ASIC
Australian Securities & Investments Commission

REPORT 245

Review of general insurance claims handling and internal dispute resolution procedures

August 2011

About this report

This report examines general insurance claims handling and internal dispute resolution (IDR) procedures in the context of motor vehicle insurance (MVI), and sets out our findings and recommendations.

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Consultation papers: seek feedback from stakeholders on matters ASIC is considering, such as proposed relief or proposed regulatory guidance.

Regulatory guides: give guidance to regulated entities by:

- explaining when and how ASIC will exercise specific powers under legislation (primarily the Corporations Act)
- explaining how ASIC interprets the law
- describing the principles underlying ASIC's approach
- giving practical guidance (e.g. describing the steps of a process such as applying for a licence or giving practical examples of how regulated entities may decide to meet their obligations).

Information sheets: provide concise guidance on a specific process or compliance issue or an overview of detailed guidance.

Reports: describe ASIC compliance or relief activity or the results of a research project.

Disclaimer

This report does not constitute legal advice. We encourage you to seek your own professional advice to find out how the Corporations Act and other applicable laws apply to you, as it is your responsibility to determine your obligations.

Contents

Executive summary

1 For consumers, the intrinsic value of an insurance product is in the ability to make a successful claim when an insured event occurs. A claim may be successful at first instance or, if initially unsuccessful, following further review through a dispute resolution process.

2 Given recent developments in the general insurance industry, and also changes that have been proposed (but not yet brought into law) to the *Insurance Contracts Act 1984* (Insurance Contracts Act), we considered it timely to conduct a review of general insurance claims handling and internal dispute resolution (IDR) procedures.

3 This review was also an opportunity for us to:

(a) test consumer concerns raised with industry and with ASIC about the effectiveness of claims handling and dispute resolution in the general insurance sector; and

(b) gain a better understanding of insurance practices, including an understanding of how general insurers manage their claims and IDR procedures.

4 We selected motor vehicle insurance (MVI) as a representative product for this review because it is the most commonly purchased retail general insurance product in Australia, and because it enabled us to include in the review some newer market entrants.

What we did

5 For this review, we asked eight general insurers (representing 20 MVI brands and approximately 75% of the direct retail MVI market) to provide statistics and internal documents in relation to claims handling and IDR procedures for MVI policy claims lodged in the period 1 January 2009 to 31 December 2009.

6 In this report we treat individually branded insurers as discrete insurers, and refer to them as ‘insurers’.

7 The information we obtained included:

(a) statistics about policies, claims handling and IDR; and

(b) copies of all internal documents, guidelines, scripts and standard letters relating to MVI claims handling and IDR.

8 In obtaining the information we did not exercise our compulsory information-gathering powers. We acknowledge the cooperation and assistance of all participating insurers.

What we found

9 The high-level findings of our review were generally positive. Only a very small number of MVI claims are formally denied, and numbers of claims-related complaints also appear to be relatively low.

10 Despite those high-level findings, our review found some aspects of both claims handling and IDR procedures that warrant further attention. These are discussed in this report and form the basis of our recommendations. Having considered procedures and practices across the industry, as well as outcomes for consumers, we think our recommendations reflect best practice and will help ensure more confident and informed consumers. A complete list of the recommendations is in the appendix to this report.

11 We think many of our findings and recommendations are likely to have a broader application across other general insurance product lines,[1] including those with higher claims-denial rates such as travel insurance and consumer credit insurance.[2]

Claims handling

12 The participating insurers received 1,176,621 MVI claims during 2009. Of these claims, 3317 (or 0.28%) were formally denied.

13 In addition to those claims that were denied, more than 7% of the claims reported to ASIC were withdrawn prior to a decision being made.

14 A number of insurers were only able to provide information about the basis on which claims were denied or withdrawn by manually extracting data or providing representative samples.

15 We think that recording and reviewing information about denied claims is important, as it may assist in identifying issues relating to disclosure, advertising, sales processes, product design or internal procedures.

16 We also think it is important to understand the circumstances in which claims are withdrawn, to ensure that policyholders are making properly informed decisions that operate in their best interests.

[1] For the avoidance of doubt, where relevant the recommendations made in this report should be read as having a general application, rather than confined to MVI.
[2] Financial Ombudsman Service (FOS), *General Insurance Code of Practice: Overview of the year 2009/2010*.

Recommendations 1(a) and 1(b)

Insurers should record information relating to denied and withdrawn claims, and should regularly analyse and review that information.

17 A significant proportion of claims are denied on the basis of non-disclosure or misrepresentation. This may suggest that consumers do not properly understand their disclosure obligations, the importance of complete and accurate disclosure, or the ramifications of failing to properly disclose relevant matters.

Withdrawn claims

18 There is a clear difference in approach between insurers regarding the effect a withdrawn claim has on future premiums. For some, a withdrawn claim will not affect a policyholder's future premium calculations, whereas others will in some circumstances take a withdrawn claim into consideration when calculating subsequent premiums for that policyholder.

Recommendation 2

Where a withdrawn claim will result in, or is likely to result in, an increase to future premiums, that should be disclosed.

19 We understand from our review that policyholders do not always receive written confirmation of a decision to withdraw a claim.

20 We think it is best practice to ensure that policyholders are fully aware of the status of their claim, and that information about re-establishing contact after a claim is withdrawn is conveyed to policyholders.

Recommendation 3

Insurers should consider providing written confirmation of a decision to withdraw a claim, and provide information to assist policyholders who may have further queries or decide to pursue the claim.

Frontline advice about making a claim

21 Generally, where frontline staff are permitted to make a decision to deny a claim at initial contact, that decision is reviewed by a claims specialist before being confirmed in writing with reasons for the denial.

22 While some insurers allowed their frontline staff more decision-making power than others, we found that protections were generally robust.

Recommendation 4

Decisions by frontline staff that result in a claim being denied should be reviewed before the decision is confirmed.

23 While some insurers will not communicate a likely decision prior to a formal decision being made, others leave open the possibility that frontline or claims handling staff might provide an assessment to the policyholder regarding the prospects of a claim in some circumstances.

24 Providing policyholders with an assessment of the likely decision, particularly where it is likely the claim will be denied, can have the effect of encouraging or otherwise influencing the policyholder to withdraw the claim rather than allowing it to proceed to a formal denial.

25 We consider it important that insurers identify the risk in allowing frontline staff to make an assessment or form (and communicate to the policyholder) an early view of a claim without the benefit of or ability to properly consider additional information that may affect the outcome.

Recommendation 5

Insurers should review current practices for assessments by frontline staff about the possible denial of a claim, and the communication of those assessments to policyholders.

Uninsured motorist extension cover

26 Uninsured motorist extension (UME) claims handling has drawn significant criticism from consumer representatives.

27 The data we obtained suggests the number of UME claims is very low. This may reflect a lack of consumer awareness of this additional cover.

28 The rate of acceptance of these claims was generally lower than for other MVI claims, but it was still reasonably high, with many insurers reporting acceptance rates of between 90% and 100%, and most above 75%.

29 A small number of policy disclosure documents contained conditions to a UME claim that appeared difficult to satisfy (e.g. that the policyholder provide evidence that the other party was uninsured), but we also found that the conditions applied in practice do not appear as onerous as described in the policy documents.

Recommendation 6

Insurers should review conditions on UME claims, and review disclosure material to ensure information about UME claims is accurate.

IDR procedures

30 Insurers operate 'multi-tiered' IDR procedures that typically have the following stages:

(a) frontline (or initial point of contact);

(b) Tier 1—the 'complaints' stage, which typically involves a review by an operational area (e.g. claims, underwriting); and

(c) Tier 2—the 'IDR' stage, which typically involves a review and decision by a centralised IDR team.

31 Not every complaint proceeds through each stage, as some types of complaints will progress immediately to Tier 1 or, in some cases, Tier 2.

32 Complaints resolved by frontline staff are not always recorded and decisions are usually communicated verbally.

33 We found that some insurers record very little information about matters at Tier 1. Others collect equally detailed data at both Tiers 1 and 2.

34 As noted in the guidance contained in Regulatory Guide 165 *Licensing: Internal and external dispute resolution* (RG 165), complaints handling is a useful means of tracking compliance issues or risks. The guidance also states that all complaints should be classified and analysed to identify systemic, recurring and single incident problems and trends, which will help eliminate the underlying causes of complaints and disputes.

