



Banc Ceannais na hÉireann
Central Bank of Ireland

Eurosystem

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Re: Themed Inspection into Household Property (Water Damage) Claims

Dear CEO

During 2013 the Central Bank of Ireland (“the Bank”) undertook a themed inspection in relation to the processing by non-life insurance companies of household property claims where damage had been caused by water. The purpose of this letter is to provide you with general feedback in relation to the findings of the themed inspection and we hope that it will be of assistance to you in developing and ensuring your own firm’s compliance. It is important that you consider the issues set out below and their relevance to your firm. Firm specific feedback will be issued in a separate letter to the insurers inspected.

We would like to take this opportunity to thank you for your co-operation in relation to this inspection and advise that due to a number of queries on the interpretation of the Consumer Protection Code (the Code), received during the inspection we have included some clarifications of the Claims Processing provisions in Chapter 7 of the Code in the appendix to this letter.

Initially, the Bank identified 10 insurers (approximately 90% of the Irish property insurance market) for onsite inspection and each of the insurers was requested to submit policy booklets, claim procedures and information regarding claims that were notified by consumers during the period 1 July - 31 December 2012 (“the review period”).



Desk Top Analysis Findings

An analysis of the household building and contents policy booklets, household property claim procedures and other information provided by the 10 insurers revealed the following findings:

- Each insurer had one or more household building and contents policy booklets in current circulation, of which:
 - It was considered that some of the household building and contents policy booklets contained terms and conditions that may not be fair or transparent to the consumer;
 - It was also considered that some of the household building and contents policy booklets contained language that was not considered to be in plain English;
 - The practice of retention was mentioned in only one insurer's policy booklet.
- All of the insurers had written household property claim procedures, as well as a procedure for catastrophic claim events.
- During the review period of 1 July to 31 December 2012, insurers were notified of a total of 11,847 household property claims where damage had been caused by water.

On-site Claim File Examination Findings

The Bank undertook 7 on-site inspections at selected insurers between April and June 2013, during which a total of 188 claim files were reviewed, and the main findings were as follows:

➤ Outsourcing

General Principle 2.10 in Chapter 2 of the Code requires a regulated entity to ensure that in all its dealings with customers and within the context of its authorisation it:

“Ensures that any outsourced activity complies with the requirements of this Code”



The Bank is concerned that a high percentage of suspected Code breaches were committed by outsourced service providers (loss adjusters). This points to insurers having ineffective controls and inadequate quality assurance monitoring of their outsourced claims processing activities. This was particularly evident from the review of the letters that outsourced service providers issued to consumers on first making contact. For example, the potential for misleading consumers by not making it clear that the outsourced service provider was acting in the insurers' interest, and that the consumer may engage, at their own expense, a loss assessor / expert appraiser to act on their behalf. Since drawing this lack of transparency to the attention of insurers, the Bank is aware that some of the insurers have already undertaken remedial action with their appointed outsource service providers.

Service level agreements held between insurers and outsourced service providers, (in this instance loss adjuster firms settling claims), must clearly identify all relevant provisions of the Code and the relevant requirements of the Minimum Competency Code 2011 (MCC) that the outsourced service provider is required to comply with, as well as identifying that appropriate training on the Code will be provided to the outsourced service providers by the insurer.

The Bank also expects insurers to have robust consumer protection quality assurance checks in place which are qualitative, quantitative and frequent.

Insurers that were found to have inadequate controls over the outsourcing of claims handling will be required to undertake a review of the oversight and controls they have in place. In this regard, the Bank will write to each of the insurers individually.

The Bank strongly recommends that all other insurers review their oversight and controls they have outsourced activities to ensure compliance with the Code.



The Bank will hold insurers responsible for any breaches of the Code by a person to whom the insurer has outsourced an activity.

➤ **Suspected Code Breaches**

The claim file review revealed a significant volume of suspected breaches of the Code, the majority of which had a minor impact on consumers. It is particularly disappointing that a high percentage of the identified breaches were committed by outsourced service providers who had been appointed by insurers to settle claims.

Among the suspected breaches of the Code identified were the following:

- Isolated instances of suspected unfair claim settlement offers being made and also unfair claim settlements being made. In one particular claim, it was noted that there were two separate instances of a proposed draft settlement offer being provided to the claimant before “*all relevant factors had been taken into account*” and did not represent “*the insurer’s best estimate of the claimant’s reasonable entitlement under the policy*” (Provision 7.15 of the Code).

The Bank is following up with the insurers in question but would emphasise to all insurers that this practice is not in compliance with Provision 7.15 of the Code.

- Failure to provide additional assistance to consumers in the making of a claim where the regulated entity has identified that the personal consumer is a vulnerable consumer (Provisions 3.1 and 7.7 d of the Code)
- Insufficient record keeping by outsourced entities throughout the claim process, and in particular when claim settlement offers are made (Provision 11.5 of the Code)
- Failure to discharge claims within 10 business days of a settlement offer being accepted (Provision 7.18 of Code)



- Failure to record complaints that were made during the claims process (Provision 10.9 of the Code)
- Isolated instances of a failure to act in the best interest of consumers at all times, including alerting the claimant to policy terms and conditions that may be of benefit to the claimant (Provisions 2.1 and 7.7 d of the Code)

➤ **Transparency and Consumer Awareness**

The Bank requested the 7 insurers who had an on-site inspection visit to provide further details of all household property claim notifications.

