Life Insurance Code of Practice

# Annual Industry Data and Compliance Report 2017–18

MARCH 2019

LIFE CODE COMPLIANCE COMMITTEE

# Contents

# Chair's message

I am pleased to present the Life Code Compliance Committee's inaugural Annual Industry Data and Compliance Report (the Report) for the reporting period 1 July 2017 to 30 June 2018 (the year). The Report aggregates data collected from Code subscribers - together with Committee compliance information – to present an enlightening snapshot of the life insurance industry and, importantly, its compliance with the Life Insurance Code of Practice (the Code) for the year.

Reflecting industry activity for the first year of formal operation of the Life Insurance Code of Practice, our Report highlights overall industry activity in terms of policies and distribution channels, together with outcomes around the important claims and complaints sections of the Code. We noted some opportunities for improvement in subscribers' recording and reporting of both claims data (where unexpected circumstances apply) and complaints data.

The Report also summarises Code compliance outcomes for the year. Code breaches reflect a mixture of high volume events - mainly legacy systems-based issues remaining as subscribers transitioned to the new Code - together with a number of isolated breaches driven mainly by human error or inadequate resourcing. Whilst subscribers appear committed to improved adherence to the Code, the Committee has noted inconsistent quality of data, documentation and processes across the industry and we encourage subscribers to continue to review and enhance the robustness and effectiveness of their Code compliance frameworks. More detailed information on subscribers' Code compliance is available in our 2017-18 Annual Report .

Recognising the challenges involved in collection and analysis of a complex dataset, we took a pragmatic and collaborative approach with stakeholders in this first year. Where relevant in the Report, we note limitations in the data provided, together with explanations to assist interpretation in light of those limitations. Despite these limitations, we consider that the Report provides a valuable overview of industry compliance activity, and a reasonable baseline from which industry can progress.

We will continue to work closely with subscribers, with the collective goal of achieving a quality industry dataset that is complete, accurate and consistent. We intend to enhance and expand upon the findings and analysis in this year's Report in future years to further inform consumers and other stakeholders about the industry's ability to self-regulate, and look forward to readers' feedback to assist in this process.

We wish to thank subscribers for the commitment and effort they applied to the implementation of their data collection processes, and anticipate constructive discussions in readiness for next year. We would also like to acknowledge our Administrator team at AFCA for the substantial effort they have undertaken in successfully planning and implementing this new, industry-wide data collection process, and in the substantial data collation, review and analysis undertaken to help produce this inaugural Report.

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

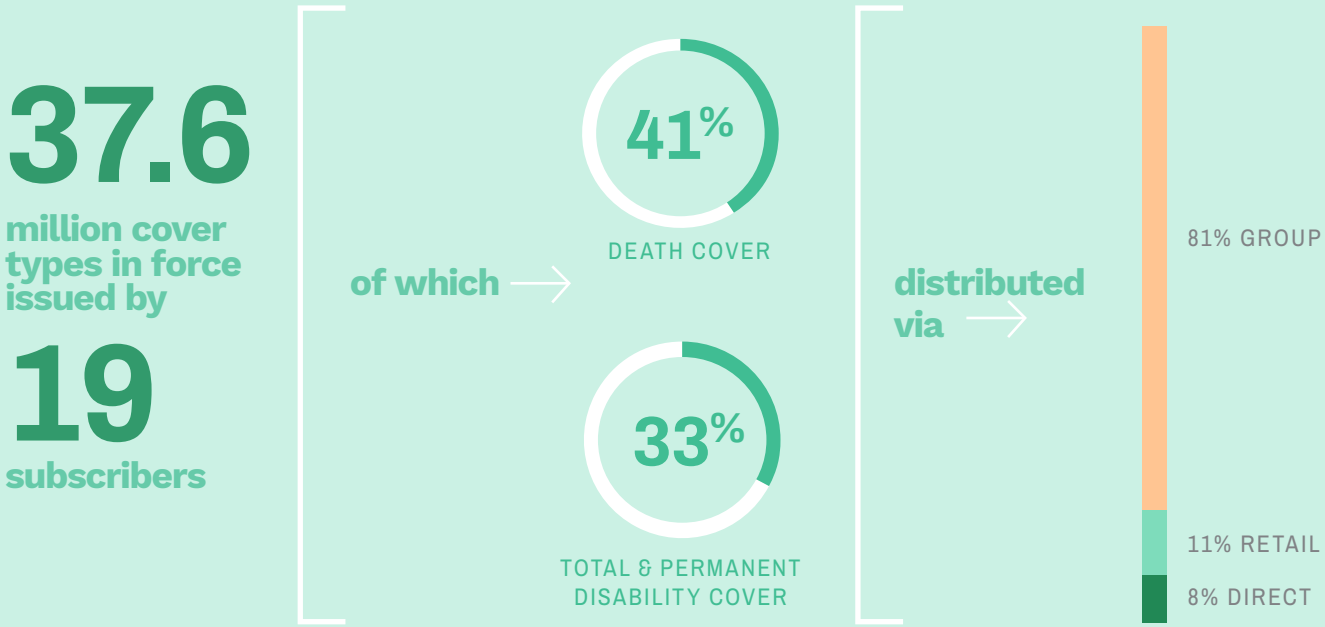
# Executive summary

## Life insurance business

At 30 June 2018, there were some 37.6 million cover types in force, with death (41%) and total and permanent disability (33%) cover predominating.

Subscribers issuing cover relied on three distribution channels – group, retail and direct – to distribute life insurance products. Although group distribution accounted for the largest proportion of cover types in force (81%), direct distribution was the channel used by the largest number of subscribers (84%).

Pleasingly, many subscribers were able to further differentiate between direct distribution carried out by the subscriber or its authorised representatives and direct distribution by third parties. This data revealed that at least 5% of cover types in force were distributed by third parties – whose activities are not currently covered by the Code. The next version of the Code is expected to go some way to addressing this gap, and the Committee urges subscribers to take accountability for the relevant conduct of third-party distributors.

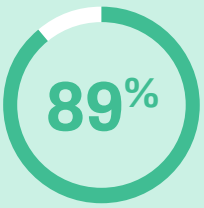


## Claims

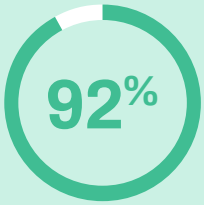
Reflecting their importance to consumers, claims standards are a key area of the Code. Subscribers assessed over 130,000 claims over the year. Income related insurance made up 37% of claims received, making it the largest contributor to total claims. Cover distributed by direct and retail channels contributed a disproportionately large share of claims.

The Code sets out timeframes within which subscribers must make a decision on claims, unless exceptional circumstances apply. Subscribers reported that most claims decisions are timely, with 89% of income related claims and 92% of non income related claims made within the required timeframes.

**131,271**
**claims assessed**




INCOME RELATED CLAIMS DECIDED WITHIN 2 MONTHS




NON INCOME RELATED CLAIMS DECIDED WITHIN 6 MONTHS

## Complaints

Subscribers reported just over 15,000 complaints from consumers this year. Most complaints were about issues related to the consumer's policy (48%) or a claim (20%). Cover distributed through direct and retail channels generated a disproportionately large share of complaints.

Under the current regulatory guidelines[1], life insurers are generally only required to record complaints that remain unresolved after five business days, and as a result, the data in this year's Report covers only those complaints. The Committee considers that good practice is for Code subscribers to monitor and record all complaints, including monitoring the complaints received by third-party distributors of their products. With the Australian Securities and Investments Commission (ASIC) signalling its intention to review internal complaints handling as part of its corporate plan,[2] the Committee hopes that for next year's Report, more subscribers will be recording and reporting on all the complaints they receive. This will enable a more detailed analysis of consumer concerns and complaint handling.

