Submission on discussion document: Insurance contract law review

Your name and organisation

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Organisation	Homeowner/Property Investor/Claimant for Canterbury Earthquake Sequence

Regarding conduct of insurers

What do you think fair treatment looks like from both an insurer's and consumer's perspective? What behaviours and obligations should each party have during the lifecycle of an insurance contract that would constitute fair treatment?

Open and honest information and full disclosure from both parties.

What has your experience been of the claims handling process? Please comment particularly on:

- information from the claims handler about:
  - timeframes and updates on timeframes
  - reasons for declining the claim (if relevant)
  - how you can complain if declined
- The handling of complaints (if relevant)

My experience of the claims handling across seven dwelling claims from the CES can be summed up in one paragraph as:

Insurers have used their expert insurance knowledge, loss handling experience and financial strength to attempt to gain a pecuniary advantage (by deception) over the claimant. They have colluded with other insurers to come up with strategies and methods to control the 'technical response' to reduce the amount of money they need to pay in claim settlements to less than the claimants are entitled to under their insurance policy contracts. This has left claimants with not enough funds to reinstate the damage caused by the earthquakes. The only option available to claimants to challenge the insurers approach is to file a claim in the courts, which is beyond the reach of most claimants.

The above summary is based on my personal experience with three different insurers across 7 dwelling claims in response to the Canterbury Earthquake Sequence ('CES'). I expand on the specific issues below. In my experience, these issues are common across all insurers.

For my seven dwelling claims, once I insisted the insurers properly recognise damage and then allow to reinstate it as the insurance policy allows, the average increase in cost to reinstate the damage (per dwelling claim) was S9 (2) (a) (difference between the final agreed settlements and

the original insurance response). This represents the average amount of money the insurers (collectively) attempted to short change me, per dwelling claim. Had I accepted their initial position, I would be in a severely compromised financial position with no way to reinstate the earthquake damage to my properties. The way the insurers accomplished this was to apply an inferior 'technical response' to my claims that did not adequately identify 'earthquake damage', nor allow to reinstate it to the policy standard. It has since come to my attention that the authors (professional engineering experts) of that 'technical response' were advocating for insurers and knew that it was not an 'insurance response' (refer para. 6. Below).

It should be recognised that the CES insurance claimants were in an extremely vulnerable position, often living in broken homes, often with financial and emotional struggles separate and additional to the insurance claims. At first, as most people did, I trusted the insurers to respond according to the promise they made in the insurance policy. In hind sight, I was extremely naïve, I did not expect them to behave as they did. In my experience, instead of providing a settlement that the policy provided, they have attempted to minimise the insurance settlement pay-out to minimise their financial losses (they see claims pay-outs simply as a cost to their business, forgetting that they have already received the benefit that is the insurance premium over many years). There are many thousands of vulnerable people who will not be aware that this was what they were doing and have therefore been taken advantage of. There are many thousands of others who have not had the emotional or financial strength, or the technical wherewithal to take the insurers on when faced with insufficient cash settlement offers. Instead they have felt they had no other choice but to accept the offers that would not allow them to reinstate their houses as the policy allowed.

Claims Handling:

1. Claims handlers provided no expected timeframes for the settlement of the claim. If they did provide timeframes for providing information, they most often failed to meet their own deadlines. The odd claims handler was ok at updating timeframes for delayed responses, but most were not.
2. Claims handlers provided no process they were following towards settlement when asked. They simply couldn't show the process they were following to ensure the intent of the policy would be met.
3. Claims handlers had little understanding of the insurance policy document. They simply followed the process they had been given and they often misrepresented (always in the insurers favour) the claimants and the insurers rights under the insurance policy contract. One simple example is claims managers (two separate insurers) informing me that I was not entitled to get any independent expert reporting and it was not covered under the policy. The policy wording clearly provided for those costs to be met under the claim, which both insurers eventually agreed with and the reports were paid for. This appears to be a common tactic across insurers to present a financial barrier to prevent claimants getting independent expert advice (since they often don't have the money available for the expert reporting).
4. Claims delayed due to the actions and inaction of the insurers. They often changed claims handlers, they often misrepresented the policy entitlements, they often misdiagnosed damage, they often used opinions of their advocates to override independent experts, they often went back on agreements, they often took a long time to disclose information (sometimes not disclosing it at all). Six out of seven of my insurance claims were settled with my private insurers six and seven years after the earthquake events. They were not complex claims, they were only made complex by the insurers not using an appropriate response that met the policy.

