Ombud recovered R187.7m in long-term insurance complaints in 2016

Ron McLaren, long-term insurance ombudsman, highlights some of the challenges and concerns of the industry, ahead of the release of his office's 2016 annual report.

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For 2016, 9,871 written requests for assistance were received of which 5,284 became chargeable complaints.

The ombudsman recovered R187.7m for complainants and awarded a further R487,335 in compensation for poor service by insurers. The office incurred expenses of R21.454m for the year, each standard case costing insurers R3,650.

Almost 50% of finalised cases were for claims which were denied of which 83% were for claims in the life insurance and disability insurance categories.

“Although the percentage of cases resolved wholly or partially in favour of complainants is lower than previous years at 28.1%, we must take into account the impact of our new operating model. If we add the cases resolved by insurers on transfer to them, this percentage rises to 37,4%-78% of cases were resolved within the first six months,” McLaren says.

Pacemaker scam

Among the most unusual complaints, of which there were several during 2016, was the case of the pacemaker scam.

Briefly stated, complainants claimed illness totalling R30.5m. “The scheme involved the allegedly unnecessary implantation of a pacemaker device into somebody who has significant cover for such a claim.”

Becoming more difficult

In general, the ombudsman reports that case finalisation is becoming more difficult. A number of reasons for this can be identified. These include more complex products, more persistent complainants and the impact of the office’s new business model which has led to simpler complaints being resolved by insurers and no longer by the office.

A total of 598 cases were reallocated from one adjudicating staff member to another to be resolved, thus requiring

additional manpower. This reallocation was either because of the complexity of the case or the persistence of the complainant.

Complainant and insurer behaviour

Some of the situations the ombudsman finds most troublesome include complainant behaviour and insurer behaviour.

The complainant behaviour issue became significant in 2015. “This occurs when the behaviour of a complainant takes on unreasonable dimensions,” McLaren says. “A persistent claim arises when a complainant rejects the office’s provisional determination, leading to the requirement for a final determination.”

In 2008, less than 1% of cases closed had final determinations, in 2012 this had increased to 5.8% and this figure nearly doubled in 2016 at 10%.
McLaren says, “The persistence of complainants impacts on our productivity as more time has to be spent on such complainants.”

“Insurer behaviour sometimes suggests a claim is being avoided at all costs,” McLaren explains. “This is where the insurer is demonstrably looking for reasons not to pay what appears to be a valid claim, often by raising a new defence if the original reason for declining the claim does not succeed.”

Another example of unreasonable behaviour on the part of the insurer is expecting a claimant to prove an exclusion on which the insurer wishes to rely, to decline a claim instead of the insurer obtaining the information itself.

In addition, insurers may expect claimants to undergo a surgical procedure or electroconvulsive therapy when considering disability claims, in the absence of policy wording requiring such treatment.

Poor underwriting practices

A major concern, McLaren says, “is insurers that have poor underwriting practices by, for instance, not conducting proper investigations at underwriting stage, but then relying on a non-disclosure defence to repudiate the policy when a claim arises. This involves the practice of shutting the eyes to the light at application stage.”

Another area of difficulty is the treatment of the equity/fairness jurisdiction by some insurers. McLaren points out, “They shy away from the very concept, yet they themselves make so called 'ex gratia' or 'goodwill' payments.”

This attitude to equity/fairness is difficult to reconcile with the TCF (Treating Consumers Fairly) approach which has been introduced by the Financial Services Board.”

Since the implementation of the office’s new business model the figures have been consistent over the past three years, despite an increase in the number of policies sold by insurers.