

Life Insurance Code of Practice

# Annual Industry Data and Compliance Report 2018–19

JUNE 2020

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# Chair's message



I present the Life Code Compliance Committee's Annual Industry Data and Compliance Report (the Report) for the period 1 July 2018 to 30 June 2019.

The Report provides a snapshot of the life insurance industry and its compliance with the Life Insurance Code of Practice (the Code) for the year. It is based on aggregated data sourced directly from Code subscribers together with compliance data from the Committee's compliance monitoring work. This is the second year that the Committee has published the Report, and therefore our first opportunity to conduct a comparative analysis of compliance performance and trends.

However, analysis of the data reported by subscribers this year and review of the data collation last year have shown a number of discrepancies between the closing balances last year and opening balance this year. This has meant limited meaningful conclusions or historical comparisons can be drawn in this Report. Given our comments last year on the initial data quality, this is not unexpected and we anticipate that next year's data will be consistent and enable full comparison.

After making allowances last year for the challenges involved in collecting and analysing the dataset for the very first time, the Committee was disappointed with the initial integrity of the data submitted by many subscribers this year. In many cases, and despite repeated resubmissions of data in some instances, there remained gaps or inconsistencies in reporting, and it was evident that there were many cases of

inadequate data quality assurance conducted prior to the initial submission. However, when the Committee's concerns were explicitly raised with the relevant subscribers, they generally acknowledged the data problems and accepted the issues being highlighted.

From the data submitted and the breach investigations conducted during the year, the Committee has been left with the impression that a number of subscribers were not taking their Code compliance obligations and the Code's true purpose seriously. Demonstrating compliance with the Code is not simply a case of ticking boxes or doing 'just enough'. It is about fully embracing the spirit of the Code by providing a high level of customer service. It also involves rigorous self-appraisal and a willingness to identify, remediate and learn from any Code breaches.

None of this can be achieved without an organisational culture that values fairness, honesty and transparency, and where consumers' best interests are placed at the heart of all decision-making. This was a constant refrain in the Financial Services Royal Commission's Final Report, and it is why the Committee has chosen to include in this Report a chapter on the need for cultural change in the life insurance industry (**page 11**). Subscribers are encouraged to use the chapter as a guide to promote a top-down organisational culture which aligns with the values in the Code, and where Code compliance is seen as a priority by everyone in the enterprise. We note that in recent months a marked improvement in subscriber responsiveness has been evident and we hope

to report more positively in our next Annual Industry Data and Compliance Report.

We remind subscribers that self-regulation is a privilege, not a right. That privilege comes with a responsibility to ensure that appropriate mechanisms are in place to monitor compliance and report code breaches via accurate quantitative data. Without an accurate and credible dataset, the life insurance industry has no baseline from which to progress and improve.

As this Report was being finalised, the COVID-19 pandemic unfolded with devastating global impacts. In addition to the current unprecedented restrictions on people's lives and movements, it is clear that there will be far-reaching health, operational and economic consequences and challenges for individuals and organisations for many months to come. In this context, the Committee has affirmed its expectation that subscribers will continue to meet their Code obligations, with prioritisation given to the treatment of vulnerable consumers and those experiencing financial hardship.

However, we acknowledge the extraordinary operational circumstances for subscribers and the likely challenges, especially in meeting some Code commitment timeframes. We will be supportive by taking exceptional circumstances into account where appropriate. In relation to the 2019-20 data submission, the Committee has already communicated to industry its intention to relax reporting deadlines and continue to align with regulatory data reporting where possible to avoid duplication of effort.

In this challenging operational environment, we will continue to work proactively with all subscribers on next year's data submission to collectively achieve the primary objective of the Annual Data and Compliance Programme: a quality industry dataset that is complete, accurate and consistent, and which can facilitate important public demonstration of and constructive commentary on industry Code compliance status and trends.



Anne T Brown  
**Independent Chair**  
**Code Compliance Committee**

# Executive summary

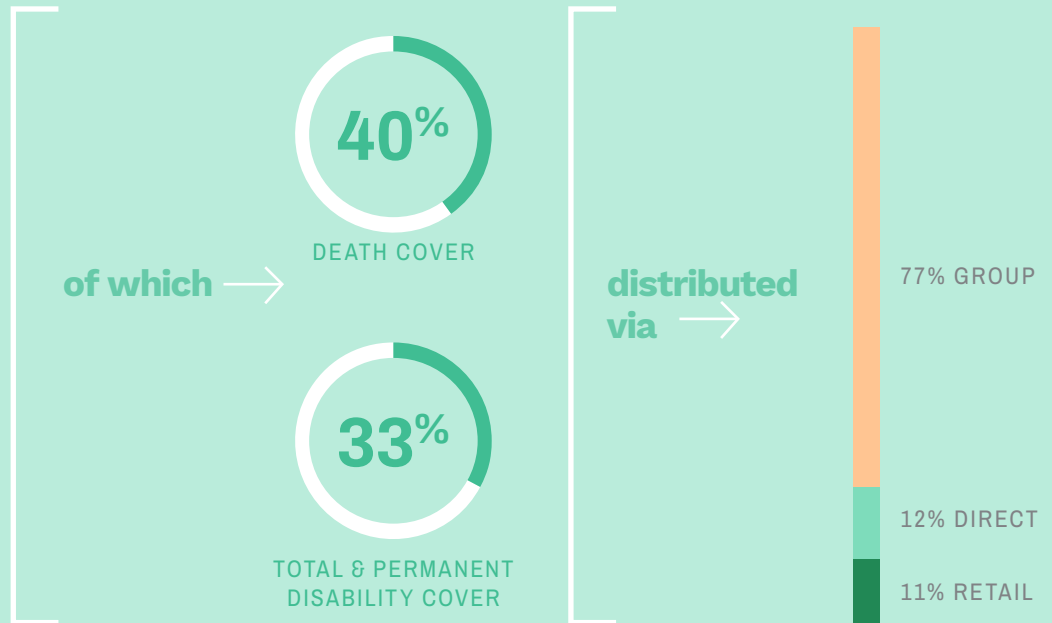
## Highlights

**41**

million cover types in force issued by

**20**

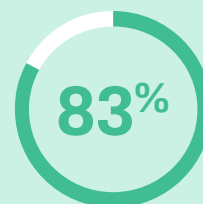
subscribers



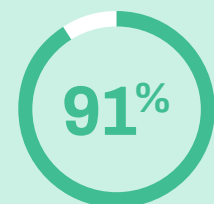
## Claims

**130,611**

claims assessed



INCOME RELATED CLAIMS DECIDED WITHIN 2 MONTHS

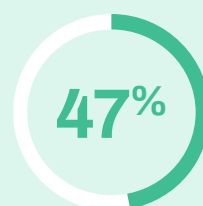


NON INCOME RELATED CLAIMS DECIDED WITHIN 6 MONTHS

## Complaints

**19,483**

complaints received



ABOUT POLICY RELATED ISSUES



ABOUT CLAIM RELATED ISSUES

## Key findings

### DATA INTEGRITY ISSUES COMPROMISE REPORT OBJECTIVES

When the inaugural Report was published last year, the Committee's intention was for it to form a baseline from which subscribers could measure and improve their Code compliance.

Unfortunately, an error in the collation of data last year and inconsistencies in the data submitted by many Code subscribers as part of this year's Annual Data and Compliance Programme (ADCP) has not enabled this to happen. More detail on the data integrity issues is provided on (page 9).

We acknowledge the higher quality data and compliance reporting this year received from smaller subscribers. However, the quality of some larger subscribers' data, along with a number of inconsistencies and gaps in their reporting indicate a need for many subscribers to improve data quality in order to have reliable data used in this Report.

While we wanted to publish insights into how subscribers have improved their Code compliance in the two years since the Code came into formal operation, we have been very limited in our ability to provide meaningful conclusions or historical comparisons.

There is no suggestion that any subscribers' data submissions were deliberately deficient. However, the results of this year's ADCP indicate an unsatisfactory attitude by many subscribers' to their data collection and verification processes. This needs to be addressed to demonstrate effective compliance with Code standards and to allow the objectives of this annual Report to be achieved.

The Committee notes the positive attitude from subscribers regarding the 2019-20 ADCP data collection process and will continue to work with industry to achieve more complete, accurate and reliable data collection.

### SUBSCRIBERS NEED TO IMPROVE THEIR CULTURE AND COMPLIANCE FRAMEWORKS

Much has been written, about improvements needed in corporate culture across the Australian financial services industry, in the wake of the Hayne Royal Commission<sup>1</sup> and the APRA prudential review into the Commonwealth Bank of Australia<sup>2</sup>.

Based on the disconnect between the ADCP attestation of most subscribers regarding the satisfactory nature of their Code compliance capability, and the Committee's experience through the ADCP process and its ongoing monitoring and investigation observations, the Committee considers that most of the life insurance industry is still on the journey towards achieving a culture endorsed by Hayne and others.

The Code provides a blueprint to help achieve the desired culture in relation to subscribers' conduct and the treatment of consumers. We therefore include in this Report a chapter on the importance of aligning organisational culture with the standards set out in the Code (page 11). This chapter aims to help subscribers understand the Committee's concerns, highlight the good practices seen from some subscribers and outline expectations of the cultural improvements needed.

<sup>1</sup> The Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry.

<sup>2</sup> APRA's Final Report on the Prudential Inquiry into Commonwealth Bank of Australia.

### SUBSCRIBERS NEED TO REVIEW THE EFFECTIVENESS OF THEIR STAFF TRAINING PROGRAMMES AND MONITORING FRAMEWORKS

Subscribers attributed 45% of breach events and 88% of isolated breaches to people-related causes, including inadequate staff training, human error and a failure to follow the correct processes and procedures. Despite this, subscribers have reported that they are meeting their Code obligations to provide underwriters and claims assessors with the required skills, training and support. Even if subscribers believe they are fulfilling their Code obligations, it appears that many are not properly assessing the effectiveness of their training programmes, particularly in relation to coverage and reinforcement of Code obligations. In the Committee's view, robust training, oversight and compliance monitoring of staff is key to reduce the adverse consumer outcomes from breaches due to people-related causes.

The Committee considers that there is value in the industry assessing the merit of a minimum standard of training and education for underwriting and claims staff, which would lead to higher standards of service to consumers and a consistent and clear benchmark for the industry.

### SUBSCRIBERS NEED TO IMPROVE THEIR PROCESSES FOR RECORDING AND REPORTING BREACHES RELATING TO CLAIMS HANDLING TIMEFRAMES

The number of claims reported as part of the ADCP that were neither determined nor identified as Unexpected Circumstances<sup>3</sup> beyond the timeframe required by the Code should have also been reported as breaches of sections 8.16 and 8.17<sup>4</sup>, however the number of reported breaches was much lower in many cases. The underreporting of these breaches signifies that subscribers' processes for recording and reporting accurately on

potential breaches relating to claims handling timeframes are inadequate.

