MOTOR ACCIDENTS AUTHORITY

DRAFT

INDUSTRY

CLAIMS HANDLING COMPLIANCE AUDIT REPORT

November 2002

EXECUTIVE SUMMARY

Background

The Compliance Unit of the MAA conducted a compliance audit of NSW CTP Insurers' claims handling practices under the Motor Accidents Compensation Act 1999 (the Act).

The objective of the audit was to assess whether the licensed insurers are complying with their statutory claims handling requirements including the Claims Handling Guidelines.

Officers of the MAA conducted the Claims Handling Compliance Audits between December 2001 and April 2002. The audit consisted of interviews with CTP claims managers and claims officers and an inspection of a total of 319 claim files made up of 70 Accident Notification Forms (ANFs) and 249 full claims.

Approximately 10 ANFs and 40 full claims were examined at each of the following CTP insurers' premises: AAMI, QBE, NRMA, Zurich, GIO and Allianz. A smaller sample of notifications with CIC Allianz and FAI Allianz was also examined at Allianz's premises.

Summary findings of MAA compliance audit

The lowest, median and highest levels of non-compliance by the insurers for each claims handling requirement audited are presented in Table 1 for ANFs and Table 2 for full claims.

The findings of the MAA's first claims handing audit indicate that the CTP insurers were generally complying with all of the claims handling requirements for ANFs, and with the majority of the requirements for full claims.

The results indicated that all insurers were paying reasonable and necessary medical expenses up to $500 for ANFs as required by the guidelines with many insurers routinely making payments up to $1000. Payments in excess of $500 were made where the insurer considered that the ANF could be finalised by making the additional medical payments and thus alleviating the need for some claimants to pursue full claims.

The audit results also indicated that insurers were complying with the majority of claims handling requirements for full claims which included making prompt requests for police reports and, once liability was admitted, making prompt payments for hospital, medical, respite & attendant care, rehabilitation & pharmaceutical expenses.

However, some important claims handling requirements for full claims had variable levels of compliance across the industry. The following actions by insurers resulted in high industry levels of non-compliance with the applicable claim handling requirement: making late offers of settlement; making late determinations of liability; slow requesting of medical evidence; late acknowledgement of receipt of claim; and not providing treating doctors' reports to claimants.

Whilst it was observed by the MAA auditors that some insurers could have been more proactive in their endeavours to resolve claims, the same was noted for some claimant solicitors who had not responded to insurer requests for further and better particulars or offers of settlement.

Since the establishment of the MAA's Compliance Unit in April 2001, the licensed CTP insurers have generally co-operated with the Compliance Unit's recommendations and responded in a timely manner to requests for information and the provision of statutory reports. All insurers have finalised claims handling complaints that have been directed to the MAA's Compliance Unit in a timely manner.

Recommendations

The MAA's Compliance Auditors have recommended that the MAA:

1. Continue to measure and assess insurers' compliance with the Claims Handling Guidelines;

2. Conduct a review of the Claims Handling Guidelines;

3. Develop a regulatory and enforcement policy and provide a clear explanation to insurers of this policy for dealing with future non-compliances;

4. Explore ways of promoting the just and expeditious resolution of claims as required by Section 80 of the Act.

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1. INTRODUCTION

1.1 Purpose of the Report

This report has been prepared to present the objective, scope, methodology and summary findings of a compliance audit of the handling of personal injury claims by licensed Compulsory Third Party (CTP) insurers under the NSW Motor Accidents Compensation Act 1999 (the Act).

The objective of the audit was to assess whether the licensed insurers are complying with the claims handling requirements under the Act including the Claims Handling Guidelines (the Guidelines) issued under Section 68 of the Act. The Claims Handling Guidelines were developed by the MAA in 2000 following consultation with the Insurance Council of Australia Ltd, the Council of the Bar Association and the Council of the Law Society.

It is a condition of a CTP insurer's licence that the insurer must comply with the Guidelines.

This report also presents recommendations in relation to future monitoring and assessment of insurers' compliance with their claims handling requirements.

