The insurer’s claims management dilemma

When asked what their expectations are if a client makes a claim, advisers invariably expect that the claim will be met. When asked what their expectations are if the claim is not covered by the policy, or is not genuine, advisers find themselves in the same position as claims practitioners whose role it is to examine these possibilities.

In this article, the need to carefully balance the sometimes-opposing demands of service provision, concurrent with the application of appropriate prudential scrutiny, are illustrated so that advisers are better equipped to deal with client’s expectations.

HOW THE DILEMMA MANIFESTS ITSELF – INSURER’S COMPETING OBLIGATIONS

Broadly speaking, there is a twofold obligation on insurers when assessing a claim. Firstly, there is the service provision obligation.

Perceptions of service provision to customers who are relying on policy benefits that will replace their income in the event of disability, or which will financially support a family upon the death of a loved one, generally revolve around how soon the insurer will pay the claim so that there is financial certainty within the shortest possible time frame.

Concurrent with the need to provide this service to clients, however, insurers also have a prudential obligation to ensure that only the right claims are met. This raises the question: “What are the right claims?”

All policyholders are entitled to the equitable consideration of their claim in the event they might need to call upon the pool of funds that is generated through premiums contributed by fellow policyholders. Equity between policyholders is established when the same rules are consistently applied to all claims which are made on the insurer. The rules which govern whether, or not, a particular claim will be met are the insurance policy provisions.

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Consequently, the right claims to be met are those claims for which coverage exists under the insurance policy and where coverage is not provided for under a policy, the right decision is to decline the claim and, in doing so preserve the collective interest of all policyholders.

Effectively insurers therefore act as gatekeepers by deciding which claims should, or should not, be met and to whom funds should be released. In the exercise of this decision-making the activities of insurers come under review by industry regulators, auditors and re-insurers.

Speedy decision making in order to pay claims reflects a customer service focus whilst ensuring that only the right claims are met reflects more of a regulatory focus. In operational terms, there can be a natural tension between the two that can lead to a dilemma for insurers as hastily made decisions may not necessarily be the right decisions and decisions which are necessarily delayed may not adequately service customers.

Insurers whose primary focus is arbitrary high-level scrutiny of all claims are unlikely to meet their client’s service expectations and will ultimately lose clientele to competitors who are able to meet those expectations.

Conversely, insurers who focus on arbitrarily short time frames in their customer service standards, which can thereby compromise the appropriate scrutiny of claims, will inevitably meet claims that should not be met. In addition to attracting the regulatory spotlight for failing to meet their prudential obligations to all policyholders, this also leads to higher overall claims costs, less sustainable premiums and ultimately the loss of clientele to competitors.

In order to overcome this dilemma, insurers need to simultaneously balance claims service provision with the appropriate scrutiny of claims so that equal attention is given to both factors with neither dominating over the other.

**POLICY VALIDATION**

When an insurer assesses an application for insurance, it determines whether it is prepared to take the risk of providing cover, the cost of providing the cover, the terms of the cover and the period of coverage, based on what has been disclosed by the applicant.

The vast majority of insurance applicants accurately disclose relevant history that allows an insurer to make an informed decision. Inevitably, though, there are applicants who do not disclose to insurers the true risk they represent and obtain insurance policies which the insurer would not have been prepared to issue, had the true risk been known.

In life insurance applications some applicants misrepresent or hide a medical history, which leads to a greater risk of a claim being made in the future, or that would attract a higher premium. In some cases they obtain a policy fraudulently with the intention of claiming for a medical condition that is presently symptomatic and disabling.

The cost of meeting claims on illegitimate policies can be very substantial when, for example, an income protection policy provides benefits to age 65, or when a trauma policy provides benefits in terms of millions of dollars.

Meeting the right claim, therefore, is not simply about ensuring that the claim is one for which coverage is provided under the policy, but one for which a policy was validly issued. Consequently, policy validation forms part of an insurer’s prudential obligation.