The Committee recently published the findings of an investigation into 11 Code subscribers' compliance with sections 8.16 and 8.17<sup>5</sup>, carried out in response to receiving a bulk referral of more than 700 alleged Code breaches from a plaintiff law firm. In response to the Committee's investigation, the subscribers involved have implemented substantial improvements to processes and procedures. The Committee is confident that this will not only improve subscribers' ability to identify and report breaches of sections 8.16 and 8.17 of the Code but will also reduce the number of breaches and provide significantly better outcomes for consumers.

### MORE CLAIMS-RELATED COMPLAINTS AND LONGER CLAIMS HANDLING TIMEFRAMES SHOW THAT SUBSCRIBERS NEED TO IMPROVE THEIR PROCESSES

Despite very similar levels of claims assessed by subscribers in both 2017–18 and 2018–19, of concern is a 52% rise in claims-related complaints and a disappointing deterioration in overall claims handling turnaround times (for example, a 6% reduction in Disability Income Insurance (DII) claims determined within two months of a receiving a claim).

These statistics demonstrate the need for stronger claims management and communication processes whilst highlighting the potential benefits of a review of culture within subscriber organisations.

<sup>3</sup> A full list of the possible scenarios qualifying as Unexpected Circumstances can be found in Chapter 15 of the Code.

<sup>4</sup> Code sections 8.16 and 8.17 deal specifically with subscribers' obligations relating to the timeframes for advising a consumer of a decision about their claim.

<sup>5</sup> [Claims and Complaints Handling Obligations: A review of compliance by Life Code subscribers](#), March 2020.

# About this report

**The 2018–19 Annual Industry Data and Compliance Report presents an overview of the life insurance industry and its compliance with the Life Insurance Code of Practice. The Report is based on data provided to the Life Code Compliance Committee by Code subscribers, covering the period from 1 July 2018 to 30 June 2019.**

## The Code

The Life Insurance Code of Practice is owned and was developed by the life insurance industry. The Code sets out each subscriber's commitments and obligations to their consumers on standards of practice, disclosure and principles of conduct for the life insurance services they deliver. These principles include being open, fair and honest. By subscribing to the Code, the industry has committed to promote a high standard of customer service and to build public trust and confidence in the industry's ability to self-regulate.

To hold subscribers accountable, the industry has set up the independent Life Code Compliance Committee to monitor and enforce compliance with the Code. The Committee utilises its Administrator team (Code team) in performing its role.

## Data collection process

Under its Charter, the Committee is required, each year, to collect and report on aggregated life insurance industry data<sup>6</sup>. The Report is based on data sourced directly from 25<sup>7</sup> subscribers who each completed a detailed data workbook that was developed in consultation with stakeholders. The data submitted includes:

- for each distribution channel,
- the volumes and types of cover in force,
- the volume of claims received and determined,
- the number and nature of consumer complaints, and
- breach data.

This contextual information is complemented with data on subscribers' compliance with the Code, sourced either directly from subscribers or from the Committee's compliance monitoring work.

<sup>6</sup> Life Code Compliance Committee Charter, clause 11(d).

<sup>7</sup> St George Life was no longer writing New Business and was in the process of transferring its business to Westpac Life. Consequently, the St George data has been integrated into that of Westpac Life.



## Data integrity issues

### DATA INTEGRITY WAS BELOW COMMITTEE EXPECTATIONS

Last year, the Committee took a pragmatic view and made allowances for some incomplete and inconsistent data received, with the expectation that going forward, subscribers would improve the quality and consistency of their data and their submission approach.

The Committee identified many large discrepancies between closing in force data submitted last year and opening in force data submitted this year. In addition, an error was identified in our collation and reporting of the closing number of lives insured by cover type and distribution method last year. To address this, we have used the much more reliable opening balances reported by subscribers this year in this Report.

The more comprehensive data validation checks undertaken by the Code team for this year's ADCP highlighted that the initial data submitted by many subscribers was inconsistent and of poor quality. These subscribers had not followed the detailed ADCP reporting guidelines for completing the data workbook and after follow-up with subscribers, there was little evidence to indicate that adequate data quality assurance was conducted prior to the data being submitted.

On a positive note, much of the higher quality data and compliance reporting this year came from smaller subscribers. Whilst the Committee acknowledges that these subscribers have less complexity to deal with than larger subscribers, they also have fewer resources at their disposal for Code compliance reporting than their larger counterparts. Larger subscribers are urged to better leverage their greater resources to improve their data and compliance reporting standards going forward.

Whilst most subscribers submitted their original data workbook on time, the majority of the subscribers writing business were required to resubmit their workbooks on multiple occasions to correct both individual data worksheets and their aggregated data. This resulted in additional work for the Committee and caused delays to its overall data collation, analysis and reporting process. Despite these efforts, the final data submissions from a number of subscribers still contained discrepancies. These discrepancies included:

- As part of the Committee's data verification process, the ADCP data submitted by subscribers was cross-checked with the comparable life insurance performance statistics published quarterly by APRA<sup>8</sup>. Several discrepancies were observed in the ADCP data versus the APRA data, most notably in relation to group determined claims, with inconsistencies that could not be fully explained by any differences in definitions.

<sup>8</sup> The Australian Prudential Regulation Authority (APRA) and Australian Securities and Investments Commission (ASIC) have also collected life insurance claims data for the 2018-19 year for publication in early 2020. Whilst some of this claims data is directly comparable with the Committee's data other data elements are not comparable, since the Committee has necessarily used specific parameters and definitions drawn from the Code, as detailed throughout this Report. For this reason, readers should also be cautious about drawing direct comparisons to other published data.

## Improving future data collection, analysis and reporting

- There were multiple discrepancies identified when cross-referencing subscribers' breach data with data relating to claims and complaints.

For example, there was a substantial gap between the number of claims that were not determined or identified as Unexpected Circumstances and the number of reported breaches of sections 8.16 and 8.17. Those sections of the Code specifically deal with Unexpected Circumstances, which allow greater time for claims decision-making<sup>9</sup>.

Whilst there were 5,989 claims which exceeded both standard and unexpected circumstances duration timeframes, subscribers only reported 1,842 breaches of those sections of the Code. This means that there were 4,147 claims that amounted to potential breaches of sections 8.16 and 8.17 that were unreported by subscribers.

Robust data collection and reporting is critical to ensure that consumers, regulators and government have confidence in the Code and its effectiveness as a self-regulatory tool.

The Committee will continue to engage with subscribers to refine its data collection approach and the instructions given to subscribers. The Committee encourages subscribers to devote adequate time and resources to the collection, verification and submission of data for the ADCP. This will enable subscribers to provide robust and accurate information that can better inform consumers and industry participants about the industry's ability to self-regulate.

The Committee hopes that future Reports on our ADCP will provide greater comfort regarding the integrity of industry data. The Committee's objective is to produce a Report that provides useful insights and draws conclusions about Code compliance trends and developments in the life insurance industry, which requires robust data collection and reporting.

<sup>9</sup> Under the Code, if unexpected circumstances do not apply, a subscriber has to provide an initial decision within two months for income-related claims and a decision within six months for lump sum claims. Exceeding this timeframe without unexpected circumstances would result in a breach of the Code.

# The Code is not yet part of the culture of all subscribers

Commissioner Kenneth Hayne QC, in his Final Report on the Royal Commission, listed six basic principles of conduct that any desirable culture should incorporate the following:

- Obey the law.
- Do not mislead or deceive.
- Act fairly.
- Provide services that are fit for purpose.
- Deliver services with reasonable care and skill.
- When acting for another, act in the best interests of the other<sup>10</sup>.

This can be summed up as ‘doing the right thing’, particularly in relation to consumers. For life insurers, ‘doing the right thing’ can be achieved by putting the Code of Practice at the heart of all decision-making and behavioural expectations. The Code is essentially a blueprint for minimum standards of good behaviour towards consumers, clearly describing how subscribers will conduct sales, handle claims and complaints, and manage third-party service providers.

Unfortunately, a number of subscribers, particularly the larger ones, do not appear to be aligning the norms and values of their organisation with the standards set out in the Code. Although the vast majority of subscribers reported that they were satisfied their organisation had processes and procedures in place to comply with the Code, the evidence supplied to support these

claims through the ADCP process and the Committee’s investigations was variable and left the Committee with doubts about the robustness of some subscribers’ Code risk and compliance frameworks.

Subscribers must do more than see their Code obligations as minimal legalistic compliance requirements. As part of the broader consumer protection framework, the Code plays an important role in the provision of better outcomes for consumers, particularly vulnerable consumers or those experiencing financial hardship. Subscribers should use the Code as a tool to ask: ‘*How will the industry’s actions or decisions impact our customers? Are we abiding by the promises we’ve made to our customers by signing up to the Code?*’ The Code should not be dusted off and checked over once a year at reporting time or when a breach allegation is made. It should be a key cultural touchstone for all personnel within each subscriber organisation, reinforced through ongoing training and management review.

A narrow interpretation or patchwork implementation of the Code reflects badly on the industry and can taint the good efforts of those subscribers that do take the Code seriously. It is also a lost opportunity for some subscribers to improve their businesses by providing better outcomes for consumers. For example, via comprehensive complaints capture and analysis or more proactive consumer communication initiatives.

<sup>10</sup> Final Report: Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Vol. 1, p. 8, February 2019.

Subscribers who do take the Code seriously demonstrate effective internal breach identification and reporting mechanisms and a much more proactive approach to accepting responsibility for breaches and taking remedial action quickly and effectively. Such subscribers also exhibit robust risk and compliance environments, with more effective management oversight and Board reporting.

The Committee appreciates that there can be operational challenges in meeting Code commitments and 100% compliance may not always be achieved. However, all too often, for a number of subscribers, the rigour in specifying processes and monitoring their effectiveness is deficient. This can point to inadequate training of, and/or understanding by, the staff, and a lack of commitment from the organisation.

We hear and accept that Boards and Management are fully committed to the Code, however the outcomes we see for some subscribers do not reflect that commitment. This indicates that there is a disconnect between the intention and the way it is implemented when cascaded throughout the organisation, which in turn suggests that monitoring and reporting of Code compliance may not as be effective as management believes.

## **Board oversight of compliance matters**

The Committee reminds subscribers of their obligation under subsection 13.3(c) of the Code to have a governance process in place to report on their compliance with the Code to their Board of Directors or Executive Management. Boards have ultimate responsibility for corporate governance, which includes ensuring enterprise-wide compliance with the Code.