The summary findings presented in this report are based on information obtained from the MAA's Claims Register, the MAA Complaints Database and files, insurer complaint summary reports, insurer self-reports on compliance, information supplied by insurers' claims staff and observations made during the audit inspection of claims files. Matters of non-compliance with legislation beyond the scope of this audit are not addressed in this report. No personal information has been presented in this industry summary report in order to protect the privacy of claimants.

This report has been prepared for the purpose described and no responsibility is accepted for its use in any other context or for any other purpose.

1.2 Scope of the Audit

The scope of the audit was limited to CTP personal injury claims for accidents on or after 5 October 1999, the date the Act commenced, lodged with insurers licensed and authorised by the MAA to underwrite CTP business in NSW. The licensed CTP insurers audited were AAMI, Allianz, CIC Allianz, FAI Allianz, GIO, NRMA, QBE and Zurich.

At the time of the compliance audit Allianz controlled CIC Allianz and FAI Allianz which respectively undertook renewal of CTP insurance policies previously written by CIC Insurance and FAI General Insurance. Because these claim portfolios were being managed and supervised by Allianz staff, a small sample of claim files from CIC Allianz and FAI Allianz was also included in the audit in addition to Allianz claims. FAI Allianz subsequently ceased to write CTP insurance policies effective from 30 June 2002.

Insurers who do not manage claims for accidents on or after 5 October 1999 were excluded from the audit. These insurers (CGU companies, Mercantile Mutual, Royal & Sun Alliance and SGIO) continue to manage run off claims made prior to that date.

Activities examined on-site as part of this audit consisted of practices, policies and procedures in the handling of Section 49 Accident Notification Forms (ANFs) and Section 74 (Full Claims) for accidents which had occurred in NSW and are subject to the Act.

Interstate accident claims and workers compensation recovery claims were excluded from the audit.

An assessment of insurers' compliance with the Treatment, Rehabilitation and Attendant Care (TRAC) Guidelines, and Section 84(2) of the Act relating to the expeditious provision of rehabilitation services once an insurer has admitted liability, was beyond the scope of the audit.

An assessment of the insurers' compliance with Section 3.1.1 to 3.1.3 of the Guidelines, regarding actions taken by the insurer to assist claimants when making their claims, was beyond the scope of the audit.

An assessment of insurers' compliance with Sections 3.9.2 to 3.9.5 of the Guidelines, regarding the conduct of its investigators, was beyond the scope of the audit.

In the absence of formal audit criteria to assess the 'reasonableness' of an offer of settlement, assessments of unreasonable offers of settlement under Section 7.2 of the Guidelines were limited to obvious cases. For example, it would have been considered an unreasonable offer of settlement if at the time of offer there was evidence on the file that a claim was clearly eligible for a particular head of damage, but that head of damage was not included by the insurer in the offer of settlement.

An assessment of insurers' compliance with Sections 9.1.1 to 9.1.7 and 9.2 of the Guidelines, regarding detailed aspects of its in-house complaint handling system was beyond the scope of the audit. Nevertheless, all insurers were assessed for compliance with the Guidelines requirements for documenting internal complaints handling processes (Section 9.1) and complaint summary reports (Section 9.1.8).

An assessment of the insurers' self-reports on compliance and complaints has also been included in this industry report.

The insurers had previously been requested by the MAA to provide at the end of 2001 self-assessments of compliance with 27 of the Guidelines requirements. The MAA auditors determined what proportion of each insurer's assessments of compliance yielded an acceptable correlation with the MAA auditors' assessments of compliance.

The MAA auditors reviewed each insurer's 6-monthly complaint summary reports covering the first half of 2002. The insurers' complaint summary reports were compared for completeness with the MAA's internal Complaint Database.

1.3 Audit Criteria

The audit criteria were limited to the following claims handling requirements of the Motor Accidents Compensation Act 1999 and the MAA Claims Handling Guidelines.

