Life Insurance Code of Practice

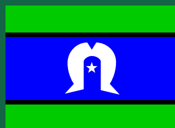
Annual Industry Data and Compliance Report 2022-23

April 2024

LIFE
CODE
COMPLIANCE
COMMITTEE

Acknowledgement of country

We acknowledge the traditional owners of Country throughout Australia and pay our respects to Elders past and present.



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Chair's message

I am pleased to present our latest report on compliance with the Life Insurance Code of Practice (the Code). This report covers breaches reported between 1 July 2022 and 30 June 2023.

This was the second consecutive year in which the number of customers impacted by breaches has declined – a pleasing result which indicates progress on delivering better customer outcomes.

But this good news is tempered by the fact that we saw an increase in breaches overall in 2022-23. It is concerning that this was the third consecutive year of increased breaches.

While some insurers reported a welcome decrease in breaches, performance of the industry suggests there is still more work to be done.

Breaches related to claims handling obligations featured prominently in the increase. Failing to address claims promptly not only breaches Code obligations but can also cause unnecessary stress and frustration for customers, eroding confidence in the industry. Meeting timeframes for claims handling and communication must be a priority focus for insurers.

Insurers reported that the overall increase in breaches was partially attributed to enhanced compliance frameworks, resulting in improved capabilities to detect, document, and report breaches. The industry's capacity to identify underlying issues and tackle the root causes of breaches is a critical element of its commitment to the Code.

With improved identification and reporting we expect to see the root causes of breaches being addressed in a sustained way.

While some insurers are reporting more breaches, we identified inconsistency and a concerning trend of what appears to be under-reporting by others. We found that some insurers were reporting breaches and complaints in numbers far below what would be expected.

Rather than indicating perfect compliance, it suggests deficiencies in processes and systems for detection and reporting breaches and complaints. Not detecting and reporting issues limits an insurer's ability to effectively remedy situations and make improvements to operations.

While some insurers reported a welcome decrease in breaches, performance of the industry suggests there is still more work to be done.

Failure to meet these obligations not only leads to customer frustration and increased complaints but also to inefficiencies and increased costs for the business, leading to heightened dispute volumes and diminished customer satisfaction.

We draw on a wide range of data and information to identify known and emerging issues. However, breach reporting is an important element of an insurer's own risk identification process and commitment to meeting its Code promise to deliver improved outcomes for its customers.

We acknowledge those insurers who have improved their breach reporting and complaints handling processes. We urge all insurers to look at their processes for detecting, recording and reporting all breaches and complaints. We expect to see under-reporting decrease in the coming year.

This reporting period also saw a surge in complaints. We note that insurers attributed part of this to the Australian Investments and Securities Commission's (ASIC) expanded definition of a complaint. While acknowledging this factor, the data shows increased breaches of claims handling obligations, including critical communication and timeframe requirements during the claims process.

Failure to meet these obligations not only leads to customer frustration and increased complaints but also to inefficiencies and increased costs for the business, leading to heightened dispute volumes and diminished customer satisfaction. Such failings also exacerbate stress and uncertainty for customers during a challenging time.

It is imperative that all insurers prioritise improvements in training, systems, and procedures to better support customers, especially during the claims process.

We also noted the high acceptance rates for reopened claims following a complaint or request for review. Although our data indicates that this issue was restricted to a small number of insurers, it emphasises the need for regular reviews of claims outcomes. Insurers should be seeking to identify areas for improvement and practices that avoid the need for reviews or complaints.

We thank insurers for their time and effort in providing data and information for this report. We remain committed to working with the industry to respond to the challenges outlined in this report and expect insurers to take proactive steps to improve compliance and safeguard consumer trust.

Jan McClelland AM
Independent Chair
Life Code Compliance Committee

Introduction

Our analysis of the information that insurers provide in the Annual Compliance Statement offers valuable insights into the industry, including emerging trends, issues and risks.

The Annual Compliance Statement is an essential part of how we monitor compliance with the Code.

In the Annual Compliance Statement, insurers must provide data about their breaches of the Code for the preceding twelve-month reporting period.

This report summarises the findings from the Annual Compliance Statements submitted by insurers for the 2022-23 reporting period.

As well as reporting the total number of breaches they identified during the reporting period, life insurers must provide details of the complaints they received and details about their handling of claims.

Our analysis of the information that insurers provide in the Annual Compliance Statement offers valuable insights into the industry, including emerging trends, issues and risks. We use this to focus on important areas of compliance and work with insurers on improving practices that provide better outcomes for customers.

Note: in this report, we use the simple term 'insurer' to refer to a life insurance institution that subscribes to the Life Insurance Code of Practice.

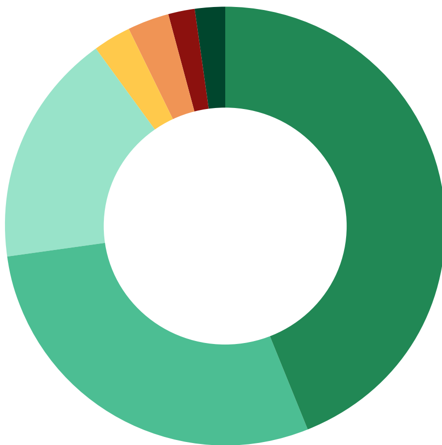
Snapshot

Industry

22 insurers subscribed to the Code at 30 June 2023

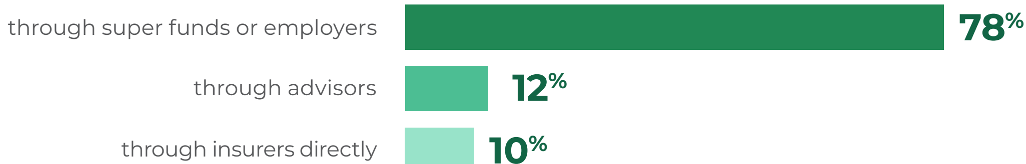
16 insurers issued life insurance policies

30.8 million covers in force:



- **44%** Death
- **29%** Total and Permanent Disability (TPD)
- **17%** Income Protection
- **3%** Customer Credit Insurance (CCI)
- **3%** Trauma
- **2%** Accident Insurance
- **2%** Funeral Insurance

6 insurers accounted for **89%** of the covers in force:



108,622

claims were assessed
2% increase on the previous year (106,025)

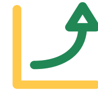
93,964

claims were determined
4% increase on the previous year (90,395)

Breaches

12,314

breaches of the Code reported
9% increase on the previous year (11,278)



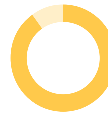
10 out of **16**

insurers reported an increase in breaches

106,266

customers affected by breaches
(including single customers impacted multiple times in a breach)

4 insurers accounted for



90%
of the breaches

12,245

breaches impacted one customer each

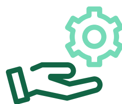
69

breaches impacted 94,021 customers
(including single customers impacted multiple times in a breach)

Complaints

75,256 complaints reported by insurers
53% increase on the previous year (49,310)

Top 3 areas for complaints:



1 **Service**
23,082 complaints
31% of the total

2 **Policy cancellations and changes**
13,297 complaints
18% of the total

3 **Sales practices and advertising**
13,250 complaints
18% of the total

TABLE 1.

Top 5 breaches by Code section

Code section		Breaches 2021-22	Breaches 2022-23	Change
8.15	Communicating claim decisions	1912	2630	▲38%
8.4	Providing regular claim updates	1068	1454	▲36%
8.3	Providing initial claim information	1006	1216	▲21%
6.7	Refunding after cancellation	228	963	▲322%
8.9	Income related claim requirements	1620	960	▼41%

TABLE 2.

Top 5 Code chapters with the most breaches

Code chapter		Breaches 2021-22	Breaches 2022-23	Change
8	When you make a claim	7742	9149	▲18%
6	Policy changes and cancellation rights	1717	1308	▼24%
5	When you buy insurance	1339	1152	▼14%
9	Complaints and disputes	139	330	▲137%
14	Access to information	273	310	▲14%

General findings

These findings highlight key patterns and trends in breach reporting based on our analysis of the Annual Compliance Statements submitted by insurers for the 2022-23 reporting period.

