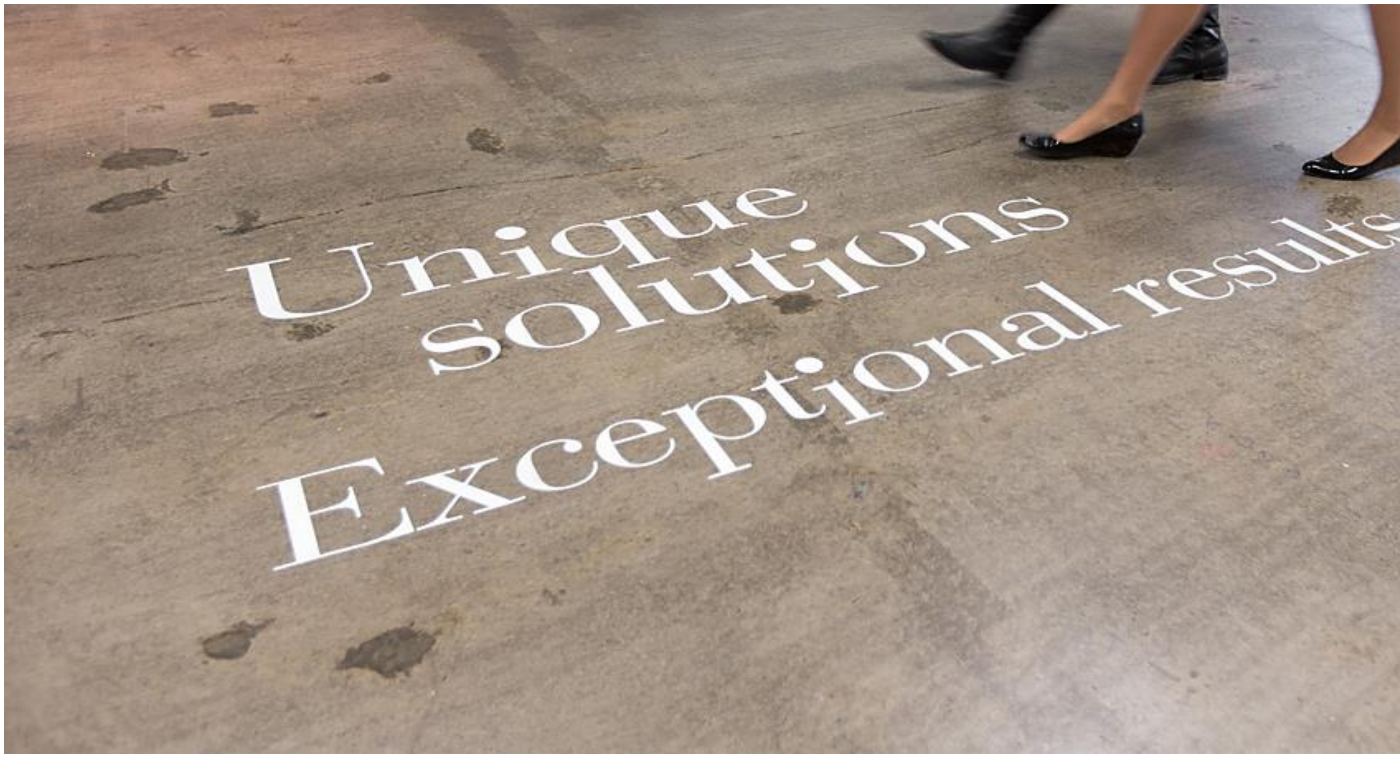
Proclaim



SUBMISSION TO ROYAL COMMISSION

CLAIMS MANAGEMENT

GOING BEYOND

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INTRODUCTION

The objective arising from the Royal Commission to remove the exemption for claims handling from regulation is, we think, a good idea. Many countries around the world have licensing regimes for claims managers. I don't envy the drafters of this legislation, however.