The audit criteria against which compliance has been assessed are Sections 70(2) and 73(3) of the Act and Sections 2.2.a, 2.2.b, 2.3, 2.4, 2.5, 2.6, 2.7.a, 2.7.b, 3.1.4, 3.1.5, 3.2.1.a, 3.2.1.b, 3.3.1, 3.3.2, 3.3.3, 3.4.1, 3.4.2, 3.4.3, 3.4.4, 3.7.1, 3.7.2, 3.7.3, 3.7.4, 3.7.5, 3.8.1, 3.8.2.a, 3.8.2.b, 3.8.2.c, 3.8.2.d, 3.8.2.e, 3.9.1, 3.9.6, 4.1, 4.2, 4.3, 4.4, 5.1.a, 5.1.b, 5.1.c, 5.1.d, 7.2, 7.3, 7.4, 7.5, 9.1, 9.1.8, 10.1.1 and 10.1.2 of the Guidelines. Some of the section numbers described in the Guidelines may differ from those given above. See comments above under Scope of the Audit relating to the limited audit criteria for Section 7.2.

Refer to Tables 1 and 2 for a description of the above Guidelines requirements.

2. AUDIT METHODOLOGY

2.1 Information Analysed Prior To Audits

Prior to the on-site examination of claims files, the licensed insurers were requested to provide to the MAA a copy of the organisation chart for their CTP line of business, the names of all CTP claims staff and the number of claims managed by each staff member.

2.2 Selection of Audit Sample

Insurers' claims to be included in the compliance audit sample were selected from the random audit sample previously used for the NEL Performance Audit conducted in 2001. The audit sample consisted of both open and closed claims.

The total sample for the compliance audit consisted of **70 ANFs** and **249 personal injury claims** related to motor vehicle accidents on or after 5 October 1999 and for which claims had been lodged prior to September 2001. Approximately 10 ANFs and 40 full claims were examined at each of the following CTP insurers' premises: AAMI, QBE, NRMA, Zurich, GIO and Allianz. A further 5 ANFs and 5 full claims were examined from each the claims portfolios of CIC Allianz and FAI Allianz, now managed by Allianz.

The list of claim files to be audited was forwarded to the licensed insurers approximately 5 days prior to the commencement of the on-site audit.

2.3 On-Site Audit

The MAA audit teams were made up of the following MAA Officers:

- Principal Compliance Officer (PCO),
- Senior Compliance Officer (SCO), and
- Senior Compliance Officer – Nominal Defendant (SCOND).

The audit team presented to the insurer premises on the dates listed in the table below:

Insurer	Audit Team	Audit Dates
GIO	SCOND*, SCO and PCO	3, 4, 5 & 7 December 2001
Zurich	SCO* and SCOND	14, 15 & 16 January 2002
AAMI	SCOND*, SCO and PCO	11, 12 & 13 February 2002
QBE	SCO* and SCOND	4, 5 & 6 March 2002
NRMA	SCOND*, SCO and PCO	8, 9, 10, 11 & 18 April 2002
Allianz	SCO*, SCOND and PCO	6, 7, 8 & 9 May 2002
CIC Allianz and FAI Allianz	SCO*, SCOND and PCO	6, 7, 8 & 9 May 2002

* indicates lead auditor

Upon arrival at the licensed insurers premises the MAA audit team provided a copy of its 'Instrument of Authorisation' to the relevant CTP Claims Managers, which provides authorised officers of the MAA with the powers of entry and inspection pursuant to section 182 of the Act.

Initial discussions were also held between the MAA auditors with the CTP Claims Managers and other relevant staff from the insurance companies.

These discussions related to the claims management practices, policies and procedures of the licensed insurers, in particular the insurers' processing of ANFs and full claims, practices relating to contacting legally represented claimants, general medical and rehabilitation issues, settlement offers and strategies, and any feedback on the Guidelines. The discussions also included the insurers' use of investigators and their internal complaints and disputes handling system.

Following these discussions, the MAA auditors examined a sample of claim files as described above.

On the final day of the on-site inspection the MAA audit team conducted interviews with individual claims assessors. Discussions with these claims assessors related to their knowledge and understanding of the Guidelines in concert with the claims management practices, policies and procedures of the insurers, strategies to settle full claims, their internal complaints and disputes handling system and any feedback on the Guidelines.