It is also essential that Boards challenge compliance shortcomings where appropriate and ensure that executive level messaging is cascaded effectively from the top down to reinforce organisational commitment and improve Code compliance outcomes when needed.

## **The Committee's role**

During 2018–19, the Committee commenced a programme of meetings with the Boards and leadership teams of Code subscribers, with the aim of enhancing engagement about and focus on Code compliance at the highest level. While the response to this programme to date has been pleasing and the ensuing discussions positive, we are yet to see evidence of improved Code compliance engagement and oversight by some subscribers. In an ongoing effort to improve the quality of subscribers' Code practices and data and compliance reporting, we will continue to engage with their Boards and Executive Management teams to pass on the information and insights gleaned from our monitoring activities.

# Life insurance business

Code subscribers provided data on the cover in force and distribution channels used during the year and information as supplied is presented below. However, data inconsistencies have meant that the Committee was not always able to draw conclusions against last year's data.

## Subscribers

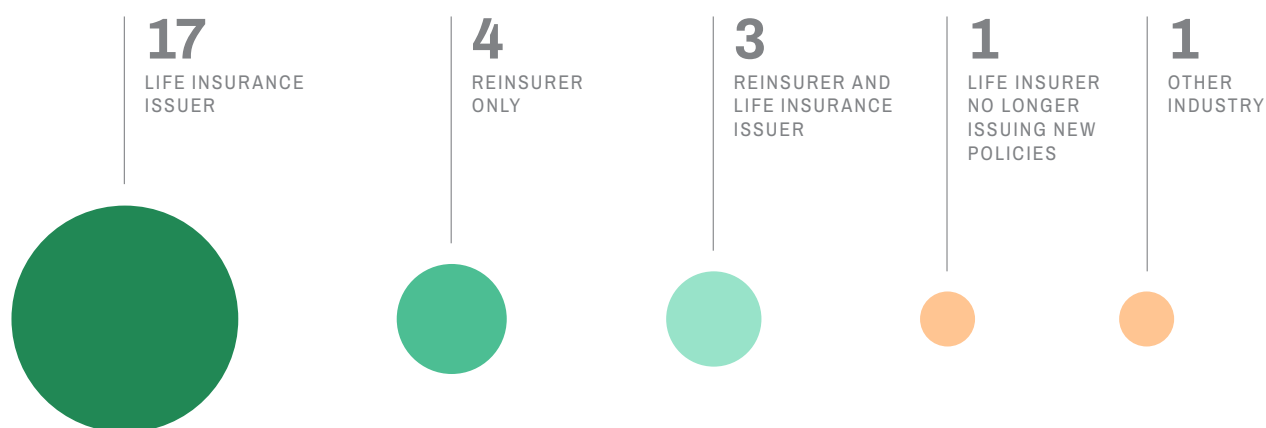
The number of subscribers to the Code increased by two during 2018–19, bringing the total to 26 (**Figure 1**). Four of these subscribers are specialist reinsurers, meaning that they only insure the risk taken on by other life insurers and do not issue life insurance cover directly to consumers.

One subscriber is categorised as an 'other industry participant': it provides claims services to the life insurance industry but does not itself issue insurance policies. A full list of Code subscribers is in **Appendix 1**.

FIGURE 1.

### A mix of subscriber types

Subscribers to the Code, 2018–19



## Benefit cover types

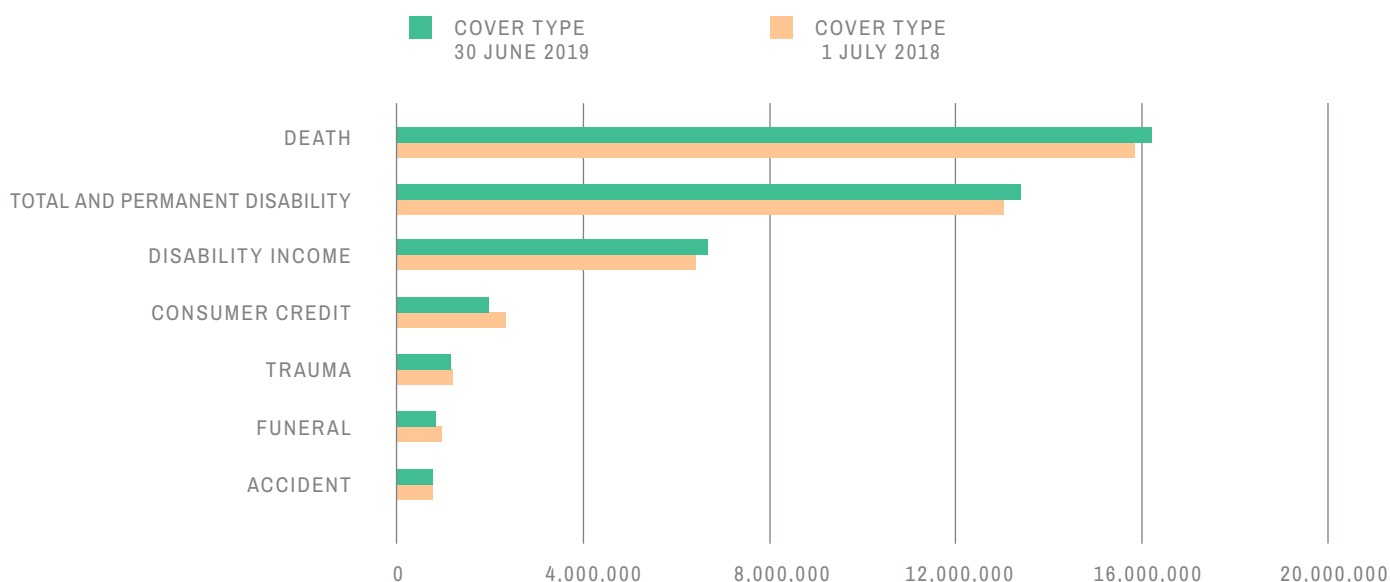
Twenty subscribers issued a total of 41 million cover types in force in the year to 30 June 2019. This equates to a marginal increase of 1% compared to the previous year<sup>11</sup>.

As was the case in 2017–18, death cover and total and permanent disability (TPD) were reported as the dominant types of cover in force (**Figure 2**), with death cover accounting for 40% of all benefit cover types in force and TPD accounting for 33%.

FIGURE 2.

### Death and TPD cover dominated

Cover types in force, 1 July 2018 and 30 June 2019



## Distribution

New life insurance business was issued by 20 subscribers in 2018–19. Subscribers relied on three distribution channels to issue new business. These were group, retail and direct (which includes direct distribution by the subscriber itself, its authorised representatives<sup>12</sup> and third parties).

(**Figure 3**) shows, for each subscriber, the distribution channels used and the proportion of that subscriber's business (measured by cover types in force) contributed by each channel.

<sup>11</sup> The opening figures at 1 July 2018 may differ from closing figures in last year's report.

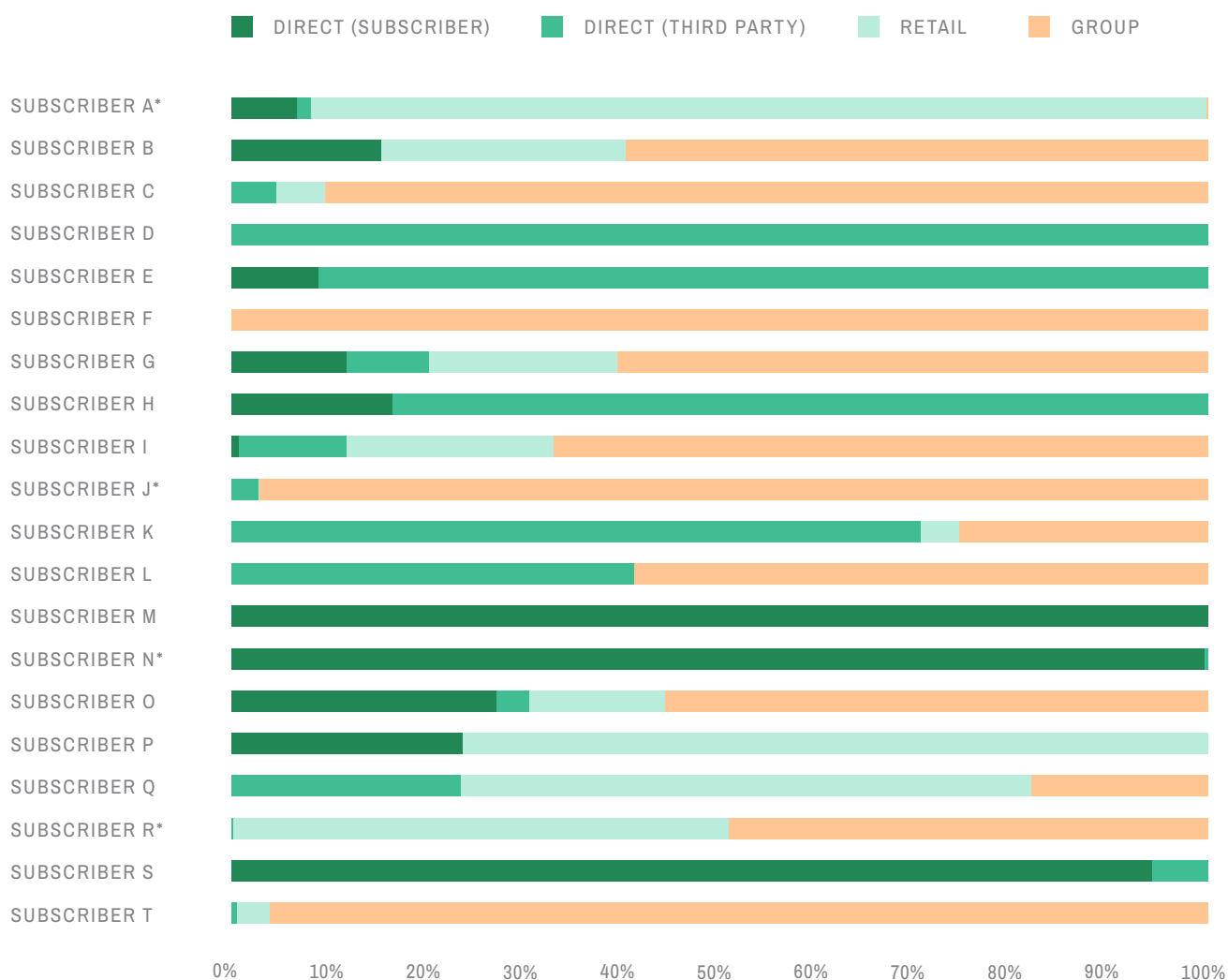
<sup>12</sup> The Code defines an authorised representative as 'a person, company or other entity authorised by us to provide financial services on our behalf under our Australian Financial Services licence, in accordance with the Corporations Act 2001. It does not include a person, company or entity that is an authorised representative of an Australian Financial Services licensee that is a related company to us.'