**15,106**
**complaints received**


ABOUT POLICY RELATED ISSUES


ABOUT CLAIM RELATED ISSUES

1 ASIC, *Regulatory Guide 165 – Licensing: Internal and external dispute resolution*, May 2018.
2 ASIC, *ASIC's Corporate Plan 2018–22: Focus 2018–19*, August 2018.

## Code compliance

Subscribers reported 164 breach events – events resulting in multiple breaches of a Code section – and nearly 8,000 isolated breaches, each affecting a single consumer.

In total, 1,766,803 consumers were actually or potentially impacted. Almost all (1,624,131 or 92%) of the consumers potentially impacted by breach events came from transition issues, where subscribers were not able to update legacy policies and IT systems to be fully Code compliant by the time they adopted the Code. Given that subscribers had nine months to transition to the Code, the number of events and consumers potentially impacted by transition-related breaches was disappointing. As the industry is now in the process of reviewing and revising the Code, it is critical that subscribers are aware of their obligations and fully prepared to comply when the new Code is introduced.

Breach events most commonly concerned policy changes and cancellation (37% of events), and system issues had the largest potential (66% of consumer impact). In contrast, isolated breaches mostly related to claims (60%) and were caused by people-related issues (99%), rather than systems-related issues.

While subscribers generally reported that they were satisfied with their Code risk and compliance frameworks, the Committee is not confident that all subscribers have robust frameworks in place. The quality of subscribers' processes appears to be inconsistent and in some instances, poor. As a result, the Committee believes that subscribers may not be accurately capturing all isolated breaches. There is room for improvement and the Committee has made several suggestions to improve the robustness of individual subscribers' compliance frameworks.

**164**

**breach events**

**7,926**

**isolated breaches**

**1,766,803**

**consumers potentially impacted**

## Looking ahead

As this is the Committee's first Annual Industry Data and Compliance Report, there are limitations to both the data and to the inferences that can be drawn. Nevertheless, the Committee was pleased to see a high level of buy-in from subscribers, who submitted their data and helped us to develop our approach to data collection in the Report's inaugural year. With continued engagement and feedback from subscribers and other stakeholders, the Committee plans to build on the benchmarks in this Report in future years.

# Introduction

**This Report presents an overview of the life insurance industry and its compliance with the Life Insurance Code of Practice (the Code) covering the period from 1 July 2017 to 30 June 2018 (the year). The Report is based on data provided to the Life Code Compliance Committee (the Committee) by Code subscribers. With this Report, the Committee aims to inform consumers, subscribers and other stakeholders about the industry's self-regulation in complying with the Code.**

## The Code

The Code is a relatively new code of practice for the life insurance industry, and was developed by the Financial Services Council (FSC). The Code commits subscribers to continuous improvement and a high standard of customer service.

The Code provides for an independent monitoring body, the Committee. By monitoring and enforcing adherence to the Code, the Committee supports the Code objectives of high customer service standards to increase trust and confidence in the life insurance industry. The Code Compliance Monitoring team (Code team) at the Australian Financial Complaints Authority (AFCA) acts as secretariat and administrator for the Committee.

## About this report

Under its Charter, the Committee is required, each year, to collect and report on aggregated life insurance industry data.[3] The Report is based on data sourced directly from 24 subscribers using a questionnaire that was developed after stakeholder consultation. It includes, for each distribution channel, the volumes and types of cover in force, the volume of claims received and finalised, and the number and nature of consumer complaints. This contextual information is complemented with data on subscribers' compliance with the Code, sourced either directly from subscribers or from the Committee's compliance monitoring work.

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

## INTERPRETING THE DATA

This was the first year of data collection, and the Code is still in the early stages of implementation. As such, there are limitations to the data, which readers should bear in mind when interpreting the findings in this Report.

- The quality of the data and reporting was not consistent across subscribers. We relied on subscribers to review the data they submitted to us to ensure its accuracy, and to let us know if there were any errors in previously submitted data. While we did not audit the data submitted by subscribers, some obvious errors in the data submitted were identified and, where practical, corrected by the Code team.
- While subscribers are capturing data on various matters, the ability to extract and report on this data – crucially, using shared definitions – is varied, with some subscribers finding it difficult or not yet possible.
- As this was the first year of both Code operation and data collection, trend analysis and year-to-year comparisons are not yet possible.

Readers should also be cautious about drawing comparisons to other published data. The Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority (APRA) have also collected life insurance claims data for publication in early 2019. This data is not directly comparable with the Committee's data, which has used specific parameters and definitions drawn from the Code, as detailed throughout the Report.

## IMPROVING FUTURE DATA COLLECTION, ANALYSIS AND REPORTING

Robust data collection and reporting is critical if consumers, regulators and government are to have confidence in the Code and its effectiveness as a self-regulatory tool. To improve data quality over time, the Committee will continue to refine its data collection approach and the instructions given to subscribers. The Committee encourages subscribers to work with the Code team to provide robust and accurate information that can better inform consumers and industry participants about the industry's ability to self-regulate.

The Committee will also develop and extend its analysis of the data collected. In particular, future reports will draw on multiple years' data to draw conclusions about trends and developments in the life insurance industry.

Finally, the Committee invites feedback from Report users about the types of data it has collected and reported and what information is most useful to stakeholders.

# Life insurance business

**The Code subscribers provided data on the cover in force and distribution channels used during the year.**

## Subscribers

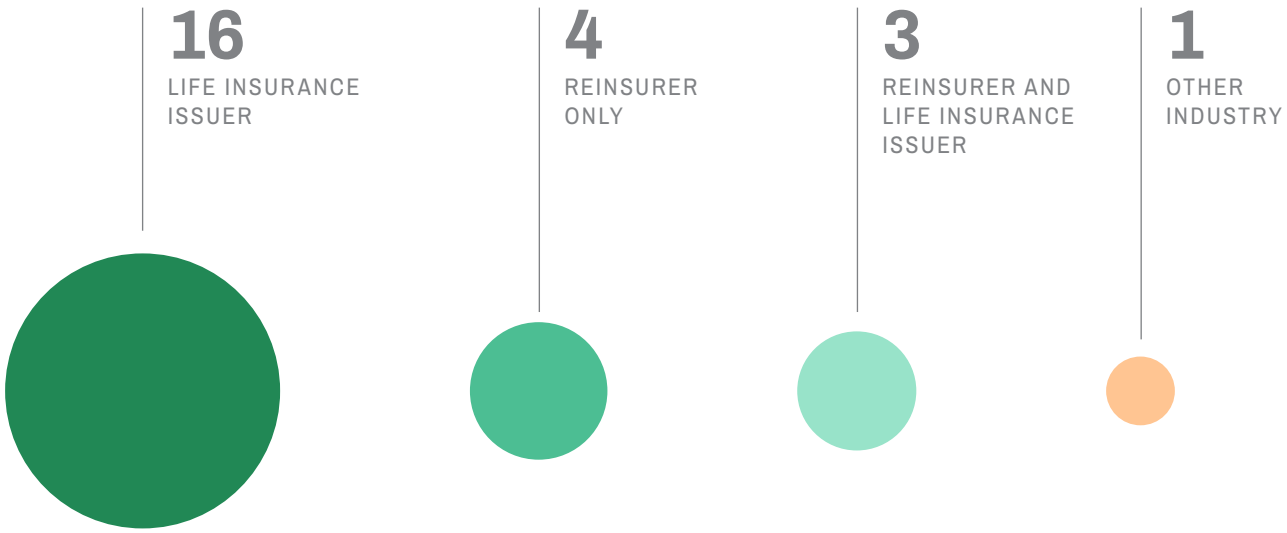
Over the year, the Code had 24 subscribers **(Figure 1)**. Most subscribers (23) are life insurance companies – that is, they issue life insurance cover to consumers through the distribution channels described later in this report. Of these subscribers, one is closed to new business and was exempted from providing numeric data; four are specialist reinsurers, meaning that they only insure the risk taken on by other life insurers and do not issue life insurance cover directly to consumers. Reinsurance business is outside the scope of the Code.

