GENERAL INSURANCE
Code Governance Committee

CGC Thematic Inquiry

Actioning insights from disputes about claim denials to improve Code compliance

Issues Paper

November 2022

Contents

1. CGC inquiry into claims handling 3
   1.1. Context 3
   1.2. Focus and objectives of this inquiry 3
   1.3. Methodology 4
   1.4. Providing your organisation's response 5
   1.5. What will happen next? 5
2. Questions and data 6
   2.1. Questions 6
   2.2. Request for sample data 6
Appendix A: Subscriber-specific data – 8

The Code Governance Committee (CGC or Committee) has distributed this issues paper to provide information about its thematic inquiry into claims decision-making. Part of the CGC's role is to drive better Code compliance, helping the insurance industry improve its service to consumers.

The CGC undertakes inquiries into various themes and areas of risk that are apparent from its monitoring of Subscriber compliance with the Code. This includes allegations of Code breaches received from consumers and/or their advocates, from AFCA, and general intelligence gathered from the CGC's engagement with Code subscribers, consumer advocates and regulators.

The CGC will publish its findings in a report, with insights and learnings for the industry and recommendations for best practice. The CGC hopes to assist Code subscribers to enhance their claims handling practices and maintain better relationships with their customers.

1. CGC inquiry into claims handling

1.1. Context

Claims handling or management is an important function of an insurer. Consumers purchase insurance to protect themselves against the unexpected loss of assets that are of value to them. The loss of an asset can occur through unexpected catastrophic events (e.g. a major flood or bushfire) or from everyday setbacks (e.g. a car accident). Irrespective of how the loss occurs, an insured consumer will look to their insurance policy to help them absorb and recover from the loss.

The way in which claims are handled – from the initial receipt of a claim from a policyholder, through to its ultimate settlement and restoration of the insured's position – plays a major role in the insured's recovery.

The Code Governance Committee (Committee or CGC) carefully considers data relating to Code subscribers' claims handling from a range of sources. It is evident that there are a wide range of issues, concerns and challenges in relation to the claims process.

From 2017 to 2021, there was an almost four-fold increase in breaches of the Code's claims handling standards reported by subscribers.

Section 7 (Claims) of the 2014 Code was the section with the most breaches in each of those years. This shows that high numbers of claims handling breaches have been an issue throughout the industry, even before the onset of COVID-19 and other recent catastrophes and significant weather events.

Claims handling is one of the most critical elements of an insurers business and the highest stakes component from a consumer perspective, so it is not entirely unsurprising that we see our highest breach numbers in this area. It is important that subscribers understand breach issues to continually drive improved practice and deliver better consumer outcomes.

1.2. Focus and objectives of this inquiry

In this inquiry, the Committee is seeking to explore the effectiveness of the insurer's decision making about claims, and how insurers use the insights about their own decision-making to improve their business processes and practices.

The Committee appreciates that subscribers consider and weigh up a range of information and evidence to support their decision on a claim. There are likely to be more 'grey areas' in some decisions and therefore greater scope for differences in views between an insurer and a claimant.

Nevertheless, consumer advocates have told the Committee that their clients have concerns about some claims being denied without sufficient evidence. They also perceive that some insurers over-rely on defect clauses, maintenance issues and wear-and-tear to deny claims.

The Committee has observed the following from its own data:

- the rate at which claims lodged are declined by Code subscribers has been increasing over time; and

- disputes about declined claims is consistently the top reason for disputes received by Code subscribers each year.

In 2020-21, there were 13,465 disputes relating to declined claims finalised by our Code subscribers. Of these, 4,992 (around 37%) of the claim denial disputes were resolved in favour of the consumer. This suggests that there may have been issues in the way these claims were assessed.

There may be a range of reasons why a consumer might raise a dispute after their claim is denied. For example, the claim decision may be valid and correctly determined but the reasons for the denial was not communicated (as required under paragraph 81 of the Code), or not communicated clearly to the claimant. It is also possible that while the claim decision may be valid and communicated clearly, the policyholder does not agree with the decision. This might in turn be because the policyholder was under the impression that the loss was covered under their insurance policy, or that the insurer has not considered relevant facts or information (as required under paragraph 69 of the Code). Alternatively, the policyholder may consider that the insurer has not corrected a mistake in the handling of a claim (as required under paragraph 62 of the Code).

Extracts from the 2020 Code

62. If we identify, or you tell us about a mistake we make in handling your claim, then we will immediately take action to correct the mistake.

69. When we assess your claim, we will consider all relevant facts, the terms of your insurance policy and the law.

81. If we deny your claim, or do not pay it in full, then we will tell you, in writing:

a. the aspects of your claim that we do not accept;

b. the reasons for our decision;

…

The Committee is interested in finding out more about the actions that Code subscribers are taking to improve their compliance with the Code, based on the insights they obtain from disputes relating to declined claims that are subsequently overturned (i.e. decided in favour of the complainant) at internal dispute resolution (IDR).

We will assess all information received from Code subscribers' written responses and follow-up meetings in relation to this inquiry to:

- determine whether Code Subscribers are using the insights from declined claims overturned at IDR to improve compliance with claims handling obligations in the Code and to improve their business processes and practices more broadly; and
- identify examples of good industry practice.

