Ref: Information Letter 3/2014 (LT&ST)

FINANCIAL SERVICES BOARD
REPUBLIC OF SOUTH AFRICA

LONG-TERM INSURANCE ACT, 1998 (ACT 52 OF 1998)
SHORT-TERM INSURANCE ACT, 1998 (ACT 53 OF 1998)

Addressee:	Long-term and short-term insurers	**File:**	10.41.1.7.2 10.41.2.7.2
Issue date	**Reply date**	**Information Letter**	**Status**
17/10/2014	-	3/2014(LT&ST)	ISSUED
Subject:	Key Findings: Complaints Management Thematic Review		

1. BACKGROUND AND PURPOSE

1.1 The purpose of this information letter is to share the key findings of the thematic review undertaken by the Insurance division of the Financial Services Board during April to June 2014 in respect of complaints management processes of insurers.

1.2 The key findings document is attached hereto.

1.3 The purpose of sharing the key findings is to encourage insurers to assess the effectiveness of their complaints management process and, where necessary, effect improvements or enhancements to complaints handling methodologies.

1.4 The key findings will inform –

1.4.1 future supervisory conduct of business reviews; and

1.4.2 planned amendments to the Policyholder Protection Rules issued under section 62 of the Long-term Insurance Act No. 52 of 1998 and section 55 of the Short-term Insurance Act No. 53 of 1998, respectively, in respect of complaints management.

1.4. Insurers are encouraged to consider the key findings together with the proposals contained in the Financial Services Board's *Discussion Document on Customer Complaint Management by regulated financial institutions, aligned to the Treating Customers Fairly framework* (the "Complaints Management Discussion Document"), to be published on the website.

2. AVAILABILITY AND INFORMATION SHARING

This Information Letter is available on the website (www.fsb.co.za) of the Financial Services Board.

REGISTRAR OF LONG-TERM AND SHORT-TERM INSURANCE

COMPLAINTS MANAGEMENT THEMATIC REVIEW: KEY FINDINGS

1. Purpose and scope of the review

During the period April to June 2014 the Insurance Compliance Department of the Financial Services Board (FSB) carried out a thematic review of the complaints management practices of a sample of insurers. The purpose of the review was to assess the quality and maturity of current complaint management processes and to identify the types of challenges faced by insurers in relation to complaints management, in anticipation of the FSB's introduction of enhanced complaints management and reporting requirements for regulated financial institutions.

A sample of 21 insurers was reviewed, comprising 9 long-term and 12 short-term insurers. A mix of intermediated and direct business models as well as small, medium and large insurers (by market share) were included in the sample. The review also focused on retail/personal lines insurance operations.

Additional criteria used when selecting specific insurers were:

- Number and nature of complaints referred to the FSB;
- Number of complaints referred to the long-term and short-term insurance Ombud schemes respectively; and
- Overturn ratio as published by the Ombud schemes.

2. Methodology of the review

The Insurance Compliance Department developed a framework to ensure that the review would facilitate comparisons between various insurers who have similar business models and/or operate within similar target markets.

At each insurer the system(s) used for complaints management were reviewed, to ensure an understanding of the practical application of the insurer's complaints processes and procedures. This systems review was also used to verify the process descriptions provided by insurers in interviews and discussions.

Records of actual complaints were further randomly selected to review the effectiveness and quality of the insurer's responses. These complaints included: Matters that were still in progress; finalised matters; complaints submitted directly by complainants; complaints received from Ombud schemes; complaints overturned by an Ombud scheme; complaints where the insurer changed its initial decision on a complaint after a complainant re-referred the matter to the insurer; and complaints where the insurer changed its initial decision after the complaint was escalated internally within the insurer.

3. Trends identified

The review identified a number of general trends:

3.1 Although some insurers have proactively begun to categorise and analyse complaints in line with the proposed TCF outcome categories, a number indicated that further guidance is required as to what is expected from them in this regard.

