

## **Understanding Reputation Risk Personal Lines Disputes – Problem Areas & Recommendations to Close the Gap**

To date, I have signed off approximately 10,000 determinations in my time with IOS. Probably 80% of these determinations have involved disputes of less than \$20,000. It is my opinion it is the smaller claims that can damage the reputation of the insurance industry as they are often ignored as a potential problem to the industry because the smaller claims can often be regarded as a nuisance rather than as a source of wisdom in terms of the reputation of the industry and improving customer service.

To state the obvious, 90% of claims arise due to poor communication. There will always of course be customers who will try and dud the insurance company but I am not talking about these cases. In the majority of disputes, the policyholder genuinely believes the damage is covered under the policy, namely the damage to the roof as a result of a storm should be paid. Most policyholders are unaware that in many policies, before storm damage is paid, they have to establish a “storm-created opening” occurred, or there was a restrictive definition of “storm”, so when their claim is rejected, they are angry. In other words, there is a perception within the general community that, when your property is damaged by a storm, it is covered by insurance. Similarly, if a person had a heart attack when they are travelling overseas, as a result of which, large medical expenses and cancellation costs are incurred, they expect to be paid. It comes as a shock to the great majority of policyholders, to find their claim has been rejected because 15 years previously, they had treatment for coronary artery disease, which they believed, dealt with the problem.

Similarly, the failure to disclose one or two minor speeding offences, would not generally be regarded by the great majority of the population (even most of you here today), as a sufficient ground to permit an insurance company to deny a claim and cancel the policy. However, it happens in cases where strict underwriting guidelines apply, particularly at the time of policy renewal, where the additional offences disclosable at renewal, tip the person over the edge to being an unacceptable risk when combined with offences disclosed at policy inception.

Surveys conducted by IOS reveal the majority of persons who come to IOS belong to the chattering classes i.e. the assertive middle class – teachers, engineers, salespeople, people who work in the IT industry, architects, small business people, lawyers, doctors, insurance personnel, farmers, employees of the service industries. The great majority are surprisingly articulate and passionate about their insurance claims, and certainly have the potential to wreck havoc on the reputation of the industry. Many applicants make it perfectly clear in their submissions that if they lose their dispute with IOS, they will be going straight to Ray Martin, Eddie McGuire, Kerry O’Brien, or all three, to expose the unmitigated wickedness perpetrated on them by the insurance company.

My colleagues and I have the opportunity to do something about this situation, and to mediate the tension between consumer and insurer. How do we do this? In the first place, we overturn the decision of the insurer in between 40% - 45% of disputes, which usually dissipates the customers’ rage somewhat, although a small percentage would never be happy unless we

were also to determine the claims officer be publicly flogged outside the Hilton Hotel, something which, at this stage, is outside our Terms of Reference.

The other significant factor I should mention is that all our determinations are anonymous and we go to a great of trouble to ensure the third parties reading our determinations cannot identify the events or the parties. Thus in instances where we find the insurance company has behaved in a manner which is less than the standard of utmost good faith, no-one knows about it apart from the parties. The UK Ombudsman, Walter Merricks, when fully appraised of the manner in which the Australian system works, said that all claims officers and senior executives of all Australian insurance companies, should kneel by their comfortable beds each night and give thanks for the existence of IOS. I wonder how many do so.

The second thing we do is to play a significant role in educating consumers, the industry and the other stakeholders in how to manage the communication process.

The point I am making is that every one of the 2,000 complainants who come to IOS each year has the potential to inflict damage on the reputation of the industry if their \$5,000 claim for their damaged roof, stolen motor vehicle or stolen luggage is not paid, particularly in circumstances where they can persuade left-wing journalists, they have received a raw deal. The raw deal might not simply relate to the decision to deny the claim but might also have something to do with the 23 telephone calls unanswered, having to deal with eight different claims officers, receiving seven differing and irreconcilable decision as to why the claim has been denied, waiting four months for a final decision, or being as alleged routinely, abused and treated with contempt by the assessor, the investigator, the telephone operator and the claims manager. Of course, I make no comment whatsoever as to whether any of the thousands of allegations of this type I have had to assess in my ten years in this role are true, (I will answer that privately) but let me assure you they are made on a daily basis by people who are passionate, articulate and intelligent, and, if they were my policyholder, I would want to mollify to some degree.