Much of the cover sold through direct (third party) distribution comprised white label products. White label products are issued by the insurer but rebranded and distributed by a third party<sup>13</sup>. In addition, some subscribers distributed their own branded products via third parties.

FIGURE 3.

**More subscribers used direct distribution**

Subscribers' cover types in force by distribution channel, 30 June 2019



\* Group distribution accounted for 0.13% of cover types in force for Subscriber A, Retail for 0.09% for Subscriber J, Direct (third party) distribution accounted for 0.21% of cover types in force for for Subscriber N and 0.02% for Subscriber R.

13 A white label product can include a number of cover types, such as death and TPD, or funeral insurance.

Most cover is distributed through the group channel, even though more subscribers use direct (subscriber) and direct (third party) channels than retail and group distribution channels than retail and group distribution channels (**Figure 4**). Cover distributed via the group channel contributed 77% of cover types in force as at 30 June 2019.

FIGURE 4.

**Group distribution accounted for most cover**

Percentage of cover in force by distribution channel, 30 June 2019

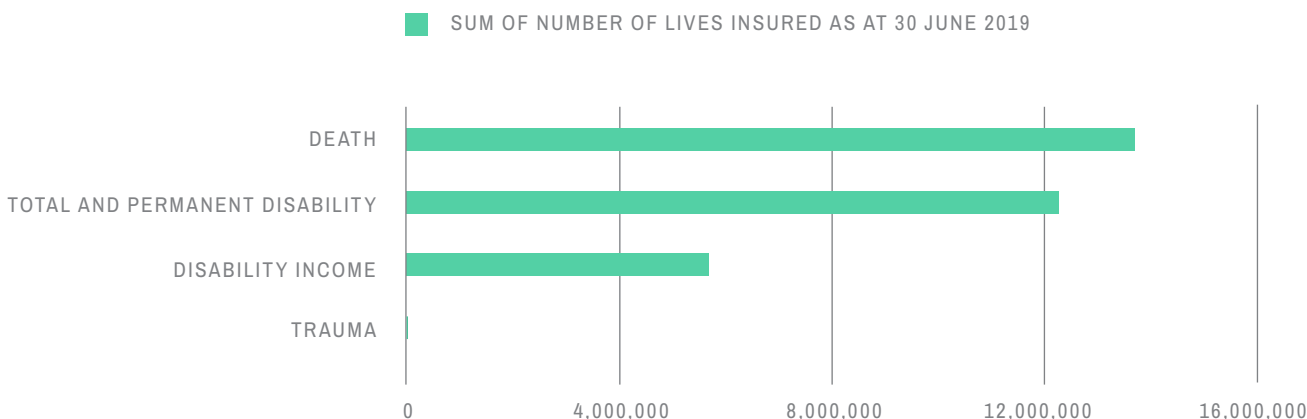


Death cover and TPD accounted for the largest proportion of cover types in force in both the group and retail insurance channels, together accounting for 82% of cover types in force via the group distribution channel (**Figure 5**) and 64% of cover types in force via retail distribution (**Figure 6**).

FIGURE 5.

**Death and TPD cover dominated group and retail distribution**

Cover types in force, group distribution, 30 June 2019\*



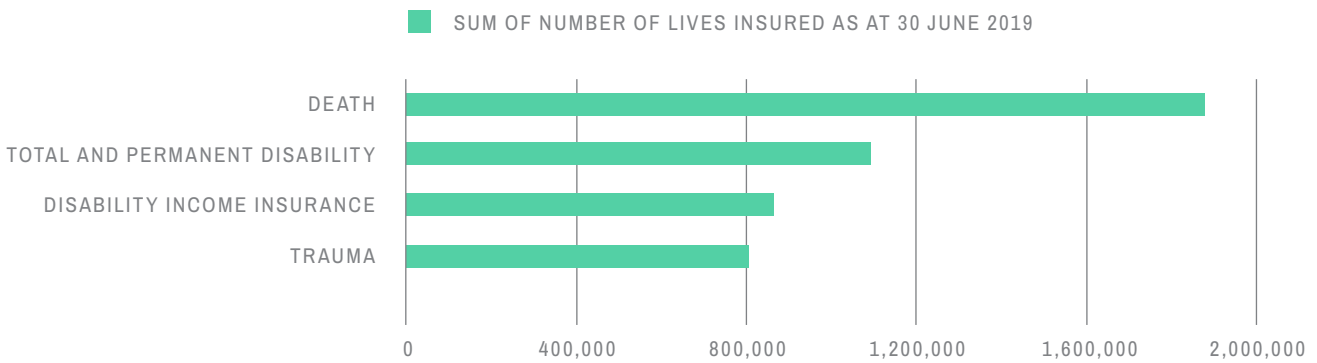
\* In addition, there were 4,699 cover types in force with trauma insurance through the group channel compared with 4,853 last year (<0.01% of cover types in force under the group channel).



FIGURE 6.

**Death and TPD cover dominated group and retail distribution**

Cover types in force, retail distribution, 30 June 2019

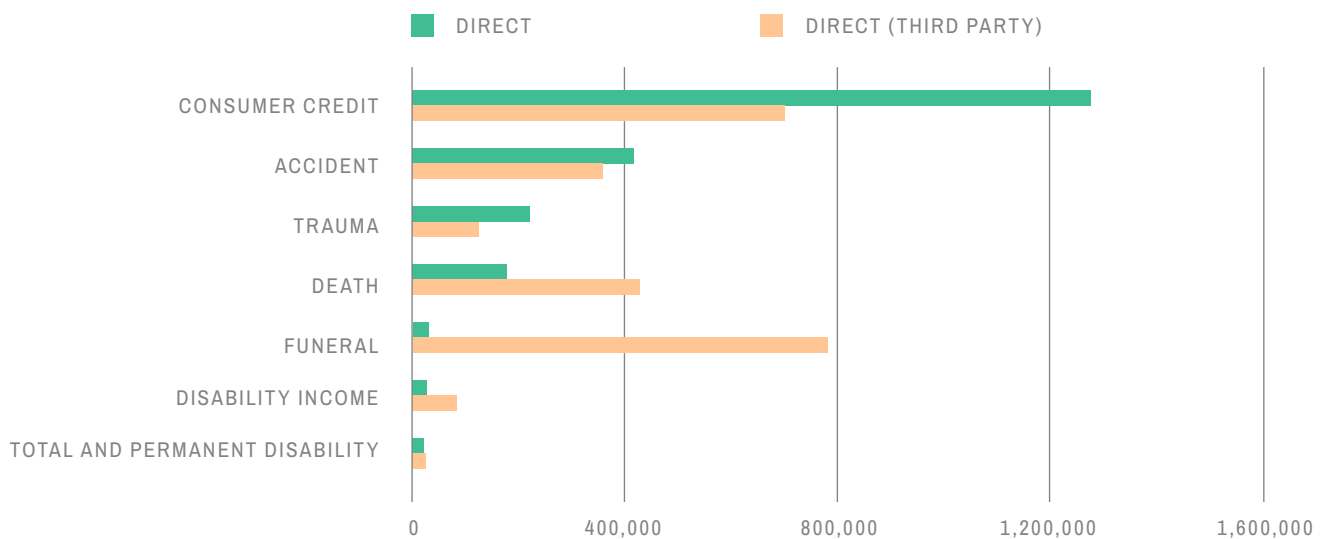


Consumer Credit Insurance (CCI) accounted for the largest proportion of cover types in force distributed directly, followed by funeral and accident insurance<sup>14</sup> (Figure 7).

FIGURE 7.

**Various cover types were distributed directly**

Cover types in force, direct distribution, 30 June 2019



The direct (third party) channel accounted for more than half (54%) of the total direct cover types in force.

As part of the Financial Services Council’s current review of the Code, the Committee has strongly advocated for third-party distributors to be bound by the Code’s standards, and for subscribers to establish a

contractual obligation with such distributors to comply with the relevant requirements of the Code. Until such time as the new Code is released, the Committee encourages subscribers to voluntarily ensure that all third-party entities with whom they enter into contracts are aware of the Code and develop processes in line with Code obligations.

<sup>14</sup> Accident insurance distributed within the direct channel increased from the previous year following the addition of two new Code subscribers writing this type of business in 2018-19.

# Claims

Consumers expect life insurers to process claims in a fair and timely manner and inform them if this is not possible. The need to improve claims standards was a pivotal driver for the Code's creation, as these are the standards that keep subscribers accountable at a time when consumers are at their most vulnerable. Claims issues still feature prominently in self-reported and alleged Code breaches, as well as in consumer complaints. Subscribers provided data on the number and nature of claims received during the year, as well as the time taken to determine them.

## Claim numbers

Subscribers assessed 130,611 claims in the 12 months to 30 June 2019, 660 fewer than in 2017–18. The majority of these (117,516) were received during the year and the rest (13,095) were received during the previous year and remained open at the beginning of 2018–19.

The number of claims determined by subscribers during the year was 111,011. By the end of the year, 19,600 claims were yet to be determined.

## Claims by cover type

As was the case last year, the highest proportion of claims received across all distribution channels was for Disability Income Insurance (DII), at 37% (**Figure 8**).

### COUNTING CLAIMS

Where one consumer makes multiple claims for more than one policy or cover type, a claim is recorded for each cover type for each policy. Some claims are withdrawn or otherwise closed before a decision on the claim is reached by the subscriber. The Committee did not collect details about these claims.

