保險業監管局
Insurance Authority

CONDUCT IN FOCUS

SPECIAL SUPPLEMENT ◆ MAY 2023

Regulatory focus on Claims Handling

Inside this special supplement:

An authorized insurer's responsibility to handle and settle insurance claims fairly and promptly

Handling and settling claims under insurance policies is integral to the conduct of insurance business. Indeed, for policyholders, being able to obtain reimbursement for losses incurred under the insurance policies they purchase is the very purpose of buying insurance.

Efficient and expeditious claims handling can, therefore, enhance an insurer's reputation in the eyes of the policyholders it serves. Poor claims handling, by contrast, through unjustified delays or inadequate explanations on claim decisions has the opposite effect and serves to erode the trust on which the insurance market must be founded.

The insurance regulatory framework in Hong Kong sets minimum principles and requirements for claims handling by authorized insurers with the objective of ensuring policyholders are treated fairly and their interests are protected in the claims handling process. In this article we explain these regulatory principles and standards. Then in the next article (on page 3), with a specific focus on medical insurance claims, we provide guidance on what the Insurance Authority ("IA") will look for in its inspection and supervision work to evaluate whether an insurer is satisfying these requirements in its claims handling practices as part of the conduct of its insurance business.

Regulatory requirements on the conduct of claims handling

When handling and settling claims under insurance policies, insurers must abide by the following principles and standards set out in Guidelines issued by the IA:

1. **Handling claims fairly and promptly** – When dealing with claims from policyholders an authorized insurer must handle and settle claims **fairly and promptly**. Whilst this principle is expressly stated in Section 7 of "Guideline on Medical Insurance Business, Guideline 31" ("GL31") it is one which has broad application to all claims handling in all lines of insurance business.

2. **Transparency and guidance** – An authorized insurer must provide policyholders with sufficient information and timely advice about the claims-handling process and clear explanations in plain language on claim results. This means that:

   - firstly, an authorized insurer must provide reasonable guidance to assist a policyholder in making a claim.
   - secondly, an authorized insurer should provide appropriate information to the policyholder on the progress of the claim assessment; and
   - thirdly, an authorized insurer should provide adequate and clear explanation of the claim decision.

   (Section 7 of GL31 and the accompanying Frequently Asked Questions issued by the IA).

3. **Robust corporate governance, policies and procedures** – An authorized insurer should have in place proper policies and procedures regarding settlement of insurance claims in order to ensure that it discharges its obligations in 1) and 2) above so that its policyholders are **treated fairly in the claims handling process**. (Section 10 of the IA's "Guideline on Corporate Governance of Authorized Insurers, Guideline 10" ("GL10")).

In applying these principles, it is recognized that an insurance policy is a contract and an insurer is obliged to pay claims in accordance with the terms and conditions of that contract. Of necessity, therefore, the claims handling process requires the insurer to have a reasonable opportunity to assess the claim and verify that it is payable under the terms and conditions of the insurance policy, and how much is payable. The onus is on the insurer to conduct its claims assessment efficiently and expeditiously to ensure that a decision on the claim can be made promptly so policyholders have certainty on whether the claim is covered within a reasonable timeframe and the amount that is to be paid. Further, the insurer must carry out the assessment fairly, only asking for sufficient (and not excessive) information that is necessary for it to assess the claim and it must assess the claim in an impartial and objective manner.

The principles and standards in the insurance regulatory framework seek to draw a balance between an insurer's need to collect sufficient information so it only pays claims within the scope of coverage, whilst at the same time ensuring that the process is clear to policyholders, promptly carried out and objectively (and fairly) completed.

The efficiency and speed at which an insurer settles claims (and the number of claims it pays versus those it rejects) is often a factor that sets the reputation of the insurer (and the insurance market as a whole). It is imperative, therefore, that all authorized insurers ensure their claims handling processes maintain the appropriate balance between assessment and promptness of claims decision so that policyholders are treated fairly in the claims handling process in line with the applicable regulatory principles.

Handling of medical insurance claims – The IA's expectations

In this article we set out the types of practices that the IA would expect to see when assessing the claims handling processes of an insurer in its inspection and conduct supervision work, against the principles and standards in the insurance regulatory framework.

