car). Where the insurer is found to have unreasonably delayed in resolving the claim, remedies may include compensation of up to $5,000 for non-financial loss such as stress and inconvenience, and up to $5,000 for consequential financial loss: Australian Financial Complaints Authority, *The AFCA Approach to Motor Vehicle Insurance Claim Delays* (AFCA Approach, 2018) 6 <https://www.afca.org.au/what-to-expect/how-we-make-decisions/afca-approaches>. Under s 57 of the *ICA* (n 26), AFCA may also award interest in respect of undue delay in processing a claim: 'Application of Interest', *Australian Financial Complaints Authority* (Web Page, 2018) <https://www.afca.org.au/about-afca/rules-and-guidelines/application-of-interest>.

180 *2020 Code* (n 8) cl 164.

181 Ibid cl 173(a).

182 Ibid cl 174. See also at pt 16 (definition of 'Significant Breach').

183 Ibid pt 16 (definition of 'Significant Breach').

184 Exposure Draft Explanatory Materials — Financial Sector Reform Bill 2020 (n 53) 11 [1.18].

185 Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 27 [1.78].

186 See ibid 29 [1.93], which makes it clear that such a commitment 'would include a direct and specific commitment by the subscriber to take specified action within a specified timeframe [and] would not include broad aspirational commitments to the public at large'.

dealings performed for, on behalf of or in relation to the person'.[187] For the reasons discussed above, breach of these timeframes would also satisfy the requirement of being 'likely to result in significant and direct detriment to the [consumer]'.[188] These changes may lead to greater accountability for excessive delays in claims handling by insurers in the coming years. It is important to note, however, that the abovementioned exemptions from the claims handling timeframes under the Code[189] mean that there is still 'no standard formula' for what will constitute a 'reasonable' time to resolve a claim.[190] If a policyholder attempts to enforce these timeframes through AFCA, or to seek compensation for the impacts of long delays, the insurer may still be able to argue, in keeping with the exemption in cl 84 of the *2020* Code, that compliance with these timeframes was 'not practical'.

2 *Keeping Policyholders Informed*

As outlined in Part III(B) of this article, the *2014 Code* requires insurers to advise policyholders about the progress of their claims 'at least every 20 business days'.[191] This requirement was identified by the Code Governance Committee as the second-largest source of breaches of the claims handling provisions of the *2014 Code* in 2017–18,[192] evidencing a 'persistent inability to keep consumers and small businesses informed of the progress of their claims'.[193] Poor communication by insurers is especially a problem in the context of natural disasters. In one survey conducted by consumer groups in the wake of flooding in Queensland in 2010–11, 78% of participants were 'never' advised about the progress of their claims, and over a third 'needed to call their insurer more than ten times' to follow up about their progress.[194]

Our findings are somewhat more positive by comparison to the abovementioned survey. As shown in Part V(C)(3) of this article, only 14.0% of our respondents did not feel they were kept informed 'regularly' or 'at least every 20 days' about the progress of their claims. However, some policyholders did indicate in their qualitative comments that little to no action was taken in respect of their claim until they followed up with the insurer. According to consumer groups, the need to follow up with insurers repeatedly exacerbates stress and anxiety for policyholders.[195] Until recently, an insurer's failure to comply with these requirements would only be addressed indirectly, if the insurer exceeded the

187 *Corporations Act* (n 36) s 1101A(2)(a), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4.

188 *Corporations Act* (n 36) s 1101A(2)(b), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4.

189 *2014 Code* (n 7) cl 7.21; *2020 Code* (n 8) cl 84.

190 *The AFCA Approach to Motor Vehicle Insurance Claim Delays* (n 179) 3.

191 *2014 Code* (n 7) cl 7.13. This requirement is retained in *2020 Code* (n 8) cl 70.

192 *General Insurance in Australia 2017–18* (n 9) 41, 44.