Finally, 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, 2017–18



## Benefit cover types

As of 30 June 2018, there were more than 37.6 million cover types in force, issued by 19 subscribers that issue life insurance. Death cover accounted for 41% of cover types in force, making it the dominant type of cover in force **(Figure 2)**. Death cover is often the base cover sold; other cover types are then added onto the policy.

Total and permanent disability (TPD) cover – which is often sold bundled with death cover – was the next largest cover type in force, making up 33% of all cover types in force. Many Australians have death and TPD cover through their superannuation fund, which is the reason for the high volume of death and TPD cover types in force.

COUNTING COVER TYPES IN FORCE

A cover type is an insurance benefit that falls under a life insurance policy. One policy may have more than one benefit (cover type in force). One consumer may have more than one policy or more than one cover type in force. The Committee collected data on the number of cover types in force in order to understand the type of life insurance cover that Australians have, and to compare this with other data. This approach was chosen as it can be applied consistently across all subscribers.

**There were**

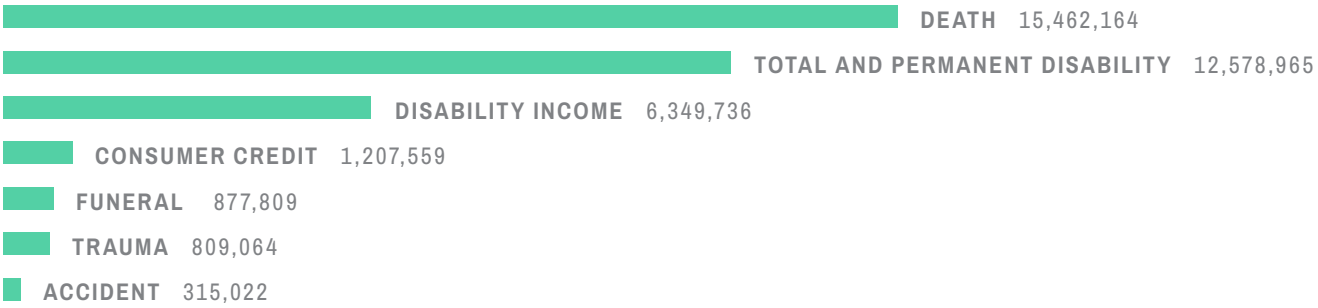
# 37,600,319

**cover types in force**

FIGURE 2.

**Death and TPD cover dominated**

Cover types in force, 30 June 2018



## Distribution

During the year, 18 subscribers issued new life insurance business. To do this, subscribers relied on three distribution channels: group, retail and direct (which includes direct distribution by the subscriber itself, its **authorised representatives**[4] and third parties.)

DEFINING DISTRIBUTION CHANNELS

**Group distribution** is the sale of group cover by a subscriber, made available to employees and/or members of superannuation funds or master trusts.

**Retail distribution** is the sale of individual cover by a subscriber through its own or other authorised representatives (financial advisers), alongside the provision of personal or general financial product advice. It includes individual insurance sold through a retail superannuation fund where each life insured is individually underwritten.

**Direct distribution**, as narrowly defined in the Code, is the sale of insurance directly by the subscriber or their authorised representatives, such as online or via a call centre. Cover sold directly is provided with only general advice or factual information, not personal advice.

Direct distribution can be further broken down into two distinct types: **direct (subscriber)** – where the cover is sold by the subscriber itself or an authorised representative – and **direct (third party)**, where the cover is sold for the subscriber by a third party – that is, a person or entity that is neither a subscriber nor the authorised representative of the subscriber.

Direct (third party) distribution is a major component of direct distribution, but is not covered by the Code.

**Figure 3** shows, for each subscriber, the distribution channels used and the proportion of that subscriber's business (measured by cover types in force) contributed by each channel. The direct (subscriber) distribution channel is the most commonly used by subscribers, with 16 subscribers reporting use of this approach. Most subscribers (13) also used direct (third party) distribution.

Much of the cover sold through direct (third party) distribution comprised white label products. White label products are issued by the insurer but rebranded and distributed by a third party.[5] At least 29 different white label products were sold by third-party distributors during the year. In addition, some subscribers distributed their own branded products via third parties.

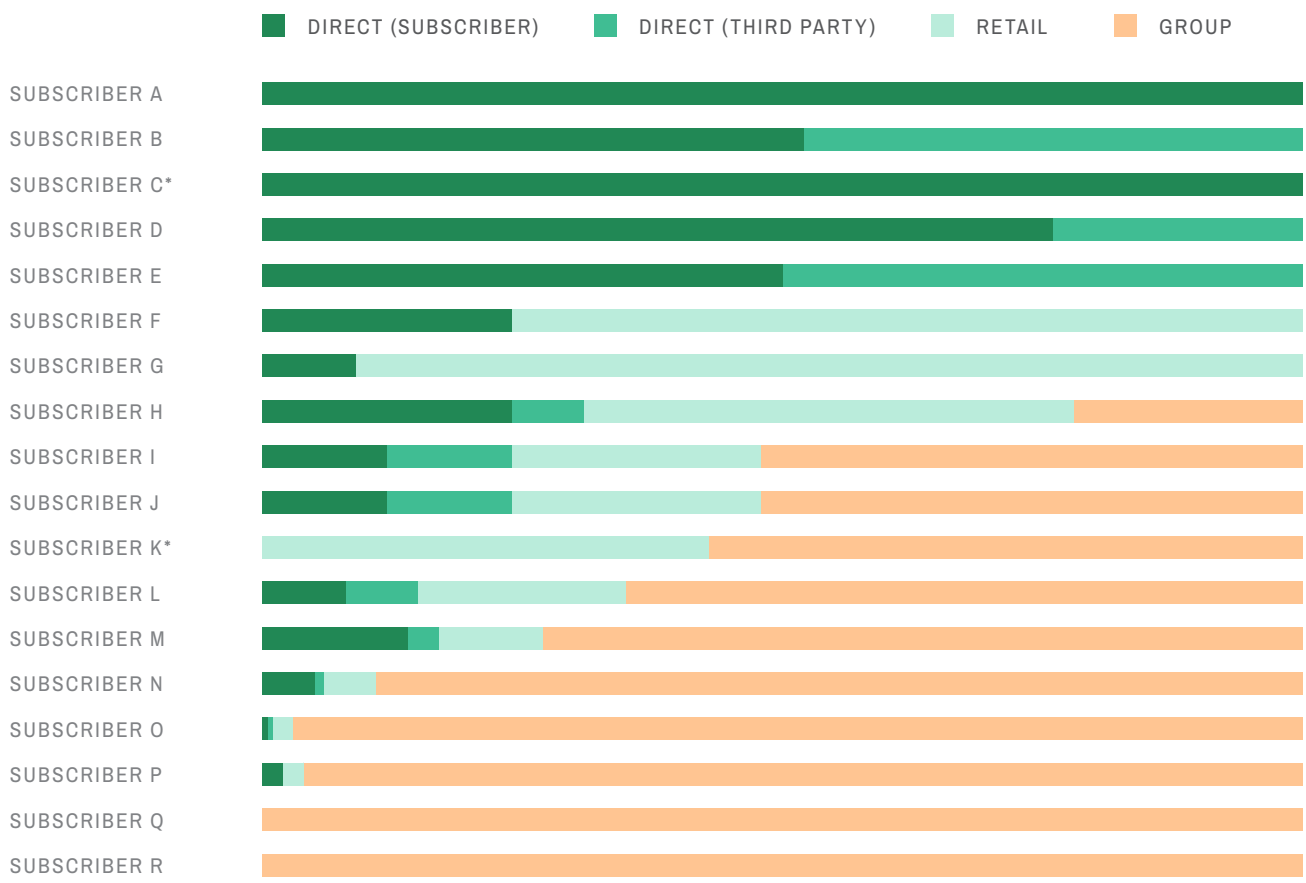
4 The Code defines an authorised representative as 'a person, company or other entity authorised by us to provide financial services on our behalf under our Australian Financial Services licence, in accordance with the Corporations Act 2001. It does not include a person, company or entity that is an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

