Banc Ceannais na hÉireann
Central Bank of Ireland
Eurosystem

T +353 1 224 6000 F +353 1 671 6561

Bosca OP 559, Sráid an Dáma, Baile Átha Cliath 2, Éire.
PO Box No. 559, Dame Street, Dublin 2, Ireland.

www.centralbank.ie

28 February 2017

Re: Thematic Inspection of Motor Damage Claims Processing

Dear CEO

The Consumer Protection Outlook Report, published in February 2016, set out the Central Bank of Ireland's (the "Central Bank") assessment of key existing and emerging risks to consumers, and listed priority themes for the industry and the Central Bank. In relation to providers of general insurance specifically, the Central Bank highlighted a risk in relation to claims handling and settlement. Conscious that insurers are facing a number of challenges in relation to underwriting, claims and profitability, it is essential that any cost-cutting measures are not at the expense of basic customer service, especially in the field of insurance claims, where consumers have already paid for that service through their premiums.

Insurers' handling of motor damage claims within the general insurance market was selected as a priority theme to further assess the risks outlined above. The Central Bank undertook a thematic inspection to assess insurers' compliance with the claims processing requirements of Chapter 7 of the Consumer Protection Code 2012 (the "Code"). This supervisory work was supported by consumer research, which was undertaken to better understand consumers' experience and overall satisfaction with the claims process, from the initial contact with their insurance providers through to the settlement (or not) of their claim. Key findings from the research are summarised in **Appendix 1** of this letter.

The inspection found that all of the insurance providers inspected have procedures and processes in place to ensure compliance with these requirements, and that while generally firms are meeting the required standards, a number of areas have been identified where firms need to improve. This is supported by the findings of the consumer research, which showed that while 74% of claimants agreed that the claims process is carried out fairly by the insurance company, when prompted on specific issues, 53% of claimants said they were dissatisfied with some aspect of the claims process. As a result, the Central Bank is requiring the inspected motor insurers to strengthen their claims processes in order to improve the customer experience of claimants. The purpose of this letter is to provide the wider industry with feedback in relation to the findings of the thematic inspection, which all insurers should now assess in the context of their motor damage claims handling processes.

Findings

The inspection consisted of a desk-based review of 16 providers of motor insurance to Irish consumers, followed by on-site inspections in five of these firms. It was noted that settlement offers for written off vehicles were fair and included an adequate analysis of the second hand car sales market. Additionally, all inspected insurers had a consistent approach to training of new claims staff and on-going supervision of all claims staff, and had a quality assurance programme in place which involved assessing claim files and monitoring consumer telephone calls to ensure compliance with the Code. The Central Bank considers this to be a positive practice to further strengthen the control environment and help deliver a better customer experience for claimants. The areas of particular concern which were identified are as follows:

1. **Policyholders were not informed of settlements paid to third party claimants**

   In three firms, instances were identified where policyholders were not informed at the time of a claim settlement, on paper or on another durable medium, of the details regarding a settlement made with a third party claimant, as required by Provision 7.21 of the Code (see **Appendix 2**). It is important that claimants are informed of settlements paid to third party claimants at the time of claim settlement, so that they are made aware of how their policy may be affected in the future, e.g. impact on no claims bonus, altered contract terms and changes to premium.

2. **Lengthy process to decide on a declined claim**

Provision 7.7 of the Code requires firms to have in place a written procedure for the effective and proper handling of claims. The average time taken to decide on declined claims was up to four weeks. In some cases, it took up to 16 weeks to inform the claimant of the decision to decline a claim, even though the insurers had all the necessary information and documentation to decline the claim much earlier in the process. This was primarily the result of the firms' internal governance arrangements. Consequently, some claimants were without the use of their cars for extended periods of time. The Central Bank requires all insurers to review their declinature process to ensure that claimants are informed at the earliest opportunity that their claim has either been accepted or declined.

3. **Claimants were not always provided with relevant contact details**

In numerous instances, claimants were not informed of the contact details of the insurer's independent claims assessor and / or expert appraiser appointed to examine the damaged vehicle as required by Provision 7.9 of the Code, and the subsequent guidance issued in December 2012 (see **Appendix 2**).

4. **Settlement payments were not paid within 10 business days**

Where a claimant had agreed to accept a settlement offer, the settlement payment was not always made within 10 business days as required by Provision 7.18 of the Code (see **Appendix 2**). Where a settlement payment is paid outside of the 10 business days' requirement, it delays the claimant's ability to use the payment to restore their vehicle to its pre-accident position.

5. **Numerous claims handlers dealing with a single claim**

It was noted that in many cases, claims were handled by more than one claims handler and in some instances, claimants had to initiate contact with their insurer on more than one occasion to get an update on the status of their claim. This can result in a claim taking longer to process, thereby delaying restoration of the claimant to their pre-accident position, and a poorer customer experience overall. While the Central Bank acknowledges that a specific claims handler

may not always be available, firms should review this aspect of their claims process to ensure a better customer experience for claimants.

