Life Insurance Code of Practice

Annual Industry Data and Compliance Report 2021-22

March 2023

LIFE CODE COMPLIANCE COMMITTEE

Contents

Chair's message

As Chair of the Life Code Compliance Committee (the Life CCC), I am pleased to present our Annual Industry Data and Compliance Report for the period of 1 July 2021 to 30 June 2022.

The Report provides an overview of the life insurance industry and its compliance with the Life Insurance Code of Practice (the Code) during the reporting period.

It was pleasing to see some positive developments in 2021-22, particularly a reduction in the number of breach events and the number of customers impacted by those breach events as well as improvements in subscribers' remediation of breach events. Breach events are single events that result in multiple breaches of a Code section and impact multiple customers.

Subscribers reported fewer breach events in 2021-22 than in previous years. Subscribers attributed this reduction in the number of breach events to their implementation of improved processes and systems with guidance and support from the Life CCC.

Importantly, the number of customers affected by breach events decreased significantly in 2021-22. Subscribers reported an overall 50% reduction in the number of customers affected by breach events during the reporting period compared with the previous year.

Subscribers also made significant efforts to remediate breach events during the reporting period, and by the end of the period, almost all breaches had been addressed. Notably, many subscribers focused on process improvements and addressing staff practices as the most common remediation methods.

While mitigating breaches is important, remediation action once a breach has occurred is essential to achieving good customer outcomes. By taking the necessary time to address customers' issues, understand the root causes of Code breaches, and implement corrective measures, insurers can establish long-term practices that aim for better outcomes for customers.

> "
>
> ...the number of customers affected by breach events decreased significantly in 2021-22 with subscribers reporting an overall **50% reduction** in the number of customers affected by breach events...

“

We urge all subscribers to review the new Code carefully and verify that they have the appropriate processes, procedures and staff training in place to minimise breaches during the transition from the old to the new Code.

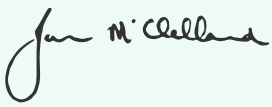
While we acknowledge and appreciate favourable progress by subscribers in meeting their obligations under the Code, the data collected during 2021-22 highlights certain areas that demand the attention of subscribers. These include:

- mitigating complaints by reviewing and enhancing products and services to ensure they meet customer needs as well as collecting, monitoring and analysing complaints data to identify root causes of breaches and opportunities for improvement
- reviewing and confirming the adequacy, reliability and effectiveness of monitoring systems and processes as well as staff supervision and training to ensure compliance with all Code obligations
- ensuring annual policy renewal notices meet the time and information requirements of the Code
- establishing and maintaining systems, processes and practices for accurate and reliable record keeping, particularly in relation to withdrawn claims.

We expect a significant improvement in these areas in the next report.

We eagerly anticipate the commencement of the new Code of Practice (Code 2.0) in July 2023. We urge all subscribers to review the new Code carefully and verify that they have the appropriate processes, procedures and staff training in place to minimise breaches during the transition from the old to the new Code. We encourage subscribers to contact us if they encounter any issues or require clarification on any matter.

I extend my gratitude to subscribers for their proactive engagement throughout the year. The industry has witnessed positive progress in 2021-22, with significant developments and improvements. These advancements would not have been possible without the engagement of subscribers, their eagerness to improve, and their willingness to accept advice and guidance. As we proceed through the 2022-23 reporting period, I encourage all subscribers to continue striving for better outcomes.



Jan McClelland AM
Independent Chair
Life Code Compliance Committee

Overview

About the Life CCC

The Life Insurance Code of Practice (the Code) is the life insurance industry's commitment to mandatory customer service standards. The Code is designed to protect customers by:

- promoting high standards of service
- providing a benchmark of consistency within the industry
- establishing a framework for professional behaviour and responsibilities.

All life insurers that are members of the Financial Services Council (FSC) are required to adopt the Code. Compliance with the Code is monitored by the Life CCC. As the Life CCC, we are independent and play a critical role in supporting the objectives of the Code and protecting the interests of customers. We do this by:

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

Each year we collect and report on aggregated industry data and provide a consolidated analysis of compliance with the Code.

About this report

This report presents an overview of compliance with the Code based mainly on the data submitted by all 23 subscribers for the 2021-22 reporting period.

Each subscriber submitted detailed data workbooks for the 2021-22 reporting period which, for each distribution channel, included:

- the volumes and types of benefits and business issued
- the number of claims received, determined, withdrawn and re-opened
- the number of claims assessed and the durations of determined and undetermined claims
- the number, nature, and outcome of customer complaints
- the number and types of breaches and the number of customers they affected
- the number of claims to which Unexpected Circumstances applied and the reasons they were determined or undetermined.

The data submitted by subscribers is complemented with additional data on compliance with the Code, sourced either directly from subscribers or from our monitoring work.

Snapshot of 2021-22

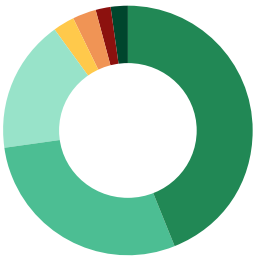
Life insurance business

23
Code subscribers[1] as of 30 June 2022

31.2 million
covers in force

issued by **17** subscribers[2]

Distribution of covers



44% Death insurance
29% Total and permanent disability insurance
17% Disability income insurance
3% Consumer credit insurance
3% Trauma insurance
2% Accident insurance
2% Funeral insurance

Type of distribution

77% group
12% retail
11% direct

106,025 claims assessed
down ↓ 4% on the previous year

90,395 claims determined
down ↓ 4.5% on the previous year
94% accepted and 6% declined

Code compliance

199,720 total customers affected by breaches
11,219 of these customers were affected by isolated breaches

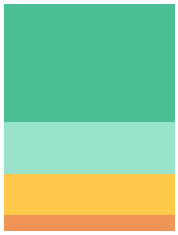
Code breaches	Customers impacted
Policy changes and cancellation rights (Chapter 6)	50.6% of impacted customers
Buying Insurance (Chapter 5)	41.0% of impacted customers
When you make a claim (Chapter 8)	7.5% of impacted customers
Other chapters	0.9% of impacted customers

Cause of breaches	Customers impacted
People	49.9% of impacted customers
Process	47.5% of impacted customers
Systems	2.4% of impacted customers
Other	0.2% of impacted customers

1 Asteron Life & Superannuation Limited (ALSL) was a subscriber until 30 September 2021 when it was fully acquired by TAL Life Limited (TAL) from 1 October 2021. This resulted in a decrease from 24 to 23 in 2021-22.

2 The remaining six subscribers who do not issue life insurance policies consist of five specialist reinsurers and one service provider.

188,501
customers affected by **59** breach events[3]



48% People
49% Process
2.5% Systems
0.5% Other

Increase in number of customers affected by people-related breaches

19% of customers affected by people-related breaches in **2020–21** vs **50%** of customers affected by people-related breaches in **2021–22**

Remediation

The 59 breach events were addressed by:

24 improving processes
21 remediating staff practices
11 enhancing systems
3 other means

11,219
customers affected by isolated breaches

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

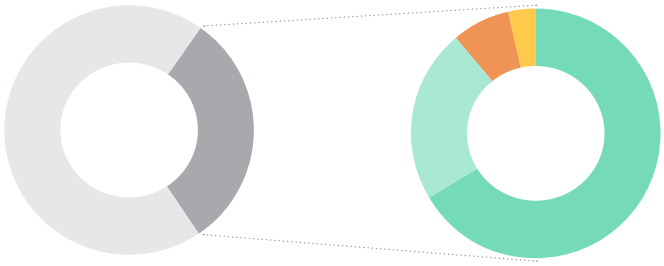
Complaints

49,310 complaints reported by subscribers
↑ up from 20,857 – 136% increase

Top 3 customer complaints:

1. **Policies**
   30%
   (Policy changes and cancellations, Policy design and disclosure, Policy terms and conditions)
2. **Service**
   22%
3. **Claims**
   15%

7,121 claims-related complaints resolved:



69% not related to decisions[4]
31% related to decisions

Resolved through Internal Dispute Resolution (IDR) process (89%):
- 1,469 had the original decision maintained (75%)
- 500 had the original decision reversed (25%)

Resolved through External Dispute Resolution (EDR) process (11%)
- 166 maintained the original decision (68%)
- 77 reversed the original decision (32%)

3 A **breach event** is a single event that results in multiple breaches of a Code section (for example, a system coding error that affects a template letter sent to multiple customers).

4 Examples of claim-related complaints that do not relate to decisions include complaints about the claims process or handling, the assessment duration and the benefit amounts.