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

FIGURE 3.

**More subscribers used direct distribution**

Subscribers' cover types in force by distribution channel, 30 June 2018




* Direct (third party) distribution accounted for 0.18% of cover types in force for Subscriber C and 0.01% of cover types in force for Subscriber K. Direct (subscriber) distribution also accounted for 0.01% of cover types in force for Subscriber K.

Although more subscribers use direct (subscriber) and direct (third party) channels than retail and group distribution channels, when assessed by cover types in force, most cover is distributed through the group channel **(Figure 4)**. Cover distributed via the group channel contributed 81% of cover types in force at the end of the year. Combined, direct (subscriber) and direct (third party) distribution contributed 8% of cover types in force.

FIGURE 4.

**Group distribution accounted for most cover**

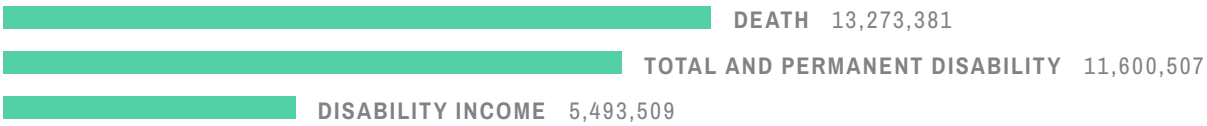
Percentage of cover in force by distribution channel, 30 June 2018

Different types of cover are associated with different distribution channels. In both the group and retail insurance channels, death cover, followed by TPD, accounted for the largest proportion of cover types in force. Combined, death and TPD cover made up 82% of cover types in force via the group distribution channel **(Figure 5)**, as well as 65% of cover types in force via retail distribution **(Figure 6)**.

FIGURE 5.

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

Cover types in force, group distribution, 30 June 2018*

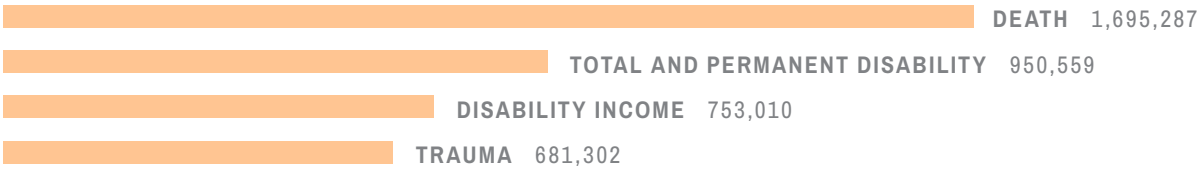



* In addition, there were 4,203 cover types in force with trauma insurance through the group channel (0.01% of cover types in force under the group channel).

FIGURE 6.

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

Cover types in force, retail distribution, 30 June 2018

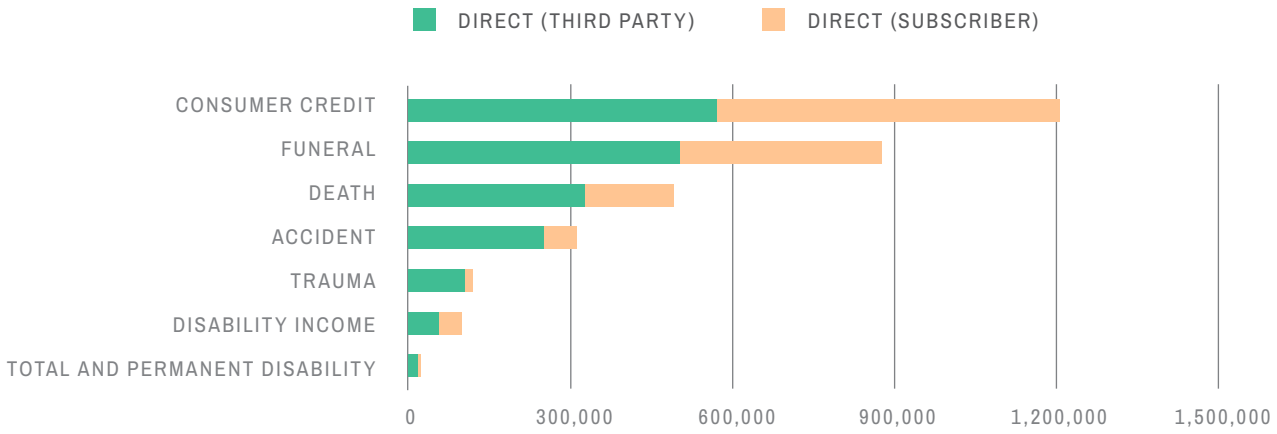



A more diverse range of cover types is distributed via the direct channel **(Figure 7)**. Consumer Credit Insurance (CCI) accounted for the largest proportion of cover types in force distributed directly, followed by funeral and death cover. These three types of policies have come under scrutiny by ASIC and the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, which have critically examined both the actual value of the policies for consumers and the ways in which they are sold. Both ASIC and the Royal Commission made reference to the Code and its effectiveness in regulating the industry.

FIGURE 7.

**Various cover types were distributed directly**

Cover types in force, direct distribution, 30 June 2018




Given the concerns raised about third-party distributors, it is noteworthy that the Code does not cover the conduct of third-party entities that sell insurance through the direct (third party) channel, which accounted for at least 58% of direct cover sold, and 5% of total cover types in force.[6] As a consequence, many consumers are not benefiting from the Code's protections, particularly regarding sales practices.

It is intended that the next version of the Code will create an obligation on subscribers to take reasonable steps to ensure they are satisfied that the distributor maintains processes and procedures that are consistent with good customer outcomes and obligations in the Code. The Committee considers this drafting does not go far enough and recommends further thought be given to how subscribers can ensure that distributors can, indirectly, be bound by the Code standards. In the interim, the Committee encourages subscribers to voluntarily ensure that all third-party entities with whom they enter into contracts are aware of the Code and develop processes in line with Code obligations.

6 Not all subscribers were able to provide data that differentiated between direct (subscriber) and direct (third party) distribution, therefore some subscribers reported all direct distribution as direct (subscriber). As a result, the amount of direct (third party) distribution is probably understated.