Insurance claims covers a wide range of classes of business, ranging from transactional in nature to highly complex. At the complex end, an Insured may have advisors and lawyers. What the industry needs is simplicity and clarity if claims management is to be formally regulated, but the complication impeding this process will be the range and types of claims in insurance. Life and general are separate industries in of themselves, and as such will require entirely separate processes.

We think the key to making the legislation work will be to keep it relatively simple. Our understanding is that the mischief intended to be regulated exists at the extreme end of the scale, where patent bad faith or dishonesty is involved, such as would be worthy of ASIC intervention. It is our opinion that the more common complaints around delays and differences in opinions on coverage issues should remain self-regulated according to Insurance Codes, albeit with stronger sanctions for failures.

The key considerations in drafting the legislation need to be

a. What is a claim for the purposes of the regulation
b. Once the definition of claim has been determined, which aspects of claims handling and claims handling 'advice' should be subject to regulation?

In considering these two things, the drafters of new regulations need to understand not only the range and types of claims that may be subject to new regulation, but also how the regulation will fit with the changing face of the insurance industry generally.

EXECUTIVE SUMMARY

Some of the key issues we discuss in this paper are:

Most complaints for general insurance claims relate to delays. Given we expect the behaviour for which the regulations intended are more regarding bad faith – misrepresentation, avoiding without evidence, imposition of unlawful requirements etc. – we believe that complaints around delays and everyday coverage issues would be better managed under current Insurance Codes.

While we believe all general and life insurance claims should be the subject of the regulations, we also believe the requirements relating to advice should only extend to policyholders and their representatives (generally insurance brokers). It should not extend to third party claimants against policyholders.

The regulations should comprehend that companies like Proclaim are managing a large volume of claims, and that they have an agency style relationship with insurers who are often offshore. If companies like us have limited authority to make decisions, is it fair we should be held responsible for decisions made outside our authority? If these decisions are being made by insurers who are offshore, will they be required to be licensed? How do you keep a level playing field?

We think the key definitions that need to be considered closely are

a. what is a claim
b. and what constitutes claim handling?

If the aim is to prevent the worst type of conduct – misrepresentations, denying claims without investigation or evidence, imposition of unfair conditions, delay to cause harm - it should be limited to that. If it is widened to more common low level complaints like delays in responses and investigation where there is no bad faith, the regulations will stretch too far and cause too much complication. Better to keep it to dishonest, reckless or negligent advice to a policyholder, and take the Insurance Council and the industry at their word to make the Codes and the policing of these more effective.

BACKGROUND

Proclaim is a claim management company, also known as a Third Party Administrator ("TPA"). We manage claims on behalf of insurers (primarily Lloyd's, but some local insurers as well) and local corporates who have self-insured claims. We pride ourselves on our systems and resources that enable us to be responsive and proactive. We have a highly qualified workforce of around 60 people (including almost 30 legally qualified team members) and we manage a large number of claims across property, liability, motor, accident and professional liability classes.

The reality is that any regulatory and licensing regime needs to take into account that a significant proportion of claims managed in this market are outsourced to companies like us. We believe our focused business model, our superior technical resources, and the results (including very low complaint numbers) demonstrate that outsourcing of claims to claim management specialists is a good business model and positive for policy holders. The improved services from specialisation – claims is our core business - benefit the client and their customers and promotes industry efficiency and so, we think, will be an area of growth in future.

We believe licensing of all claims managers including TPAs is a positive development, however the regulation needs to recognise that the industry is changing - more outsourcing, more transformative automation - and there needs to be care in drafting legislation. We think to work that it should be limited to the big problems that need fixing and not areas already regulated by Code and customer preferences(after all, there is still plenty of competition and consumers can move after a bad service experience).

Some of the issues you need to consider carefully are:

a. Companies like Proclaim and other TPAs work under contract from corporates or insurers with a delegated authority. In our case that may be to manage claims up to a certain monetary value - for corporates this could be as little as $2000 or $5000 - for insurers this is usually higher - from $25,000 to over $100,000. So while our services are geared towards managing the majority of smaller claims, the higher value (and often contentious) claims are beyond our authority. The ability to make decisions and keep to time lines really is hard to control, even with our best efforts. So in drafting legislation, you need to consider not only who is managing the claim but who has authority to make decisions regarding the claim. This will complicate the licensing regime, particularly if the ambit of claims advice being regulated is wide.