Causes of breaches

The following three causes accounted for 99% of all reported breaches:

- Human-related causes – 9,754 breaches (79%)
- Deficiency in process or procedure – 2026 breaches (16%)
- System error or failure – 367 breaches (3%)

As Chart 1 shows, at the industry level, there has been no change in the reported top three causes of breaches since the inception of the Code.

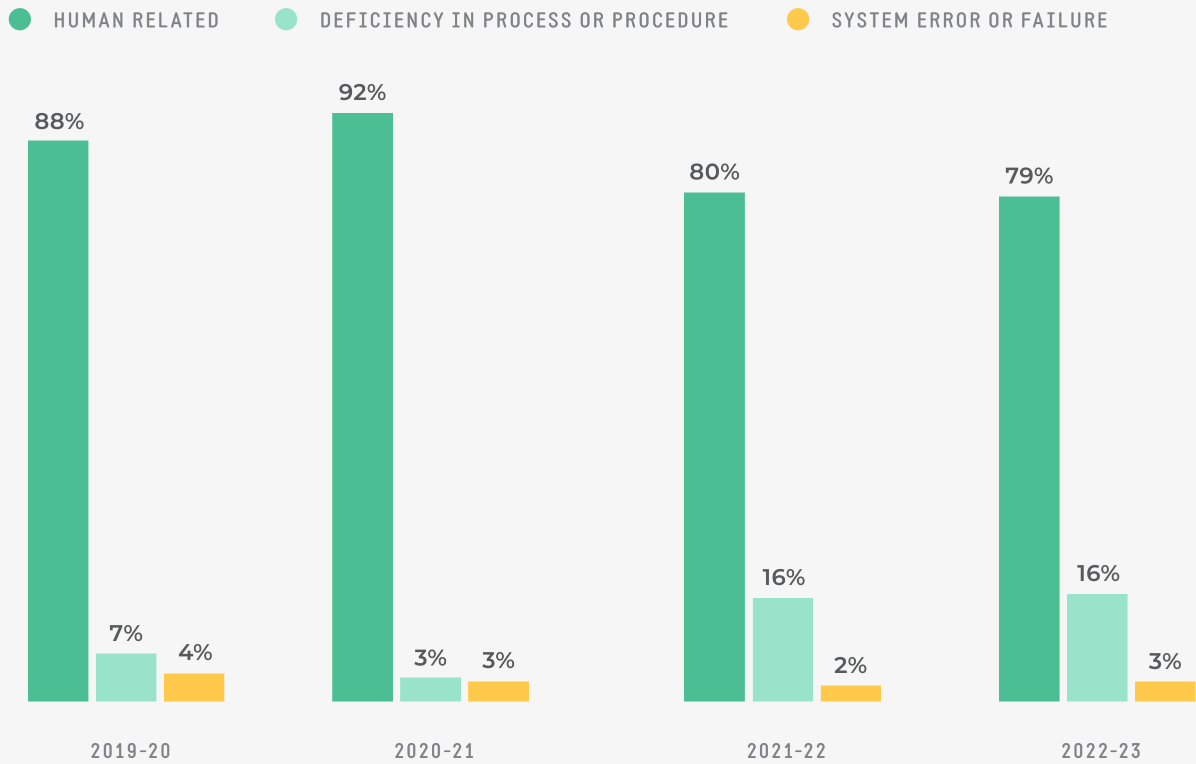
The category 'human-related causes' includes human error, resourcing issues and employees not following established processes and procedures.

Of the breaches reported as having 'human-related causes', most were attributed to human error (46%). This has been the most common cause for the last three reporting periods.

Resourcing issues also featured prominently among reported causes, accounting for 23% of the breaches from 'human-related causes'. In explaining these issues, insurers cited the ongoing effects of COVID 19, high levels of staff overturn, difficulty with staff retention, and a lack of experienced staff.

While we acknowledge the impact that the COVID-19 pandemic has had on resourcing, we expect to see these issues addressed and normalised in the coming reporting period.

Insurers must strengthen their efforts to better train and develop staff. It is crucial that increases in staff levels are accompanied by comprehensive onboarding and training processes, as well as thorough oversight. A comprehensive program for staff training and development can also improve retention rates, increasing experience across the organisation.



Impact of breaches

Breaches for this reporting period impacted 106,266 customers, a decrease of 47% on the 199,720 recorded in the 2021-22 reporting period. The number of customers impacted by breaches has now decreased two years in a row.

The decrease in impacted customers comes despite an increase in overall breaches for the reporting period.

This suggests that insurers are working to address the root causes of breaches that impact high numbers of customers.

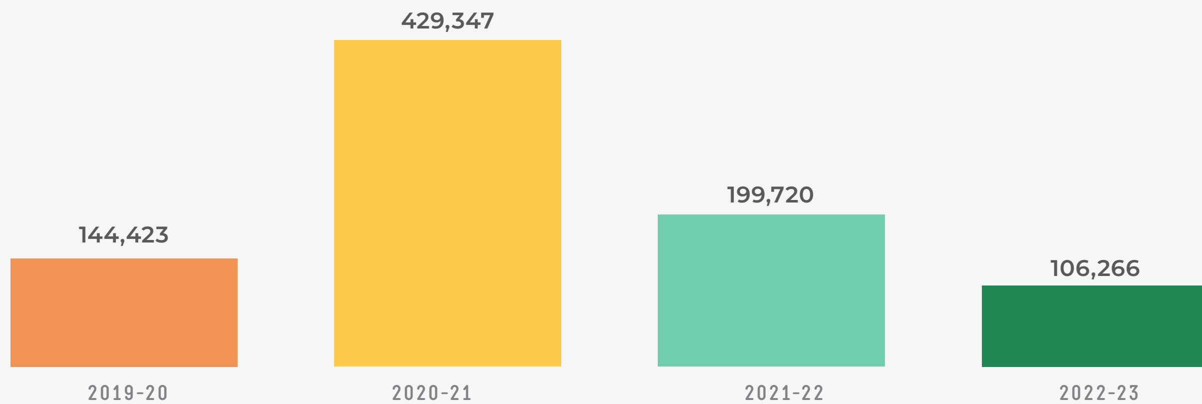
Failures with systems and automation for annual notices has been an issue and we have been working closely with insurers to address this. Our important work highlighting issues in this area has brought breaches to light, some of which have been reflected in reporting.

It is vital that insurers focus on improvements to reduce all breaches. However, breaches that impact high numbers of customers indicate systemic issues, which must be assessed as a priority.

We hope to see a continued reduction in customers impacted by breaches in the next reporting period.

CHART 2.

Customer impact of breaches in the past four reporting periods



Top three breaches by customer impact

1 Obligation to provide annual notices to Consumer Credit Insurance customers (section 4.7(g) of the Code)

Customer impact: 24,978

In 24,978 annual notices it sent to policyholders, an insurer failed to explain that cover for its CCI life insurance policy only extended until the policyholder turned 65 years old.

The breach was caused by human error. A third-party administrator reviewed and updated the annual notice template letter and had mistakenly removed the section that explained the period of cover.

The insurer remediated the breach by process reviews and improvements.

2 Obligation to provide annual notices to non-CCI customers (section 6.3 of the Code)

Customer impact: 15,322

Having overlooked a collection of legacy policies held in an old system, an insurer failed to send annual notices to 15,322 customers, with some dating back to the commencement of the Code in July 2017.

The breach was caused by an incorrect procedure related to the legacy policy and a system which was not set-up to generate the annual notices for these policyholders.

The insurer remediated the breach by process reviews and improvements.

3 Obligation to provide annual notices to non-CCI customers (section 6.3 of the Code)

Customer impact: 8,077

An insurer failed to send annual notices to 8,077 customers over an eight-day period due to a corrupted batch of files. It meant the third-party administrator responsible for sending the notices could not do so.

The breach was caused by a system failure and the insurer remediated the breach with a system fix.

Remediation

We analyse remediation information to understand how insurers respond to breaches and to offer insights into the practices employed across the industry.

Remediation is designed to address the root cause of the breach, prevent the breach from reoccurring and deliver sustained compliance.

The most common forms of remediation reported by insurers were:

- providing information to customers
- training staff
- increased resourcing.

These forms of remediation were also the top three in the previous reporting period.