193 Ibid 44.

194 Legal Aid New South Wales (n 16) 12 (emphasis omitted).

195 Ibid; Consumers' Federation of Australia et al (n 109) 116–17.

claims handling timeframes in the Code, and the policyholder made a complaint to IDR or to AFCA. However, the changes discussed in Part II(C) of this article may enable the requirement for insurers to inform policyholders about the progress of their claims 'at least every 20 business days' in cl 70 of the *2020 Code* to be designated an 'enforceable code provision' alongside the timeframes for claim resolution in pt 8 of the Code. As with the aforementioned timeframes, the requirement in cl 70 is likely to satisfy the criterion of being a 'direct and specific'[196] commitment, the breach of which is 'likely to result in significant and direct detriment to the [consumer]'.[197]

3 *Problems with Investigations*

As outlined in Part II(A) of this article, insurers are entitled not to pay fraudulent claims.[198] This means that they have a 'legitimate need to investigate' claims in which fraud is suspected,[199] in which case the timeframe within which the insurer must make a decision is extended to 12 months.[200] More broadly, insurers are also entitled to a 'reasonable period of time' to inquire into the circumstances of a claim, and to request information to determine whether the terms and conditions of a claimant's policy are satisfied.[201] Yet consumer groups argue that the insurance industry overestimates the incidence of fraudulent claims, resulting in an excessive rate of investigations that delay access to policy benefits and exacerbate financial hardship for policyholders.[202] Recent studies and inquiries have highlighted significant problems with the conduct of such investigations.[203] First, insurers frequently fail to explain the investigation process to policyholders and inform them of their rights (including their right to an interpreter or support person, and their right to make a complaint about the conduct of the investigation).[204] Indeed, it is common for policyholders to learn that fraud was alleged against them only after they receive a letter denying their claim.[205] Secondly, investigators typically insist on holding interviews at policyholders' homes, making it difficult for policyholders to end the interview if they feel uncomfortable.[206] Thirdly, interviews are often incredibly long and demanding, in some cases exceeding

196 Explanatory Memorandum, Financial Sector Reform Bill 2020 (n 61) 29 [1.93]. See also *Corporations Act* (n 36) s 1101A(2)(a), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4.

197 *Corporations Act* (n 36) s 1101A(2)(b), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 1 cl 4.

198 *ICA* (n 26) s 56.

199 *Roadblocks and Roundabouts* (n 14) 12. See also *Own Motion Inquiry* (n 15) 6.

200 *2014 Code* (n 7) cl 7.18, pt 15 (definition of 'Exceptional Circumstances').

201 Tarr et al, 'Utmost Good Faith and Accountability' (n 34) 155–6. See also *Matton Developments* (n 33) 70 [248] (Flanagan J).

202 See, eg, *Guilty until Proven Innocent* (n 14) 7, 12–13.

203 Ibid; *Own Motion Inquiry* (n 15) 14–15; *Roadblocks and Roundabouts* (n 14) 7–11.

204 *Guilty until Proven Innocent* (n 14) 12, 23–4, 30, 35; *Own Motion Inquiry* (n 15) 7, 14–15, 25, 47.

205 *Guilty until Proven Innocent* (n 14) 23.

206 Ibid 26–7, 29–31; *Own Motion Inquiry* (n 15) 26–7; *Roadblocks and Roundabouts* (n 14) 10.

five hours in length.[207] Policyholders routinely feel bullied and intimidated by investigators, reporting interview tactics that make them feel 'like criminals',[208] including 'overt suggestions' of conspiracy and implications that they are 'lying or at fault'.[209] Finally, policyholders are being overwhelmed by requests for a wide range of documents, including 'criminal record checks, social media histories, birth certificates, telephone and text message records … and information about family members and friends'[210] with little relevance to the claim. Much of this conduct has not, until recently, been covered by the legal frameworks outlined in Parts II and III of this article. The *2014 Code* does not contain any standards for the conduct of investigations, beyond the requirement for insurers to 'conduct claims handling in an honest, fair, transparent and timely manner'.[211]

Our study suggests that for policyholders, the distinction between a fraud investigation and routine information-gathering by insurers can be quite blurred. As shown in Part V(C)(2) of this article, a surprisingly high proportion —28% — of our respondents said their insurer conducted an investigation into their claim, but only 9.7% were interviewed by an investigator. Clearly, many respondents perceived their claim as having been 'investigated' despite never having been interviewed, perhaps because they interpreted the word 'investigate' to include any document requests or assessment of their claim by third-party service providers. Such perceptions may reflect the breadth and volume of evidence being requested by insurers as proof of a claim: as shown in Part V(C)(3), 32.2% of our respondents agreed with the statement 'I felt overwhelmed by the number of documents that I was asked to provide'. However, even if the proportion of respondents who were interviewed (9.7%) represents the 'true' investigation rate for our sample, this is still high compared to ASIC's finding that only 1.1% of comprehensive car insurance claims are investigated.[212] Only one of our respondents, or 0.07% of those interviewed, said their claim was denied for fraud,[213] lending support to ASIC's conclusion that fraud is found in only a small minority of investigated claims, indicating a 'need for insurers to reconsider the process they use to select claims for investigation'.[214] Finally, our findings indicate that the conduct of investigations falls short of best practice in several respects. Thirty-seven per cent of our respondents who were interviewed said

207 *Guilty until Proven Innocent* (n 14) 7, 12, 26, 31, 39, 53, 77; *Own Motion Inquiry* (n 15) 29–30; *Roadblocks and Roundabouts* (n 14) 10.