3.2 Those insurers that appeared to be struggling with their complaints management process were hampered by a lack of one or more of the following:

- a centralised complaints register to enable regular and accurate trend analyses;
- trained and experienced staff that were dedicated to complaints management and with the necessary expertise in relation to both complaints management and the insurer's business;
- an appropriate delegation of authority to the complaints handling function to make independent and fair decisions, without interference from operational areas or budgetary conflicts;
- management taking an active interest and role in complaints management;
- the use of management information reports to track the feedback given on complaints and the re-occurrence of complaints by the same complainant as an indication whether the first call resolution strategy is effective;
- quality checks and/or audits of the complaints management process, including the quality of complaints analysis and resolution; and
- a complaints management process that includes complaints handled or escalated to outsourced entities, and specifically to binder holders[1] and intermediaries.

4. Specific findings

Paragraphs 4.1 to 4.14 below are a summary of the FSB's key findings and observations from the thematic review. In some cases we include details of specific questions insurers were asked, as well as a small selection of actual responses obtained from insurers, in order to illustrate widely divergent current approaches to complaints management within the insurance industry.

4.1 The effectiveness of systems for complaints management and consolidated record keeping

In order to capture, store, monitor and analyse complaints data an insurer should have a system with these functionalities as a minimum, but that would also allow the insurer to appropriately categorise complaints and conduct a root cause analysis and/or identify complaints trends. (Going forward, the proposal is that complaints categories should be aligned to TCF outcomes). An insurer should also, regardless of the sophistication of its complaints management systems, be able to demonstrate that it captures and/or consolidates all complaints in an appropriate register. If a consolidated complaint register is not available, it is not possible to conduct a meaningful root cause analysis, as discussed in paragraph 4.2.

A number of insurers indicated that they are struggling with outdated systems which do not have all the functionalities they require. In other instances insurers have more than one complaints system in place and these systems cannot be aligned or integrated

[1] A binder holder refers to an underwriting manager or non-mandated intermediary as defined in Part 6 of the Regulations issued respectively under Section 72 and Section 70 of the Long- and Short-term Insurance Acts.

with one another. A number of insurers also indicated that they keep different complaints registers in different branches, divisions and/or departments. In some cases, although the insurer does maintain a consolidated complaints register, the accuracy of data is compromised as various underlying systems are used, each with different data capturing and formatting rules. Many insurers pointed out that different business units have different interpretations regarding complaints categorisation and capturing.

A number of insurers have no automated complaints management system in place and manually capture complaints on a spread sheet. Although this does not necessarily mean the sysem is ineffective, the room for human error and data inconsistency is increased. Consistent complaints categorisation is also more difficult.

Interestingly, there was no clear correlation between the size of insurers sampled and the sophistication or quality of their complaints management systems or registers.

The following question was posed to insurers:

How and on how many systems are complaints recorded?

Reponse (a)

Records of complaints are drawn from different forms and platforms such as our IT systems, e-mails, spread sheets, our website as well as social media.

Response (b)

All complaints are sent to the Head Office where it is captured on one system.

Response (c)

We record all calls, correspondence and notes on our internal system. Complaints can, however, not be captured on this system and we manually capture it on spread sheets.

Response (d)

Within the company we record all complaints electronically on the system. Binder holders and intermediaries should maintain their own electronic registers.

4.2 Root cause analysis and corrective action

An insurer should be able to analyse its complaints data in order to determine the main reason(s) for complaints. This will enable the insurer to pro-actively identify trends and take any corrective action that may be required with regards to a product, a process, a specific employee or type of complaint, or in relation to the complaints management process itself.

Without conducting a root cause analysis an insurer cannot effectively respond to complaints related information as the same type of complaints will re-occur without the ability to take preventative steps to address the actual origin/root cause of complaints.

