

Changes to the ISO Commission

Claire Dale has now been with the ISO Commission as a Consumer Representative since replacing Deborah Rundle in September 2006. Claire is a researcher at Auckland University who has co-authored articles on family businesses and business growth, as well as in her particular field of interest, child poverty.

At the end of March 2007, Raewyn Fox completed her 6 year term on the ISO Commission as a Consumer Representative. Raewyn is the Chief Executive of Family Budgeting Services and, as such, has direct knowledge of how some consumers can be adversely affected financially by disputes with insurers.

From April 2007, Sam Huggard will join the ISO Commission, taking Raewyn's place as the other Consumer Representative. Sam lives in Wellington where he is Communications and Campaigns Organiser for the Council of Trade Unions and he has been actively involved in other voluntary groups in Auckland, Wellington and Dunedin.

The Industry Representatives on the ISO Commission are now Dr Ian McPherson, Group Chief Executive of Southern Cross Healthcare Society and Rieny Marck, Chief Executive Officer of Lumley General Insurance (N.Z.) Ltd. Ian is also Chairman of the ISO Board.

The ISO Commission confirmed Alison Timms's continued appointment as Chairperson for her second term of 2 years, commencing in March 2007.

Changes to the ISO Office

The ISO Office has had a busy start to the year, with a 41% increase in the number of complaints received for investigation. Coinciding with this, we have welcomed 2 new staff members: Bronwyn Thurston, who has joined us from AMP Financial Services and Victor Lee, who is a law graduate. We have also welcomed back Sharee Lowe from parental leave. Sharee and Chris Gibson are both working flexible hours to fit in with family.

Our legal team now consists of Leon Bowker, Sharee, Chris, and Victor. Unfortunately, we have to farewell Leon in June, when he leaves us to travel overseas. Iain Opray and Lionel Hinton are the team leaders of fire and general and health, and life and savings respectively. Keith Ryan and Sid Narraway work part time as Case Managers in their areas of expertise.

Most of your initial dealings will be with Amanda Hannam or Judy Scrivener. If you have any questions, or would like to talk to any one of the ISO Office staff, please contact us in the first instance on 0800 888 202. We are always happy to help with enquiries. Where appropriate, you can be transferred directly from the ISO Office to the Office of the Banking Ombudsman.

Callers' Corner

Between September 2006 and March 2007, we received 1,957 telephone enquiries on the 0800 number which, when compared to the same period last year, was down by 171 telephone calls. We accepted 127 complaints for formal investigation between September 2006 and March 2007, which is up by 37 complaints, compared to the same period last year. Breaking those complaints down into sectors, 69 were in fire and general; 22 in health; 29 in life; and 7 in savings.

In this Issue

Changes to the ISO Commission

Changes to the ISO Office

Callers' Corner

ISO Conference – "Best Practice"

ISO's Reports to Participants

Consumer Information Sheets

When is a Heart Attack not a Heart Attack?

In this publication, the Insurance & Savings Ombudsman is referred to as "the ISO" and the ISO Terms of Reference are referred to as "TOR". In the case studies, "P" is used to denote Participant and "C" to denote Complainant.

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ISO Conference – “Best Practice”

In our last Assessment, we referred to our upcoming conference and its theme of “Best Practice” in complaints handling and industry practice generally. The 1-day conference on Tuesday 26 September 2006, was preceded on the Monday by a “Conflict Resolution and Complaint Handling Workshop” facilitated by Trevor Slater, National Relations Manager for the Financial Industry Complaints Service Ltd (“FICS”) in Australia. Because the workshop was limited to 40 attendees, some potential attendees missed out on what proved to be a very worthwhile workshop. **(However, Trevor will be running another full day workshop for us in Wellington in June. Places will be strictly limited and cost \$350 per person. Contact us now to reserve your place.)**

Trevor was also a guest speaker at the conference, together with fellow Australians, Nina Harding (keynote speaker), a highly experienced and internationally renowned dispute resolution specialist and Dr Grant Lester, a Consultant Forensic Psychiatrist with a special interest in the management of unusually persistent complainants. Other non-industry guest speakers included barrister, Daniel McLellan, who specialises in insurance law and was a major contributor to the popular “Reasonable Care” workshop and David Russell, who spoke about plain English in policy wordings and chaired the “Industry Standards – Codes of Practice” panel discussion.

