Monitoring Compliance with the Life Insurance Code of Practice 2020-21 Retrospective

The Annual Report of the
Life Code Compliance Committee

LIFE CODE COMPLIANCE COMMITTEE

SEPTEMBER 2021

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Chair's message

I am pleased to present the Annual Report of the Life Code Compliance Committee (the Committee) – the independent body that administers and enforces the Life Insurance Code of Practice (the Code). The report covers the period 1 July 2020 to 30 June 2021 and is a comprehensive overview of the Committee's activities and achievements, along with Code subscribers' compliance with the Code during the year.[1]

COMMITTEE'S ACHIEVEMENTS

While not without its challenges, the year has been an extremely productive one for the Committee. As the pandemic continued to disrupt our way of living and working, we remained focused on meeting our Charter obligations and achieving each of the priorities set out in our Work Plan.

Building on the improvements we made to our compliance monitoring and breach investigation processes in 2019–20, further efficiencies were introduced this year. These improvements enabled the completion of 294 assessments and investigations – a record number for the Committee (**page 18**).

We also published 68 Determinations and released our first Own Motion Inquiry (OMI) in March 2021, examining subscribers' compliance with section 3.2 of the Code regarding review and updating of medical definitions (**page 12**). A second OMI on subscribers' compliance with section 6.3 regarding provision of annual statements (**page 23**) was also commenced during the year and is on track to be published in the fourth quarter of 2021.

We released our third Annual Industry Data and Compliance Report (Data Report) in April 2021 (**page 11**). Every year the delivery of this important industry benchmark requires a significant undertaking by all subscribers involved. The Committee was encouraged to see subscribers adopt a rigorous approach to their data collection and quality assurance processes. This enabled us to produce a report that provides valuable insights into the life insurance industry and its compliance with the Code during a particularly challenging year. I extend my thanks to subscribers for their input, cooperation and engagement in the course of this work.

We highlighted in the Data Report that demonstrating compliance with the Code commitments is of more heightened importance in the context of a pandemic, where people's lives and livelihoods are under ongoing threat. The Code's obligations should guide subscribers' decision making towards fair, respectful, transparent, and timely outcomes for all life insurance customers but particularly those who are vulnerable or experiencing financial hardship. To assist with this, the Committee released Guidance Note 4 in November 2020 to clarify subscribers' obligations to customers wanting to change the terms of their life insurance policy or having difficulty meeting their premium payments, as set out in section 6.5 of the Code.

1 'Year' in this report refers to the reporting period 2020-2021 unless stated otherwise.

During the year, we continued our engagement with the Financial Services Council (FSC) on its review of the Code and contributed high-level feedback on the March 2021 draft. While we were disappointed that some of our previous feedback was not reflected in the revised draft, we will continue to engage with the FSC on the review of the Code and look forward to sharing our further insights and feedback during the consultation process.

As we embark on our fifth year of operation, the Committee is well placed to continue its work plan and monitoring activities, to further support industry in this ongoing and challenging environment.

82%

of all Code breach allegations during 2020–21 were of the Code's claims and complaints chapters

SUBSCRIBER COMPLIANCE

Despite consistent pleas from the Committee for subscribers to ensure their breach detection processes are robust, we have once again seen subscribers report low numbers of significant breaches, yet our active monitoring continues to result in previously unidentified significant breaches. This is disappointing given the number of guidance resources we have provided for subscribers to help them strengthen these processes.

To address this, the Committee recently published a Significant Breach Obligations Guidance Note to help subscribers identify and report all significant breaches to the Committee within the required timeframe. We encourage all subscribers – including those who believe they are capturing and reporting all significant breaches – to make use of this important resource, and we will continue to closely monitor subscribers' compliance with these obligations.

In 2020-21, almost two-thirds of the 149 alleged Code breaches were referred by customers. While in 2019–20, less than one-third of the 127 alleged Code breaches came directly from customers. This notable increase in Code breach allegations submitted by life insurance customers to the Committee indicates an increased awareness of the Code as a consumer protection and their rights under the Code.

For the fourth consecutive year, the highest number of alleged breaches were of the Code's claims and complaints chapters. Together, these two chapters accounted for 82% of all Code breach allegations. Considering the Committee's focus on subscribers' compliance with these chapters in recent years, and our various guidance resources relating to sections 8.16, 8.17 and 9.10 regarding claims and complaints, it was disheartening to note that almost one-third of all alleged Code breaches related to these three sections. We urge all subscribers to revisit the guidance resources to identify any existing compliance gaps and make improvements to ensure consistent compliance with these important obligations. The Committee has also recently released two additional Guidance Notes focusing on compliance with sections 8.16 and 8.17 of the Code to further support industry improvement in this area.

As we embark on our fifth year of operation, the Committee is well placed to continue its work plan and monitoring activities, to further support industry in this ongoing and challenging environment.

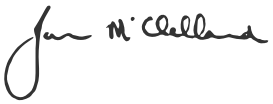
APPRECIATION

I take this opportunity to thank my predecessor, Anne Brown, whose term as Chair of the Committee ended in April 2021. Anne worked tirelessly during her three years in the role to improve and enforce the understanding of good industry practice, and to strengthen the credibility of the Committee and its compliance monitoring activities. The bulk of the work covered by this Annual Report was carried out during Anne's tenure and is a testament to her commitment to drive best practice within the life insurance industry.

My thanks also to our Administrator, the Code Compliance and Monitoring team (Code team) at the Australian Financial Complaints Authority (AFCA), for its excellent work during the year. In the face of numerous challenges, including the turnover of several senior staff members and the need to conduct most external stakeholder engagement remotely because of the pandemic, the Code team provided invaluable support and guidance to the Committee this year, producing some outstanding work along the way. I extend my particular thanks to Sally Davis, former General Manager, who resigned in March 2021, and Ankit Dang, Compliance and Operations Manager. Sally and Ankit, along with Acting General Manager, René van de Rijdt, have ably led the Code team and provided the Committee with vital industry expertise throughout the year.

I also thank AFCA CEO David Locke, FSC CEO Sally Loane, and current and former FSC executives, Nick Kirwan, Jamie Kennedy and Ashley Davies, for their willing engagement throughout the year.

Finally, I would like to thank my fellow Committee members, Alexandra Kelly and David Goodsall, and also Philippa Heir, the Committee's alternative consumer representative, for their invaluable expertise and contribution to Committee activities this year, and for their support of me in my first term as Chair.



Jan McClelland AM
Independent Chair
Code Compliance Committee

Year at a glance

Monitoring and enforcement activities

294
Investigations and assessments completed

33
Significant Code breaches received from 20 referrals

38
Significant breaches assessed and confirmed

149
Alleged Code breaches received from 64 referrals

104
Code Allegations determined as breaches

70
Determinations, case studies and guidance notes issued

2
Own Motion Inquiries - one published and another commenced

Committee achievements

- ✓ Published 68 Determinations, 1 Guidance Note and 1 Case Study to help subscribers improve the quality and consistency of their compliance reporting
- ✓ Completed a record number of investigations
- ✓ Published its first Own Motion Inquiry
- ✓ Published the 2019–20 Annual Industry Data and Compliance Report

Introduction

2020–21 was the fourth year of operation for the Life Insurance Code of Practice (the Code). The Code is administered, monitored, and enforced by the independent Life Code Compliance Committee (the Committee).

This report summarises subscribers' compliance with the Code in 2020–21 and the Committee's activities and achievements during the year. It provides a snapshot of compliance trends and service standards in the life insurance industry for the year, drawn from an aggregation of Code subscribers' data and insights from the Committee's Code compliance monitoring work. More information about the Code and its purpose is provided in Appendix A.

CODE SUBSCRIBERS

Life insurers that are members of the Financial Services Council (FSC) are required to adopt the Code. As of 30 June 2021, there were 24 Code subscribers (listed in **Appendix B**), comprising 23 life insurers (including reinsurers) and one non-insurer.[2] During the course of the 2020–21 reporting year, The Colonial Mutual Life Assurance Company ceased to be a Code subscriber after being acquired by AIA Australia Ltd through a statutory Part 9 portfolio transfer. All life insurers writing new business covered by the Code in the Australian market are subscribers to the Life Insurance Code of Practice.

24

Code subscribers as of 30 June 2021

The Committee

Subscribers' compliance with the Code is monitored by the Committee, an independent body established on 1 July 2017. The Committee's purpose is to support the Code objectives of high customer service standards to increase trust and confidence in the life insurance industry. The Committee does this by:

- monitoring, enforcing, and reporting on Code compliance
- working collaboratively to improve Code standards and promote industry best practice.

The Committee is bound by obligations set out in its Charter[3] and the Code.

While it may investigate a possible Code breach, the Committee cannot:

- mediate or resolve individual disputes
- determine a person's legal rights or legal entitlements
- order compensation
- provide individual outcomes such as resolving a disputed claim decline or expediting a claim.

2 The register of subscribers, is published on the Life CCC website at www.lifeccc.org.au, A copy of the register is also available on the FSC website https://www.fsc.org.au/policy/life-insurance/code-of-practice/

3 Life CCC Charter - https://lifeccc.org.au/resource/charter/

MEMBERS

The Committee is made up of three members:

- **an independent Chair**, Ms Jan McClelland AM, co-appointed by the FSC and the AFCA Board
- **an independent industry representative**, Mr David Goodsall, appointed by the FSC
- **a consumer representative**, Ms Alexandra Kelly, appointed by the consumers' directors of the AFCA Board.

Ms McClelland was appointed as Chair of the Committee on 1 June 2021, replacing Ms Anne T Brown at the completion of her role as Chair on 23 April 2021.

Profiles of the Committee members are provided in **Appendix C**.

During the year, there was one occasion where Ms Kelly identified a conflict of interest in relation to a Code breach referral/ investigation and recused herself from Committee deliberations on the matter. In accordance with the Committee's Charter, its alternate consumer representative, Ms Phillipa Heir, took Ms Kelly's place on this occasion.