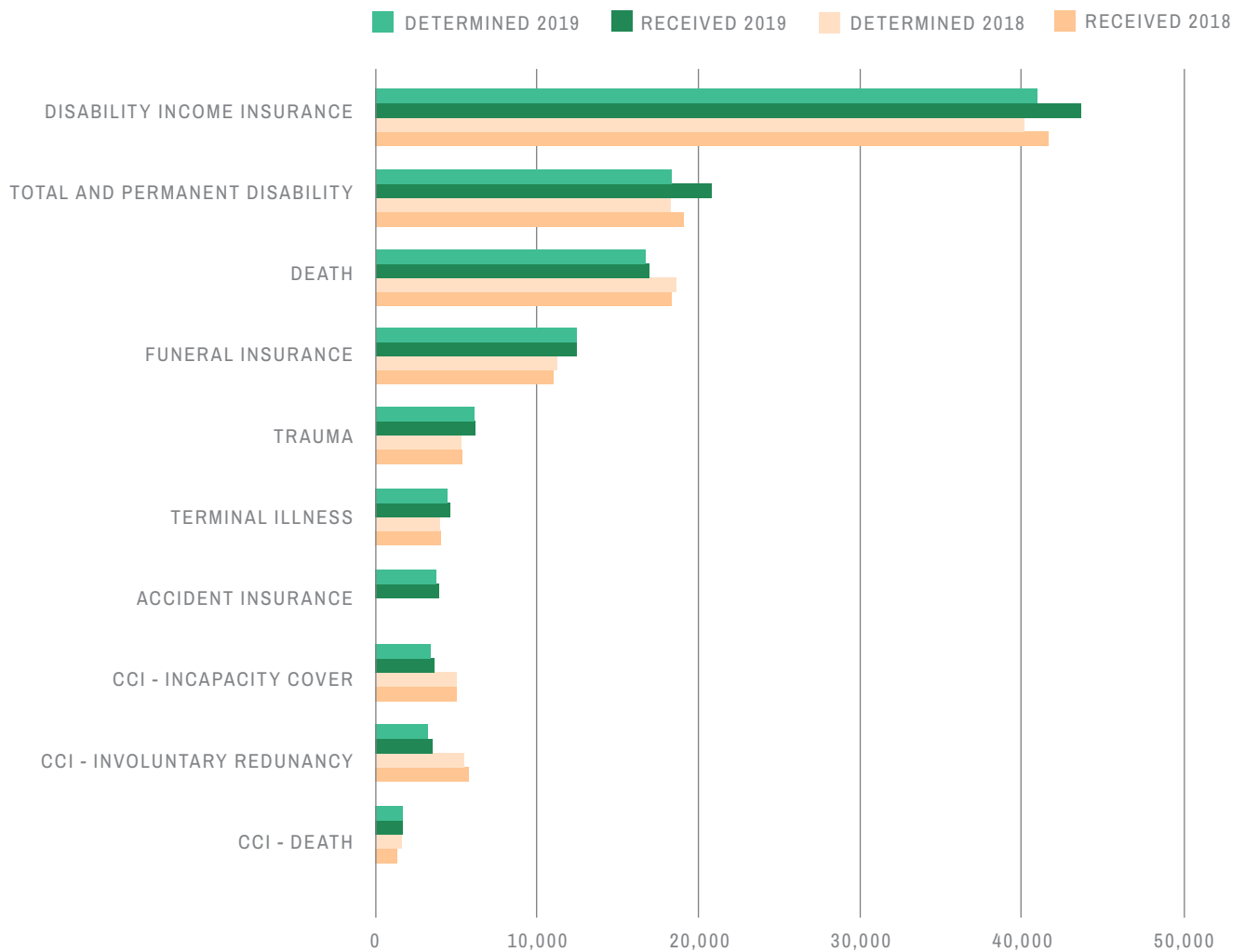
A determined (finalised) claim is one where the subscriber has made a decision to either admit or decline the claim or proceed to a return to work or rehabilitation trial, as defined in the Code. For the purpose of an income-related insurance claim, the date a claim is determined is the date a decision was made to admit or decline the claim.

The next most common claims were TPD and death cover, accounting for 18% and 14% of total received claims respectively.

FIGURE 8.

**Claims determined kept pace with claims received**

Number of claims received and determined by cover type, 2017-18 and 2018-19



**Claims by distribution channel**

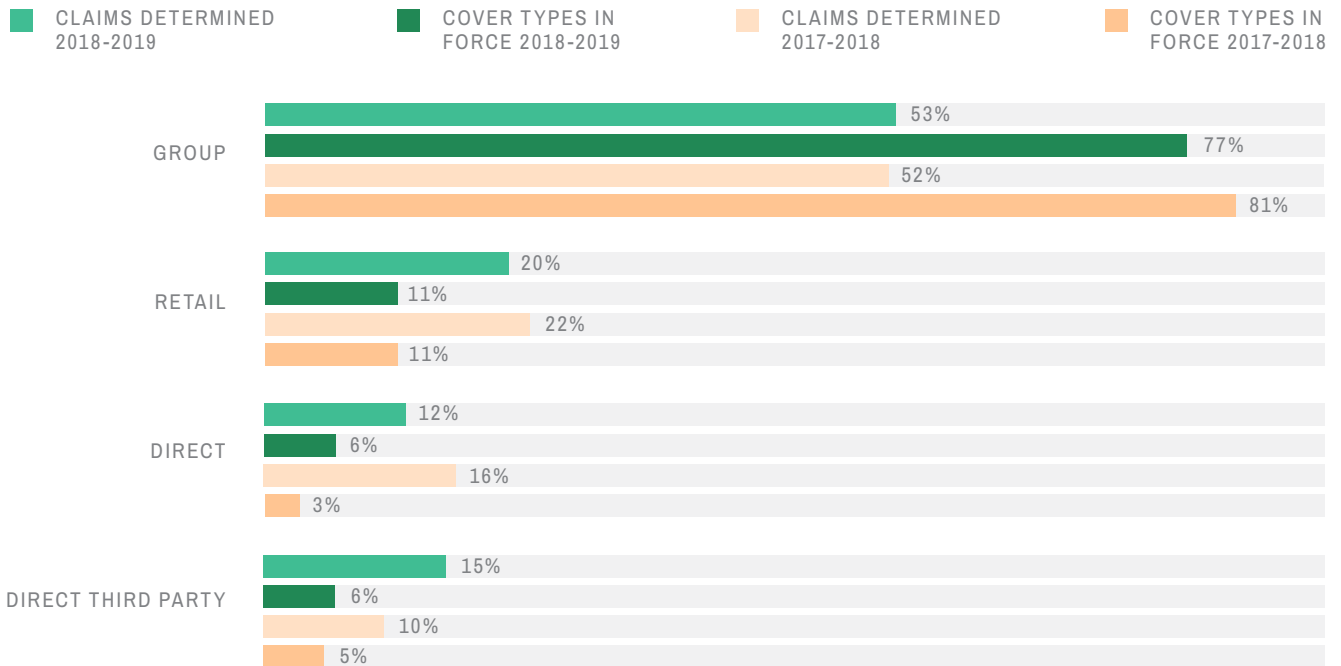
Whilst group insurance made up 77% of the cover types in force in 2018–19, only 53% of claims determined over the same period were for group cover (**Figure 9**). In contrast, the retail distribution channel accounted for 20% of determined claims but just 11% of cover types in force.

Similarly, cover distributed through the direct distribution channel represented only 12% of cover in force but accounted for 27% of determined claims.

FIGURE 9.

**Group accounted for fewer claims**

Percentage of cover types in force and claims determined by distribution channel, 2017-18 and 2018-19



**Time to assess claims**

The Code sets out timeframes in which subscribers must make a decision about claims. For income-related claims, an initial decision is required within the later of two months from the date the subscriber is notified of the claim or two months after the end of the waiting period<sup>15</sup>. For non-income related claims, subscribers have six months from the later of being notified of a claim or the end of any waiting period to make a decision<sup>16</sup>.

Of all decisions for income-related claims, subscribers reported that 83% were made within the required two months, while 17% were made in excess of two months (**Figure 10**) (89% and 11% respectively for 2017-18). This equates to a 6% deterioration in consumer outcomes, with 7,802 of such claims not resolved within two months this year in comparison to 5,299 in the previous year.

There was a minimal deterioration for non-income related claims, where a decision was made within the required six months for 91% of claims and in excess of six months for 9% of claims (**Figure 11**) (92% and 8% respectively for 2017-18).

15 Life Code of Practice Chapter 8 – Section 16 - When you make a claim

16 Life Code of Practice Chapter 8 – Section 17 - When you make a claim

FIGURE 10.

**Most claim decisions were reported as timely**

Decision timeframe for determined and undetermined income-related claims, 2017-18 and 2018-19

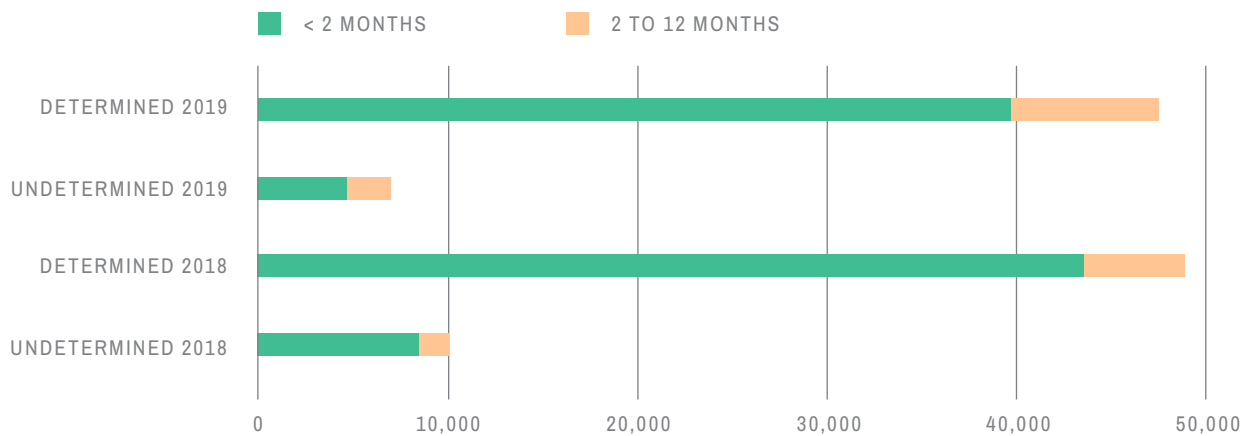
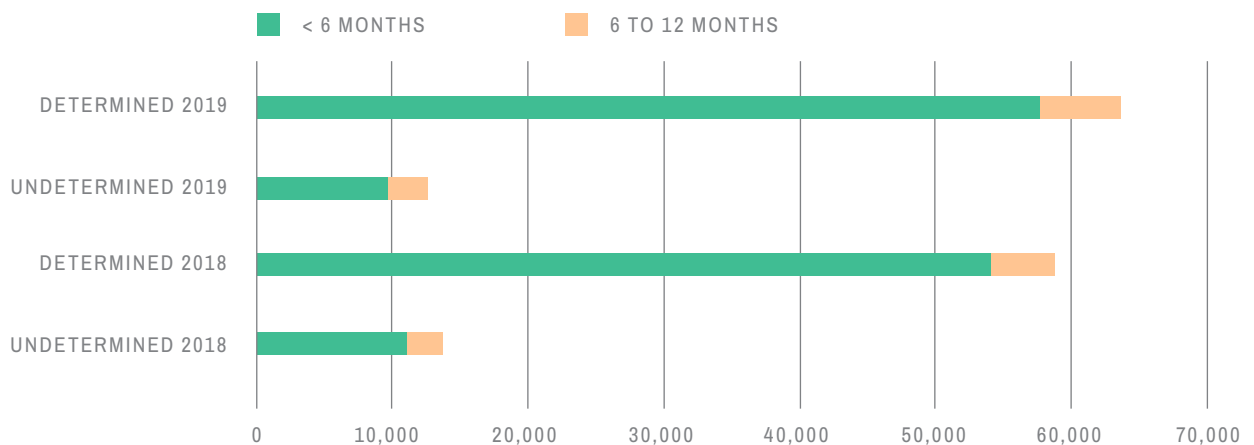


FIGURE 11.

