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Insurance and Savings Ombudsman Conference

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Thank you for your very kind invitation

I have been asked to speak on the way IEC does its business in the Australian setting, disclosure, fraud and any recent cases of interest, all within 30 minutes presumably with some question time.

Firstly, I will assume that all of you have a basic awareness of IEC and its history; if you don't then I suggest you go to our website which is **iecltd.com.au** which will allow access to all of our annual reviews since 1992, and importantly to the publication bought out after our tenth year of operations, "**The History of IEC".**

Down to business.

Financial Services Reform (FSR)

Under FSR legislation, the regulator ASIC released its policy guidelines (PS 139) for the approval of industry based, EDR schemes. This required that financial service licence holders had to be members of an ASIC approved industry based EDR scheme. The guidelines were based on the Federal Minister's Benchmarks which IEC and other major schemes participated in drawing up. Consequently and as we had been in existence since 1991/92, compliance was relatively painless. The Benchmarks are:

- Accessibility
- Independence
- Fairness
- Accountability
- Efficiency
- Effectiveness

The IEC scheme was approved in August 2000 with the main changes relating to quarterly reporting to ASIC of statistical data and reporting on possible systemic issues and cases of serious misconduct.

Systemic Issues

This has caused a great deal of angst amongst insurance companies as this is not what was envisaged of the scheme that they created back in 1991. Our emphasis accordingly has been on facilitating resolution rather than sanctioning. The process, agreed with ASIC, requires that the matter be first referred to the member involved for resolution and correction if necessary. If resolved to my satisfaction, a report on the matter is referred to the Board of IEC with the name of the insurer involved left out. A copy of this report will then be referred to ASIC.

If the insurer does not take the required action to my satisfaction, in effect meaning that the systemic issue or misconduct is likely to recur, I shall identify the insurer involved in my report to the Board and that report will then be referred to ASIC for its consideration. On two occasions I have identified a recalcitrant insurer.

Issues reported on thus far include:

- Exchange of Information
- Timelines in providing Notices of Response
- Delays in payments after settlements
- Delays in implementing determinations
- Failure to advise of the availability of the IEC Scheme
- Failure to advise of the Insurer's own IDR process
- Delays in providing IDR decision

This process will be reviewed in light of some concerns that our focus has been too much on procedural matters rather than the 'meaty stuff' coming out of determinations and dealings with member companies. Needless to say, there are strong and divergent views on the degree to which an industry based EDR scheme should be doing the work of the regulator.

Evolution of IEC

The IEC Scheme has evolved from a simple EDR facility for the general insurance industry which included an enquiries and information service to one that

- Has a strong educational focus
- Is involved in improving industry standards through its role as monitor of both the Code of Practice and the Privacy Code
- Has adopted a *quasi regulatory* function with its obligation to monitor and report on systemic issues and serious misconduct by its members

An effective scheme needs to look beyond its primary role and develop an approach that is geared to rasing standards for its members. It requires a different and more hands on educational approach aimed at raising the bar. There needs to be continual improvement in industry performance. Expectations of consumers and the Regulator are not static.

Jurisdictions

There are three levels of decision making:

- The **Claims Review Panel** which is a tri-partite body dealing with the more complex matters other than those involving an allegation of fraud up to $150,000
- The **Referee** who has sole jurisdiction to deal with all fraud matters (more later) up to $150,000 and
- The **Adjudicator** who deals with matters of a lower value and less complex nature up to $5,000

The mix of referrals is as follows:

- Panel 50%
- Referee 10%
- Adjudicator 40%

Together with the secretariat which will settle approximately 13%-15% of all mattes referred to the scheme for resolution, the decision makers will determine the dispute, through expert evaluation rather than mediation and conciliation, which may still in occur in limited circumstances but is generally conducted at the case manager level. We favour this approach for several reasons:

- Because of its heightened impact as an educational tool and its role in lifting the standards of industry practice.
- The matter has already been considered afresh by the insurer's own IDR unit
- Prospects for a conciliated response are normally fleshed out by the case manager beforehand

Code of Practice

To understand this approach you need to understand the relationship between the Code of Practice and the IEC scheme. All insurers must participate in the IEC Scheme. Also, both the TOR and the Code require the establishment by each insurer of a separate and discreet Internal Dispute Resolution Unit (IDR). This means that a dispute is reviewed by another section of the insurer with the result that 36% (in the previous year 39%) of all matters referred to it by the consumer, have been overturned in their favour, thus reducing the number of matters that have required IEC involvement.