# Claims

**For consumers, it is crucial that life insurers process claims in a fair and timely way. Claims issues helped to drive the creation of the Code and put claims standards at its centre. Claims issues still figure prominently in Code breach reports and in complaints from consumers. ASIC and APRA also continue to monitor and report on industry claims handling.[7]**

**Subscribers provided data on the number and nature of claims received during the year, as well as the time taken to finalise them.**

## Claim numbers

Subscribers assessed 131,271 claims this year. Of these, most – 111,486 (85%) – were received during the year, while 19,785 were claims that were received during the previous year and remained open at the beginning of the year. Subscribers finalised 109,587 claims during the year, almost as many as were received. By the end of the year, subscribers were yet to finalise 20,014 claims.

COUNTING CLAIMS

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

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

## Claims by cover type

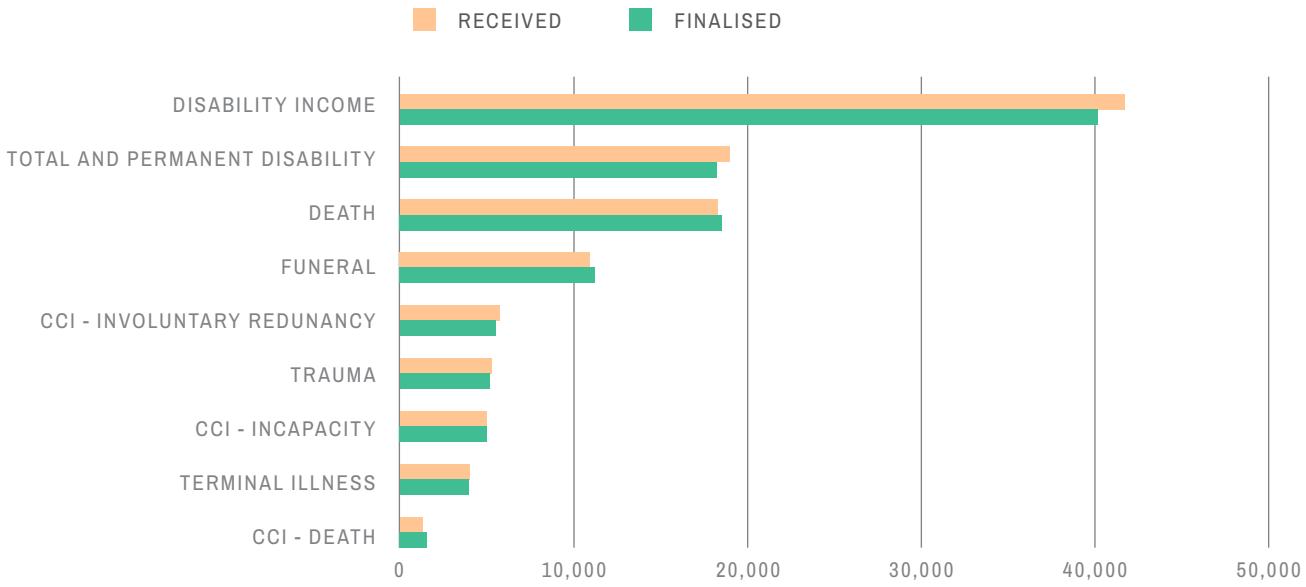
Reflecting 37% of claims received, Disability Income insurance was by far the largest contributor to total claims across all distribution channels **(Figure 8)**. Disability Income made up a much higher proportion of claims because multiple small claims arising from illness, injury and accident can be made on a Disability Income insurance policy, which is not the case for large non income related policies. TPD and death cover claims were the next most common, respectively making up 17% and 16% of total received claims. For each cover type, subscribers finalised a similar number of claims as were received, resulting in a stable number of claims in progress across all cover types.

7 18-150MR APRA and ASIC release new life-claims data - https://asic.gov.au/about-asic/news-centre/find-a-media-release/2018-releases/18-150mr-apra-and-asic-release-new-life-claims-data/

FIGURE 8.

**Claims finalised kept pace with claims received**

Number of claims received and finalised by cover type, 2017–18




## Claims by distribution channel

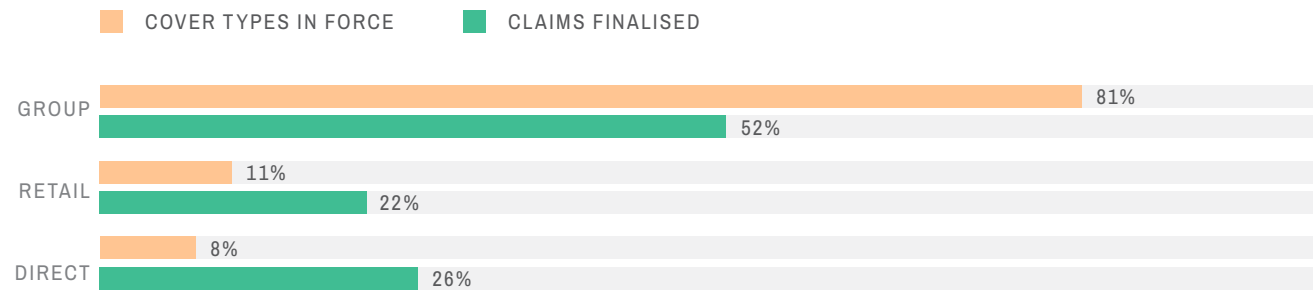
The group distribution channel accounted for a smaller share of claims than might be expected given its market share of cover types in force relative to retail and direct distribution channels. While group insurance made up 81% of the cover types in force in 2018, only 52% of claims finalised during the year were for group cover **(Figure 9)**.

In contrast, the direct distribution channel made up just 8% of cover in force, but accounted for 26% of finalised claims. Similarly, cover distributed via the retail channel comprised 22% of finalised claims, but just 11% of cover types in force.

FIGURE 9.

**Group accounted for fewer claims**

Percent of cover types in force and claims finalised by distribution channel, 2017–18



## 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.[8] 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.[9] For both types of claim, the timeframe can be extended up to 12 months if unexpected circumstances apply.

### MEASURING CLAIM ASSESSMENT DURATION

Sections 8.16 and 8.17 of the Code require subscribers to measure the time taken to assess a claim beginning from the date the subscriber is 'notified' of the claim. Complicating the matter, the term 'notified' is not defined in the Code. However, while consulting with subscribers about the data to be collected for this report, the Committee became aware that most subscribers measure claim assessment duration not from the date they are notified of a claim, but from the date they receive a claim form or claim documentation (labelled the 'claim received' date).

Aware that subscribers may not be able to provide claim assessment duration data from the claim notified date, this year, the Committee instead requested data on claim assessment duration measured from the claim received date. As a result, the claim assessment duration data in this year's report does not align with the requirement for Code compliance.

The Committee has determined that it will continue to use the 'claim received' date for the purposes of monitoring compliance with sections 8.3, 8.16 and 8.17 of the Code. In addition, as part of the Code review, the Committee has recommended that the relevant Code sections be revised and clarified.

Subscribers reported that 89% (43,656) of decisions for income related claims in the year were made within the required two months **(Figure 10)**. Some 11% of decisions (5,299) were not made within the required timeframe. Similarly, in 92% (53,953) of non income related claims, a decision was made within the required six months, while decisions on 8% (4,637) of claims took longer than 6 months **(Figure 11)**.

8 Life Insurance Code of Practice, section 8.16.

9 Life Insurance Code of Practice, section 8.17.

FIGURE 10.