Recommendation 7

Insurers should review their systems and processes for recording and analysing Tier 1 complaints to align them with systems used at Tier 2, so that they are able to extract useful information to address the underlying causes of complaints.

35 Many decisions made at Tier 1 are communicated to complainants verbally. Where decisions are confirmed in writing, those letters generally refer only to the next level of IDR and do not make any reference to external dispute resolution (EDR).

36 For those complainants who do not proceed to Tier 2, which represents more than two-thirds of all complaints, the response received at Tier 1 will effectively be their final response.

Recommendation 8

Decisions at Tier 1 should be confirmed in writing, and the content of those letters aligned with the final response provided at Tier 2.

Disclosure issues

37 While not the focus of this review, we identified some issues regarding the accuracy and clarity of disclosure in relation to excesses and no-claims discounts (NCD) schemes.

38 Given the complexity and importance of these matters, we think there is scope for improvements to ensure that disclosure is as complete, accurate and as clear as possible.

Recommendation 9

Insurers should review and, where appropriate, improve disclosure and/or make available additional information on excesses and the operation of NCD schemes.

Further work by ASIC

39 We have met with all participating insurers to discuss our findings. We acknowledge that the practices identified in this report may not reflect current practices of all relevant insurers, and that in a number of cases insurers are working towards or have already made changes to practices consistent with our recommendations.

40 We will work with the Insurance Council of Australia and insurers to encourage appropriate responses to our findings and the adoption of our recommendations.

41 We will follow up specific issues identified by our review with individual insurers, including some issues that we have not covered in this report.

42 We will also review ASIC's consumer education material relating to those issues where we have identified potential for greater consumer understanding and awareness, and add to or improve existing material as appropriate.

A Background

Key points

We invited eight general insurers to participate in a broad industry review of claims handling and IDR procedures. We selected MVI as a representative product for this review.

The objectives of the review were to test consumer concerns about claims handling and IDR procedures, and provide us with a better understanding of current practices.

We requested statistics and internal documents in relation to MVI policies for claims made during the period 1 January 2009 to 31 December 2009.

In December 2009 there were more than 8.5 million MVI policies in force, 87% of which were comprehensive policies. The market share of participating insurers varied significantly.

Purpose of this review

43 For consumers, the intrinsic value of an insurance product is in the ability to make a successful claim when an insured event occurs. A claim may be successful at first instance or, if initially unsuccessful, following further review through a dispute resolution process.

44 No insurer-specific comparative data is published about the claims handling performance of Australian insurers. It is therefore not possible for consumers to shop around on the basis of quality, efficiency or fairness of claims handling.

45 Equally, while there are regulatory frameworks applying both to claims handling and IDR, we think there is scope for greater understanding of the extent to which current practices align with those frameworks and meet relevant standards.

46 We considered it timely to conduct a review of general insurance claims handling and IDR procedures, given:

(a) recent industry consolidation;

(b) the entry of new insurers into personal insurance lines;

(c) the continued development and promotion of online insurance distribution; and

(d) the Government's review of the Insurance Contracts Act.

47 Relevantly, the Financial Ombudsman Service's (FOS) 2009–10 annual review recorded that general/domestic insurance disputes were up 32% for the period overall and that the biggest category related to MVI (41%).[3]

48 This review was also informed by themes arising out of consumer complaints that have been made to ASIC, including concerns about:

(a) insurers deterring policyholders from lodging claims;

(b) unreasonable delays and poor communication in relation to claims handling; and

(c) multi-tiered IDR procedures frustrating and ultimately deterring some complainants.

49 The objectives of this review were to:

(a) test these consumer concerns, which have also been raised publicly and with Government;[4] and

(b) provide us with a better understanding of insurance practices, including an understanding of how general insurers manage their claims and IDR procedures.

Scope of this review

50 We selected MVI as a representative product for this review because it is the most commonly purchased retail general insurance product in Australia, and because it enabled us to include in the review some newer market entrants. This aspect has allowed us to compare the claims handling systems and procedures of newer entrants against those of more established insurers.

51 In early 2010, we invited eight general insurers (representing 20 MVI brands and approximately 75% of the direct retail MVI market) to participate in a broad industry review of claims handling and IDR procedures.

52 Our selection of the insurers and brands included in the review was based on:

(a) market prominence and market share; and

(b) representation of different sections of the industry, including bank-owned, new entrants and online issuers.

53 We requested statistics and internal documents in relation to MVI policies for claims made during the period 1 January 2009 to 31 December 2009.

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[3] FOS, *Financial Ombudsman Service 2009–2010 annual review*.
[4] Including in submissions to: R Cornell, *Independent review of the General Insurance Code of Practice*, Insurance Council of Australia, 30 October 2009; and the Senate Economics Committee review of the Australian Consumer Law (September 2009).

54 The initial information request included:

(a) statistics about policies, claims handling and IDR; and

(b) copies of all internal documents, guidelines, scripts and standard letters relating to both MVI claims handling and IDR.

55 We obtained further information via follow-up requests made to each of the participating insurers to clarify our understanding of the initial information provided.

What this review does not cover

56 The following issues were outside the scope of this review and do not expressly form part of the analysis or recommendations:

(a) the quality of actual decision making in the claims handling procedures reviewed;

(b) insurers' underwriting practices;

(c) the conduct of fraud investigations;

(d) preferred repairer networks or other arrangements in relation to insurers and the automotive repair industry; and

(e) assessment of vehicle damage related to MVI claims.

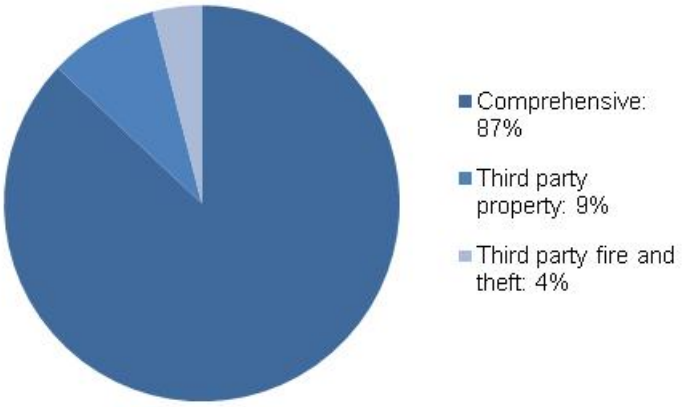
MVI market: Number and type of policies in force

57 Table 1 and Figure 1 show the number and types of MVI policies in force in December 2009, across the group of participating insurers.

Table 1: MVI policies in force across participating insurers

Type of insurance	Figure
Comprehensive	7,436,218
Third-party	760,271
Third-party fire and theft	386,581
Total	8,583,070

Figure 1: Types of policies issues by participating insurers



58 The participating insurers reported considerable divergence in market share, with individual insurers having as many as approximately 1.8 million policies and as few as approximately 2000 policies in force at the time of the review.

B Regulatory landscape

Key points

General insurance is subject to the statutory and self-regulatory standards and requirements of:

- the *Corporations Act 2001* (Corporations Act) (paragraphs 59–65);
- the Insurance Contracts Act (paragraphs 66–68);
- the *Australian Securities and Investments Commission Act 2001* (ASIC Act) (paragraphs 69–70);
- the General Insurance Code of Conduct (GI Code) (paragraphs 71–73); and
- the Australian Prudential Regulation Authority (APRA) (paragraphs 74–75).

Corporations Act

59 General insurance products are financial products for the purposes of the *Corporations Act 2001* (Corporations Act). General insurers must be licensed by ASIC in accordance with Ch 7 of the Corporations Act in order to provide financial services.

60 The Corporations Act sets out the general obligations of an Australian financial services (AFS) licensee, including that they:

(a) provide financial services covered by the licence efficiently, honestly and fairly;

(b) comply with financial services laws (including the Insurance Contracts Act); and

(c) where dealing with retail clients, have a dispute resolution system that includes IDR procedures complying with ASIC standards and requirements, and have membership of an approved EDR scheme (for insurers, this is generally FOS).

61 ASIC standards and requirements for IDR are set out in RG 165. IDR is considered in more detail in Section E of this report.

62 General insurance products are subject to disclosure requirements under the Corporations Act and the Insurance Contracts Act.