ADMINISTRATOR

The Code Compliance Monitoring team (Code team) at the AFCA acts as Administrator for the Committee under an outsourcing agreement with the FSC. The Code team is led by the Acting General Manager, René van de Rijdt. Ankit Dang is the Compliance and Operations Manager for the Committee. Profiles of key Code team staff are at **Appendix C**.

The Code team supports the Committee by:

- providing administrative support
- engaging with subscribers and stakeholders
- investigating alleged Code breaches
- undertaking Code monitoring work
- collecting and analysing aggregated industry data
- preparing reports for the Committee
- promoting compliance with the Code
- undertaking other work as directed by the Committee.

The Code Compliance Monitoring team (Code team) at the AFCA acts as Administrator for the Committee under an outsourcing agreement with the FSC.

In addition to the improvements we proposed to the Code in January 2019, the Committee welcomed the opportunity to provide further feedback on the Draft Code 2.0 in March 2021 including:

- governance matters relating to enforceable provisions and the definition and determination of a significant breach
- the clarity and readability of Code obligations
- the definition and treatment of vulnerable consumers
- the need for the Code's obligations to be the responsibility of the subscriber, not the consumer, and
- compliance of the Code by third party distributors.

The case study provided on **page 30** of this report illustrates the need to improve the Code's definition of 'pressure selling' and to require third party distributors to be bound by the Code's obligations via a contractual agreement with a Code subscriber. In the Committee's view, enhancements to these aspects of the Code would provide greater protection for life insurance customers and help mitigate the risk of subscribers breaching the Code.

Disappointingly, some of our prior feedback was not reflected into Draft Code 2.0. This includes our recommendation to amend the obligation to review medical definitions to include off-sale policies - our OMI into section 3.2 regarding medical definitions has identified the lack of coverage of off-sale policies as a significant gap in the Code's protection of consumers holding such policies. It also included our recommendation for the Committee to have the authority to publish Determinations about individual subscribers on an identified basis - this would align the Code with the change to AFCA Rules which allows named determinations.

We encourage the FSC to reconsider our previous recommendations to increase consumer protections and subscriber accountability, and to carefully consider our further recommendations for improving Code 2.0 to ensure that it is sufficiently fit for purpose and enforceable.

We welcome the opportunity to make further contributions to the review of the Code over the coming year through consultation processes and ongoing engagement with the FSC on the development of Code 2.0.

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Committee activities and achievements

2020–21 was the Committee's busiest and most successful year so far. Despite the ongoing operational challenges posed by the COVID-19 pandemic and some turnover of staff at the Administrator level, we had our most productive year in terms of investigations and assessments, and we delivered on each of the key priorities set out in our 2020–21 work plan.

The Committee met five times during the year. At our final meeting for the year (June 2021), we welcomed new Independent Chair, Ms Jan McClelland AM, who replaced outgoing Chair, Ms Anne Brown, at the completion of her role in April 2021. (**Appendix D** contains details of all Committee meetings for the year.)

Investigating Code breach allegation referrals and assessing self-reported breaches remained a priority throughout the year. Following the substantial improvements made to our compliance monitoring and breach investigation processes in 2019–20, including the introduction of a delegation's framework to enable the Code team to triage Code breach allegations and allocate the Committee's resources towards matters of greatest significance, we introduced further efficiencies this year. These efficiencies allowed us to complete 294 investigations and assessments – almost three times as many as the previous year and the highest number in the Committee's four years of operation.

An overall increase in the experience and knowledge of both the Committee and the Code team also contributed to a higher output of investigations work this year. Code subscribers also played an important role: their willingness to respond to our enquiries in a transparent and timely manner, and to cooperate with our investigations and proposed remediation measures enabled us to complete our work efficiently.

Progression of other matters and initiatives during 2020–21 included:

- 68 Determinations and one case study published;
- a Guidance Note on section 6.5 of the Code to help subscribers comply with their obligations to customers when they wish to change their policy or are experiencing financial hardship (published in November 2020);
- the Committee's inaugural Own Motion Inquiry – an investigation into subscribers' compliance with section 3.2 of the Code which requires subscribers to review the medical definitions of all on-sale policies at least every three years (published in March 2021) (**page 12**); and
- the commencement of a second Own Motion Inquiry (due for release in the first half of the 2021–22 year) – an investigation into subscribers' compliance with section 6.3 of the Code, which requires subscribers to provide an annual notice in writing each year prior to the anniversary of the life insurance policy;

- the 2019–20 Annual Industry Data and Compliance Report (published in April 2021) (**page 11**); and
- additional meetings with individual subscribers during the year to discuss compliance reporting and data quality, as well as current industry developments and issues (**page 13**).

The Committee also continued to provide other general guidance to subscribers to help improve the quality and consistency of their compliance reporting. This included engaging with subscribers through the Code team about their Code obligations and consulting with them on the preparation of guidance resources such as the Annual Data Compliance Programme and Own Motion Inquiries. Further details about the Committee's engagement with subscribers and other stakeholders is on **page 13**.

Key reports

ANNUAL INDUSTRY DATA AND COMPLIANCE REPORT

As required under our Charter, the Committee published an annual data report on the life insurance industry and its compliance with the Code of Practice.

Released in April 2021, the 2019–20 Annual Industry Data and Compliance Report (Data Report) was based on quantitative data collected from 25 Code subscribers who each completed a detailed data workbook that was developed in consultation with stakeholders. This data was complemented with data on subscribers' compliance with the Code, sourced either directly from subscribers or from the Committee's compliance monitoring work.

It was the third year that the Committee has published the Data Report and we were pleased to see subscribers apply far more rigour to the data collection and quality assurance processes than was the case in 2018–19. Better quality reporting provided us with a valuable oversight of industry practice in a particularly challenging year, marked by significant changes to consumer protection laws, increased awareness of consumer rights and the difficulties associated with business continuity during the COVID-19 pandemic.

Key findings included:

- Covers in force fell by 20% during the year which was likely impacted by the introduction of new laws to protect superannuation funds and control the sale of consumer credit insurance and funeral cover.
- Most claims decisions were made within the timeframes set out in the Code. Where Unexpected Circumstances delayed claims decisions, most subscribers were able to provide an explanation for the delay.
- Overall complaint numbers were similar to the previous year; however, complaints about claims rose 40%, with most of these relating to the time it took subscribers to assess customers' claims.
- Breach events relating to claims, policy changes and cancellation rights impacted the majority of customers.
- Subscribers attributed 93% of all isolated breaches to people-related causes, despite saying they have competency frameworks in place to ensure staff comply with their Code obligations.

The Committee expressed concern at the prevalence of subscribers identifying human error as the cause for a substantial number of isolated breaches, given that we flagged the need to address this issue in the 2018–19 Data Report. Subscribers were urged to conduct a root-and-branch analysis of why staff continue to make mistakes leading to Code breaches, including a thorough review of Code competency training and monitoring activities.

Whilst acknowledging the challenges to subscribers' operating and working environments during the year, the Committee considers that demonstration of robust Code compliance has never been more crucial, with the obligations built into the Code guiding and assisting subscribers towards making decisions that are fair, respectful, transparent and timely for all customers.

Completing the Data Report each year is a significant effort for the Committee, the Code team, and subscribers. We were pleased with the level of engagement by subscribers and their willingness to help us achieve a quality industry dataset, and we thank them for their ongoing efforts.

93%

of all isolated breaches were attributed by subscribers to people-related causes

OWN MOTION INQUIRY INTO COMPLIANCE WITH SECTION 3.2

During the year, the Committee completed its first OMI and published the findings in a report[4] in March 2021.

The OMI was based on data collected from relevant subscribers in relation to their frameworks for complying with section 3.2 of the Code, which requires subscribers to review the medical definitions of all on-sale policies at least every 3 years. If the medical definitions are updated, this must be done in consultation with relevant medical specialists, and subscribers must communicate any changes to customers (other than for group policies).

The data provided by subscribers reported a 100% compliance rate across the elements of section 3.2: all subscribers reported that they had reviewed (and where appropriate updated or scheduled to update) the medical definitions for their on-sale products within the required 3-year timeframe, the reviews had involved consultation with relevant medical specialists and all updated medical definitions had been communicated or were slated to be communicated to customers. Furthermore, all participating subscribers confirmed that they have appropriate compliance frameworks in place to ensure ongoing compliance with section 3.2 of the Code.

While the Committee was reassured by the overall results of the OMI and about the ongoing ability of Code subscribers to maintain this good practice in the future, we did note some variation between subscribers as to how they review medical definitions. This prompted seven recommendations in the report to improve industry practice in this area and better customer outcomes.

4 *Obligations relating to the review of medical definitions: Report on an own motion inquiry into Life subscribers' compliance with section 3.2 of the Life Insurance Code of Practice*

OWN MOTION INQUIRY INTO COMPLIANCE WITH SECTION 6.3

In April 2021, the Committee commenced an OMI into subscribers' compliance with section 6.3 of the Code which relates to the obligation to provide an annual notice in writing each year prior to the anniversary of the life insurance policy and important information it should contain.

As part of the OMI, we collected data from subscribers in May 2021 about the number of on-sale and off-sale products, the processes and procedures used by subscribers to enable compliance with section 6.3 of the Code and the number of breaches of section 6.3 recorded by subscribers between 1 January 2019 and 31 December 2020.

A report detailing the findings from this OMI is scheduled for publication during the second half of 2021.

GUIDANCE NOTES

The Life CCC published **Guidance Notes** to help subscribers interpret and apply specific Code obligations that continue to present compliance issues including:

- **Section 8.16** – covering subscribers' obligations to customers when assessing income-related claims
- **Section 8.17** – covering subscribers' obligations to customers when assessing non-income-related claims
- **Significant Breach Obligations** – assisting subscribers to identify significant breaches of the Code, setting out the Committee's expectations in relation to identification and reporting of Significant Breaches

Engaging with stakeholders

The Committee and Code team engaged with various stakeholders during 2020–21. Due to ongoing travel and social restrictions caused by the COVID-19 pandemic, most of these engagements occurred remotely.