The statistical data provided by the 7 insurers revealed the following information for a 12 month period to 31 December 2012:

- 24,629 claims were notified
- 3,618¹ were declined by insurers (15%)
- 6,436 were subsequently withdrawn by the claimants (26%)

The Bank is concerned that these statistics may indicate that consumers were not aware of the features of the product they have purchased, e.g. the exclusions to the policy, or that a combination of incurring a policy excess of up to €1,000 and the loss of no claims bonus may have exceeded the value of the claim. Of equal concern to the Bank is that some of the insurers do not capture the reasons why claims are declined or withdrawn and those insurers that do capture the reasons do not undertake any trend analysis to identify any potential improvements in product design or communications. The Bank expects insurers to capture and analyse data that has consumer significance.

¹ The most common reasons for insurers declining claims were no insured peril or wear and tear.



The Bank also considered that policy booklets contained a number of terms and conditions that may not be fair or transparent to consumers, and therefore insurers have been requested to review aspects of their respective policy booklets. These issues are being raised with the individual insurers and we note that some insurers have already taken corrective action.

➤ **Retentions**

Data received on the claim settlements notified during the period 1 January 2012 and 31 December 2012 indicated that 23% of the monetary amount of retentions were never claimed. Insurers contend that the practice of retentions is, among other matters, intended to prevent fraud.

It was noted in most of the claim files reviewed that insurers had applied a retention amount against a claim settlement offer, which in the vast majority of instances was 30% of the settlement offer amount. With the exception of one insurer, the first occasion that insurers inform a claimant of a retention amount is at the settlement offer stage. The Bank also noted that some insurers were closing claims before the retention period had expired and that reminders were not issued to claimants in every instance that a retention amount had been applied.

The Bank expects insurers to be transparent with consumers about the practice of retentions at the commencement of a home insurance contract, including mention of the practice in the insurer's respective policy booklet and also at the claim notification point. Insurers should make all reasonable efforts to ensure that claimants are reminded that a retention was made on their claim.

The practice of retentions raises issues that the Central Bank intends to further engage with the industry on, to ensure the best interests of consumers are protected.



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The Bank is considering enforcement actions in respect of a number of insurers concerning the findings of this themed inspection and the insurers concerned will be contacted in due course.

It is appreciated that not all of the issues referred to in this letter may be applicable to your institution. These findings should be brought to the attention of your Compliance Officer and Internal Audit and we would expect that they are incorporated into the review of your institution's compliance with the Code.

Should you have any queries in relation to the contents of this letter, please contact Kevin Stabb at kevin.stabb@centralbank.ie or Fiona Daly at fiona.daly@centralbank.ie.

Yours sincerely

Mick Stewart
Deputy Head of Consumer Protection
Banking, Insurance, Investments & Policy Division



APPENDIX

CODE CLARIFICATION

During the on-site inspection visits a number of Code interpretation queries were highlighted in relation to the Claims Processing provisions in Chapter 7 of the Code, and the following are a summary of these:

- *Provision 7.7 e) - a record must be maintained of all conversations with the claimant in relation to the claim.*

This provision requires that a record must be maintained of all conversations between a regulated entity, or a regulated entity's third party representative, with the claimant or the claimant's third party representative.

- *Provision 7.11 - at the claimant's request and with the claimant's written consent, a regulated entity must engage with a third party which a claimant has appointed to act on his or her behalf in relation to a claim.*

This provision applies to any third party appointed by the claimant to act on his/her behalf in relation to the claim and would include family, friends, neighbours etc., as well as professional parties such as public loss assessors or solicitors.

- *Provision 7.16 - a regulated must, within ten business days of making a decision in respect of a claim, inform the claimant on paper, on paper or on another durable medium, of the outcome of the investigation explaining the terms of any offer of settlement.*

The terms of an offer include details of any retention amount that is applied to a claim settlement, and the time period in which the retention will be held for.

- *Provision 7.17 - a regulated entity must allow a claimant at least ten business days to accept or reject and offer.*



The intention of this provision is that a claimant shall be advised of the ten business day consideration period at the same time as a claim settlement offer is made and not at the time when the claim payment is made. While this provision does not specify the manner in which the regulated entity should inform the claimant of the time period to accept or reject the offer, the Bank expects insurers to be able to demonstrate evidence of compliance with this provision, in accordance with provision 11.10 of the Code

- *Provision 7.18 - the regulated entity must discharge the claim within ten business days from the date the claimant has agreed to accept the offer.*

This provision would also include any payments that the claimant is entitled to receive under the claim settlement agreement, e.g. retention payments.

- *Provision 7.19 - if a regulated entity decides to decline the claim, the reasons for that decision must be provided to the claimant on paper or on another durable medium.*

While this provision refers specifically to the reasons that a claim is declined, the Bank expects insurers to link the reason for declining a claim to the terms and conditions of the policy, e.g. the policy booklet, policy schedule, etc.

- *Claim Complaints* - a number of insurers asked for clarity about complaints that are made during the negotiating period of a claim settlement. For example, if a claimant registers dissatisfaction at the claim settlement amount that is being offered the insurer need only treat it as a complaint once the negotiations on the settlement offer have been completed and if the consumer is not satisfied with the outcome. This should then be handled in accordance with the complaints procedure of the firm and recorded in the complaints log.