Industry representatives contributed to the “Industry Standards – Codes of Practice” and “The Way Forward” panel discussions.

We believe those attending the conference gained a valuable new insight into how complaints can be a useful tool to develop best practice in customer contact. The guest speaker sessions were especially valuable and very well received. Nina gave some very good examples of organisations with a proactive approach to complaints, using complaints to improve service levels, customer loyalty, retention, goodwill and profits.

The light-hearted creative policy wording session after lunch was appropriately timed and gave attendees an opportunity to display their writing and team-work skills.

The conference concluded with the ISO Commission’s annual meeting, featuring Beverley Wakem CBE, Parliamentary Ombudsman, as the guest speaker.

More information about the conference, including conference papers, is available on our website www.iombudsman.org.nz.

ISO’s Reports to Participants

For some time, the ISO Scheme has provided monthly information, detailing the complaints accepted for consideration about each Participant, on a confidential basis. While this information might be useful for some Participants, we have received feedback which indicates that it is not particularly meaningful for other Participants.

Following enquiries, we have been informed that some Participants believe it would be of great assistance to know about their performance and receive an indication if there are areas in which any improvement could be achieved.

Therefore, we would like to provide Participants with more meaningful information about the complaints under investigation and their complaints processes in quarterly reports. We intend to start the new reporting process in about April 2007.

Any comments would be appreciated and can be forwarded to info@iombudsman.org.nz.

Case Study 1

On 16 February 2006, C arranged health insurance with P.

In May 2006, C applied for pre-approval for hysterectomy surgery.

P declined the claim, on the basis that the surgery was due to a pre-existing condition. P believed the surgery related to a symptom, urinary retention, which existed before the policy start date of 16 February 2006

- Pre-existing condition

In order to decline the claim on the basis of the pre-existing condition exclusion, P had to show that C was “aware, or ought reasonably to have been aware, of a health condition, symptom or event” which occurred or existed before the policy start date of 16 February 2006.

C had consulted her doctor on 4 February 2006, with urinary retention which required catheterization. Her doctor treated this as a urinary tract infection. On the application for insurance, C had disclosed “an existing medical condition” on the declaration (cystitis), which her doctor had diagnosed as a “uti”.

P was entitled to decline claims for pre-existing conditions, in situations where the insured had not disclosed an “existing medical condition or symptoms of such condition”. P’s declination letter, stated “[t]he need for catheterisation for acute urinary retention should have been disclosed when you completed your Medical Declaration.”

However, the Case Manager believed C had complied with her duty by disclosing the diagnosed condition (cystitis), which she believed had caused the symptoms (urinary retention). If P wanted to know about the symptoms of this condition, then it should have made further enquiries. It was on notice about the condition.

The Case Manager did not believe it was fair or reasonable to expect disclosure of the symptoms of an already disclosed medical condition and the wording of the policy supported this position. A pre-existing condition was defined as a “health condition occurring or existing, or any health condition which relates to a symptom ...”. In this sense, a pre-existing condition is either a diagnosed health condition or, alternatively, a health condition relating to symptoms, but is not expressed in the policy as being both. The Case Manager believed, based on the medical notes, that C’s doctor considered the urinary retention to be a symptom of the diagnosed condition – a urinary tract infection, or “uti”.

Consumer Information Sheets

As indicated in the September 2006 issue of *Assessment*, we have prepared a series of consumer information sheets on issues which are frequently the subject of complaints made by consumers to the ISO. The consumer information sheets are now available on our website www.iombudsman.org.nz, under “*News & Publications*”, or copies can be requested by contacting the ISO Office directly.

The Consumer Information Sheets cover the following topics:

1. Breach of conditions of driver’s licence;
2. Modifications to vehicles;
3. Proving your loss;
4. The law – duty of disclosure;
5. Disclosure – material facts;
6. Sudden or gradual damage;
7. Basis of settlement – motor vehicle claims;
8. Policy excesses;
9. Personal Superannuation Plans – Withdrawals and Transfers; and
10. Health Disclosures.