208 *Roadblocks and Roundabouts* (n 14) 4, 7.

209 Ibid 7. See also *Guilty until Proven Innocent* (n 14) 7, 25–6.

210 *Roadblocks and Roundabouts* (n 14) 9.

211 *2014 Code* (n 7) cl 7.2.

212 *Roadblocks and Roundabouts* (n 14) 3.

213 As shown in Part V(D)(2) of this article, a total of two respondents — or 1.9% of those whose claims were denied — selected fraud as the reason for this. However, only one of them said their claim had been investigated.

214 *Roadblocks and Roundabouts* (n 14) 4. The majority of investigated claims examined by ASIC were found to be valid, and only 4.0% were declined for fraud: at 3.

they were not offered a choice of location for the interview, and just under 38% of those whose claims were investigated were asked to pay fees or costs relating to the investigation, or had investigation fees taken out of their settlement. Most concerningly, a high proportion of those interviewed agreed with the statements 'I felt intimidated, bullied or harassed during my interview' (48.6%); and 'I was treated like a criminal or guilty of fraud' (43.8%).

Problems with the conduct of investigations were considered by the Insurance Council of Australia in its review of the *2014 Code*, which supported the incorporation of mandatory claim investigation standards into what is now pt 15 of the *2020 Code*.[215] When these standards come into force in July 2021, insurers will be required to review fraud indicators used to identify claims for investigation 'to make sure they remain relevant, appropriate and do not discriminate'.[216] If an investigator is appointed to investigate a claim, insurers will need to ensure they conduct the investigation 'in an appropriate and respectful manner',[217] and that any requests for information or documents are 'reasonable and relevant to the claim under investigation'.[218] Policyholders will need to be provided with written information explaining their rights and responsibilities during the investigation process,[219] including their right to access an interpreter, or to have a legal representative or support person present when being interviewed.[220] Policyholders will need to be offered a choice of location, time and date for any interviews.[221] They will need to be offered a break every 30 minutes and interviewed for no longer than 90 minutes in one sitting.[222] Where an investigation has continued for four months, insurers will be required to review the claim and determine if there is sufficient cause for the investigation to continue.[223] The Insurance Council of Australia has emphasised that these 'mandatory' standards in pt 15 differ from the 'best practice guidance' contained in the *2020 Code* in relation to family violence, mental health and other issues, which is 'not mandatory'.[224] The 'mandatory' nature of these standards may therefore make them easier for individuals and regulators to enforce by comparison to other Code provisions, including the general requirement for insurers to 'conduct claims handling in an honest, fair, transparent and timely manner' in cl 7.2 of the *2014 Code*. The expansion of the powers of the Code Governance Committee to impose sanctions for breaches of

215 *Review of the General Insurance Code of Practice* (n 86) 50, 105–7.

216 *2020 Code* (n 8) cl 195.

217 Ibid cl 193(b).

218 Ibid cl 200(a).

219 Ibid cls 201–2.

220 Ibid cls 205, 207, 208.

221 Ibid cl 210.

222 Ibid cls 214–16, 219–20.

223 Ibid cls 196–9.

224 *Review of the General Insurance Code of Practice* (n 86) 5.

the *2020 Code*,[225] including the 'additional sanctions' for 'significant breaches' discussed in Part II(C) of this article, may also provide stronger incentives for insurers to monitor their compliance with pt 15. Finally, the changes discussed in Part II(C) of this article may also enhance the enforceability of these standards by allowing ASIC to designate them as 'enforceable code provisions'.[226]

B *Issues with Claims Outcomes*

1 *Accepted Claims and Exposure to Financial Loss*

The existing data on general insurance claims indicates that the majority of claims are accepted.[227] As outlined in Part V(D) of this article, our study confirms this, with 86.7% of our respondents saying their claims were accepted in full or in part. However, this picture is complicated by the fact that significant proportions of our home contents insurance respondents (26.0%), building insurance respondents (27.0%) and car insurance respondents (22.4%) said they received a cash settlement or payout that was less or significantly less than their repair, rebuilding or replacement costs. A small proportion (3.5%) of building insurance respondents could not repair or rebuild their homes due to an inadequate payout.