2.4 Audit Reporting

Each insurer was sent a draft report on its individual levels of compliance and the reports were finalised taking into consideration the comments received back from the insurer. Every claims handling requirement was assessed for each ANF and full claim audited. There were four possible assessments of compliance: compliance, non-compliance, not applicable or not determined. Each insurer was sent a copy of its individual Claims Handling Compliance Audit Report in August 2002.

Compliance was assessed strictly in accordance with the Guidelines requirements. For example, if the insurer was required to acknowledge the receipt of a claim by sending an acknowledgement letter to the claimant within 5 working days, a non-compliance would have been recorded if the letter was sent on the 6th working day after receipt of the claim (see requirement 3.2.1.a in Table 2).

This report presents a summary of the key findings for the industry. The lowest, median and highest levels of non-compliance for each claims handling requirement from the insurers' individual compliance reports have been presented in Tables 1 and 2 of the following section.

3. FINDINGS – ASSESSMENT OF COMPLIANCE

The lowest, median and highest levels of %non-compliance found for the eight licensed insurers (including CIC Allianz and FAI Allianz) are presented in the following two tables. Table 1 presents these findings for the claims handling requirements relating to Accident Notification Forms and Table 2 presents the findings for full claims.

For example, the insurer with the highest % Non-Compliance for Requirement 3.3.1 in Table 2 was calculated as follows:
%non-compliance = (7 claims not complied/40 claims audited)*100 = 18%

TABLE 1 INDUSTRY NON-COMPLIANCE RESULTS FOR ACCIDENT NOTIFICATION FORMS

Ref	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
2.2.a	Provide written advice to injured person on whether provisional liability determined within 10 days of receipt	0	0	22
2.2.b	Insurer to advise ANF is not a claim and if additional damages to be claimed, a claim form needs to be lodged within 6 months	0	0	67
2.3	Provide written advice to injured person on whether provisional liability accepted for pedestrians and passengers within 10 days of receipt	0	0	14
2.4	advise claimant within 5 days if information contained in ANF insufficient to determine provisional liability	0	0	7
2.5	pay reasonable & necessary medical expenses up to at least $500	0	0	0
2.6	promptly respond to all reasonable requests for info and assistance from injured person	0	0	0
2.7.a	advise injured person nearing time limit or dollar amount expiration that full claim will be required for further payments	0	0	10
2.7.b	request new medical certificate only where condition has changed or injured person claiming for injuries in addition to those in ANF medical certificate	0	0	0

TABLE 2 INDUSTRY NON-COMPLIANCE RESULTS FOR FULL CLAIMS

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
Making Claims				
3.1.5	provide reasons in writing for rejecting claim	0	0	0
S73(3)	explanation for delay in lodging claim outside 6 months accepted/rejected by insurer within 2 months of receiving explanation	0	0	3
Acknowledgement of Claims				
3.2.1.a	date claim received by insurer & acknowledgement letter sent within 5 days.	7	30	73
3.2.1.b	insurer to advise it will provide copies of treating doctors' reports & police report it has on file, unless otherwise directed by claimant	0	0	100
Claims Information & Investigation				
3.3.1	request police report within 5 days of receipt of claim	0	3	18

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
3.3.3	follow up requests for police reports through dedicated liaison officer/s on weekly basis if delays occur	0	0	0
S70(2)	if applicable, explanation for delay in reporting accident to the police, rejected by insurer within 2 months of receiving explanation	0	0	0
3.4.1	admission or denial of liability (or breach of duty of care) as expeditiously and justly as possible within 3 months of proper notice of claim	5	21	50
3.4.2	advise claimant on decision of liability ASAP within 20 days of receipt of relevant information if that would be less than 3 months	0	12	20
3.4.3	If contributory negligence alleged insurer must advise claimant of % alleged.	0	0	0
3.4.4	admission of denial or admission of liability must be disclosed in a Section 81 Notice.	0	9	41
Requests for Information by the Insurer				
3.7.1, 3.7.2, 3.7.4	Insurer not to duplicate requests for information or request information that is irrelevant to the claim	5	21	62