While remediation efforts to address breaches that impact high numbers of customers seems to be driving some improvement, overall breaches have increased year on year. So, there is more work to do.

Current remediation practices, which are consistent across insurers, may not be enough to address the root causes of breaches.

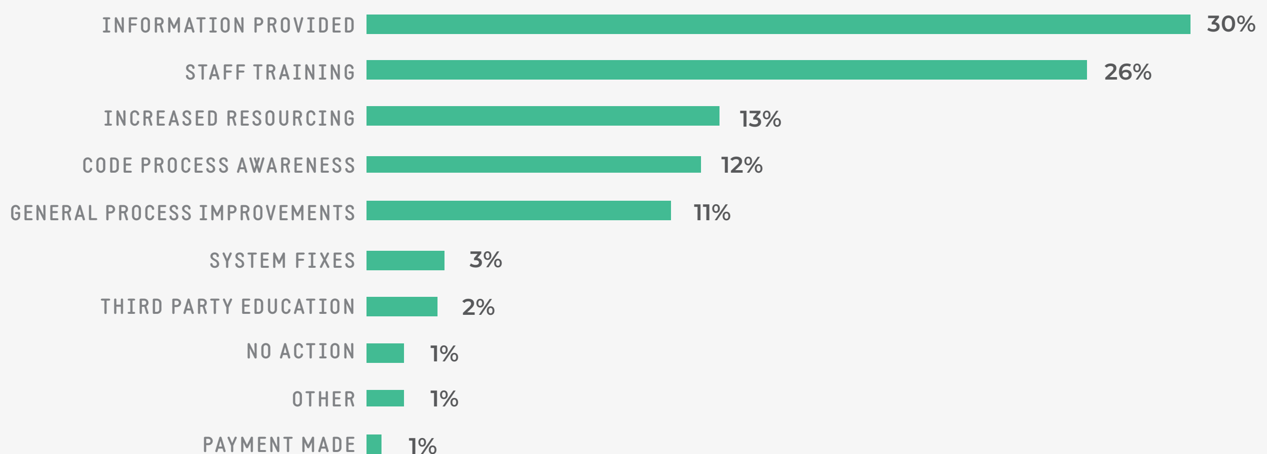
We urge insurers to strengthen their efforts to identify and address the root causes of recurring breaches.

Staff training will always be an important form of corrective action, but it is crucial that insurers also get processes right to support staff and minimise the risk of breaches. This includes continuing to invest in technology.

To reduce the risk of human error, insurers should consider technology to automate repetitive tasks. They should also consider technology to monitor and predict steps or processes, which can flag anomalies and trigger intervention and corrective action.

Technology and reporting capabilities that help to draw insights from breach data are also important. Such capabilities can help to identify common issues and trends and help to improve products and services.

Improvements in these areas must be aimed at preventing breaches as much as remediating breaches.



Examples of remediation

EXAMPLE 1

An insurer reported five breaches after our investigation found its staff had misunderstood when delays on claims constituted a breach.

The five breaches that it reported impacted **1,127** customers.

The insurer remediated these breaches with staff training on Code obligations, including correctly reporting the claim decision timeframe, reasons for delays, and whether a breach occurred.

EXAMPLE 2

An insurer reported a significant breach after they failed to advise lump-sum claimants to seek financial advice.

The breach impacted **7,048** customers.

The insurer remediated the breach by reviewing and updating all relevant letter templates and process guides. It also provided extra training for all its claims staff.

The insurer remediated the breach with system fixes which ensured that it sent notices regardless of arrears payments or cancellation risks.

EXAMPLE 3

A merger of two insurers led to process reviews that uncovered a significant breach regarding a failure to generate annual policy notices for certain policyholders. When a policyholder's account was in arrears, the system failed to generate an annual notice before the anniversary date of the policy.

This significant breach impacted **5,000** customers.

The insurer remediated the breach with system fixes which ensured that it sent notices regardless of arrears payments or cancellation risks. The insurer also implemented changes that meant it would issue annual notices earlier than it previously did. To further prevent these breaches, the insurer confirmed it had reconciliation and exception report monitoring to ensure compliance with Code requirements.

Key observations

Breaches of claims obligations:
some improvements but more to do

Chapter 8 of the Code, 'When You Make a Claim', covers crucial obligations for communication, claims assessment, decision-making, and support mechanisms.

While we saw improvements from some insurers, the overall increase in breaches of obligations related to management of customer claims shows many need to do more.

Chapter 8 of the Code, 'When You Make a Claim', covers crucial obligations for communication, claims assessment, decision-making, and support mechanisms. The obligations ensure timely assistance for customers and fair treatment throughout the claims process.

This chapter saw the greatest increase in breaches in the 2022-23 reporting period. With a total of 9,149 breaches, this was an increase of 18% from the 7,742 breaches in 2021-22.

This was driven by increases in breaches of the following obligations:

- communicate a claims decision within 10 business days of receiving all necessary information (section 8.15) – 38% increase
- inform customers about the progress of their claim at least every 20 business days and to respond to requests within ten business days (section 8.4) – 36% increase
- explain the claim process to a customer within 10 business days of the insurer being notified of the claim (section 8.3) – 21% increase.

As Chapter 8 also had the most breaches in the 2021-22 reporting period, we are concerned that some insurers continue to have difficulty complying with these obligations.

9,149

breaches as a result of non-compliance with Chapter 8 of the Code, 'When You Make a Claim'

Reviewing breaches, understanding their root causes and taking action to address them is an essential part of operations, effective self-regulation, ongoing compliance with the Code and improved customer outcomes.

We acknowledge that the claims process can be complex and brings a heightened risk for breaches, and we recognise that many insurers are working hard to minimise errors in this area. The heightened risk of breaches, however, emphasises the need for good systems and processes to support staff, protect customers and mitigate risks.

The claims process is critical for customers, and insurers must get all aspects of claims-handling right. The claims process often comes when customers are trying to get through life's most challenging moments, such as income loss leading to financial difficulty, serious illness or injury, or death of a loved one.

Poor practice can exacerbate customer vulnerability, so insurers must ensure a timely, efficient, compassionate and stress-free claims process.

of insurers (six insurers) reported improvements despite the increase in breaches overall

Despite the increase in breaches in the aggregate, we were encouraged to see six insurers (38%) reported improvements. Given our previous calls for attention to breaches of Chapter 8, the improvements are cause for some optimism. We would like to see further improvements in the next reporting period.

If we see a further increase in breaches, we will engage directly with the insurers and seek to understand:

- the root cause analysis they conducted to identify the cause of the ongoing non-compliance
- the solutions they propose to implement to improve compliance and the timeframes for implementing them.

Insurers must recognise the importance of proactively reviewing processes, procedures and quality assurance in claims handling operations.

Reviewing breaches, understanding their root causes and taking action to address them is an essential part of operations, effective self-regulation, ongoing compliance with the Code and improved customer outcomes.

CHAPTER 8, SECTION 8.15

Delay in communication of claims decisions

Despite improvements from some, too many insurers failed to meet the obligation to communicate a claims decision to a customer within 10 business days of receiving all the information it needed (section 8.15 of the Code).

Nine insurers reported breaches in this period, down from 11 in the previous period.

In this reporting period, insurers reported 2,630 breaches of this obligation, an increase of 38% on the 1,912 breaches reported in 2021-22.

However, this increase was driven mainly by one insurer that accounted for 1,943 breaches (74% of the total). Given the significance of this insurer's non-compliance, we will engage with the insurer to better understand the issue and ensure it is acting to improve compliance.

Letting customers know of decisions on claims within the required timeframes can help to alleviate their stress and anxiety and demonstrate commitment to addressing their needs.

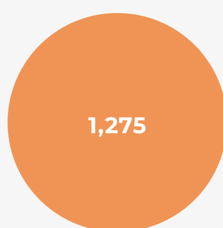
Failing to meet the timeframes set out in the Code obligation may not only exacerbate a customer's stress and anxiety, but may lead to more complaints against an insurer, which increases workloads and poses reputational risks. Meeting the timeframes set out in the Code is good for both customers and insurers.

Insurers must do more to reduce breaches of this obligation in the next reporting period.