These findings indicate that many insured Australians remain exposed to out-of-pocket costs in case of natural disasters or other unforeseen events causing damage to their property. This can be particularly devastating for building insurance policyholders confronted with a shortfall in cover following a total loss. Most homes in Australia are covered by 'sum insured' policies, which only provide cover up to a specific amount,[228] rather than 'total replacement' or 'replacement value cover' policies which promise to rebuild a home 'to its original size and standard regardless of depreciation or age and in accordance with prevailing building standards'.[229] Previous surveys suggest that at least 28% of homes[230] — or as many as 81%[231] — are 'underinsured' in the strict sense, meaning that the maximum amount payable under the owner's sum insured policy would not

225 *2020 Code* (n 8) pt 13.

226 See *Financial Sector Reform Act 2020* (n 52) sch 1.

227 See, eg, *General Insurance in Australia 2017–18* (n 9) 32.

228 *Natural Disaster Insurance Review* (n 2) 6, 146.

229 Ibid 145.

230 *Promoting Financial Resilience* (n 2) 1; Chloe Lucas, Christine Eriksen and David Bowman, 'A Crisis of Underinsurance Threatens to Scar Rural Australia Permanently', *The Conversation* (online, 7 January 2020) <https://theconversation.com/a-crisis-of-underinsurance-threatens-to-scar-rural-australia-permanently-129343>.

231 One survey carried out in 2000 found that 81% of Australian homes were underinsured by 10% or more, and 59% were underinsured by 30% or more. However, a 2002 survey cited in the same ASIC report reported a much lower rate of underinsurance, finding that 27.5% of homes were underinsured by 10% or more: *Getting Home Insurance Right* (n 18) 12.

suffice to cover rebuilding costs if the home was completely destroyed.[232] An even larger proportion — 83% — of Australians are underinsured for their home and contents according to a broad definition employed by Quantum Market Research, which includes anyone who 'cannot resume their same standard of living' following a crisis.[233]

According to the Insurance Council of Australia, most policyholders are 'unaware of the potential for out of pocket expenses' when purchasing insurance, particularly as advertising often creates '[m]isconceptions about the extent of coverage' by implying that the insurer will provide complete cover.[234] As shown in Part V(D)(1)(b) of this article, of those of our building insurance respondents who received a cash settlement that was less than their repair or rebuilding costs, a total of 50.9% said they 'underestimated the cost of repairs/rebuilding' when selecting a level of cover, 'did not update' their level of cover to account for rising costs, or 'received incorrect advice about the right level of cover' for them. These responses reflect the difficulty of estimating repair or rebuilding costs in case of a hypothetical future event.[235] Sum insured policies place the onus of performing this complex task — described by ASIC as one 'requiring specialist knowledge and expertise'[236] — on consumers, who often decide upon the sum insured by using the market value of their home as a guide, or simply making a guess as to the likely costs of rebuilding.[237] When estimating the replacement value of home contents, consumers frequently focus on high-value items such as computers, but forget to include everyday necessities such as furniture.[238] Many fail to review their sum insured to ensure that it covers home renovations or new purchases.[239] These tendencies put consumers at risk of being exposed to financial loss despite having insurance.

Recommendations to address home building underinsurance have focused on improving the accuracy and transparency of online calculators provided by insurers to assist consumers in selecting a sum insured; and the availability of information on natural disaster risks and indicative rebuilding costs for

232 Ibid 14. See also *Natural Disaster Insurance Review* (n 2) 93.

233 Quantum Market Research, *The Understand Insurance Research Report* (Report, October 2013) 8 <https://understandinsurance.com.au/assets/pdf/FINAL%20Understand%20Insurance%20Research%20Report.pdf> ('*Understand Insurance*').

234 *Too Long; Didn't Read* (n 25) 39.

235 This difficulty applies particularly to 'low-probability' yet 'high-loss' events such as natural disasters: Booth and Williams (n 4) 38.

236 *Getting Home Insurance Right* (n 18) 19.

237 Susan Bell Research, *Insuring Your Home: Consumers' Experiences Buying Home Insurance* (Report No 416, October 2014) 15–16, 64–7 <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-416-insuring-your-home-consumers-experiences-buying-home-insurance/> ('*Insuring Your Home*').

