Life Insurance Code of Practice

Annual Industry Data and Compliance Report 2019–20

APRIL 2021

LIFE CODE COMPLIANCE COMMITTEE

Contents

Chair's message

I am pleased to present the Life Code Compliance Committee's Annual Industry Data and Compliance Report (the Report) for the period 1 July 2019 to 30 June 2020.

The Report aggregates data sourced directly from Code subscribers, together with data from the Committee's compliance monitoring work, to provide a snapshot of the life insurance industry and its compliance with the Life Insurance Code of Practice (the Code) during the reporting period.

This is the third year that the Committee has published the Report, and we were pleased to see subscribers apply far more rigour to the data collection and compliance reporting process than was the case last year. Despite some issues with the initial completion of subscribers' data workbooks, which resulted in the need for repeated submissions and related delays, we noted an overall improvement to subscribers' processes for assuring the quality and accuracy of their data.

Better quality reporting has provided us with a valuable overview of the industry in what has been a particularly challenging year. Code subscribers have been operating in an issues-rich environment, marked by significant changes to consumer protection laws following the Financial Services Royal Commission, an increasing awareness by customers of their consumer rights, and the difficulties associated with business continuity during the COVID-19 pandemic.

> *"Better quality reporting has provided us with a valuable overview of the industry in what has been a particularly challenging year."*

These challenges are at the heart of many of the Report's key findings (page 6), which include a substantial drop in the number of covers following new legislation to protect superannuation balances, and a rise in the number of customer complaints about claims as well as sales and advertising since the previous year.

The Committee acknowledges that these challenges have had an impact on operating and working environments; however, we remind subscribers that the obligations built into the Code are especially important during difficult times. They guide subscribers' decision making towards outcomes that are fair, respectful, transparent and timely for all customers but particularly those who are vulnerable or may be experiencing financial hardship. In this context, demonstrated compliance with the Code has never been more crucial.

> *... if subscribers are serious about preventing breaches, we would urge them to look beyond **who** or **what** caused the breach to find out **why** the breach occurred.*

While the number of isolated breaches fell by 57% since the previous reporting period, it was disappointing to note the prevalence of isolated breaches attributed to people-related issues – namely, human error or a failure by staff to follow established processes and procedures. Given subscribers' assertions that they have frameworks in place to ensure the competency of their underwriters and claims staff, the Committee is at a loss to understand why people-related issues continue to be the cause of so many breaches.

Are subscribers' competency frameworks not sufficiently robust? Or are subscribers simply nominating 'human error' or 'processes and procedures not being followed' as a default option instead of investigating the root cause of the breach? Either way, if subscribers are serious about preventing breaches, we would urge them to look beyond *who* or *what* caused the breach to find out *why* the breach occurred.

In a similar vein, the Committee is sceptical of Code subscribers' declarations that they have the necessary processes and procedures in place to achieve Code compliance, including processes around training, monitoring and breach correction. While we know that some subscribers are doing well in these areas, we also know from our analysis of their breach reporting, in tandem with our own compliance investigations, that several other subscribers have a way to go to ensure their Code risk and compliance frameworks are successfully detecting, resolving and preventing breaches.

We thank subscribers for their ongoing effort and commitment to helping us achieve a quality industry dataset and we look forward to further positive discussions with them as we prepare for the 2020–21 data submission.

Anne T Brown
Independent Chair
Code Compliance Committee

Executive summary

2020 Data at a glance

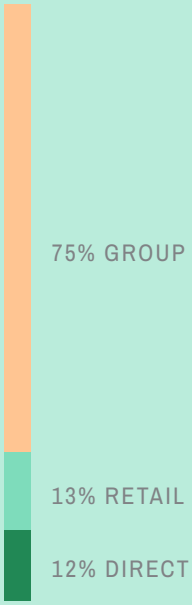
33 million cover types in force issued by **19** subscribers

of which →

DEATH COVER

TOTAL & PERMANENT DISABILITY COVER

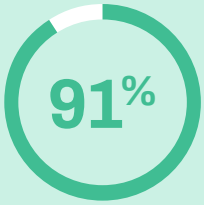
distributed via →



Claims

125,880 claims assessed

INCOME RELATED CLAIMS DECIDED WITHIN 2 MONTHS



NON INCOME RELATED CLAIMS DECIDED WITHIN 6 MONTHS

Complaints

20,394 complaints received

ABOUT POLICY RELATED ISSUES

ABOUT CLAIM RELATED ISSUES

Key findings

NEW CONSUMER PROTECTION LAWS RESULTED IN 8.3 MILLION FEWER COVERS

Covers in force this year reduced by 20% compared to 2018–19 (down from 40.9 million to 32.6 million). The decline is largely attributable to the cancellation of covers as a result of the *Protecting Your Super* (PYS)[1] and *Putting Members' Interests First* (PMIF)[2] laws, which were introduced in response to the Royal Commission into Banking, Superannuation and Financial Services to protect consumers' superannuation funds from being eroded by insurance premiums.

Group cover was particularly affected by the new superannuation laws, and the industry experienced a 23% reduction in covers during the year.

Sales of Consumer Credit Insurance (CCI) and Funeral insurance also declined following a tightening of the ASIC regulations for the sale of these products. As a result, some subscribers ceased distributing these products, either directly or as white-label products via third-party sellers, and overall 25% fewer CCI covers and 20% fewer Funeral insurance covers were in force.

MOST CLAIMS DECISIONS WERE MADE WITHIN THE REQUIRED TIMEFRAMES

The numbers of claims received and determined were similar to last year, each declining by just 3%. The number of claims in progress across all benefit types also remained stable as subscribers finalised a similar number of claims as were received. Pleasingly, most claims decisions were made within the timeframes set out in Chapter 8 of the Code, with 80% of income-related claims made within two months and 91% of non-income related claims made within six months.

MOST SUBSCRIBERS WERE ABLE TO PINPOINT A REASON FOR APPLYING UNEXPECTED CIRCUMSTANCES TO A CLAIM

This year, for the first time, subscribers were asked to report on the number of claims where Unexpected Circumstances applied as referred to in sections 8.16 and 8.17 of the Code. They were also required to give specific reasons (as listed in Chapter 15 ('Definitions') of the Code) for applying Unexpected Circumstances to these claims.

The Committee was encouraged to see that most subscribers were able to provide this information and clearly identify the reason for applying Unexpected Circumstances to a claim. Regrettably, two subscribers confirmed that they were unable to identify and record the reasons for applying Unexpected Circumstances on any of the claims where Unexpected Circumstances applied and one of these subscribers appeared to have no framework in place for doing so.

In the Committee's view, simply recording that a claim is in Unexpected Circumstances is not sufficient. We expect subscribers to be able to record the specific Unexpected Circumstances reason so that they can understand why delays are occurring and take steps to prevent them where possible.

> *"This year, for the first time, subscribers were asked to report on the number of claims where Unexpected Circumstances applied ..."*

1 PYS – https://www.legislation.gov.au/Details/C2019A00016
2 PMIF – https://www.legislation.gov.au/Details/C2019A00079

SMALL INCREASE IN COMPLAINT NUMBERS OVERALL BUT BIG INCREASE IN COMPLAINTS ABOUT GROUP COVER

Subscribers received and assessed 911 more complaints than in 2018–19 – an increase of just under 5%. Reflecting the Code's higher standard of complaints recording (and recognising that many subscribers have enhanced their complaints reporting capabilities in preparation for compliance with forthcoming new ASIC regulations), the Committee asked subscribers to provide information on, where possible, complaints resolved within five business days. The inclusion of these additional complaints in subscribers' data submissions has contributed to the slight increase in overall complaint numbers.

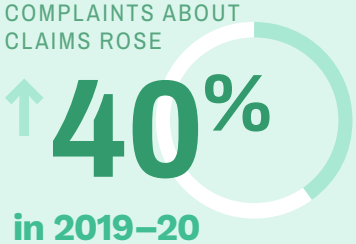
Complaints about cover distributed via the group channel rose by 55% this year, most likely due to increased awareness of consumer rights, better reporting by subscribers, and the introduction of the *Protecting Your Super* and *Putting Members' Interest First* laws.

SUBSCRIBERS RECEIVED AND ASSESSED

911

more complaints than in 2018–19

COMPLAINTS ABOUT CLAIMS ROSE



↑40%

in 2019–20

CLAIMS-RELATED COMPLAINTS INCREASED BY 40%

Complaints about claims rose 40% this year. More than trebling in number, the sharpest surge was in complaints about the amount of time subscribers took to assess customers' claims. There was also a 25% rise in complaints about claims decisions.

Feedback from subscribers indicates that the COVID-19 pandemic had some impact on their ability to assess claims in a timely manner during the last quarter of the reporting period, leading to an increase in customer complaints. Employees transitioning to remote working arrangements and, in some cases, offshore claims processing and call centres closing, caused delays and impacted response times.

The impact of the pandemic on some customers' financial circumstances may also have driven the rise in claims-related complaints, as their need for claims to be decided quickly and favourably became more urgent.

POLICY AND CLAIMS-RELATED BREACH EVENTS HAD THE MOST CUSTOMERS IMPACTED

Breach events relating to claims, policy changes and cancellation rights impacted the most customers in 2019–20.

Policy-related breach events accounted for 69% of all the potential customer impacts (double the number of customers impacted in 2018–19). A single subscriber reported three breach events involving non-compliance with section 6.3 – namely, failure to provide customers with annual notices containing certain information specified in section 6.3. Each of these three breach events impacted or potentially impacted more than 20,000 customers.

Claims-related breach events accounted for 75% of all breach events compared to 41% in 2018–19. These breach events impacted 39,260 customers – more than a quarter of all customers impacted by breach events during the year.

> *We urge subscribers to conduct a root-and-branch analysis of why their staff continue to make mistakes that lead to Code breaches, including a thorough review of all Code competency training and monitoring activities.*

SUBSCRIBERS CONTINUE TO ATTRIBUTE MOST ISOLATED BREACHES TO HUMAN ERROR DESPITE ASSURANCES THAT THEIR COMPETENCY FRAMEWORKS ARE UP TO SCRATCH

According to subscribers, 93% of isolated breaches this year were caused by people compared to 88% last year. Human error was given as the reason for 34% of all people-related breaches, while staff failing to follow established processes or procedures caused a further 32%.

Subscriber feedback indicates that the rise in breaches with a people-related cause is due to resourcing issues, challenges ensuring that staff have the necessary skills and capability, improvements to breach reporting, and the operational challenges of staff working remotely during the last quarter of the reporting period because of the pandemic.

The Committee acknowledges that these factors did, to some extent, make it more difficult for subscribers to manage and oversee their workforce and may well have resulted in mistakes and instances of non-compliance during the final quarter of the reporting period.

We are nonetheless concerned at the prevalence of subscribers identifying human error and staff not following processes or procedures as the cause of most isolated breaches. While subscribers have assured us that they have competency frameworks in place that are aligned to all underwriter and claims roles, we are doubtful about the effectiveness of these frameworks. We also question whether subscribers are taking steps to establish, record and act upon the root cause of the breaches, and to ensure that their staff fully understand their Code compliance obligations.

To quote from the Banking Code Compliance Committee's report on *Building Organisational Capability*, when a breach occurs for which human error is to blame, it is often the case that staff conduct or actions have been influenced or constrained by internal systems, processes, technology, training and/or organisational culture.[3]

We urge subscribers to conduct a root-and-branch analysis of why their staff continue to make mistakes that lead to Code breaches, including a thorough review of all Code competency training and monitoring activities.

3 Building Organisational Capability: How banks can improve compliance with the Banking Code of Practice and deliver better customer outcomes, Banking Code Compliance Committee, February 2021.

About this report

The 2019–20 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 2019 to 30 June 2020.

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 customers 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.[4] The Report is based on data sourced directly from 25 subscribers who each completed a detailed data workbook that was developed in consultation with stakeholders.