63 Chapter 7 of the Corporations Act provides the framework for disclosure about financial products, services and advice. There is a tailored Product Disclosure Statement (PDS) regime for general insurance products that takes

into account all of the information an insurer is required to provide under the Insurance Contracts Act and the information an insurer would provide through their policy terms and conditions, and so:

(a) removes certain PDS content requirements for general insurance products;

(b) removes certain PDS content requirements where the information is disclosed by the insurer in another document (e.g. policy terms and conditions); and

(c) specifies how an insurer is to disclose significant characteristics or features of a general insurance product and the rights, terms, conditions and obligations attached to the product.

64 Most insurers state in their PDS words to the effect that 'the terms and conditions of the PDS and the policy schedule constitute our contract with you'.

65 'Handling insurance claims' is specifically excluded from the definition of a financial service in the Corporations Act: s766A(2)(b) and reg 7.1.33(1)–(2) of the *Corporations Regulations 2001* (Corporations Regulations). This means that ASIC's powers under Ch 7 generally do not apply to claims handling; however, proposed amendments to the Insurance Contracts Act would introduce new powers for ASIC if brought into law: see paragraph 68.

Insurance Contracts Act

66 The Insurance Contracts Act regulates the content and operation of insurance contracts. At s13 it enshrines a statutory 'duty of utmost good faith' between an insured and an insurer:

> A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

67 The Insurance Contracts Act also sets out what consumers must do when applying for an insurance policy, including their duty to disclose to the insurer all relevant information about the risks the insurer is accepting.

68 A Bill to amend the Insurance Contracts Act was introduced into Parliament in 2010, but did not pass the Senate before the federal election in August. If passed, the proposed reforms in that Bill would give ASIC powers to:

(a) take licensing action for a breach of the duty of utmost good faith in relation to claims handling;

(b) take representative action on behalf of third-party beneficiaries (as well as policyholders); and

(c) intervene in any proceedings under the Insurance Contracts Act (based on s1330 of the Corporations Act).

ASIC Act

69 The *Australian Securities and Investments Commission Act 2001* (ASIC Act) contains ASIC's consumer protection powers in relation to financial products and services, including general insurance.

70 It includes prohibitions against misleading or deceptive conduct, unconscionable conduct, and false or misleading representations. The exclusion for claims handling in the Corporations Act is not mirrored in the ASIC Act.

GI Code

71 The General Insurance Code of Practice (GI Code) is a voluntary self-regulatory industry code developed by the Insurance Council of Australia.[5]

72 All but one of the participating insurers subscribe to the current GI Code. Unlike other self-regulatory industry codes in the financial services industry (such as the Code of Banking Practice and the Mutual Banking Code of Practice), the provisions of the GI Code are not contractually binding on subscribers and do not provide any right of action to a consumer or policyholder.

73 Relevantly, the GI Code sets standards for both claims handling and complaints handling procedures.

APRA

74 The Australian Prudential Regulation Authority (APRA) regulates prudential standards for deposit-taking institutions, general and life insurers and superannuation funds (excluding self-managed funds).

75 APRA supervises general insurers under the *Insurance Act 1973* (Insurance Act). APRA's responsibilities under the Insurance Act include:

(a) authorising companies to carry on a general insurance business; and

(b) monitoring authorised general insurers to ensure their continuing compliance with the Insurance Act—in particular, with the Insurance Act's minimum solvency requirements.

[5] The current version of the GI Code took effect on 1 May 2010.

C Claims handling procedures

Key points

Our review confirmed that a very high level of MVI claims are accepted, with only about 0.3% of claims received by the participating insurers formally denied.

We also identified higher rates of 'withdrawn' or 'cancelled' claims (more than 7% of claims made).

Participating insurers varied in their ability to extract and report information on both denied and withdrawn claims.

Even with the low levels of denied claims for MVI policies, our view is that recording and analysing information about declined claims is important; it may assist in identifying issues or trends relating to disclosure, advertising, sales processes, product design, customer service or internal procedures.

We also consider that understanding the reasons for and the incidence of withdrawn claims provides a more complete understanding of claims handling.

Accepted claims

76 Our review confirmed that a very high level of MVI claims are accepted and that arrangements work well in the majority of cases.

77 Our review necessarily examined more closely those claims that were not accepted, whether because they were formally denied or were withdrawn prior to a decision being made.

Denied claims

78 The participating insurers received a combined total of 1,176,621 MVI claims during 2009. Of these claims, 3317 (or 0.28%) were formally denied.

79 The lowest rates of denied claims were approximately 0.07%.[6] The highest rate was 8%, although it should be noted this was derived from a relatively low number of claims.

[6] One insurer reported no claims denied, for reasons described in paragraph 130. No other insurer took this approach to the consideration of general MVI claims, although some applied a similar approach to UME claims.

Variations in reporting and the quality of information

80 We asked the insurers to provide information about the basis on which claims were denied.

81 One insurer was unable to provide a breakdown of reasons for denial, and a further eight could only do so by manually reviewing files.[7] Two of those insurers provided a breakdown based on a random sample of 100 denied claims.

82 Even with the low levels of denied claims for MVI policies, our view is that recording information about denied claims, including reasons for denial, is important as it allows review and analysis of such information, which may assist in identifying issues or trends relating to disclosure, advertising, sales processes, product design, customer service or internal procedures.

Recommendation 1(a)

Insurers should record information relating to denied claims, and should regularly analyse and review that information.

Most common reasons for claims denial

83 While there was a relatively high degree of commonality in the participating insurers' descriptions of the underlying reasons for MVI claims denials, it was not possible to correlate this information exactly across all insurers.

84 We were able to determine, however, that the most common category for claims denial was non-disclosure or misrepresentation. For the majority of insurers, this appeared to relate to pre-contractual disclosure or misrepresentation rather than to a fraudulent claim.

85 Other common reasons for denial were lack of cover and driving under the influence of alcohol.

86 In addition, one insurer reported that 55% of denied claims were denied because the policyholder only had third-party cover (and presumably was seeking cover for their own damage)[8] and two insurers listed restricted driver exclusions as a common reason for claims denials. One reported that 'Policy exclusion'—including driver age exclusion and unlisted household member exclusion—accounted for 38% of their denied claims, while the other reported that the restricted driver exclusion was their highest denial category at 27% of denied claims.

[7] One insurer, for example, recorded all denied claims as a breach of policy conditions.
[8] It appears that most insurers would treat these claims as withdrawn, unless there was a specific dispute about the scope of the cover.

Duty of disclosure

87 The Insurance Contracts Act sets out the legal duty of disclosure that a policyholder owes their insurer.[9]

88 The Insurance Contracts Act also sets out the remedies available to an insurer if the policyholder fails to comply with the duty of disclosure. These vary depending on whether the disclosure is considered to be innocent or fraudulent, but any finding of non-disclosure can have significant implications for the policyholder's ability to claim under the relevant policy, and it may also impact on the ability of policyholders to obtain insurance in the future.

89 The fact that a significant proportion of claims are denied on the basis of non-disclosure or misrepresentation suggests that consumers may not properly understand their disclosure obligations, the importance of complete and accurate disclosure, or the ramifications of failing to properly disclose relevant matters.[10]

Communicating claims denials

90 All of the participating insurers write to the policyholder when a claim is denied.

91 The claim denial letters we reviewed were all consistent with the GI Code, which states (at clause 3.4.5) that:

> If we deny your claim, we will provide:
>
> (a) written reasons for our decision to deny your claim;
>
> (b) information about our complaints handling procedures; and
>
> (c) on request … copies of reports from our service providers which we have relied on in assessing your claim.

92 In most cases policyholders will also be advised by phone of the decision to deny their claim.

Quality of claim denial letters

93 We requested copies of (de-identified) claim denial letters from the insurers, including examples showing claims denied on the basis of policy exclusions and non-disclosure.

[9] MVI is prescribed as an 'eligible contract of insurance' for the purposes of the Insurance Contracts Act and so is subject to specific duty of disclosure rules as set out in s21A. Proposed reforms to to the Insurance Contract Act would also affect the questions asked of a consumer at policy inception and renewal.

[10] The proposed amendments to the Insurance Contracts Act, referred to in paragraph 68, include changes to the duty of disclosure that are intended to reduce the risk for policyholders of failing to disclose relevant matters.