238 Ibid 71.

239 *Getting Home Insurance Right* (n 18) 9, 38, 44; Quantum Market Research, *Understand Insurance* (n 232) 15; *Insuring Your Home* (n 237) 67.

households.[240] Most recently, a requirement was incorporated into the *2020 Code* for consumers purchasing or renewing insurance policies to be provided with an online calculator that is 'reviewed and updated' to ensure accuracy.[241] However, such measures have limited capacity to address the broader problem of exposure to financial loss for policyholders who already believe themselves to be fully covered. Most insurers already offer sum insured calculators,[242] yet many consumers distrust their estimates, assuming them to be a 'deliberate sales ploy' to 'push up' premiums.[243] Furthermore, even an estimate that would cover the cost of rebuilding a home destroyed by 'an isolated event (such as a house fire)' will be inadequate if the home is 'lost during a more widespread event (such as a bushfire)'.[244] This is due to inflation in building costs following events affecting a large number of homes, when demand for labour and materials can soar.[245] Changes to local council and building code requirements to improve the capacity of homes to withstand extreme weather events can also lead to unexpected costs for policyholders rebuilding older homes.[246] Yet despite calls for total replacement building insurance policies to be made more widely available,[247] sum insured policies continue to dominate the market.

However, for most of our respondents who accepted a cash settlement that did not cover their repair, rebuilding or replacement costs, their exposure to financial loss was not the result of 'underinsurance' in the strict sense. As shown in Part V(B), only around 2% of home contents and building insurance respondents respectively — and 9.2% of car insurance respondents — made their claims in relation to a total loss. The majority of our respondents were claiming in relation to partial losses, which would not, at least in theory, be expected to result in a gap in cover.[248] Most of these claims were resolved by way of a cash settlement. It is therefore more likely that the extent of exposure to financial loss in our sample reflects problems with the calculation of cash settlements, which, according to Consumer Action Law Centre, are 'often not in the best interests' of policyholders,

240 *Getting Home Insurance Right* (n 18) 19, 30; *Natural Disaster Insurance Review* (n 2) 76; *Insuring Your Home* (n 237) 20–1; Financial System Inquiry Committee, *Financial System Inquiry: Final Report* (Report, November 2014) 227 <https://treasury.gov.au/publication/c2014-fsi-final-report>; *Too Long; Didn't Read* (n 25) 36–42.

241 *2020 Code* (n 8) cl 48. See also *Review of the General Insurance Code of Practice* (n 86) 32, 35.

242 *Too Long; Didn't Read* (n 25) 35.

243 *Insuring Your Home* (n 237) 15. See also Insurance Council of Australia, *Consumer Research on General Insurance Product Disclosures* (Research Report, February 2017) 32 <https://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf>.

244 *Too Long; Didn't Read* (n 25) 39. For example, 'rebuilding … reportedly increased by 75% following Cyclone Tracy in Darwin in 1974, and by 35% in Newcastle after the 1989 earthquake': *Getting Home Insurance Right* (n 18) 12, 50.

245 *Getting Home Insurance Right* (n 18) 8, 46, 50–2, 57; *Natural Disaster Insurance Review* (n 2) 94–5.

246 *Getting Home Insurance Right* (n 18) 38, 43–4; *Recent Trends in and Preparedness for Extreme Weather Events* (n 2) 161–2; *Insuring Your Home* (n 237) 16, 70, 90; Lucas, Eriksen and Bowman (n 230).

247 See, eg, *Getting Home Insurance Right* (n 18) 46; *Natural Disaster Insurance Review* (n 2) 98.

248 *Natural Disaster Insurance Review* (n 2) 7, 93.

as the settlement amount 'is not guaranteed to cover the full cost of rebuilding houses and repairing property'.[249]

Problematically, cash settlement offers by insurers are often based on quotes representing what it would cost the insurer to repair or rebuild the property. Such estimates are generally much lower than the actual costs that would realistically be incurred by policyholders if they accept the offer, as they do not have access to the bulk trade discounts available to insurers.[250] For this reason, 'cash settlement' clauses that expressly limit the amount payable under a policy to the lesser of what it would cost the insurer *or* the policyholder to complete repairs were identified as examples of potentially unfair terms that may be challenged under the UCT provisions in the *ASIC Act*.[251] Even where a contract does not expressly limit the amount payable in this way, policyholders may not be aware that they have the option of obtaining their own quotes and negotiating the cash settlement offer to ensure that it is fair and realistic. As noted in Part II(C), the *2020 Code* contains a vaguely worded requirement for insurers to provide policyholders with information about 'how decisions are made on cash settlements'.[252] The recent amendments to the *Corporations Act* discussed in Part II(B)(1) — and in particular, the requirement for insurers to provide a Cash Settlement Fact Sheet if they choose to offer a cash settlement instead of repairing or replacing the policyholder's property[253] — may provide policyholders with better information to determine whether a cash settlement offer would leave them exposed to financial loss.