The data submitted included for each distribution channel:

- the volumes and types of cover in force and business issued,
- the volume of claims received and determined,
- the volume of claims assessed durations of determined and undetermined claims,
- the number and nature of customer complaints,
- the number of types of breaches including sections and potentially impacted customer, and
- the number of claims and reason for determined and undetermined where Unexpected Circumstances applied.

4 Life Code Compliance Committee Charter, clause 11(d).

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

Integrity of the dataset

IMPROVEMENTS TO THE DATA COLLECTION PROCESS RESULTED IN BETTER REPORTING

In an effort to avoid repeating the data integrity and subscriber submission issues of last year's ADCP[5], the Committee sought feedback from subscribers and made a number of alterations and enhancements to the data workbook and user guide.

One of the key changes was the inclusion of a new *Data Integrity* section in the workbook to enable subscribers[6] to highlight and explain any significant or unexpected data variances from the previous year that do not meet expected outcomes, and to identify and analyse any data trends. In addition, 'validation' cells were also introduced to highlight any discrepancies for early attention or clarification.

Where possible, we also aligned the ADCP claims data collection requirements with the relevant Australian Prudential Regulation Authority (APRA) Reporting Standard.[7] This was done to prevent a repeat of the discrepancies we saw last year between the ADCP data received and the life insurance performance statistics published by APRA for the reporting period, and to make the reporting process less cumbersome for subscribers.

Pleasingly, this led to the findings in our report being broadly consistent with life insurance data published by APRA and the Australian Securities and Investments Commission (ASIC) for the 2019–20 reporting period.

> *"... the Committee sought feedback from subscribers and made a number of alterations and enhancements to the data workbook and user guide."*

5 LCCC Annual Industry and Data Compliance Report 2018–19.
6 This was not a requirement for reinsurer-only subscribers or subscribers who are 'other industry participants'.
7 APRA Reporting Standard LRS 750.0 Claims and Disputes (October 2018).

ISSUES PERSIST WITH INTEGRITY OF DATA SUBMISSIONS

Overall, subscribers undertook the data collection and reporting process in a far more positive manner than last year. Twenty-four out of the 25 subscribers submitted their data workbook on time, with only one subscriber requesting (and receiving) an extension to the deadline.

We continued, however, to see issues with the way many subscribers initially completed their workbook, particularly in terms of the data validation process. In some cases, it was evident that they had not followed the instructions in the user guide, choosing instead to fall back on prior-year approaches for completing the workbook.

Consequently, most of the subscribers writing business were required to resubmit their workbooks – some more than once – to correct errors within their individual data worksheets. We held one-to-one video conferences with each of these subscribers to review their workbooks and provide feedback and advice on the integrity of their data.

Subscribers were overwhelmingly cooperative and responsive to these reviews and, in some cases, we saw subscribers engage with us prior to completing their workbooks to clarify certain reporting requirements and ensure they were following the correct procedures.

While we acknowledge that subscribers have made significant improvements to their Code compliance reporting since last year, the Committee would still like to see more rigour applied to the data collection and reporting to avoid the requirement for repeated submissions and related delays.

ATTESTATIONS OF CODE COMPLIANCE AND DATA QUALITY HAVE IMPROVED

After expressing our concern in last year's report that subscribers' attestations of their Code compliance capability did not match the findings of our ADCP, the Committee was pleased to see a marked improvement in the data verification process.

The attestation requirements were modified this year, with subscribers asked to provide an overview of the process undertaken to assure the quality and veracity of the data prior to sign-off. While all subscribers completed this process, the fact that so many workbooks were required to be resubmitted indicates that closer scrutiny of the data is needed by subscribers earlier in the process.

Many subscribers reported increased support and engagement from senior management for the verification of Code compliance data this year, although there were exceptions. The Committee will continue to discuss ongoing issues in this area with the relevant subscribers' Boards and Executive Management teams to encourage continued and sufficient high-level support in the future.

Life insurance business

There were 20% fewer covers in force during 2019–20 compared to the previous reporting period. The number of covers in force decreased across all distribution channels, with the biggest decline in the group and direct distribution channels, largely due to regulatory changes relating to superannuation and the sale of CCI and direct life insurance.

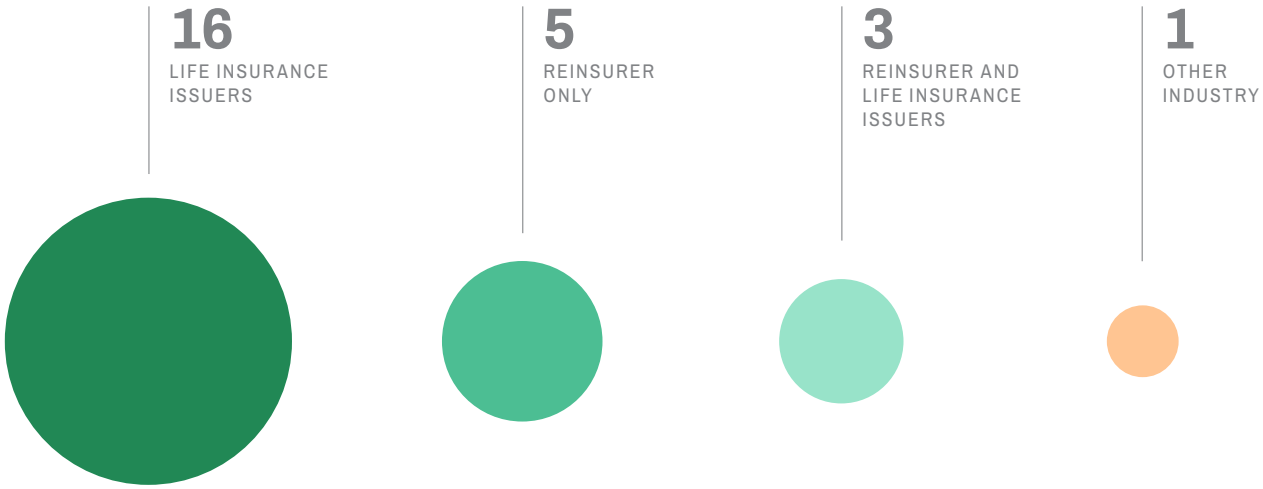
Subscribers

As of 30 June 2020, there were 25 subscribers to the Life Insurance Code of Practice **(Figure 1)**, one less than the previous year. During the 2019–20 reporting period, St Andrews Life Insurance Pty Ltd and St George Life Limited ceased to be Code subscribers after they stopped writing new business. Pacific Life Re (Australia) Pty Ltd was the only new subscriber to the Code in 2019–20.

Five Code 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 customers. 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, 2019–20



Covers in force

To understand the type of life insurance cover that Australians have, the Committee collects data each year on the number of covers in force for each benefit type. A cover is an insurance benefit under a life insurance policy. One policy may have more than one cover. One customer may have more than one policy or more than one cover in force.

THE NUMBER OF COVERS IN FORCE FELL BY 20%

The number of covers in force during 2019–20 decreased significantly from the previous reporting period. Where subscribers reported 40.9 million covers in force during 2018–19, that number fell by 20% to 32.6 million during 2019–20.

The decline in the number of covers was largely due to millions of group covers being cancelled after the enactment of two key pieces of legislation that were developed in response to the Royal Commission into Banking, Superannuation and Financial Services (Financial Services Royal Commission).

The first, *Protect Your Super* (PYS), came into effect on 1 July 2019, with the aim of preventing consumers' retirement savings from being eroded by insurance premiums. Under PYS, if a customer has insurance as part of their super and no contributions have been deposited into their account for 16 months, the insurance will be cancelled unless the customer opts to retain it – regardless of the balance of the fund.

The second, *Putting Members' Interests First* (PMIF), became operational on 1 April 2020. PMIF is designed to safeguard superannuation fund members' savings by requiring super funds to cancel insurance cover for members where the member has an account balance below $6,000 or is a new member under the age of 25.

Also contributing to the fall in the number of covers in force was the decline in sales of CCI and Funeral insurance following a tightening of the rules around how these products are sold. More information about this is provided on page 17.

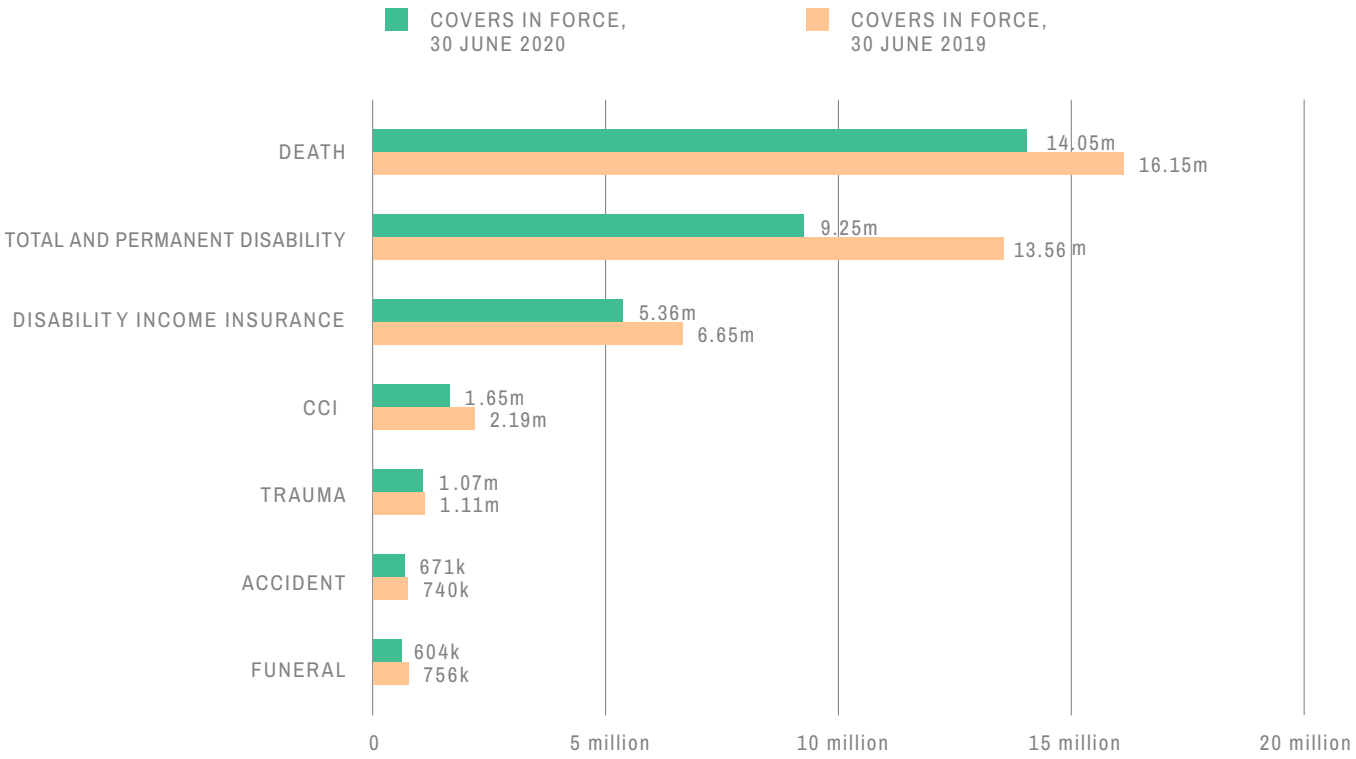
DEATH AND TPD MADE UP THE MAJORITY OF COVERS IN FORCE

Death and Total and Permanent Disability (TPD) covers remain the two most prevalent benefit types in force, as was the case in 2017–18 and 2018–19 **(Figure 2)**. This year, Death cover made up 43% of all benefit covers in force – an increase of 3% from the previous year – while TPD accounted for 28%, a decrease of 5% compared with 2018–19.