94 We note this request may have allowed for some selection by the insurers of the letters they provided to us, but assume that what was provided was representative of standard correspondence.

95 We also reviewed internal claims handling guidance, which confirmed that the participating insurers generally instruct staff to include the reasons for denial in a claim denial letter, consistent with the requirements of the GI Code.

96 The quality of the claim denial letters we reviewed was generally high. The letters typically included the following information:

(a) the reasons the claim was denied, including the factual basis for the denial;

(b) references to the cover provided, policy section, clause and page number where appropriate, as well as relevant policy exclusions; and

(c) references to IDR and EDR procedures, often provided as an additional brochure that outlined and explained complaints handling processes.

Withdrawn claims

97 'Withdrawn' claims are those that are notified to the insurer but, for various reasons, do not proceed to an acceptance or denial decision. Different insurers use different terminology including 'withdrawn', 'cancelled' or 'closed' to refer to these claims. In this report we will use the umbrella term 'withdrawn'.

98 A low rate of 0.3% for formal denials of claims does not mean that every other claim was accepted.

99 In addition to those claims that were denied in 2009, more than 7% were withdrawn.[11] One insurer reported that 32% of claims made in 2009 were withdrawn.

Variations in reporting and quality of information

100 We consider that understanding the reasons why claims are withdrawn and monitoring the rates at which they are withdrawn provides a more complete understanding of claims handling, product features and design, as well as of consumer behaviour and understanding, than focusing only on denied claims.

101 We asked those insurers that recorded withdrawn claims to provide a breakdown of the reasons that those claims were withdrawn.

[11] Three insurers did not record the numbers of claims withdrawn and so were unable to report a figure.

102 Only seven insurers were readily able to provide this information.[12]

103 Other insurers provided a representative breakdown based on a sample of 100 withdrawn claims.

Reasons for claims being withdrawn

104 The significant variations in the way insurers categorise and record information about withdrawn claims mean that it is not possible to reach any firm conclusions regarding the reasons why and the circumstances in which claims are withdrawn.

105 It was evident, however, that one of the most common categorisations of claims withdrawn was 'not pursued' or 'withdrawn by policyholder' or relevant equivalent. In some cases 'not pursued' might relate to the absence of any demand from the other party to an incident, or failure by the policyholder to respond to enquiries, but in many cases it will also cover circumstances where the policyholder requests that the claim not proceed.

106 We also asked the participating insurers why claims might be withdrawn. A wide variety of reasons were suggested, including where:

(a) the amount of the claim is less than or similar to the excess;

(b) the policyholder claims directly from the at-fault third party;

(c) the insurer is unable to contact the policyholder, or information necessary to consider the claim is not provided by the policyholder;

(d) no claim or demands are made by the third party;

(e) the policyholder decides not to proceed;

(f) the claim was lodged incorrectly;

(g) the claim is withdrawn during or after investigation (e.g. at the instigation of the policyholder);

(h) stolen goods are recovered intact;

(i) there is no or inappropriate cover for the incident; or

(j) there is no policy in effect at the time of claim.

107 As this list indicates, there will be some circumstances in which the policyholder initiates the withdrawal, and there may be other circumstances in which the insurer effectively initiates the withdrawal—for example, by advising the policyholder that their policy is unlikely to cover the notified incident.

108 The circumstances in which a policyholder might lodge a claim and subsequently decide that it is not worth pursuing—for example, because the

[12] One of those insurers listed approximately 60% of the withdrawn claims as 'closed'.

amount claimed is close to the excess or there is no appropriate cover—are relevant to the issue of providing frontline advice about making claims, discussed at paragraphs 120–141.

109 At a minimum, we consider that there is scope for further work by industry to review whether policyholders withdrawing claims are making properly informed decisions that operate in their best interests.

110 We also observed that a significant number of withdrawn claims occurred where the policy had lapsed or was not in effect. We are not in a position to speculate on why so many policyholders thought they were covered and discovered only post-claim that the cover was not current, but suggest this is also an area that might warrant further review.

Recommendation 1(b)

Insurers should record information relating to withdrawn claims, and should regularly analyse and review that information.

Effect of withdrawn claims on future premium assessments

111 We asked participating insurers whether the withdrawal of a claim would impact on that policyholder's next premium assessment.

112 The effect of a withdrawal on future premium calculations might in some situations be a factor policyholders would consider relevant when deciding whether or not to pursue a claim, in particular where the value of the claim is close to the amount of the excess.

113 While the majority of insurers do not take withdrawals into account, there is a clear difference in approach across the industry.

114 Four insurers take withdrawn claims into account when calculating future premiums for an individual policyholder.

115 One insurer will only increase premiums if it incurred costs in relation to the claim prior to it being withdrawn, while another might increase a premium if damage to the insured vehicle that was incurred in the relevant incident was not repaired.

116 Two other insurers reported that they might increase premiums after considering a policyholder's claim and incident history.

Recommendation 2

Where a withdrawn claim will result in, or is likely to result in, an increase to future premiums, that should be disclosed.

Communicating claims withdrawals

117 A number of the insurers provided examples of claim withdrawal letters in response to our request for pro-forma letters and other customer communications confirming receipt of a claim, advising of the progress of a claim and advising about the decision on a claim. Other insurers did not provide copies of such letters.

118 The letters we reviewed included invitations to make contact again in the event that the policyholder wanted the claim re-opened or simply had any queries, and confirmed appropriate contact details.

119 We consider that it is useful in some situations to provide written confirmation containing such information where a claim is withdrawn, and in most other cases to provide that information verbally. Information about re-establishing contact after a claim is withdrawn may be particularly important where a policyholder withdraws a claim without having had an opportunity to thoroughly consider their options, particularly where a claim is withdrawn at a very early stage.

Recommendation 3

Insurers should consider providing written confirmation of a decision to withdraw a claim, and provide information to assist policyholders who may have further queries or decide to pursue the claim.

Frontline advice about making claims

120 One of the concerns consistently raised by consumer representatives, albeit a concern based on anecdotal evidence, relates to the alleged practice of some insurers of suggesting to a policyholder over the telephone (at the point of initial contact) that their claim cannot or is unlikely to proceed or be accepted. Such advice might be given, for example, on the basis that the underlying policy has lapsed, the policy does not cover the incident or the loss claimed is less than the excess.

121 Consumer representatives are concerned that policyholders with legitimate claims may be dissuaded from making or pursuing a claim, or be given incorrect advice. Because this ‘advice’ is not categorised as a claim denial (it would be more likely to be recorded as a withdrawn claim, if in fact a claim is recorded at all) there will be no written confirmation of the reason the claim was denied, in turn reducing the opportunity a policyholder may otherwise have to seek further advice and/or dispute the decision.

122 The focus of our review was not on information provided by frontline staff in response to an inquiry from a policyholder, but rather the role of those staff where a claim has been made.

123 Our review has confirmed that some insurers authorise frontline staff to make claims decisions at the initial stage of contact, typically over the telephone.

124 That authorisation generally extends only to approving claims, with frontline staff authorised to deny claims only in very limited circumstances.

125 Authorisation to determine a claim at this early stage is generally also dependent on the type of claim, with some claims referred to a specialist team or claims manager.[13]

126 Four insurers estimate that approximately 95% of claims were determined during the course of the call made by the policyholder to notify the insurer of the claim.

Review procedures for frontline decision making

127 Generally, where a decision to deny a claim is verbally communicated to a policyholder at initial contact, that decision is reviewed by a claims specialist before being confirmed in writing with reasons for the denial. The frontline staff themselves are not authorised to provide written confirmation of their decision nor is that decision final until it has been reviewed.

128 Ensuring a frontline decision is reconsidered by someone with the necessary expertise in assessing claims is an important safeguard for policyholders in the event that the frontline decision was not appropriate in the circumstances.

129 We would be concerned if frontline staff were able to deny a claim at the point at which the insurer was notified by a policyholder without any further review to ensure the correct decision was made.

Recommendation 4

Decisions by frontline staff that result in a claim being denied should be reviewed before the decision is confirmed.