**Most claim decisions were reported as timely**

Decision timeframe for determined and undetermined non-income related claims, 2017-18 and 2018-19



The Code provides for a longer claim assessment duration of up to 12 months where Unexpected Circumstances apply. The Code requires subscribers to tell the consumer why the delay has occurred and keep them informed about the progress of their claim.

Subscribers reported 18,896 determined and undetermined claims that exceeded the standard timeframe during the year, a 34% increase on the previous year’s total of 14,036. According to subscribers, unexpected circumstances applied to 12,907 (68%) of these claims, leaving 5,989 claims which exceeded both standard and Unexpected Circumstances duration timeframes (1,732 more than previous year).

Under the Code, if Unexpected Circumstances do not apply, a subscriber has to provide a decision within two months for income-related claims or six months for lump sum claims. Exceeding this timeframe without Unexpected Circumstances would result in a breach of the Code.

The Committee notes that there remains a substantial gap between the number of claims that are neither determined nor identified as Unexpected Circumstances and the number of reported breaches of sections 8.16 and 8.17, with the latter significantly lower. The underreporting of these breaches indicates that subscribers’ processes for recording and reporting accurately on breaches relating to claims handling timeframes are inadequate.

# Complaints

Complaints are an important indicator of consumer dissatisfaction and a source of valuable information for subscribers about what they need to do to facilitate better consumer outcomes. Subscribers recorded 19,483 complaints from consumers during 2018–19, an increase of 4,377 (or 29%) on the previous year.

Subscribers reported

**19,483**  
complaints

## Complaint causes

As was the case in 2017-18, the category of ‘policies in force’ was the largest single cause of complaints in 2018–19. There were 5,606 complaints related to this category – the equivalent of 29% of all complaints received within the 2018-19 year and an increase of 34% since the previous year.

Complaints related to claims, specifically claim decisions, claim handling and claim assessment duration, were the source of the second highest number of complaints.

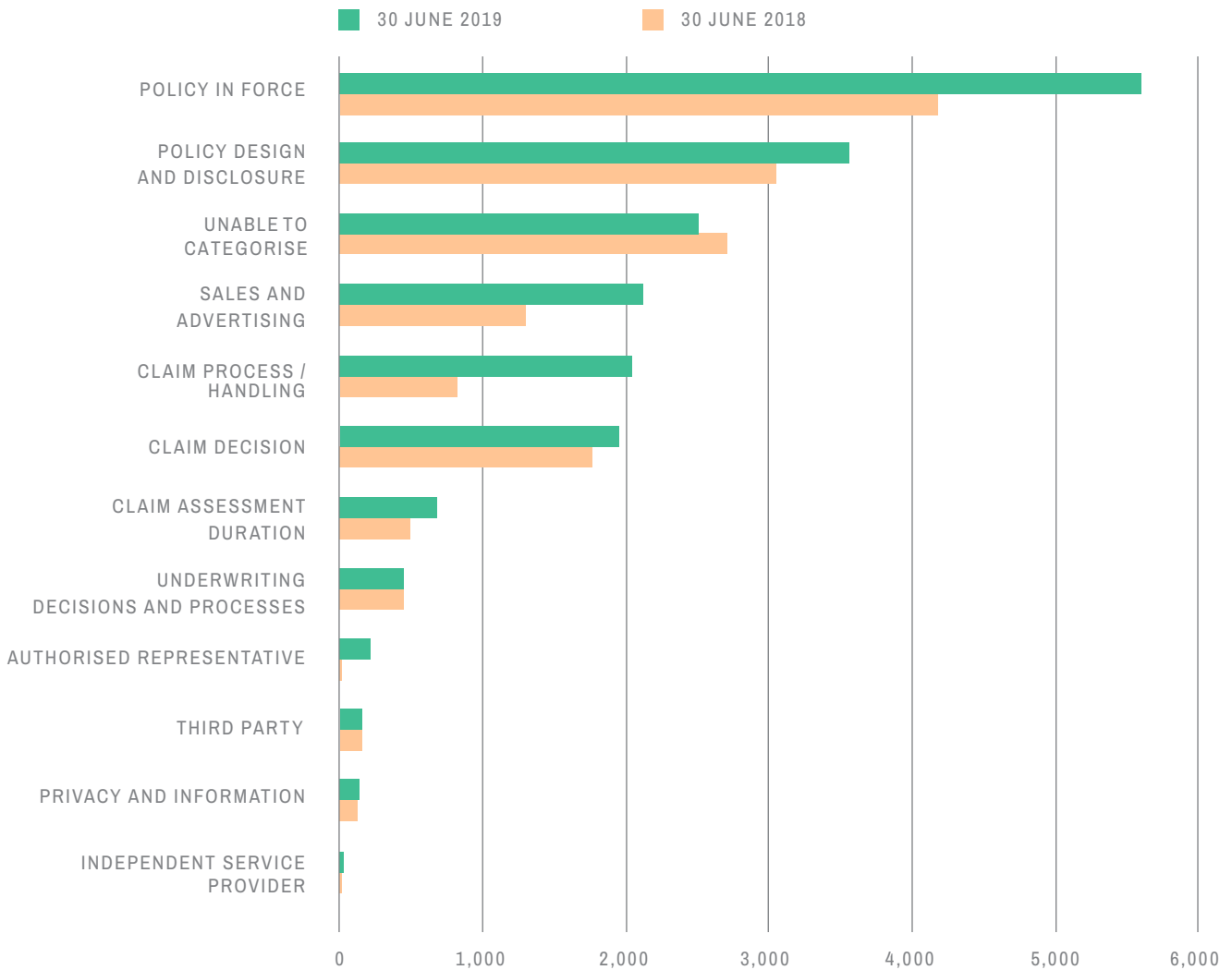
This, totalled 4,692 (or 24% of all complaints) (**Figure 12**), representing an increase of 52% since the previous year.

Another substantial source of complaints, accounting for 3,566 (or 18% of the total), was policy design and disclosure. Complaints of this kind increased by 17% since the previous year.

FIGURE 12.

**Policy and claims-related issues drove most complaints**

Cause of complaints received, 2017-18 and 2018-19



Despite ongoing efforts by the Committee to work with subscribers on the level of detail of the complaints data provided, it was disappointing to note once again that a significant number (2,514) of complaints were not able to be categorised by cause. In one case, a subscriber was unable to identify the cause of 1,435 (25%) of the 5,737 complaints it received during the year.

The Committee notes that development of a common industry classification regime may be worthwhile and urges all subscribers to review their capability to accurately identify, record and analyse causes of complaints in order to drive continuous improvement. We will continue to work with subscribers on this over the coming year.

## Complaints by distribution channel

Of the three distribution channels, retail received the highest number of complaints (9,632 or 49% of the total), despite accounting for only 11% of cover types in force (Figure 13). Complaints about products distributed via retail channels rose by 40% in 2018–19.

Complaints about cover distributed directly also increased substantially over the same period, up 21% to a total of 7,127 complaints. Like retail-distributed cover, directly distributed cover generates a disproportionately large share (37%) of

complaints whilst representing only 12% of cover types in force.

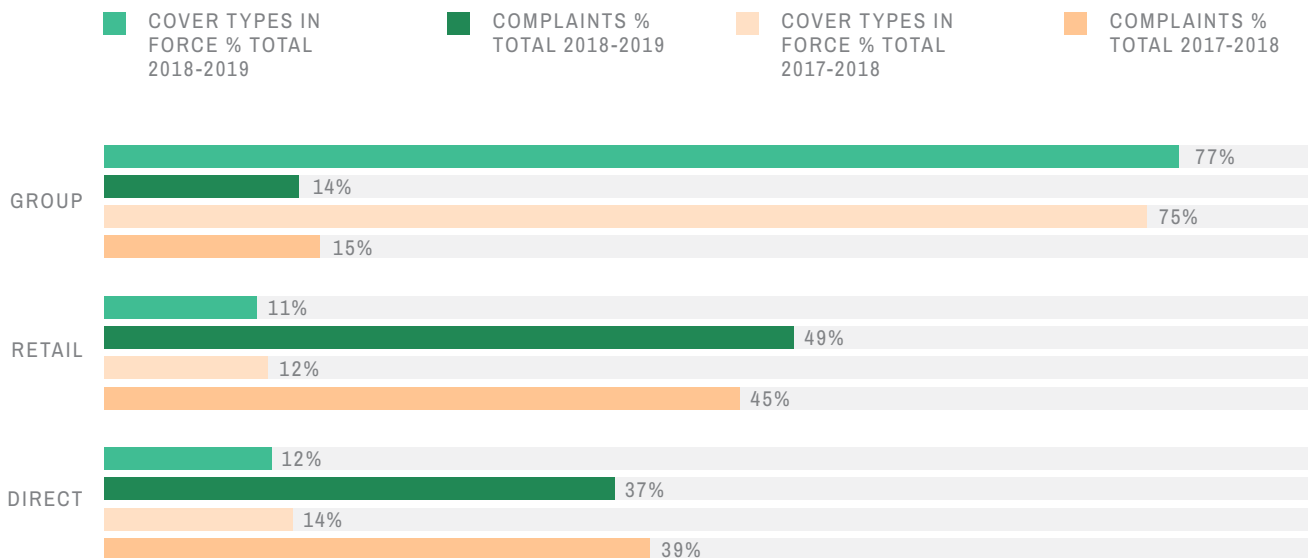
Cover distributed by the group channel continues to generate the fewest complaints of all (2,724 or 14%), even though it accounts for 77% of cover types in force.

It was not possible from the information provided to determine the reasons for the higher overall complaints reporting by subscribers for 2018–19.

FIGURE 13.

### Direct and retail distribution accounted for disproportionate complaints

Percentage of cover types in force and complaints by distribution channel, 2017-18 and 2018–19





# Code compliance

In 2018–19, subscribers reported 101 breach events, 38% fewer than the previous year. Conversely, isolated breaches of the Code increased by 45% over the same period, with 11,483 reported. The majority of all the self-reported breaches occurred as part of a breach event, where a single cause led to multiple breaches of a Code section.