**Most claim decisions were reported as timely**

Decision timeframe for finalised and undetermined income related claims, 2017–18

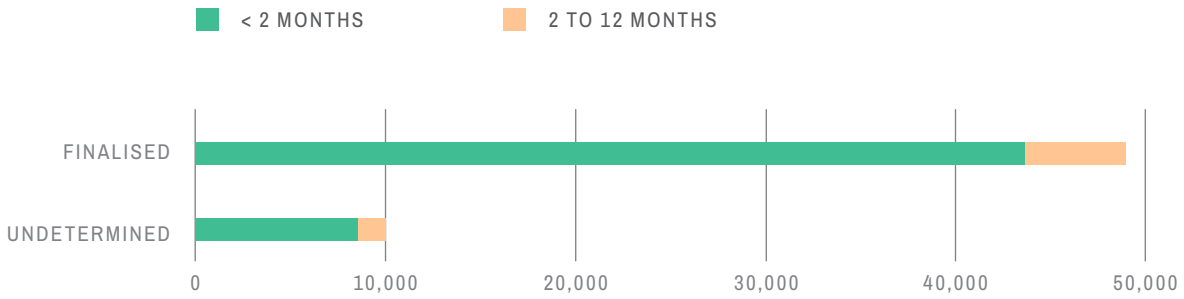
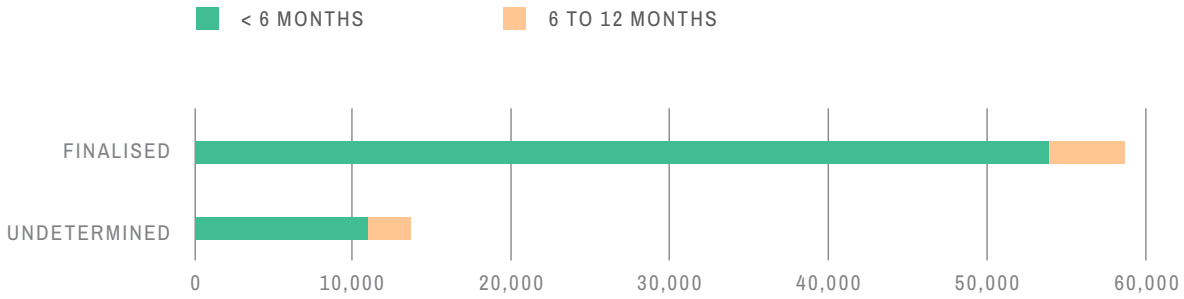



FIGURE 11.

**Most claim decisions were reported as timely**

Decision timeframe for finalised and undetermined non income related claims, 2017–18




The Code provides for a longer claim assessment duration of up to 12 months where **unexpected circumstances**[10] apply. The Code requires subscribers to tell the consumer why the delay has occurred and keep them informed about the progress of their claim.

For the year, subscribers reported a total of 14,036 finalised and undetermined claims that exceeded the standard timeframe; of these, unexpected circumstances reportedly applied to 70% (9,779 claims), leaving 4,257 claims which exceeded both standard and unexpected circumstances duration timeframes. If claim assessment duration exceeds the two- or six-month timeframe and unexpected circumstances do not apply, this constitutes a breach of the Code.

10 The Code defines 'unexpected circumstances' as 'a) your claim has been notified to us more than 12 months after the later of the date of disability or the end of your waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of your claim from the intervening period; b) for a claim for total and permanent disability, we cannot reasonably satisfy ourselves on the basis of the information provided in the six months after the end of your waiting period that your condition meets the requirements of your Life Insurance Policy; c) we have not received reports, records or information reasonably requested from an Independent Service Provider, your doctor, a government agency or other person or entity (including a Reinsurer); d) the Policy-owner or Group Policy-owner has disputed or taken a protracted period to consider our decision; e) you or your Representative have not responded to our reasonable enquiries or requests for documents or information concerning your claim; f) there are difficulties in communicating with you in relation to the claim due to circumstances beyond our control; g) there is a delay in the claims process that you have requested; or h) the claim is fraudulent or we reasonably suspect fraud or non-disclosure that requires further investigation.'

The Committee notes there is a substantial gap between the number of claims that are neither determined nor identified as unexpected circumstance and the number of reported breaches of sections 8.16 and 8.17, with the latter substantially lower. This suggests to the Committee a deficit in either breach reporting or, more likely, the ability to report on claims that were in the unexpected circumstances category. Both factors may have contributed.

Moreover, few subscribers are able to report on the reasons claims are flagged for unexpected circumstances. If the causes of the unexpected circumstances are not identifiable, the Committee questions how subscribers can identify and implement required changes to their processes to reduce the numbers of claims being determined outside the normal target timeframes. Criticism of claims handling timeframes was a significant impetus for the creation of the Code and the Committee expects subscribers to have systems in place to monitor and report on it. The Committee will examine these issues in greater depth in 2018–19.

# Complaints

**During the year, subscribers recorded a total of 15,106 complaints from consumers. Complaints are an important indicator of consumer dissatisfaction and a source of information for subscribers to facilitate system and process improvements. The Committee will monitor complaints to see trends over future years as an indicator of industry's progress in dealing with consumers. We are aware that some subscribers do not record complaints made to third party distributors. The Committee considers that subscribers should also monitor and record the complaints received by third party distributors of their products.**

**Subscribers reported**

**15,106**

**complaints**

## Complaint causes

The largest single cause of complaints related to the category of 'policies in force', which mostly comprises complaints about policy changes or cancellation. This category accounted for 4,187 complaints, or 28% of the total. With 3,051 complaints, or 20% of the total issues of policy design and disclosure were another major source of complaint. All subscribers reported complaints about a policy in force or policy design and disclosure.

COUNTING COMPLAINTS

A complaint is 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.[11] Under the current ASIC regulatory guide, life insurers are only required to record complaints that remain unresolved after five business days, (except for a complaint or dispute relating to hardship, a declined insurance claim, or the value of an insurance claim).[12] The figures in this report relate only to this subset of complaints as many or even most subscribers do not record complaints resolved within five business days. However, as subscribers have committed to the higher standard of recording of complaints imposed by the Code – and with ASIC planning to review dispute resolution standards, rules and data collection this year[13] – the Committee hopes to be able to report on all recorded complaints next year.

11 Life Insurance Code of Practice, section 15.

12 ASIC, *Regulatory Guide 165 – Licensing: Internal and external dispute resolution*, May 2018.

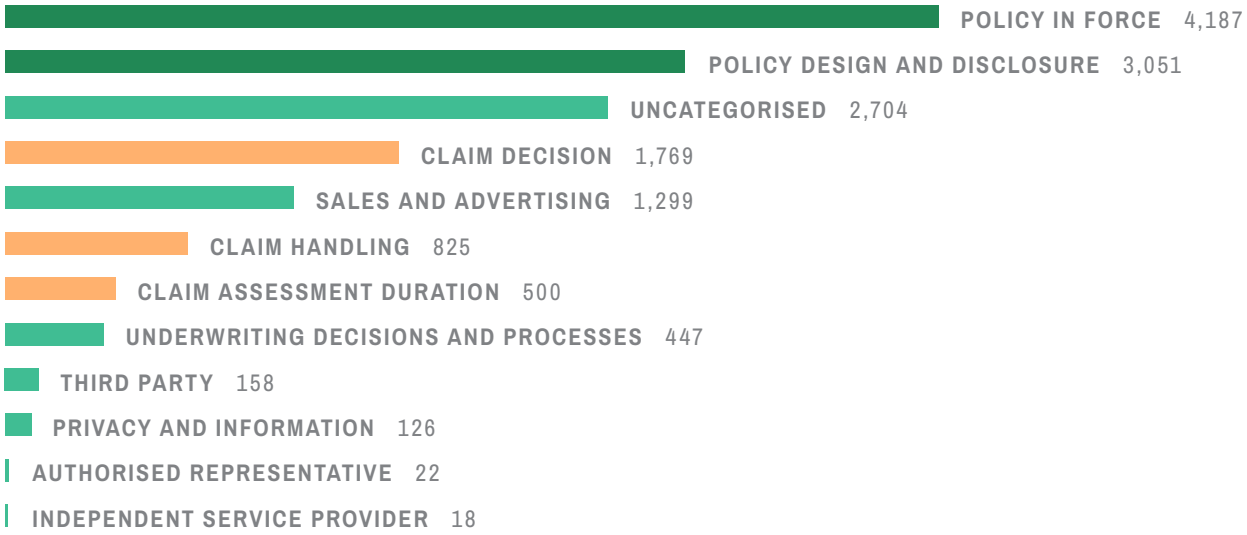
13 ASIC, *ASIC's Corporate Plan 2018–22: Focus 2018–19*, August 2018.