Educational Focus

This should be a vital role for any Industry based EDR scheme. IEC tackles this through a combination of the following:

- An information and enquiries service (last year 67500 contacts)
- Written and reasoned determinations distributed to all members and not just those involved. An annual index of determinations is inserted into our website for public information.
- Periodical industry forums (open to anyone) and industry liaison meetings generally with the schemes *frequent flyers.*
- IEC publications such as the Annual Review and periodical IEC Updates, Practice Notes etc.
- The National IEC Conference
- ADR Group forums for consumer groups and community groups
- Funding support for an annual national consumer representative's conference.
- Code monitoring and individual member reviews by the secretariat

Statistics

As a consequence of this innovation as well as the impact of the drought on claims relating to motor vehicles, home building and home contents disputes, plus the restructuring of the industry in Australia has seen a fall in referrals from a peak of 2557 in the 2001/02 year to 2046 in 2002/03 and 1734 this past year. Overall, this constitutes a fall of 32% in two years. An increase in the fees imposed on insurers for matters determined by the scheme hasn't hurt either.

This must be kept in context from the point of view of the industry's approach to paying claims. Last financial year is good example. Just over **26.7M** personal lines policies generated just over **2.5M** claims. Of these 2.5M claims, a mere **12,354** required an IDR review with approximately **14%** then going on to IEC for resolution (a mere **0.07%** of all claims).
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Keep in mind that it is compulsory for an insurer to refer dissatisfied claimants to its IDR unit, an obligation which is closely and regularly monitored by IEC during its periodical reviews of industry conduct in relation to the Code of Practice.

Future Issues

1. Measures to deal with new corporate governance requirements
2. Greater emphasis on risk management and a risk management programme/policy
3. Independent Review
4. Expansion of jurisdiction
5. Name Change
6. Primacy of the IEC Board

The Fraud Referee

This innovation arose out of the difficulties faced by a tripartite panel to determine issues relating to fraud, generally due to the logistical and financial difficulties in dealing with interstate disputes. I felt that a single decision maker could more easily travel and meet with claimants rather than relying on the papers as generally the Panel does. This has proven very successful with both parties relishing the opportunity to present their cases in person. This in turn provided greater opportunity for the Referee to test the credibility and accuracy of the parties and their material.

The oral hearing, which is conducted in about 85% of cases, is:

- Informal
- Does not allow cross examination
- Is inquisitorial in nature

The process is that of an informal interview s distinct from interrogation

Burden Of Proof

It is not necessary for the insurer to prove fraud, it is merely sufficient if it can prove on the balance of probabilities, that it was reasonable for it to have denied the claim on the basis of fraud. When that occurs, the Referee advises the parties that this is not a matter suitable for resolution by the scheme and the consumer retains the option of seeking redress elsewhere.

Statistics

Since inception there have been **1887** matters referred to the Referee with a support rate for insurers of **61.6%** and an overturn rate in favour of consumers of **29.2%.** A further **3.5%** have been settled. Both the workload and the outcome rates have fluctuated over the years as the following charts will show.

Full Exchange of Information & Special Circumstances

One of the great innovations for the schemes as a result of ASIC PS 139 was the requirement that matters should generally only be determined on material available to both parties. Amendments were made to the TOR (see Cause 8) to ensure that the insurer, upon receipt of a dispute referral notice from IEC respond in writing, advise of:

- Reasons for the IDR decision
- Documents or information relied upon
- Any material requested to be considered as privilege or to which 'special circumstances' apply and reasons for their application

This material is also made available to the claimant. It is also incumbent on an insurer to advise the consumer of any means by which the consumer may rebut the document or information involved in a claim of 'special circumstances'.

The Referee (and other decision makers) cannot rely on material that is not made available to the other party, unless it is determined to come within the umbrella of special circumstances. In relation to material considered to be privileged, if it does not come within 'special circumstances', it will not be used. If the material satisfies the test of special circumstances it may be used subject to any terms and condition considered appropriate, and the material will not be shared with the other party.

When does 'special circumstances' exist?

1. Where the material may be harmful or embarrassing to a party if released.
2. Where it may endanger a third party.
3. Where it contains commercially sensitive information.
4. Where it is considered appropriate by the Referee to delay its release.
5. Where other special circumstances exist.

The onus of course is on the party asserting the existence of 'special circumstances' to prove on the balance of probabilities. Since 2001, the number of applications for special circumstances has reached 183 with the insurer successful in approximately 60% of applications.

Issues dealt with

- Minimal or Insignificant fraud (1997)
- Cultural Awareness (1997)
- Proof of Ownership (1997 & 1998)
- Oral Examinations (1998)

- Sufficiency of Reasons for Denial of a Claim (1998)
- Expert Evidence (1999 & 2000)
- Interviews by Investigators (1999)
- Full Exchange of Information (2001)
- Special Circumstances (2001)
- Indicia of Fraudulent Behaviour (2002)

Non-Disclosure

We all know that there are two aspects to the duty of non-disclosure:

1. the general duty not to misrepresent material facts
2. the duty to disclose material facts

Both protect the insurer from accepting a risk which is greater than it appears.