**101**   
breach events

**11,483**   
isolated breaches

## Top 5 breach event type

1. Policy changes and cancellation rights
2. When you buy insurance
3. Sales practices and advertising
4. When you make a claim
5. Complaints and disputes

## Top 5 isolated breach types

1. When you make a claim
2. When you buy insurance
3. Access to information
4. Sales practices and advertising
5. Policy changes and cancellations

**73,695**   
consumers potentially impacted

## Breach events

Subscribers reported 101 breach events which covered 39 sections of the Code and potentially impacted 62,212 consumers.

As was the case in 2017–18, most breach events involved chapter 6 of the Code, which sets out subscribers' obligations relating to policy changes and cancellation rights and accounted for 36% of all the potential consumer impacts (**Table 1**). Notable issues included:

- subscribers' failure to provide consumers with annual notices containing certain information specified in section 6.3;
- 15 breach events related to communication during the term of the policy<sup>18</sup>, impacting or potentially impacting 22,626 consumers and accounting for just under a quarter (23%) of the total; and
- a single event led to breaches of subsections concerning cancellation rights, namely, the consumer's entitlement to a refund of any money owed by the subscriber within 15 business days of the consumer cancelling their life insurance policy<sup>19</sup>. This event accounted for 11% of breach events with a potential impact on 6,590 consumers.

Breach events concerning chapter 5 of the Code, which sets out subscribers' obligations when selling insurance, had the second highest consumer impact this year.

### COUNTING BREACHES

A breach is any instance of non-compliance with the Code. Breaches may be isolated or part of a breach event. A **breach event** is an event that results in multiple breaches of a Code section from the same cause at the same point in time (for example, a system coding error impacting a template letter sent to multiple consumers). An **isolated breach** is a single breach resulting from a specific cause at a point in time and impacting one consumer (for example, a claims officer declining a specific claim due to their mistaken interpretation of a process or circumstance).

For this report, the Committee did not collect data about significant breaches, as defined in the Code. See the Committee's 2018–19 Annual Report for information about significant breaches<sup>17</sup>.

A single subscriber's self-reported breach of section 5.14(b) accounted for 77% of breach events for this chapter. The subscriber reported that its template letters did not include advice to consumers about their right to obtain information used to assess their insurance application, potentially impacting 12,972 consumers. The subscriber has since taken corrective action by notifying all impacted consumers and updating its template letters.

<sup>17</sup> [Monitoring Compliance with the Life Insurance Code of Practice: 2018 –19 Retrospective](#), September 2019.

<sup>18</sup> Life Insurance Code of Practice, section 6.3(a–e)

<sup>19</sup> Life Insurance Code of Practice, section 6.7

TABLE 1.

**Policy changes and cancellation breach events had the most impact**

Breach events and their potential consumer impact by Code chapter, 2018-19

| Code chapter                              | Events     |             | Consumer impact |             | Year-on-year impact ranking change |         |
|---|------------|-------------|-----------------|-------------|------------------------------------|---------|
|   | No.        | Percent     | No.             | Percent     | 2018-19                            | 2017-18 |
| 6. Policy changes and cancellation rights | 22         | 22%         | 22,626          | 36%         | 1                                  | 1       |
| 5. When you buy insurance                 | 9          | 9%          | 16,799          | 27%         | 2                                  | 5       |
| 4. Sales practices and advertising        | 7          | 7%          | 13,838          | 22%         | 3                                  | 2       |
| 8. When you make a claim                  | 41         | 41%         | 5,645           | 9%          | 4                                  | 3       |
| 9. Complaints and disputes                | 13         | 13%         | 2,075           | 3%          | 5                                  | 7       |
| 3. Policy design and disclosure           | 5          | 5%          | 1,159           | 2%          | 6                                  | 4       |
| 1. Code objectives                        | 2          | <2%         | 67              | <1%         | 7                                  | 8       |
| 14. Access to information                 | 2          | <2%         | 3               | <1%         | 8                                  | -       |
| <b>Total</b>                              | <b>101</b> | <b>100%</b> | <b>62,212</b>   | <b>100%</b> |                                    |         |

Breaches of the Code's sales and advertising standards, set out in chapter 4, accounted for 22% of the potential consumer impact of breach events compared to just 4% for the previous year. Most of these breaches related to the sale of CCI, including information that must be disclosed to the consumer at purchase and in annual notices<sup>20</sup>. In one instance, a subscriber self-reported three apparent breaches, potentially impacting 12,473 consumers. These instances were subsequently investigated, with the Committee determining that, as the products in question were sold under a third party's AFSL, the subscriber was not technically in breach of the Code.

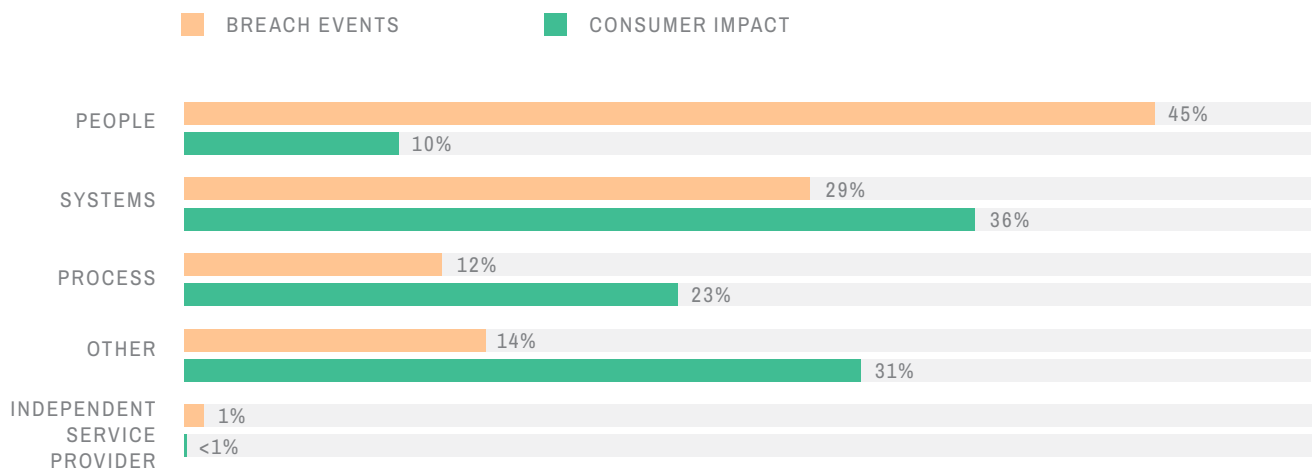
People-related issues (mainly those relating to resourcing) were reported by subscribers as the cause of 45% of breach events but accounted for just 10% of the potential consumer impact (**Figure 14**). Conversely, whilst only 29% of breach events were caused by a system issue, these breaches tended to impact large number of consumers, accounting for almost 36% of the potential consumer impact of breach events. Some subscribers named 'other' causes as the reason for breach events. Several subscribers were unable to identify a single root cause of their reported breach events stating that a combination of resourcing, human error and lack of training on Code compliance and process was responsible. 'Other' causes represented 14% of breach events and accounted for 31% of the potential consumer impact.

<sup>20</sup> Life Insurance Code of Practice, section 4.7(f), (di) & (giii)

FIGURE 14.

### Systems causes had the greatest consumer impact

Percentage of breach events and their potential consumer impact by cause, 2018-19



### Isolated breaches

Subscribers reported 45% more isolated breaches in 2018-19 than in 2017-18. There were 11,483 isolated breaches in 2018-19, each impacting a single consumer.

Isolated breaches were of a different nature to breach events. Almost all (92%) isolated breaches recorded this year related to the Code’s claims obligations, set out in chapter 8 (Table 2).

In particular, subscribers reported breaches of sections:

- 8.3, which states that subscribers must, within 10 days of being notified of a claim, explain the cover and claim process;
- 8.4, which requires subscribers to keep consumers informed of the progress of a claim every 20 days; and
- 8.15, which requires subscribers to inform consumers of the claim decision within 10 days of gathering all required information.

#### All significant breach events should be self-reported to the Committee throughout the year

As breach events generally impact multiple consumers, the Committee would expect most of these to be significant in nature, and therefore self-reportable under the Code. However, just less than half of all breach events recorded by subscribers as part of the ADCP were reported as significant breaches to the Committee during the reporting year.

The Committee expects subscribers to more carefully consider whether each breach event was significant and, if so, report it to the Committee.

There were also breaches of section 8.16 and 8.17 concerning claim assessment timeframes.

As was the case in 2017–18, isolated breaches of the Code’s standards relating to buying insurance (chapter 5) were the second most common this year. However, whilst they accounted for 26% of all isolated breaches last year, they made up just 4% of breaches this year. Most related to sections:

- 5.12, which requires subscribers to inform consumers about whether cover will be provided within five business days of gathering the necessary information about the application; and
- 5.14 (a–c), which requires subscribers to advise consumers of the reasons for not offering cover, or offering cover on alternative terms; to inform consumers of their right to the information used to assess the application within 10 days; and to notify consumers of the options if they disagree with the subscriber’s decision.

**TABLE 2.**  
**Claims accounted for most isolated breaches**  
Isolated breaches by Code chapter, 2018-19

| Code chapter                              | Isolated Breaches |             | Year-on-year ranking change |         |
|---|-------------------|-------------|-----------------------------|---------|
|   | No.               | Percent     | 2018-19                     | 2017-18 |
| 8. When you make a claim                  | 10,588            | 92%         | 1                           | 1       |
| 5. When you buy insurance                 | 508               | 4%          | 2                           | 2       |
| 14. Access to information                 | 133               | 1%          | 3                           | 5       |
| 4. Sales practices and advertising        | 116               | 1%          | 4                           | 3       |
| 6. Policy changes and cancellation rights | 84                | <1%         | 5                           | 7       |
| 9. Complaints and disputes                | 34                | <1%         | 6                           | 4       |
| 7. Consumers requiring additional support | 18                | <1%         | 7                           | 8       |
| 3. Policy design and disclosure           | 1                 | <1%         | 8                           | 6       |
| 11. Information and Education             | 1                 | <1%         | 8                           | –       |
| 1. Code objectives                        | –                 | –           | –                           | 9       |
| <b>Total</b>                              | <b>11,483</b>     | <b>100%</b> |                             |         |

Unlike breach events, processes and systems each accounted for a very small percentage of isolated breach causes (4% processes, <1% systems). As was the case in 2017–18, the overwhelming majority (88%) of isolated breaches were reported as being caused by people (**Figure 15**). The biggest contributor, accounting for 52% was resourcing issues, primarily resulting from moving staff to meet resourcing needs in specific areas, without staff being adequately trained before doing so.