SUBSCRIBERS

The Committee continued to engage with Code subscribers throughout the year, holding meetings with Board members and senior executives for discussions about subscriber Code compliance, the Code review and current and emerging industry issues.

The Code team also met with subscribers, holding regular one-on-one meetings to discuss issues including data quality and compliance reporting, and interpretation of specific Code sections that were the subject of breaches and significant breaches. Extensive subscriber engagement was also undertaken by the Code team as part of the Annual Data and Compliance Programme for both 2019–20 and 2020–21, and for the collection of data for two Own Motion Inquiries.

FSC

We engaged with the FSC throughout the year, meeting regularly with FSC executives and members of the FSC's Life Board Committee. Our engagement with the FSC included providing updates about the budget and work plan, key monitoring activities and investigations, the development of Guidance Notes and Own Motion Inquiries, and the onboarding process for new Code subscribers. The Committee also met with the FSC in December 2020 to discuss the status of the FSC's review of the Code and the Committee's Charter, and the Committee and Code team members attended the FSC Life Insurance Summit in Sydney in April 2021.

CONSUMER GROUPS

In past years, the Committee and the Code team have met with a range of consumer advocates at conferences and events around Australia, to raise awareness of the Code and the Committee's work and to better understand consumer concerns about life insurance. Unfortunately, many of these conferences and events were not held during 2020–21 because of the pandemic. While this hampered our opportunity to engage with consumer representative groups during the year, we were pleased that the Code Compliance and Operations Manager was able to attend Financial Counselling Australia's annual conference in Darwin in May 2021.

REGULATORS AND POLICY

The Code team met regularly with ASIC during the year to share high-level information on current monitoring work and priorities and discuss regulatory matters of relevance to the life insurance industry.

AFCA

As the provider of administrative services to the Committee and a referrer of alleged Code breaches, AFCA is an important stakeholder. In 2020–21, the Code team provided internal training on the Code to AFCA systemic issues and external dispute resolution staff to assist their understanding of the content and the information needed to refer any Code breach allegations to the Committee. The Code Team also worked with AFCA to streamline the referral process.

Complying with the Charter

The Committee complied with its Charter obligations for the 2020–21 period.

Looking ahead

In addition to ongoing focus on the core functions and responsibilities outlined in its Charter, the Committee will continue to produce guidance resources to help subscribers improve their compliance reporting, and further develop and refine internal processes for monitoring subscribers' Code compliance. Specific priorities for the Committee in 2021–22 include the following:

- Publishing the **Annual Report**, addressing Committee activities and achievements.
- Publishing the **Annual Industry and Data Compliance Report**.
- Conducting two **Own Motion Inquiries** to examine and report on the industry's compliance with specific sections of the Code. The first to be published will be the OMI into subscribers' compliance with section 6.3 of the Code (see **page 23**).
- Conducting **Code breach investigation and monitoring** work resulting from Code breach allegations and subscriber self-reported non-compliance.
- Publishing **Determinations and case studies** to guide subscriber Code compliance.

Monitoring and enforcement of subscriber compliance

HOW THE COMMITTEE MONITORS COMPLIANCE

The Committee monitors subscribers' compliance with the Code in several ways, including by:

- investigating significant breaches reported by subscribers[5];
- receiving and investigating referrals from members of the public and others that a subscriber has breached the Code; and
- undertaking proactive, targeted investigations of compliance in specific areas.

In this report, the term 'referral' means a referral to the Committee of one or more alleged Code breaches by a person, their representative, AFCA, subscribers, or anyone who thinks that a Code breach has occurred.

182

Alleged Code breaches in 2020–21 ↑ up 6% compared to 2019–20

Total reported Code breaches in 2020–21

When a matter is referred or reported to the Committee, there is usually more than one Code breach involved. For transparency, (**Table 1a**) in this section deals with each individual breach, while (**Table 1b**) deals with the number of matters.

In 2020–21, there were 84 matters containing 182 alleged Code breaches reported to or identified by the Committee. This total of 182 is up fractionally (6%) from the prior year. Of these, 33 were reported as significant breaches by subscribers, while the remaining 149 alleged Code breaches were reported by individuals or their representatives as breach referrals or identified by the Committee through its monitoring activities. (**Table 1a**) provides a comparison of significant and alleged Code breaches over the last 4 years, broken down by applicable Code chapter.

Continuing a trend that has occurred every year since the Code was adopted, most significant and alleged Code breaches in 2020–21 related to the Code's claims handling obligations: 45% of all self-reported significant breaches and 66% of all customer-lodged breach allegations related to this issue.

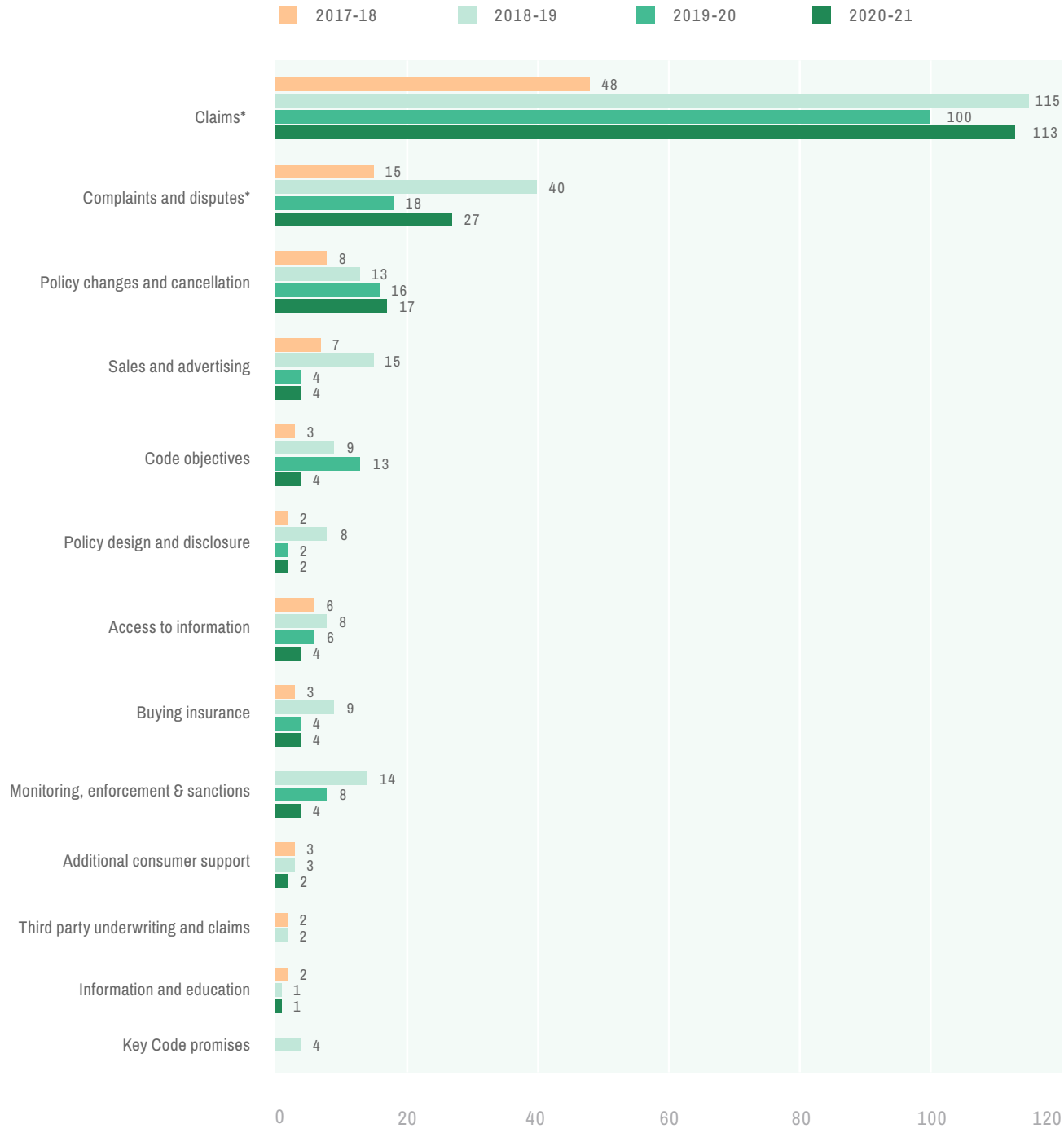
5 Subscribers are required to report all other breaches they do not deem to be significant, as part of their ADCP submission.

Interestingly, the number of claims-related significant breaches fell by 35% compared to 2019–20, while the number of breach allegations increased by 27%.

Complaints handling is the category with the second highest number of reported breaches, accounting for 15% of the 2020–21 total reported breaches. There was a 50% increase in both reported allegations and significant breaches compared to the previous year.

FIGURE 1.

Total breaches by Code chapter, year on year



* Excludes 2017-18 bulk referral numbers to allow more realistic year-to-year comparison. The bulk referral allegation of more than 700 potential breaches were dealt with via a dedicated investigation, with results published in the Committee's report: *Claims and Complaints Handling Obligations: A review of compliance by Life Code subscribers*. The report is available on the Committee website at www.lifeccc.org.au.

TABLE 1a.