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
3.7.3	ensure all correspondence in plain English	0	0	0
3.7.5	As per stat declaration in claim form advise recipient of the date of accident what inquiries are about and ensure inquiries are relevant to the claim.	0	0	0
Medical Evidence				
3.8.1	promptly request hospital discharge summaries/clinical notes and any treating doctors reports	0	16	32
3.8.2.a	request a medical examination of the claimant, if considered appropriate	0	0	0
3.8.2.b	ensure examination is arranged at a time and place readily accessible to claimant	0	0	0
3.8.2.c	insurer should advise claimant of availability of MAA to resolve disagreements on any medical issues	0	0	0

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
3.8.2.d	insurer to pay reasonable expenses to claimant for attendance at medical appointment arranged by insurer or assessment by MAS.	0	0	0
3.8.2.e	copy of treating doctor report to be provided by insurer to the claimant within 10 days of receipt, unless doctor has indicated in writing this would be inappropriate	0	44	100
Use of Investigators				
3.9.6	investigators shall not provide a legal opinion in their reports but provide a factual report	0	0	0
Contacting Legally Represented Claimants				
4.1	send requests for information to the claimant's solicitor directly, where requested to do so by the claimant	0	0	0
4.2	may contact legally represented claimant where there was no response or acknowledgement to correspondence within 10 days & an attempt has been made by insurer to confirm receipt of correspondence or after acknowledgement there is no substantive reply within 20 days	0	0	3

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
4.3	copy of offer of settlement may be sent to legally represented claimant where there is no response to the offer within 10 days. Insurer to attempt to confirm offer received by sol before letter going to claimant.	0	0	3
4.4	may contact legally represented claimant about rehab assessment or plan. Copy of rehab plan or correspondence should be sent to solicitor and where possible be advised of any communication with client before contacting directly.	0	0	0
Payment of Medical and Treatment Expenses				
5.1.a	once liability admitted, insurer meeting reasonable & necessary (properly verified & relates to mva) hospital, medical, respite & attendant care, rehabilitation & pharmaceutical expenses on an as incurred basis.	0	0	3
5.1.b	insurer advised claimant, within 10 days of receipt of account if any medical treatment expenses will not be paid and claimant advised of right to refer dispute to MAS	0	5	10
5.1.c	insurer not to pay any treatment expenses once claim has settled and prior to settlement monies unless by agreement with claimant.	0	0	0
5.1.d	at the time of making offer of settlement of 24 hrs prior to settlement conference, CARS assessment or Court, insurer to provide a full list of paid and unpaid out of pocket expenses on its file	0	0	48

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
Settlement				
7.2	duty of insurer to make a reasonable offer of settlement to claimant within 1 month of parties or MAS assessor agreeing condition has stabilised or within 2 months after claimant has provided all relevant info required to support the claim which ever is the later	0	3	18
7.3	offer clearly states the separate components of the damages and the amount for each head of damages and any relevant calculations	0	0	11
7.4	if not satisfied with offer, claimant advised matter can be referred to CARS	0	0	33
7.5	finalised claim – settlement monies paid within 21 days of settlement unless insurer waiting for workers comp, Centrelink of HIC payment notices. Settlement monies paid within 21 days of receipt of those notices.	0	0	10

4. FURTHER OBSERVATIONS

Further observations were recorded by the auditors where issues of concern were observed that are beyond the scope of the Compliance Audit. Further observations are considered to be indicators of potential non-compliances or areas where claims handling performance may be improved.

Whilst it was observed by the MAA auditors that some insurers could have been more proactive in their endeavours to resolve claims, the same was noted for some claimant solicitors who had not responded to insurer requests for further and better particulars or offers of settlement.

5. DISCUSSION and RECOMMENDATIONS

5.1.1 Compliance Assessment by MAA

Tables 1 and 2 indicate that the CTP insurers were generally complying with all the claims handling requirements for ANFs, and with the majority of the requirements for full claims.

The MAA auditors found that all insurers were paying reasonable and necessary medical expenses up to $500 for ANFs as required by the guidelines with many insurers routinely making payments up to $1000. Payments in excess of $500 were made where the insurer considered that the ANF could be finalised by making the additional medical payments and thus alleviating the need for some claimants from pursuing full claims.