There was a reduction in the number of covers in force across all benefit types. Death cover decreased by 13%, TPD by 32%, Disability Income Insurance (DII) by 19%, CCI by 25%, Funeral insurance by 20%, Accident insurance by 9% and Trauma by 4%.

FIGURE 2.

Covers in force, 30 June 2019 and 30 June 2020



Distribution

During the year, 19 subscribers issued new life insurance business. Subscribers used three distribution channels: group, retail and direct (which includes direct distribution by the subscriber itself, its authorised representatives[8] and third parties).

There were 149 benefit types written across all distribution channels, compared to 217 last year. This 31% decrease is most likely due to the withdrawal of many CCI and Funeral insurance products from the market following a tightening in the regulations around how these products are sold.

Figure 3 shows, for each subscriber, the distribution channels used and the proportion of each subscriber's business (measured by covers in force) contributed by each channel. As we have seen each year since 2017–18, the most commonly used means of distribution are the direct (subscriber) and direct (third party) channels.

8 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.'

FIGURE 3.

Subscribers' cover types in force by distribution channel, 30 June 2020[9]

COVERS IN FORCE DECREASED ACROSS ALL DISTRIBUTION CHANNELS

The number of covers in force decreased across all channels, with the biggest decline in the group and direct distribution channels:

- Cover distributed via the **group** channel fell by 23% to 24.5 million.
- Cover distributed via the **retail** channel decreased 9% to 4.2 million.
- Cover distributed via the **direct (subscriber)** channel fell by 4% to 2.1 million.
- Cover distributed via the **direct (third party)** channel fell 25% to 1.9 million.

The introduction of the PYS and PMIF laws have had a significant impact on covers in force. Millions of covers relating to superannuation funds were cancelled. The group channel was particularly affected by these laws, with subscribers reporting 7.2 million fewer group covers in force in 2019–20 than the previous year.

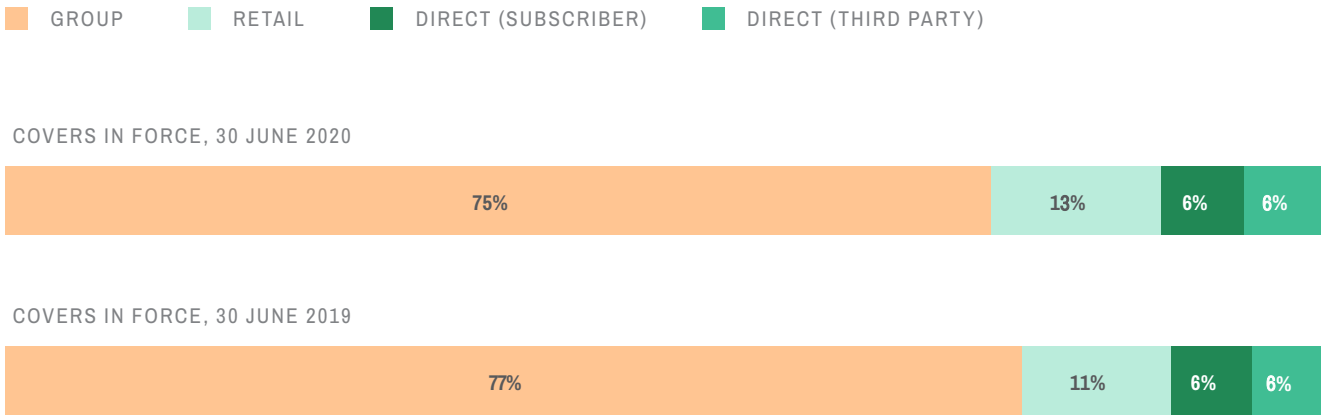
MOST COVER WAS DISTRIBUTED VIA THE GROUP AND RETAIL CHANNELS

Although more subscribers use direct (subscriber) and direct (third party) channels than retail and group distribution channels, most cover is distributed through the group and retail channels **(Figure 4)**. Cover distributed via the group channel contributed 75% of covers in force at the end of the year, while the retail channel accounted for almost 13% of all covers in force. Combined, direct (subscriber) and direct (third party) distribution contributed 12% of covers in force.

9 Subscribers in Figure 3 are deidentified in a randomized order.

FIGURE 4.

Percentage of covers in force, by distribution channel, 30 June 2020



DEATH AND TPD COVERS DOMINATED GROUP AND RETAIL DISTRIBUTION

In both the group and retail insurance channels, Death and TPD covers accounted for the largest proportion of covers in force. Combined, these two benefit types made up 82% of covers in force via the group channel **(Figure 5)** and 62% of covers in force via retail distribution **(Figure 6)**.

FIGURE 5.

Number of covers in force, group distribution, 30 June 2019 and 30 June 2020

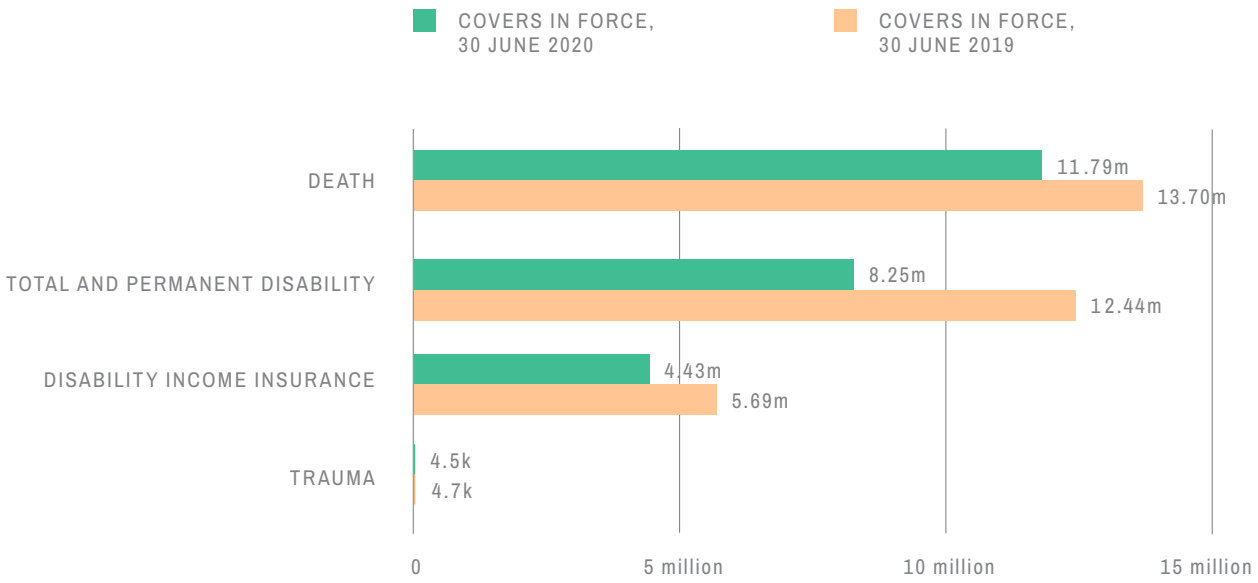
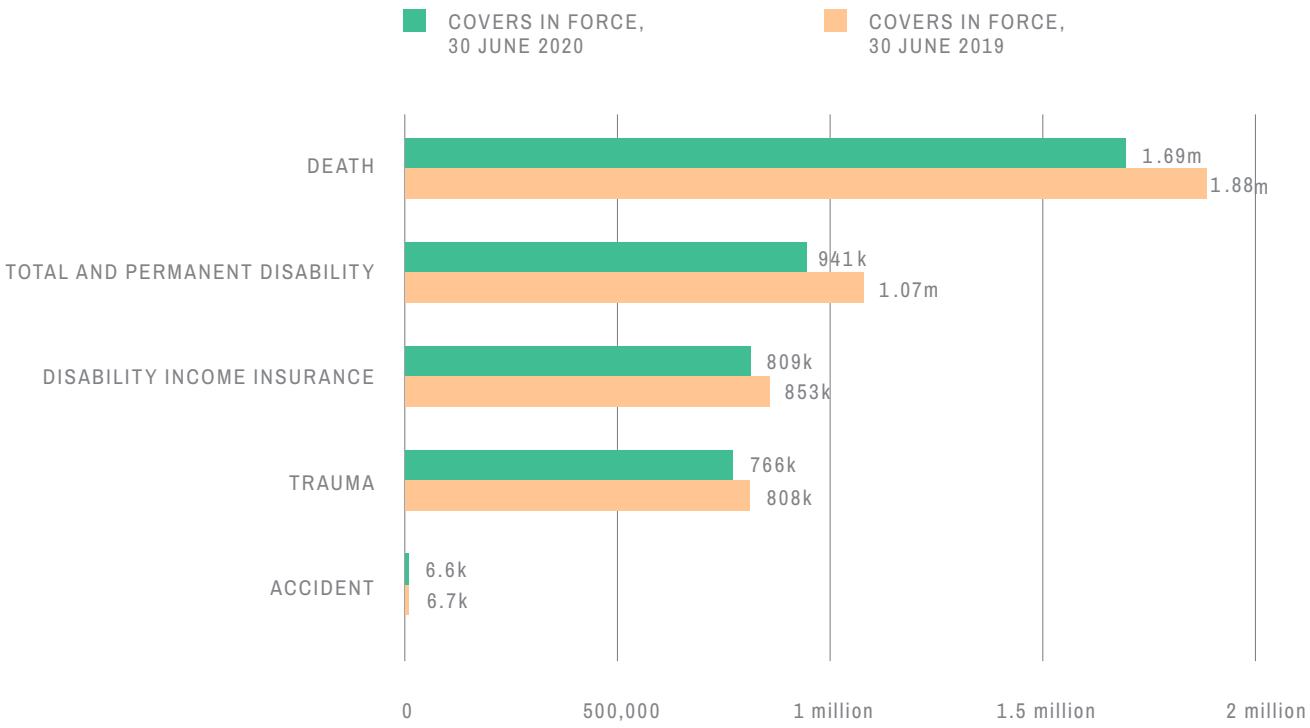


FIGURE 6.

Number of covers in force, retail distribution, 30 June 2019 and 30 June 2020



TIGHTENING REGULATIONS LED TO A FALL IN PRODUCTS DISTRIBUTED VIA THE DIRECT CHANNEL

A more diverse range of benefit types, including CCI, Accident insurance, Funeral insurance and Death cover, was distributed via the direct channel this year **(Figure 7)**.