Significant and alleged breaches, by Code chapter

	2017-18*		2018-19		2019-20		2020-21	
Code chapter	Significant	Alleged	Significant	Alleged	Significant	Alleged	Significant	Alleged
Claims*	5	43	9	106	23	77	15	98
Complaints and disputes*	1	14	1	39	2	16	3	24
Policy changes and cancellation	7	1	7	6	7	9	12	5
Sales and advertising	4	3	4	11	-	4	1	3
Code objectives	-	3	1	8	-	13	-	4
Policy design and disclosure	2	-	-	8	-	2	1	1
Access to information	-	6	-	8	1	5	-	4
Buying insurance	3	-	7	2	3	1	-	4
Monitoring, enforcement and sanctions	-	-	14	-	8	-	1	3
Additional consumer support	-	3	-	3	-	-	-	2
Third party underwriting and claims	1	1	-	2	-	-	-	-
Information and education	-	-	-	1	-	-	-	1
Key Code promises	-	-	-	4	-	-	-	-
Total*	**23**	**74**	**43**	**198**	**44**	**127**	**33**	**149**

* Excludes 2017-18 bulk referral numbers to allow more realistic year-to-year comparison. The bulk referral allegation of more than 700 potential breaches were dealt with via a dedicated investigation, with results published in the Committee's report: *Claims and Complaints Handling Obligations: A review of compliance by Life Code subscribers*. The report is available on the Committee website at www.lifeccc.org.au.

Note: There were also 2 web audit breaches in 2017-18 that fell under the Information and education Code chapter.

Case study

Non-compliance with several Code sections leads to a breach of the underpinning Code principles

On 27 October 2017, a TPD claim was lodged by a man who had life insurance with the subscriber. The subscriber declined the claim on 17 August 2018 and the man subsequently lodged a complaint with the AFCA, alleging breaches of multiple sections of the Code: sections 1.5, 1.6, 8.5, 8.6, 8.11(d), 8.20, 8.24, 9.12, 10.3 and 10.4. Reviewing the allegations, the Committee ascertained that the subscriber was also potentially in breach of sections 8.4 and 8.17 of the Code.

The Committee determined (and the subscriber acknowledged) that the subscriber was in breach of sections 1.5, 8.4, 8.5, 8.17, 9.12 and 10.4. In terms of alleged breaches of other sections of the Code, the Committee found that section 8.11(d) did not apply, and the allegation was unfounded. It also found the subscriber had not breached sections 1.6, 8.6, 8.20, 8.24 and 10.3.

Further details of the Committee's Determination and the subscriber's breaches of the Code sections outlined above can be found on the Committee's website at https://lifeccc.org.au/resources/notice-of-determination-cx5919/. For the purposes of this case study, however, we draw subscribers' attention to the breach of Code section 1.5.

Section 1.5 is a principles-based Code obligation designed to ensure that when they offer products and services to their customers, subscribers abide by the following principles:

- clarity and transparency
- fairness and respect
- honesty
- timeliness
- communications in plain language.

The obligations set out in section 1.5 underpin many other Code sections and as occurred in this matter, a breach of one or more Code obligations may result in non-compliance with section 1.5. In this case, the subscriber acknowledged that, as a result of breaching sections 8.4, 8.5, 8.17 and 9.12, it had also breached section 1.5 (a), (b) and (d) of the Code because:

- on one occasion it did not respect the customer's request to notify him before contacting his GP;
- it did not respond to the customer or provide him with information in a timely manner; and
- it omitted to mention the possibility of exploring topics such as the customer's mental health when responding to his query about the purpose of an interview and request for more detail.

The subscriber's untimely and/or incomplete responses to the customer on some topics gave him cause for concern and resulted in him distrusting the process. This is inconsistent with the spirit of the Code.

Subscribers should be mindful of community expectations that claims and complaints will be handled consistently and compassionately, with commercial standards of decency and fairness, and in a timely manner. The duty of utmost good faith is a long-standing core principle in the relationship subscribers have with their policy holders, underpinning the trust that customers place in their insurers.

Investigation Activity by the Committee

Despite the operational challenges brought about by the COVID-19 pandemic and some resourcing issues caused by staff turnover at the Administrator level, the Committee assessed and finalised a record number of matters during 2020–21 (**Table 1b**).

Following the successful implementation of a triage system and delegation framework the previous year, the Committee enhanced a number of processes during 2020–21 which led to improved efficiencies and enabled us to complete 294 investigations and assessments – 192 more than in 2019–20.

As of 1 July 2021, the Committee had 56 open Matters. Since that date, more than 23 further Matters have been closed (consisting of 53 individual sections) and the Committee looks forward to reporting a further decrease in the number of carried over Matters in next year's Annual Report. Of the 144 matters closed by the Committee in 2020-21, 54 matters were triaged by the Code team, 12 matters were withdrawn by the customer and the remaining matters were closed following either a Determination or a case study published by the Committee.

> **… the Committee enhanced a number of processes during 2020–21 which led to improved efficiencies and enabled us to complete 294 investigations and assessments …**

TABLE 1b.

Summary status of Matters overseen by the Committee

	Received	Closed in 2017-2018	Closed in 2018-2019	Closed in 2019-2020	Closed in 2020-2021	Open at 1 July 2021
2017-18 Matters*						
Investigations	56	16	11	19	10	-
Significant Breaches	23	3	5	15	-	-
Total 2017-18 Matters	**79**	**19**	**16**	**34**	**10**	**-**
2018-19 Matters						
Investigations	79	-	17	27	32	3
Significant Breaches	23	-	7	7	8	1
Total 2018-19 Matters	**102**		**24**	**34**	**40**	**4**
2019-20 Matters						
Investigations	74	-	-	27	31	16
Significant Breaches	21	-	-	6	7	8
Total 2019-20 Matters	**95**	**-**	**-**	**33**	**38**	**24**
2020-21 Matters						
Investigations	64	-	-	-	44	20
Significant Breaches	20	-	-	-	12	8
Total 2020-21 Matters	**84**	**-**	**-**	**-**	**56**	**28**
All Years						
Investigations	273	16	28	73	117	39
Significant Breaches	87	3	12	28	27	17
Total Matters All Years	**360**	**19**	**40**	**101**	**144**	**56**

* Excludes 2017-18 bulk referral numbers to allow more realistic year-to-year comparison. The bulk referral allegation of more than 700 potential breaches were dealt with via a dedicated investigation, with results published in the Committee's report: *Claims and Complaints Handling Obligations: A review of compliance by Life Code subscribers*. The report is available on the Committee website at www.lifeccc.org.au.

Significant breaches

The Code requires subscribers to report significant Code breaches to the Committee within 10 business days of identifying the breach. Under the current Code, whether a breach is significant can only be determined by a subscriber using the definition of a significant breach set out in chapter 15 of the Code.[6] In 2020–21, subscribers reported a total of 33 significant breaches – 25% fewer than the previous year. The Committee reviewed 48 (including some that were reported in previous years) and confirmed 38 as significant Code breaches during the year (**Table 2**). No significant breaches met a condition for imposition of a sanction.

33

Significant breaches reported by subscribers in 2020–21 ↓ down 25% compared to 2019–20

6 Life Insurance Code of Practice - https://lifeccc.org.au/resource/codes-of-practice/

The Code requires subscribers to report significant Code breaches to the Committee within

10 business days of identifying the breach

As we have consistently stated in previous Annual Reports, the Committee believes that some subscribers are not adequately reporting all significant breaches of the Code. Despite the guidance provided in recent years on the need to implement a positive compliance culture, along with robust processes and procedures in place for identifying and reporting significant breaches, we continue to receive a high volume of breach allegations (see **page 24**), often against subscribers that report few significant breaches, which suggests under-reporting.

In response to our concerns that some subscribers are failing to identify all significant breaches of the Code, the Committee recently published a Guidance Note, focused specifically on the Code's Significant Breach Obligations. The Guidance Note will help subscribers to interpret and apply these obligations to ensure they identify and report significant breaches to the Committee within the required timeframe. The Guidance Note also outlines the processes for remediating significant breaches, including the circumstances in which the Committee will close a significant breach matter.

We encourage all subscribers – including those who believe they are capturing and reporting all significant breaches – to make use of this important resource, and we will continue to closely monitor subscribers' compliance with these obligations.

> **"As we have consistently stated in previous Annual Reports, the Committee believes that some subscribers are not adequately reporting all significant breaches of the Code.**

TABLE 2.

Significant breaches reported*, reviewed† and confirmed‡ by Code chapter

	2017-18			2018-19			2019-20			2020-21		
Code chapter	Significant	Reviewed	Confirmed	Significant	Reviewed	Confirmed	Significant	Reviewed	Confirmed	Significant	Reviewed	Confirmed
Policy changes and cancellation	7	-	6	7	-	-	7	4	4	12	16	12
Sales and advertising	4	-	4	4	4	-	-	-	-	1	1	1
Claims	5	-	1	9	4	4	23	12	12	15	17	12
Policy design and disclosure	2	-	2	-	-	-	-	-	-	1	-	-
Buying insurance	3	-	2	7	-	-	3	8	8	-	5	4
Third party underwriting and claims	1	-	1	-	-	-	-	-	-	-	-	-
Code objectives	-	-	-	1	1	1	-	-	-	-	-	-
Access to information	-	-	-	-	-	-	1	1	1	-	-	-
Monitoring, enforcement and sanctions	-	-	-	14	-	-	8	7	7	1	5	5
Information and education	-	-	-	-	-	-	-	-	-	-	-	-
Key Code Promises	-	-	-	-	-	-	-	-	-	-	-	-
Complaints and disputes	1	-	1	1	-	-	2	2	1	3	4	4
Total	**23**	**-**	**17**	**43**	**9**	**5**	**44**	**34**	**33**	**33**	**48**	**38**

* A significant breach reported by a subscriber to the Committee.

† Significant breach reviewed by the Committee.

‡ Significant breach confirmed as such by the Committee.

CLAIMS

Chapter 8 of the Code on Claims accounted for just under half of the 33 significant breaches reported by subscribers in 2020–21. The Code protections relating to how subscribers handle claims are among the most important, as they are designed to ensure that customers receive a high standard of service at a time when they may be at their most vulnerable.