The audit results also indicated that insurers were complying with the majority of claims handling requirements for full claims which included making prompt requests for police reports (3.3.1) and, once liability was admitted, making prompt payments for hospital, medical, respite & attendant care, rehabilitation & pharmaceutical expenses (5.1.a).

However, some important claims handling requirements for full claims had high levels of non-compliance across the industry as indicated by the median levels of %non-compliance. The MAA auditors considered that, as a general guide, non-compliance levels for an individual insurer were high when they exceeded 10% of the audit sample as this may indicate high levels of non-compliance across the insurer's entire claims handling portfolio.

The following practices by insurers resulted in high industry levels of non-compliance with the applicable claims handling requirement: making late determinations of liability (3.4.1); slow requesting of medical evidence (3.8.1); late acknowledgement of receipt of claim (3.2.1.a); not providing treating doctors' reports to claimants (3.8.2.e); and making unnecessary requests for information (3.7).

The highest levels of non-compliance for the above requirements were not confined to one or two insurers, but were spread across all of the insurers audited. These non-compliances often related to an insurer not acting within a specified time limit. It should be noted that a non-compliance was recorded against an insurer regardless of the amount of time by which the insurer exceeded the time limit. For example, requirement 3.4.1 was assessed as a non-compliance if liability for a claim was determined one day after the 3 month time limit had elapsed following proper notice of a claim.

One insurer had a high level of non-compliance (18%) with requirement 7.2 relating to making reasonable offers of settlement. This occurred as a result of the insurer failing to make an offer of settlement within the specified time limit – it was not that the MAA auditors considered the offer as being unreasonable.

5.1.2 Compliance Self-Reports by Insurers

Since the establishment of the MAA's Compliance Unit in April 2001, the licensed CTP insurers have generally co-operated with the Compliance Unit's recommendations and responded in a timely manner to requests for information and the provision of statutory reports.

All the insurers prepared an annual self-assessment report to the MAA on their compliance with the Guidelines (Guidelines requirement 10.1.1). These reports were submitted in January 2002 and covered the 2001 calendar year. The insurers completed a template table supplied by the MAA consisting of 27 of the Claims Handling Guidelines requirements listed in Tables 1 and 2. Whilst all insurers made a considerable effort in completing their self-assessments of compliance, it was noted that most insurers had not described the methodology used to make their assessments. In addition, the assessments of compliance were variable in the manner in which they were reported, ranging from semi-quantitative (eg. partially complied) through to quantitative (eg. 88% Compliance) assessments.

The MAA auditors determined the percentage of the 27 requirements for which there was an acceptable correlation between compliance assessments made by each insurer and the MAA. The extent of the correlation for each insurer is not a measure of compliance performance, rather it is an indicator of the reliability of the insurer's self-assessments of compliance. The percentage of compliance assessments with an acceptable correlation was determined for each insurer, and ranged from a minimum of 65% to a maximum of 85% across the industry.

All insurers complied with Guidelines requirement 9.1.8 by providing the MAA with a 6-monthly report on complaints and outcomes. Each insurer's complaint summary report for the 6-month period ending 30 June 2002 was compared with the MAA complaint database for accuracy and completeness. The insurers' complaint summary reports were generally complete and accurate, and complaints were generally being resolved to the MAA's satisfaction and in a timely fashion.

However, one insurer's complaint summary report did not include all the complaints that had been referred to it by the MAA. The insurer subsequently provided to the MAA an updated report that was complete and accurate. Another insurer did not include old Act complaints in its report although it wasn't clear from the Guidelines whether this was a requirement. The MAA advised the insurer that it would address this issue in its review of the Claims Handling Guidelines.

Recommendation 1: MAA to Conduct Further Compliance Monitoring and Assessment

It is recommended that ongoing monitoring be conducted of insurers' compliance with the claims handling guidelines.