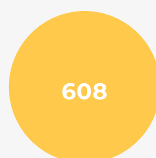
The new Code, which came into effect on 1 July 2023, extends the timeframe for communicating claims decisions from 10 business days to 15 business days. We view this change as disappointing because we consider 10 business days to be sufficient time to communicate a decision.

As a result of the extended timeframe, we anticipate fewer breaches in future years. We are monitoring insurers' compliance with the new timeframe closely and will act when we observe non-compliance. We know that many insurers regularly complied with the requirement to communicate the decision within 10 business days and, despite the change in the requirement, we encourage them to continue to do so.

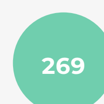
In the 2022-23 reporting period, most breaches of section 8.15 of the Code (88%) were attributed to human-related causes:



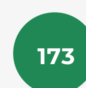
HUMAN ERROR



INADEQUATE RESOURCING



INADEQUATE TRAINING



STAFF NOT FOLLOWING ESTABLISHED PROCESSES

To address these causal issues and to mitigate future breaches, insurers must ensure they maintain adequate staffing levels, and that staff are trained, well supported, and monitored.

… insurers must ensure they maintain adequate staffing levels, and that staff are trained, well supported, and monitored.

Examples of breaches

EXAMPLE 1

A customer lodged a trauma insurance claim due to a medical condition which was initially declined by the insurer.

The customer then lodged a complaint with the Australian Financial Complaints Authority (AFCA) about the decision. AFCA overturned the insurer's decision and ordered it to pay the claim benefit, legal fees and interest to the customer.

Following this decision, AFCA referred the matter to us, alleging a potential breach of section 8.15 of the Code.

We reviewed the case and confirmed that the insurer had all the information it needed and had completed all enquiries to decide on the claim within 6 business days of the claim being lodged. However, the insurer did not notify the customer of its decision until 95 business days after it had all the required information.

We determined this to be serious non-compliance.

To remediate the Code breach, the insurer provided training to its claims team, instructed its team responsible for quality assurance to monitor for similar issues, and reviewed its process documents.

EXAMPLE 2

An insurer reported a significant breach of the obligation to communicate a claims decision to a customer within 10 business days after identifying errors in its reporting tool.

The tool had recorded claims as having met the 10-business day timeframe, when they had not. The breach impacted 5,681 customers.

The insurer discovered that its reporting tool was drawing on an incorrect date in the case file, and this led to an incorrect calculation of time.

The insurer's remediation actions included staff training, improvements to processes, and better use of automation. We are monitoring the insurer's remediation to ensure sustained compliance.

Read our full determination.

CHAPTER 8, SECTION 8.4

The obligation to provide updates and responses

Insurers reported an increase in breaches of the obligations to inform customers about the progress of their claim at least every 20 business days and to respond to requests within ten business days (section 8.4 of the Code).

Twelve insurers reported breaches of these obligations in 2022-23, up from 10 insurers in the previous reporting period.

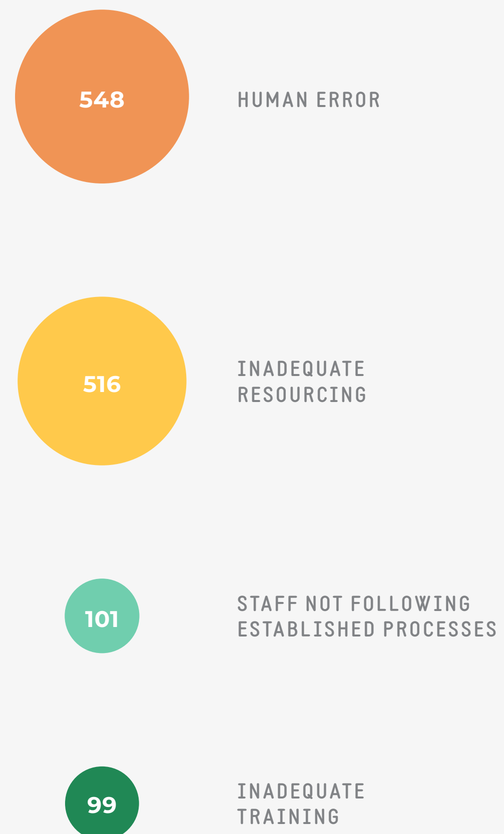
Insurers reported 1,454 breaches of section 8.4 in this reporting period, a 36% increase on the 1,068 breaches in 2021-22.

Regular and timely communication, whether it be about the progress of a claim or in response to a request, provides peace of mind for customers. It offers a transparency that builds trust with customers and demonstrates a commitment to meeting customer needs at a difficult time.

Non-compliance with the Code's obligation to inform customers about the progress of a claim or to respond to requests within timeframes can heighten anxiety and frustration for customers during a time when they need reassurance. It reflects poor customer service, damaging the insurer's reputation.

Breaches of this nature may also lead to unnecessary escalations and complaints, creating an administrative burden that adds to workloads and risks further breaches, non-compliance and disputes.

In the 2022-23 reporting period, most breaches of section 8.4 of the Code (87%) were attributed to human-related causes:



With these causal issues, we consider it paramount that insurers ensure their staffing levels are always adequate and staff are capable of performing their roles competently.

Examples of breaches

EXAMPLE 1

We received a complaint from a customer that an insurer:

- was taking an unreasonable amount of time to decide the outcome of a claim
- had failed to update them on the progress of the claim
- had not responded to requests for information.

Our investigation found that the insurer failed to provide updates to the customer at least every 20 business days, resulting in two breaches of section 8.4 of the Code.

The insurer also failed to respond to six separate requests for information within 10 business days in the same period, resulting in a further six breaches.

The insurer attributed the breaches to the underperformance of the claims manager.

Because multiple breaches occurred over an extended period, we determined that this was serious non-compliance.

The insurer terminated the employment of the claims manager and increased monitoring of the process. It also implemented improved systems to reduce the likelihood of similar breaches occurring.

EXAMPLE 2

We received a complaint from a customer that an insurer had taken too long to decide on their Income Protection claim and failed to keep them updated throughout the process.

Our investigation found that the insurer failed to provide updates to the customer at least every 20 business days and failed to respond to four requests the customer made for updates within the required 10 business days – a breach of section 8.4 of the Code. The insurer did not respond at all to two of these requests.

We deemed the breaches as serious non-compliance, as the failure to respond to information requests during the protracted claim assessment increased the customer's vulnerable circumstances and potential harm.

The insurer attributed the breach to the poor performance of the claims manager.

In response, the insurer confirmed it:

- provided extra training for the claims manager
- reduced the delegated authority on assessment for the claims manager
- increased the portfolio oversight by senior managers.

The insurer also issued a payment of $24,000 to the customer as a gesture of goodwill for errors made in the claim assessment.

CHAPTER 8, SECTION 8.3

Failing to explain and notify

Some insurers continued to find difficulty complying with the requirement to explain the claim process to a customer within 10 business days of the insurer being notified of the claim (section 8.3 of the Code).

Section 8.3 requires an insurer to advise the customer of:

- the cover and the claim process
- the reasons that an insurer requests certain information
- any waiting periods that apply prior to the claim payments
- the best contact details regarding the claim.

In the 2022-23 reporting period, 11 insurers reported 1,216 breaches of this obligation, a 21% increase on the 1,006 breaches in 2021-22 reporting period.

Explaining the process to a customer within 10 business days is crucial for transparency and helps manage consumer expectations.

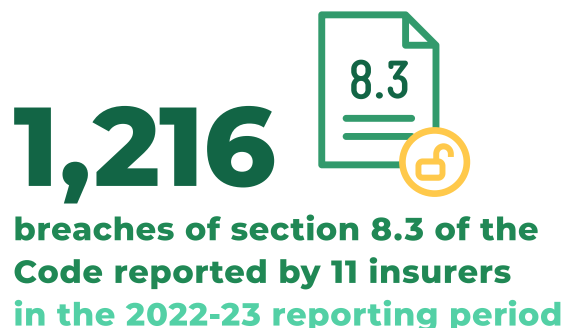
Providing a clear explanation of the process helps alleviate stress for a customer. It ensures they are well-informed about the next steps in the claims process and relieves them of the worry that uncertainty can bring. This transparency can help build trust between the insurer and the customer because the customer understands how their claim is going to be handled.