If the licensing regime is predicated on a company like us taking responsibility for claims for which we don't have authority, we believe there needs to be a balance in

a. limiting the behaviour to unconscionable style conduct and
b. ensuring that our demonstrated best endeavours are an adequate discharge of our duties.

Creating a situation where insurers who delegate authority but retain some decision making may require a license isn't practical. We think the solution is to limit the type of conduct considered bad faith - dishonest dealings in effect – where we are comfortable having influence (as we wouldn't be party to it and would withdraw if we got a sense of that).

If it is planned to regulate things like delays in response and coverage issues (which we think it too extreme) there may also be a need to create a benchmark dollar value at which it is recognised that an insured would have an advisor and so there should be greater flexibility around time taken to establish coverage and resolve claims. We suggest that amount be $100,000. Flexibility could also be limited to wholesale/commercial type customers, so domestic consumers without advisors get greater protection.

Is there a point at which delays in responsiveness should be regulated? We would think this should be at extremes - where delays are such as to be unconscionable. For example, cases where an insurer refused to investigate or respond or ignored repeated requests over a lengthy period may qualify as a failing in advice to a policyholder.

b. You need to consider whether claims involving third party claimants against policyholders of insurers (who are defending the interests of their policyholder) should also be subject to the licensing regime.

If the objective of the licensing regime is to promote fair dealing with holder of insurance policies, then the third party claimants would seem a step removed from that objective. There is no question that we as TPAs and insurers should deal with those claimants fairly at all times. The question is whether these claimants should be entitled to the same protection under the legislation as policyholders? We would say that it should be different and that self-regulation and Insurance Codes should provide adequate protection for fair dealing for third party claimants. As a TPA we aren't giving advice or the equivalent to a third party so we don't see it is appropriate to include any obligations other than to a policy holder in providing service and advice.

c. In considering b, and whether third party claimants fall within the definition of claims for regulation, you also need to understand how this class of business works in practice. Proclaim and similar companies manage a large number of third party claims for bodily injury or property damage that are within 'self – insured retentions'. Typically these are claims where companies have high excesses or deductibles (from $5,000 to 500,000) and contract with a TPA to manage those claims. In most cases there is a monetary value at which these claims may become an insurance claim, but the question is where do these claims fit? Will they be considered insurance claims for the purposes of the legislation or will a claim require an actual insurance policy response (accepted or denied) to be subject to regulation?

To bring b and c together with an example. A company like Coles or Woolworths has a large number of accidents that occur in their supermarkets. If there are allegations

of negligence against Coles, a claim may be made against them by that injured third party. Most claims like this are managed within Coles' self -insured retentions, and they have a claim department internally set up to manage these claims. The two questions that arise are:

1. Would the conduct of Coles claim managers be intended to be subject to the regulation? Would the regulations extend to claimants who are making a claim against Coles for personal injuries? Noting
a. It is not a direct claim against an insurance policy;
b. It is also likely to be within an excess and so no claim will ever be made under an insurance policy
c. Claimants are often legally represented or have that option (and often at a no win no fee arrangement so have access to this option)

Our view is that this type of claim should not be contemplated by the regulations. These claims can be best managed with something similar to what we see in London which is a regime where Insurers are self -regulating in having a Code to deal fairly with third parties.

DEFINITIONS

The key issues from the claims user perspective is clarity which requires simplicity…..the focus, in our view, needs to be in simple definitions of the key concepts requiring regulation.

The key definitions will be 'claims' and 'claims handling' - so what is a claim and what falls to be regulated, and then what aspects of claims handling and advice should be included.

So what 'claims' will be included in the definition? There are a large range of insurance classes, are they all intended to be captured? Are there possible distinctions or exceptions that make sense, or is it easier just to include all?