Key Observations

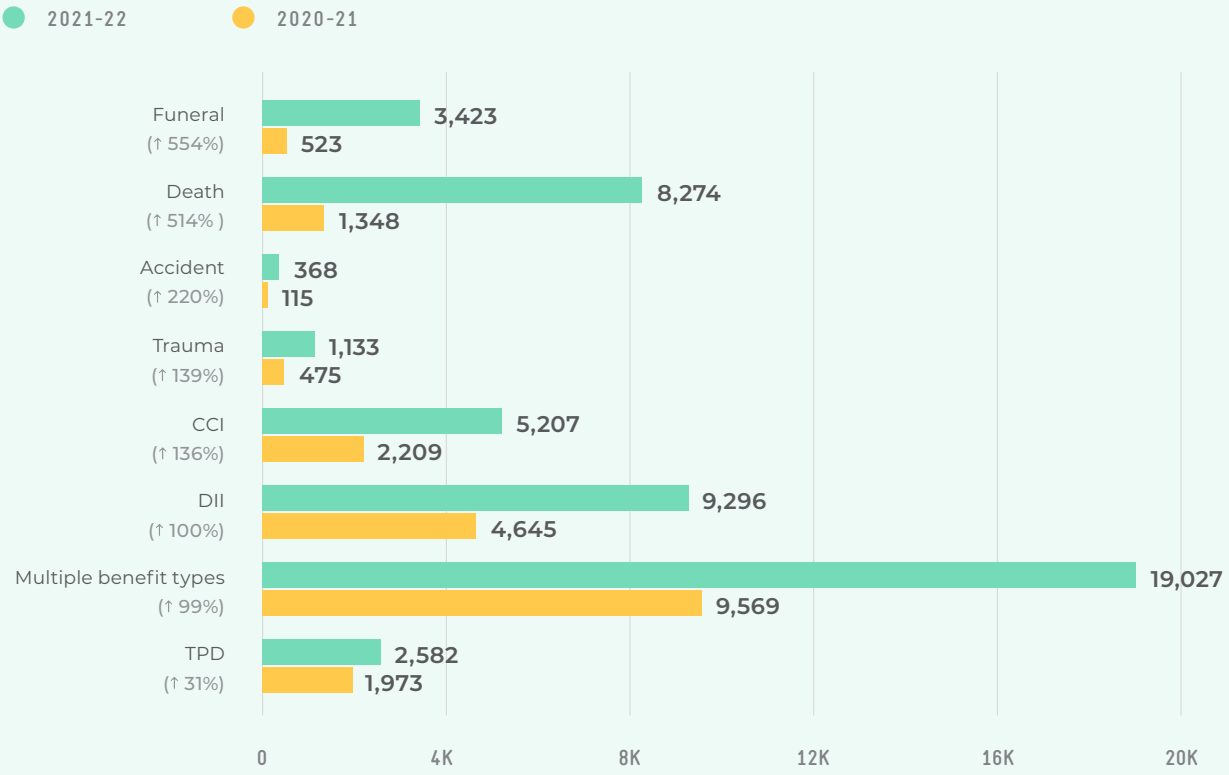
Significant increase in complaints

This reporting period saw a significant increase in complaints across all benefit types. This large increase in complaints is concerning and subscribers should continue to use this data to identify opportunities to improve their products and services.

> … subscribers should continue to use this data to identify opportunities to improve their products and services.

FIGURE 1.

Two-year comparison of complaints numbers



Subscribers reported a combination of factors they believe have resulted in the increase in complaints. These include:

- Changes to the definition of a "complaint" under the Australian Securities and Investments Commission (ASIC) Regulatory Guide 271 (RG271) which requires reporting of all complaints resolved within five business days (in effect from 5 October 2021).
- New requirements for Product Design and Distribution Obligations (DDO) under ASIC's Regulatory Guide 274 (RG274) which requires third-party distributors to report complaint-related information to life insurers (in effect from 5 October 2021).
- Media attention on funeral claims following the collapse of Youpla Group, formerly known as the Aboriginal Community Benefit Fund (ACBF).
- Class action lawsuits and websites such as Demand My Refund contributed to an increase in complaints related to consumer credit insurance products.

> … diagnostic capabilities as well as cultivating a culture that values complaints, will produce beneficial outcomes for both customers and life insurers.

The numbers of complaints reported in 2021-22 indicate that subscribers have much work to do to improve.

We expect to see subscribers thoroughly examine the nature and root causes of the complaints they report to identify ways they can rectify issues and prevent their reoccurrence.

Subscribers should continue to invest in technology and reporting capabilities to analyse complaints data. This will assist in identifying improvements to both the complaints process and the products and services offered. These diagnostic capabilities as well as cultivating a culture that values complaints, will produce beneficial outcomes for both customers and life insurers.

Improved processes and procedures

Subscribers reported fewer breach events – 59, down from 93 in the previous year – and a substantial drop in the number of customers affected by breaches –from nearly 430,000 in 2020-21 to fewer than 200,000. Subscribers attributed the reduction in breaches to their efforts to improve processes and procedures.

Subscribers cited remediation work, including addressing resourcing issues as an important factor. Also, efforts to improve staff capabilities through training and increased awareness of Code obligations contributed to the positive result.

Improvements to processes were also reported as important. This included effective use of automation to streamline processes and procedures that underpin the work of staff. Enhanced quality assurance checks to ensure compliance with the Code also saw better results.

We welcome this commitment to continual improvement and encourage subscribers to learn from our guidance and benchmark reporting.

↓53.5%

decrease in the number of customers affected by breaches – from nearly 430,000 in 2020-21 to fewer than 200,000

> Enhanced quality assurance checks to ensure compliance with the Code also saw better results.

> … we undertook an Own Motion Inquiry (OMI) into section 6.3 of the Code which found 76 breaches (including 29 significant breaches) affecting 198,000 customers.

Notices still an issue – templates must be compliant

The obligation to provide customers with a compliant annual notice, outlined in section 6.3 of the Code, remains an issue for some subscribers.

The annual notice provides information for customers about their life insurance policies, including the specifics and costs of their cover. By failing to issue an annual notice on time or failing to include all relevant information in an annual notice, subscribers can adversely affect customers.

Having seen this emerge as an area of concern, we undertook an Own Motion Inquiry (OMI) into section 6.3 of the Code which found 76 breaches (including 29 significant breaches) affecting 198,000 customers.

In 2021-22, non-compliance with section 6.3 of the Code comprised of 16 breach events and 1,467 isolated breaches.

While these breaches affected far fewer customers than in the previous year – from 373,343 in 2020-21 to 99,203 in 2021-22 – they still accounted for half of customers affected by all Code breaches across the year. Since the publication of the OMI report in February 2022, we have received 10 additional significant breaches of section 6.3.

Reducing breaches of this section of the Code is essential to delivering good outcomes for customers. To improve, subscribers should conduct regular reviews to identify and remediate breaches as early as possible. An important part of this is implementing the recommendations set out in the OMI report.

The need for compliant templates extends beyond the annual notice and it is crucial that all templates meet requirements.

In one instance, a subscriber recorded a breach that affected more than 70,000 customers when it discovered that it had been using a non-compliant letter about buying insurance. The letter failed to include necessary information and the subscriber had been using it since the inception of the Code in 2017.

Breaches of this kind, and the associated ramifications for customers, are avoidable and subscribers should review their template letters and notices to make sure that they comply with requirements across all sections of the Code.

1,467

isolated breaches as a result of non-compliance with section 6.3 of the Code in 2021–22

Breaches caused by people affected the most customers

Subscribers can do more with their staff to minimise breaches of the Code.

The breaches that were caused by people affected more customers than breaches caused by systems or process failures in 2021-22. Indeed, they accounted for half of all breaches affecting customers – a significant increase on the 19.5% of 2020-21.

Targeted training, guidance materials and more robust quality assurance procedures can help build the capability of staff, offer exceptional customer service, and improve Code compliance.

Subscribers appear to have improved processes and systems over the past year, evident in the fewer customers affected by breaches caused by these failures. The number of customers affected by breaches caused by process failures dropped significantly, from 221,194 in 2020-21 to 94,982 in 2021-22. The number of customers affected by breaches caused by system errors decreased from 96,090 in 2020-21 to 4,773 in 2021-22.

4,773

customers affected by breaches caused by system errors
down ↓ from 96,090 in 2020-21

More than half of withdrawn claims were uncategorised

Subscribers were unable to categorise 55% (2,776 out of 5,090) of withdrawn claims in 2021-22.

This comprised a mix of subscribers who:

- did not record the information
- could not do so due to system limitations
- classified the reasons differently under the subscriber or customer categories
- recorded some reasons but not others.

Subscribers requested that the Life CCC align its claim withdrawn reasons with the FSC approved reasons during the 2021-22 data collection industry consultation.

The FSC approved the claim withdrawn reasons in conjunction with subscribers as a result of ASIC's feedback following its findings in the 2019 Total and Permanent Disability(TPD) Report.

The Life CCC expects subscribers to take this result seriously and work towards improvements in the coming year.

Having the information recorded properly is fundamentally a matter of good record-keeping that should be part of standard processes for all subscribers. It also allows a subscriber to understand the reasons why a claim is withdrawn. This helps to improve products and services, which delivers better outcomes for life insurers and customers.

Code compliance

In 2021-22, the industry experienced a decrease of over 50% in the number of customers impacted by breach events.

Data overview 2021-22

2,613,988

customers affected by 767 breach events and 45,323 isolated breaches in last five years

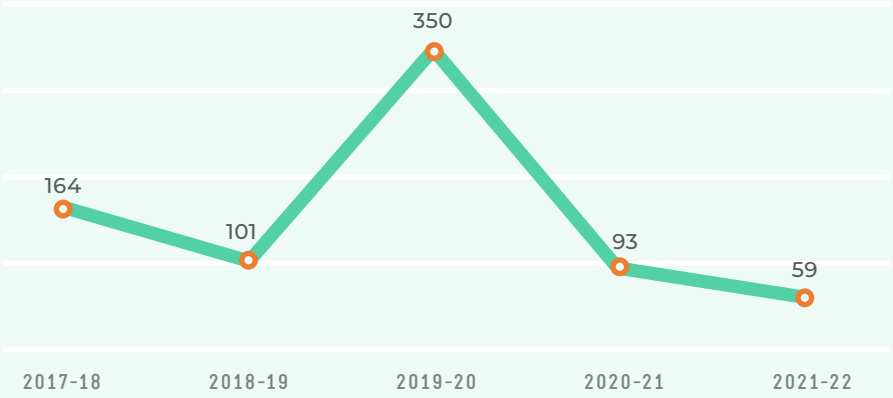
59

breach events of the Code in 2021-22
↓ 37% from 93 in 2020–21

11,219

isolated breaches of the Code in 2021-22
↑ 15% from 2020–21

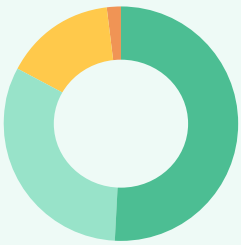
Breach events reported by subscribers 5-year history



2021-22

had lowest number of breach events **(59)** since the formal operation of the Code.