1.3. Methodology

This inquiry will consist of:

1. Questions as set out in Section 2 of this paper; and

2. A request for data relating to a sample of denied claims, the basis for the decision, the basis for overturning the decision at IDR, and the insights gained by the organisation about the claims decisions.

The Code team (the CGC's secretariat) will review the information provided and arrange follow-up meetings with each participating Code subscriber to discuss their responses. It is possible that the Code subscriber will be asked to provide additional explanatory information following the meeting.

We anticipate that a report will be published in Q4 of 2022-23 with insights and learnings for the industry including sharing and recommending good practice. Code subscribers participating in this inquiry will not be identified in the publication.

1.4. Providing your organisation's response

Please respond to each of the information requests in this Issues Paper. Please also provide relevant supporting documents where required.

Please provide your organisation's response to **info@codecompliance.org.au** by close of business on **23 January 2023**.

If you have any questions prior to providing a written response, please contact the Code Team at info@codecompliance.org.au or via the contact details below.

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1.5. What will happen next?

Stage 1	CGC Issues Paper released	14 November 2022
Stage 2	Submissions due	23 January 2023
Stage 3	Initial analysis of data and information from Code Subscribers	January / February 2023
Stage 4	Meetings with Code Subscribers	February/March 2023
Stage 5	Further Analysis	March/April 2023
Stage 6	Report finalisation and publication	By 30 June 2023

2. Questions and data

2.1. Questions

Please provide a written response, including supporting evidence, to each of the questions below.

The questions are designed to provide us with context on your organisation and its processes in relation to clams handling and business process / practice improvement.

1. Please provide an overview of the process for the review of a claim denial, from the time a complaint about the claim decision is received from a consumer to the time that the final IDR decision is made and communicated.
2. Please confirm the data shown in relation to your organisation in Appendix A, and provide data for missing information.
3. Please describe and provide supporting evidence of how your organisation uses data / information from IDR overturns on claims denial decisions (i.e. resolve in favour of the consumer) to inform process / practice improvement, improve product / service delivery, and improve compliance with the Code. Your response should highlight what analysis is undertaken at IDR to identify the underlying causes of a claim being incorrectly denied. Please explain and provide supporting evidence of any reporting of this analysis and actions to Senior Executives within your organisation.
4. Please provide details and evidence of specific actions, business / process improvement programs or product and service delivery improvements that have been initiated over the past 3 years, as a result of the above, and outcomes, or intended outcomes.

2.2. Request for sample data

The CGC requests the following data from your organisation:

5. A sample of 20 complaints about denied claims relating to home insurance that were resolved in favour of the consumer (i.e. the claim denial was overturned) in the period from 1 January 2022 to 30 September 2022.
    - Please note the importance of a random sample and one that provides the CGC with sufficient and useful insights into how your organisation reviews and overturns claims denial decisions at IDR. We have not prescribed an approach to achieve this but would be pleased to discuss your proposals for achieving this.
6. For each complaint, please provide the following:

Information		Supporting documentation
(a)	A summary description of the nature and size of the claim that was denied	Copy of the claim that was lodged by the consumer
(b)	An explanation of why the claim was denied	Copy of the claim denial letter and associated correspondence

Information	Supporting documentation
	Copy of any evidence or information that was relied upon to deny the claim, including information provided by loss assessors, investigators or other external experts that might have been involved in the assessment of the claim.
(c) Summary of the issues that were reviewed at IDR	All complaint management documents including supporting internal notes, analysis, correspondence and information examined during the process of reviewing the decision to deny the claim
(d) Describe the outcome of the IDR review & internal recommendation to resolve the claim denial complaint in favour of the consumer	All complaint management documents including supporting internal notes and analysis
(e) Final decision of the IDR review	Copy of correspondence between your organisation and the complainant explaining the final decision

Appendix A: Subscriber-specific data –

Please confirm the information in the table below or provide missing information.

		2021-22				2020-21			
		Number		Value ($)		Number		Value ($)	
		Retail	Wholesale	Retail	Wholesale	Retail	Wholesale	Retail	Wholesale
A	Claims lodged	X	X			X	X		
B	Claims lodged – home insurance	X	N/A		N/A	X	N/A		N/A
C	Declined claims	X	X			X	X		
D	Declined claims – home insurance	X	N/A		N/A	X	N/A		N/A
E	Complaints resolved	X	X			X	X		
F	Complaints resolved in consumer's favour	X	X			X	X		
G	Number of [E] relating to home insurance	X	N/A		N/A	X	N/A		N/A
H	Number of [F] relating to home insurance	X	N/A		N/A	X	N/A		N/A

		2021-22				2020-21			
		Number		Value ($)		Number		Value ($)	
		Retail	Wholesale	Retail	Wholesale	Retail	Wholesale	Retail	Wholesale
I	Number of [E] relating to home insurance and declined claims	X	N/A		N/A	X	N/A		N/A
J	Number of [F] relating to home insurance and declined claims	X	N/A		N/A	X	N/A		N/A