Further consumer information sheets are being prepared covering the following topics:

1. Jewellery Insurance;
2. Pre-existing Conditions - Health and Travel; and
3. Disability Insurance.

The initial 8 consumer information sheets were sent out to all Community Law Centres, Citizen Advice Bureaux and Family Budgeting Services nationwide in November 2006. A feedback questionnaire was sent out to all Family Budgeting Services in February 2007. We aim to use the results to assist us in evaluating the value of the information provided and providing additional information sheets.

The consumer information sheets provide general advice on the selected topics. The practices and requirements of insurers can vary and, therefore, consumers should always check with their own insurer about its approach to many of the issues covered by the consumer information sheets.

We have included the following extracts from the **Pre-existing conditions – Health and Travel** Consumer Information Sheet:

What is a pre-existing condition?

Each policy will contain its own definition for “*pre-existing condition*”. It is important to note that, while you may not consider that the health condition requiring treatment is a pre-existing condition, the policy will define what the insurer regards as a pre-existing condition. **Read your policy carefully** to determine what is a pre-existing condition and how the policy treats pre-existing conditions.

Generally, a pre-existing condition is any **health condition** or **symptoms**, of which **you were aware**, or for which you had sought **medical treatment** or **advice**. This includes any health condition/s, which had not necessarily been diagnosed, but of which you had **symptoms**.

...

Claims for undisclosed pre-existing conditions

If you do not tell the insurer about a pre-existing health condition, or symptoms, and you make a claim for it, or anything related to it, the insurer will probably decline the claim.

Accordingly, the Case Manager did not believe P could rely on the exclusion for pre-existing conditions to decline the claim.

Complaint upheld

Case Study 2

In September 2003, C and her partner arranged mortgage protection insurance with P.

In September 2005, C suffered a heart attack and made a claim. P declined the claim, because P believed C’s heart attack did not meet the definition of “*HEART ATTACK*” under the terms and conditions of the policy.

The policy provided a benefit for defined “*Critical Illnesses*”, including “*HEART ATTACK*”, which was defined in the policy, as follows:

“... *The diagnosis shall be supported by the following criteria being consistent with a Heart Attack.*

A) *Current elevation of cardiac enzymes which are considered to be diagnostic of an acute infarction.*

B) *New electrocardio-graphic changes ...* (“the heart attack definition”).

Having examined the medical evidence, the Case Manager believed C had suffered a heart attack. However, the diagnosis of a heart attack needed to be supported by both criteria of the heart attack definition in order to be eligible for a benefit under the policy. The medical evidence did not show any “[c]urrent elevation of cardiac enzymes” or “[n]ew electrocardiographic changes”. C’s Troponin I reading of 0.38 ng/ml would not, according to medical research, equate to “*symptoms typical with abnormal enzymes*”.

Therefore, because C’s heart attack was not as severe as the heart attack specified in the policy, the Case Manager believed that C was not eligible for a benefit.

C requested a Recommendation, on the basis that the heart attack C suffered was more common than the one specified in the policy and, therefore, P was in breach of the Fair Trading Act 1986 (“the Act”). Because C had not provided any relevant, new information, or proper grounds, to support her request, the Assessment could not be changed. However, the ISO considered the issues raised by C.

An insurance policy is designed to cover specific risks and does not cover all risks. Insurers underwrite policies and provide particular benefits based on the statistical risk of claims. In this instance, P limited its risk to the more severe heart attacks and did not cover the more common type of heart attack.

This is because the policy excludes cover for pre-existing conditions which the insurer has not been told about and which it has not agreed to cover. This means that a condition, which develops after the policy commencement, will be excluded if it relates to a pre-existing condition.

...

Be Aware!

If you currently have a health insurance policy and you are considering changing to another insurer, then you need to think very carefully about whether the other company will cover your pre-existing conditions. Often, you may have developed conditions, or symptoms of a condition, which would be covered if you remained with your current health insurer. But if you change policies, you might later discover your new policy does not cover the relevant condition.

When is a Heart Attack not a Heart Attack?

Some insurance policies are sold as “**Trauma**” cover and other policies provide “**Critical Care**” benefits. They provide a lump sum benefit when the insured suffers, or is diagnosed with, one of a number of defined health conditions, or events defined in the policy. One health event usually covered is a heart attack. Each policy will define the severity of a heart attack required to be eligible for a benefit. The benefit is generally dependant on the insured suffering a heart attack, supported by the diagnostic criteria contained in the policy. Unfortunately, not all heart attacks are covered.