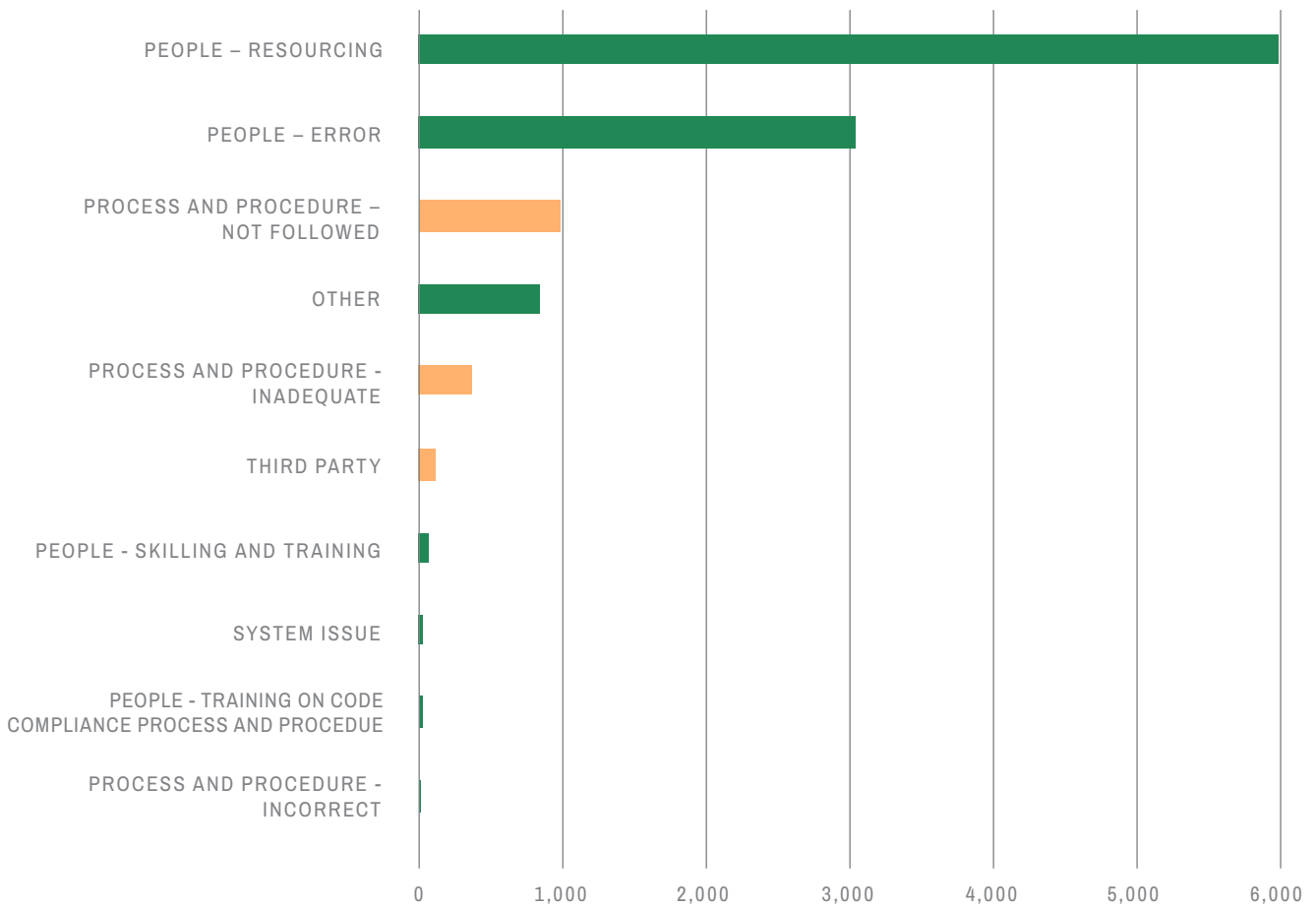
A combination of staff failure to follow an established process and staff errors caused a further 4,031 isolated breaches (35%).

Only 9% of isolated breaches were attributed to ‘other’ reasons, but from the details provided by subscribers, it is clear many of these could have been allocated to people-related issues including staff error, staff not correctly following processes and procedures, and lack of staff training on Code compliance.

FIGURE 15.

**Most isolated breaches were caused by people related issues**

Isolated breaches by cause, 2018-19



**Claims and underwriting skills and training**

In an effort to understand how subscribers are complying with their obligations under the Code to provide their claims and underwriting personnel with appropriate skills, training and support<sup>21</sup>, a qualitative ADCP data component was added this year. Subscribers were asked to evidence how they satisfy compliance with these obligations, including how they ensure that the skills and training of their claims assessors and underwriters remain appropriate and current.

Subscribers appeared to be conscious of the skills and training obligations under the Code, with smaller organisations appearing to have better documented processes.

Most subscribers either had a competency framework in place or were in the process of developing their frameworks with 68% of subscribers reported having documented skills and competency frameworks aligned to all underwriter and claims roles.

21 Life Insurance Code of Practice, section 5.15 and section 8.20

Compliance arrangements generally reported clear oversight, use of approval limits, and formal reviews and audits for underwriting and claims staff.

Subscribers in general did not have a clearly identified minimum training or educational standard for claims and underwriting staff. They instead rely on experience, reference checking and in some cases, skills testing for new staff. Existing staff are taught skills largely through internal training with some (generally optional) support from outside organisations such as reinsurers or the Australian Life Underwriting and Claims Association. The Committee considers that there is value in the industry assessing the merit of adopting a minimum standard of training and education for underwriting and claims staff, which could lead to higher standards of service to consumers and a consistent and clear benchmark for the industry.

The frameworks reported training on Code requirements in only 60% of cases. While the Committee understands that all staff receive some training on the Code, we expected to see specific Code training for underwriting and claims staff because of the detailed communication obligation in the Code.

In most cases the frameworks did not include any guidance on customer service or any behavioural training. The Committee notes that these are essential components of dealing with vulnerable consumers, and would hope to see all subscriber frameworks explicitly reference such guidance in future.

Overall, subscribers' responses to this component of the questionnaire were somewhat perplexing to the Committee. On the one hand, subscribers claim that they are meeting their obligations under the Code to provide underwriters and claims assessors with the required skills, training and support. Yet, on the other hand, 45% of breach events and 88% of isolated breaches reported were attributed by subscribers to people-related causes, including inadequate staff training, human error and a failure to follow the correct processes and procedures.

Furthermore, 92% of isolated breaches related to the Code's claims standards, particularly around lack of communication with consumers and claims timeframes. While the Committee's review confirms the existence of subscribers' training frameworks, the number of breaches specific to staff training raises questions around the effectiveness of these training frameworks, particularly in relation to Code obligations.

Even if subscribers believe they are fulfilling their requirements under sections 5.15 and 8.20 of the Code, it appears that in a number of cases they are not properly assessing the effectiveness of their training programmes, nor sufficiently monitoring the capability and compliance outcomes for their staff.

## Investigation into subscribers' compliance with claims and complaints handling obligations

During the year, the Committee completed a review of 11 Code subscribers' compliance with sections 8.16, 8.17 and 9.10 of the Code. The review was initiated by the receipt of more than 700 alleged breaches of the Code from a plaintiff law firm in February 2018 and the findings published in March 2020<sup>22</sup>.

The Committee's review of the 11 subscribers' underlying processes and procedures for these Code sections identified that most of the subscribers involved were non-compliant with, and also lacked robust frameworks to monitor compliance with sections 8.16, 8.17 and 9.10 of the Code, particularly in relation to the treatment of Unexpected Circumstances as specified in sections 8.16/8.17.

## Code risk and compliance frameworks

All but three of the 25 Code subscribers reported that they were satisfied their organisation had the necessary processes and procedures in place to comply with the Code, including processes for training, compliance monitoring, breach rectification and continuous improvement.

The Committee does not share subscribers' confidence that their compliance frameworks are sufficiently robust. In the Committee's view, with evidence of its recent investigation into subscribers' compliance with claims and complaints handling obligations and the ADCP data integrity issues previously noted, there is a sense that some subscribers are paying mere lip service to their Code obligations – talking the talk but not walking the walk. The Committee expects subscribers to improve their compliance frameworks as a matter of priority, so that potential breaches are detected before they occur, actual breaches are identified, reviewed, escalated and corrected promptly, and that effective periodic compliance reviews and attestations are undertaken to ensure the efficacy of all compliance data.

<sup>22</sup> [Claims and Complaints Handling Obligations: A review of compliance by Life Code subscribers](#), March 2020.



# Appendix 1

## List of Code subscribers at 30 June 2019

|    |  |
|----|--|
| 1  | AIA Australia  |
| 2  | Allianz Australia Life Insurance Limited                           |
| 3  | AMP Life Limited   |
| 4  | Asteron Life   |
| 5  | ClearView Life Assurance Limited                                   |
| 6  | EMLife*  |
| 7  | General Reinsurance Life Australia Ltd                             |
| 8  | Hallmark Life Insurance Company Ltd                                |
| 9  | Hannover Life Re of Australasia Ltd                                |
| 10 | HCF Life Insurance Company Limited                                 |
| 11 | Integrity Life Australia Limited                                   |
| 12 | MetLife Insurance Limited  |
| 13 | MLC Limited  |
| 14 | Munich Reinsurance Company of Australasia Limited                  |
| 15 | NobleOak Life Limited  |
| 16 | OnePath Life Limited (Wealth Australia, ANZ)                       |
| 17 | QInsure Limited  |
| 18 | RGA Reinsurance Company of Australia Limited                       |
| 19 | SCOR Global Life Australia Pty Ltd                                 |
| 20 | St Andrew's Life Insurance Pty Ltd                                 |
| 21 | St George Life Limited #   |
| 22 | Swiss Re Life & Health Australia Limited                           |
| 23 | TAL Life Limited   |
| 24 | The Colonial Mutual Life Assurance Society (trading as Commlnsure) |
| 25 | Westpac Life Insurance Services Limited (WLISL)                    |
| 26 | Zurich Australia Limited   |

\* Claims Service Provider

# Current subscriber – no longer writing New Business – Part 9 in progress – Inforce data included into WLISL ADCP reporting

**Life Insurance Code of Practice**  
**Annual Industry Data and Compliance**  
**Report 2018–19**

To make a Code breach referral visit  
our website [LifeCCC.org.au](http://LifeCCC.org.au) or email  
[info@codecompliance.org.au](mailto:info@codecompliance.org.au)