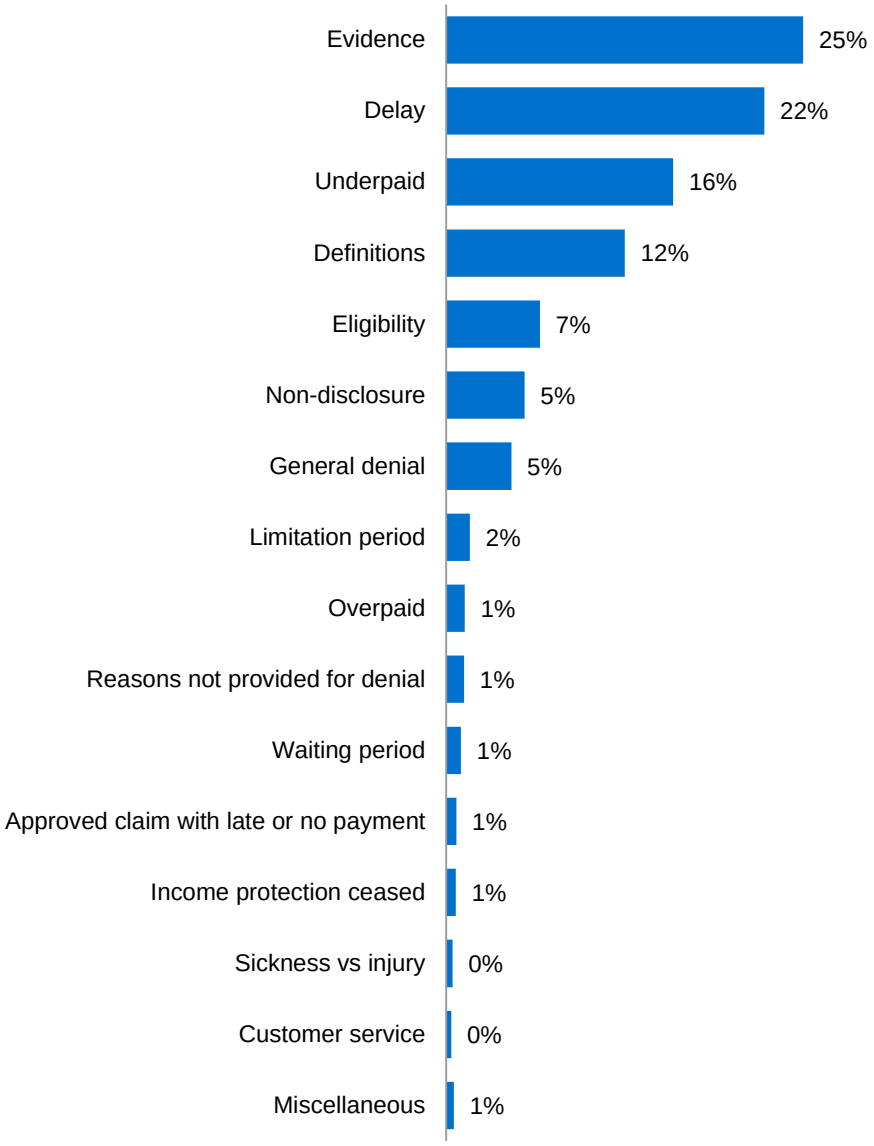
Contents

202 Figure 21 provides a breakdown of the disputes about claims. From the data we analysed, the largest proportion of disputes about claims related to evidence that the policyholder was required to provide to the insurer to assess their claim (25%), followed by delay (22%), and policyholders being underpaid for a claim (16%).

Figure 19: Breakdown of disputes under 'Claim' category (2013–end March 2016)



Note: See Table 27 in Appendix 2 for the complete data in this figure (accessible version).

Source: ASIC and external third parties

203 Approximately 32% of all disputes about claims (including disputes about policy definitions) were specifically about declined claims (in addition, some of the disputes about evidence and delay also related to claims that were ultimately declined).

Stroke

258 We reviewed eight policy definitions for 'stroke' (all trauma cover), and found that they significantly differed in threshold requirements.

259 For example, in half of those reviewed, the definition of 'stroke' required:

(a) the onset to be greater than 24 hours; or

(b) a neurologist to confirm diagnosis; and

(c) clinical evidence—computed tomography (CT) scan, angiogram, magnetic resonance imaging (MRI) or 'other reliable' or 'similar scanning' techniques.

260 For others, the threshold was less prescriptive in that the requirement to meet the definition was neuro-imaging evidence or, in another case, a diagnosis by two neurologists.

261 The disputes we reviewed in this area indicated that a history of common conditions such as headaches may be grounds for insurers declining a claim on the basis that a stroke was caused by a pre-existing condition. The disputes also indicated that insurers may decline claims based on one aspect of clinical evidence, despite the effect of the stroke on the policyholder and other clinical evidence supporting the diagnosis.