5. Claims handlers followed a process that does not align with the insurance policy. Insurers claims handlers insist it is their right to prove the loss and to control the reinstatement (when policy wording and case law show otherwise, refer High Court case Parkin vs Vero [65]). They then use their expert advocates to provide solutions and costings that are not fully and properly disclosed. All along this is proposed by the insurer as a correct 'in policy' response, but then then at the end of their process an out of policy cash settlement is proposed by the insurer based on their advocates views. On further investigation, the information they provide can be seen to not properly recognise damage nor allow to reinstate it in accordance with the policy and the cost of the true remediation is far greater than they were proposing.

'Technical Response' (insurers advocates advice using inappropriate standards, i.e. MBIE Guidance):

6. The insurers have colluded to come up with a technical response that does not recognise 'earthquake damage' adequately, nor allow to reinstate it as the 'full replacement' policy allows. This approach has been led by the EQC (in collusion with private insurers), by engaging a group of engineering advocates to provide a technical response for the insured event, for which *'..there was no brief or intent to meet the requirements of either the EQC Act or private insurer contracts.'* (Dave Brunsdon Leader of the Engineering Advisory Group who, working for the EQC, created the technical response to the insured event, the CES, which later became the 'MBIE Guidance').
7. The EQC convinced the DBH (became MBIE) to deliver the technical response as 'MBIE Guidance' issued under the Building Act, proposing that its aim was to provide solutions that would be 'acceptable to insurers and homeowners'. It is not plausible that it would ever be 'acceptable' to homeowners when the document never met the standard defined in the insurance policy contract or the EQC Act.
8. Every insurer I dealt with used the MBIE Guidance as their default 'insurance response'. Only after many years of delays and objections did they accept the position for my claims that it was not an appropriate document to use as they couldn't show how it met the policy standard.
9. Refer to High Court Young vs Tower (CIV-2015-409-000222 [2016] NZHC 2956) for an example of an insurers response where initially the insurers engineering expert (advocate) was briefed to follow MBIE Guidance (reinstatement value $484,688), vs courts finding once the standard of the policy was properly recognised (reinstatement value $1,620,887).
10. Refer to recent Disputes Tribunal finding where it was identified that MBIE Guidance was not equivalent to an insurance policy response and therefore not fit for purpose (CIV-2017-009-001658).

Common Insurers Strategies:

11. Insurers insisting it was their right to control the proof of loss, using their advocates opinions rather than independent experts.
12. Insurers not willing to work with insured to agree to an engagement instruction for experts to enable them to meet the policy standard.
13. Insurers not informing (or misinforming) claimants of their rights under the policy, even when specifically questioned on their incorrect interpretation. One example here is insurers failed to advise claimants it was the claimants obligation to prove the loss.

Instead the insurers incorrectly informed me they would not pay for experts reports that were covered by the insurance contract if I engaged experts to report.

14. Insurers asserting they could not instruct experts to meet the standard provided in the policy since it would cause a precedent (they later changed their mind on this for my claims, but as I understand it, not generally for others). For example, it is only a structural engineer who can comment on what is 'structural damage', and what the appropriate remediation is to meet an 'as new' standard (within their area of expertise). If the structural engineer is not instructed to meet this standard, they will default to a lessor standard to save their client money. I have recorded evidence of this (meeting minutes) from a high up manager of an insurance company, but I am prevented from sharing the details or the insurer due to a non-disclosure agreement the insurer insisted I sign to enable settlement of my insurance claim.