Breach event causes:



- People 30
- System 9
- Process 19
- Other 1

Top 5 isolated breach types:

1. When you make a claim
2. Policy changes and cancellations rights
3. When you buy insurance
4. Access to information
5. Complaints and disputes

↑480%

increase in the number of isolated breaches caused by inadequate process and procedures in 2021-22

“

With increased turnover of staff, subscribers face gaps in knowledge …

Fewer customers affected by breach events

The industry saw a reduction by more than half in the number of customers affected by breach events in 2021-22.

The reduction was primarily due to a drop in the number of customers affected by breaches of section 6.3 of the Code. The 55% overall decrease is a positive result that reflects improvements in subscribers' systems and processes, as well as increased awareness of their Code obligations.

Breach events affected 188,501 customers this year, down from the 419,627 in 2020–21.

Claims obligations and Policy changes and cancellation rights

Most breach events related to two chapters of the Code: obligations when customers make a claim (chapter 8) and policy changes and cancellation rights (chapter 6).

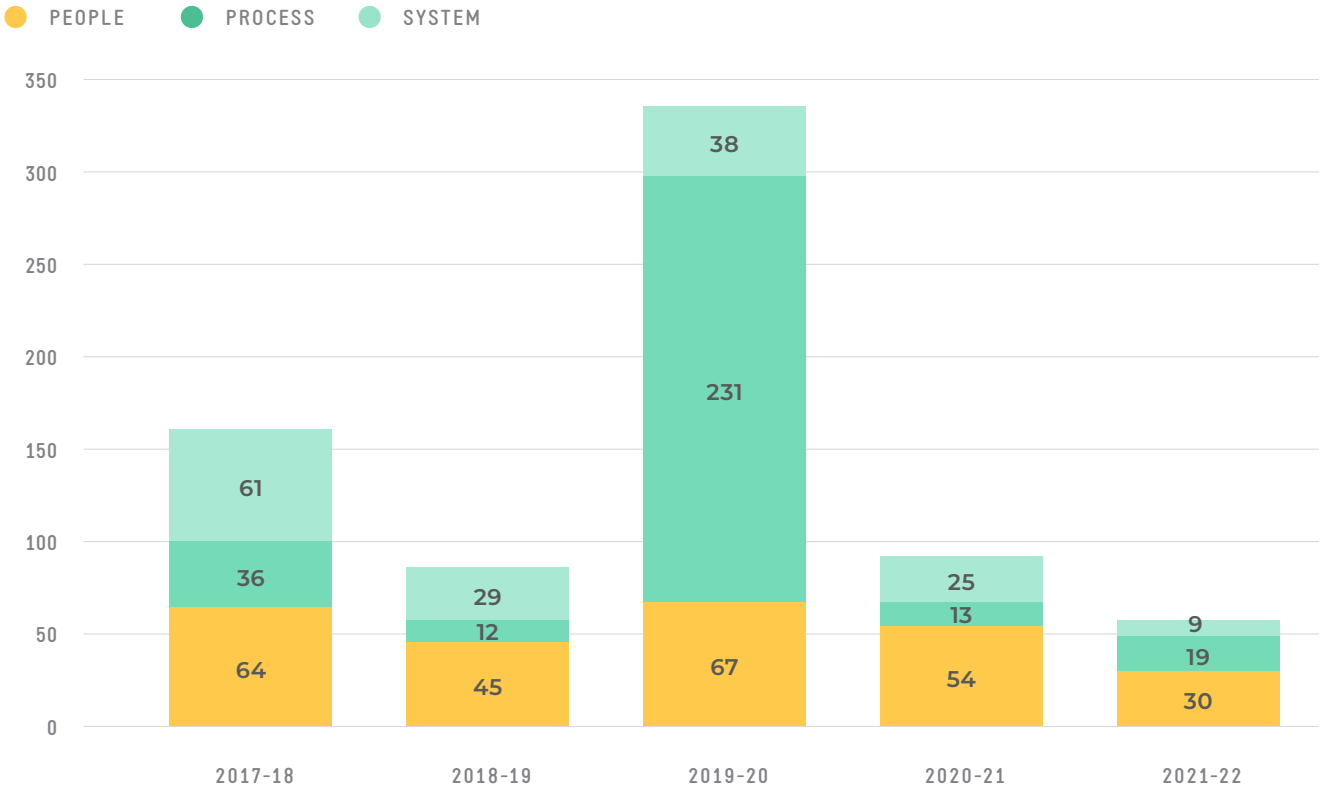
These chapters accounted for 39 of the 59 breach events.

Subscribers reported staff turnover and the associated challenges to business continuity as a major contributing factor to the breaches of chapter 8. With increased turnover of staff, subscribers face gaps in knowledge and need to devote time and resources to training new staff to a level of full competency.

Despite improvements over 2021-22, systems and processes continue to be a root cause of breaches of chapter 6. Subscribers should make the effort to review the systems they have for notifying of policy changes and cancellation rights to ensure they effectively and reliably support ongoing implementation of Code obligations.

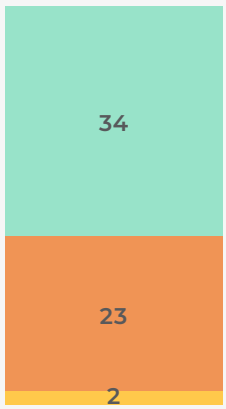
FIGURE 2.

Top 3 breach event causes, 2017–18 to 2021–22



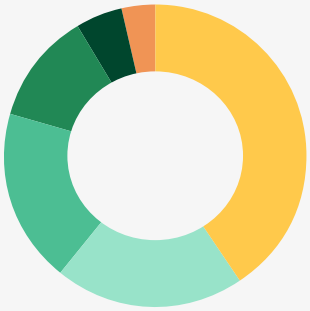
Remediation of breach events

All 59 breach events required some form of remediation by the subscriber. At the time of collating the data, subscribers reported that:



- remediation was **completed** for 34 of the breach events
- remediation was **ongoing** for 23 of the breach events
- remediation had **not commenced** for 2 of the breach events

Remediation varied across the breach events. Subscribers reported undertaking:



- **41%** process improvements for **24** breach events
- **20%** additional resourcing for **12** breach events
- **19%** system enhancements for **11** breach events
- **12%** training specifically on Code compliance process and procedures for **7** breach events
- **5%** other types of remediation for **3** breach events
- **3%** staff training for **2** breach events

Isolated breaches

An **isolated breach** affects a single customer.

In the five years of the Code, subscribers have reported a total of 45,323 isolated breaches.

An isolated breach affects a single customer. Subscribers reported a total of 11,219 isolated breaches in 2021-22 – 15% more than the previous year.

Although there was an increase in the past year, the majority of the reported isolated breaches was from one subscriber. This subscriber accounted for 68% (7,576) of all isolated breaches in 2021-22. The subscriber cited staff turn-over and issues with staff retention as major contributing factors to the increase.

> Although there was an increase in the past year, the majority of the reported isolated breaches was from one subscriber.

45,323

isolated breaches reported by subscribers in the five years of the Code

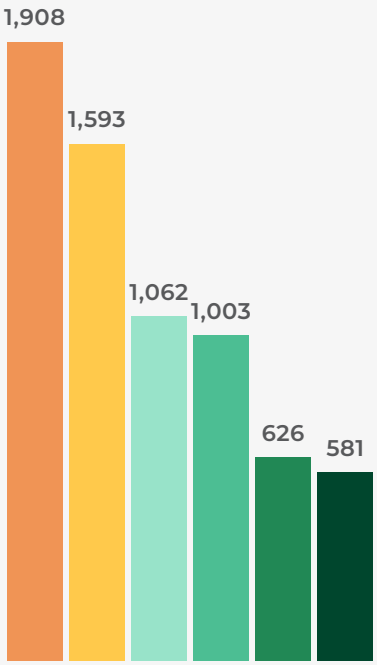
TABLE 1a.

Number of isolated breaches

Subscriber	2017-18	2018-19	2019-20	2020-21	2021-22
A	200	40	29	9	9
B	2,484	1,037	536	125	-
C		1	-	10	6
D	236	-	1	112	181
E		3	-	4	14
F	126	436	70	808	263
G	38	18	15	-	24
H	2	-	-	-	-
I	1,982	675	632	4,563	7,576
J	43	245	253	556	688
K	811	-	-	-	-
L	-	18	-	-	-
M	16	6	9	83	244
N	847	7,158	1,400	1,488	666
O	-	856	922	913	-
P	663	937	941	795	873
Q		10	12	188	172
R	30	12	15	15	7
S	-	-	5	-	-
T	437	24	71	33	40
U	11	1	53	7	33
V	-	6	11	11	423
Total	**7,926**	**11,483**	**4,975**	**9,720**	**11,219**

The majority of isolated breaches in 2021-22 related to the claims obligations set out in chapter 8 of the Code.

Of the isolated breaches of chapter 8:



- **1,908** related to the obligation to inform customers of a claim decision within 10 business days of gathering all the required information (section 8.15)
- **1,593** related to the obligation to inform customers if their upcoming claim payment is going to be delayed and the reason (section 8.9(f))
- **1,062** related to the obligation to keep customers informed of the progress of a claim every 20 business days (section 8.4)
- **1,003** related to the obligation to explain the cover and claim process within 10 business days of being notified of a claim (section 8.3)
- **626** related to the obligations to customers when assessing non-income-related claims (section 8.17)
- **581** related to the obligations to customers when assessing income-related claims (section 8.16)

TABLE 1b.