Case study 9: Consumer expectation gap—What is a stroke depends on the diagnostic test used

The policyholder had a stroke and was asked to provide evidence of a particular diagnostic test to the insurer. A small percentage of the time, strokes are not able to be detected using this diagnostic test. The policyholder provided other information from their hospital.

The stroke significantly impacted the policyholder's life. However, the claim was declined under the policy's trauma cover on the basis that there was no evidence of the stroke on that particular diagnostic test.

The dispute was resolved by settlement after the policyholder raised it with EDR.

262 In the disputes we reviewed, there were 11 disputes about the policy definition of 'stroke' (3% of all definition-related disputes). This involved seven insurers with one insurer the subject of five of these disputes.

Cancer

263 A review of the 13 definitions for specific cancers and 'cancer' highlights the complexity of the condition and the requirements to meet the definition. In most cases, the definition stated that specific tumours are included. Where some excluded specific cancers, they included them under a specific definition (e.g. 'prostate cancer'). All these definitions were contained in

individual risk policies, as part of trauma cover, with some policies containing multiple definitions for different types of cancer.

264 Generally, insurers required the cancer to be characterised with 'uncontrolled' or 'unlimited growth' and 'spread of malignant cells' and the 'invasion' of tissue. Furthermore, the definitions also included various medical and histological classifications. One insurer also required pathology tests to confirm the cancer.

> Note: This characterisation may present difficulties in terms of applying the definition in a constant manner. The words used are not qualitative and appear ambiguous, which may result in different interpretation and different outcomes.

265 The following case studies give examples of claims declined on the basis of policy definitions for cancer.

Case study 10: Outdated requirement for pathology test

The policyholder was diagnosed with liver cancer by CT scan. However, the claim was declined because the definition of cancer in the policy stated that the cancer must be 'confirmed by pathology results'. The policyholder's doctors contacted the insurer to explain that pathology tests are no longer used by the medical profession to diagnose or confirm liver cancer. The policyholder's doctors determined that a liver biopsy (a pathology test) would be life threatening and unreasonable in the circumstances, given the severity of the policyholder's illness.

The dispute was resolved by settlement after the policyholder raised it with EDR.

Case study 11: Consumer expectation gap—Severity of cancer matters

The policyholder notified the insurer that they were diagnosed with cancer and it was removed. After asking a number of questions, the insurer advised the policyholder that they did not consider their condition would be covered since the cancer was removed and there was 'no destruction of normal tissue'.

Some years later, the policyholder again enquired about this matter. The insurer informed them that the decision or advice initially provided might have been incorrect. The insurer looked into the matter and settled the claim over the phone for the amount insured at the time of the diagnosis. The policyholder raised the matter of interest on that amount considering the initial incorrect decision or advice and was referred to the insurer's IDR process. The matter of interest payable was questioned given the initial record of the phone conversation could not be found and no claim was lodged.

The policyholder raised the matter with EDR and the dispute was resolved with the claim being paid.

Issue category	Percentage of total
Advertising/sales practices	4%
Administration	3%
Application	2%
Adviser misconduct	2%
Buyback	0%

Note: This is the data contained in Figure 18.

Table 27: Breakdown of disputes in 'Claim' category (2013–end March 2016)

'Claims' issue sub-category	Percentage of total
Evidence	25%
Delay	22%
Underpaid	16%
Definitions	12%
Eligibility	7%
Non-disclosure	5%
General denial	5%
Limitation period	2%
Overpaid	1%
Reasons not provided for denial	1%
Waiting period	1%
Approved claim with late or no payment	1%
Income protection ceased	1%
Sickness versus injury	0%
Customer service	0%
Miscellaneous	1%

Note: This is the data contained in Figure 19.

Reports and submissions

REP 245 *Review of general insurance claims handling and internal dispute resolution procedures*

REP 413 *Review of retail life insurance advice*

REP 471 *The sale of life insurance through car dealers: Taking consumers for a ride*

REP 492 *A market that is failing consumers: The sale of add-on insurance through car dealers*

Senate inquiry into the scrutiny of financial advice—Submission by the Australian Securities and Investments Commission

Other references

APRA, CPG 220 *Risk management*

APRA, CPS 220 *Risk management*

APRA, *Life insurance institution-level statistics*

APRA, LPS 320 *Actuarial and related matters* (PDF 241 KB)

APRA, QLIP June 2016 (PDF 720 KB)

APRA, SPS 250 *Insurance in superannuation* (PDF 41 KB)

APRA, SPG 223 *Fraud risk management*

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Insurance Council of Australia, *General Insurance Code of Practice*

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Trowbridge, John, *Review of retail life insurance advice*