A number of insurers conducted no or very limited root cause analysis of complaints, only addressing complaints on a reactive case-by-case basis. In some cases, insurers explained that they do carry out root cause analysis, but could provide little or no evidence that they had taken corrective action in relation to identified complaint trends.

The following question was posed to insurers:

What are the root causes/trends that have been identified for the majority of complaints?

Reponse (a)

We do not know as we do not have the data available.

Response (b)

The majority of complaints are due to repudiated claims, unsatisfactory service and premium refunds.

Response (c)

We do not settle claims within the specified service level agreements.

4.3 Inclusion of complaints management in the audit scope and/or plan

Only half of the insurers reviewed could demonstrate that their complaints management processes, or at least certain areas thereof, are included in the scope of either internal or external audit.

In a few instances, although the insurer advised that the complaints process is indeed audited, they were not in a position to provide evidence of related audit findings or of action taken in response to audit findings.

When no independent review of its complaints management is conducted within an insurer, the insurer will not be in a position to determine objectively and accurately whether its internal processes or policies are consistently and correctly applied.

The following questions were posed to insurers:

Is the complaints handling process and information provided to the insurer audited? If yes, how often and by whom?

Response (a)

Yes, monthly audits are done on complaints by our internal audit department.

Response (b)

Yes, the Compliance team audits the information while they are doing their annual audits at the different agents.

4.4 Complaint categorisation

In a number of instances complaints are captured in accordance with their source (i.e who they are received from), and there is no clear and consistent categorisation of the nature of or reason for the complaint. Where complaints are categorised according to type or reason, the extent to which the categories were aligned to TCF outcomes differed significantly.

It was further identified that some insurers have too many categories (sometimes in excess of 100) which made it impossible to meaningfully identify any trends and/or conduct a root cause analysis. In other cases it was found that the categories are not

"closed" and that employees could add to the list of already existing categories. This resulted in duplication of categories which again skewed any trend and/or root cause analysis. For example "premium refund" and "refund of premium" were set up as different categories on one insurer's system.

Most insurers also have a complaints category named "Other" for complaints that do not naturally fall within any specific complaints category. Although the need for such a category is accepted, instances were observed where this category appeared to have been used indiscriminately, with a large proportion of complaints categorised under "other", thus undermining the ability to conduct a proper root cause analysis as discussed in paragraph 4.2.

The following questions were posed to insurers:

What categories are currently being used to capture complaints?

Are you aware of the proposed TCF categories for complaints and what difficulties do you foresee in reporting in these categories?

Response (a)

We use the source of the complaint as the category. We are reviewing the process to align to the TCF categories.

Yes, we are aware of the categories and the biggest difficulties are that complainants approach the Ombud directly and intermediaries not understanding their role regarding TCF, but we will train them.

Response (b)

Currently we use the following main categories: advice, fund performance, service and admin issues, fraud, product flaws and claims related.

Yes, we are aware of the categories. We need to train everyone on the TCF categories who is involved in the complaints handling process on what type of complaints falls within which category – especially when a complaint falls into more than one category.

Response (c)

Complaints are classified into: Ombud, FSB and general service complaints. We have 20 categories and 132 sub-categories.

Yes, we are aware of the categories and foresee a number of difficulties: the first to establish a consistent approach to identify complaints as per the categories. Secondly, defining key factors such as fairness which are likewise understood by us and our clients. The last difficulty is building the categories into the system.

4.5 Monitoring Ombud complaints and overturn ratios

An insurer's complaints management system should enable it to specifically monitor complaints referred to Ombud schemes, including the overturn ratio, as published by the different Ombud schemes. In particular, we would expect an insurer to understand why its overturn ratio is high relative to the industry or its peer group, where applicable. (As mentioned above, one of the criteria for selecting insurers to participate in this review was a relatively high Ombud overturn ratio).