6. **Complainants were not given the opportunity to use the insurer's complaints procedure**

In a number of instances where claims handlers had verbally dealt with complaints made by claimants during the claims process, claims handlers had not complied with Provision 10.8 of the Code (see **Appendix 2**) by failing to:

- offer the complainant an opportunity to have their complaint investigated through the insurer's complaints procedure; or
- make a note on the claim file that the complainant had been given the opportunity to have their complaint investigated.

The Central Bank is concerned that this practice may result in legitimate complaints not being properly addressed, to the detriment of the claimant.

7. **Claimants were not always provided with a scope of works**

Claimants, who chose to have repairs carried out by an approved repairer of their insurer, were not always provided with details of the repairs to be undertaken as part of the claim settlement offer, i.e. the scope of the repairs, on paper or on another durable medium, as per Provision 7.16 of the Code (see **Appendix 2**). Some insurers had relied on the approved repairer to provide the claimant with a copy of the scope of repairs to be completed, but the insurers had not maintained a copy of same on the claim file as per Provision 11.5 c) of the Code (see **Appendix 2**). It is important that claimants are provided with a scope of works in order to have a record of the specific repairs made to their car, so that in the event of any problems arising from the repair at a later date, the scope of works will enable them to have the work verified.

Next Steps

Firms are required to consider the issues identified in this letter and the findings from the Central Bank's consumer research, in the context of their own governance and business processes and procedures, and to take all remedial action necessary to ensure that they are acting in the best interests of claimants. The Central Bank expects that this letter will be discussed and minuted at the

firm's next board meeting. Additionally, the Central Bank is engaging directly with those firms where issues have arisen. Formal supervisory requirements, with specific timelines for remediation are being imposed on those insurers where areas of concern were identified. The Central Bank will have regard to contents of this letter when conducting future supervisory engagements.

Should you have any queries in relation to the contents of this letter, please contact Kevin Stabb at kevin.stabb@centralbank.ie or Christine Evans at christine.evans@centralbank.ie

Yours sincerely

Pat Sage
Head of Function
Consumer Protection: Supervision Division

Appendix 1

Key Findings from Research

The consumer research found that, of the claimants surveyed:

- 74% agreed that the claims process is carried out fairly by the insurance company;
- The majority of claimants (89%) found the overall process of reporting the damage to their car relatively easy;
- Those claimants with just one person handling their claim were more satisfied: 75% of claimants with just one person handling their claim reported high levels of overall satisfaction, compared to 32% of claimants with more than one person handling their claim;
- 77% of claimants, whose claims were accepted, reported that they were satisfied with the settlement offered;
- 23% of claimants, whose claims were accepted, said the insurance provider did not inform them about how the settlement of the claim would impact on their no-claims bonus;
- Only 28% of claimants, whose cars were repairable, said that they were informed that they could appoint their own loss assessor;
- 53% of claimants surveyed said, when prompted, that they were dissatisfied with some aspect of the motor claims process. However, less than half (43%) of these claimants said they informed the insurer of their dissatisfaction.

Appendix 2

Code Provisions

Item 1 - Provision 7.16 of the Claims Processing section in Chapter 7 of the Code:

"A regulated entity must, within ten working days of making a decision in respect of a claim, inform the claimant, on paper or on another durable medium, of the outcome of the investigation explaining the terms of the offer of settlement. When making an offer of settlement, the regulated entity must ensure that the following conditions have been satisfied:

a) The insured event has been proven, or accepted by the regulated entity;

b) All specified documentation has been received by the regulated entity from the claimant, and

c) The entitlement of the claimant to receive payment under the policy has been established."

Item 2 - Provision 7.9 of the Claims Processing section in Chapter 7 of the Code:

"Where a regulated entity engages the services of a loss adjustor and / or expert appraiser it must notify the claimant of the contact details of the loss adjuster and / or expert appraiser it has appointed to assist in the processing of the claim and that such loss adjustor and / or expert appraiser acts in the interest of the regulated entity and the regulated entity must maintain a record of this notification."

Guidance issued in December 2012:

"5.4 Clarification regarding loss adjustors and expert appraisers:

For the purpose of provision 7.9, loss adjustors and/or expert appraisers are viewed as independent professionals who provide a service to regulated entities when assessing a claim."

Item 3 - Provision 10.8 of the Errors and Complaints Resolution section in Chapter 10 of the Code:

"Where a regulated entity receives an oral complaint, it must offer the consumer the opportunity to have this handled in accordance with the regulated entity's complaints procedure."

Item 4 - Provision 7.21 of the Claims Processing section in Chapter 7 of the Code:

"Where the policyholder who is a consumer is not the beneficiary of the settlement the policyholder must be advised, on paper or on another durable medium, by the regulated entity, at the time that settlement is made, of the claim final outcome of the claim including the details of the settlement. Where applicable, the policyholder must be informed that the settlement of the claim will affect future insurance contracts of that type."

Item 5 - Provision 7.18 of the Claims Processing section in Chapter 7 of the Code:

*"Where a **claimant** has agreed to accept the offer made by the **regulated entity** to settle a claim, the **regulated entity** must discharge the claim within ten **business days** from the date the **claimant** has agreed to accept the offer, once the appropriate amount has been agreed subject to finalisation of legal costs, where applicable."*