Clearly outlining the process helps customers know what to expect, including the timeframes involved and the documentation they need to provide. It prepares them and reduces surprise and frustrations. When they know the process, a customer can navigate it more effectively, which helps them make informed decisions.

Additionally, prompt communication supports the overall efficiency of the claims process, contributing to a smoother resolution for both the customer and the insurer.

While we saw breaches of this obligation from 11 insurers, one accounted for 56% of the breaches. Six insurers reported increases in breaches from the previous reporting period, three reported decreases, and seven reported no change.

Insurers cited human error and inadequate staff resourcing as the cause of most breaches. We reiterate that insurers must maintain adequate staffing levels and ensure that staff are well supported and monitored to reduce breaches and the impact on customers.



breaches of section 8.3 of the Code reported by 11 insurers in the 2022-23 reporting period

Changes to the obligation with the 2023 Code

In effect since 1 July 2023, the 2023 version of the Code, at clause 5.5, breaks the obligation down into sub-clauses, which will allow for more specific reporting. We expect this will facilitate better identification and targeting of problem areas and better remediation.

Clause 5.5 of the 2023 Code

Within 10 Business Days of the Claim Received Date, we will tell you:

a. how you can access the Life Code, in line with clause 1.3

b. about your cover and any waiting periods that may apply

c. about all the relevant benefits under the Life Insurance Policy you are claiming on

d. about the claims process and how to contact us for more information.

To ensure customers are receiving the information and advice they need, and to ensure better compliance with the obligation, insurers should:

- review and refine their processes for explaining the claims-handling process
- ensure automated systems can accurately track the timeframe, prompt action from staff, and provide oversight for management on risks of non-compliance
- provide comprehensive training to staff on the obligation and how processes work to meet it
- review, test and monitor automated systems to ensure they can send the right communication to the right customers within the timeframes.

Regular audits and reviews also help ensure compliance with this obligation and create a culture of responsiveness and transparency within the insurer.

In effect since 1 July 2023, the 2023 version of the Code, at clause 5.5, breaks the obligation down into sub-clauses, which will allow for more specific reporting.

Examples of breaches

EXAMPLE 1

We received an allegation of a Code breach that alleged an insurer did not meet the Code's timeframes when assessing a claim.

As part of our investigation, the insurer identified 62 breaches of section 8.3 of the Code.

The insurer attributed the breaches to human error and the underperformance of the claims assessor over an extended period.

In response, the insurer addressed the staff underperformance, paid interest to the customers affected by the breaches, and improved its processes.

... the insurer did not provide the customer with the required information until it communicated the decision on the claim, 47 business days after the customer lodged the claim.

EXAMPLE 2

We received an allegation from a customer that an insurer had handled their claim poorly.

Our investigation found that the insurer had failed to explain all the required information to the customer within ten business days of the claim being lodged, which amounted to a breach of section 8.3 of the Code. Furthermore, the insurer did not provide the customer with the required information until it communicated the decision on the claim, 47 business days after the customer lodged the claim.

The insurer attributed the breaches to human error by an inexperienced claims assessor.

In response, to address the issue, the insurer provided direct feedback and training to the claims assessor, reassigned the claim to a different staff member with active supervision from a technical claim consultant, and provided training to all staff.

Read our full determination.

Spotlight

Under-reporting breaches

Consistently reporting no breaches or very few breaches over extended periods raises concerns that an insurer may not have adequate systems in place to identify, record and report breaches.

Accurate reporting is essential for identifying and addressing systemic issues, improving services and outcomes. Under-reporting breaches compromises the integrity and effectiveness of the self-regulatory framework.

A failure to effectively identify and report breaches risks concealing patterns of non-compliance, leaving problems unaddressed and causing consumer detriment. Identifying issues early, remediating them and learning from them improves an insurer's business and enhances its reputation. It can also avoid more serious and costly regulatory interventions later.

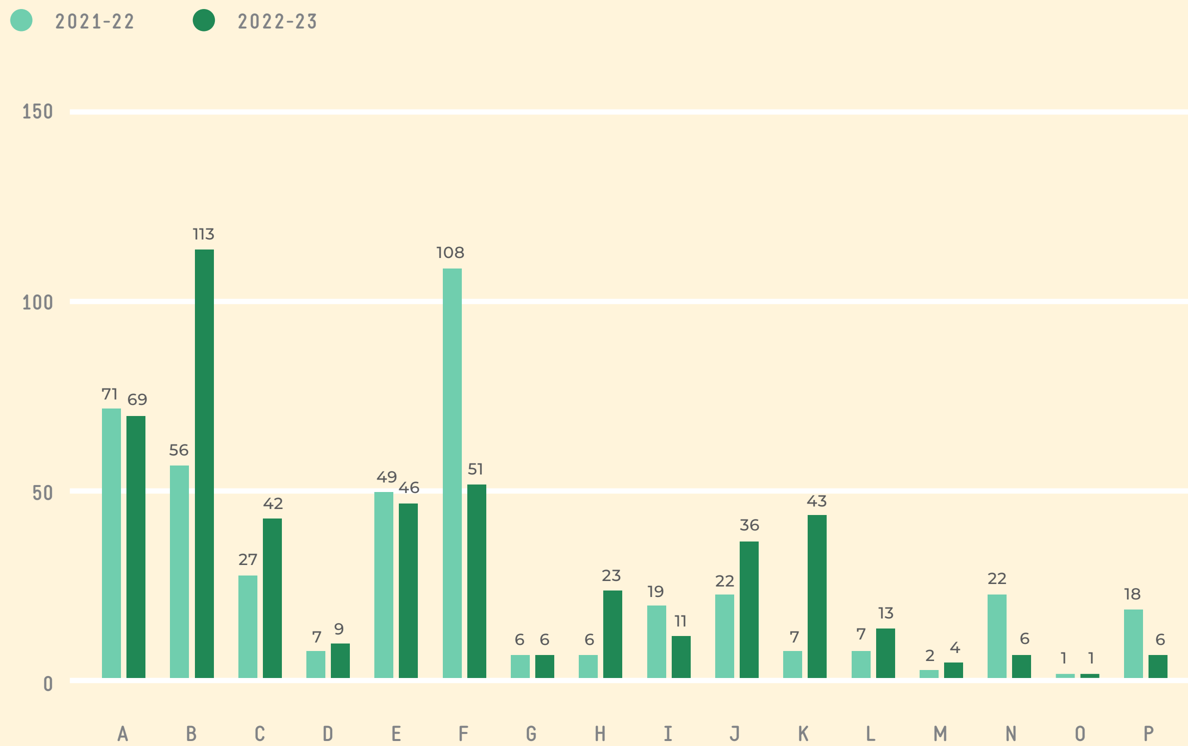
insurers reported less than 10 breaches in the 2022-23 reporting period

All insurers should embrace a culture of compliance, driven by accurate reporting, transparency and accountability. Every insurer should work to make sure its board and all staff understand the benefits of a culture of compliance.

In the 2022-23 reporting period, four insurers reported less than 10 breaches. These four also featured among the insurers with the lowest rates of reported breaches per 100,000 covers in force.

In the previous reporting period, three of the same four insurers reported less than 10 breaches for the year, and two featured among the lowest rates of reported breaches per 100,000 covers in force.

Consistently reporting no breaches or very few breaches over extended periods raises concerns that an insurer may not have adequate systems in place to identify, record and report breaches.



While we are concerned with suspected under-reporting in all areas, we highlight the following as high-risk areas to which we will direct further attention and scrutiny.

Chapter 8 of the Code: When you make a claim

Chapter 8 is the life insurance industry's commitment to fair and efficient treatment of claimants. It outlines key principles and procedures to ensure transparency, prompt communication, and ethical conduct by insurers.

In the last four reporting periods, three insurers reported 18 or fewer breaches of Chapter 8. These insurers also had the lowest rates of claims-related breaches per 100,000 covers in force.

Chapter 9 of the Code: Complaints and disputes

Chapter 9 is the life insurance industry's commitment to a structured and fair process for complaints-handling. Effective complaints-handling is crucial for accountability and customer satisfaction.

In the last four reporting periods:

- Two insurers did not report any breaches of Chapter 9
- Ten insurers reported ten or fewer breaches each.