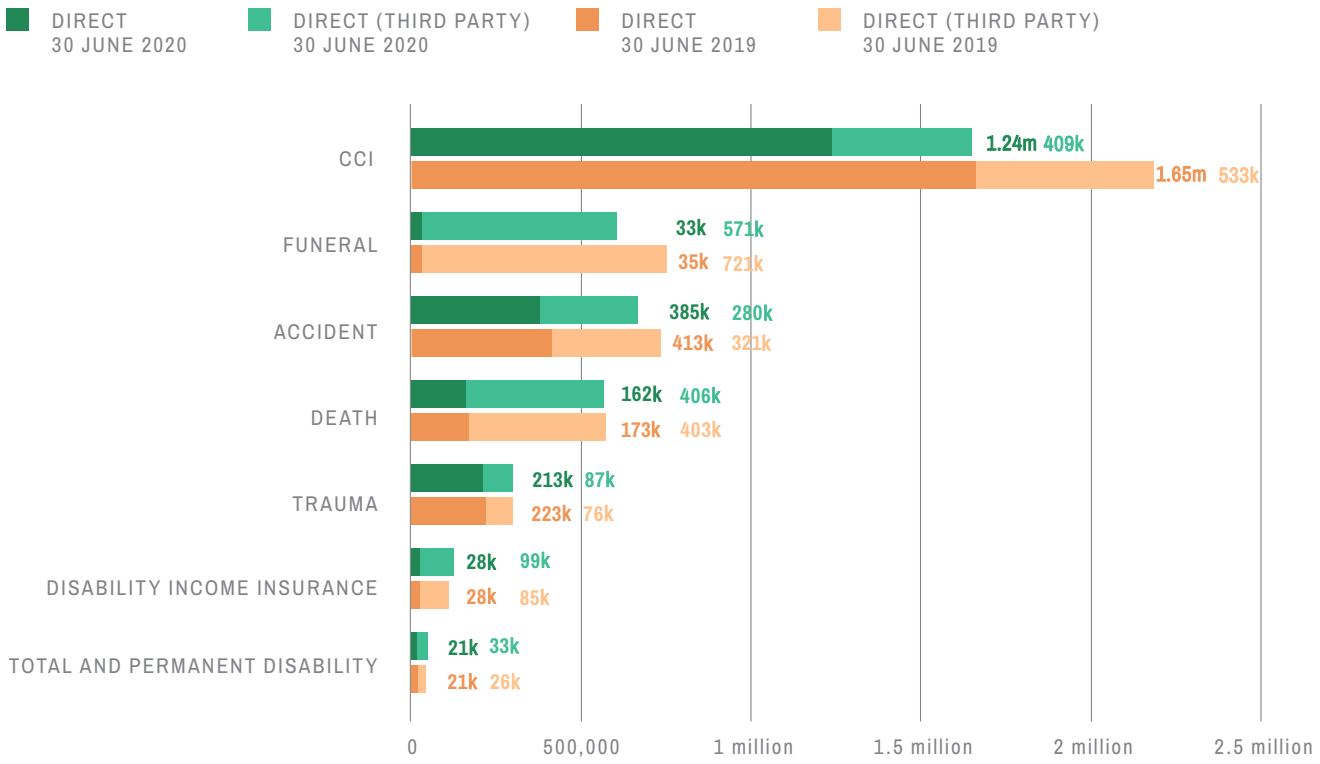
CCI continued to account for the largest proportion (42%) of covers in force distributed directly, but there were 25% fewer CCI covers in force via this channel in 2019–20 than the previous year. Similarly, Funeral insurance, which was the third most dominant benefit type distributed directly, also saw a significant reduction (20%) in covers in force.

The most likely explanation is the withdrawal of many CCI and Funeral insurance products from the market during the year. As recommended by the Financial Services Royal Commission, which highlighted the widespread customer detriment that has resulted from the sale of add-on insurance products such as CCI, there has been a tightening of regulation around the way these products are sold. This includes a ban by ASIC of cold-call sales of direct life insurance including CCI.[10] Some subscribers have responded by ceasing to distribute these products.

10 "ASIC to ban unfair cold call sales of direct life insurance and CCI", ASIC media release 19-335MR, 4 December 2019.

FIGURE 7.

Number of covers in force, direct distribution, 30 June 2019 and 30 June 2020



WHITE LABEL PRODUCTS ACCOUNTED FOR MOST OF THE COVERS ISSUED VIA THE DIRECT (THIRD-PARTY) CHANNEL

The direct (third-party) channel accounted for 47.5% of the total direct covers in force compared with 54% last year. Some subscribers distributed their own branded products via third-parties but most of the cover sold through direct (third-party) distribution comprised of white label products. White label products are issued by the insurer but rebranded and distributed by a third-party.[11]

Subscribers offered 135 different third-party white label benefit types in 2019–20. This is almost half as many as the previous year.[12] The number of third-party white label products for which subscribers wrote business also fell this year, from 104 to 65 (a reduction of 38%). CCI and Funeral insurance account for a large proportion of the white label products offered by subscribers; as discussed above, regulatory changes to the sale and distribution of CCI and Funeral insurance have led to some subscribers choosing to withdraw these products from the market altogether, including through white labelling.

THIRD-PARTY DISTRIBUTORS SHOULD BE BOUND BY THE STANDARDS OF THE NEW CODE

Given the increasingly significant use of third-party distributors, the Committee notes that the Financial Services Council (FSC) is considering adopting our recommendation 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. In the meantime, the Committee encourages subscribers to voluntarily ensure that all contracted third-party entities are bound by the Code.

11 A white label product can include a number of benefit types, such as Death and TPD, or Funeral insurance.
12 2% of the third-party white label cover types offered during 2018–19 was accounted for by one life insurer. As the insurer ceased to be a Code subscriber during 2019–20, its data has not been included in this report.

Claims

Customers 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 customers are at their most vulnerable. Claims issues still feature prominently in self-reported and alleged Code breaches, as well as in customer complaints.

Subscribers provided data on the number and nature of claims received during the year, as well as the time taken to determine them and the reasons for applying Unexpected Circumstances to some claims.

Claim numbers

Subscribers assessed 125,830 claims in the 12 months to 30 June 2020. This is 4,731 (or 3.6%) fewer than in 2018–19. Of these, 112,213 claims were received during the year, while the rest (13,667) were received during the previous year and remained open at the beginning of 2019–20.

The number of claims determined by subscribers during the year was 108,265 – a decrease of less than 3% from the number of claims determined in 2018–19. By 30 June 2020, 17,615 claims were yet be determined.

Subscribers assessed

125,830

claims

COUNTING CLAIMS

Where one customer makes multiple claims for more than one policy or benefit type, a claim is recorded for each benefit type for each policy. Some claims are withdrawn or otherwise closed before a decision on the claim is reached by the subscriber. In 2019–20, the Committee expanded its claims data collection to include withdrawn and re-opened claims.

A determined 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.

Claims by benefit type

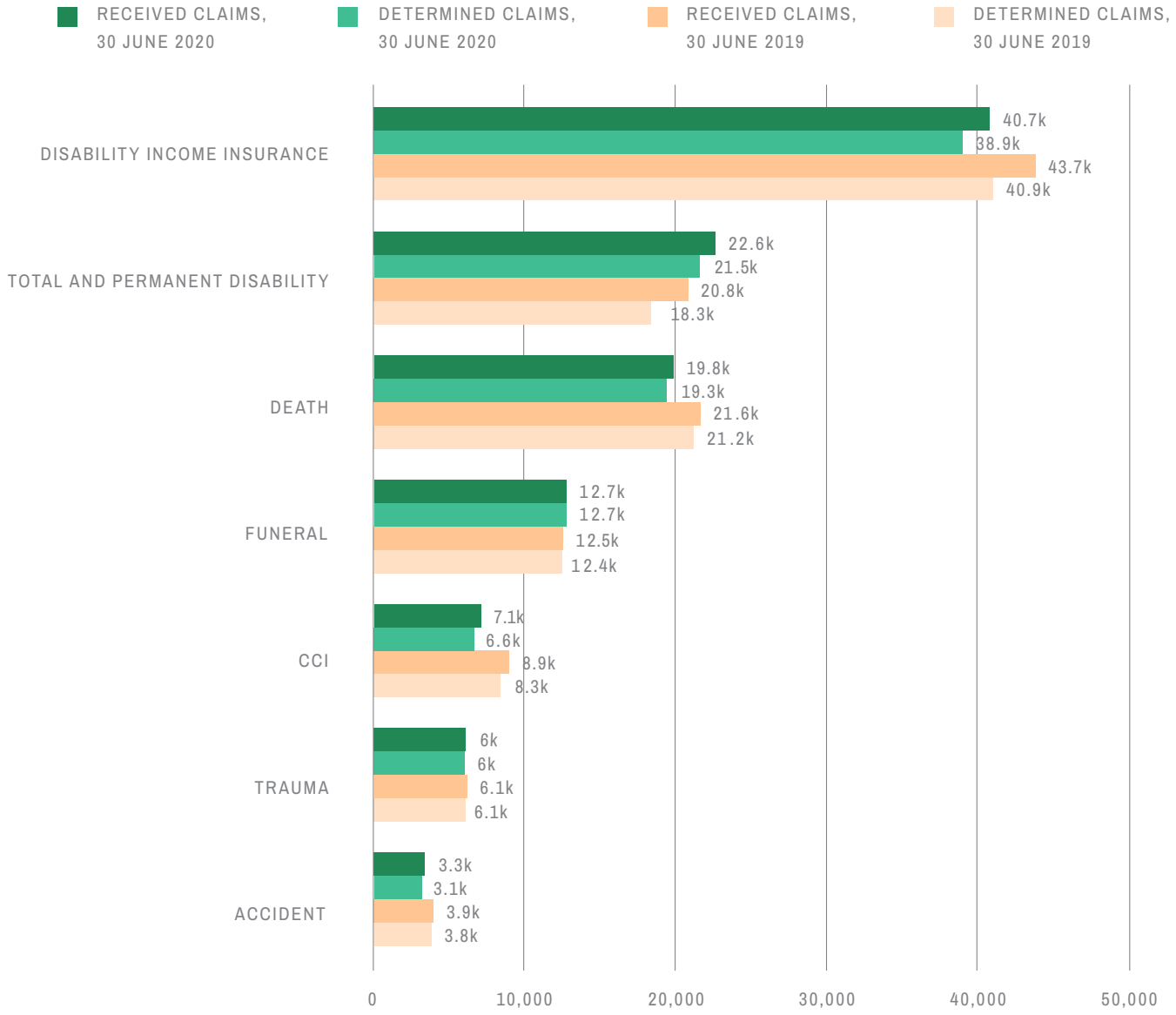
The highest proportion of claims received across all distribution channels was for DII, at 36% **(Figure 8)**. Claims for TPD and Death cover were the next most common, respectively making up 20% and 18% of total received claims.

CLAIMS DETERMINED KEPT PACE WITH CLAIMS RECEIVED

The representation of each benefit type as a proportion of all claims received has remained similar for the last three years, with DII accounting on average for around 37% of total received claims, TPD averaging around 18% and Death cover averaging around 16%. For each benefit type, subscribers finalised a similar number of claims as were received, resulting in a consistent number of claims in progress across all benefit types.

FIGURE 8.

Number of claims received and determined in 30 June 2019 and 30 June 2020



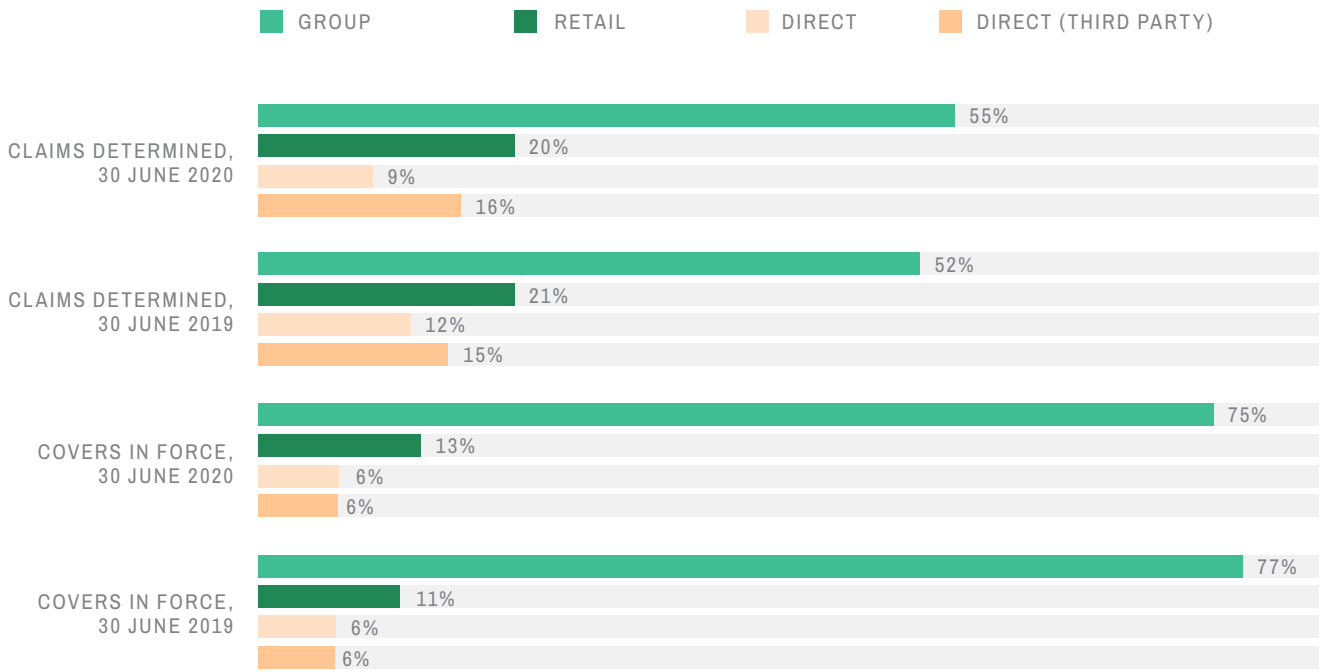
Claims by distribution channel

There was minimal change to the percentage of covers in force and claims determined by distribution channel from the 2018–19 reporting period **(Figure 9)**. The group distribution channel represented 75% of all covers in force and accounted for 55% of claims determined. Retail insurance represented 13% of covers in force and accounted for 20% of determined claims.

