
2008 ALUCA TurksLegal Scholarship

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The cover provided by current trauma products in relation to many medical conditions is often technically complex and may be hard for laypeople to interpret. This may mean that on occasions some claims sit at the margins.

How do you think the process of managing customer expectations and ultimately reaching fair and equitable claims decisions in relation to these claims can be improved?

Introduction

The complex nature of Trauma products begins with a plethora of events covered under a typical “Standard” version and is compounded by more events covered under “Comprehensive” options. Adding to this are other events that trigger only a partial payment of the sum insured, often with different amounts payable. These events are provided in a flexible package of features, buy-back options and permutations with other products. Embedded within them is an assortment of medical terms, acronyms and exclusions.

By its very nature, Trauma needs to reference medical definitions to determine if and when a benefit is payable. What is or isn’t a ‘heart attack’ or ‘cancer’ is impossible to define in layman’s terms. It must, therefore, be defined using clinical terminology, diagnostic criteria and language unfamiliar to the majority of those who recommend it or purchase it.

Take as an example, the Cancer definition for the award winning¹ Total Care Plan offered by Comminsure. It refers to “malignant cells”, “major interventionist treatment”, “Clark Level” and “Breslow thickness”; words most consumers do

not comprehend. It also sets out 6 types of cancer that are *included* and 14 types of cancer that are *excluded*.

Even with the use of medical terms, the interpretation of definitions remains contestable. In the matters of *Larwint v Norwich Union*² and *MLC v O'Neill*³ the court was called upon to determine the meaning of “Heart Attack”. FICS has similarly issued determinations concerning the definition of “Heart Attack”⁴ and “Angioplasty”⁵.

With around 15% of claims declined for not satisfying the definition⁶, it is evident the industry has scope for improvement.

For the purposes of this paper, reference to Trauma definitions will largely be confined to cancer and cardiac related events, as these account for 85% of all claims⁷. Most comments can equally apply to other events.

How could the industry improve trauma products to make what they cover as clear and comprehensible as possible?

The same competitive market forces that expanded the number of events covered by Trauma insurance are likely to prevent any radical product rationalisation or simplification of product design.

Pricing and affordability considerations dictate that not every cancer or heart attack can be covered. Promotional literature and the advice offered by financial planners must therefore openly and unambiguously convey that there are exceptions.

The respective Product Disclosure Statements for the three leading Trauma products⁸, contain an extensive list of covered events that include “Cancer”. Within close proximity of each list is text indicating that there is no cover where the event occurs within the first 90 days. There is no similar indication that not all cancers are covered. It is only when the customer refers to the glossary or definition of medical terms, does it become apparent that there are some exceptions. Anyone looking solely at the list could be lulled into believing all cancers are covered. Despite the onus being on the customer to consider the

entire PDS, the industry could do more to alert the customer earlier that not every form of cancer or heart attack is covered.

A Plain English statement along the lines of “Not all Cancers are covered by this product” should be included in the PDS and the policy document. At the time of claim, a similar wording should appear in the covering letter and standard claim form to direct the insured to the policy conditions and to be aware that not all conditions that fall under the heading of Cancer or Heart Attack are covered.

Such an approach has been adopted by the Association of British Insurers (ABI). In the updated version of the “Statement of Best Practice for Critical Illness Cover” released in April 2006, the ABI mandates the use of extended headings in the following format:

- **Cancer** – *excluding less advanced cases*
- **Heart Attack** – *of specified severity*

This message is reinforced by the ABI recommended text for describing Trauma products:

“The complete list of conditions we cover is set out below. These headings are only a guide to what is covered. The full definitions of the illnesses covered and the circumstances in which you can claim are given in the policy. These typically use medical terms to describe the illness but in some cases the cover may be limited. For example:

- Some types of cancer are not covered
- To make a claim for some illnesses, you need to have permanent symptoms”

This approach alerts the customer at the earliest opportunity that the extent of cover is restricted. Australian insurers should embrace this approach as one step in the process of better informing customers.

Better training and support materials for Business Development Managers and advisers, would also assist. A few years ago ING published a useful handbook for advisers that gave insight into the medicine behind Trauma definitions and helped them to explain the definitions to customers. It included diagrams and text. Regrettably, this approach was not embraced by competitors and the guide is no longer produced.

Marketing “Cancer only” policies or policies tailored for females would simplify the product in terms of the number of events. The use of medical terms and the exclusion of less severe forms of cancer however, would still persist.

How can the industry increase the level of professionalism and transparency in the process of arriving at fair and equitable claims decisions?

Whenever customer expectations are not met, there is a risk of adverse publicity, complaint and litigation. Well documented processes, open communication and procedural fairness are essential to mitigate this risk.

Some denials will be more objective than others, e.g. the histopathology report is unequivocal that the Melanoma is below both the requisite Clark level and Breslow thickness. Where the evidence is more ambiguous, the following process should be followed:

1. The assessor should firstly consider if the evidence satisfies the definition for another event. On occasion, insurers have rightly declined a Heart Attack claim on the basis that the definition was not met, yet failed to recognise that the insured qualified for a partial payment under Angioplasty after undergoing treatment.
2. In all cases where the assessor forms an initial view that the claim does not satisfy any of the relevant policy definitions, the file should be referred to the Chief Medical Officer for opinion.
3. The CMO should either confirm that the definition has not been met or recommend additional evidence that should be obtained to enable further consideration to be given to the claim.
4. In some circumstances, it may be prudent for the CMO to consult with colleagues who specialise in Oncology or Cardiology, to obtain a more expert opinion.
5. In the most borderline of cases and particularly those involving large sums insured, consideration should be given to arranging a review of the original tumour specimen or ECG tracing by an independent specialist.