As a result all insurers have a process whereby they validate the disclosure of information that has been provided in the application for the policy. The level at which this validation occurs is usually commensurate with certain risk factors which are apparent at the time of the application, or which may manifest themselves at the time of a claim.

**NON DISCLOSURE OR MIS-REPRESENTATION IN APPLICATIONS FOR INSURANCE**

In certain circumstances where non-disclosure or mis-representation has occurred in the application for a policy, that was relevant to the insurer’s decision whether or not to offer the insurance, an insurer will be entitled to avoid a policy. Avoidance means that the policy will be treated as never having existed and consequently a claim under the policy will not be met.

It needs to be remembered that the very purpose of insurance is to provide certainty in uncertain times, such as when a death occurs or when sickness or injury results in the inability to earn income. Applicants who fail to disclose or misrepresent the true risk to insurers cannot take comfort in having an insurance policy, if it will not respond to a claim, in circumstances where the insurer would not have issued cover in the first instance.

There needs to be a greater awareness by policy applicants that the certainty they seek for themselves and their families, in the event they need to claim upon a policy, may be illusory if they have failed to properly disclose their true circumstances at the time of policy application.

**CLAIMS DECISION MAKING – OFTEN DEPENDENT ON ACCURATE AND RELIABLE INFORMATION PROVIDED BY THIRD PARTIES**

Prudent insurers decide which are the right claims to meet based upon information that is proven, not just assumed, to be accurate. That is because, where there is a financial benefit to be gained from the insurance, some clients provide information which may not be candid in order to access those benefits.

Making the right claims decision can be delayed if there is an impediment to accessing reliable and accurate information upon which claims validation depends and these delays are usually at odds with customer’s expectations.
Commonly, in claims made on life insurance policies, insurers will need validating information from one, or several, of the following entities before being able to make a decision in respect of a claim:

<table>
<thead>
<tr>
<th>Information Provider</th>
<th>Information Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>medical certification, medical reports and medical histories</td>
</tr>
<tr>
<td>Accountants</td>
<td>financial records and taxation returns</td>
</tr>
<tr>
<td>Centrelink</td>
<td>centrelink payment records, sick leave certification records</td>
</tr>
<tr>
<td>Employers</td>
<td>employments records, sick leave records, statements of duties</td>
</tr>
<tr>
<td>Medicare</td>
<td>medical records</td>
</tr>
<tr>
<td>Coroners</td>
<td>reports of death to the Coroner by police, post mortem examination reports, post mortem pathology reports, death certificates</td>
</tr>
<tr>
<td>Solicitors</td>
<td>wills, letters of probate</td>
</tr>
<tr>
<td>Pathologists</td>
<td>pathology test results</td>
</tr>
<tr>
<td>Hospitals</td>
<td>Medical records and medical reports</td>
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In order to obtain this information, insurers send written authorities from their clients, or from their estates, to these entities in order to allow the insurer access to the information necessary to determine a claim. Along with the written authority, insurers also undertake to meet the costs of the entity in providing the insurer with the information it needs.

Apart from providing the written authority and a promise to meet the costs, insurers have no direct influence over how quickly the information necessary to their decision-making will be provided to them. As a result, if a medical report is essential to the assessment of a claim and a medical practice or hospital does not respond quickly to the request from the insurer, then the insurer is placed in the situation of potentially failing to meet the service expectations of its customers. Alternately, if it waives the need for the provision and analysis of the report, the insurer may be failing in its prudential duty to ensure that only the right claims are met.

There are many factors that have the potential to delay the provision of information, which is needed by insurers to assess a claim, and which can consequently add to delay in making the right claims decision. A good example is the format in which many information authorities are written and how they are, consequently, accepted or rejected.