15. Using advocates to override independent expert opinions, with no transparency on how the advocates were engaged. One insurer initially insisted their experts were appropriate to use and would meet the policy standard, then later admitted they were acting for them as advocates when it was found they were trying to override independent expert opinions. They would not disclose the engagement instructions they were using for their own experts (advocates) to show how their advice was independent and how it met the policy contract. I have evidence of this but am prevented from sharing it due to a non-disclosure agreement the insurer insisted I sign to enable settlement of my insurance claim.

16. Using advocates acting outside their area of expertise to provide opinions to use to deny claims. Insurers using non-qualified nor equivalent experts to deny a claim is common across insurers. I have evidence of this but am prevented from sharing it due to a non-disclosure agreement the insurer insisted I sign to enable settlement of my insurance claim.

17. Insurers not making elections that should be made under the policy within a reasonable time frame. I have evidence of this but am prevented from sharing it due to a non-disclosure agreement the insurer insisted I sign to enable settlement of my insurance claim.

18. Insurers withholding material information relating to the claimant's loss. One insurer withheld information relating to the costing of their settlement figures and would not disclose where their figures came from. I have evidence of this but am prevented from sharing it due to a non-disclosure agreement the insurer insisted I sign to enable settlement of my insurance claim.

19. Insurers not properly engaging with the claimant to respond to the claim. Instead they create their own response to the claim, based on different terms of reference (not necessarily relating to the policy) and assert that it is the correct approach. This is more aligned with the adversarial approach that is common when in claims litigation.

20. Insurers threatening to start the process all over again using a new set of experts. This tactic was used to apply pressure to accept an out of policy cash settlement.

21. Insurers using short duration Limitations defence waivers to apply pressure on the claimant when discussing out of policy cash settlement offers. They would commonly not answer any questions leading up to the deadline, and then withhold providing another extension until close to the time the waiver ran out. This would force the claimant to expend money to be prepared to file with the courts to protect their right to a claim. It also becomes an emotional roller coaster for the claimant each time the insurer does not extend the Limitations waiver until the last minute. I have evidence

of this but am prevented from sharing it due to a non-disclosure agreement the insurer insisted I sign to enable settlement of my insurance claim.

22. Insurers initially using a process proposing to reinstate the damage, then changing their process to offer cash settlements for the cost to reinstate. More recently they have moved to cash settling for indemnity value only which leaves the claimant with not enough money to reinstate, with a number unsure of their rights under the policy. Changing their processes in this way without clearly outlining the claimant's rights has confused many claimants. Most are not aware they may now reinstate their dwellings and the insurer must meet the cost of that once incurred. Many claimants are now required to file in the court simply to protect their legal right to a claim.

23. When settling claims, insurers include a disclaimer that all their provided information (used previously to support their position on the quantum) cannot be relied on by the claimant. This information should be made clear to the insured at the start of the claims settlement process and not just disclosed at the end.

Complaints:

24. Insurers do not follow the complaints process in the Fair Insurance Code. They do not disclose their complaints process. They do not use independent staff who were not involved in your claim, they ignore information that puts them in a bad light and they do not issue letters of deadlock when required to.

Fair Insurance Code:

25. The fair insurance code is a joke. Insurers do not seem to be aware of what is required by them and do not follow it.

26. Insurers are not honest and transparent in their dealings with claimants. One example is, they will not disclose their engagement instructions for their advocates.

27. They do not answer questions when they realise the answers could prejudice their position or require them to properly respond to a claim. An example is an insurer withholding the details surrounding where their costing of the loss came from.

28. There is no independent oversight to ensure they are following the Fair Insurance Code, which gives them leeway to do what they like.