Deciding to withdraw a claim

130 One insurer reported no denied claims, on the basis that its assessment procedure results in policyholders whose claims would not be paid being advised of that likelihood, and as a result invariably withdrawing their claim.[14]

[13] These could include claims on a cover note, for third-party property damage or fire and theft, or UME claims. While claims can only be denied after review by a specialist team or manager, they can still be withdrawn at the frontline.
[14] This insurer received a relatively small number of claims, and confirmed that if a policyholder refused to withdraw their claim it would proceed to a formal denial.

131 Another insurer's claims handling system provides a prompt for rejection advice once the customer has provided all of the necessary information. The customer is still able to proceed with a claim after being verbally advised that their claim will be rejected.

132 While some insurers will not communicate a likely decision prior to a formal decision being made, others leave open the possibility that frontline or claims handling staff might provide an assessment regarding the prospects of a claim in some circumstances.

133 Providing policyholders with an assessment of the likely decision, particularly where it is likely the claim will be denied, can have the effect of encouraging or otherwise influencing the policyholder to withdraw the claim rather than allowing it to proceed to a formal denial.

134 While we are not in a position to assess whether or not the extent to which advice of this nature is accurate or reasonable, there does appear to be some risk in allowing or encouraging a policyholder to make a decision based on a frontline assessment.

135 That risk relates to the quality of the frontline assessment (and the existence of appropriate monitoring processes), as well as to the ability of a policyholder to then reconsider or seek further advice about their claim.

136 A number of insurers also allow frontline staff to provide information about cover prior to a claim being lodged, although this is generally only in relation to inquiries that are straightforward.

137 Consumer concerns in this area were raised during consultation on recent changes to RG 165, and the Insurance Council of Australia has suggested the issue could be addressed in the GI Code.[15] We encourage industry to work with consumer representatives to better understand their concerns, and to consider an appropriate self-regulatory response to this issue.

Considering claims on a lapsed policy

138 There may be additional reasons to ensure a claim is more comprehensively considered depending on the type of claim or reason for which it might be denied. A good example of this is claims that are likely to be denied because cover has lapsed.

139 It is part of one insurer's procedures to advise policyholders at the point of lodgement that cover has lapsed, but to give them the option of proceeding to allow the claim to be considered further. Where the policyholder takes up this option, the claim is referred for consideration of special circumstances,

[15] ASIC understands that the Insurance Council of Australia has proposed an amendment to the GI Code that would require frontline staff to ask policyholders who enquire about a possible claim if they would like to lodge a claim for determination.

such as whether all renewals have been sent to the correct address or whether the claim should receive special consideration on the basis of the length of time the policyholder has been a customer.

140 Despite the initial negative assessment of a claim this further consideration may result in the claim being paid, whether in whole or in part. This will only occur, however, where the policyholder requests that the further review take place.

141 We consider that there is a risk of poor outcomes for individual policyholders whenever frontline staff are able to make a decision or form (and communicate to the policyholder) an early view of a claim without the benefit of or ability to properly consider additional information that may affect the outcome.

Recommendation 5

Insurers should review current practices for assessments by frontline staff about the possible denial of a claim, and the communication of those assessments to policyholders.

D UME cover and claims handling

Key points

Consumer representatives have raised concerns about UME with ASIC, including that the conditions to a UME claim are unreasonably onerous.

The conditions for UME cover are generally standard, although we did identify some conditions that might be more difficult to satisfy.

In practice, insurers often require less from a policyholder making a claim than disclosure would suggest.

Insurers receive relatively small numbers of UME claims. The rate of acceptance for these claims are high, but are generally lower than for other MVI claims.

142 UME cover provides additional protection for those holding policies below the level of comprehensive cover (third-party cover, third-party fire and theft cover, and other policies that do not provide cover for damage to their own vehicle), allowing a policyholder to claim for damage to their own vehicle to a maximum amount, typically between $3000 and $5000.

143 UME cover can reasonably be characterised as an additional benefit for policyholders who have otherwise chosen the more limited cover of a third-party type policy.

144 Most of the participating insurers offered UME cover on relevant MVI policies.

Conditions on cover

145 Consumer representatives have raised concerns about UME cover with ASIC, including both that insurers are not making policyholders aware of this cover and that if a policyholder does seek to benefit from the cover, the conditions on UME claims are unreasonably onerous.

146 While there is no single approach to UME cover, our review suggests that the conditions on claims are typically that:

(a) the other party to the accident is 100% at fault;[16]

(b) the other party to the accident is uninsured; and

[16] In contrast, a small number of insurers allow the other party to be only 50% or more at fault.

(c) the policyholder provides contact details for the other party to their insurer, including the other party's name, address and registration details.

147 A small number of insurers also require that the incident be reported to police.

148 Our review suggests that conditions that might be considered unnecessary are rare; however, we would encourage insurers to review applicable conditions to ensure they are appropriate and do not present an unreasonable barrier to cover.

149 In practice, many insurers said they would only require the policyholder to provide the other party's telephone number and verbal confirmation that the other party is uninsured to be able to claim, and would not deny a claim solely because a policyholder had not provided everything they were contractually obliged to provide.

150 Where disclosure is inconsistent with practice there is a risk that policyholders would not progress to making or inquiring about the option of making a claim. We think it is important that policyholders are given accurate information about their obligations and any conditions to cover.

Recommendation 6

Insurers should review conditions on UME claims, and review disclosure material to ensure information about UME claims is accurate.

UME claims

151 The participating insurers received relatively low numbers of UME claims in 2009. As noted at Table 1, in December 2009 there were 1,146,852 third-party and third-party fire and theft policies in force. In contrast, nine insurers received less than 100 UME claims, with others receiving only in the low- to mid-hundreds.

152 The rate of acceptance of these claims was generally lower than for other MVI claims, but was still reasonably high, with many insurers reporting acceptance rates of between 90% and 100%, and most above 75%.

153 One insurer only accepted 55% of UME claims.[17] Notably, the cover provided by this insurer was subject to a number of conditions that might be difficult to satisfy, including that the policyholder provide evidence that the other party was uninsured. In practice, the insurer was often proactive with

[17] That insurer received 163 UME claims in 2009.

establishing this evidence themselves and their lower acceptance rate can be attributed to the manner in which they lodge their claims.

154 In contrast, the insurer with one of the most accessible UME policies received the highest number of claims (1243) and had an acceptance rate of 93%.

155 The low number of claims and the lower rate of acceptance than for general MVI claims may suggest both that policyholders are often not aware they have the benefit of UME cover and are not aware at the time of an incident that they should collect information such as the contact details of the other party.

156 UME cover is an important additional protection for policyholders who do not have comprehensive cover, particularly those who may have chosen a lower level of cover for affordability reasons. This additional protection is only of value, however, where policyholders are aware of it and understand their obligation to collect information required for a claim.

157 There may be scope for industry to consider increasing consumer awareness of UME cover, and take further steps to ensure that policyholders have information about their cover and the information they will need to collect if they intend to make a claim.

158 We would also encourage industry to work with consumer representatives to better understand why this is seen as a problematic area.

E IDR procedures

Key points

All participating insurers operate a multi-tiered IDR structure, typically involving:

- frontline;
- Tier 1; and
- Tier 2.

Systems and procedures at frontline and, in many cases, at Tier 1 are typically less sophisticated, capturing less information and providing more informal responses to complainants than is the case at Tier 2.

A significant proportion of complaints do not proceed beyond Tier 1. As many insurers do not provide a written response at Tier 1, many complainants will not receive any written response.

Despite the use of multi-tiered structures, most disputes were resolved within the timeframes required by RG 165 and the GI Code.

The level of overturn (disputes decided in favour of the complainant) varied considerably between the participating insurers. We consider that more work is necessary to properly understand the reason for these variances.

Regulatory framework

159 As described in Section B, IDR (or complaints handling) in the general insurance industry is subject to both statutory and self-regulatory requirements and standards.

Corporations Act

160 Under s912A(1)(g) of the Corporations Act, an AFS licensee that provides financial services to a retail client must have a dispute resolution system that complies with s912A(2) of the Corporations Act.

161 Section 912A(2) states that a dispute resolution system must consist of:

(a) an IDR procedure that:

(i) complies with standards and requirements made or approved by ASIC, in accordance with regulations made for the purposes of s912A(2)(a)(i); and

(ii) covers complaints against the licensee made by retail clients about the provision of all financial services covered by the licence; and

(b) membership of one or more EDR schemes that:

(i) are approved by ASIC, in accordance with regulations made for the purposes of s912A(2)(b)(i); and

(ii) cover complaints against the licensee made by retail clients about the provision of all financial services covered by the licence.