Insurers cannot possibly conceive of every single set of circumstances that might lead to a claim being made and therefore the written claims authority is broadly worded. The intention is so that when a claim is made, and the insurer needs further information, the authority is accepted and the information is supplied to the insurer by the third party. This is to avoid the need for the insurer having to constantly go back to the client for another or more specific authority, which would inevitably lead to further delay in the assessment of the claim.

No matter how the written authority is worded, some third parties will reject the authority if it is not an original, if they consider it to be non-specific to their organisation, or if they consider it to be out of date, or too broad.

Frustratingly for both insurers and their clients, there often seems to be little consistency in the type of authority that will be accepted by some third parties despite the fact that they usually fall under the same information governance umbrella. In practice, one hospital, area health service or doctor will respond to an information request by an insurer when a neighbouring one will not despite the format of the information authority being the same. This adds to delay when the insurer then needs to go back to a client to obtain an authority which the hospital, doctor or medical practice claims is more specific to its requirements.

### COMPELLING FACTORS – THE NATURE OF THE INFORMATION BEING Sought

The nature of the information needed in order to determine a claim will largely be driven by the nature of the insurance product and the circumstances under which the claim is made. If the claim circumstances are complex or unusual, then the nature of the information the insurer needs in order to make the right claims decision can be complex, and the time frame it may take for the insurer to be provided that information, can be protracted.

For example, if a death claim is made in respect of a person who has gone missing whilst travelling overseas (presumed deceased), in a country where the medico-legal system is ineffective or non-existent, where post-mortem identities are poorly validated and where the body of the deceased is not found, an insurer is likely to initiate further time-consuming inquiries, before it is prepared to meet such a claim.

Similarly, the cause of death in a more sophisticated medico-legal jurisdiction might lead to further inquiries being made of coroners that, in turn, may validly lead to delay. An example of this is where death is certified as being caused by “multiple chemical toxicity”.

A death from this cause may be the result of accidental domestic or industrial poisoning. The possibility also exists that it arises from misadventure in the use of illicit recreational drugs. If it is established that the deceased was also using these illicit drugs pre-policy, the insurer may not have been prepared to issue insurance cover in the first instance and the insurer may be entitled to avoid the cover in its entirety, despite the fact that a claim has now eventuated.

In some coronial jurisdictions, there are presently delays of many months in obtaining some coronial information, particularly post mortem pathology results and, consequently, if that information is necessary to validating a policy or deciding a claim, delays with the decision will result.
HOW INSURERS DECIDE WHAT LEVEL OF SCRUTINY NEEDS TO BE APPLIED TO CLAIMS

Most insurers implement some type of claims vetting to determine what information they need to analyse in order to make the right claims decision. This is a risk assessment protocol whereby certain characteristics within claims are identified so that scrutiny of each claim is commensurate to the risk inherent in each claim.

In addition to the specific technical requirements of the contract of insurance, such as medical certification to substantiate a fracture in the event of a specified injury benefit, for example, insurers also profile claims for characteristics that indicate the claim may not be genuine or the policy may not have been validly issued.

In simple terms, a claim for two months of benefits under an income protection policy where a broken limb has resulted from a workplace injury would attract a lesser level of scrutiny than a long term claim for an undiagnosed sickness, on a newly issued policy, by a policy holder who is unable to provide any evidence of having been in work for two years before the policy commenced.

Typically, in income protection claims, for example, insurers will look for a combination of the following features to determine the level of scrutiny that is to be applied to each claim:

- The benefit term
- The quantum of the monthly benefit
- The age and occupation of the claimant
- Whether the claim is for an injury or a sickness
- Clinically reliable evidence of injury or sickness
- The duration for which disability is estimated to occur
- How long the claim occurred after the policy commenced
- The type and efficacy of the medical treatment that is being provided
- Unexplained or unreasonable delays with the reporting of the claim to the insurer
- Whether the sickness is one likely to have been in existence before the policy commenced
- How long the claimant has been visiting the medical practitioner who provides the medical certification
- Whether the injury is a new one or whether it is an exacerbation of one that existed before the policy commenced.