Recognizing that claims under different lines of business may require different practices, the practices set out below focus on the handling of medical insurance claims. The best practices cited emerge from our observations in our complaints handling and supervision work and also take account of the Insurance Core Principles ("ICP") promulgated by the International Association of Insurance Supervisors. ICP 19.10, which requires insurers to handle claims in a timely, fair and transparent manner, is particularly relevant in this respect, as it is from this that the principles and standards on claims handling in the IA's Guidelines are drawn:

1. An authorized insurer should establish documented claims handling procedures with indicative time periods for handling claims

Insurers should document their claims handling procedures, setting out all steps that need to be taken from the claim submission to its final settlement and payment. As best practice, these procedures should include timeframes for each of the steps in the claims handling process and the overall handling of the claim. When the insurer is seeking information from medical providers or any other party, it should have set time periods to follow up responses (if a response is outstanding). Claims settlement authorities for claims handlers should be established, documented and periodically reviewed so that a claims handler's decision-making authority reflects his/her requisite experience and technical expertise.

Monitoring processes should be established against the timeframes which the insurer sets for the steps in the claims handling process, with alerts or escalation to claims personnel with higher authority when the timeframes are exceeded. This enables focus to be put on claims which go beyond the pre-set timeframes, so that the insurer can assess whether the longer period for handling the claim is justified, and what can be done to expedite matters.

2. An authorized insurer should provide policyholders with clear guidance on what information needs to be submitted when making a claim

Insurers should provide clear guidance to policyholders on what information needs to be submitted when making a claim under an insurance policy and clearly state within what period of time the claim should be submitted to the insurer. This may, for example, include providing guidance notes/checklists as part of the claim form. This information should also be published in an easily accessible part of the insurer's website. Best practice would also be for insurers to publish expected timeframes for claims settlement, albeit insurers may manage policyholder expectations by indicating that the actual time required to handle claims may be dependent on the complexity of the claim, the completeness of the information submitted and the timeliness of responses from relevant parties (e.g., medical providers).

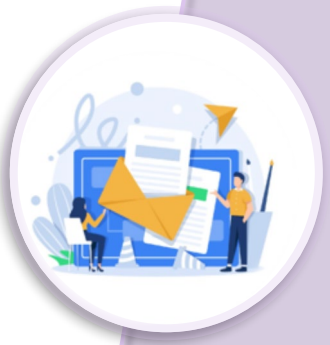
3. An authorized insurer should ensure its claims handling processes and assessments are fair

It is a basic principle of insurance contract law that the burden lies with the policyholder when submitting a claim, to prove that the loss being claimed has occurred and was caused by a risk insured under the policy. However, once the policyholder has established the issues of loss and causation by a risk insured (for example, with the receipts for the costs incurred for the medical treatment and the diagnosis of the condition covered under the policy which has given rise to the treatment), the burden of proof shifts to the insurer. This means the insurer must pay the claim in accordance with the terms and conditions of the policy unless it can legitimately establish that the claim falls within one of the exclusions in the policy or should otherwise not be paid under the policy.

In practice, when an insurer assesses a claim and is reviewing the medical documents, it will be looking to ascertain that the loss is indeed caused by the risk(s) insured under the policy and that none of the exclusions apply. If an insurer is seeking to rely on an exclusion clause to exclude a claim, *it must get on with it*. If there is no indication in the medical information or the circumstances of the claim that an exclusion might apply, the insurer's enquiries should stop there (as any further requests may be unreasonable or oppressive).

Claims handlers must be objective and impartial in their assessment and base their review solely on reviewing relevant information provided against the policy terms and conditions and not pay heed to irrelevant factors (such as achieving loss ratio targets against which performance may be being measured). Handling claims fairly, means assessing the amount that needs to be paid under the terms and conditions of the policy in a way which is fair (and not biased in favour of the insurer). Further, insurers should ensure that judgements on information that require medical expertise, are based on opinion sought from properly qualified persons (such as a Chief Medical Officer or persons with medical background/experience).

4. An authorized insurer should provide regular periodic updates to claimants



After a claim has been made, an insurer should firstly acknowledge receipt as soon as practicable (if not immediately) and thereafter, in the course of its handling of the claim, provide updates on the status of the claim to the policyholder in a timely manner and within set periods until the claim is settled. If the process is longer than the indicative timelines published by the insurer, such updates should indicate the reasons for this and, if possible, should indicate the expected timing of a decision.