Subscribers reported 15 significant claim breaches this year – 8 fewer than the previous year. While breaches of the Code's claims obligations were fairly evenly spread across several different clauses within chapter 8, the key clauses breached related to:

- the timing around informing a customer about a claim decision (sections 8.15–8.17)
- a subscriber's obligation to provide clarity of benefits entitlements, contact points and when the customer can expect to be contacted about progress on the claim (sections 8.2–8.4)
- a delay to an income protection payment (section 8.9).

Subscribers nominated a range of people-related issues, including staff turnover, inadequate staff training, human error, and a failure to follow the correct processes and procedures, as the cause of most claims-related breaches.

Case study

A subscriber breaches the Code by not treating a customer's request to review a declined claim as a complaint

A woman had life insurance with the subscriber as part of her superannuation fund membership. The life insurance policy, which included a Total and Permanent Disability (TPD) benefit, was a group policy held by the trustee for its members, which included the woman.

In March 2015, the woman lodged a TPD claim, which was declined by the subscriber in August 2016. Dissatisfied with the decision, the woman sought a review by lodging a complaint with the trustee via her legal representative on 7 August 2017, and the trustee referred the complaint to the subscriber.

The woman's legal representative made two follow-up enquiries with the subscriber – one on 24 November 2017 and one on 5 January 2018. The subscriber responded on 10 January 2018, stating that the file had been reallocated to a new claims assessor and the woman needed to provide two current treating doctor reports. As a result of the new information the subscriber accepted the TPD claim and sent the Trustee their decision on 27 February 2018.

Under section 9.10 of the Code, when a subscriber receives a complaint via a trustee, the subscriber must respond, where possible, in a timeframe that enables the trustee to provide its final response to the complaint within 90 calendar days. The response must include certain information, including the final decision and information about external dispute resolution options.

As the woman did not receive a response to her complaint within 90 days of lodging it, her legal representative alleged a breach of section 9.10.

The subscriber explained that it had not met the 90-day timeframe because it did not treat the first letter as a complaint, managing it instead as a continuation of the claims handling process. As new information was received with the complaint, the subscriber reviewed it as part of their assessment process and reopened the claim. By the time it provided the trustee with its decision, 204 calendar days had passed between the subscriber receiving the complaint and accepting the claim.

The Committee determined that the subscriber was in breach of section 9.10, not only due to the significant delay in issuing a decision about the claim, but also because the subscriber's final decision letter to the trustee did not advise that, if requested by the complainant, the subscriber would supply copies of the documents and other information it relied on to assess the complaint within 10 business days. This is a requirement under section 9.10(b) of the Code.

The breach was also found to be systemic, as the subscriber did not treat requests for the review of a declined claim as a complaint prior to this matter being raised. The subscriber has since updated its processes to ensure that all requests for declined claims to be reviewed are treated as complaints and subject to the timeframes set out in section 9.10.

In investigating the matter, the Committee also determined that the subscriber was in breach of section 8.18, which requires subscribers to suggest customers seek financial advice to help manage their claim payment when the subscriber is making a lump sum payment. The claim acceptance letter the subscriber sent to the trustee did not include this financial advice wording, as the subscriber believed it was the trustee's role to suggest that customer seek financial advice.

In the case of group policies, as the subscriber is only in contact with the policy owner (the trustee), their obligation under section 8.18 is to provide the policy owner with the financial advice wording, on the understanding that the policy owner would communicate this information to the customer.

As the subscriber was in breach of section 8.18 in relation to all claim acceptance letters issued in respect of group policies, the Committee determined this amounted to systemic non-compliance with the Code.

The request for a review of a declined claim falls under the definition of a complaint in the Code. While subscribers may choose to deal with such complaints through their claims handling process, the Committee notes the obligations under chapter 9 of the Code will apply to such complaints.

POLICY CHANGES AND CANCELLATION

The second highest number of reported significant breaches in 2020–21 concerned policy changes and cancellation rights, covered in chapter 6 of the Code. These are an important group of protections because they keep insurers accountable to customers, particularly during times of economic uncertainty (such as the COVID-19 pandemic), when people may be looking to amend or cancel their policy following changes to their financial situation.

There were substantially more chapter 6 breaches reported by subscribers this year compared to previous years. For each of the three prior years, subscribers self-reported 7 breaches. In 2020–21, this rose to 12 breaches – an increase of 71%.

All but two of the self-reported significant breaches of chapter 6 related to section 6.3, which requires customers to be provided with an annual notice, in writing, prior to the anniversary of the Policy. The notice must include information about the customer's level of cover, the amount for which they are insured, the details of any increase in their premiums, and advice about policy changes and cancellation rights.

Increase in Chapter 6 self-reported breaches in 2020-21 compared to three prior reporting periods

> **We anticipate the findings of the OMI in relation to annual notices will provide a clearer picture of why there has been an increase in significant breaches of section 6.3 …**

Section 6.3 provides important consumer protections, as a renewal notice enables a customer to review whether the product is still suitable for their needs; alerts them to the cover they hold and the claims process, potentially triggering a claim; and gives them information about their options, including hardship assistance.

As this report was being prepared, the Committee was in the process of conducting an OMI into subscribers' compliance with section 6.3 of the Code. The OMI will examine the number of on-sale and off-sale products, the processes and procedures used by subscribers to enable compliance with section 6.3 of the Code and the number of breaches that occurred in the 2019 and 2020 calendar years.

Since the OMI commenced in April 2021, subscribers have reported five significant breaches of section 6.3 to the Committee, highlighting this as an area of ongoing risk for the industry. We anticipate the findings of the OMI in relation to annual notices will provide a clearer picture of why there has been an increase in significant breaches of section 6.3, and how Code subscribers can improve their monitoring and compliance going forward.

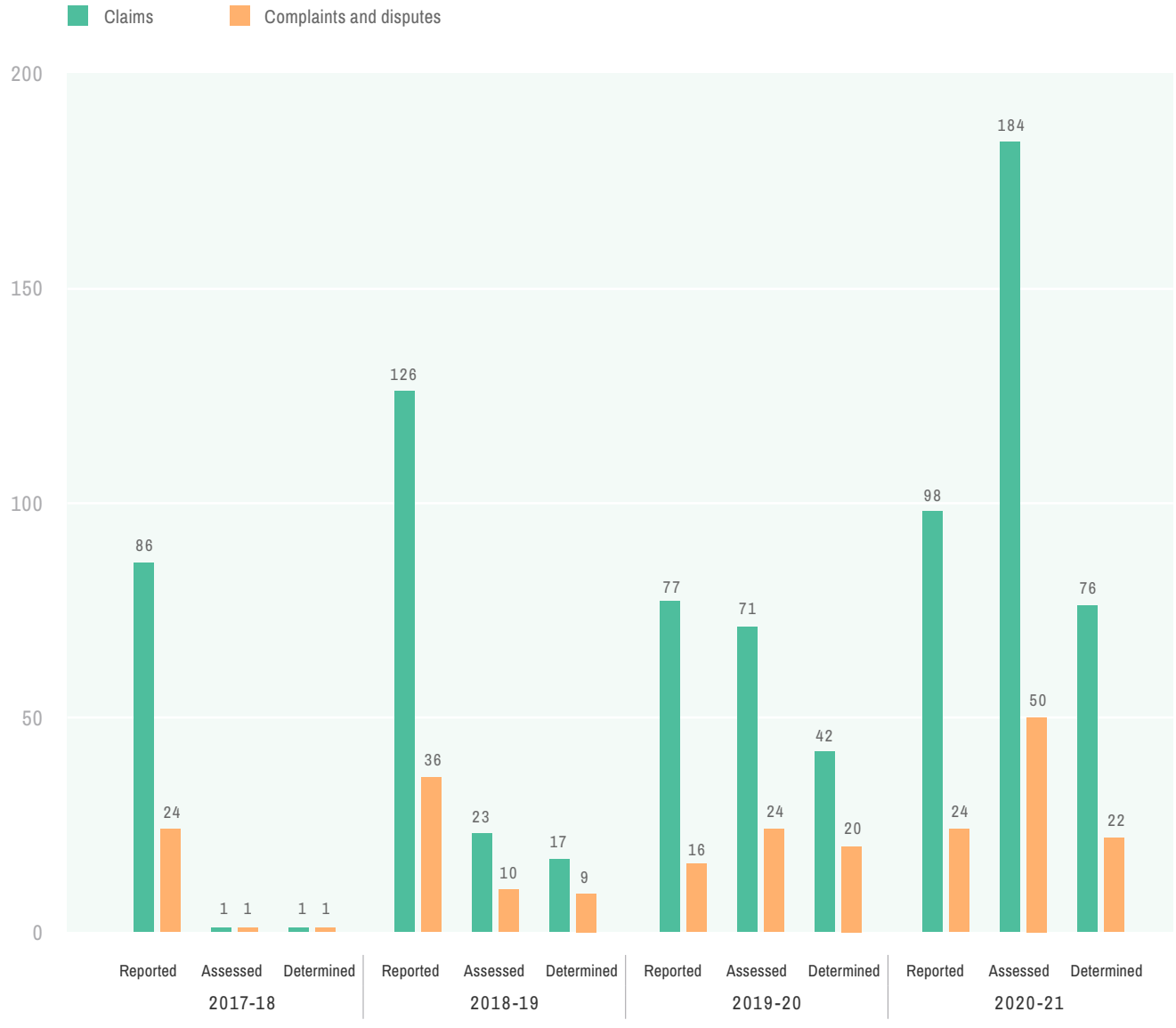
Alleged Code breaches

Anyone can refer an alleged breach of the Code to the Committee. The Committee then has the discretion to investigate any referral it receives; determine whether a breach or breaches occurred with the alleged breach or any Code obligation; agree with the subscriber on corrective measures; and monitor their implementation.

Thanks to the introduction of more efficient processes, an increase in the knowledge and experience of the Committee and Code team, and greater responsiveness by subscribers, the Committee was able to assess a record 294 breach allegations during 2020–21 – three times more than the previous year (**Table 3**). Many of these were allegations made in prior years when the Committee was not sufficiently resourced to assess them. Of all the alleged breaches assessed in 2020–21, 104 were determined as Code breaches.