Dispute resolution:

29. The only real avenue open to the average claimants to resolve their disputes is the courts. This is expensive, time consuming and heavily weighted in favour of the insurers due to their financial strength and expertise in the insurance arena. This avenue only open to those claimants who have some financial backing and the ability and emotional strength to take the fight to court. Where the claimants feel they have been short changed up to $100,000 it is often not a sensible choice to take a claim to court given the costs and risks involved. The insurers appear to use this knowledge to their advantage. They seemed to realise that they are better off letting a percentage of claims enter the court system and spend money on fighting those claims, which most often result in negotiated settlements that don't set precedents, than accept the true cost of reinstatement across all claims. In fact, insurers likely use the number of claims filed in the court as an indicator as to whether they are being too generous with their claim settlements. If the number of court claims was low, it would indicate they have been too generous with their claims settlements which would likely have cost them a large amount of money across all of their claims. The only way the insurers will be discouraged from using this strategy will be for a light to be shone

on it and for it to be called out for what it really is. The number of claims that were filed in the court speaks for itself, however, it should not be confused with the real number of dissatisfied claimants which is much greater.

Other comments

We welcome any other comments that you may have.

As at the date of writing this submission, I have been successful in settling all bar one of my insurance claims (last repair about to get underway) with my insurers without the adversarial approach of litigation.

Whilst it was initially difficult and time consuming to convince the insurers to use an agreed process that was different to their standard way of using their own advocates not engaged to the policy standard, we did finally agree to settle the claims using the following high level process (proposed by me):

1. agree to the terms of reference up front to define 'earthquake damage' and define the standard to reinstate to, when engaging any experts.

2. agree on the independent experts to engage.

3. I engage the experts to act independently using the agreed instructions.

4. the insurer reviews the expert reporting and elects how they want to settle the claim.

5. we enter into settlement discussions (negotiation) or I reinstate the damage and the insurer pays.

The insurance industry and the regulations around it has failed the insured homeowners by not coming up with a similar 'independent' process at the start of the CES response. Instead, it has been left up to the insurers to determine the level of response, not unlike the fox looking after the chicken coop.

I believe there needs to be significant financial penalties (or disincentives) against insurers for:

1. *Mispresenting entitlements*
2. *Not being transparent or withholding information*
3. *Providing deceptive or misleading information*
4. *Using a process which has significantly delayed claims settlements (average of 7 years for my claims)*
5. *Not disclosing that the process they are using is not providing a policy standard of settlement.*
6. *Using advocates who are working for the insurer to a brief that was not intended to meet the policy standard of entitlement (and not disclosing this fact to the claimant).*

I believe there needs to be a complaint resolution service that is independent from the insurers themselves and their governing body.

I believe there should be an independent body who perform customer satisfaction surveys on

how complaints are handled. There should be public disclosure of the survey results (comparing insurers) so that consumers may make informed decisions at time of purchase on number of complaints made and number of complaints upheld.

I believe there needs to be independent oversight of claims settlements to ensure that insurers are delivering on the promise that was made when the policy was sold. Insurers run their claims settlement as a separate part of their business, with financial goals and incentives for to reduce costs. This incentivises the insurers to operate the claims handling side of the business in a way that minimises pay-outs. There is no independent oversight to ensure that the claims settlement process is fair or equitable and meets the policy terms. The insurers get away with whatever the claimants, the regulations and any oversight will allow them to get away with. A vulnerable population is as risk of unfair treatment if there is no independent oversight.

In my opinion the Fair Insurance Code is simply ineffectual as the insurers do not follow it in their normal claims settlement process, nor in their complaints handling processes (in my personal experience).

I believe the insurers should be compelled by the legislation to only use independently engaged experts, engaged to report to the policy standard acting at arms length. Or, if the policy allows, provide the insured with the means to do this and inform them they are entitled to do that.

I believe if the insurers choose to control the insurance response, they should be legally obliged to show how the response meets the standard required by the policy. If they were meeting that standard, it would not be an onerous requirement.

I believe every insurance policy should provide financial assistance for the claimant to prove the claim and get independent insurance claims handling advice.

I believe there should be a statutory time limit on claims settlements, with automatic penalties for delays in settling claims.

I believe there should be an independent insurance advisory service set up for insurance customers. Given the insurers record of not adequately advising the insureds of their rights and entitlements under the policy, it is essential that either they are held accountable for this lack of appropriate advice or the advice is provided via another avenue.