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6. Once any further evidence has been obtained and the CMO concludes that no definition has been satisfied, the file should be reviewed by a Team Leader or Claims Manager, to ensure that all appropriate factors have been considered and all internal procedures followed.
 7. The procedural fairness protocols that apply to TPD claims also need to be embraced when a Trauma claim is denied. When communicating the initial view that the claim cannot be met, it is essential that clients understand the insurer is not denying the existence or significance of the event to them. The reasons why the claim is considered to be ineligible should be clearly set out and any evidence or documents relied upon attached. The insured and their treating doctor should be invited to submit any comments or additional evidence they consider will add further merit to the claim.
 8. Within the parameters permitted by the National Privacy Principles, the adviser should be kept informed of the progress of the claim and the basis for the decision.
 9. When communicating the denial, the insured must be informed of the right to internal and external dispute resolution options.
 10. Depending upon the terms of reference, the Claims Review Committee may wish to recommend or authorise payment of the claim as on an ex-gratia or good faith basis

If advisers and customers are made aware upfront of the steps a company will commit to taking for those claims at the margins, they may be more willing to accept the outcome. A letter or brochure could be used to explain this.

Should claims assessors have access to other information such as the product actuary's pricing decisions and a knowledge of the data categories used in the pricing. If so, what are the potential pitfalls in terms of litigated claims disputes and product disclosure?

Claims assessors should restrain themselves to being the arbiters of technical facts and leave it to the likes of a Claims Review Committee or Executive Management to recommend or approve commercial decisions.

A claim at the margin is unlikely to have a substantial pricing impact, otherwise it would have been identified as a material risk worth insuring in the first place. Consequently, any reference to pricing assumptions is likely to yield a factor in the order of 0.5% or less. In isolation, this seems able to be ignored, but when multiple instances of borderline events are combined, a significant proportion of the profit margin can be eroded.

Making exceptions increases the risk of binding precedents and may result in comparable circumstances being treated differently, simply due to the dollars involved. Why should a 'borderline' claim of \$50,000 be paid, yet an equally borderline case for \$1.5 million not be paid if they have equivalent merits?

If a borderline case falls within the "intent" of the cover, then it must become the impetus for modifying the policy conditions at the next product review. Failing to do so, only perpetuates uncertainty for assessors, customers and advisers.

How and when should companies use independent medical experts in assessing these claims?

The majority of claims are for events where the requirements to satisfy the definition have already occurred by the time the insurer learns of the claim. As such, the opinion of the insurer's Chief Medical Officer will usually suffice. This may be supplemented occasionally with the opinion of the reinsurer. In only the rarest of cases, and at the discretion of the CMO, will it be necessary to canvass an independent evaluation of the submitted evidence.

Less frequently claimed events such as Parkinson's Disease and Multiple Sclerosis, or any of those predicated upon permanent impairment, more lend themselves towards an independent medical opinion. As with TPD claims, appropriate weight should be given to the opinion of the life insured's treating specialist. It would be prudent however, especially with larger sums insured and with younger claimants, to seek an independent opinion to corroborate that the definition had been met or to challenge such an assertion.

To what extent should companies engage with treating doctors in reaching their decision and, if so, how should they go about doing this?

Engaging with the treating doctor is necessary for all borderline cases. In the first instance, it provides an opportunity to seek further information and to clarify uncertainties.

To avoid misunderstandings and in anticipation of a potential dispute, written communication should be preferred. All such correspondence should be composed with input from the CMO and ideally should be signed by them. Alternatively, where clarification is likely to result in admission of the claim, it may be appropriate for CMO to speak directly with the doctor and follow this up with a letter to obtain written confirmation of the discussion.

Engaging the treating doctor also provides an opportunity to explain why an event may be a cancer or heart attack in the clinical sense, but not one that is covered by the policy. Whether or not the treating doctor agrees with where you have drawn the line in constructing the definition; if they can concede that their patient does fall in the minority of excluded events, it may assist in persuading the claimant of the validity of the decline.

Conclusion

The rejection of claims for failing to meet the precise policy definition inevitably results in consumers crying foul at the use of “fine print”. It is therefore vital that insurers appropriately manage expectations - both at the point of sale and at the time of claim, about what is and isn’t covered. Any claim that sits at the margins must be subject to a comprehensive and balanced assessment that affords procedural fairness.

The goal must be to ensure that the customer understands the rationale for the decision and feels that their claim was given a fair hearing; even if they are not pleased with the outcome.

References

- ¹ Joint media release issued on 20th February 2008 by Plan For Life and the Association of Financial Advisers Ltd announcing winners of 2007 Product and Service Quality Awards. Comminsure judged winner of 2007 Trauma / Critical Illness Award
- ² Larwint Pty Ltd v Norwich Life Australia Ltd [2006] VSC 187
- ³ MLC Limited v O'Neill [2001] NSWCA 161
- ⁴ Financial Industry Complaints Service Determination 3336907466
- ⁵ Financial Industry Complaints Service Determination 3304574377
- ⁶ 1996 – 2002 Employers Reinsurance Corporation Critical Illness Claims Survey
- ⁷ Industry Trauma Experience 2001-2005, presented by Eddie McEllin of Gen Re at 2008 ALUCA Conference
- ⁸ Comminsure, Asteron and Aviva were rated as the 3 leading Trauma products Plan for Life and the Association of Financial Advisers Ltd in their 2007 Product and Service Quality Awards.