FIGURE 2.

Top 2 common Code Chapter breaches reported*, assessed† and determined‡



* Alleged Code breaches reported to the Committee by a person, personal representative, AFCA or other third party.

† Code breach allegations assessed by the Committee. This can include allegations received in previous reporting periods.

‡ Allegations determined by the Committee as Code breaches.

TABLE 3.

Code breaches reported*, assessed† and determined‡ by Code chapter

	2017-18*			2018-19			2019-20			2020-21		
Code chapter	Reported	Assessed	Determined	Reported	Assessed	Determined	Reported	Assessed	Determined	Reported	Assessed	Determined
Claims	86	1	1	126	23	17	77	71	42	98	184	76
Complaints and disputes	24	1	1	36	10	9	16	24	20	24	50	22
Policy changes and cancellation	1	-	-	6	-	-	9	-	-	5	6	-
Sales and advertising	2	-	-	10	-	-	4	1	1	3	5	-
Code objectives	3	-	-	8	-	-	13	-	-	4	9	1
Policy design and disclosure	-	-	-	8	-	-	2	1	-	1	8	-
Access to information	6	-	-	11	3	2	5	1	1	4	13	2
Buying insurance	-	-	-	4	-	-	1	-	-	4	7	1
Monitoring, enforcement and sanctions	-	-	-	-	-	-	-	-	-	3	3	-
Additional consumer support	3	-	-	3	-	-	-	-	-	2	5	-
Third party underwriting and claims	1	-	-	3	-	-	-	-	-	-	2	1
Information and education	1	-	-	1	-	-	-	1	1	1	2	1
Key Code promises	-	-	-	4	-	-	-	3	-	-	-	-
Total	**127**	**2**	**2**	**220**	**36**	**28**	**127**	**102**	**65**	**149**	**294**	**104**

* Alleged Code breaches reported to the Committee by a person, personal representative, AFCA or other third party.

† Code breach allegations assessed by the Committee. This can include allegations received in previous years.

‡ Allegations determined by the Committee as Code breaches.

Alleged Code breaches: from referral to remediation

1. REFERRAL

A person, personal representative or AFCA makes a referral. We apply a triage process to check whether the referral is covered by the Code and to decide whether and how to proceed.

Where a matter falls within the Committee's jurisdiction, we consider whether the subscriber involved is currently being (or has previously been) investigated by the Committee for a breach of the same Code section. If not, we will commence an investigation. If so, we will consider the merits of investigating the new matter, taking into account factors including (but not limited to):

- impact on the person or people involved
- whether the matter is likely to be isolated or industry wide
- whether guidance or a key principle could be developed as a result of any investigation
- whether the Committee should conduct a wider inquiry into the area of concern, rather than an individual investigation.

We will also consider whether the issue being raised in the new referral occurred before or after the previous investigation took place. If it occurred before the previous investigation, we will look at whether the cause of the issue has been addressed by the remedial outcomes of the investigation. If it occurred after the completion of the previous investigation, it may indicate that the remedial action was insufficient or that an event was not isolated, and that escalation and investigation is warranted.

2. INVESTIGATION AND DETERMINATION

If we decide to investigate, we ask for necessary information from the person (including an appropriate Privacy Authority) and the subscriber. We review the facts to ascertain whether a breach or breaches have occurred and whether the issue may be systemic and/or serious.

We issue a Determination setting out our findings and share it with the person who made the referral, the subscriber involved, and (on a de-identified basis) with all subscribers.

> **If there was a breach, we work with the subscriber to identify and agree appropriate remediation.**

3. REMEDIATION

If there was a breach, we work with the subscriber to identify and agree appropriate remediation. The investigation is closed when we are satisfied the subscriber has completed the agreed remedial action.

ALLEGATIONS RECEIVED DURING THE YEAR

During 2020–21, the Committee received 64 referrals containing a total of 149 alleged Code breaches which is 17% more allegations of potential breaches of Code obligations this year in comparison to previous year (**Table 3**). Almost two-thirds of these allegations were referred directly by life insurance customers, in a clear indication that they are becoming increasingly aware of their consumer rights and the Code's role in protecting those rights. Another 21% of allegations were referred on behalf of individuals by third party advocates (either consumer advocates or legal representatives), while almost 12% were referred to the Committee by AFCA.

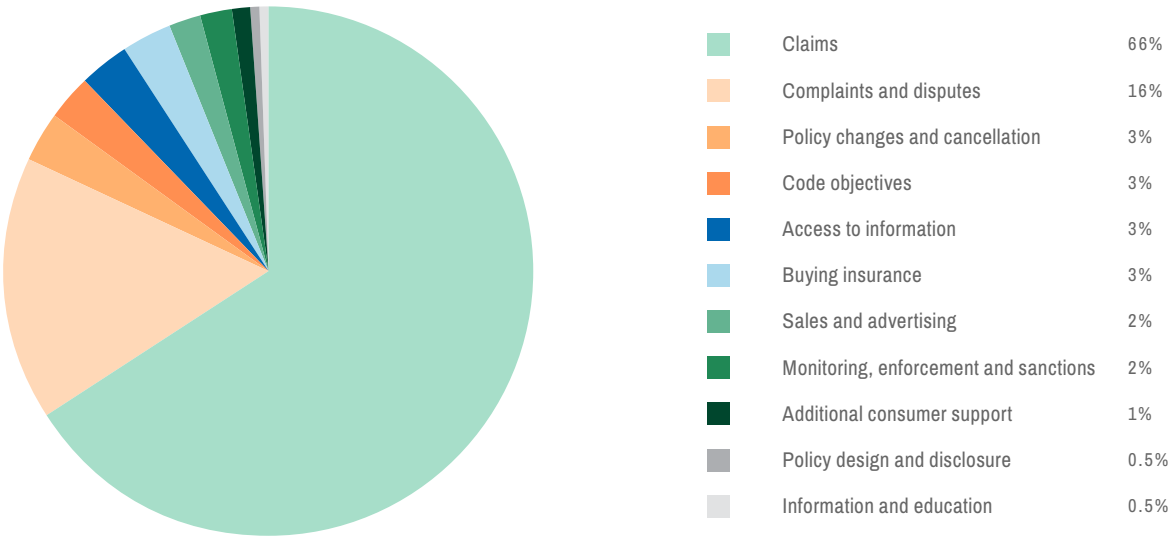
For the fourth year in a row, the highest number of alleged breaches were of chapter 8 ('When you make a claim') and chapter 9 ('Complaints and disputes') of the Code. Together, claims and complaints accounted for 82% of all Code breach allegations during 2020–21.

Despite seeing a reduction in the number of alleged claims and complaints related breaches in the previous year, the Committee received 31% more allegations of potential breaches of these Code obligations this year than in 2019–20 (122 this year compared to 93 last year). There were 27% more claims-related Code breach allegations (98 this year compared to 77 last year) and 50% more Code breach allegations relating to complaints and disputes (24 this year compared to 16 last year) (**Table 4**).

Given our focus in recent years on subscribers' compliance with the Code's claims and complaints obligations – namely sections 8.16, 8.17 and 9.10[7] – it was disappointing to note that between them, these three Code sections accounted for 30% of all alleged Code breaches for the year.

FIGURE 3.

Alleged breaches by Code chapter 2020-2021



7 During 2019–20, the Committee published two guidance resources to help subscribers improve their compliance with the Code's claims and complaints obligations. The first was a Guidance Note (November 2019) on interpreting and applying section 9.10 of the Code. The second was *Claims and Complaints Handling Obligations: A review of compliance by Life Code subscribers* (March 2020) a report containing the findings of our investigation into 11 Code subscribers' compliance with sections 8.16, 8.17 and 9.10 of the Code, initiated by the receipt of a bulk referral of more than 700 alleged breaches from a plaintiff law firm.

TABLE 4.

Comparison of alleged breaches by Code chapter, year on year

	2017-18*		2018-19		2019-20		2020-21	
Code chapter	No.	%	No.	%	No.	%	No.	%
Claims*	43	58%	106	53%	77	61%	98	66%
Complaints and disputes*	14	19%	39	20%	16	12%	24	16%
Policy changes and cancellation	1	2%	6	3%	9	7%	5	3%
Sales and advertising	3	4%	11	6%	4	3%	3	2%
Code objectives	3	4%	8	4%	13	10%	4	3%
Policy design and disclosure	-	-	8	4%	2	2%	1	0.5%
Access to information	6	8%	8	4%	5	4%	4	3%
Buying insurance	-	-	2	1%	1	1%	4	3%
Monitoring, enforcement and sanctions	-	-	-	-	-	-	3	2%
Additional consumer support	3	4%	3	1%	-	-	2	1%
Third party underwriting and claims	1	1%	2	1%	-	-	-	-
Information and education	-	-	1	1%	-	-	1	0.5%
Key Code promises	-	-	4	2%	-	-	-	-
Total	**74**	**100%**	**198**	**100%**	**127**	**100%**	**149**	**100%**

* excludes 2017-18 bulk referral numbers to allow more reasonable year-to-year comparison

CLAIMS ISSUES IN ALLEGED CODE BREACHES

Alleged breaches of the Code's claims standards accounted for 66% of all alleged breaches in 2020–21 (**Table 4**). While the alleged breaches spanned several sections of chapter 8, most related to the timeframes for advising customers about the status of their claims.

For the third year in a row, section 8.17 was the Code section with the highest number of alleged breaches. Section 8.17 relates to the requirement to make a decision on a lump sum claim within six months, or 12 months if Unexpected Circumstances apply. If Unexpected Circumstances apply to a claim, the subscriber must inform the customer that this is the case, explain why and give the customer an option to disagree. The subscriber must then provide a decision on the claim within 12 months from the date that the claim was notified.