Insurers should provide such updates to the policyholder directly. For example, many insurers provide e-portal accounts to policyholders through which they can submit and monitor claims progress and give updates or feedback on claims quickly.

5. An authorized insurer should have in place proper arrangements with its appointed licensed insurance agents and licensed insurance brokers clearly setting out their roles in the claims process

Whilst insurers should seek to update its policyholders directly on claims, an insurer may also wish its appointed licensed insurance agents to assist policyholders during the claims process. For example, an insurer may expect (as an additional, but not exclusive, means of communication) to provide updates which are sent to policyholders, to the servicing agents in its appointed insurance agency force who can assist in discussing the claim with the policyholder and advising the policyholder on the insurer's claims process. Where an insurer requires members of its appointed agency force to perform this type of role in the claims handling process, it must provide its agents with adequate training and ongoing support (such as through claims clinics and claims hotlines).

Unlike licensed insurance agents, licensed insurance brokers represent the policyholders in placing, arranging and servicing insurance policies. As such, the obligations of a licensed insurance broker in the claims handling process are dictated by the scope of services in the broker company's client agreement with the policyholders they represent. Per Standard and Practice 3.7 in the Code of Conduct for Licensed Insurance Brokers, unless otherwise stated in the client agreement, a licensed insurance broker should (where requested by the policyholder) provide the client with reasonable assistance in submitting any claim under an insurance policy arranged by the broker and pass on any relevant information received from the policyholder in relation to the claim as soon as possible. Further, a licensed insurance broker should exercise due care to discharge all obligations in relation to the administration, negotiation and settlement of such claims to the extent it has the obligation to do so under its client agreement.

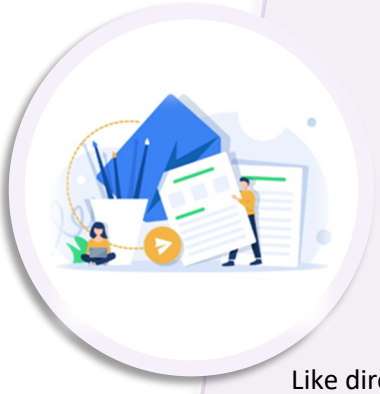
Since the extent of a licensed insurance broker's role in the claims process depends, in large part, on the scope of services in its client agreement, as best practice, insurers should agree in writing with the broker companies through which it accepts insurance policy placements, the arrangements which will reflect the role the broker company will play in the claims handling process. If an insurer is aware that a broker company does not have the requisite authority to handle claims on behalf of the policyholder, then all communications on claims should be made directly with the policyholder.

6. An authorized insurer should have in place effective measures for combating fraudulent claims

The insurance regulatory framework also requires an authorized insurer to have in place effective measures for combating fraudulent claims (section 8.10 of GL10). Fraudulent insurance claims undermine the principles of mutual benefit and risk pooling on which insurance is based, depleting the pooled funds from which only genuine claims are intended to be paid. The fraud detection controls which an insurer should implement, however, should seek to find the balance between the need to investigate potential fraudulent claims without sacrificing the overall obligation to handle genuine claims fairly and promptly.

The Hong Kong Federation of Insurers ("HKFI") has established the Insurance Fraud Prevention Claims Database ("IFPCD") which currently covers motor insurance and medical insurance claims and mirrors industry-led initiatives in other developed insurance markets. IFPCD is designed as a tool with self-learning capability to detect potential fraudulent claims so that insurers can trigger focused investigations speedily whilst ensuring the prompt settlement and payment of genuine claims continues.

The IA takes into account an authorized insurer's membership and active participation in the IFPCD in assessing the adequacy of the insurer's anti-fraud measures. Any insurer which is not a member (or not actively participating) in IFPCD when it is eligible to do so can expect greater scrutiny and will need to explain what measures it is taking to combat fraudulent claims and how those measures strike a sound balance between investigating potentially fraudulent claims whilst ensuring that genuine claims are settled in a fair and prompt manner.