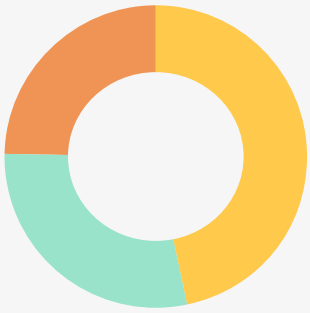
Isolated breaches by Code chapter, 2021–22

Code chapter name	Code chapter number	Isolated breaches 2021-2022	% of total	Ranking by year				
				17-18	18-19	19-20	20-21	21-22
When you make a claim	8	7,721	69%	1	1	1	1	1
Policy changes and cancellations rights	6	1,699	15%	7	5	5	3	2
When you buy insurance	5	1,328	12%	2	2	2	4	3
Access to information	14	272	2%	5	3	4	2	4
Complaints and disputes	9	136	1%	4	6	6	6	5
Policy design and disclosure	3	36	<1%	6	8	9	5	6
Customers requiring additional support	7	15	<1%	8	7	8	7	7
Sales practices and advertising	4	11	<1%	3	4	3	8	8
Code objectives	1	1	<1%	-	-	-	9	9
Information and Education	11	-	-	-	8	10	10	-
Standards for third parties dealing with underwriting or claims	10	-	-	-	-	11	-	-
Monitoring, enforcement and sanctions	13	-	-	-	-	7	-	-
Total	-	**11,219**	**100%**	-	-	-	-	-

Causes of isolated breaches

For the fifth year in a row, the main cause of isolated breaches in 2021-22 was people. Subscribers attributed 80% of all isolated breaches to human error.

Of the isolated breaches caused by people, the most common reasons were:



- **44%** staff error
  (an increase of 18% on 2020-21)
- **27%** staff failing to adhere to established processes or procedures
  (a decrease of 7% on 2020-21)
- **23%** resourcing issues
  (a decrease of 19% on 2020-21)

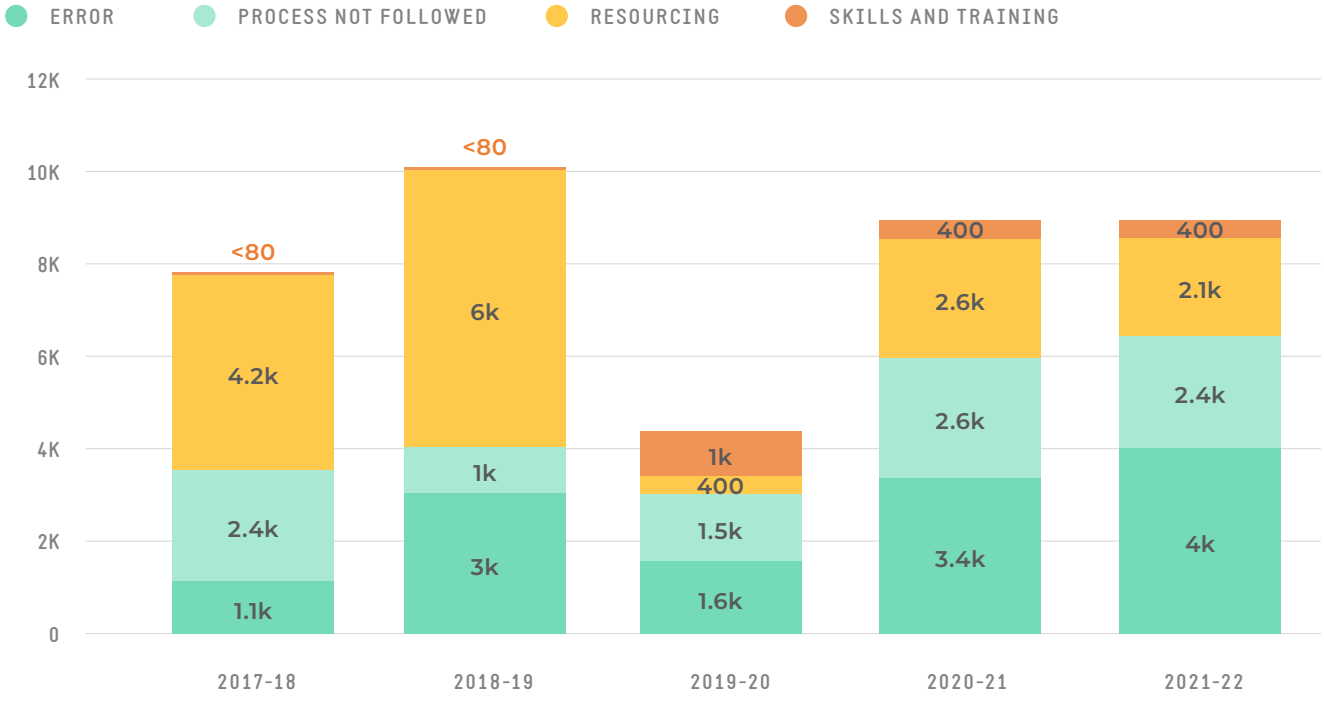
While the increase in staff error is concerning, the reduction in isolated breaches attributed to staff failing to adhere to processes or procedures is a positive sign.

The number of isolated breaches caused by inadequate process and procedures (including third-party processes) in 2021-22 went up by 1,505, an increase of 480% on the previous year.

> … the reduction in isolated breaches attributed to staff failing to adhere to processes or procedures is a positive sign.

FIGURE 3.

Isolated breaches caused by people-related issues, 2017–18 to 2021–22



Claims

Subscribers provided data on the 106,025 claims they assessed during the year.

This included the time taken to determine them, the number of claims withdrawn and re-opened, as well as the reasons for applying Unexpected Circumstances to some claims.

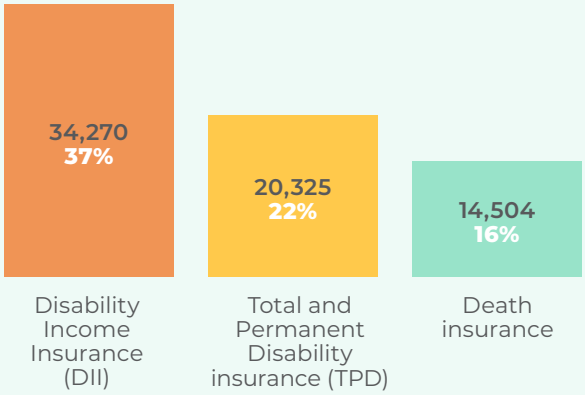
Data overview 2021-22

106,025
claims assessed by subscribers
↓ 4% compared to 2020–21

2,953
(3%) fewer claims were received in 2021-22
possibly due to the decrease in the number of lives insured by 788,949

34,270
Disability Income Insurance (DII) claims received (the highest proportion across all distribution channels (37%))

Top 3 claim types across all distribution channels:



↓33%
decrease in the number of Consumer Credit Insurance (CCI) claims in 2021-22

↓11%
decrease in the number of Accident cover claims in 2021-22

5,090
claims withdrawn
5% of all claims received

326
re-opened claims yet to be determined
as at 30 June 2022

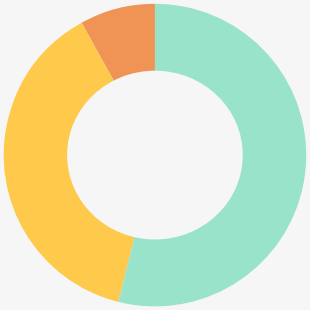
12,249
determined and undetermined claims for which UC applied in 2021-22
↓ 2% from 12,494 in 2020–21

A snapshot of claims numbers

- 3% (2,953) fewer claims were received in 2021-22 possibly due to the decrease in the number of lives insured by 788,949.
- The highest proportion of claims received across all distribution channels was for DII.
- Despite representing 17% of lives insured, DII accounted for 37% (34,270) of all claims received.
- Claims for TPD had 22% (20,325) of claims and Death insurance had 16% (14,504).
- CCI recorded the sharpest drop in claims received, falling by 33% (1,132).
- Claims for Accident cover also recorded a decrease of 11% (323).

Claims withdrawn

Subscribers reported that 5,090 claims (5.5% of all claims received) were withdrawn during the year, down from the 5,779 withdrawn in 2020-21.

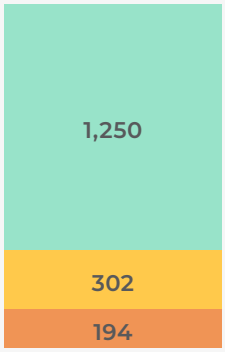


- **54%** Customer withdrawal (2,742) up 15% on 2020-21
- **38%** Subscriber withdrawal (1,931) down 8% on 2020-21
- **8%** Other reasons (417) down 7% on 2020-21

For 2021-22, we asked subscribers to provide more details about the reasons for claim withdrawals for each category.

Of the 4,673 claims that were withdrawn by the customer or subscriber, 59% (2,776) could not be categorised.

Of the 41% (1,897) that could be categorised:

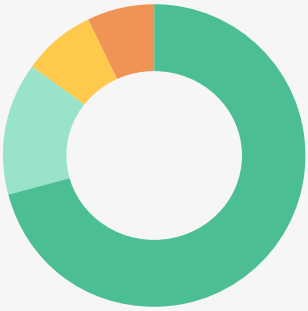


- **66%** (1,250) were withdrawn by subscribers because there was no reply or response to a request for information from the customer
- **16%** (302) were withdrawn by a mixture of subscribers and customers because of changes in circumstances
- **10%** (194) were withdrawn by subscribers because of ineligibility.

The benefit types with the most claim withdrawals:

- **47%** DII (2,388) down 4% on 2020-21
- **33%** TPD (1,672) up 6% on 2020-21
- **8%** Death (414) down 1% on 2020-21

The withdrawn claims based on distribution channels:



- **71%** Group (3,603)
  7% of all Group claims received (51,972) during the year
- **14%** Retail (693)
  4% of all Retail claims received (18,173) during the year
- **8%** Direct Third-Party (437)
  2.5% of all Direct Third-Party claims received (16,895) during the year
- **7%** Direct (357)
  5.5% of all Direct claims received (6,387) during the year

Two-thirds of claims were withdrawn by subscribers because there was no response from the customer to a request for information. This indicates a need to improve the claims assessment process to ensure it is clear and simple for customers and they are not withdrawing due to the complexity of the claims process. We encourage subscribers to:

- only request relevant information, rather than a customer's entire medical or employment file
- use plain English when making requests for information
- streamline the use of authorities where possible to minimise forms a customer needs to complete
- offer additional support for customers in vulnerable circumstances.