Sections 21 of the Insurance Contracts Act (I/C A) requires an insured to disclose all information that is known and is relevant to the insurer in making its decision to accept the risk and on what terms. What is relevant is an objective test of a reasonable person in those circumstances.

Section 21A requires the insurer to ask specific questions relevant to it making a decision to accept the risk, thus assisting the insured to satisfy the duty. However, S.21A only applies to 'eligible contracts of insurance' i.e. contracts of insurance for new business or insurance covering *inter alia* motor vehicles, travel, home contents etc.

Whilst S.21 requirements must be satisfied before a contract of insurance is entered into, including renewals, S.21A does not apply to renewals.

Changes to the duty of disclosure are currently being considered by the Federal Government as part of the review of the Insurance Contracts Act. Public submissions have targeted a number of areas for review and for details of the issues surrounding the duty of disclosure you are directed to the following website; **icareview.treasury.gov.au.**

From IEC's perspective, our focus has been on the duty's impact on claimants before the scheme. To this end, we have been quite influential in having the legislation changed. This occurred following the Annual Review of 1995 which highlighted problems in the application of S.21 and S.22. This resulted in meetings with the government and eventually Parliament passed the current S.21A which, according to the Explanatory Memorandum was "*designed to redress (the) imbalance and improve the capacity of an insured to comply with the duty of disclosure by requiring insurers to ask specific questions in respect of a proposed contract of insurance, in default of which the insurer is deemed to have waived the duty of disclosure.*"

Despite this improvement we highlighted the problem caused by it not relating to renewals. Consumers are required to answer correctly the questions asked of them on the proposal form and yet at renewal stage where the duty of disclosure arises again, they will be required to disclose, rather than answer questions

about, material that they were not required to tell the insurer about in the first instance.

Another issue of importance to IEC is the issue of the court's ability to disregard avoidance whee there has been a "little bit of fraud". This enables the court to disregard avoidance where it would be harsh and unfair not to do so and the insurer has not been prejudiced or any prejudice is minimal or insignificant. This was recognised by the Australian Law Reform Commission in it s report of 1982 and which is the basis of the current Section 31.

From our perspective, the section does not apply to innocent non-disclosure. It allows an insurer, following an innocent breach of the disclosure obligations, to reduce its liability to nil via S.28 (3). This normally occurs where an insurer can establish under tis underwriting guidelines that it would not have written the risk has there been full disclosure. Although S 28 (3) will achieve a just result, there are occasions where it does not.

These are just two of many issues being considered as part of the government's review of the Insurance Contracts Act. The duty of disclosure is a major issue for the insurance industry and there is great interest in the outcomes of this review.

I would again refer you to **icareview.treasury.gov.au**

Cases of interest to IEC

1. Unoccupancy

In the Annual Reviews in 1998 and 1999, we commented on a number of reasons why this subject can cause confusion and dispute

Firstly, there may be misunderstanding as to the meaning of the term, sometimes compounded by its being artificially defined in the policy

Secondly, many insurers will provide cover if they are notified that a building is unoccupied albeit on specific terms, which in turn raises underwriting issues.

Thirdly, many policies do not set out clearly what cover, if any, applies when a building is unoccupied.

The majority of policies provide full cover if a building is unoccupied for less than 60 days. Thereafter, the situation becomes complex. In case no. **18508** the issue was whether the insurer was entitled to deny a claim because the home had been unoccupied for more than 60 days, in which case, cover for theft, which was the event giving rise to the claim, was excluded. There was a dispute between the parties as to whether the claimants were provided with a copy of the policy wording but, in any event, the Panel noted the policy was a 96-page document. A clause on page 23 stated that if the home were unoccupied for 60 days or more, "special conditions and possibly restrictions on cover apply". However, a clause at page 39 stated there was no cover for theft from a residential home which was unoccupied. No reference was contained in this clause to the 60 days period for which cover was provided in the other clause. Also, the term "unoccupied" was specially defined as being established if "*no-one is living in the home*".

Now the term "*unoccupied*" has been judicially defined as meaning something quite different from the term "*not living in*". The courts have stated "occupancy" may be constituted by such matters as "*the regular daily presence of someone in the building"* and the words "*become unoccupied*" must relate to the "*absence of physical presence in the building"* as distinct from "*physical presence outside the building*". (See *Mazourca v Atlantic & British General Insurance* (1971) Lloyd's reports, a decision of the House of Lords.) This subtle but critical difference would not be clearly understood by most policyholders.