The extent to which insurers proactively monitored Ombud complaints and complaint ratios differed. In particular, it was evident that insurers who allow binder holders and intermediaries to handle complaints on their behalf, do not effectively manage and/or have control over complaints lodged with the binder holder and/or intermediary. In most instances, the insurer only became aware of such complaints once they were received from the Ombud. This observation is further elaborated on in paragraphs 4.10 and 4.11.

In instances where insurers were able to show that they had conducted a root cause analysis of their high overturn ratio, insurers identified, amongst others, the following reasons:

- ineffective claims handling process;
- insufficient communication with the complainant;
- poor service;
- lack of training or expertise by employees dealing with complaints; and
- misleading or confusing product material.

A number of insurers defended their overturn ratio by explaining that the relatively high ratio was simply an indication of the insurer's efforts to co-operate and preserve a good relationship with the Ombud, and not a reflection on the quality of its complaints management. This view is rather disturbing, as it suggests that despite the Ombud view the insurer does not recognise the validity of the complaint and will therefore be unlikely to take any action to address the relevant root cause or improve their complaints management process.

One insurer submitted that the Ombud does not have the necessary expertise and knowledge to deal with their complaints as their products are more complex than those offered by the rest of the insurance market. Again, this view is of concern as it is likely to result in the insurer disregarding the Ombud's view and not taking corrective action in response to the high overturn ratio.

Many insurers also expressed their frustration during the review that complainants "choose" not to approach the insurer directly, but rather approach the Ombud directly. In these instances, insurers were not able to explain why complainants did not approach them or whether they had made any efforts to improve this process. In this regard also see paragraph 4.14 below.

4.6 Complaints turn-around time and adherence to the complaints policy

Most insurers have internal rules regarding the maximum time that it should take to resolve a complaint. There are normally different rules depending on the type or source of the complaint, for example a service complaint as opposed to a complaint received from an Ombud scheme.

These insurers would also monitor the average turn-around time on complaints through management information and could identify through exception reports when the maximum timeframes are exceeded.

These rules are usually included in the insurer's internal complaints handling policy.

Employees dealing with complaints normally receive training and understand what is required of them to adhere to the allocated time-lines.

In some instances, however, it was found that despite having internal policies and timelines, insurers either do not adhere to their internal rules or do not even measure turn-around time and compliance with their own complaints policy. In other instances the internal turn-around time appeared unreasonably lengthy, raising doubts whether this was consistent with TCF Outcome 6.

It is noteworthy that insurers that did not measure turn-around times, were also not able to provide a root cause analysis of complaints.

The following question was posed to insurers:

What is the average turn-around time for each type of complaint?

Response (a)

Service related claims, which include claims complaints, are dealt within approximately one or two weeks and complaints referred to the Ombudsman within 90 days.

Response (b)

Claims complaints – 59 days, Service complaints – 21 days and Sales complaints – 56 days.

4.7 Lodging complaints on-line

Most insurers have functionality available on the insurer's website for complainants to register/lodge a complaint on-line. The level of sophistication in this regard varies quite significantly between insurers.

In some instances, although the functionality was available, it was not easy to lodge a complaint as this option could only be found after clicking on various tabs on the website.

4.8 Complaints monitoring at distribution channel level

In order to identify possible mis-selling or other poor outcomes arising from the way its products are distributed, an insurer would be expected to monitor the number and nature of complaints at distribution channel level, for example by distinguishing between complaints arising from direct channels, the insurer's own representatives, independent intermediaries, binder holders, affinity relationships, etc.

Most insurers reviewed did monitor complaints per distribution channel to varying degrees including in some cases at individual representative level (typically in the case of "tied agent"[2] models). In some cases this type of monitoring was done on an *ad hoc* basis. There was, however, a significant variance in how insurers use this information. In some instances, even where distribution channel monitoring occurred more frequently, insurers did not necessarily do anything proactive with the information. Certain insurers advised they they discuss the findings with the intermediary or third

[2] In the context of this thematic review a tied agent means an intermediary that promotes and markets the products of only one insurer.

party concerned, but there was little evidence available of these discussions having taken place or of any formal processes in this regard.