Most of the section 8.17 matters considered by the Committee involved the subscriber failing to adequately notify the customer that Unexpected Circumstances applied to their claim. Taken together with section 8.16, which creates the same obligations as section 8.17 but with a shorter timeframe for making a claim decision, these two Code sections accounted for almost 31% of claims-related Code breach allegations and 20% of all Code breach allegations for the year.

Given the ongoing compliance issues with timeframes and Unexpected Circumstances, the Committee recently released two Guidance Notes to further assist subscribers in their understanding of and compliance with their obligations under Code sections 8.16 and 8.17.

TIGHTER CLAIMS HANDLING REGULATIONS COMMENCE ON 1 JANUARY 2022

From 1 January 2022, anyone who provides claims handling and settling services for ASIC-regulated insurance products will be regulated as a financial service under the Corporations Act and must have an Australian Financial Services Licence (AFSL). Entities with an existing AFSL must apply for a variation to their licence so it covers the new financial service of claims handling and settling.

As part of these reforms, all AFS licensees must comply with certain claims handling and settling obligations, which ASIC has set out in an information sheet (INFO 253), released in May 2021. These obligations either reference or reflect similar obligations set out in the Code, stating that insurance claims must be handled and settled:

- in a timely way
- in the least onerous and intrusive way possible
- fairly and transparently
- in a way that supports consumers, particularly those experiencing vulnerability or financial hardship.

This reinforces the importance of the Code in protecting consumers and providing guidance to subscribers in meeting their obligations.

COMPLAINTS AND DISPUTES ISSUES IN ALLEGED CODE BREACHES

As was the case for the three previous years, chapter 9 was again the source of the second highest number of breach allegations in 2020–21. The Committee received a total of 24 complaints-related breach allegations for the year – 50% more than we received in 2019–20.

More than half of these (58%) related to section 9.10, which requires subscribers to respond in a timely way to people's complaints received via a superannuation fund trustee, while one-fifth (20%) related to the requirement under section 9.12 to communicate the response to a complaint within 45 days.

Twenty of the 24 complaints-related Code breach allegations considered by the Committee in 2020–21 were determined to be breaches of the Code. As noted above, we are disappointed to see an increase in breach allegations relating to section 9.10, in light of the various resources we have provided subscribers to enhance their monitoring of and compliance with this Code obligation in recent years.

The continued prevalence of breach allegations relating to the time subscribers are taking to respond to customer complaints is concerning – especially as subscribers will be required to comply with ASIC's updated internal dispute resolution requirements (RG 271[8]) from 5 October 2021. This is an emerging area of risk for the industry and the Committee will continue to scrutinise subscriber compliance with the Code's complaints obligations.

8 ASIC's RG 271 Internal dispute resolution

Claims and complaints data can be useful for identifying and responding to potential systemic issues, and for assessing whether insurance products are providing value for customers. Subscribers are encouraged to closely examine their claims and complaints data to determine any frictions or 'pain points' that may be causing customers to withdraw claims and/or lodge complaints. This, coupled with a healthy complaints culture throughout the organisation, will help drive better customer outcomes and reduce claims and complaints-related Code breaches.

Case study

Pressure selling by a third party distributor puts a subscriber at risk of a Code breach

A customer purchased a life insurance policy in 2018 via a third party distributor that was not an Authorised Representative of the subscriber. The third party distributor was selling the policies under its own Australian Financial Services Licence (AFSL).

The Committee received an allegation that the subscriber had breached section 4.6 of the Code, which obliges the subscriber to make clear to anyone distributing its policies that pressure selling is not permitted. While not disputing that the third party distributor had engaged in pressure selling, the subscriber noted that it had made clear to the third party distributor that pressure selling was not permitted by:

- ensuring this information was in the contract;
- requiring the distributor to make annual declarations;
- reviewing and approving sales scripts;
- conducting annual audits of calls; and
- reviewing the third party's training documents.

The subscriber acknowledged that the third party distributor had nonetheless engaged in pressure selling, and once this was identified, the subscriber tried to address the issue by asking the distributor for more frequent reporting on complaints and by initiating a new process to review calls. The Committee subsequently determined that the subscriber's actions satisfied the requirement in section 4.6 to make it clear to the distributor that pressure selling is not permitted. The other sections in chapter 4 of the Code did not apply because the distributor was not an Authorised Representative of the subscriber.

There have been significant changes in industry practices since this time, driven largely by the recommendations in the final report of the Financial Services Royal Commission and subsequent regulatory initiatives, such as ASIC's ban on unfair cold call sales of direct life insurance and Consumer Credit Insurance.

As part of the Code review process now underway, the Financial Services Council has indicated it supports the Committee's recommendation that the Code be changed to apply to third party distributors who act for a subscriber through a contractual arrangement. The Committee notes that life insurance policies issued by subscribers but sold under another party's AFSL are currently not covered by the obligations in chapter 4 of the Code.

The Committee considers it would be best practice for subscribers to actively monitor the selling of all life insurance policies they issue. Where pressure selling or other inappropriate conduct is identified, the Committee encourages subscribers to proactively engage with the third parties and/or customers and consider appropriate compensation.

As a way of promoting transparency and accountability within the life insurance industry, the Committee would prefer to be able to publish identifiable information about Code breaches in all our Determinations and case studies …

Investigation outcomes

Resourcing at the Administrator level and the Delegations Framework enabled the Committee to significantly clear the backlog of investigations held over from the previous years and led to 68 Determinations being issued during the year – 28 more than in 2019–20. In line with the Committee's Charter, these Determinations were published on a de-identified basis via our website and shared with all subscribers as a way of informing them about how breaches can occur, how the Committee assesses them and key learnings to assist in the prevention of their occurrence. One other matter considered by the Committee during the year was converted into a de-identified case study which was also published and shared with subscribers for educational purposes.

As a way of promoting transparency and accountability within the life insurance industry, the Committee would prefer to be able to publish identifiable information about Code breaches in all our Determinations and case studies, to be consistent with the change to AFCA rules to allow named determinations. The Committee has consistently recommended to the FSC that the Charter and the Code be amended to allow for identified reporting to occur, we are disappointed not to see these changes incorporated into Code 2.0.

While the Committee will continue to advocate for the powers to publish identifiable Determinations and case studies under the Code, we nonetheless encourage subscribers to circulate these de-identified resources throughout their businesses for compliance education and training purposes. We also encourage subscribers and other interested stakeholders to sign up via the Committee's website to receive timely notifications regarding the publication of Determinations, case studies and other Committee reports and resources.

68

Determinations issued during 2020–21

↑ 28 more than in 2019–20

Remediation and Sanctions

As part of the Committee's investigations, subscribers may be required by the Committee to engage in corrective action and remediate any breaches as determined by the Committee.

If so, the Committee will work with a subscriber to agree on the relevant corrective action and the remediation timeframe, as well as to monitor the subscriber's progress and implementation of the corrective action. Remediation may include both internal and external activities.

Internal actions usually focus on improvements to subscribers' compliance frameworks. These often include enhancing the compliance/operational procedures and structures – for example, increased staff training and supervision, amendment of documentation such as letter templates, commissioning a formal review or audit of relevant aspects of the subscriber's compliance with the Code. In some instances, it may also include product amendment/withdrawal.

External actions can include amendment of information on websites or in relevant marketing material, and remedial communications and associated actions with people impacted.

The Committee's investigation process cannot offer customers an individual outcome to their dispute, and any compensation that arises out of an investigation by the Committee is at the discretion of subscribers.[9]

However, the Committee encourages subscribers to promptly remediate customers where our investigation uncovers unfair or unjust treatment.

Over the past year, the Committee has been pleased to see subscribers demonstrate increased cooperation and commitment to their breach remediation efforts. Most subscribers' remediation action plans have been comprehensive, implemented within the agreed upon timeframes, and are effective to remediate Code breaches.

As noted under the Code, the Committee has the power to impose sanctions on subscribers, however this is triggered only:

- after a subscriber has failed to implement the corrective measures to address a Code breach within the timeframe agreed in accordance with the Committee's formal determination, or
- where the Committee fails to reach agreement in a reasonable time with a subscriber about the corrective action to be taken to address a Code breach.

There were no sanctions issued by the Committee during the 2020–21 year, as no events occurred which gave rise to the use of its sanctioning powers.

9 Readers should note that if an individual outcome is desired, particularly in relation to financial disputes, this can be pursued via an appropriate internal or External Dispute Resolution (EDR) process at www.afca.org.au.

Appendix A. About the Life Insurance Code of Practice

Developed by the life insurance industry through the Financial Services Council (FSC), the Code was introduced on 1 October 2016 for a transitional period of nine months, coming into formal effect on 1 July 2017. The Code commits subscribers to continuous improvement and a high standard of customer service.

The Code includes 10 Key Code Promises for subscribers to adhere to:

1. We will be honest, fair, respectful, transparent, timely, and where possible we will use plain language in our communications with you.
2. We will monitor sales by our staff and our authorised representatives to ensure sales are appropriate.
3. If we discover that an inappropriate sale has occurred, we will discuss a remedy with you, such as a refund or a replacement policy.
4. We will provide additional support if you have difficulty with the process of buying insurance or making a claim.
5. When you make a claim, we will explain the claim process to you and keep you informed about our progress in making a decision on your claim.
6. We will make a decision on your claim within the timeframes defined in the Code, and if we cannot meet these timeframes you can access our complaints process.
7. If we deny your claim, we will explain the reasons in writing and let you know the next steps if you disagree with our decision.
8. We will restrict the use of investigators and surveillance, to ensure your legitimate right to privacy.
9. The independent Code Compliance Committee will monitor our compliance with the Code.
10. If we do not correct Code breaches, sanctions can be imposed on us.

These general principles underpin the Code's specific obligations, which cover the many aspects of a customer's relationship with a subscriber, namely:

- policy design and disclosure
- sales and advertising
- buying insurance
- policy changes and cancellation
- customers requiring additional support
- claims
- complaints and disputes
- third party underwriting and claims
- information and education
- access to information.