None of the above features or combination of those features, on their own, indicates that the claim is non-genuine, however, the case below illustrates the type of scenario that insurers need to be watchful for.

A middle aged insured person has been a heavy manual worker for 35 years and has a new income protection policy. In the application for insurance, the insured did not disclose any adverse medical history of any kind. One month after the policy commences the insured makes a claim for advanced osteoarthritis of their spine. In the medical certification that accompanies the claim form, the treating rheumatologist indicates that the insured has a long history of regular consultations with them for back pain which has resulted in the insured having to be absent from work on frequent occasions, over many years, and which will mean that the insured cannot return to their occupation at all.

Claims such as those in the example above will attract further scrutiny because the medical condition, which apparently pre-dates the insurance cover, was not disclosed in the application and may have led to the coverage being declined, or amended, by the application of a back exclusion.

THE ITERATIVE NATURE OF CLAIMS ASSESSMENT IN ONGOING CLAIMS

The proof that needs to be provided in respect of a claim depends on the product upon which the claim is being made. In income protection claims the standard proofs usually consist of medical certification, financial information and completed claim forms.

The vast majority of claims are met on the provision and analysis of these standard proofs.

The difficulty with assessing claims, and particularly ongoing income protection claims, is that there is a further decision to be made on a regular basis as to whether to continue to release funds to the policyholder. It cannot simply be assumed that because a policyholder has been in receipt of benefits for an extended period of time that they will, in all circumstances, continue to be entitled to the benefit.

Insurers can provide many examples of having met an ongoing claim in good faith, upon the production of persuasive medical certification of total disability provided by a treating doctor only to find subsequently, that the client has returned to work and has fraudulently claimed further benefits by failing to advise the insurer, or the doctor, of their return to work.

In order to facilitate the provision of service to their customers, insurers need to be able to rely on the medical certification that is commonly provided by the client’s treating doctor, however, experience indicates that some clients may not be frank with those doctors. If a client lies to their treating doctor about their symptoms and their complete inability to work, when in fact they are actually working, then the doctor may inadvertently continue to certify disability where it does not exist.

It is that type of activity from which insurers must safeguard themselves and the rest of their policyholders, but which can have the effect of “raising the bar” in terms of the type and standard of proof that insurers will require before meeting claims.
An insurer could deliberately “raise the bar” for all policyholders and require a much higher degree of proof by everyone before a claim is met, in an attempt to identify the few that are illegitimately claiming benefits. This would however delay the settlement of most claims that are legitimate and adversely affect the majority of genuine claimants.

Insurers must therefore apply a level of scrutiny that is appropriate to each individual claim and which is commensurate with the risk inherent in each claim so that they meet their prudential and service obligations concurrently.

SUMMARY

In 2007 Australian life insurers paid their customers $2.098 billion in claims (Source: The Risk Store website 2008), which provided financial certainty for many thousands of policyholders, their families, and businesses in circumstances where a lack of financial support could have led to ruinous consequences for the individuals involved.

Insurers want to meet all valid claims made upon all validly issued policies, however, claims service provision cannot simply be viewed as meeting all claims within arbitrarily short time frames, irrespective of what the circumstances are. Doing so would mean that insurers are failing in their prudential obligations to all policyholders, to ensure that only the right claims are met.

The issue for insurers is that only providing service without counterbalancing it with appropriate scrutiny is as undesirable as arbitrarily applying high level scrutiny to all claims without due consideration being given to service considerations.

Successful claims management will be facilitated when both service and appropriate scrutiny are implemented side by side for the benefit of all policyholders.