Claims re-opened

Subscribers re-opened 1,919 claims in 2021-22, a decrease of 10% on 2020-21.

Of the reopened claims during the year:

- **66%** (1,270) were admitted (72% in 2020-21)
- **17%** (326) were undetermined at 30 June 2022
- **14%** (264) were declined (15% in 2020-21)
- **3%** (59) were withdrawn (5% in 2020-21)

The number of re-opened claims that remained undetermined at 30 June 2022 increased by 88% in 2021-22 (up from 173 claims in 2020-21). This was largely due to two subscribers who reported an increase in re-opened TPD claims that remained undetermined.

A single subscriber accounted for 73% (239) of the total number of re-opened claims that remained undetermined at 30 June 2022.

Admitted re-opened claims

Of the 1,270 re-opened claims that were admitted:

- **54.5%** (693) were admitted after having received additional information about the claim
- **26%** (329) were admitted for other reasons
- **19.5%** (248) were admitted following a review or lodgement of a complaint about the claim

The most frequently admitted claims in 2021-22 were Death (83% of all admitted re-opened claims) and Funeral (80%). This contrasts with last year where Trauma (82%) and DII (80%) were the two benefit types that were most frequently admitted.

Importance of getting all information

Most re-opened claims were admitted as a result of a customer providing additional information. If a subscriber can get all the required information at the outset, they are likely to be able to assess the claim without the need to go back and forth with the customer.

Subscribers should ensure the information and advice they provide customers is clear and accessible, so the customer knows exactly what information they must provide at the outset.

Majority of re-opened claims were admitted following a complaint

Subscribers re-opened 339 claims following a request to review the claim or a complaint about the claim. Of these, 73% (248) were admitted.

Subscribers should closely examine claims that have been re-opened and admitted after a request to review it or a complaint. The details may offer insights into areas for process, system or people improvements.

Claim decision timeframes

Chapter 8 of the Code sets out timeframes in which subscribers must make decisions about claims.

For income-related claims, subscribers have two months from being notified of the claim or two months after the end of the waiting period to make an initial decision, whichever is later.

For non-income-related claims, subscribers have six months from being notified of the claim or from the end of any waiting period to make a decision, whichever is later.

Subscribers assessed 4,463 fewer claims than in 2020-21, a 4% decrease.

Despite a drop in the number of claims assessed, there was no noticeable improvement in the number of income-related claims determined within two months. Consistent with the previous year, 20% (6,689 out of 32,943) of all decisions for income-related claims were not made within two months.

This result continues a trend we have seen emerge in recent years. The number of income-related claims determined within the required timeframe has decreased steadily over five years, indicating an area for subscribers to focus improvements on.

For non-income-related claims, though, there was a slight improvement in 2021-22. The number determined within six months increased to 90% (51,561 out of 57,452) from 88% (53,234 out of 60,425) the previous year.

By benefit type, TPD accounted for the largest number of non-income-related claims that took more than six months to be determined. This accounted for 88% (5,191 out of 5,891) of all such claims. TPD was followed by Death (6%) and Trauma (3%). The ranking is consistent with the statistics last year and reflects the level of complexity in TPD assessments.

FIGURE 4.

Timeframes for determined claims (income-related)

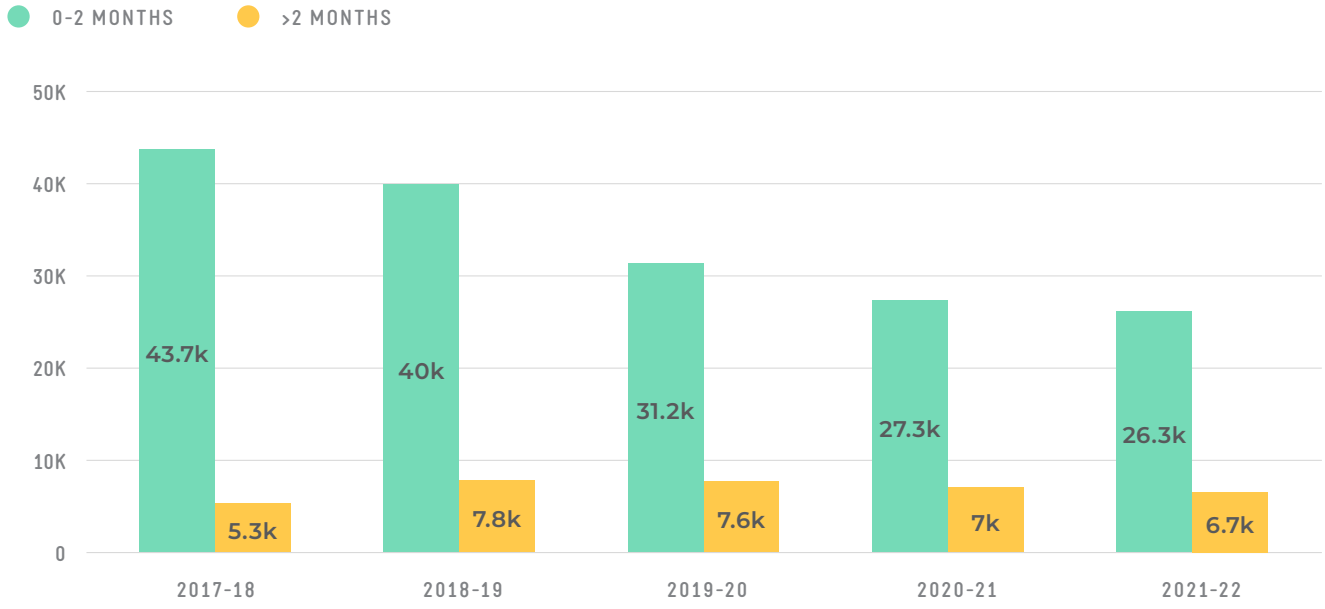


FIGURE 5.

Timeframes for determined claims (non-income-related)

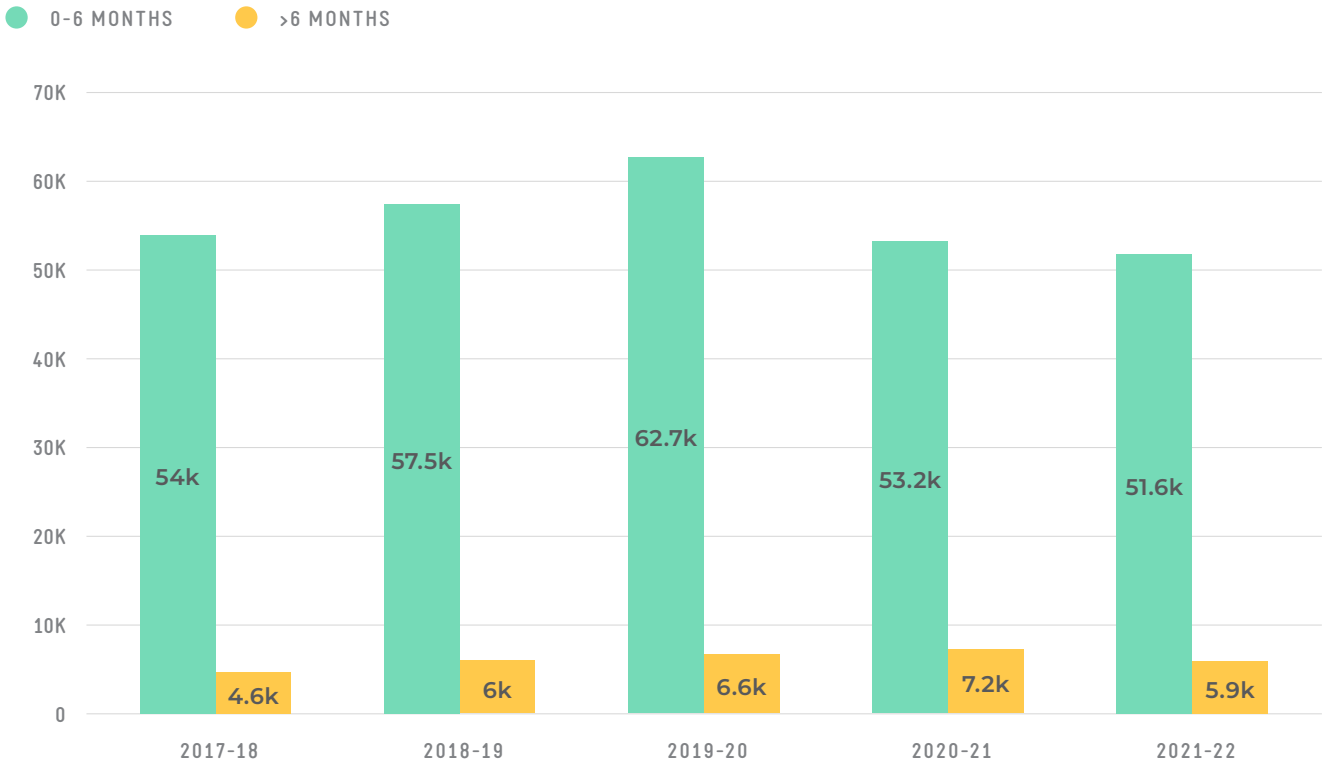
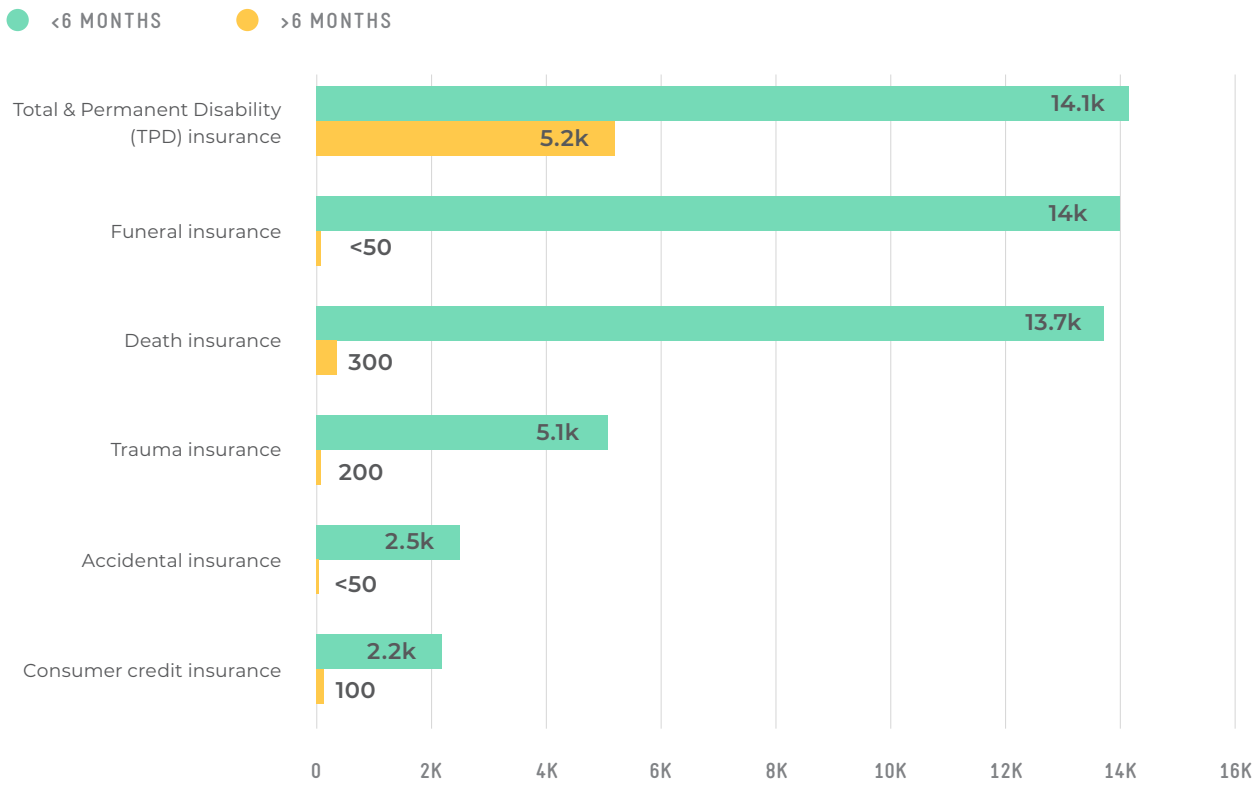