2 *Claim Denial Rates and a Lack of Transparency on Withdrawn Claims*

As noted by Legal Aid New South Wales, '[h]istorically, the insurance industry has based its reputation on its ability to keep relatively low rejection rate[s] of

249 'Government Must Regulate Exploitative Insurance Claims' (n 163).

250 Law Council of Australia, Submission to Treasury (Cth), *Extending Unfair Contract Terms Protections to Insurance Contracts* (30 August 2018) 17–18 <https://www.lawcouncil.asn.au/publicassets/4634c190-bc46-e911-93fc-005056be13b5/3498%20-%20Unfair%20Contract%20Terms%20-%20Insurance%20Contracts.pdf>; *Denied* (n 19) 19–20.

251 See Replacement Explanatory Memorandum, Financial Sector Reform (Hayne Royal Commission Response — Protecting Consumers (2019 Measures)) Bill 2019 (Cth) 14 [1.23] <https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r6453>.

252 *2020 Code* (n 8) cl 79.

253 *Corporations Act* (n 36) ss 948B, 948C, as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cl 18. A Cash Settlement Fact Sheet would need to include 'the options for settlement legally available' to the policyholder under the insurance contract (for example, the option to have the insured product repaired or replaced and the option to receive a cash payment); a statement setting out the amount of each component of the cash settlement being offered and the sum insured under the insurance contract, 'a statement that the [insured] should consider obtaining independent legal or financial advice before settling'; an outline of the policyholder's rights of review (if applicable); and 'any other information prescribed by the regulations': *Corporations Act* (n 36) s 948F(1), as inserted by *Financial Sector Reform Act 2020* (n 52) sch 7 cl 18.

claims for most insurance products'.[254] In 2017–18, general insurers denied just 2.4% of over 2.9 million home and car insurance claims by consumers and small businesses.[255] The denial rate was highest for home insurance claims.[256] Yet the proportion of withdrawn or cancelled claims — 8.5% — was more than triple that of denied claims.[257] By contrast, as outlined in Part V(D) of this article, only 2.4% of respondents taking part in our study withdrew or cancelled their claims, while 7.2% — or 9.6% of building insurance respondents, 7.0% of home contents insurance respondents and 4.9% of car insurance respondents — had their claims denied.

The comparatively high claim denial rate reported by our respondents may reflect what the Code Governance Committee describes as 'gaps in the collection of claims-related data',[258] which complicate the interpretation of formal acceptance and denial rates.[259] Claims recorded by insurers as 'denied' include only those claims that proceed to a formal decision, while 'withdrawn' claims include all claims discontinued at the preliminary stage of the process outlined in Part III of this article.[260] At this preliminary stage, the *2014 Code* allows frontline staff to provide policyholders wishing to lodge a claim with informal assessments of whether their policy would cover the loss or damage, providing that they do not seek to 'discourage' the policyholder from formally lodging a claim.[261] Yet consumer groups and ASIC have expressed concern that frontline staff taking telephone calls from policyholders frequently fail to advise them of their right to have a claim properly decided; and that such assessments can, in practice, strongly influence policyholders to refrain from lodging a claim, or to discontinue it.[262] Consumers are required to 'disclose relevant and material matters' — including

254 Legal Aid New South Wales (n 16) 9, citing 'Myths about General Insurance', *Insurance Council of Australia* (Web Page) <https://web.archive.org/web/20120115023756/http://www.insurancecouncil.com.au/ForConsumers/Consumerinformation/MythsaboutGeneralInsurance/tabid/1840/Default.aspx>.

255 In 2017–18, insurers received 2,901,459 home and car insurance claims, of which 68,727 were denied. The denial rate for all 4,094,192 retail claims received that year — including home, car, personal and domestic property, travel, consumer credit, residential strata and sickness and accident insurance claims — was 4.0%: *General Insurance in Australia 2017–18* (n 9) 28–9, 31.