HINTS TO ADVISERS

1. Disclosing the true risk to the insurer

   The purpose of life insurance products is the financial certainty provided in the event of a crisis, such as a death or disability. This certainty may not exist if the policy was not validly issued so to ensure this certainty for your clients, in the event of a claim, you can assist by:
   
   - Encouraging clients to fully and accurately disclose their history in application forms
   - Reminding clients that a claim being met is contingent upon the policy having been validly issued which, in turn, is dependent upon the client having accurately disclosed the true risk to the insurer.
   - Informing clients what the consequences may be, at the time of a claim, if the client has failed to accurately disclose their history (including the avoidance of the policy).
   - Inform clients that insurers do check the accuracy of disclosures in applications because they have a prudential obligation to do so
   - Don’t be tempted to filter disclosures made by clients with comments such as: “that was a long time ago” “but its not a problem at the moment” “I don’t think it’s relevant” “you never saw a specialist for it”

2. Be frank with clients regarding exclusions and waiting periods, etc

   If a client has a policy exclusion then be frank with them and advise them what the situation is likely to be in the event they make a claim. Similarly, if the client has a waiting period and has not exhausted the waiting period, then manage their expectations as to what the claim outcome will be.

   Don’t create unrealistic expectations in clients where you know there is no coverage under the policy as it just leads to frustration and dissatisfaction in clients.

3. Prompt notification of claims

   If your client wishes to make a claim then they should be encouraged to do so promptly to avoid any problems (and delays) caused to the insurer in obtaining contemporaneous and accurate information on which to base a decision.

   If, for example, your client fails to notify an income protection claim for 12 months and then claims they were totally disabled for that previous twelve months, the obvious question the insurer is likely to ask is, “How have you supported yourself financially for 12 months if you’ve had no income?”

   If you are unsure as to whether the client will exceed a waiting period, or who may not qualify for a benefit now but potentially at some future time, then call the insurer for advice and assistance on when to lodge the claim.

4. Understanding the insurer’s requirements and ensuring your client knows what they will be

   In order to assist the insurer to make the right claims decisions as soon as possible, make yourself familiar with their requirements in the event of a claim, before a claim arises.

   Ask the insurer to provide you with their standard claim forms and standard claims requirements so you are familiar with what a client will need to provide.

   If, for example, the policy is an indemnity policy, then the insurer will need proof of the level of lost income and will require financial records. Some people consistently fail to lodge taxation returns and then become frustrated when the insurer needs them to settle the claim.

   Explain these issues to avoid delays at the time of making a claim.
5. Assist your client with making the claim

Most clients will not have made a claim previously and if they do have to make one, they are likely to be ill, injured or bereaved.

This is a time when you can add value in the service you provide to your clients by assisting them with the claims process. If the client is unable to deal with the insurer or seeks your assistance then you should be able to assist in explaining the detail of the coverage, the need for information by the insurer and the quickest manner in which it can be provided.

If medical information requested from a doctor has not been forthcoming, then the insurer can often be assisted if the insured communicates directly to their doctor, the urgent need for the provision of information.

6. Assist with the provision and flow of information needed to assess claims

If information is requested by an insurer in order to assess a claim then assist with obtaining it promptly. Usually an explanation of why it is relevant to the claim will suffice but sometimes clients are reluctant to provide relevant information.

Remember the insurer has a prudential obligation to assess accurate and reliable information and a reluctance to provide it, when it is necessary to the claims decision and has been properly explained to the client, may be perceived as disingenuous by the insurer.

Clients who are reluctant to, or decline to, provide information which is relevant and necessary to their insurer’s decision making also place their claim in jeopardy because insurers may decline claims where they cannot properly assess them.

7. Explaining delays

There needs to be transparency between insurers, advisers and clients so that claims requirements are understood and that there is a combined effort to obtain them as quickly as possible.

If there is a delay with an insurer making a claims decision then you need to know why the delay exists and be able to explain it to your client. Often the reason why a delay is occurring has not been sufficiently explained to a client and they have not had the opportunity to remedy it. This is particularly the case where the insurer is waiting on information from a third party over whom it has no real influence but which is often more quickly resolved through the direct intervention of the client.