To help encourage a culture of reporting, insurers should:

- ☑ ensure staff understand the Code and its promises
- ☑ have clear reporting procedures that are easy to follow and all staff know and can access
- ☑ create an environment where employees feel comfortable reporting breaches without fear
- ☑ improve monitoring frameworks using automated systems to monitor and track compliance
- ☑ conduct internal audits and reviews of processes and procedures to test compliance
- ☑ engage external auditors or consultants periodically to provide an independent assessment of compliance
- ☑ carefully consider their benchmark reports and understand the implications, particularly where reporting appears inconsistent with peer insurers.

We intend to increase our scrutiny on reporting outliers in the coming periods to minimise the risk of under-reporting and maintain the effectiveness of the Code.

Re-opened claims

A high rate of acceptance for claims reopened following a complaint or a request for review raises concerns about the quality of the initial assessments.

Insurers reported 1,594 reopened claims in the 2022-23 reporting period. Of these:

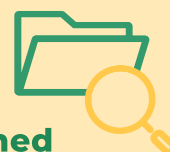
- 1,051 (66%) were admitted
- 254 (16%) were undetermined
- 158 (10%) were declined
- 131 (8%) were withdrawn.

Three insurers accounted for 1,219 (76%) of the 1,594 reopened claims.

A complaint or a request for review was the catalyst for 282 claims being reopened. Of these, 251 (89%) were admitted, an increase on the 73% in the last reporting period.

1,219

of the 1,594 reopened claims were due to three insurers



For a customer, having a claim re-evaluated is a significant burden that takes time and energy.

Given that we called attention to the high number of claims being reopened and admitted in our 2021-22 data report, this increase is a disappointing result.

For a customer, having a claim re-evaluated is a significant burden that takes time and energy.

For an insurer, frequently re-evaluating claims places a strain on resources, increases costs and has an adverse effect on overall efficiency.

Addressing this issue by improving the initial claims assessment process is crucial for fair outcomes, for maintaining customer trust, for continued compliance with obligations, and for efficient operations.

Insurers must analyse the claims that were admitted after being reopened to understand the issue and ensure improvements that prevent recurrence. Drawing insights from these incidents and acting to improve is an important piece of an insurer's work.

We will make further enquiries with insurers that have had the highest ratio of these claim outcomes across the last two years to understand how they analyse and act on their data to improve practices.

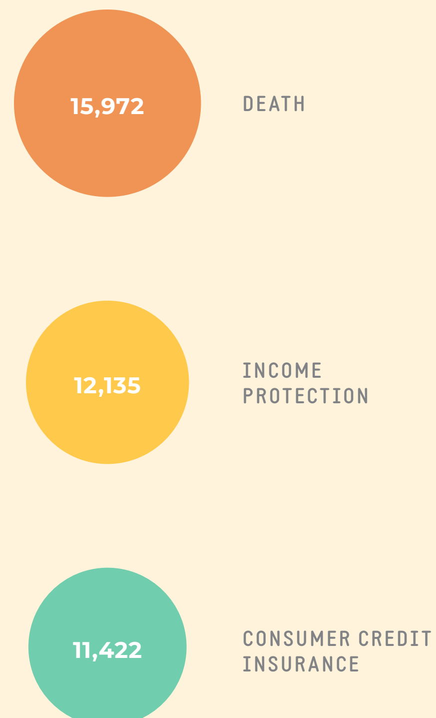
A surge in complaints

We saw a significant increase in reported complaints in the 2022-23 reporting period.

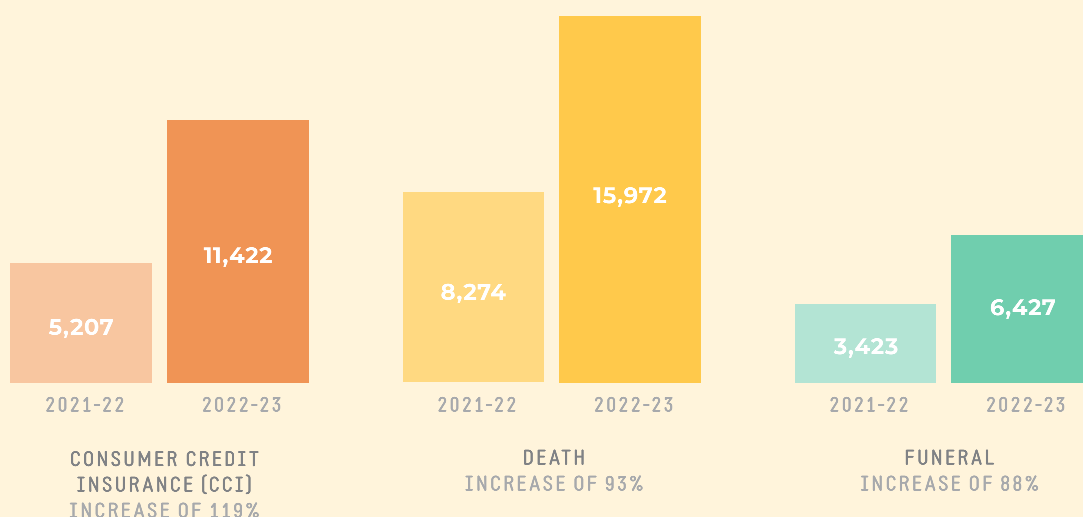
Insurers reported receiving 75,246 complaints in 2022-23, a 53% increase on the 2021-22 period, and the highest number in a six-year upward trend.

While all channels had an increase, complaints about insurance obtained directly from insurers (Direct and Direct Third-Party channels) saw a sharp increase, rising 76% from 14,717 in 2021-22 to 25,846 in this reporting period.

Insurance products that were subject of most complaints:



Insurance products with the largest increases in complaints:



Service was the most common reason for complaints, accounting for 31% of the total (23,082 complaints). Some insurers attributed this increase to greater volumes of calls in call centres and the extended wait times for customers.

One insurer was responsible for 80% of the reported complaints about CCI. The insurer cited the prevalence of third-party fee-for-service firms such as, 'Claimo', 'Remediator' and 'Get My Refund'. These companies actively solicit complaints from customers via social media with offers to claim refunds on a 'no win, no fee' basis.

Insurers noted that an increase in complaints was expected in this period as a consequence of regulatory change in 2021-22, which brought in a broader definition of complaint and led to improved complaints-handling and reporting practices.

Complaints act as a valuable indicator of potential problems or challenges within an organisation.

Complaints data is fundamental in shining a light on practices and processes that require improvements. Collecting data and taking the time to analyse it is vital for identifying and understanding the causes of complaints, addressing them, and improving customer experiences and outcomes.

Insurers need to do more to reduce the number of complaints.

Complaints data is fundamental in shining a light on practices and processes that require improvements.

Data

Breaches

CHART 5.