However, I am delighted to say the industry is confident the new General Insurance Code of Practice will abolish all these problems. The full implementation of the Code commenced on 18 July last and will require insurance companies to do some amazing things, including none of the above and to make a decision about a claim within ten days, unless a longer period is agreed with the policyholder. I dare say it may be difficult to negotiate extended periods with a policyholder when they want the claims officer publicly flogged outside the Hilton. The Code of Practice requires insurance companies to do many other fantastic things including (and I quote from clause 1.17)

- “(a) to promote better more informed relationships between insurers and their customers;
- (b) to improve consumer confidence in the general insurance industry;
- (c) to provide better mechanisms for the resolution of complaints and disputes;
- (d) to commit insurers and the professions on which they rely to higher standards of customer service.”

I thought in the time remaining I would provide you with an analysis of three disputes, all of which initially involve comparatively small sums of money but which ultimately cost the individual insurance company involved, significantly in terms of reputation and money, both of which are very dear to most CEOs.

In Determination No. 20675 (which was discussed in the 2005 *Annual Review*) the fundamental issue for consideration was whether the insurer had complied with its obligations

to act with utmost good faith towards its policyholder when, in the context of a consumer credit policy, it denied a claim for disability benefits on the grounds the disablement arose from a pre-existing condition.

The applicant took out the policy to protect him with respect to payments he was obliged to make for a motor vehicle loan. He made the claim for benefits based on a condition which he described as reactive anxiety, stress and depression by way of a claim form which reached the member on or about 30 January 2001. Two days later, the member denied the claim on the basis it arose from a pre-existing condition, shortly after the applicant was admitted to a psychiatric institution, the motor vehicle was repossessed, and the applicant subsequent sustained what he said was substantial losses totalling approximately \$20,000.

The Panel found the claim form indicated the applicant was claiming for a new illness, notwithstanding some years previously he suffered from a similar condition. The claim form was accompanied by a medical certificate from the applicant's doctor who was asked if there were "any connection of prior illness with this particular illness", to which the doctor replied "– Not really – coped well. Was discharged from navy", which was when the earlier illness arose. In these circumstances, the Panel concluded that this statement from the doctor should have removed any doubts the member's claims officer had as to the length of time between the two events and, as was stated in the determination should have "persuaded a reasonably objective and diligent claims officer that the illness giving rise to the claim was a new illness" or, at the very least, "the claims officer should have sought additional information from the doctor, or obtained his own medical counsel."

The Panel went on to find the member had unreasonably denied the claim and failed in its obligations to act with utmost good faith towards the applicant because it did not apply the principles of scrupulous fairness to the process of dealing with the claim and by doing so, "ought to have known of the distinct likelihood the vehicle may be repossessed".

There was a lot more to this case as the policy was cancelled in mysterious circumstances, possibly in fact by the finance company, and the complexities resulted in the applicant requiring the assistance of a solicitor. This was a very rare case in which, in all the circumstances, the Panel ordered the member to also pay the applicant's legal costs, which it has the power to do in clause 10.2(b)(vii) of the Terms of Reference. However, this is a power that is exercised in most exceptional circumstances, of which this case was one.

In Determination No. 23662, the insurance company denied a claim brought by an 83-year-old man due to cancellation of international travel following diagnosis of a heart condition on the basis the condition was pre-existing. The Panel was particularly interested in the fact the policy issued in this case was designed specifically for mature-aged persons i.e. persons aged between 70 and 84. One of the issues for determination was whether treatment the applicant had received in 1989 when an angioplasty was performed, constituted a pre-existing condition. The particular feature of this case that brings it into this paper is the fact the policy was designed for older persons, and yet the member was taking a strict view in terms of its pre-existing exclusion entitlements.

The Panel stated, in the course of its determination,

"It would be well known to member's underwriters, as is to the majority of the members of the public, the great majority of persons aged between 70 and 84 years, and certainly 83 years and 8 months, would be in less than perfect health. When an insurer chooses to provide travel insurance to the mature-aged traveller, it must inevitably follow the member's underwriters are dealing with

a section of the population that are less likely to be in excellent health than persons 40 or 50 years younger. This view is reinforced by the definition of 'existing medical conditions' contained in the policy which makes specific reference to the fact 'hypertension alone, controlled by medication is not considered an existing health disorder'."