Cover distributed through the direct distribution channel represented 12% of covers in force and accounted for 25% of determined claims.

FIGURE 9.

Percentage of covers in force and claims determined by distribution channel, 30 June 2019 and 30 June 2020



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.[13] 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.[14]

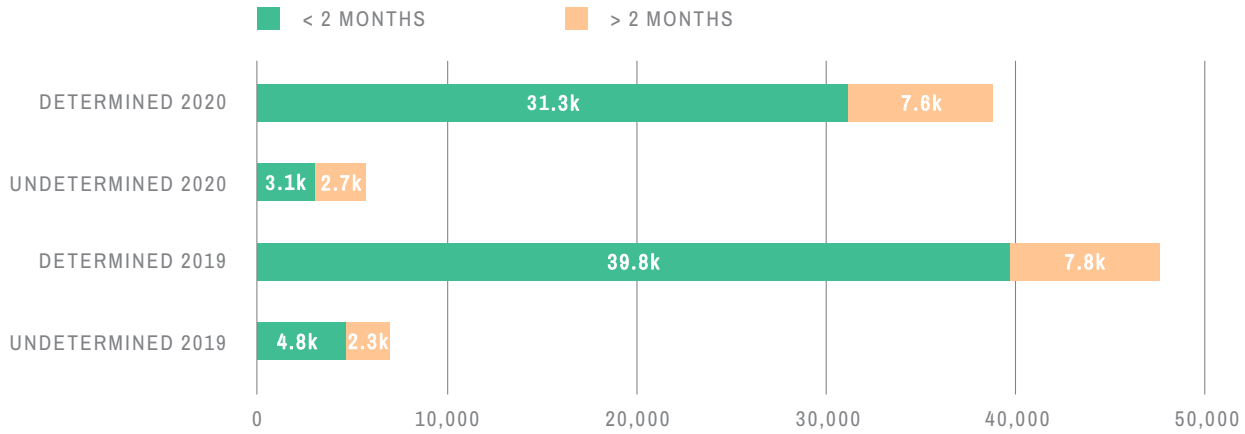
80% OF INCOME-RELATED CLAIMS DECISIONS WERE MADE WITHIN TWO MONTHS

Of all decisions for income-related claims, subscribers reported that 80% were made within the required two months, while 20% were made in excess of two months **(Figure 10)** (83% and 17% respectively for 2018–19). This equates to approximately 3% deterioration, year on year, in customer outcomes.

13 Life Code of Practice Chapter 8 – Section 16 – When you make a claim.
14 Life Code of Practice Chapter 8 – Section 17 – When you make a claim.

FIGURE 10.

Decision timeframe for determined and undetermined income-related claims, 30 June 2019 and 30 June 2020

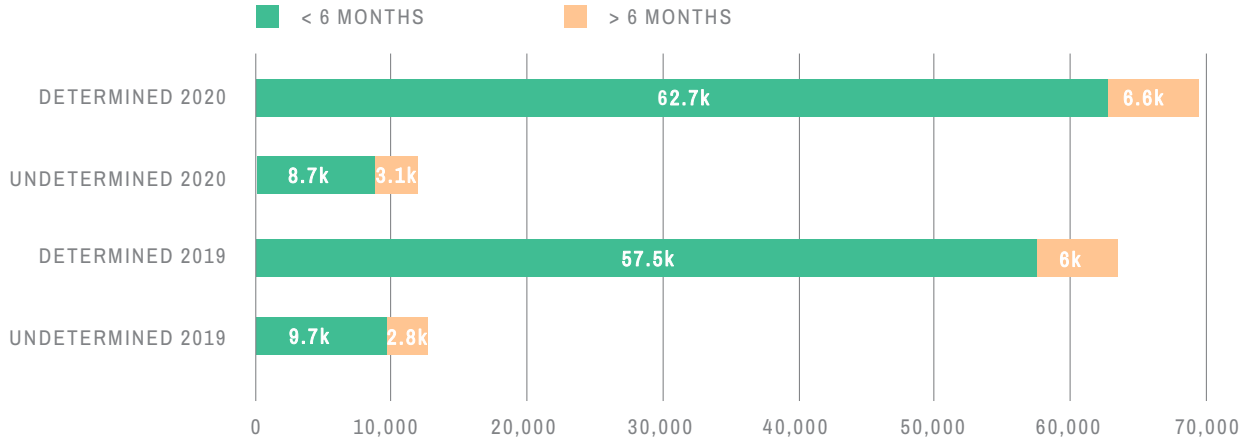


91% OF NON-INCOME RELATED CLAIMS DECISIONS WERE MADE WITHIN SIX MONTHS

There was minimal change (<1%) from the previous year 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)**. Most of the claims not made within the six-month timeframe were TPD claims, where the subscriber had not received requested information from third parties and was therefore unable to make a decision.

FIGURE 11.

Decision timeframe for determined and undetermined non-income related claims, 30 June 2019 and 30 June 2020



Unexpected Circumstances

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 customer why the delay has occurred and keep them informed about the progress of their claim.

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

REASONS FOR APPLYING UNEXPECTED CIRCUMSTANCES TO CLAIMS

In line with our ongoing focus on subscribers' compliance with the Code's claims handling obligations,[15] and to better understand why we have seen a prevalence of systemic breaches in this area over recent years, the Committee asked subscribers to report on the number of claims where Unexpected Circumstances applied, as referred to in sections 8.16 and 8.17 of the Code.

As part of this process, subscribers were asked to provide the combined number of **determined claims** during 2019–20, and **received** and **undetermined claims** as at 30 June 2020 where Unexpected Circumstances applied. They were also required to give specific reasons (as set out in Chapter 15 ('Definitions') of the Code) for applying Unexpected Circumstances to these claims **(Figure 12)**.

Encouragingly, most subscribers were able to provide detail about 93% of these claims,[16] as well as the reasons for having applied Unexpected Circumstances.

Out of the 93% of claims that subscribers were able to provide information on:

- 38% were applied because subscribers had not received the necessary information from the customer, the customer's representative or another third party within the required timeframe.[17]
- In 14% of these claims subscribers applied Unexpected Circumstances because they had received no response to their enquiries or requests for documents or information about the claim from either the customer or their representative.[18]
- For 4% of these claims, subscribers said they applied Unexpected Circumstances because the claim was either fraudulent, potentially fraudulent or misleading, and required further investigation.[19]

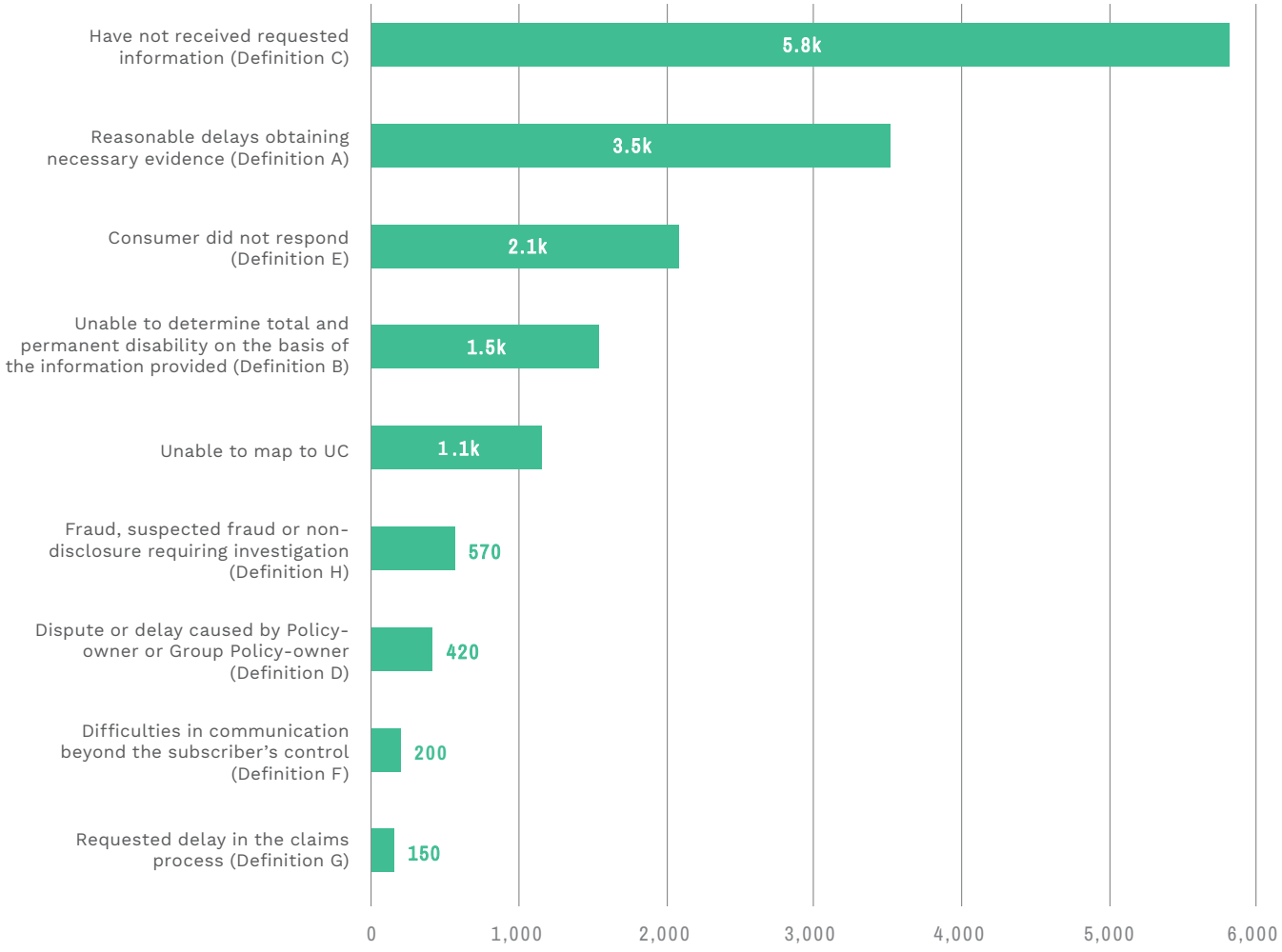
Five subscribers accounted for the 7% of claims where no reason was given for the application of Unexpected Circumstances. Two of these subscribers accounted for the majority of these claims. Following discussions with these two subscribers, the Committee ascertained that one subscriber had undertaken systems changes to enable staff to record the reasons for applying Unexpected Circumstances to claims but had not communicated the change in process to its staff. The other subscriber does not have a reporting framework in place to record why Unexpected Circumstances are applied to a claim. The Committee will continue working with this subscriber to resolve the issue.