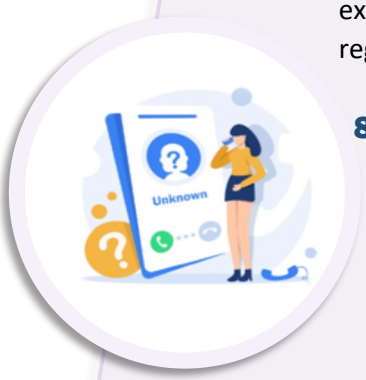
7. An authorized insurer should have in place arrangements with its reinsurers to ensure claims can be handled fairly and promptly

Authorized insurers need to have in place adequate reinsurance arrangements (per section 8(3)(c)(i) of the Insurance Ordinance (Cap. 41) ("IO")), as reinsurance is a necessary part of the insurance market, enabling risk to be spread and the losses of the few to be borne by the many (being the concept that underlies the principle of insurance).

Like direct insurance, coverage under the terms of a reinsurance treaty or agreement depends on the terms and conditions stated in the contract. Depending on the coverage, this may include procedural conditions requiring the insurer (as reinsured) to obtain the reinsurer's prior authorization before settling a claim under the insurance policy issued by the insurer (and the reinsurer bearing its share of the coverage for the claim under the reinsurance, is contingent on such prior authorization or consent being given). In these circumstances, in practical terms, the insurer's decision on a claim from a policyholder (particularly a large claim) may be dependent on the reinsurer's decision to provide its consent/authorization.

Where this is the case, the insurer (as reinsured) should agree with the reinsurer either contractual or indicative timelines for the reinsurer to revert on its decision to provide authorization/consent, so that the insurer can reach a decision on the claim under the original insurance policy in a prompt and fair manner.

Reinsurers which are authorized insurers in Hong Kong are also subject to the principles and standards for claims handling under the insurance regulatory framework and the IA would expect the reinsurer to work with the insurer to establish such arrangements (and to meet the regulatory principles and standards generally in its claims handling).



8. An authorized insurer should ensure that claims are handled by qualified, competent and experienced claims personnel

Inviting or inducing or attempting to invite or induce a person to make a decision on the making or settlement of a claim is a "regulated activity" under the IO. Giving an opinion on the making or settlement of a claim is also considered "regulated advice" under the IO. A person carrying on regulated activity or giving regulated advice in this respect is generally required to be licensed under the IO.

As an exception to this, section 123(4) of the IO exempts employees of authorized insurers from being licensed if the only regulated activities they carry on are to process claims lodged under contracts of insurance issued by the insurer.

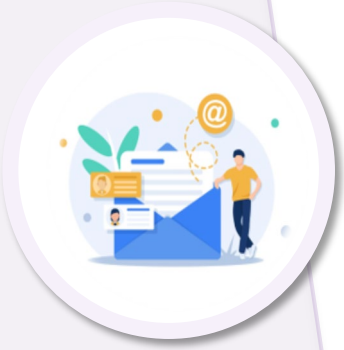
Irrespective of whether claims personnel working for authorized insurers need to be licensed or can take the benefit of the exemption in section 123 of the IO, the insurer should ensure its claims personnel have been trained and are sufficiently experienced to perform their duties in adjusting claims. **Serving as a claims handler adjusting claims for an insurer is one of the most important professions in the insurance industry. It involves the person having the right mix of technical expertise in insurance (particularly in the relevant line of business), strong analytical skills, an ability to exercise impartial and balanced judgement, competence in communicating with policyholders, licensed insurance agents and licensed insurance brokers and strong people skills.** It is the responsibility of the directors and management of an insurer to ensure that its claims personnel are appropriately qualified and sufficiently experienced in claims handling to discharge their duties. Ongoing training, supervision and support should be provided to claims personnel and the claims functions should be appropriately resourced to perform this most important task. Levels of authority should be assigned according to expertise and experience. Further, claims handlers must have access to other professional expertise if this is required to assist them discharge their duties (for example, qualified medical personnel or lawyers).