Breaches of the Code for the last four reporting periods

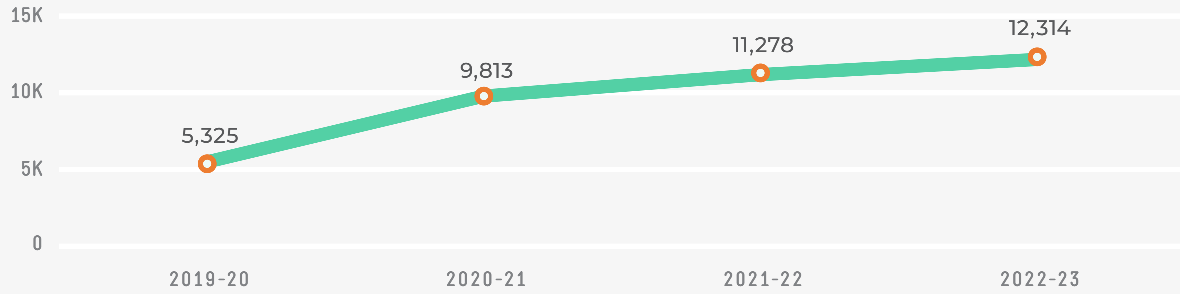
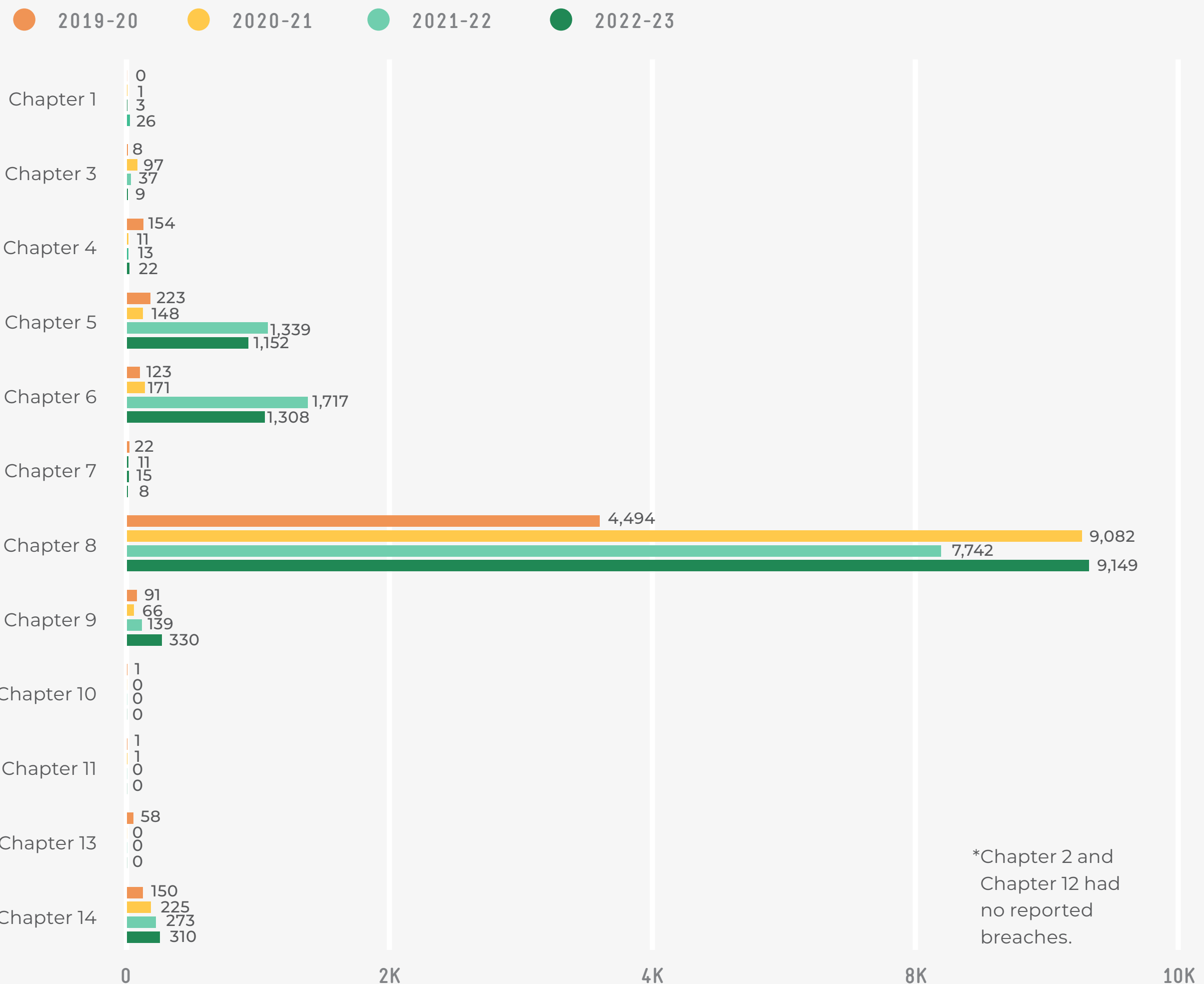


CHART 6.

Breaches by Code chapter in the last four reporting periods*



*Chapter 2 and Chapter 12 had no reported breaches.

Complaints

CHART 7.

Reported complaints in the last four reporting periods

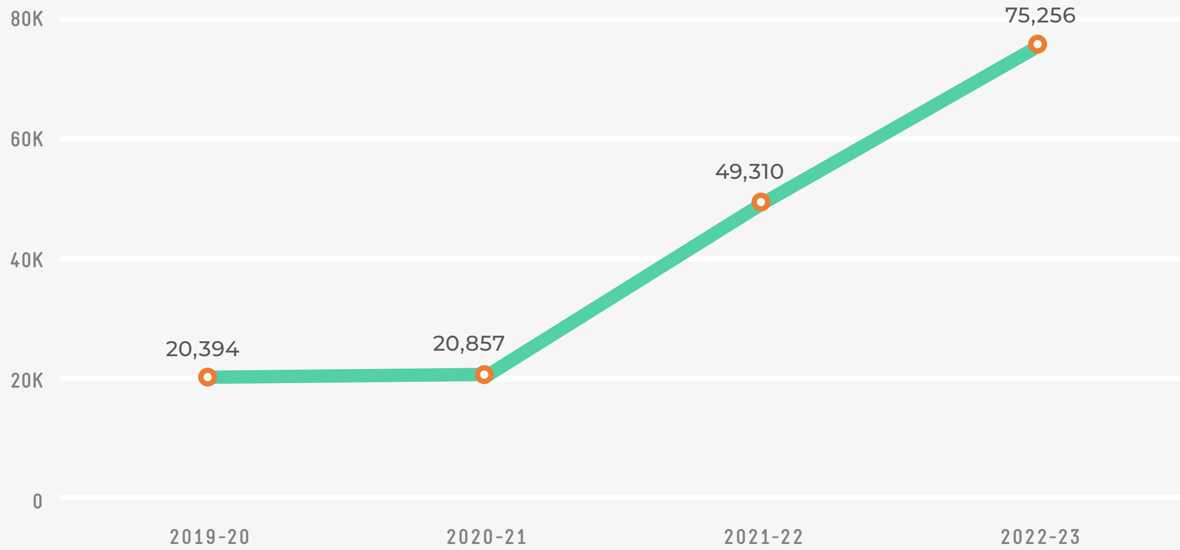


CHART 8.

Reported complaints by distribution channel in the last four reporting periods

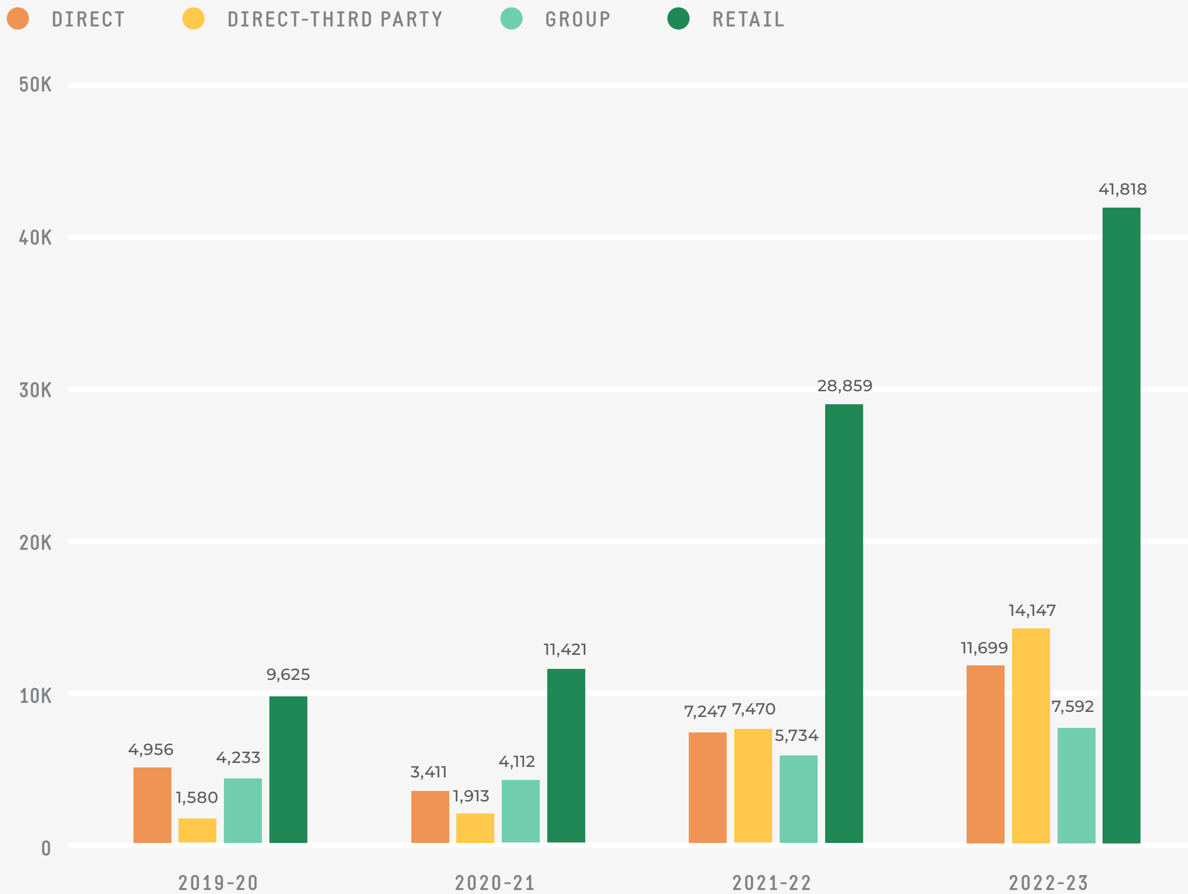


CHART 9.