For the exact wording of the requirements, see s912A(2) of the Corporations Act.

Corporations Regulations

162 Under reg 7.6.02(1) of the Corporations Regulations, when considering whether to make or approve standards or requirements relating to IDR, ASIC must take into account:

(a) Australian Standard AS ISO 10002-2006 *Customer satisfaction—Guidelines for complaints handling in organizations* (AS ISO 10002-2006); and

(b) any other matter ASIC considers relevant.

RG 165

163 RG 165 sets out ASIC's standards and requirements for IDR procedures.

164 The key requirements for IDR procedures are that financial service providers:

(a) adopt the definition of complaint set out in AS ISO 10002-2006:

> An expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected.

(b) provide a 'final response'[18] to a complainant within a maximum of 45 days, which must be in writing and set out:

(i) the final outcome of the complaint or dispute at IDR;

(ii) the complainant's right to take the complaint to EDR; and

(iii) the name and contact details of the relevant EDR scheme; and

(c) have a system for informing complainants about the availability and accessibility of the relevant EDR scheme.

165 In February 2011, ASIC announced changes to RG 165 that allow a more flexible approach to be taken where a complaint is resolved to the complainant's complete satisfaction by the end of the fifth business day after

[18] A final response is required for all claims-related complaints, but may not be required for other complaints that are resolved to the customer's complete satisfaction within five business days.

the complaint is received.[19] A final response is not required for those complaints, unless the complainant has requested a response in writing, and details of the complaint need not be captured and recorded.

166 The arrangements for complaints resolved within five business days do not apply to complaints about a denied insurance claim, the value of an insurance claim, or hardship.

167 Relevantly, this means that a final response is required for all complaints about a denied insurance claim or the value of an insurance claim.

GI Code

168 The GI Code is a voluntary self-regulatory industry code designed to raise standards and improve the way claims and compensation are handled by insurers.

169 Whereas RG 165 generally refers only to complaints,[20] the GI Code draws a distinction between 'complaints' and 'disputes'. This is an important distinction.

170 Under the GI Code, an insurer has 15 days to respond to a complaint or to agree a reasonable alternative timeline. The insurer must notify the complainant of the response and provide information about how the complainant can have the complaint reviewed by a different employee who has the appropriate expertise, knowledge and authority. There is no requirement to give this notification in writing.

171 If the complainant wants this response reviewed, the complaint will then be treated as a dispute, which is also subject to an initial 15-day response timeline. The GI Code states that the insurer will respond to the dispute in writing, giving reasons for the decision and information about how and when to access available EDR schemes. The requirement to respond in writing appears to apply irrespective of the outcome of the dispute.

172 In practice, insurers operate 'multi-tiered' IDR procedures that typically have the following stages:

(a) frontline (or initial point of contact);

(b) Tier 1—the 'complaints' stage, which typically involves a review by an operational area (e.g. claims, underwriting); and

[19] Media Advisory (11-23AD) *Revised internal dispute resolution procedures for financial institutions* (16 February 2011).
[20] RG 165 uses the terms 'complaints' and 'disputes'; however, the term 'dispute' is generally reserved for certain matters that fall under the *National Consumer Credit Protection Act 2010* (National Credit Act) and so that definition is not relevant to this review. Otherwise, RG 165 does not draw a practical distinction between complaints and disputes for AFS licensees. This means, for example, that the general 45 day maximum timeframe at IDR applies to all complaints from the date they are received, irrespective of how they may be characterised internally by a licensee.

(c) Tier 2—the 'IDR' stage, which typically involves a review and decision by a centralised IDR team.

173 Although insurers tend to reserve the term 'IDR' to the Tier 2 stage, the Corporations Act and RG 165 apply the term 'IDR' to the entire internal complaints handling process and 'complaint' to all types of complaints or disputes, however described by the insurer. This is the approach we have adopted in this report.

IDR statistics

174 We asked participating insurers to provide data about complaints lodged in 2009.

175 It is clear from the responses received that there is little consistency between the participating insurers in the collection of and ability to report on information about complaints. Most insurers do not record complaints resolved at the frontline, and some do not collect comprehensive data at Tier 1.

176 There was also little correlation between numbers of complaints and numbers of policies, claims or denied claims. Some insurers who reported similar numbers of claims made and claims denied reported very different numbers of complaints.

Numbers and types of complaints

177 We asked participating insurers for numbers of complaints at each level of IDR.

178 In 2009, the insurers received approximately 20,000 Tier 1 and 6498 Tier 2 complaints.[21]

179 Of the Tier 2 complaints, 5885 were claims related.

180 As reported at paragraph 78, our review found that in the same period 3317 claims were denied. These figures show that significant numbers of complaints are made about matters not involving claim denials, and suggests that even where a claim is paid some policyholders remain dissatisfied and seek further review of the claims decision.

181 While there was some variation across individual insurers, the top three subjects of complaints at Tier 2[22] were:

(a) issues of liability and claims denial;

(b) the amount and terms of settlement; and

(c) issues around excesses.

[21] Some insurers were unable to provide an exact figure for complaints at Tier 1.
[22] As noted at paragraph 192, information was limited at Tier 1.

Multi-tiered IDR procedures

182 The use of multi-tiered IDR procedures by the general insurance industry is often the subject of criticism by consumer representatives, who suggest that they have the effect of frustrating and ultimately deterring some complainants.

183 In contrast, other sectors (such as the banking sector) tend to have centralised complaints departments, resolving complaints either at the initial point of contact or escalating them immediately to an IDR team.

184 We asked participating insurers a series of questions about their IDR procedures at each level, and reviewed related documentation provided to us.

Frontline

185 Most insurers attempt to resolve a complaint at the first point of contact with frontline staff[23] even before it is treated as a Tier 1 complaint.

186 The timeframe for resolution by frontline staff is generally short, typically within 24 hours or by the end of the next business day. The longest reported timeframe was three days.

187 We found that complaints resolved by frontline staff are unlikely to be recorded and decisions are usually communicated verbally to complainants.

188 Some types of complaints will be automatically escalated from the frontline to Tier 1 or to Tier 2. Typically, these include complaints about denial of a claim and may also include complaints about the value of a settlement or complaints about a claim which is still being considered.

Tier 1

189 If the complaint is not resolved by frontline staff, the issue is recorded and escalated, generally to Tier 1.

190 Many insurers use operational staff at Tier 1. This means that if the complaint involves claim denial, for example, it will be referred to the relevant claim team, typically to the team leader.

191 Some insurers escalate certain types of complaints directly to Tier 2. For example, seven of the participating insurers automatically escalate complaints about denial of claims, and two others offer this as an option.

192 We found that some insurers record very little information about matters at Tier 1. Others collect equally detailed data at both Tiers 1 and 2.

[23] Usually, frontline staff are customer service or call-centre staff.

193 In some cases, we found that information at Tier 1 is recorded in a way that does not facilitate data extraction and reporting.

194 As a result of using different systems at Tier 1 and Tier 2, some insurers find it difficult to track a matter across both tiers—for example, once a dispute reaches Tier 2 it may be difficult to determine the decision or the basis for the decision made at Tier 1.

195 As noted in the guidance contained in RG 165, complaints handling is a useful means of tracking compliance issues or risks. The guidance also states that all complaints should be classified and analysed to identify systemic, recurring or single incident problems and trends, which will help eliminate the underlying causes of complaints and disputes.

Recommendation 7

Insurers should review their systems and processes for recording and analysing Tier 1 complaints to align them with systems used at Tier 2, so that they are able to extract useful information to address the underlying causes of complaints.

Tier 2

196 Where a complaint is not resolved at Tier 1 it progresses to Tier 2, generally to a centralised IDR team (sometimes referred to as ‘customer relations’ or ‘risk management’).

197 In contrast to Tier 1, where decision makers may be operational staff, Tier 2 decisions are made by staff who specialise in dispute resolution.

198 We found that decision-making models at Tier 2 differ across participating insurers.

199 Eight insurers use panels at this level, which meet either on a weekly basis or as required. While the composition of the panel varies between insurers, some include senior executives.