Appendix B.
List of subscribers

As at 30 June 2021, the Code had 24 subscribers.

Name	Date of adoption
1. AIA Australia Limited	30 June 2017
2. Allianz Australia Life Insurance Limited	30 June 2017
3. AMP Life Limited	30 June 2017
4. ClearView Life Assurance Limited	30 June 2017
5. EMLife Pty Ltd*	14 March 2018
6. General Reinsurance Life Australia Ltd	30 June 2017
7. Hallmark Life Insurance Company Ltd (part of the Latitude Financial Services Group)	30 June 2017
8. Hannover Life Re of Australasia Ltd	30 June 2017
9. HCF Life Insurance Company Pty Ltd	1 July 2018
10. Integrity Life Australia Limited	1 July 2018
11. MetLife Insurance Limited	30 June 2017
12. MLC Limited	30 June 2017
13. Munich Reinsurance Company of Australasia Limited	30 June 2017
14. NobleOak Life Limited	30 June 2017
15. OnePath Life Limited (a company of ANZ Wealth Australia Limited)	30 June 2017
16. Pacific Life Re (Australia) Pty Ltd	19 February 2020
17. QInsure Limited	15 September 2017
18. RGA Reinsurance Company of Australia Limited	30 June 2017
19. SCOR Global Life Australia Pty Ltd	30 June 2017
20. Suncorp Life & Superannuation Limited (trading as Asteron Life)	30 June 2017
21. Swiss Re Life & Health Australia Limited	30 June 2017
22. TAL Life Limited	30 June 2017
23. Westpac Life Insurance Services Limited	30 June 2017
24. Zurich Australia Limited	30 June 2017

* EMLife is not a life insurer and adopted the Code, under section 2.1(b).

Appendix C. Committee members and administrator staff

MS JAN MCCLELLAND AM, BA HONS, BLEGS, FAICD, FACEL, FIML

COMMITTEE CHAIR (INCOMING)

Jan McClelland AM is an experienced Chief Executive, Chair and Company Director in government, private and not for profit organisations across a wide range of industry sectors.

Jan is a former Director General of the NSW Department of Education and Training and Managing Director of the NSW TAFE Commission. She is currently Deputy Chancellor of the University of New England (UNE), Chair of the Gateway Network Governance Body (GNGB), and a member of the Advisory Board of NSW Circular and of audit and risk committees in legal, health and local government sectors. Jan is also Chair of HeartKids Limited and a Director of Stewart House.

Jan is also Managing Director of a management consultancy practice providing advisory services across public, private and not for profit sector organisations in the areas of strategic planning, organisation reviews, complaints handling, and industry codes of practice.

Jan has previously served as chair/member of boards and governance bodies in transport, waste, agriculture, medical technologies, legal and professional services, and insurance. Her roles have included Chair of the Medical Technology Association of Australia (MTAA) Code Compliance Committee and Chair of the Professional Practice Review Committee of the NSW Consumer Tenancy and Trader Tribunal (now NSW Civil and Administrative Tribunal). She has also been a member of the NSW Motor Accidents Authority Council and NSW Administrative Decisions Tribunal, and a Director of Waste Services Environmental Solutions, Central Coast Redevelopment Authority and State Transit Authority.

Jan holds a Bachelor of Arts (Honours) Degree and a Bachelor of Legal Studies. She is a Fellow of the Institute of Company Directors, a Fellow of the Australian Institute of Leaders and Managers and a Fellow of the Australian Council of Educational Leaders.

Jan was awarded a Member (AM) in the General Division of the Order of Australia in the Australian Day 2015 honours list, for significant service to a range of education, business, social welfare, and community organisations and to public administration.

MS ANNE T BROWN, BA, CA, GAICD

COMMITTEE CHAIR (OUTGOING)

Anne has substantial knowledge and practical experience of Australian regulatory environments, risk management, corporate governance, and financial markets infrastructure.

Anne is a non-executive director of Air Services Australia and the Clean Energy Regulator, a member of the Australian Securities and Investments Commission's Markets Disciplinary Panel and a member of the Finance, Audit and Risk Committee of Monte Sant'Angelo Mercy College Limited.

Previously Anne was Chief Risk Officer with ASX Limited following its merger with SFE Corporation Limited, where she also chaired a range of broader group executive committees and oversaw integration strategy, risk management and policy for ASX's two clearing houses. Anne also represented ASX as the Chair and executive committee member of CCP12, an influential global industry association of all major international clearing houses. Prior to the ASX/SFE merger, Anne held senior management positions with SFE and KPMG.

Anne holds a double major degree in accountancy and computer science from Heriot-Watt University, Edinburgh. She is a member of the Institute of Chartered Accountants of Scotland and a graduate member of the Australian Institute of Company Directors.

MS ALEXANDRA KELLY, LLM, BPSYCH

CONSUMER REPRESENTATIVE GAICD

Alexandra is the Director of casework at the Financial Rights Legal Centre, which operates a legal advice line for credit and debt, 50% of the National Debt Helpline in NSW, the Mob Strong Debt Help line a dedicated national service for Aboriginal and Torres Strait Islanders, and the National Insurance Law Service.

As a solicitor at Financial Rights Legal Centre for the last 13 years she has had the privilege of speaking to consumers about their lived experiences of financial services products, including life insurance; advocating on individual and systemic issues; and lobbying and advocating from an evidence-based position.

Alexandra is a non-executive director of CHOICE and a member of the Australian Consumer Law Subcommittee of the Law Council. She is committed to social justice, consumer advocacy and consumer education as to their financial rights.

Alexandra has a Bachelor of Laws (Hons) and Bachelor of Psychology from Australian National University and Master of Laws from Sydney University and a graduate member of the Australian Institute of Company Directors.

DAVID GOODSALL,
BA, FIAA, FAICD, CERA

INDUSTRY REPRESENTATIVE

David Goodsall has spent his career advising institutions in the financial services, general insurance and health insurance industries in Australia and overseas. David has extensive commercial and boardroom experience both as a director, and having advised many major institutions in life insurance, reinsurance, and broader financial services on a range of transactions, product, strategy, risk management, culture, governance, and regulatory issues.

David is a consulting actuary and co-founder of Fiduciary Dynamics, a specialist advisory firm that provides strategic governance and risk management advice to financial services companies. He is an independent director and chair of the Audit and Risk Committee of BrightsideCo Insurance. Previously David was a senior partner in the Financial Services practice of Ernst & Young, leading the Actuarial practice, as well as an independent director of ClearView Wealth, and Medical Insurance Australia. He was President of the Institute of Actuaries of Australia in 2012.

David holds a BA majoring in actuarial studies, is a Fellow of the Institute of Actuaries of Australia, a Fellow of the Australian Institute of Company Directors, and a Chartered Enterprise Risk Actuary.

SALLY DAVIS,
BCOMM, LLB, GRAD DIP (ARTS) GAICD

GENERAL MANAGER – CODE COMPLIANCE AND MONITORING (OUTGOING)

Until her resignation in March 2021, Sally Davis was General Manager – Codes at AFCA and former CEO of the Banking Code Compliance Committee. Prior to being appointed to these roles in September 2015, she was Senior Manager of Systemic Issues at FOS and had worked at AFCA and its predecessor schemes for over 15 years.

Sally is a graduate of the Mt Eliza Business School and an accredited mediator. She holds a Bachelor of Commerce and a Bachelor of Laws degree from the University of Melbourne and a Graduate Diploma (Arts) from Monash University.

During her time at AFCA, Sally worked regularly with all relevant stakeholders to enhance the knowledge and effectiveness of Codes of Practice in the financial services industry. She also provided support to the Committees in their monitoring of those Codes, shared insights from monitoring activities and added value back to industry and consumers.

ANKIT DANG,
BCOMM HONS, MPA

COMPLIANCE AND OPERATIONS MANAGER – CODE COMPLIANCE AND MONITORING

Ankit Dang is a Code Compliance and Operations Manager at AFCA. His role is dedicated to the oversight of all aspects of the operation that supports the Life Code Compliance Committee including delivering on the work plan, managing the Life Code Compliance Committee's budget, helping and guiding the Life Code Compliance Committee in monitoring activities within the Life insurance industry and maintaining a positive relationship with all stakeholders. Ankit is passionate about driving positive change within the Life Insurance Industry.

RENÉ VAN DE RIJDT,
LLB

ACTING GENERAL MANAGER – CODE COMPLIANCE AND MONITORING

René van de Rijdt was appointed Acting General Manager – Codes at AFCA and Acting CEO of the Banking Code Compliance Committee in March 2021. His role includes oversight of the work plans, budgets, strategic direction and operational management of five independent Committees which monitor compliance with codes of practice across the financial services industry covering the banking, customer owned banking, general insurance, life insurance and insurance broking industries.

René has worked at AFCA and its predecessor schemes since 2011 and has been a member of the Code team since 2017, working as Code Compliance Investigations Manager prior to his appointment as Acting General Manager – Codes. He has a background in law and external dispute resolution and holds a Bachelor of Law from Monash University and a Bachelor of Planning and Design from the University of Melbourne.

René maintains good relationships with regulators, industry, and consumer groups. He is passionate about providing positive consumer outcomes and ensuring continuous improvement in the financial services industry by supporting the Life Code Compliance Committee.

Appendix D.
Committee meetings

Date	Attendance			
	JAN MCCLELLAND	ANNE T BROWN	ALEXANDRA KELLY	DAVID GOODSALL
8 October 2020		✓	✓	✓
8 December 2020		✓	✓	✓
2 March 2021		✓	✓	✓
15 April 2021		✓	✓	✓
15 April 2021 - Strategy		✓	✓	✓
22 June 2021	✓		✓	✓

The Annual Report of the Life Code Compliance Committee 2020-21

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