9. An authorized insurer should have in place balanced, impartial and transparent dispute resolution procedures for claims disputes

A policyholder may dispute an authorized insurer's decision that a claim is not covered under an insurance policy or the amount covered is lower than the amount claimed. An authorized insurer should, therefore, establish internal procedures whereby, when a legitimate dispute arises, the insurer will review the claim. Such internal review may be in the form of an appeal process which should be conducted in a balanced and impartial manner, for example by escalating the original decisions to claims handlers with greater experience who were not involved in the original decision being disputed. The review process should be made transparent to policyholders, so they know of its existence and how to access it. The claims handlers dealing with an appeal should take account of the reasons put forward by the policyholder for disputing the decision on a claim. When a decision is made on the appeal, the insurer should communicate the reasons for its decision to the policyholder in writing in clear, plain and understandable language. An insurer may wish to implement a process for further appeals to be made (based on additional information provided by the policyholder).

If, after exhaustion of the insurer's internal appeal process, the policyholder wishes to continue to dispute a claim decision, the insurer should refer the policyholder to appropriate external dispute resolution procedures, such as the Insurance Complaints Bureau ("ICB") (if applicable). The IA considers an authorized insurer's membership of the ICB to be an important part of an authorized insurer's dispute resolution process, and integral to an insurer's obligation to handle claims fairly.

10. An authorized insurer should have in place robust corporate governance and monitoring for the claims process



An authorized insurer should have in place proper policies and procedures to underpin its claims handling processes. Such policies and procedures must be founded on the principles of ensuring claims are handled fairly and promptly and policyholders are treated fairly throughout the claims process. As well as documenting processes for handling claims, with indicative timelines and clear escalation to claims personnel with requisite experience and qualifications, the IA expects to see the following as part of an insurer's corporate governance on claims:

- The insurer should review its claims handling procedures periodically to ensure the procedures are sufficient to meet the objective of handling claims in a fair, prompt and transparent manner.

- When reviewing its claims handling procedures, the review should include personnel from outside of the claims workstream who can challenge the procedures from the perspective of the policyholder. Where it is proposed to amend claims procedures to require additional information to be provided on claims (or additional steps in the procedure to be taken by policyholders or the insurer before settling the claims), documented justification must be recorded stating how, despite the amendment, the claims procedures remain fair and prompt.

- The insurer should collect and present statistics on its claims handling to its board of directors (and relevant committees such as risk committee) on a regular basis. Such statistics should include claim rejection rate, aging analysis on claims, progress of particular major claims above a certain threshold (e.g. top 10 major claims), fraudulent claims data, data on claims subject to the appeal process etc. In terms of conduct, the IA would expect to see discussion at board level of these statistics in the context of: (i) its obligation to handle claims fairly and promptly; (ii) its overall exposure to conduct risk; and (iii) the impact of its claims handling processes on the overall corporate culture of the insurer.

11. An authorized insurer must have in place proper arrangements, monitoring and controls when using third parties to perform any of its claims functions

If an authorized insurer engages a third party in its claims handling process, the insurer is responsible for ensuring the third party is sufficiently qualified and experienced to carry out its work and must maintain close oversight and monitoring over the third party. The insurer (and its board of directors) remains ultimately responsible for the work performed by the third party in the insurer's claims handling process and for ensuring the provision of fair and transparent claims handling to its policyholders. Further, if an authorized insurer uses a third party as part of its claims processes, the insurer is responsible for ensuring that the third party responds and carries out its work in such a way as to enable the insurer to handle the claim in a fair and prompt manner (and it must have service level agreements in place and adequate monitoring to ensure this).

Where the work of the third party involves outsourcing by the insurer to the third party of its claims assessment functions, the insurer must comply with any other applicable requirements in the insurance regulatory framework such as the IA's Guideline on Outsourcing (Guideline14).

Delivering the claims promise is probably the most important part of an insurer's obligations to its policyholders. Indeed, it is precisely the reason why insurance exists and the important social role it performs. It is imperative, therefore, that authorized insurers meet the minimum requirements for claims handling set out in the insurance regulatory framework so that trust in the insurance market continues to be reinforced.

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Monitoring and controls over third party handlers

Documented claims procedures and indicative timelines

Statistic and periodic review of procedures

Indicative timelines and guidance on information to be submitted by claimants

Balanced and impartial dispute resolution

Ensure the claims assessment is fair

Regulatory Principles and Standards

- Handle Claims fairly and promptly
- Transparency on claims process
- Robust Corporate Governance

Qualified / experienced claims personnel

Periodic updates to claimants

Arrangements with reinsurers for efficient response

Measures to combat fraud - IFPCD

Clear role for intermediaries on claims process