Monitoring will include:

- reauditing the insurers' compliance with their claims handling requirements in 2003;
- comparing the audit results with the baseline results obtained for each insurer and the industry in 2002;
- analysing the insurers' compliance self-reports;
- reviewing the insurers' complaint summary reports;
- reviewing information relating to claims handling compliance and performance from insurer surveys and claimants surveys.

The next audit sample could also include sub-samples of mature and recent claims to monitor the effectiveness of any claims handling changes that may have been implemented by an insurer.

5.2 Adequacy of Claims Handing Requirements

Some insurers expressed concern to the MAA auditors that some Guidelines requirements with time limits had been set at maximum performance levels. For example, to comply with Guidelines requirement 3.2.1.a an insurer must acknowledge receipt of a claim within 5 working days. The MAA auditors accept that this particular timeframe sets a high performance standard rather than a minimum compliance standard.

The MAA auditors also noted that some of the Guidelines requirements were not clearly expressed or may not be achieving the best outcomes for claimants. For example, Requirement 4.1 is silent on whether an insurer may send courtesy copies of correspondence to a claimant's solicitor directly to the claimant.

Notwithstanding the difficulties insurers have experienced trying to comply with some of the guidelines, it should be noted from Tables 1 and 2 that for each requirement at least one insurer had a level of non-compliance less than 10%. Indeed in most cases the median level of non-compliance was 0%, indicating that most of the Guidelines requirements are achievable.

Recommendation 2: MAA to review the Claims Handling Guidelines

It is recommended that the MAA conduct a review of the Claims Handling Guidelines.

The purpose of the review will be to ensure Guidelines requirements are clearly expressed and will help to achieve appropriate outcomes for claimants and the Motor Accidents Scheme.

The review of the Claims Handling Guidelines is currently underway. The MAA has asked the insurers to rank the significance of each claims handling requirement. The insurers have also been requested to submit recommendations for any changes, deletion or additions to the Claims Handling Guidelines.

5.3 Promotion of Appropriate Claims Handling Outcomes

In order to promote continuous improvement in insurers' compliance with the guidelines the MAA will document its regulatory and enforcement policy. The policy will allow the insurers flexibility for innovative claims management to ensure appropriate outcomes are achieved for claimants.

Recommendation 3: MAA to develop a Regulatory and Enforcement Policy

It is recommended that the MAA document its regulatory and enforcement policy for dealing with non-compliances, which will provide insurers consistency and certainty regarding action that will be taken by the regulator for any breaches.

5.4 Expeditious Resolution of Claims

It was observed by the MAA auditors that some insurers could have been more proactive in their endeavours to resolve claims (see Further Observations in Section 4). The same was also noted for some claimant solicitors who had not responded to insurer requests for further and better particulars or offers of settlement.

Recommendation 4: MAA to Explore Ways to Expedite the Resolution of Claims

It is recommended that the MAA explore ways of promoting the just and expeditious resolution of claims as required by Section 80 of the Act. This may include:

- conducting surveys of scheme participants;
- developing new claims handling or medical assessment guidelines; and
- conducting a performance review of claims handling.

MOTOR ACCIDENTS AUTHORITY
REPORT TO THE LAW AND JUSTICE COMMITTEE
NOVEMBER 2002

Scheme performance indicators

In evidence to the Legislative Council's Standing Committee on Law and Justice in May 2000, the MAA identified four scheme performance indicators. Each of the performance indicators is addressed in this section based on the operation of the Motor Accidents Compensation Act 1999 since it started on 5 October 1999, to the end of September 2002. The four scheme performance indicators are affordability, effectiveness, fairness and efficiency.

Affordability

The affordability of Green Slips prices has improved according to three measures:

- Average premiums
- Ratio of premiums to average weekly earnings
- Price paid by the majority of Sydney metropolitan passenger vehicle owners.