FIGURE 6.

Timeframes for determined claims by benefit type (non-income-related)



Unexpected Circumstances

The Code provides for a longer claim assessment of up to 12 months where Unexpected Circumstances (UC) apply. In such cases, subscribers must tell the customer why the delay has occurred and keep them informed of the progress of their claim. Exceeding this timeframe without UC would result in a breach of the Code.

Applying Unexpected Circumstances to claims

It was encouraging to see the improvement in the number of subscribers who were able to provide specific reasons for applying UC to claims in 2021-22.

The overall number of determined and undetermined claims for which UC applied remained steady. There were 12,249 reported in 2021-22, down 2% on the previous year's 12,494.

The main reasons for applying UC in 2021-22, included:

- Not receiving the necessary information from the customer (40% of claims, 4,911).
- Being notified of the claim more than 12 months after the date of the disability (21% of claims, 2,511).
- Not being reasonably satisfied that the information met the requirements of the policy for a TPD claim (15.4% of claims, 1,890).

There were 279 claims (from 6 subscribers) that could not be mapped to UC. This represented 2% of the total number of UC claims this year.

While there was an increase in claims that cannot be mapped (131 claims from 3 subscribers in 2020-21), there was an overall improvement in the number of claims that could be classified – taking it to 98% of claims.

Complaints

Complaints are a valuable source of information for subscribers – they highlight issues and opportunities for improvement to facilitate better customer outcomes.

We saw an increase in the number of complaints received and assessed by subscribers in 2021-22 with 49,310 complaints – up 136% compared to 2020–21.

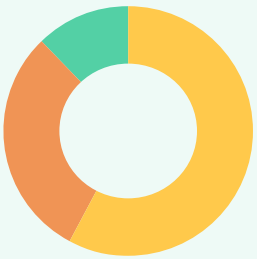
Data overview 2021-22

49,310

complaints reported by subscribers

↑ 136% compared to 2020–21

Complaints by distribution channel



58% retail

30% direct (including third-party)

12% group

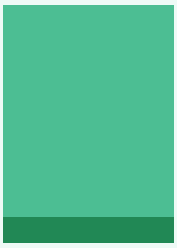
Top 3 complaint causes:

1. Policies
2. Service
3. Claims

Top 3 complaints by benefit:

1. Disability Income Insurance
2. Death insurance
3. Consumer credit insurance

Dispute resolution process



89% Internal Dispute Resolution (IDR)

11% External Dispute Resolution (EDR)

7,811

claims-related complaints resolved in 2021-22

2,926

claims-related complaints assessed in the Retail channel (increase from 31% to 37%)

336

Claims-related complaints that resulted in some sort of ex-gratia payment (down from 855 in 2020-21)

Subscribers advised that changes to ASIC's RG271 and RG274 had an effect on the number of complaints reported.

First, changes to RG271 expanded the definition of complaint, resulting in subscribers recording more expressions of customer dissatisfaction as complaints in 2021-22. It also requires subscribers to report on all complaints, even those that were resolved within five business days.

WITH CHANGES TO ASIC'S RG271, THE DEFINITION OF A COMPLAINT NOW INCLUDES:

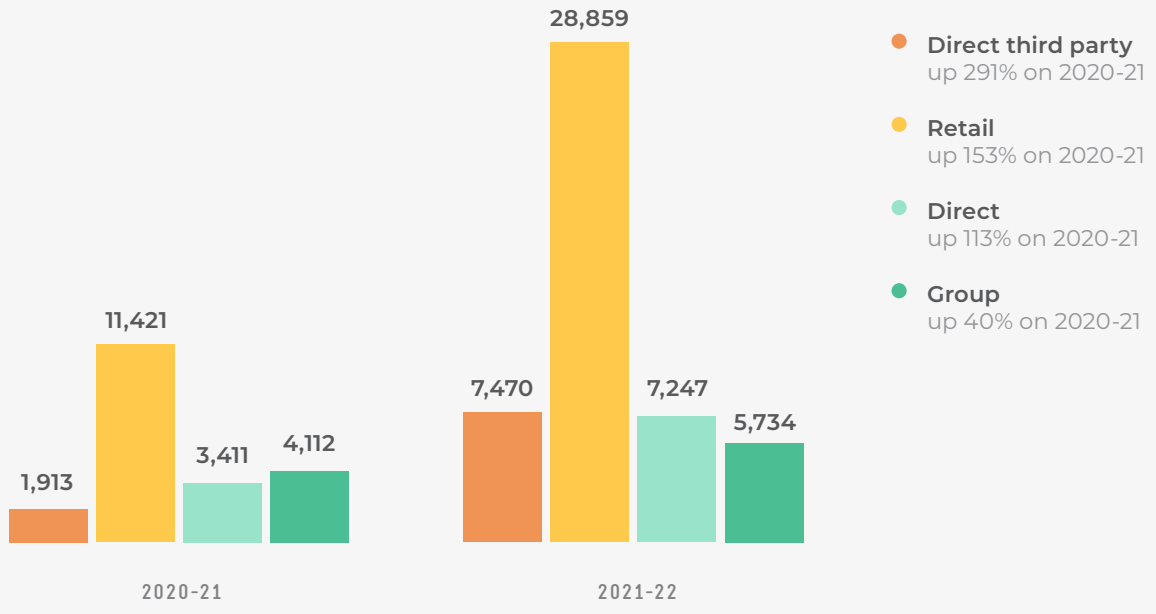
- dissatisfaction about an organisation and staff, where a response or resolution to the complaint is legally required
- dissatisfaction expressed on social media if the complaint is about the subscriber and the author of the complaint is contactable or identifiable.

> "... many subscribers reported investing in the update of their systems and processes to better identify and record complaints, leading to more accurate reporting.

And, in preparing for ASIC's RG271, many subscribers reported investing in the update of their systems and processes to better identify and record complaints, leading to more accurate reporting.

Second, changes to RG274, meant that, under requirements for DDO, third-party distributors must report complaint-related information to life insurers. This increased the number of reportable complaints for subscribers.

All distribution channels saw an increase in reported complaints in 2021-22:



Complaints about cover distributed via the Retail channel received the most complaints, with 58% (28,859) of the total in 2021-22. This was followed by Direct (including third-party) with 30% (14,717) and Group with 12% (5,734).

In 2021-22, three new categories of causes of complaints were introduced. These categories aimed to assist subscribers to improve the way they record and report complaints. The three causes of complaints were:

> These (three new) categories aimed to assist subscribers to improve the way they record and report complaints.

Subscribers reported that they were unable to categorise 3% (1,469 out of 49,310) of complaints in 2021-22, a decrease from 3.8% (781 out of 20,857) in 2020-21.