Many Complainants are disappointed with the fact that, while they have suffered a heart attack, it is not covered by the heart attack benefit. The ISO considers that, at law, an insurer is entitled to define the severity of the heart attack covered and is not bound to cover all heart attacks. Insurers underwrite policies and provide particular benefits, based on the statistical risk of claims and, for this particular benefit, have generally limited their risk to the more severe heart attacks. Insurance policies will always be limited in the cover provided and cannot cover all health conditions or events. The ISO does not believe that this is a breach of the Fair Trading Act 1986.

Prior to 2000, the clinically accepted diagnostic criteria for a heart attack included the presence of elevated levels of the cardiac enzyme, CK-MB. However, after 2000, the diagnostic criteria were redefined and relied, in part, on the presence of the elevated cardiac biomarker, Troponin. Troponin is a far more sensitive measure of heart muscle damage than cardiac enzymes. Because of its sensitivity, an elevation in Troponin levels can occur without any rise in cardiac enzymes and can detect very small heart attacks which, according to the earlier diagnostic criteria, may not be considered a heart attack. Hospitals in New Zealand are now using Troponin as a measure.

In many instances, a Complainant has suffered a heart attack according to the new criteria, i.e. an elevation of Troponin levels, but the policy still requires elevated cardiac enzymes. If the insured was not tested for the presence of elevated cardiac enzymes, then the ISO considers whether the elevated Troponin levels approximately equate to an elevation of cardiac enzymes. If the insured was tested for the presence of elevated cardiac enzymes and the evidence is that there was no elevation, then the insurer is entitled to decline the claim.

However, given that the elevation of Troponin levels is now preferred to CK-MB for diagnosing a heart attack, the ISO relies on the reasonable presumption that all insurance policies currently being offered, use Troponin as part of the diagnostic criteria for defining a heart attack. Insurers who continue to offer policies, relying on the earlier definition based on elevated levels of cardiac enzymes, risk breaching the Fair Trading Act 1986.

The ISO referred to *Larwint Pty Ltd v Norwich Union Life Australia Ltd* [2006] VSC 187. In *Larwint*, the insured suffered a heart attack, which was diagnosed, in part, by the presence of elevated cardiac enzymes.

The insured made a claim to his insurer for the heart attack. The insurer denied liability, because an electrocardiogram failed to show associated electrocardiographic changes and, therefore, did not fall within the definition of a heart attack in the policy. The plaintiff argued, amongst other things, that the policy should be interpreted in the context of its purpose. The plaintiff submitted the purpose was to offer cover “*in relation to any heart attack suffered by ... and clearly diagnosed*”.

The court dismissed the plaintiff’s argument, as follows:
“*I do not consider the construction of cl C.14 for which the defendant contends to be productive of an extraordinary, absurd or unjust result. The wording of the policy simply limits the type of heart attack in relation to which a benefit is payable to one demonstrated by the presence of the two diagnostic criteria listed in the definition ...*” (ISO’s emphasis).

Accordingly, the ISO believed P was entitled to specify and limit the types of heart attacks for which a benefit was payable and did not believe the policy was misleading and deceptive. The policy provided a benefit for heart attacks, but only severe heart attacks, which met the criteria in the policy.

The ISO appreciated that cardiac enzymes were no longer the preferred diagnostic measure for diagnosing heart attacks. However, the ISO also understood that cardiac enzymes were still a recognised technique for diagnosing heart attacks and were used in C’s case. As such, the ISO did not believe there was a breach of the Act. In this respect, the ISO referred to *MLC Limited v O’Neill* [2001] NSWCA 161. In *O’Neill*, Hodgson JA, discussed the application of new medical technology as follows:
“*The situation at the present seems to be that the diagnostic criteria set out in the policy, namely clinical electrocardiogram and biochemical assessment, are still regarded as appropriate diagnostic methods, and are still considered as satisfactory for detecting major heart attacks. There are, however, new techniques that can detect less severe heart attacks.*”

The ISO believed this rationale was directly applicable to this case.

Therefore, there was no issue of ineffective cover, or a breach of the Act.

Complaint not upheld