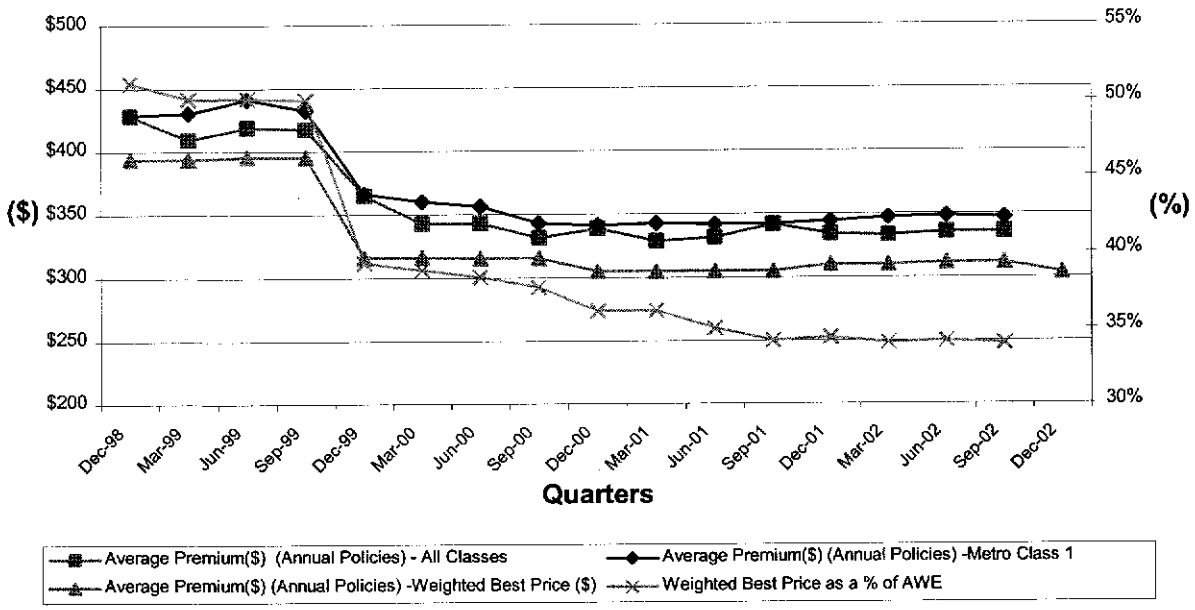
Average premium
The average premium for a Sydney metropolitan passenger vehicle dropped from $441 in June 1999 to $341 in December 2000 increasing to $347 (excluding GST) in September 2002. The average annual premium over all vehicle classes in NSW has dropped from $419 in June 1999 to $336 in September 2002.

Premiums and Average Weekly Earnings
The price of a Green Slip premium has dropped while average weekly earnings have increased. As a proportion of average weekly earnings, weighted best price has dropped from 50% before the reforms to 34% in September 2002.

Premiums reduce for most vehicle owners
At September 2002, more than 70% of owners of metropolitan passenger vehicles paid $318 or less (excluding GST) for a Green Slip.

For the first year after the commencement of the legislation, the MAA had the power to reject a premium if the MAA 'was not satisfied ... that the majority of policies relating to passenger motor vehicles in metropolitan areas will attract a premium of not more than approximately $330'. In the first year of the scheme, more than 70% of premiums for metropolitan passenger vehicles were $330 or less. The $330 mark has now dropped to $318 and is expected to drop further still.

Average Premiums



Effectiveness

To measure scheme effectiveness the experience of the first three years of the new scheme is compared with the last three years of the old scheme at the corresponding point of development.

Number of claims and time periods

		Old scheme	New scheme	% difference
Number of notifications	ANFs		17,654	
	Direct full claims		23,217	
	Converted ANFs		8,804	
	Full claims		32,021	
	Total notifications	40,834	40,871	0.1%
Average time to notification (days)	ANFs		25.5	
	Full claims	113.6	100.8	-11.2%
	Total notifications	113.6	84.5	-25.6%
Average time to liability decision (days)	Full claims	125.0	96.6	-22.7%
Average time to first payment to claimant (days)	ANFs		41.8	
	Total notifications	171.6	98.1	-42.9%
Finalisations	Full claims	15,383 (37.7%)	12,308 (38.4%)	
	Total notifications	15,383 (37.7%)	19,536 (47.8%)	27.0%
Average time to finalisation (days)	ANFs		156.2	
	Full claims	350.4	350.6	0.1%
	Total notifications	350.4	280.1	-20%