200 Other insurers have a single decision maker to consider a Tier 2 dispute, although that may still involve a consultative process—for example, with technical officers, team leaders, underwriting teams and relevant business units.

201 Overall, we found that Tier 2 complaints are more effectively and comprehensively recorded than frontline or Tier 1 complaints.

Final response letters

202 Both RG 165 and the GI Code require written confirmation of a final IDR decision.[24]

203 Written communication of a final decision is an important part of the complaints handling process because it informs a complainant of the final outcome of the complaint and the basis on which the decision was made, which in turn allows the complainant to obtain advice about that decision and consider further options. A written response also informs complainants of the right to refer the complaint to EDR and provides contact details for the relevant EDR scheme.

204 Our review suggests that the participating insurers might not be meeting this obligation in all cases.

Tier 1

205 We asked insurers for examples of letters provided at Tier 1.

206 We found that resolution of complaints and disputes at this level will often not be confirmed in writing and, as a result, relatively few examples were provided. Practice varies across insurers.

207 A number of insurers will respond in writing if the complaint concerns a claim denial. Others may respond in writing only if:

(a) the manager decides to;

(b) the complaint was not decided in the complainant's favour; or

(c) the complainant specifically requests it.

208 For those letters that we were able to review, there was typically reference only to the next tier of IDR (Tier 2), with no reference to EDR.

209 As noted above, the number of complaints that progress to Tier 2 is less than one-third of those that reach Tier 1. This means that the response provided at Tier 1 is effectively the final response for the majority of complainants.

210 FOS has recognised this issue and, in the July 2010 issue of *The Circular*,[25] suggests that members:

> should beware of the situation when its first-tier response does not clearly inform the applicant:
>
> - it is a final decision, and

[24] As noted at paragraphs 165–167, RG 165 provides that a final written response may not be required where a complaint is resolved within five days, although it will always be required for complaints about a denied claim or the value of a claim.
[25] *The Circular* is a regular publication from FOS on dispute resolution issues.

- what the dispute resolution process is following this initial response, including further IDR steps and/or EDR.

In these situations, it is possible FOS will accept this response as being the 'IDR Response' and proceed with reviewing the dispute, even if the 45 day period has not lapsed to ensure an efficient and timely handling of the dispute.

211 This is an aspect of the multi-tiered approach to IDR that we think has greatest capacity for poor outcomes for complainants. Like FOS, we think that insurers should recognise that a Tier 1 response may be the final response for many complainants.

212 As noted at paragraphs 165–167, the February 2011 changes to RG 165 mean that a final response must be given for all complaints:

(a) not resolved within five business days of receipt; and

(b) involving hardship, a declined insurance claim or the value of an insurance claim (regardless of whether they are resolved within five business days of receipt).

213 While a Tier 1 response may not necessarily be the final response, it should otherwise align with a Tier 2 final response in that it should:

(a) be a written response;

(b) explain the decision reached at this stage; and

(c) explain the next steps available to the complainant, including escalation to Tier 2 as the immediate next step but also the availability of EDR in the event that the complaint remains unresolved.

Recommendation 8

Decisions at Tier 1 should be confirmed in writing, and the content of those letters aligned with the final response provided at Tier 2.

214 For the avoidance of doubt, this recommendation is subject to the exception in RG 165 for non claims-related complaints resolved within five business days.

Tier 2

215 In the majority of cases, a final response letter will be sent once a complaint has been considered at Tier 2. Our review suggests that these letters are generally expressed in clear, plain language and contain relevant information, including information about EDR.

216 Our review found that there may be instances where Tier 2 complaints do not result in a final response being given in writing—for example, where a complaint is resolved in favour of the complainant.

217 There is other evidence to suggest that some insurers may not confirm all final responses in writing, even where the dispute is not resolved in favour of the complainant.

218 This was of particular concern, and appears directly inconsistent with obligations set out in RG 165. We have followed up these issues with individual insurers as relevant.

IDR timeframes

219 RG 165 states that a maximum timeframe of 45 days applies to an IDR process, including any process that involves multiple tiers.

220 The GI Code requires subscribers to adhere to the following timeframes:

(a) respond to complaints (Tier 1) within 15 business days;

(b) respond to disputes (Tier 2) within 15 business days; and

(c) update the complainant on the progress of the dispute every 10 days.

221 Our review found that the procedures of participating insurers for IDR timeframes were consistent with both the requirements of RG 165 and the GI Code.

222 We asked for data showing the time actually taken to finalise complaints. The information provided showed that most complaints were resolved within 30 days, with only a very small number exceeding 45 days.[26]

Levels of overturn at IDR

223 The *General Insurance Code of Practice: Overview of the year 2009/2010* report stated that 33% of all personal line general insurance complaints were overturned (i.e. decided in the complainant's favour).

224 We asked insurers to tell us about overturn rates for claims-related complaints. Our review suggests that the experience of individual insurers varies considerably, with some significantly higher[27] than 33% and some significantly lower.[28]

225 While overturn rates in the vicinity of 33% may reflect the importance of effective and accessible IDR (and EDR) procedures for policyholders, high rates of overturn may possibly reflect poor initial decision making.

[26] The distinction between complaints and disputes made by industry mean that we were not always able to determine whether these timeframes were inclusive of Tier 1.
[27] In one case, the overturn rate was approximately 60%.
[28] Some insurers reported rates between 10% and 15%.

226 As noted earlier, the quality of decision making in the claims handling process was outside the scope of this review; however, we would encourage industry to consider the implications of both high and low overturn rates, particularly as a possible measure of the quality of both claims decision making and IDR.

F Disclosure issues: Excesses and NCD schemes

Key points

Our review identified a wide range of excesses that can apply to MVI policies; however, we do not think they are always adequately disclosed.

One insurer set out examples of excesses in policy schedules that are not disclosed in the PDS. When excesses are disclosed in the PDS, some examples are unclear or lacking sufficient detail to allow a consumer to properly understand when the excess might apply.

Our review also identified disclosure issues concerning the operation of NCD schemes.

227 While the focus of this review was on claims handling and IDR procedures, we also identified some issues relating to disclosure that we consider warrant some comment in this report.

228 The issues we identified arose in relation to two particularly complex aspects of the structure of insurance cover and pricing: excesses and the operation of NCD schemes.

229 We encourage industry to consider the issues we have identified and consider whether changes or improvements could be made to current practices.

230 We may also undertake further work in relation to one or both of these areas.

Recommendation 9

Insurers should review and, where appropriate, improve disclosure and/or make available additional information on excesses and the operation of NCD schemes.

Excesses

231 Our review identified a wide range of excesses that can apply to MVI policies, including standard or basic excesses, additional excesses, and special or imposed excesses. A typical policy might include between one and seven different excesses.[29]

[29] Where a claim is made, it is possible for multiple excesses to apply, however, others may be mutually exclusive.

232 Insurers generally operate a standard or basic excess, the amount of which can generally be increased by policyholders in return for a decreased premium (and, in some cases, decreased for an increased premium).

233 Additional excesses might also apply depending on the circumstances of a particular policyholder, driver or incident. These include age excesses (e.g. for drivers under 25 years of age), undisclosed or inexperienced driver excesses, and excesses for theft or other non-collision incidents.

234 Special or imposed excesses may apply depending on the type of vehicle insured (e.g. high-performance vehicles), use of the vehicle, or if a driver's driving record or past claims history suggests there may be additional risk.

235 As noted earlier in this report, one of the more common reasons for a claim being withdrawn is that the claim amount is close to the excess.[30] This suggests that at least some of those policyholders had not appreciated the relevance, amount or existence of the excess when proceeding to lodge their claim.

236 Our review identified the issues set out below. These reflect approaches by different insurers rather than general industry practice, but may be relevant to any lack of understanding in relation to excesses.

Table 2: Disclosure issues around insurance policy excesses

PDS not including all relevant excesses	There was one example where certain excesses were set out in policy schedules but not disclosed in the PDS. We consider that the PDS should include a complete list of all relevant excesses.
Unhelpful descriptions of excesses and when they will apply	In some cases the existence of excesses was disclosed, but the description of the excess and the circumstances in which it would apply were unclear or lacking sufficient detail to allow a consumer to properly understand when the excess might apply. We consider that explanations of excesses should be clear and understandable.