4.9 Monitoring complaints to binder holders and intermediaries

When an insurer uses the services of binder holders and/or intermediaries, most insurers explained that they expect these third parties to keep complaints records: however, this data is not integrated into the insurer's complaints register/s. These insurers were not able to consolidate the information as the registers were mostly in different formats and/or systems.

Some insurers do not require that the registers kept by binder holders or intermediaries are submitted to the insurer on a regular basis. Without this data it was found that insurers are not aware of complaints and cannot proactively identify or respond to trends.

In some instances insurers would, on an *ad hoc* basis only, review the complaints register of binder holders and intermediaries, but only after the complaints have been finalised. The insurer could therefore not influence the effectiveness of the complaints handling process or the decision made on the complaint.

Where an insurer does not have access to or does not monitor complaints to binder holders or intermediaries, its complaints data will clearly be inadequate and its ability to carry out root cause analysis compromised.

In the case of binder models, where the name of the underwriting insurer is not clearly disclosed, this unfairly inhibits complainants' access to the insurer and results in complainants not approaching the insurer directly, or at all.

The following questions were posed to insurers:

Are intermediaries, representatives and tied agents expected to keep record of all complaints and report on them?

If yes, how often and in what format do they report to you?

Response (a)

No. We do not keep record of complaints received against brokers. Internal representatives are expected to keep record and report on them.

Response (b)

They are obliged to keep a register but they do not have to report to us.

We don't know, but it is part of the Internal Audit scope.

Response (c)

Yes, only upon our request. The format would be spread sheets.

4.10 Training on complaints handling

It was apparent that full-time employees of an insurer responsible for complaints handling usually receive at least some form of training on complaints handling, but this was much less evident in business models where third parties such as binder

holders or service providers deal with complaints in relation to the insurer's products or services.

4.11 Internal escalation process

The review revealed significant differences in approach regarding the extent to which insurers have internal escalation processes in place where complaints are not resolved at first instance. Practices vary from comprehensive internal arbitrator models, to a "take it or leave it" approach where customers dissatisfied with the insurer's initial response are referred to the Ombud or other external recourse.

In the long-term insurance industry in particular, it was noted that a number of insurers believe that the effectiveness of complaints handling is related to the existence of an internal arbitrator – usually a senior full-time employee of the relevant insurer. These insurers pointed out that they were focusing on ensuring that the internal arbitrator plays a bigger role in complaints management.

Nevertheless, the review did not show any clear correlation between the existence of an internal arbitrator and the general effectiveness of the insurer's complaints management processes.

The following question was posed to insurers:

Does the complaints handling process provide for an escalation process?

Response (a)

There is no escalation process. The complainant can escalate it to the Ombud or a court of law.

Response (b)

We have an escalation process but it has not been implemented in the business.

Response (c)

Yes, the complaints handling process provides for a specific escalation process for each type of complaint. Complaints which are not resolved within 30 days from initial submission must be reported to the Compliance Manager and the CEO.

Response (d)

In complex cases the complaints are escalated to the relevant manager and if still unresolved a case is prepared for the complaints resolution committee.

4.12 Using complaints data to improve product or service design

Insurers that conduct a root cause analysis of complaints were generally in a position to demonstrate the changes or enhancements that they have made to existing products or services. In these instances the insurers could also see a direct correlation between the change in a product / service and the reduction of complaints linked to that product or service.

The following question was posed to insurers:

Have any amendments been made to your products based on the feedback

from complaints?

Response (a)

Amendments were made to our policy wordings to remove ambiguity, where it appeared that complainants did not understand our policy wordings.

Response (b)

We changed the name of the product and we now phone clients after inception to ensure they understand the product.

Response (c)

No, as our products are governed by legislation.