In the Committee's view, it is not sufficient for a subscriber simply to record that a claim is in Unexpected Circumstances. We expect subscribers to be able to record the specific reason for applying Unexpected Circumstances to a claim so that they can understand why delays are occurring and take steps to prevent them where possible.

15 A Committee review into 11 subscribers' compliance with sections 8.16 and 8.17 (and section 9.10) of the Code was published in our March 2020 report, *Claims and Complaints Handling Obligations: A review of compliance by Life Code subscribers.*
16 According to the reasons for applying Unexpected Circumstances that are set out in Chapter 15 of the Code.
17 Unexpected Circumstances definition (c).
18 Unexpected Circumstances definition (e).
19 Unexpected Circumstances definition (h).

FIGURE 12.

Why subscribers applied Unexpected Circumstances to determined and undetermined claims, 30 June 2020



Complaints

Complaints are an important indicator of customer dissatisfaction and a source of valuable information for subscribers about what they need to do to facilitate better customer outcomes. Subscribers recorded 20,394 complaints from customers during 2019–20. While this was an increase of just under 5% compared to 2018–19, we continue to see a year-on-year increase in the number of complaints received and assessed.

Subscribers reported

20,394

complaints

Complaint numbers

Subscribers received and assessed 911 more complaints this year than last year – an increase of just under 5%. This year, for the first time, subscribers were asked to include complaints resolved within five business days as part of their complaints reporting (see box opposite), and this expanded reporting scope may have contributed to the increase.

Despite the relative stability in overall complaint numbers since last year, there were marked differences in the number of complaints by distribution channel compared to 2018–19. Complaints about cover distributed via the group channel increased by 55%, while cover distributed via the direct (third party) channel decreased by 46%. Further insight into why these differences may have occurred is provided below under 'Complaints by distribution channel'.

COUNTING COMPLAINTS RESOLVED WITHIN FIVE DAYS

The Code defines a complaint as *"...an expression of dissatisfaction made to the Subscriber, related to its products or services, or the Subscriber's complaint handling process itself, where a response or resolution is explicitly or implicitly expected".*

As some companies used the ASIC definition of complaints as being those unresolved after five days, the Committee accepted this for the first two years of the ADCP reporting.

This year, we asked subscribers to report according to the Code definition of a complaint and, where they could not, to explain why this was the case and tell us what remediation they are undertaking.

Out of all the subscribers only one subscriber reported that they did not have the capability to report on the complaints that were resolved within 5 days. It has been confirmed that this will be remediated by 5 October 2021.

Complaint causes

As we have seen each year since 2017–18, policy and claims-related issues are at the centre of most customer complaints, with complaints about sales and advertising practices not far behind **(Figure 13)**.

POLICY-RELATED COMPLAINTS DECREASED BUT STILL TOP THE CHART

Complaints related to policies – mainly policy changes or cancellation, and policy design and disclosure – accounted for just under 8,000 complaints, or around 39% of the total number of complaints in 2019–20. While they continue to attract the highest number of complaints each year, policy-related complaints decreased overall from the previous reporting period. There were 15% fewer complaints relating to 'Policy in force' and 12% fewer complaints about policy design and disclosure this year.

COMPLAINTS RELATING TO CLAIMS ROSE 40%

When combined, complaints about claims (claims decisions, claims handling and claims assessment duration) were the source of the second highest number of complaints for the year. Together, claims-related complaints totalled 6,560 (or 32% of all complaints). Of these, just over half related to DII and a quarter related to TPD cover, which is not surprising given that, together, these two benefit types accounted for 56% of claims received across all distribution channels.

Complaints about claims rose 40% this year. The sharpest surge was in complaints about the amount of time subscribers took to assess customers' claims, which more than trebled in 2019–20. There was also a 25% rise in complaints about claims decisions.

Feedback from subscribers indicates that the COVID-19 pandemic had some impact on their ability to assess claims in a timely manner during the last quarter of the reporting period, leading to an increase in customer complaints. Employees transitioning to remote working arrangements and, in some cases, offshore claims processing and call centres closing, caused delays and impacted response times.

SALES AND ADVERTISING COMPLAINTS INCREASED BY 47%

Complaints about sales and advertising practices accounted for 15% of all complaints for the year, with subscribers receiving 3,117 such complaints 1,000 (47%) more than in 2018–19.

Paradoxically, subscribers recorded substantially fewer breaches of the Code's sales and advertising standards than last year. Breaches of these standards accounted for less than 0.1% of the potential customer impact of breach events in 2019–20, with 148 customers impacted (more detail about Code breaches is provided in the following chapter of this report).

It is curious that despite the increase in the number of complaints there was such a large decrease in breaches reported. Subscribers should keep this in mind when reviewing their sales and advertising materials and the need to ensure that all communications, including Product Disclosure Statements (PDS), are clear, accurate and up to date.

CATEGORISING THE CAUSE OF COMPLAINTS HAS IMPROVED

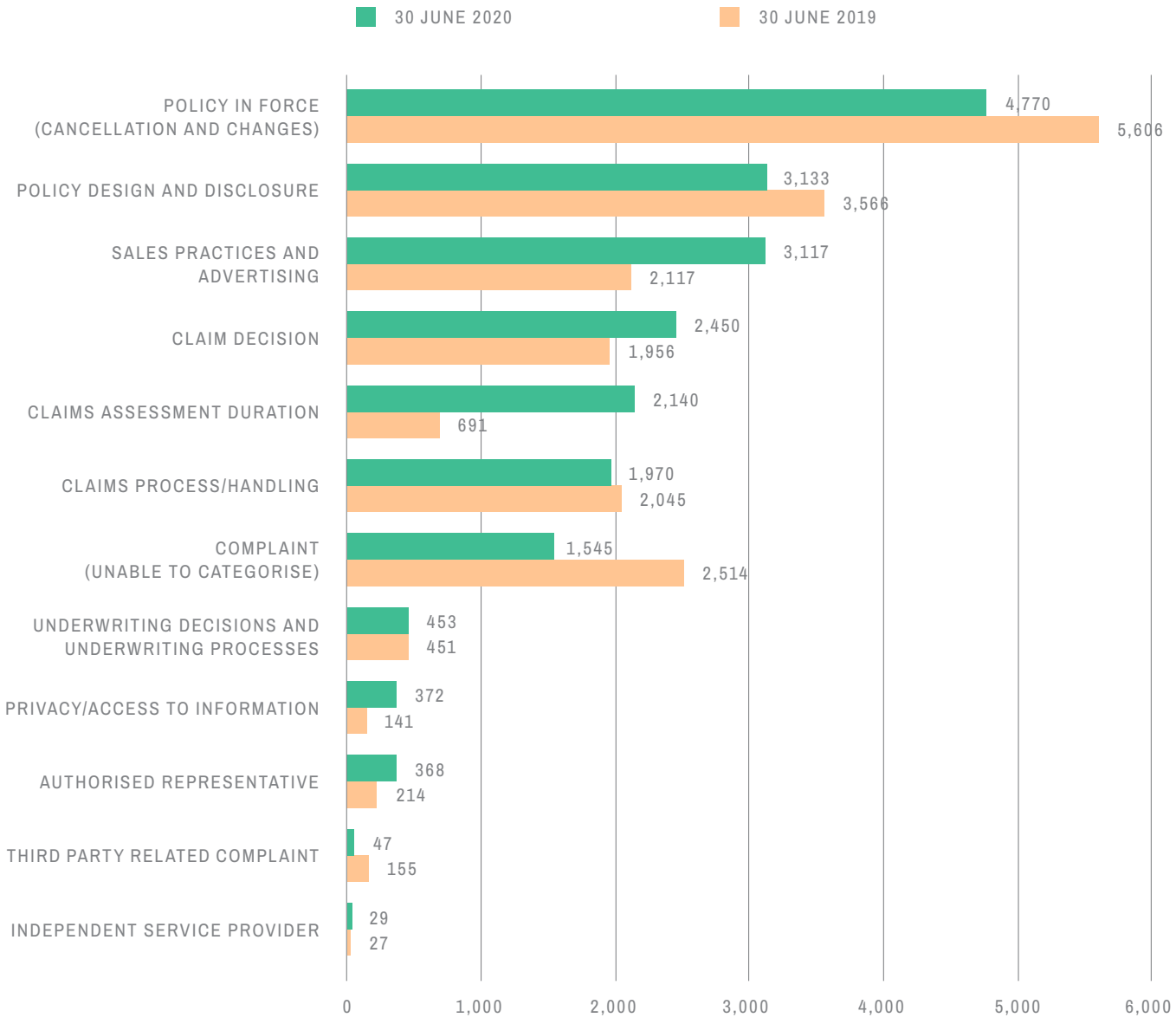
The Committee was pleased to note a significant reduction in the number of uncategorised complaints this year. Complaints that were not able to be categorised by cause last year totalled 2,514. This year, they totalled 1,545 – a 39% decrease. This signals a positive improvement in subscribers' recording and reporting capability.

For the 1,500 plus complaints whose cause did not fit into one of the nominated categories, feedback from subscribers indicates that most of these complaints related to specific products and/or the level of service the customer received from the subscriber. These explanations have not been highlighted in any substantial numbers in previous years and were therefore not included as categories in the list of causes in the Workbook.

The Committee will take this feedback on board and look at ways to enhance the categories of complaint causes for next year's ADCP.

FIGURE 13.

Cause of complaints received, 30 June 2019 and 30 June 2020



Complaints by distribution channel

MOST COMPLAINTS WERE ABOUT COVER DISTRIBUTED VIA RETAIL AND DIRECT CHANNELS

Despite accounting for only 13% of covers in force, and consistent with last year, retail received the highest number of complaints out of the three distribution channels in 2019–20, with 9,625 complaints (or 47% of the total). Complaints about products distributed via retail channels remained relatively stable (<2% change) in 2019–20 **(Figure 14)**.

After seeing a 21% increase last year, the number of complaints about cover distributed directly fell 8% this year, from 7,127 in 2018–19 to 6,536 in 2019–20. Like retail distributed cover, directly distributed cover generates a disproportionately large share (32%) of complaints while representing only 12% of covers in force.

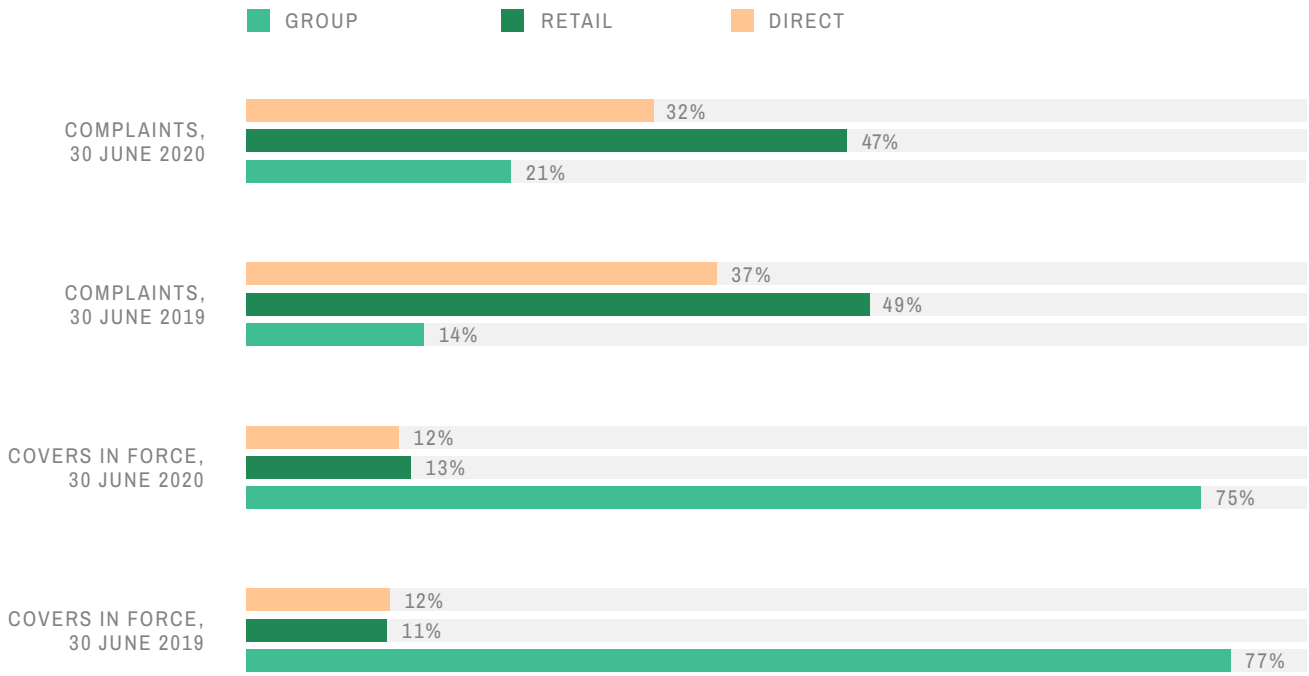
GROUP COVER COMPLAINTS INCREASED 55%

Although it accounts for 75% of covers in force, cover distributed by the group channel continues to generate the fewest complaints (21% of the total). Despite this, complaints about group cover rose by 55% (1,509) this year, from 2,724 in 2018–19 to 4,233 in 2019–20.