256 In 2017–18, insurers received 827,785 home insurance claims, of which 59,602 — or 7.2% — were denied. Only 9,125 — or 0.4% — of 2,073,674 car insurance claims received that year were denied: ibid 29, 31.

257 In 2017–18, insurers received 2,901,459 home and car insurance claims, of which 247,429 were withdrawn. The withdrawal rate was 12.9% for home insurance claims, and 6.8% for car insurance claims: ibid 29, 31–2. Similarly, a 2011 inquiry by ASIC found that while only 0.3% of car insurance claims were denied, the proportion of withdrawn claims was significantly higher at over 7%: *Review of General Insurance Claims Handling* (n 6) 17, 20 [98]–[99].

258 *General Insurance in Australia 2017–18* (n 9) 32.

259 General Insurance Code Governance Committee, *General Insurance in Australia 2016–17: Industry Practice and Code Compliance* (Report, March 2018) 27 <http://www.afta.com.au/uploads/1/cgc-report-general-insurance-in-australia-201617.pdf> ('*General Insurance in Australia 2016–17*').

260 *General Insurance in Australia 2017–18* (n 9) 30–1.

261 *2014 Code* (n 7) cl 7.8. This requirement is retained in *2020 Code* (n 8) cl 58.

262 *Review of General Insurance Claims Handling* (n 6) 23 [120]–[121], 25 [132]–[136]; Legal Aid New South Wales (n 16) 10–12.

their recent claims history — when applying for a new insurance policy.[263] One reason why a policyholder might be reluctant to proceed with a claim when told that it is unlikely to succeed is that they may be concerned that a denial will affect their ability to obtain future insurance or will lead to them being charged higher premiums. The claim is then recorded as 'withdrawn or cancelled', if it is recorded at all.[264] Our denial rate of 7.2% may thus include claims that were *perceived* as having been denied by respondents — for example, if they were advised over telephone that their claim was unlikely to be accepted because they were not covered for losses resulting from a particular event. Policyholders who withdraw their claims in these circumstances forego their right to have their claim formally refused and recorded in writing;[265] and thus their right to seek review of the decision through IDR or AFCA.[266] These indications of claim withdrawals that are effectively encouraged by the insurer highlight the need for greater transparency surrounding all claims that are denied, withdrawn or cancelled.[267] Transparency could be improved through requirements for insurers to report in greater detail on the reasons for claim withdrawal and the circumstances in which it occurs (for example, following an informal assessment by frontline staff). Detailed reporting on the reasons for claim denial would also assist in determining whether the relatively low denial rate reported by insurers is maintained for claims relating to natural disasters.[268]

3 *Penalising Policyholders for Making Claims*

As outlined in Part V(D) of this article, a small proportion (9.1%) of our respondents said their insurer declined to provide them with further insurance after their claim had been resolved. Others, in their qualitative comments, indicated that their premiums increased significantly after they made a claim. The practice of refusing to provide future cover to policyholders after a claim is made, even when the claim is ultimately paid out, was highlighted by ASIC in the context of comprehensive car insurance.[269] This practice can have serious consequences, as consumers who are refused cover must disclose this when applying for a policy with another insurer, who may then decide to impose higher premiums or decline the application altogether.[270] Yet the *2014 Code* places no limits on insurers'

263 Enright et al (n 40) 38 [3.8].

264 *Review of General Insurance Claims Handling* (n 6) 23 [121].

265 See *2014 Code* (n 7) cl 7.19.

266 Legal Aid New South Wales (n 16) 12.

267 See *General Insurance in Australia 2016–17* (n 259) 27; *General Insurance in Australia 2017–18* (n 9) 31, 34; *Review of General Insurance Claims Handling* (n 6) 21–2 [104]–[110].

268 There are indications that claims related to some natural disasters — particularly floods — are rejected at higher rates. For example, the rejection rate for claims related to flooding in Queensland in 2010–11 was approximately 15%: Legal Aid New South Wales (n 16) 9, citing Mark Solomons et al, 'Exposing the Fat Cats behind the Shamed Insurers', *Courier Mail* (Brisbane, 8 April 2011) 6.

269 *Roadblocks and Roundabouts* (n 14) 11.