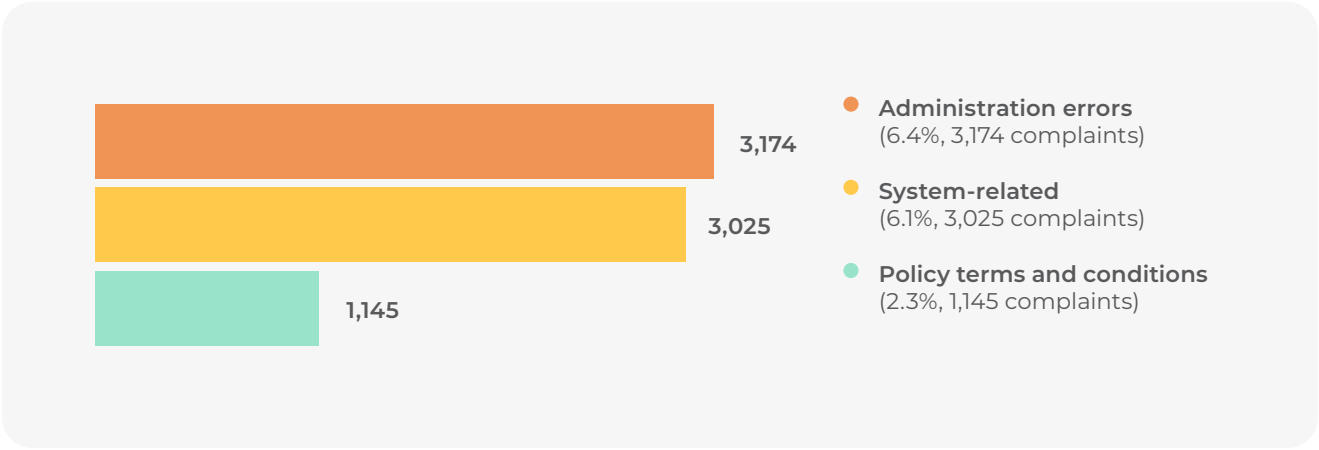
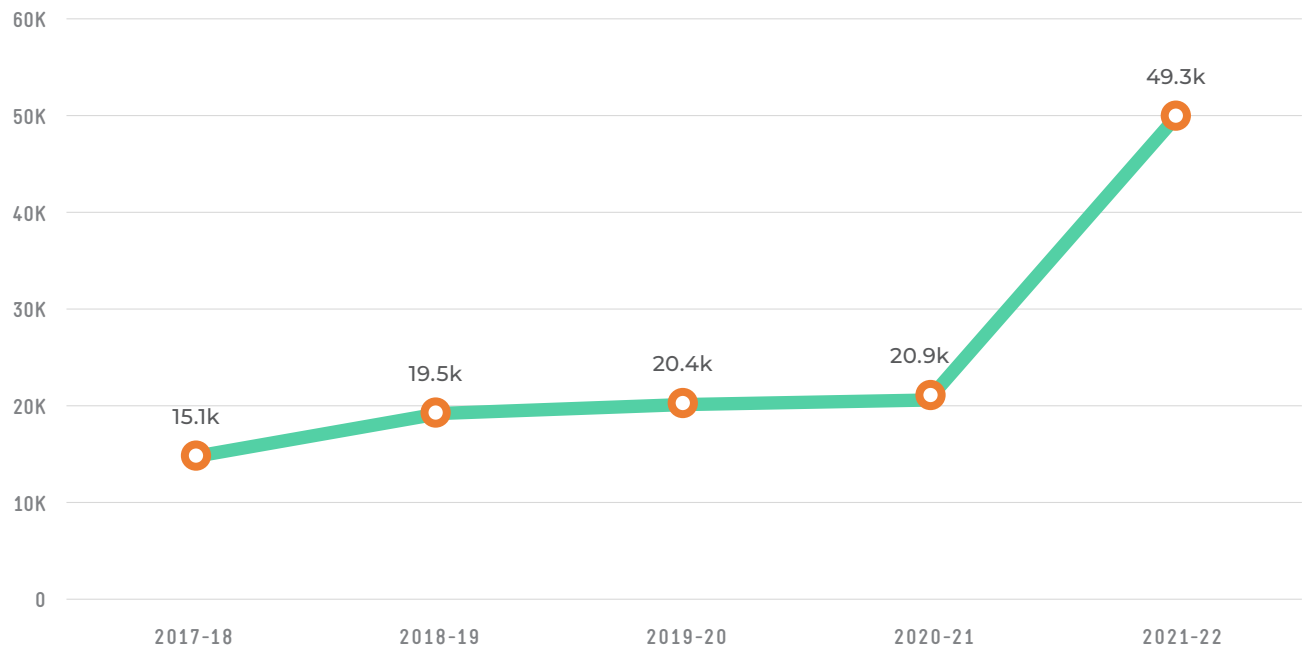


FIGURE 7.

Number of complaints received by subscribers, five years to 2021-22



Top three causes of complaints

Policy issues continue to attract the highest number of complaints, as has been the case since 2017–18. Service-related complaints was the second most cited cause of complaints, followed by claims.

- **Policy-related complaints** rose 77% in 2021–22, accounting for 30% (14,648) of all complaints:
  - Of policy-related complaints, 'Policy in force' – namely, policy changes or cancellation – had the most in 2021-22 with 10,257 complaints. This has been the top cause of policy-related complaints each year since 2017–18, accounting for a total of 30,566 complaints since we started collecting data from subscribers.
  - There were also 3,246 complaints related to policy design and disclosure and 1,145 complaints related to policy terms and conditions in 2021-22.
- Subscribers nominated **'service'** as the cause of 22% (10,839) of all complaints:
  - Complaints about the level of service provided to customers was the source of the second highest number of complaints, a rise from the third most cited cause in 2020-21.
- **Claims-related complaints** was the source of the third highest number of complaints for the year, with 15% (7,628) of all complaints:
  - This was a rise on the number of claims-related complaints recorded in 2020-21 (6,073).

14,648

policy-related complaints in 2021-22

↑ 77% increase from previous year

  - In 2021-22, we saw a decrease in the number of complaints regarding a claim decision. These dropped from 2,584 to 1,753 in the past year.
  - However, there was a general increase in the number of claims-related complaints received in all other categories: claims assessment duration, claims benefit adjustment and claims process/handling.
  - Of all claims-related complaints, 56% related to DII and 24% related to TPD. This is not surprising given that, together, these two cover types accounted for 59% of claims received across all distribution channels in 2021-22.

Complaints about the level of service provided to customers was the source of the second highest number of complaints, a rise from the third most cited cause in 2020-21.

FIGURE 8.

Number of complaints received by cause

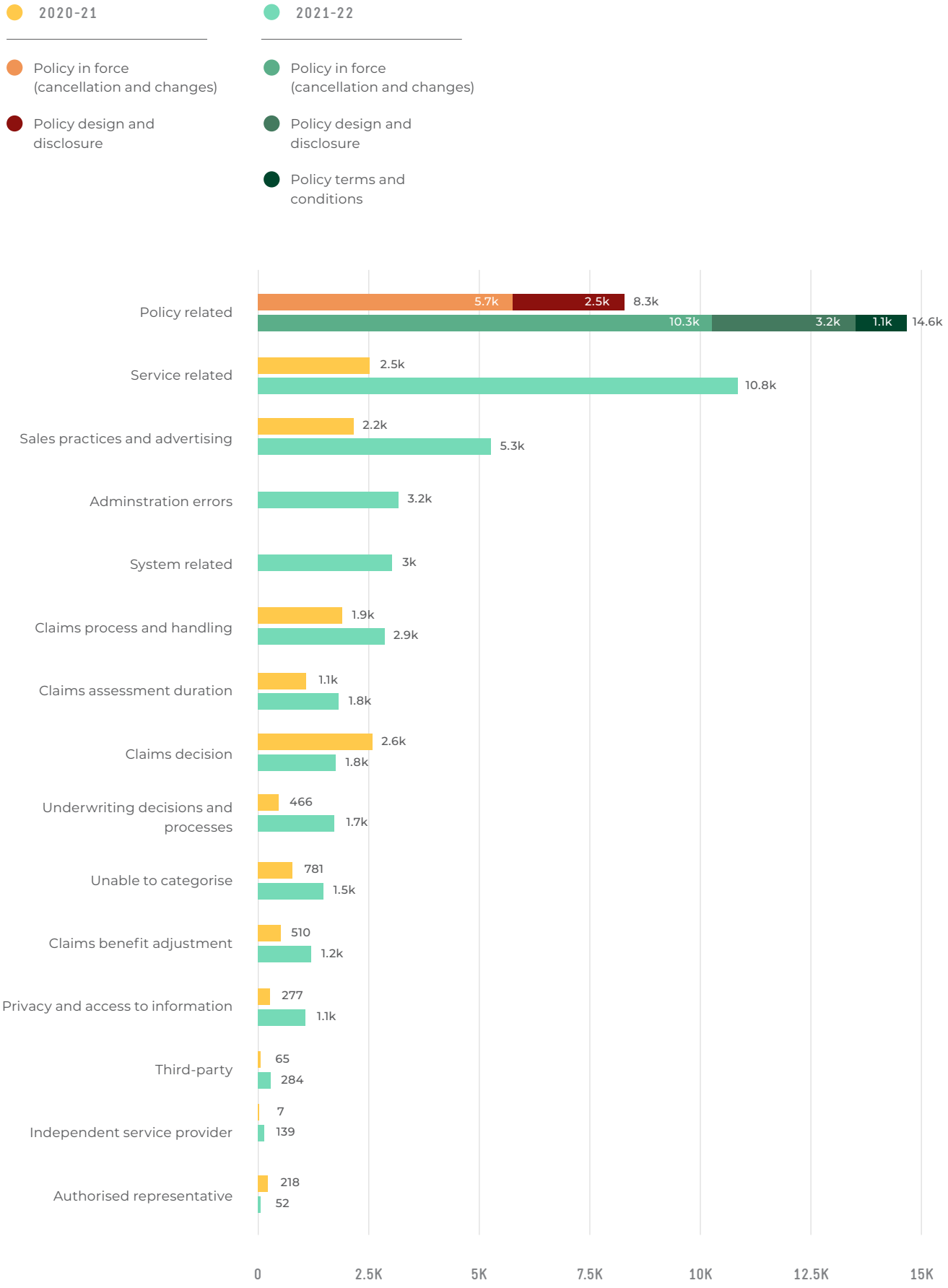
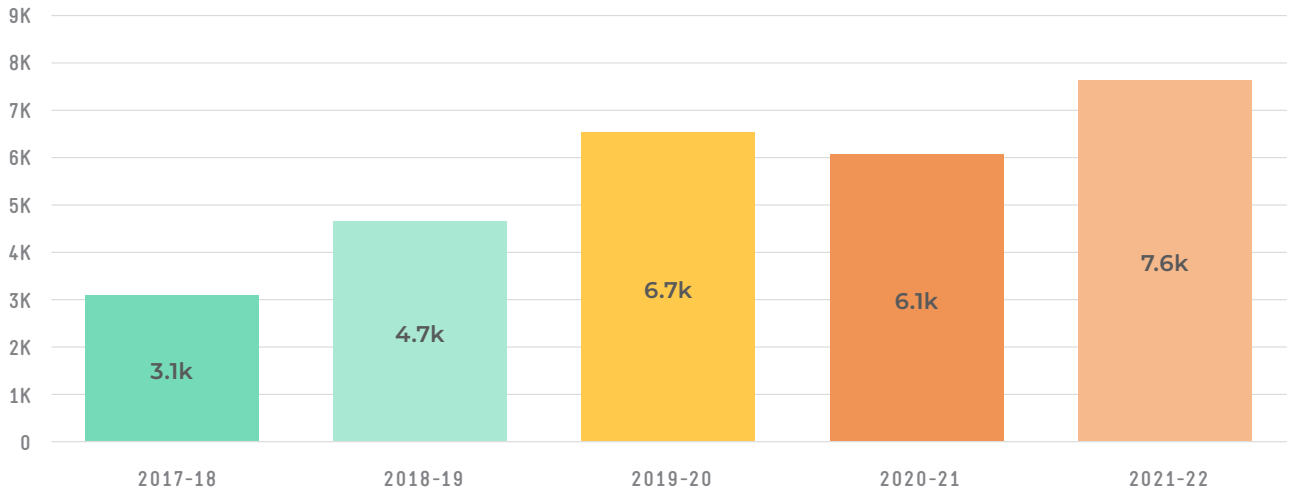