This increase could be explained by multiple factors, such as the media coverage of the new PYS and PMIF laws resulting in increased awareness of consumer rights.

FIGURE 14.

Percentage of covers in force and complaints by distribution channel, 30 June 2019 and 30 June 2020



Code compliance

In 2019–20, subscribers reported 350 breach events compared to 101 in the previous year. Conversely, isolated breaches of the Code fell from 11,483 in 2018–19 to 4,975 this year. 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.

350
breach events

4,975
isolated breaches

Top 5 breach event types:

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

Top 5 isolated breach types:

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

144,423
customers potentially impacted

DEFINING BREACHES

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 customers).

An **isolated breach** is a single breach resulting from a specific cause at a point in time and impacting one customer (for example, a claims officer declining a specific claim due to their mistaken interpretation of a process or circumstance).

A note about this year's compliance data

At first glance, this year's compliance data reveals a massive surge in Code breaches. There were more than three times as many breach events as last year, and almost double the number of customers potentially impacted as a result (**Tables 1a and 1b**).

A closer examination of the data, however, shows that the numbers are significantly influenced by the reporting of a handful of subscribers. In the case of breach events, two subscribers reported three-quarters of all breach events for the year. One of these subscribers reported almost 24 times more breach events than it had in the previous year, impacting almost 20,000 customers.

The other subscriber reported four times more breach events than in 2018–19, impacting almost 21,000 customers.

The data for isolated breaches was similarly influenced by the reporting of three subscribers, each of which recorded a significant decrease in the number of these breaches compared to the previous year (**Tables 2a and 2b**).

The overall breach data for this year should therefore be viewed in the context of these statistical variances rather than as a comparison to previous years' compliance reporting. We have included year-on-year data comparisons where relevant and where meaningful conclusions can be drawn.

Breach events

BREACH EVENTS TREBLED BUT 76% WERE REPORTED BY JUST TWO SUBSCRIBERS

Subscribers reported 350 breach events as part of the ADCP this year – a substantial uptick on the 101 breach events reported last year. A total of 139,448 customers were impacted or potentially impacted by the breach events, which is around 77,000 more than in 2018–19.

As discussed above, these figures are heavily influenced by the fact that 76% of all breach events recorded were attributable to just two subscribers. One subscriber accounted for 237 breach events; the other subscriber accounted for 28 (**Table 1a**).

> *"Subscribers must carefully examine each breach event to determine whether it was significant and, if so, report it to the Committee."*

ALL SIGNIFICANT BREACH EVENTS SHOULD BE SELF-REPORTED TO THE COMMITTEE THROUGHOUT THE YEAR

Subscribers must carefully examine each breach event to determine whether it was significant and, if so, report it to the Committee.

Of the 350 breach events recorded during the year, 242 were identified by subscribers as being significant breaches of the Code and subsequently reported to the Committee.

Subscribers fully remediated 216 (62%) of the 350 breach events. By contrast, at the time this report was published, only 118 of the 242 significant breaches (49%) reported to the Committee had been remediated.

The Committee continues to encourage subscribers to actively report significant breaches throughout the reporting period and to ensure that remediation for all breaches is implemented efficiently.

TABLE 1A.

Number of breach events and customers potentially impacted by Code subscribers' breach events over the last three reporting periods[20]

	Number of Breach Events			Potential Number of Customers Impacted		
Subscriber	**2017-18**	**2018-19**	**2019-20**	**2017-18**	**2018-19**	**2019-20**
A	2			1,300		
B	7	5	1	921,389	21	455
C	21	7	28	392	222	20,597
D		3	10		168	771
E		6	3		547	69
F		1	1		1	1
G	17	12	14	8,025	1,951	1,217
H	11	15	17	113,479	17,721	13,474
I	3	2		214	36	
J		3			12,473	
K	1	8	11	1,837	732	7,757
L		11			2,800	
M	2	6	2	422	31	2,591
N	2	10	237	1,635	1,358	19,434
O	38	2	12	51,487	14,073	1,781
P	29	1	2	38	382	554
Q	1	1	4	75	2	60,695
R	3	3	4	9,384	1,145	242
S	27	5	4	649,200	8,549	9,810
Grand Total	**164**	**101**	**350**	**1,758,877**	**62,212**	**139,448**

POLICY AND CANCELLATION RIGHTS BREACH EVENTS HAD THE HIGHEST NUMBER OF CUSTOMERS IMPACTED

As we saw in the previous two reporting periods, breach events related to chapter 6 of the Code, which sets out subscribers' obligations relating to policy changes and cancellation rights, had the highest customer impact, accounting for 69% of all the potential customer impacts in 2019–20 (**Table 1b**).

This is almost double the number of customers impacted by chapter 6 than in 2018–19 and is largely attributable to a single subscriber reporting three breach events involving non-compliance with section 6.3 – namely, failure to provide customers with annual notices containing certain information specified in section 6.3. Each of these three breach events impacted or potentially impacted more than 20,000 customers.

Breach events concerning chapter 8 of the Code, which sets out subscribers' obligations when customers make a claim, accounted for 75% of all breach events this year (261 out of 350) compared to 41% in 2018–19. These breach events impacted 39,260 customers – more than a quarter of all customers impacted by breach events during the year. The majority of chapter 8 breach events were attributed to the two high-reporting subscribers.

20 The Committee notes that not all subscribers in the list above were subscribers to the Code in all three reporting periods.

TABLE 1B.

Breach events and their potential customers impacted by Code chapter, 2019–20

Count of Type of Breach (Breach event)		Event		Customer Impact		Year on year Impact Ranking change		
Row Labels	Chapter	Number	%	Number	%	19-20	18-19	17-18
Policy changes and cancellations rights	6	36	10.3%	96,693	69.34%	1	1	1
When you make a claim	8	261	74.6%	39,260	28.15%	2	4	3
When you buy insurance	5	35	10.0%	2,494	1.79%	3	2	5
Policy design and disclosure	3	3	0.9%	498	0.36%	4	6	4
Complaints and disputes	9	11	3.1%	293	0.21%	5	5	7
Sales practices and advertising	4	2	0.6%	148	0.11%	6	3	2
Access to information	14	2	0.6%	62	0.04%	7	8	8
Consumers requiring additional support	7		0.0%		0.00%	8		-
Information and Education	11		0.0%		0.00%	9		
Standards for third parties dealing with underwriting or claims	10		0.0%		0.00%	10		
Monitoring, enforcement and sanctions	13		0.0%		0.00%	11		
Code objectives	1		0.0%		0.00%	-	7	6
Grand Total		**350**	**100.0%**	**139,448**	**100.0%**			

A SURGE IN BREACH EVENTS – THE COMMITTEE'S PERSPECTIVE

A substantial increase in breach events could be construed as negative because of the potential customer detriment and because it implies that subscribers' breach prevention processes are insufficient. The Committee certainly expects all subscribers that report a breach event to thoroughly review their breach prevention processes to avoid a recurrence.

At the same time, the Committee takes a constructive view of the increase in breach event reporting, as it demonstrates that some subscribers have improved their compliance reporting capabilities to ensure they capture and report all Code breaches. It also indicates a cultural shift, whereby they are willing to be more open about instances of non-compliance to understand the root causes and prevent similar breach events from occurring in future.

The Committee encourages all subscribers to look more closely at their compliance obligations and investigate ways to improve their breach reporting to ensure they capture, remediate and learn from all breach events and isolated breaches.

RULE CHANGES TO CCI SALES LED TO FEWER SALES AND ADVERTISING BREACH EVENTS

One of the biggest changes since 2018–19 was the substantial reduction in the number of breach events relating to the Code's sales and advertising standards, set out in chapter 4. Where breaches of chapter 4 accounted for 22% of the potential customer impact of breach events last year (impacting almost 14,000 customers), this year they accounted for less than 1% (impacting 148 customers). Last year, most of the chapter 4 breaches were for non-compliance of the obligations around selling CCI as set out in section 4.7. This year, there was a single breach event relating to section 4.7.

The reduction in chapter 4 breaches is potentially due to the tightening of regulation around the sale of CCI following the recommendations outlined in the Final Report of the Financial Services Royal Commission – particularly ASIC's ban on unfair cold call sales of direct life insurance and CCI – which has led to a 38% reduction in the number of white label products sold through direct (third party) distribution.

PROCESS ISSUES CAUSED MOST BREACH EVENTS, BUT PEOPLE-RELATED ISSUES HAD THE HIGHEST CUSTOMER IMPACT

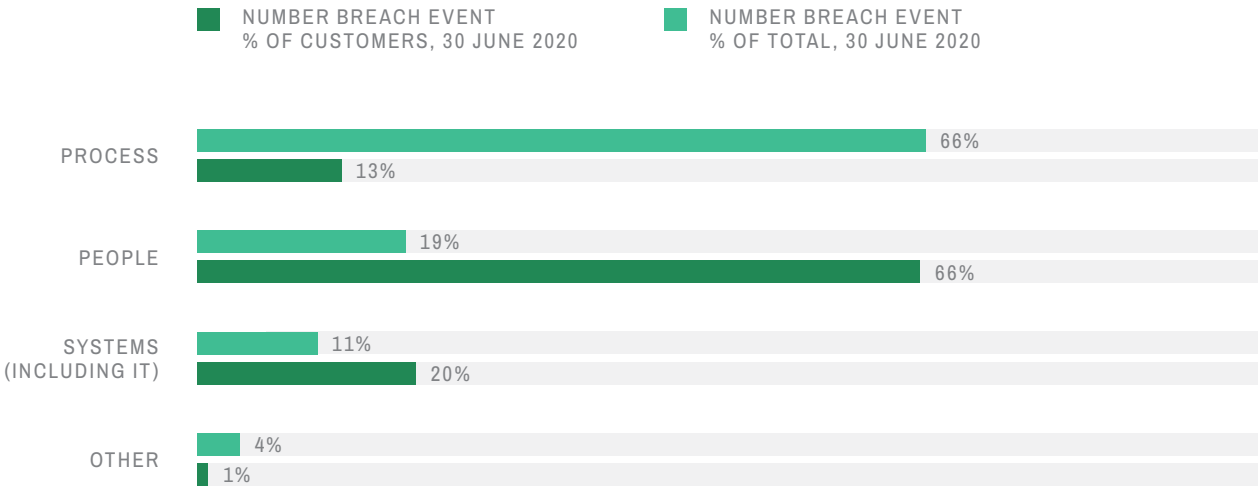
Sixty-six per cent of breach events were caused by process-related issues, accounting for 13% of the potential customer impact of all breach events.