270 Ibid.

ability to refuse to provide further insurance after a claim is made, and requires only that the insurer provide the policyholder with their reasons for the decision, as well as details of their complaints process.[271]

While ASIC has proposed that the Code be amended to require that '[c]onsumers whose claims are paid … not be declined further insurance unless compelling and exceptional reasons exist',[272] this proposal was not incorporated into the *2020 Code*. In any case, it would not deter insurers from preventing policyholders from renewing their policies by increasing premiums to unaffordable levels. This is a common occurrence in the aftermath of natural disasters, when policyholders may simultaneously find themselves subject to steep premium increases and plummeting property values, preventing them from moving out of an area deemed high-risk,[273] and leading some to opt out of having insurance altogether.[274] As Mendelson and Carter note, '[t]he system, as it currently operates, enables insurers to have a great amount of autonomy to accept or decline a risk'.[275] The consequences of such autonomy for policyholders may become more apparent in the context of increasingly frequent extreme weather events in the coming decades.

VII CONCLUSION

Despite the importance of 'honest, fair, transparent and timely' claims processes and outcomes for consumers of general insurance, there has been little research to date focusing on the experiences of policyholders who make claims upon their policies. In light of the predicted increase in the frequency and intensity of extreme weather events due to climate change, and given the important role of insurance in reducing disaster recovery costs, there is a need for further research into the efficiency and transparency of claims handling by insurers and the fairness of the outcomes that consumers are receiving through this process. In

271 *2014 Code* (n 7) cl 4.8.

272 *Roadblocks and Roundabouts* (n 14) 13.

273 For example, following Cyclone Yasi in Queensland, some homeowners seeking to renew their policies faced premium increases of 300% or more: *Natural Disaster Insurance Review* (n 2) 6. See also Booth and Williams (n 4) 39–40; Amanda Gearing, 'Post-Disaster Recovery Is a Marathon, Not a Sprint: The Need for a State-Sponsored Recovery Scheme' (2018) 24(1) *Pacific Journalism Review* 52, 64–5; Alexis Carey, 'Experts Warn of "Red Zone" Insurance Risk as Severe Weather Spreads', *News.com.au* (online, 23 February 2020) <https://www.news.com.au/finance/money/costs/experts-warn-of-red-zone-insurance-risk-as-severe-weather-spreads/news-story/7c53467ad08a523806b84208a1b664ef#.9hpxn>.

274 See, eg, *Recent Trends in and Preparedness for Extreme Weather Events* (n 2) 73 [3.44]. This concern applies particularly to home contents insurance, with previous studies suggesting that consumers have a 'lower tolerance' for increases in their home contents insurance premiums than in their building insurance premiums: *Natural Disaster Insurance Review* (n 2) 49 [5.13], citing George Barker and Richard Tooth, 'Insurance Law and Economics: An Analysis of the Demand for House and Contents Insurance in Australia' (Working Paper No 1, ANU Centre for Law and Economics, 2008) 7.

275 Danuta Mendelson and Rachel Carter, 'Catastrophic Loss and the Law: A Comparison between 2009 Victorian Black Saturday Fires and 2011 Queensland Floods and Cyclone Yasi' (2012) 31(2) *University of Tasmania Law Review* 32, 46.

this article, we address this gap in the research by carrying out an analysis of our survey of Australians who recently made a claim on a building, home contents or comprehensive car insurance policy. Significant proportions of policyholders taking part in our study made their claims in relation to loss or damage caused by a storm, flood, bushfire or another extreme weather event. Our study indicates that for most policyholders, making an insurance claim is an efficient process that they regard positively. However, for a significant minority of policyholders, there are indications of delays and poor communication and investigation practices by insurers that make the process a burdensome and overwhelming one. Moreover, while most claims are accepted — and although most consumers are 'unaware of the potential for out of pocket expenses' when purchasing insurance[276] — significant proportions of policyholders nonetheless find themselves exposed to repair, rebuilding or replacement costs not covered by their cash settlement or payout. There are also indications of problems with transparency regarding the circumstances in which claims are withdrawn or cancelled. Finally, a small proportion of policyholders are refused further insurance after they make a claim, while others are effectively prevented from renewing their policies by unaffordable increases in their premiums. Our findings indicate potential problems with compliance with the legal frameworks outlined in Parts II and III of this article — including the requirement for insurers to 'conduct claims handling in an honest, fair, transparent and timely manner' in cl 7.2 of the *2014 Code*. Our findings also highlight gaps in consumer protection that need to be addressed, especially if insurance is to play a role in spreading the costs of disaster recovery and facilitating climate change adaptation for governments, emergency relief agencies and others in the coming decades.

276 *Too Long; Didn't Read* (n 25) 39.