NCD schemes

237 The majority of insurers operate an NCD scheme, although the details of those schemes vary.[31]

238 Typically, these schemes involve discounts on premiums based on the absence of at-fault or unrecoverable claims within previous insurance periods, with the policyholder obtaining further discounts for each

[30] Issues relating to excesses were also the third most common basis for complaints: see paragraph 181.
[31] Three of the newer entrants to the market did not operate a NCD scheme at the time of our review.

consecutive claim-free period up to a maximum level (referred to by some insurers as Rating 1). There are generally five to six levels, with the discount for a Rating 1 driver ranging between 45% and 70%.[32]

239 An at-fault claim generally results in the policyholder dropping back one level, or in some cases two.

240 Where Rating 1 is maintained for a certain period, typically for 1–2 years, many insurers reward policyholders with a 'Rating 1 for life' classification or similar, meaning that the rating will not be affected by any future claims. Policyholders may also receive other benefits as part of having attained lifetime maximum discount status, such as window/windscreen breakage benefits and discount car hire.

241 In most cases, ratings protection can be purchased by a policyholder where they have reached the maximum NCD rating but have not yet qualified for a lifetime maximum rating (or if a lifetime maximum rating is not available with the particular policy). This comes at an additional cost, but allows a policyholder to make at least one at-fault claim during the relevant policy period without a negative impact on their rating.

242 Rating 1 and Rating 1 for life arrangements are often a feature of marketing for MVI policies and are likely to be important customer-retention tools for insurers, potentially having a significant impact on policyholders' decision making when obtaining and renewing cover.

243 We consider that it is important that policyholders properly understand the operation of an NCD scheme, including the cost of additional protection and the impact of a claim not only on their rating but on future pricing decisions.

244 Our review identified the issues set out below.

Table 3: Disclosure issues in relation to NCD schemes

Disclosure of the cost of ratings protection	Our review suggests that where ratings protection is purchased, the additional cost is not separately disclosed in policy schedules or the PDS. While it may not always be possible to describe or disclose the cost of this option, where it is possible to do so we think policyholders should be made aware of the cost of both fixed and additional components of their premium.

[32] Some insurers operate rating scales that extend ratings below the 0% base level, for example where a policyholder on a base level rating makes an at-fault claim.

Disclosure about how NCD schemes work	Some insurers provide very detailed information about the operation of their NCD schemes, whether in their PDS or in separate brochures, including the number of levels, amount of discounts, impact of claims and criteria for ability to purchase NCD protection. Others provide very little information. We think consumers should be able to understand the operation of NCD schemes.
Disclosure about the impact of a claim on premium	Even where a policyholder's claim does not affect their NCD rating (e.g. where a policyholder's rating is protected by either Rating 1 for life or purchased rating protection), it is evident that in some cases future premiums may still increase as a result of a claim.[33] Some insurers disclose this possibility, although the quality and clarity of that disclosure varied, but others do not appear to disclose this possibility at all. Where relevant, we consider that it is important to clearly and prominently disclose that protections and discounts offered under an NCD scheme may not entirely protect against premiums increasing as a result of a claim. We consider that this practice raises issues that go beyond disclosure. We expect consumer understanding of the fact that a claim may result in higher premiums, even where their rating is protected, would be poor and in some cases the practice may be inconsistent with information about and promotion of NCD schemes. We intend to undertake further work on this issue.

[33] While the NCD itself is unaffected, the discount is only applied after the premium has been increased as a result of the claim.

Appendix: Table of recommendations

Table 4: Recommendations for general insurance claims handling and IDR procedures

Recommendations 1(a) and 1(b)	Insurers should record information relating to denied and withdrawn claims, and should regularly analyse and review that information
Recommendation 2	Where a withdrawn claim will result in, or is likely to result in, an increase to future premiums, that should be disclosed
Recommendation 3	Insurers should consider providing written confirmation of a decision to withdraw a claim, and provide information to assist policyholders who may have further queries or decide to pursue the claim
Recommendation 4	Decisions by frontline staff that result in a claim being denied should be reviewed before the decision is confirmed
Recommendation 5	Insurers should review current practices for assessments by frontline staff about the possible denial of a claim, and the communication of those assessments to policyholders
Recommendation 6	Insurers should review conditions on UME claims, and review disclosure material to ensure information about UME claims is accurate
Recommendation 7	Insurers should review their systems and processes for recording and analysing Tier 1 complaints to align them with systems used at Tier 2, so that they are able to extract useful information to address the underlying causes of complaints
Recommendation 8	Decisions at Tier 1 should be confirmed in writing, and the content of those letters aligned with the final response provided at Tier 2
Recommendation 9	Insurers should review and, where appropriate, improve disclosure and/or make available additional information on excesses and the operation of NCD schemes

Key terms

Term	Meaning in this document
AFS licensee	A person who holds an Australian financial services licence under s913B of the Corporations Act Note: This is a definition contained in s761A of the Corporations Act.
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
ASIC Act	*Australian Securities and Investments Commission Act 2001*
AS ISO 10002-2006	Australian Standard AS ISO 10002-2006 *Customer satisfaction—Guidelines for complaints handling in organizations*
Ch 7 (for example)	A chapter of the Corporations Act (in this example numbered 7)
claims handling procedures	The procedures of an insurer for assessing and deciding on claims made by policyholders
complainant	A person who has made a complaint to or against an insurer and whose complaint is at any stage of IDR or EDR
complaint	An expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected Note: This is a definition contained in AS ISO 10002-2006.
Corporations Act	*Corporations Act 2001*, including regulations made for the purposes of that Act
Corporations Regulations	Corporations Regulations 2001
dispute	A complaint that is unresolved to the satisfaction of the policyholder and insurer becomes a dispute. Under the GI Code, the matter is then reviewed by a different employee who has the appropriate expertise, knowledge and authority
EDR	External dispute resolution
excess	The amount of money a policyholder has to pay in the event of a claim
FOS	Financial Ombudsman Service—an ASIC-approved EDR scheme

Term	Meaning in this document
general insurance product	Has the meaning given in s761A
GI Code	The General Insurance Code of Practice, developed by the Insurance Council of Australia
IDR	Internal dispute resolution
IDR procedures, IDR processes or IDR	Internal dispute resolution procedures/processes that meet the requirements and approved standards of ASIC under RG 165
Insurance Contracts Act	*Insurance Contracts Act 1984*
Insurance Act	*Insurance Act 1973*
MVI	Motor vehicle insurance
multi-tiered IDR procedures	IDR procedures that include internal appeals or escalation mechanisms
National Credit Act	*National Consumer Credit Protection Act 2009*
NCD scheme	No-claims discount scheme
overturn	Where a complaint or dispute is decided in the policyholder's favour
PDS	Product Disclosure Statement
policyholder	A person who holds an insurance policy with an insurer
policy schedule	A document that contains the details of a policy (e.g. the term, the premium and what is covered)
premium	The amount of money charged by an insurer for coverage
Product Disclosure Statement	A document that must be given to a retail client in relation to the offer or issue of a financial product in accordance with Div 2 of Pt 7.9 of the Corporations Act Note: See s761A for the exact definition.
RG 165 (for example)	An ASIC regulatory guide (in this example numbered 165)
s1330 (for example)	A section of the Corporations Act (in this example numbered 1330), unless otherwise specified
Terms of Reference	The document that sets out an EDR scheme's jurisdiction and procedures, and to which scheme members agree to be bound. In some circumstances it might also be referred to as the scheme's 'Rules'
UME cover	Uninsured motorist exclusion cover

Related information

Headnotes

claims denial, claims handling, complaints, disclosure, disputes, excess, external dispute resolution (EDR), final response, general insurance, internal dispute resolution (IDR), motor vehicle insurance (MVI), multi-tiered IDR procedures, no-claims discount (NCD) schemes, uninsured motorist exclusion (UME) cover, withdrawn claims

Regulatory guides

RG 165 *Licensing: Internal and external dispute resolution*

Legislation

ASIC Act

Corporations Act, Ch 7, s766A(2)(b), 912A(1)(g), 912A(2), 1330; Corporations Regulations, 7.1.33(1)–(2), 7.6.02(1)

Insurance Act

Insurance Contracts Act, s13, 21A

National Credit Act

Reports

FOS, *Financial Ombudsman Service 2009–2010 annual review*

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Other documents

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