Appendix 1 – ‘the EQCs standard for inspections and repairs _MBIE Guidance.pdf’ (attached to email)

Appendix 2 - *Copy of a letter sent to the Chairman of the Board of one of NZs major insurers in 2018 to outline the difficulties I was having with their insurance response….*

Dear [redacted]

The reason for this letter is to give you visibility of the common tactics that [redacted] appear to be using to deny claimants their policy entitlements and which I believe cause delay to the settlement of the outstanding insurance claims.

I hope that you can use your unique perspective at the governance level, to enable you to see that the effect that the slow settlement of claims is having on your customers who simply would like to move on with their lives. I also hope that my perspective, as your customer, allows you to look honestly at the grass roots of your organisation to see what is truly happening operationally. I doubt the view that I propose will be either palatable, or what you are used to hearing from those who work for you and are used to providing you with a certain perspective of their operations. Feel free to investigate the specific details of my claim to further understand any of the issues that I raise.

Background:

I have a dwelling that is insured by [redacted] ([redacted])

That dwelling was damaged in the Canterbury Earthquake Sequence starting in September 2010.

Since my claim was passed over cap from the EQC in July 2016, I have been working with [redacted] to establish the damage to my dwelling and the appropriate policy response for that damage. [redacted] and I have made many agreements relating to how to engage appropriate experts and who to use to determine the damage and the appropriate restoration.

We are now almost in complete agreement on the damage and the standard to repair (please see attached letter to [redacted] latest representative). However, [redacted] appears unwilling to engage on the remaining (few & minor) disagreements (identified to them in October 2017) with the independent experts reporting. [redacted] is even unwilling to articulate what their disagreements are.

The Issues:

I believe that [redacted] is saying one thing in public (recent press releases) around its response to these insured events and at the same time applying quite a different process for many claimants. What I have found during my discussions and dealings with [redacted] appears to be common across many other claimants (yes, we do talk to each other).

It has taken a lot longer to get to this stage than I expected. I put many of these delays due to the lack of transparency (of [redacted] process) for your customers.

Some specific, and common, roadblocks I have identified are:

1. [redacted] has attempted to prevent me from engaging independent experts to prove the loss. They did this by denying meeting the costs of expert reporting that was necessary to resolve

the claim. Instead they indicated it was their right to bring in their own experts to prove the claim loss. I have since found out, and [redacted] have agreed, that the onus is in fact on the claimant to prove their loss.

2. [redacted] has tried to control the use of experts when reporting on the damage and the remediation for my property. They have tried to use experts who are closely aligned with them and whom are not independent (in house experts, PMO). Those experts have attempted to over-ride the recommendations of the true independent experts. This appears to be a breach of the Fair Insurance Code.

3. [redacted] refused to engage experts to the policy standard when asking for remediations as they indicated that would set a precedent (that they did not want to set). The independent experts are the only ones who are qualified to comment on whether their proposed remediation meets the standard of the policy, or not (within their area of expertise). This appears to be a breach of the Fair Insurance Code.

4. [redacted] goes to great lengths to not outline the process towards settlement of the insurance claim. Though this has been repeatedly asked for [redacted] cannot provide it. This appears to be a breach of the Fair Insurance Code.

5. [redacted] taking a negotiating stance in their response to the claim, rather than being willing to work with the insured on a proper policy response.

6. [redacted] continuingly changing claims managers and 'forgets' previous agreements that have been made. As soon as some progress appears to be happening, claims managers are changed with the new claims manager taking a long time to come up to speed with the claim. This appears to be a breach of the Fair Insurance Code.

7. [redacted] not being honest and transparent in their dealings with claimants. They often ignore simple requests for information and cannot provide any details behind the processes they have used and the decisions they have made. They change previous agreements without any reasonable explanation as to why. This appears to be a breach of the Fair Insurance Code.

I am as committed to settling my insurance claim in an efficient manner as I was at the beginning of my dealings with [redacted], 18 months ago.

I would be very interested in your perspective of the issues that I raise and welcome you to get in contact with me to discuss the content of this letter and the details of my claim.