For example, you could distinguish between:

a. Life and general insurance
b. Retail or domestic claims where the policy holder is an individual, and higher protection may be justified, and Commercial classes of insurance that are largely intermediated

Or within commercial you could argue that the more complex classes like professional liability need to be carved out with different standards. Or that claims above $100,000 should have differing standards to recognise the reality of their greater complexity and weight.

Which leads to questions:

If a company has an insurance broker or retains a lawyer does that make any difference? Should regulation be less where interests are balanced by retaining a paid professional to advice and work on your behalf?

If the objective of the regulation is to ensure insurers handle claims efficiently, honestly and fairly…..there does not appear to be a basis for a distinction between types of claims. It has been argued that this requirement is already covered off by the duty of utmost good faith in the Insurance Contracts Act, which may be so, but it has not proved an effective method of managing claims conduct in the past.

A key consideration is 'what is a claim' for the purposes of this regulation. Is it all claims made pursuant to or under an insurance policy? What if a claim is, in opinion of a Claim Manager, not covered….can conduct be regulated in denying a claim that may or may not be

covered? This would seem an important area to clarify. Can a claim manager say it isn't subject to the regulations if their view is that it isn't covered? I assume this would not be an intended result of the regulation.

And what about self-insured claims and claims within an excess or deductible…should they be considered any differently if they aren't being administered by or subject to insurance coverage? Is this complicated by an insurer conducting the defence of a claim and settling within the excess? If the policyholder is aggrieved about that settlement, is that type of conduct intended to be 'advice' in settling a claim? We have lots of experience in settling claims for low amounts within an excess where we know it is a good result but brokers or policyholders are unhappy, often as they don't truly understand the risk. Again, we don't think this is really the high risk area the regulations should be contemplating.

So if we assume that all claims, general, life and workers compensation, fall within the regulation, the key definition will be what aspects of dealing with the claim will be considered '**claims handling'.** From the Commission report it seems the following aspects of the claims process are contemplated…

1. investigating claims and policy interpretation;
2. conducting settlement negotiations;
3. preparing estimates of loss or damage, or likely repair costs; and
4. Making recommendations about mitigation of loss.

In our view the high value claims management processes are in investigation, coverage and settlement / resolution and particularly in those areas where you deal with a policyholder. Most of the issues that arise in these areas are due to perceived delays - sometimes due to unrealistic expectations on part of an Insured. It is not uncommon for claimants/ policy holders or their representatives to fail to respond to repeated requests for information to enable assessment of a claim, but then expect instant turnaround once they furnish information.

If you are planning to regulate these areas you will need to consider what is the conduct you are trying to prevent? Is it dishonesty and reckless behaviour you are targeting? Is it really going to be good for the industry and regulators and the industry if delays and time frames and difference in opinions on coverage are part of this? It will increase complications and volumes of complaints where there is a large element of subjectivity. Then you would have added complications - is investigating a small claim different to the investigation of a larger monetary claim? Is there an actual dollar amount at which a claim requires more liberal time frames? Claims can increase in complexity at several inflection points. 50k, 100k, and above. If you had to choose one number 100k would seem sensible. If you are going to cast a wide definition of claims handling, any obligations around provision of advice on claims above 100k should be more liberal. If you narrow the definition of claims handling advice to unconscionable conduct this becomes a simpler drafting and enforcement exercise.

And once you have sorted what is claims handling and what conduct and advice you are regulating, to whom is the duty owed? We assume it will be policyholder and/ or their representative? We think third party claimants under liability policies should not be contemplated.

CONCLUSION

If the definition of 'claims' is as wide as we anticipate - to include all life and general insurance claims – we think the definition of 'advice' in 'claims handling' should be more limited.

It should be limited to the type of conduct that does merit regulator intervention - cases involving dishonesty, bad faith, collusion or unfair use of market power, particularly in retail cases where the balance is skewed.

We think most of the day to day complaints around delays and service providers should remain the domain of the various Insurance Codes of Conduct - after all, consumers do have a choice, so there remains a service imperative. If complaints are effectively about service, though, that should be within the ability of the industry to sort.