Combined, the three types of claims-related issues - claim decisions, claim handling and claim assessment duration - were the second largest source of complaints. In total, subscribers received 3,094 claims-related complaints (20% of the total). The claim decision was the most common issue in claims-related complaints **(Figure 12)**.

FIGURE 12.

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

Cause of complaints received, 2017-18




Disappointingly, subscribers were unable to categorise 2,704 (18%) complaints by cause, a significant number. This may reflect subscribers' data capture or system limitations or misalignment between subscribers' complaint categories and those used by the Committee to collect complaints data. Some subscribers noted that a number of their uncategorised complaints concerned poor-quality or delayed service not related to a claim. The Committee will work with subscribers to improve the granularity of complaints data provided in future.

## Complaints by distribution channel

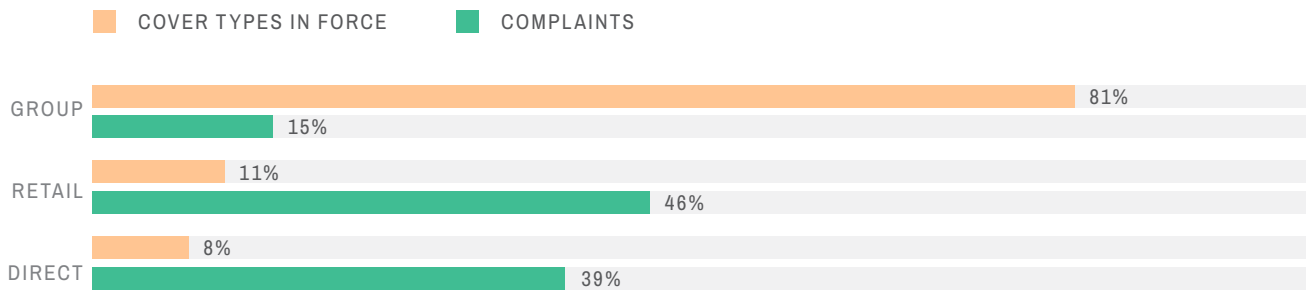
Retail distribution, although it made up only 11% of cover types in force, accounted for the largest proportion of complaints, with 6,871 complaints – 46% of the total **(Figure 13)**. Similarly, cover distributed directly generated a disproportionately large share of complaints, constituting just 8% of cover types in force but accounting for 39% of complaints (5,902). Consumers buying policies directly do not receive personal advice and may therefore have a poorer understanding of these products, which may contribute to consumer dissatisfaction and complaints.

Conversely, cover distributed by the group channel generated only 15% of complaints (2,333), despite accounting for 81% of the cover types in force. Subscribers that issue life cover to group policy owners may only record complaints which come to them directly, while group policy owners may receive additional complaints that are not recorded by the subscriber, meaning that this figure may not reflect the whole picture.

FIGURE 13.

**Direct and retail distribution accounted for disproportionate complaints**

Percent of cover types in force and complaints by distribution channel, 2017-18



# Code compliance

**During the year, subscribers reported 164 breach events and 7,926 isolated breaches of the Code. Almost all of the self-reported breaches occurred as part of a breach event, where a single cause led to multiple breaches of a Code section. Of the 1,766,803 consumers potentially impacted by breaches of the Code, most - 92% (1,624,131) - were from breach events that arose from subscribers' difficulty transitioning to be fully Code compliant. Breach events and isolated breaches tended to concern different Code sections and have different causes.**

**164**

**breach events**

**7,926**

**isolated breaches**

### Claims accounted for most breach event types

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

### Claims accounted for most isolated breach event types

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

**1,766,803**

**consumers potentially impacted**

## Breach events

Subscribers reported 164 breach events impacting or potentially impacting 1,758,877 consumers and covering 44 sections of the Code.

Breaches of chapter 6 of the Code, which sets out subscribers' obligations concerning policy changes and cancellation rights, accounted for almost all of the potential consumer impact (95%) of breach events **(Table 1)**. Two issues in particular contributed. Firstly, subscribers failed to provide consumers with annual notices containing certain information specified in section 6.3. Subscribers reported 47 breach events for subsections relating to communication during the term of the policy[14], impacting or potentially impacting some 1,160,789 consumers and thereby accounting for almost two-thirds (66%) of the potential consumer impact of breach events.

Secondly, a single event resulted in breaches of subsections[15] concerning the information subscribers must give to consumers who are struggling with premium payments or wish to change the terms of their life insurance policy. Each subsection breach potentially affected 137,800 consumers for a cumulative impact of 413,400.

COUNTING BREACHES

A breach is any instance of non-compliance with the Code. Breaches may be isolated or part of a breach event. A breach event is an event that results in multiple breaches of a Code section with the same cause from the same point in time. An isolated breach is a single breach resulting from a specific cause at a point in time and impacting one consumer.

For this report, the Committee did not collect data about significant breaches, as defined in the Code – see the Committee's 2017-18 Annual Report for information about significant breaches.[16]

TABLE 1.

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

Breach events and their potential consumer impact by Code chapter, 2017–18

| Code chapter | Events | | Consumer impact | |
|---|---|---|---|---|
| | No. | Percent | No. | Percent |
| Policy changes and cancellation rights | 60 | 37% | 1,672,509 | 95% |
| Sales practices and advertising | 15 | 9% | 70,686 | 4% |
| When you make a claim | 54 | 33% | 8,615 | <1% |
| Policy design and disclosure | 1 | <1% | 3,000 | <1% |
| When you buy insurance | 12 | 7% | 2,322 | <1% |
| Monitoring, enforcement and sanctions | 1 | <1% | 1,360 | <1% |
| Complaints and disputes | 3 | 2% | 296 | <1% |
| Code objectives | 1 | <1% | 75 | <1% |
| Consumers requiring additional support | 14 | 9% | 14 | <1% |
| Information and education | 3 | 2% | 0 | 0 |
| **Total** | **164** | **100%** | **1,758,877** | **100%** |