The Panel also referred to judicial authority dealing with the commercial purpose of the policy, the fact the applicant's doctor classified the applicant as being "very well" when he took out the policy. In the circumstances, the Panel concluded the member has not established the terms of the policy exclusion on which it relied.

I believe the interesting feature of this case is that, once again, an 83-year-old man who was assessed as being in good health at the time he took out the policy, would expect to be covered if he became ill during the course of his journey unless there was a clear and obvious link between any pre-existing condition from which he suffered and the condition giving rise to the claim. It seemed to me in this case, the member was setting a very high standard in terms of health requirements for policyholders who, of necessity, would be aged between 70 and 84 years. In other words, if you are marketing a policy for this section of the community, the commercial purpose of the policy should be utmost in the claims officer's mind when considering whether to accept or deny a claim, if a suspicion of pre-existing illness exists.

In another travel case, the insurance company denied liability because the luggage was unattended when the policyholder left it outside the door of her hotel room. The problem facing the member was that it was impossible for the applicant to do anything else because of the requirements of the travel provider to leave it there. The Panel thus had recourse to section 54(5) of the Act which does not permit an insurance company to rely upon a policy term when it is virtually impossible to comply with it.

The third case I would like to discuss with you in this context is Determination No. 23969. This was one of those policies that was taken out after the applicant received unsolicited information in the mail outlining the policy benefits and shortly prior to taking out the policy, she received a brochure which said:

"The good news is that from as little as 23cents a day you can have complete peace of mind. Knowing that if the unexpected should occur, you will receive a cash payment of up to \$100,000 to help ease the pain of your injury. And this can be doubled to \$200,000, for less than double the premium."

The letter accompanying the brochure made the following statement:

"With the [company] accident protection plan you can relax, knowing that if you are ever unlucky enough to have a specified accident, you can receive a financial payment."

The problem was the policy provided very limited benefits and only provided protection for such serious injuries as a 100% loss of use of the limb, paraplegia, etc. Whilst the policy, (which was not sent to the applicant until approximately a week after inception) did indicate that only specified benefits were provided, the Panel nevertheless found the insurance company was not entitled to rely upon the strict policy terms and it replaced the policy which the member offered the applicant, with the statutory policy i.e. the policy contained in the regulations made pursuant to the Act, which provided much broader benefits and covered the applicant for a partial loss of use of a limb. In making its determination, the Panel stated:

"In failing to specifically identify in the original letter and brochure that the policy only covered specified events, a customer might easily be led to believe that the cover was more comprehensive than it was. In other words, the introductory letter and the brochure had the effect of reasonably

creating in the applicant's mind that she had substantial cover in the event of her suffering a significant accident and whilst she was invited to read the policy which she received at least a week after she had entered into the insurance contract, the policy did not clearly alert her to the fact that cover under the policy was very limited indeed compared with, for example, the cover provided in the statutory policy."

In my opinion, in all these cases, the insurance company embarked on a rigid adversarial process in denying the claim, which was to their ultimate detriment both in terms of the monetary consequences, and the reputation of the wider industry. Reputation is very important both in terms of marketing and profit. There are significant sections of the community that are uninsured, a situation which is of no advantage to the community or the insurance industry and the Government. I mention the Government which might have an expectation the insurance industry will have a significant financial role to play in times of disaster, which, according to Al Gore, will be times that we will experience with greater frequency in the future. I understand the insurance industry is very interested in this topic.

One area which I believe needs to be the subject of significant and possibly urgent attention is the issue of financial literacy. After ten years in my role, I believe many people are ignorant on basic insurance concepts such as the need to make proper disclosure, to read and understand insurance contracts and how the Insurance Contracts Act can impact upon insurance disputation. They are also somewhat ignorant of the requirement to pay premiums on time, to be aware of policy limits on such items as jewellery and the need to notify an insurance company before you undertake renovations, or go on an extended overseas holiday and many other circumstances where there is a significant disparity between the expectations of consumers, as to the coverage provided by a policy, and the reality. I think the IOS, the ICA, ANZIIF and the AILA play a significant role in this regard, and it is the small claims that provide the greatest learning and insight into the problems I have outlined.

I hope you regard my proselytising as helpful.