In this dispute, the issue also arose as to whether the insurer would have provided cover if the full circumstances in relation to occupancy of the property had been disclosed. Examination of the insurer's underwriting material revealed a considerable discretion existed for the underwriter to grant cover for unoccupancy e.g. if the owners were currently seeking a tenant for the property or it was being renovated. In these circumstances, the underwriter would be expected to provide cover. However, there was no material before the Panel as to how that discretion would have been applied. In all the circumstances, the Panel found the insurer should indemnify the claimant in response to the claim because the insurer had not established it had clearly communicated the nature and extent of the cover that would be provided in the event unoccupancy was established, nor had it demonstrated in accordance with its underwriting procedures, that it would not have provided cover in the event the full facts and circumstances had been made known to it.

In the Panel's opinion, the following matters ought to be considered by an insurer in a dispute centred upon whether a building was unoccupied or not for an excessive period of time.

1. Has the building been unoccupied within the meaning of that term as judicially defined for a period of in excess of the period allowable under the policy?
2. If the term "unoccupancy" is specifically or artificially defined in the policy, has that meaning been properly conveyed to the policyholder?
3. In the event there is discretion to grant cover (which, in the Panel's opinion, is the case with most policies) when the unoccupancy period has been exceeded, how would that discretion have been exercised in the circumstances relevant to the particular dispute.
4. If it is alleged there has been a failure to disclose unoccupancy of the premises, the details of the precise question asked and answer provided is required, as well as details of what the insurer would have done if full disclosure had been made.
5. In the event the policy exclusion is established, it is still necessary to demonstrate as required by section 54 of the Insurance Contracts Act, that the fact of unoccupancy was capable of causing or contributing to the loss. In many instances e.g. a fire or burglary, this may not be difficult. However, if for example, a number of burglaries also occurred in nearby occupied properties, then this may be more difficult to prove.

Changes in lifestyle result in properties being unoccupied whilst people travel, own a second house, or renovate and redesign. In our opinion, this is an important area of the law which gives rise to potentially large claims. We believe it requires careful attention.

2 – Landlord's Insurance

The Panel has determined a number of disputes between landlords and their insurers as a result of the activities of violent, irresponsible and drunken tenants. We have uncovered three types of landlord cover.

- **a- Actual landlords insurance** - designed to address the problems faced by landlords that are likely to be the subject of an insurance claim and includes cover for rent default and certain types of malicious damage.
- **b- Combined landlord's and household insurance policy** which is clearly described in those terms.
- **c- Home buildings policy** which included almost as an afterthought, add-on landlord benefits.

In Determination No. 18021, the Panel ascertained the only reference to landlord's cover, was at pages 43 and 44 of the policy. Apart from this reference, for all other intents and purposes, it was marketed as a typical home buildings insurance policy, which would be covered by the standard cover provisions of the Insurance Contracts Act Regulations. These policies are primarily designed for the owner occupier and are regularly sold over the telephone. In this policy, the term "home" was defined as "*any fully enclosed building (with walls and a roof) used primarily for domestic purposes at the site that can be locked up*". The policy however, contained an exclusion of the type often found in home buildings policies which excluded intentional damage by persons living in the home or who have entered the home with the consent of the insured.

We can understand an insurer not wanting to insure events that arise out of intentional or malicious acts of policyholders or their family members and invitees, because the owner/occupier policyholder should be able to exercise control over persons who live in the property or their guests. However, a landlord is an entirely different situation. In the first place, whilst the landlord has the ultimate decision as to the persons to whom he is agreeable to lease the property, he is frequently dependent upon others, such as an estate agent for this purpose. Many persons may behave well during the process of negotiating a lease, but may behave differently during domestic life. Most leases give the tenant the exclusive right to occupy the premises with only limited rights of inspection by the landlord. He therefore has no control over what persons the tenant invites onto the premises, or what they do there. In these circumstances, the Panel believes that any insurance policy which is marketed and sold as a home buildings policy and is primarily designed for owner/occupiers, should clearly inform a landlord that intentional and malicious damage, and particularly, fire damage perpetrated by invitees/tenants is excluded. No doubt the mortgagee or financier of the premises would also like to know in what circumstances a property destroyed by fire may be covered. In determination no. 18021, the policyholder had no idea that tenant's damage was excluded and failed in his claim for fire damage caused by one of his tenants.

For these reasons, the industry should give attention to this growing area of disputation and potential inequity and consider providing landlord's insurance in a policy designed for that purpose. The issue of communication of policy terms has been addressed in the new Public Consultation Draft Code of Practice and considered by the committee undertaking a review of the Insurance Contracts

Act. The issue of proper communication of potentially devastating and unexpected policy terms is one of ongoing interest and concern for the Scheme.

Other issues likely to feature in our forthcoming Annual Review include concerns over the **cancellation of policies by the policyholder** and the problems arising from **insurance claims and tumultuous relationships**

End.