4.13 Compensation payments

The majority of insurers reviewed allow for some form of compensation payment in their complaints management process. The level of record keeping of compensation payments, however, varied significantly between insurers.

A wide range of interpretations exist as to what is regarded as a compensation payment. In the short-term insurance industry, it is mostly understood and applied as a waiver of the complainant's excess on a claim. In the long-term insurance industry it is most often described as a form of compensation to apologise for poor service and any inconvenience caused to the complainant.

Some insurers have clear rules regarding these payments and some have gone so far as to specify maximum amounts that can be paid in regard to specific types of complaints. Compensation payments are normally approved by senior management at an insurer.

In a few instances insurers kept no record of compensation payments, and although they confirmed that such payments occur, there was no supporting management information available.

Proper monitoring of the reasons for and the frequency and quantum of compensation payments can provide useful insight into problem areas and trends, to facilitate proactive product or process improvement. There was however little evidence of this approach, with compensation payments in the main being used as a purely reactive means of making good for poor customer treatment after the fact.

There are also inconsistent approaches in regard to which area of the business carries the cost of compensation payments. In some instances, the area responsible for the conduct giving rise to the complaint carries the cost, while in other cases compensation payments come out of a separate cost centre.

Most insurers explained that they do not specifically budget for these payments as they are concerned that this would drive incorrect behavior. In either case, there was little evidence that the risks of conflicts of interest had been considered in determining the basis on which compensation payments are made.

An additional observation in relation to compensation payments is that there is no clear distinction made or recorded between compensation payments made to make good a loss attributable to the insurer's actions, or purely as a gesture of goodwill or

"ex gratia" payment.

The following questions were posed to insurers:

How is provision made for compensation payments?

What percentage of the total number of complaints was resolved by paying a compensation payment?

What is the average compensation amount being paid to resolve complaints?

Response (a)

Payments are made from the Claims Department's budget.

There is no data available as we don't track this.

We normally waive excess, so this not a payment in cash.

Response (b)

Payments are made out of the department's budget that made the error. This is done to teach the business unit lessons on enhanced service and to ensure that mistakes are not repeated.

2.3%

R3 182.

Response (c)

No specific provision is made but if any payment is made, it will be from the Claims budget.

1.5% of all claims include a compensation payment.

There are no specific records but payments can be between 50%-80% of the value of the claim.

4.14 First call resolution of complaints

In numerous instances it was apparent that complainants complain more than once, on the same issue, to an insurer before the complaint is resolved.

It was further found that in many instances complaints are incorrectly or prematurely recorded as "completed" by employees before the complaint is in fact fully concluded. This was due to a number of reasons, including inadequately trained employees, staff errors or negligence, poor systems, and generally poor customer service standards.

The extent to which insurers monitor "first call resolution" varies. In some instances there was a direct correlation between the effectiveness of first call resolution and the number of complaints that an insurer receives and/or the number of complaints that are referred to an Ombud scheme.

5. Next steps

Insurers are encouraged to consider the findings of this review to assess the effectiveness of their complaints management process, including the extent to which their current practices are consistent with the proposals contained in the FSB's *Discussion Document on Customer Complaint Management by regulated financial institutions, aligned to the Treating Customers Fairly framework* (the "TCF Complaints Management Discussion Document" – available at www.fsb.co.za).

Where such an assessment identifies weaknesses in an insurer's complaints management process, the insurer should consider proactively effecting improvements or enhancements to its process, in anticipation of the introduction of stronger regulatory requirements in this regard.

The review findings will also be used by the FSB as a point of reference when supervisory conduct of business reviews of insurers are conducted.

The findings will also inform planned amendments to the Policyholder Protection Rules issued under section 62 of the Long-term Insurance Act No. 52 of 1998 and section 55 of the Short-term insurance Act No. 53 of 1998, respectively, in respect of complaints management, as contemplated in the Complaints Management Discussion Document.