People-related issues (mainly those relating to resourcing) were reported by subscribers as the cause of 19% of breach events but accounted for 66% of the potential customer impact (**Figure 15**). Conversely, whilst only 11% of breach events were caused by a system issue, these breaches tended to impact large numbers of customers, accounting for almost 20% of the potential customer 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 4% of breach events and accounted for less than 1% of the potential customer impact.

FIGURE 15.

Percentage of breach events and their potential customer impact by cause, 30 June 2020



Isolated breaches

ISOLATED BREACH NUMBERS FELL BY 57%

There were 4,975 isolated breaches reported this year – 57% fewer than last year's total of 11,483 isolated breaches **(Table 2a)**. Each breach impacted a single customer.

As was the case for breach events, reporting by a small number of subscribers has influenced the overall compliance picture for isolated breaches this year. One subscriber reported 5,758 fewer isolated breaches than the previous year.

TABLE 2A.

Number of customers potentially impacted by Code subscribers' isolated breaches over the last three reporting periods

Subscriber	2017-18	2018-19	2019-20
A	200	40	29
B	2,484	1,037	536
C		1	-
D	236	-	1
E		3	-
F	126	436	70
G	38	18	15
H	2	-	-
I	1,982	675	632
J	43	245	253
K	811	-	-
L	-	18	-
M	16	6	9
N	847	7,158	1,400
O	-	856	922
P	663	937	941
Q		10	12
R	30	12	15
S	-	-	5
T	437	24	71
U	11	1	53
V	-	6	11
Grand Total	**7,926**	**11,483**	**4,975**

Isolated breaches were of a different nature to breach events. As has been the case in recent years, the vast majority of isolated breaches recorded this year (85%) related to the Code's claims obligations, set out in chapter 8 (**Table 2b**).

Most isolated breaches relating to chapter 8 related to 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 customers informed of the progress of a claim every 20 days; and
- 8.15, which requires subscribers to inform customers of the claim decision within 10 days of gathering all required information.

There were also breaches of sections 8.16 and 8.17 concerning claim assessment timeframes, which is reflected in the high number of customer complaints relating to this issue. Subscriber compliance with these Code sections has been an area of concern for the Committee in recent years following a number of systemic breaches. Along with section 9.10 of the Code, sections 8.16 and 8.17 were the focus of our Claims and Complaints Handling Obligations report[21] and will be the subject of two forthcoming Guidance Notes to be published in 2021.

The Committee acknowledges that, overall, subscribers have improved their compliance with the Code's claim assessment timeframe obligations. However, the number of isolated breaches of sections 8.16 and 8.17 reported each year as part of the ADCP indicates that greater compliance efforts are needed by some subscribers.

FAILURE TO INFORM CUSTOMERS CAUSED MOST 'BUYING INSURANCE' BREACHES

Like last year, isolated breaches of the Code's standards relating to buying insurance (chapter 5) were the second most common in 2019–20 and once again accounted for 4% of all isolated breaches. Most related to sections:

- 5.4, which requires subscribers to inform customers about whether cover will be provided within five business days of their application if no further information is required;
- 5.12, which requires subscribers to inform customers 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 customers of the reasons for not offering cover or offering cover on alternative terms; to inform customers of their right to the information used to assess the application within 10 days; and to notify customers of the options if they disagree with the subscriber's decision.

The above Code sections apply in the early stages of the customer's relationship with the insurer. Subscribers should therefore be concerned that isolated breaches are occurring during their initial interaction with customers and make efforts to improve their compliance in this area.

21 Claims and Complaints Handling Obligations, March 2020.

TABLE 2B.

Isolated breaches by Code chapter, 2019–20

Isolated Breaches - Number of Impacted (Potentially) customers		Isolated Breaches		Year on year Ranking change		
Section Name	Chapter	Potentially impacted Customers	% of total	2019-20	2018-19	2017-18
When you make a claim	8	4,233	85.1%	1	1	1
When you buy insurance	5	188	3.8%	2	2	2
Sales practices and advertising	4	152	3.1%	3	4	3
Access to information	14	148	3.0%	4	3	5
Policy changes and cancellations rights	6	87	1.7%	5	5	7
Complaints and disputes	9	80	1.6%	6		4
Monitoring, enforcement and sanctions	13	58	1.2%	7		-
Consumers requiring additional support	7	22	0.4%	8		8
Policy design and disclosure	3	5	0.1%	9		6
Information and Education	11	1	0.0%	10		-
Standards for third parties dealing with underwriting or claims	10	1	0.0%	11		-
Code objectives	1			-	-	-
Grand Total		**4,975**	**100%**			

SUBSCRIBERS CONTINUE TO ATTRIBUTE MOST ISOLATED BREACHES TO HUMAN ERROR

Unlike breach events, processes and systems each accounted for a tiny percentage of isolated breach causes (4% processes, <1% systems). Instead, the overwhelming majority (93%) of isolated breaches were reported as being caused by people (**Figure 16**). The percentage of breaches with the same cause last year was 88%.

Subscribers said resourcing issues caused most people-related isolated breaches in 2018–19. This year, the two biggest contributors were human error (the cause of 34% of all people-related breaches) and the failure of staff to follow an established process/procedure (the cause of 32% of all people-related breaches).

> *"Subscribers said resourcing issues caused most people-related isolated breaches in 2018–19."*

People-related Code breaches: What is really the cause?

Subscribers must scrutinise why so many Code breaches are being ascribed to people-related issues and ask what they can do to mitigate the problem.

Feedback from subscribers indicates that resourcing challenges, challenges ensuring that staff have the skills and capability required, improvements to breach reporting, and the operational challenges of staff working from home during the COVID-19 pandemic have all contributed to a rise in breaches caused by people-related issues.

The Committee recognises that these factors did, to some extent, make it more difficult for subscribers to manage and oversee their workforce, particularly during the last quarter of the reporting period. They may well have resulted in occasional mistakes and instances of non-compliance.

However, considering the assurances we received from more than two-thirds of subscribers in last year's ADCP that they either had in place, or were developing, competency frameworks aligned to all underwriter and claims roles, it was surprising to see a 5% increase this year in the proportion of isolated breaches blamed on people-related issues. It raises questions about the efficacy of these frameworks and throws doubt on subscribers' ability to ensure that staff understand their Code compliance obligations.

Subscribers should conduct a close review of their Code competency training, focusing on the following questions:

- Is the compliance training being rolled out to staff ineffective or focused on the wrong things?
- Are the outcomes being monitored and measured against Code compliance?
- Is the training being provided across the business and appropriately tailored to different teams (e.g. claims vs marketing vs IT)?
- Does the training include scenario-based learning and real-life case studies of Code breaches?
- Are employees' Key Performance Indicators (KPIs) mapped to Code competency and training outcomes?

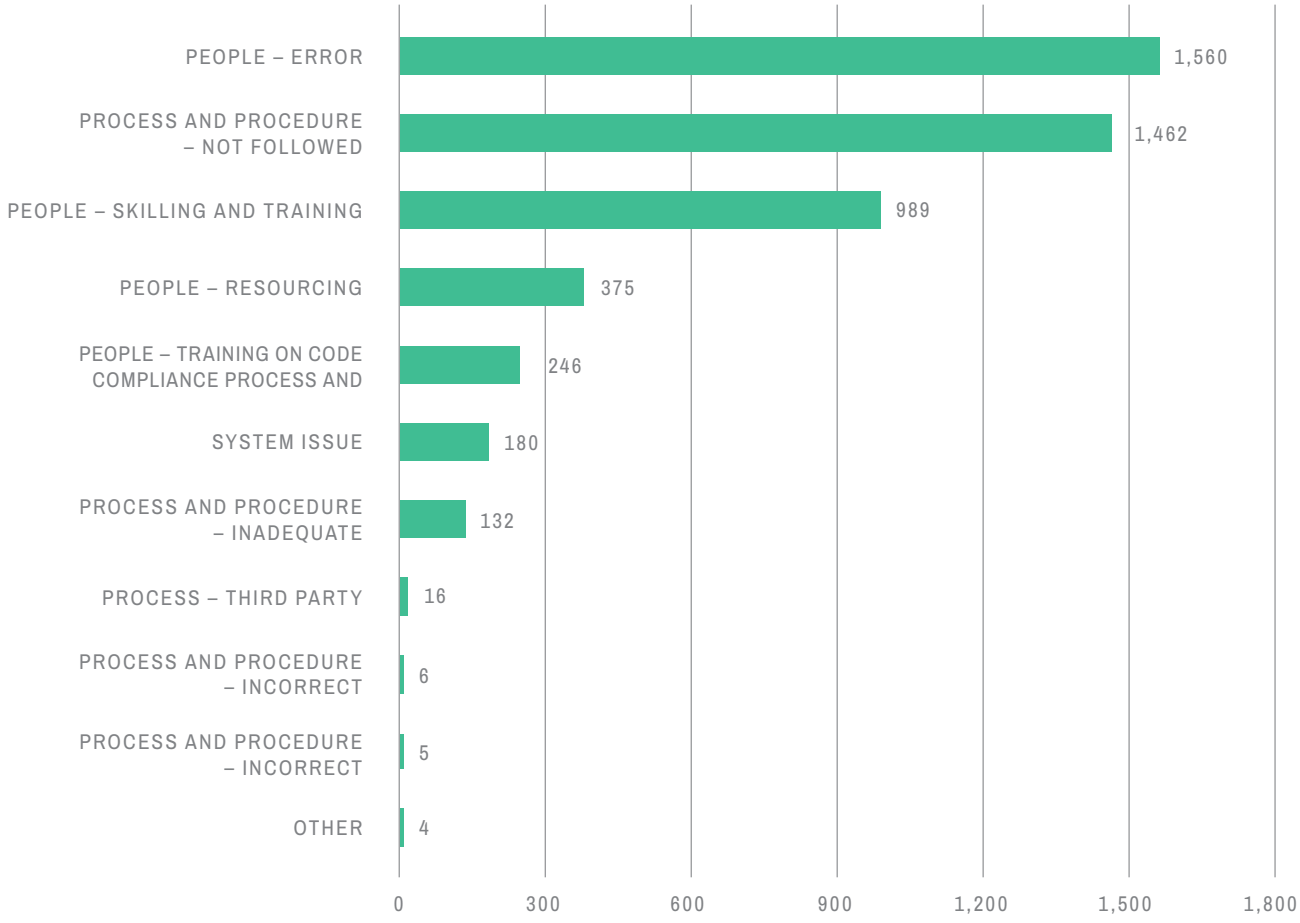
Code competency should not be a matter of providing homogenous, organisation-wide training via an e-learning module once a year. It should be responsive to staff training needs, tailored to specific business areas and reflective of actual Code breach incidences.

SUBSCRIBERS HAVE BECOME BETTER AT CATEGORISING ISOLATED BREACH CAUSES

Less than 1% of isolated breaches were attributed to 'other' reasons this year, compared to 9% in 2018–19. After commenting in last year's report that subscribers were incorrectly categorising some people-related breaches as being caused by 'other' reasons, the Committee was pleased to see subscribers correct this in the 2019–20 ADCP.

FIGURE 16.

Isolated breaches by cause, potentially impacted customers, 30 June 2020



> *... there is a sense that some subscribers are paying mere lip service to their Code obligations ...*

CODE RISK AND COMPLIANCE FRAMEWORKS

All 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.

As indicated in our previous ADCP reports, the Committee does not share subscribers' confidence that their compliance frameworks are sufficiently robust. In the Committee's view, with evidence of our 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.

Appendix 1
List of Code subscribers at 30 June 2020

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

* Claims Service Provider

Life Insurance Code of Practice

Annual Industry Data and Compliance Report 2019–20

To make a Code breach referral visit our website **LifeCCC.org.au** or email **info@codecompliance.org.au**