FIGURE 9.

Claims-related complaints, five years to 2021-22



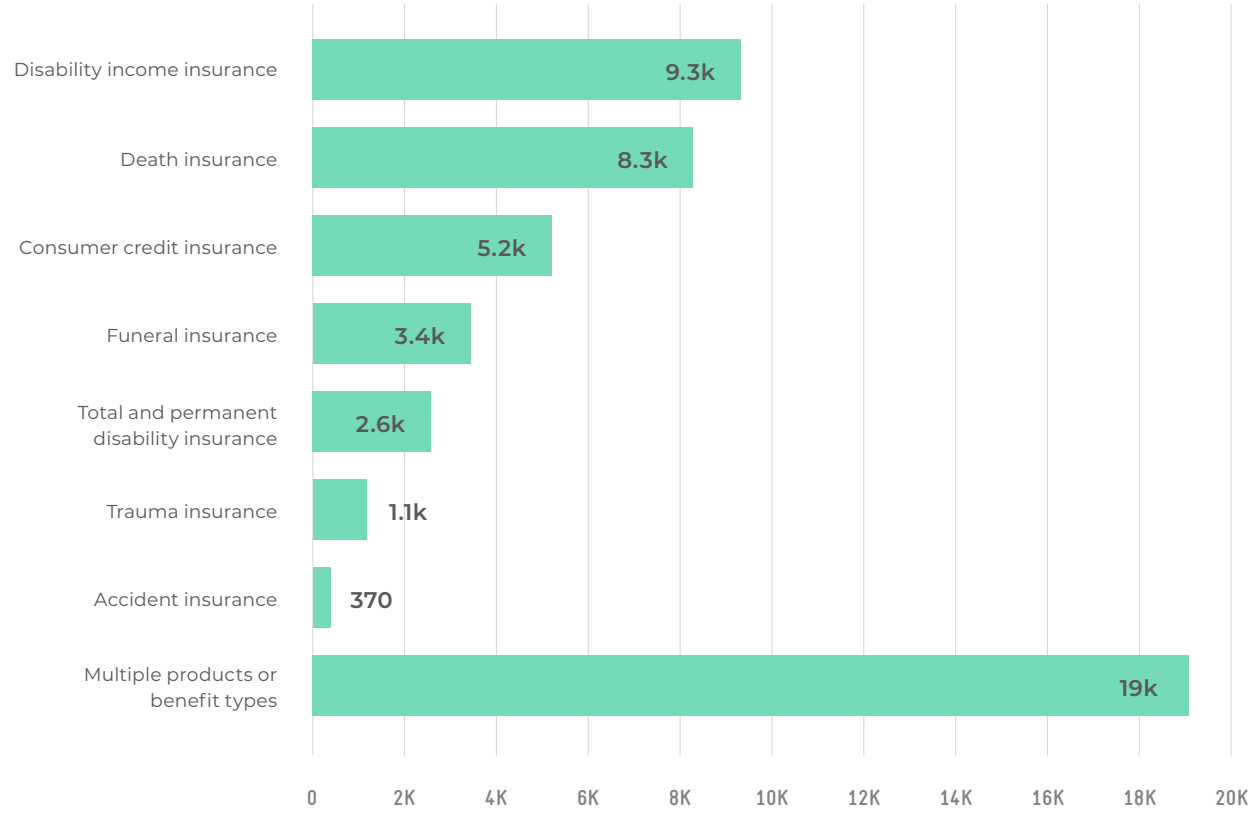
Complaints received by benefit type

Death, DII and CCI were the benefit types that received the highest number of complaints in 2021-22. DII accounted for 19% of the total, Death 17% and CCI 11%.

Only 39% of all complaints this year related to multiple products/benefit types, compared to 46% in 2020-21.

FIGURE 10.

Complaints received by benefit type



Complaints relating to claims

In 2021-22, the total number of claims-related complaints assessed was 7,811. This included undetermined complaints that relate to claims carried over from the previous reporting period.

The Group channel accounted for 47% (3,705) of all complaints relating to claims in this reporting period – a decrease on the 61% of 2020-21.

By contrast, the number of claims-related complaints assessed in the Direct Third-Party channel more than doubled from 4.5% in 2020-21 to 11% (894) in this reporting period.

There was also an increase in the number of claims-related complaints assessed in the Retail channel from 31% to 37% (2,926). This was largely attributed to the new requirements for DDO under ASIC's RG274.

Outcomes of complaints related to claims

Of the 7,811 claims-related complaints that subscribers assessed:

- 63% (4,909) did not relate to claim decisions
- 28% (2,212) related to claim decisions
- 6% (494) were undetermined in 2021-22
- 3% (196) were withdrawn.

Of the 2,212 complaints about claim decisions that were resolved, 26% (577) had the original decision reversed, while 74% (1,635) maintained the original decision.

We are pleased with the improvement in the percentage of decisions that were maintained. In the last reporting period, this was 55%. The increase indicates efforts from subscribers to improve claim assessment and decision-making processes.

Dispute resolution processes

Most of the complaints about claim decisions were managed via IDR processes and did not require escalation to the Australian Financial Complaints Authority (AFCA). This was the case both for complaints resolved in favour of the subscriber and for complaints resolved in favour of the customer.

IDR processes resolved 89% (1,969) of complaints regarding a claim decision, while only 11% (243) were resolved through an EDR process.

Ex-gratia payments

Claims-related complaints that resulted in some sort of ex-gratia payment accounted for just 4.7% of the total number of these complaints (336 out of 7,121). This is a notable decrease from 2020-21 where 15.5% (855 out of 5,528) of these complaints resulted in ex-gratia payments.

This decrease was largest in the Group channel, with a 79% drop in the number of claims-related complaints that resulted in ex-gratia payments. It decreased from 623 in 2020-21 to 131 in 2021-22.

In 2021-22, two subscribers accounted for 81% (or 273 out of 336) of the total number of claims-related complaints which resulted in ex-gratia payments.

Annual Data and Compliance Report 2021-22

Appendix 1

Code subscribers in 2021–22

As at 30 June 2022, there were 23 subscribers to the Life Insurance Code of Practice, one less than the previous year. Asteron Life & Superannuation Limited (ALSL) was a subscriber until 30 September 2021 when it was fully acquired by TAL Life Limited (TAL) from 1 October 2021. This resulted in a decrease from 24 to 23 in 2021-22.

Five Code subscribers are specialist reinsurers, meaning that they only insure the risk taken on by other life insurers and do not issue life insurance cover directly to customers. One subscriber is categorised as an 'other industry participant'.

1	AIA Australia Limited
2	Allianz Australia Life Insurance Limited
3	ClearView Life Assurance Limited
4	EMLife Pty Ltd (Code subscriber since 14 March 2018)[5]
5	General Reinsurance Life Australia Ltd
6	Hallmark Life Insurance Company Ltd
7	Hannover Life Re of Australasia Ltd
8	HCF Life Insurance Company Limited (Code subscriber since 1 July 2018)
9	Integrity Life Australia Limited (Code subscriber since 1 July 2018)
10	MetLife Insurance Limited
11	MLC Limited
12	Munich Reinsurance Company of Australasia Limited
13	NobleOak Life Limited
14	OnePath Life Limited (a company of Zurich Australia Limited)
15	Pacific Life Re (Australia) Pty Ltd (Code subscriber since 19 February 2020)
16	QInsure Limited (Code subscriber since 15 September 2017)
17	Resolution Life Australasia Limited (formerly AMP Life Limited)
18	RGA Reinsurance Company of Australia Limited
19	SCOR Global Life Australia Pty Ltd
20	Swiss Re Life & Health Australia Limited
21	TAL Life Limited
22	TAL Life Insurance Services Limited (ex-Westpac Life Insurance Services Limited)
23	Zurich Australia Limited

5 Claims Service Provider

Life Code Compliance Committee
lifeccc.org.au