14 Life Insurance Code of Practice, section 6.3(a-e)

15 Life Insurance code of Practice, section 6.5 (a-c)

16 https://www.fos.org.au/custom/files/docs/life-ccc-20172018-annual-review.pdf

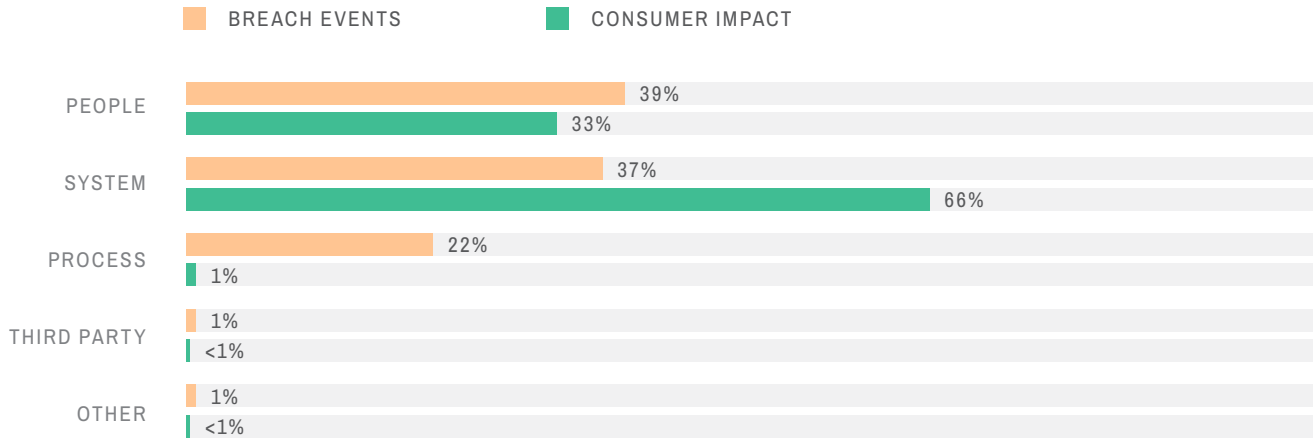
Breaches of the Code's sales and advertising standards, set out in chapter 4, accounted for 4% of the potential consumer impact of breach events. Most of these breaches related to the sale of consumer credit insurance, including information that must be disclosed to the consumer at purchase and in annual notices.

Although only 37% of breach events were caused by a system issue, these breaches tended to affect large numbers of consumers, accounting for two-thirds (66%) of the consumer impact of breach events (**Figure 14**). For example, in one case, a subscriber was unable to merge IT systems after an acquisition, which meant it could not generate compliant annual notices. Legacy policies on legacy IT systems were another cause. People-related causes – predominantly resourcing – caused 39% of breach events and accounted for 33% of the potential consumer impact.

FIGURE 14.

**Systems causes had the greatest consumer impact**

Percent of breach events and their potential consumer impact by cause, 2017–18




The vast majority of the potential consumer impact from breach events (92% or 1,624,131) resulted from difficulty in subscribers transitioning to the Code, rather than breach events that arose post-Code adoption. Among the transition-related breach events were failures to comply with the section 6.3 requirements concerning annual notices. The cause of these events were reported to the Committee as mostly due to legacy policies and legacy IT systems being unable to issue compliant annual notices in time for Code adoption. These breach events were self-reported to the Committee by subscribers when they transitioned to the Code. The Committee has been working with those subscribers and monitoring remedial action.

As the Committee has previously noted, while some transition issues were to be expected, subscribers' obligation to comply with the Code began at adoption. Subscribers must continually ensure that legacy products and IT systems are compliant and should proactively remediate any consumer detriment that occurs while they address non-compliance, rather than wait for the Committee to initiate such remediation.

## Isolated breaches

Subscribers reported 7,926 isolated breaches, impacting or potentially impacting the same number of consumers. Isolated breaches therefore accounted for less than half a percent of the total potential consumer impact of breaches.

As well as impacting only one consumer per breach, isolated breaches were of a different nature to breach events **(Table 2)**. The majority of isolated breaches (60%) concerned the Code's claims obligations, contained in chapter 8.

In particular, subscribers reported breaches of section

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

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

After claims-related breaches, those to do with buying insurance (chapter 5) were the next most common, making up around one-quarter (26%) of isolated breaches. Most of these breaches related to section 5.12, that subscribers inform consumers about whether cover will be provided within five business days of gathering the necessary information about the application.

TABLE 2.

**Claims accounted for most isolated breaches**

Isolated breaches by Code chapter, 2017–18

| Code chapter | Breaches and consumer impact | |
|---|---|---|
| | No. | Percent |
| When you make a claim | 4,749 | 60% |
| When you buy insurance | 2,063 | 26% |
| Sales practices and advertising | 537 | 7% |
| Complaints and disputes | 333 | 4% |
| Access to information | 77 | 1% |
| Policy design and disclosure | 75 | <1% |
| Policy changes and cancellation rights | 50 | <1% |
| Consumers requiring additional support | 38 | <1% |
| Code objectives | 4 | <1% |
| **Total** | **7,926** | **100%** |

Whereas breach events typically reflected systems issues, isolated breaches were reported as overwhelmingly caused by people (99%), rather than processes (1%) or systems (1%) **(Figure 15)**. Specifically, the biggest contributor, accounting for 4,202 isolated breaches (53%), was resourcing problems, where subscribers moved staff to meet resourcing needs in specific areas, but without these staff being fully trained. Together, staff failure to follow an established process and staff errors caused a further 3,540 isolated breaches (45%).

The Committee expects the number of isolated breaches to fall in future years as training improves and staff become more familiar with the Code and its claims requirements.

FIGURE 15.

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

Isolated breaches by cause, 2017–18


## Code risk and compliance frameworks

Subscribers reported that they were confident in their Code risk and compliance frameworks. Subscribers were also able to describe some of their systems, processes and procedures supporting Code compliance.

In response to the Committee's data questionnaire, almost all subscribers (22 of 24) stated that they were satisfied their organisation had processes and procedures in place to comply with the Code, including processes for training, compliance monitoring, breach rectification and continuous improvement. The two subscribers that answered in the negative qualified their answers by explaining that they had identified some aspects of the risk and compliance framework which may not be Code compliant, and noting that they were working through those issues. The Committee welcomes these subscribers' proactive, candid and thorough assessment of their compliance frameworks.

Despite other subscribers' positive self-assessment, the Committee is not confident in the robustness of all subscribers' compliance frameworks. The quality of the processes described and evidenced in supporting documents was variable for some subscribers, including some large organisations. Based on our observations throughout the review, it is also unclear, in many cases, whether formal processes and procedures are actually implemented and operating effectively in practice.

Indeed, in reviewing self-reported breaches and investigating alleged breaches, the Committee has previously found that not all subscribers have processes in place to enable full compliance and to detect, report on and remediate breaches. For example, some subscribers did not have a procedure and process document illustrating how they meet obligations for specified Code sections.

There is room for improvement in subscribers' compliance with the Code. In particular, subscribers need to develop and maintain robust compliance frameworks that should include periodic management compliance attestations and documented compliance processes mapped to all sections of the Code. These processes and procedures must be communicated to staff with a targeted training program that includes regular

refresher training, and incorporates the guidance issued from time to time by the Committee. The framework should provide for early risk detection to prevent breaches, while capturing in real time the Code breaches that do occur and reviewing and escalating these appropriately. There should be a clear and transparent escalation process to a Breach Review/Compliance Committee, plus Code compliance oversight by the Chief Executive Officer and Board, who drive a culture of Code compliance. Subscribers need the capacity to report on compliance with each Code section and crucially, they should act proactively to remediate breaches and prevent future breaches. Once in place, compliance frameworks should not be 'set and forget'. Instead, subscribers must regularly review and improve the effectiveness of these frameworks.

# Appendix 1
# List of Code subscribers at 30 June 2018

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

^ Claims Service Provider

# Life Insurance Code of Practice

## Annual Industry Data and Compliance Report 2017–18

**To make a Code breach referral email:**
info@codecompliance.org.au