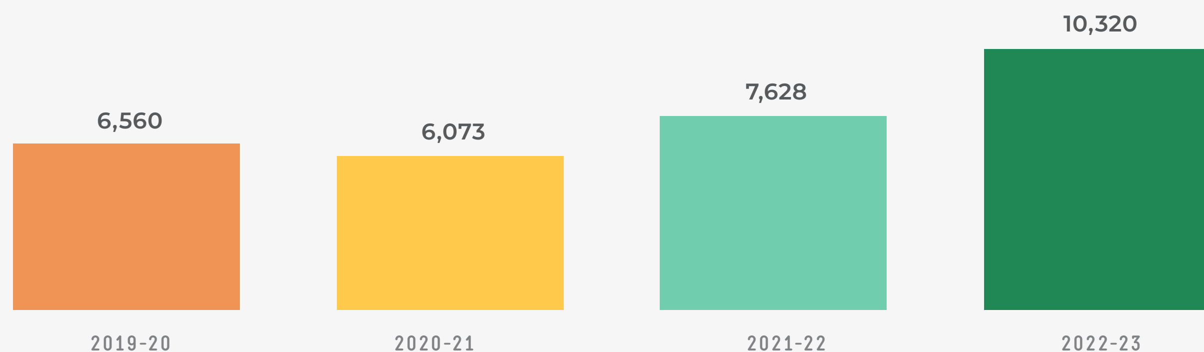
Reported complaints by product type in the last four reporting periods

Product type	2019-20	2020-21	2021-22	2022-23
Death	8,754	2,696	8,274	15,972
Income Protection	10,394	9,290	9,296	12,135
CCI	5,974	4,418	5,207	11,422
Funeral	934	1,046	3,423	6,427
TPD	5,662	3,946	2,582	3,881
Trauma	2,962	950	1,133	1,810
Accident	738	230	368	289
Multiple benefits	5,370	19,138	19,027	23,320

0 5K 10K 15K 20K 25K

CHART 10.

Reported claims-related complaints in the last four reporting periods



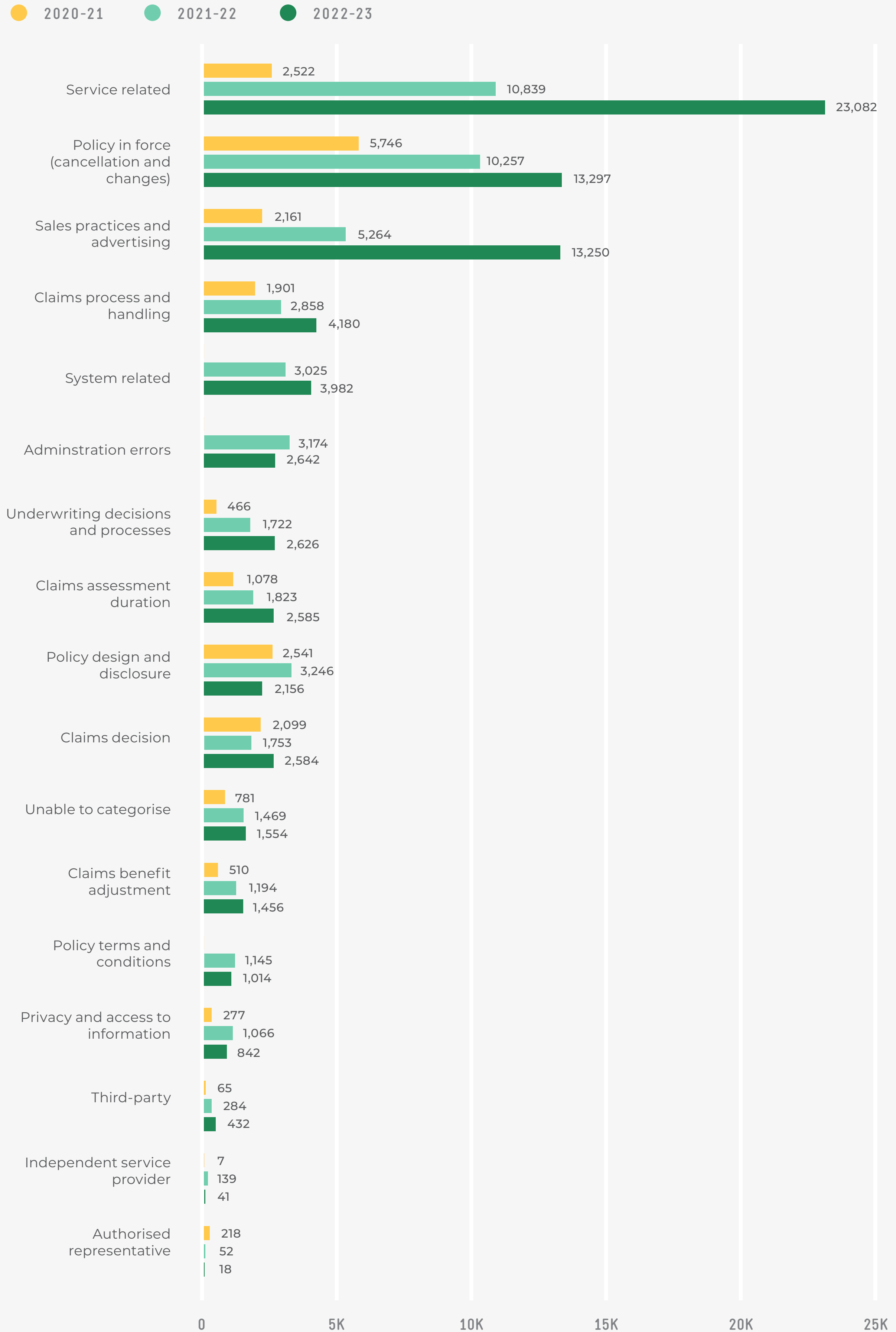


CHART 11.
Number of complaints received by cause in the last three reporting periods
2020-21
2021-22
2022-23
Service related
2,522
10,839
23,082
Policy in force (cancellation and changes)
5,746
10,257
13,297
Sales practices and advertising
2,161
5,264
13,250
Claims process and handling
1,901
2,858
4,180
System related
3,025
3,982
Adminstration errors
3,174
2,642
Underwriting decisions and processes
466
1,722
2,626
Claims assessment duration
1,078
1,823
2,585
Policy design and disclosure
2,541
3,246
2,156
Claims decision
2,099
1,753
2,584
Unable to categorise
781
1,469
1,554
Claims benefit adjustment
510
1,194
1,456
Policy terms and conditions
1,145
1,014
Privacy and access to information
277
1,066
842
Third-party
65
284
432
Independent service provider
7
139
41
Authorised representative
218
52
18
0
5K
10K
15K
20K
25K

CHART 12.

Dispute resolution process in the reporting period

92%
Internal Dispute Resolution (IDR)

8%
External Dispute Resolution (EDR)

Claims

CHART 13.

Claims assessed and determined in the last four reporting periods

CLAIMS ASSESSED CLAIMS DETERMINED

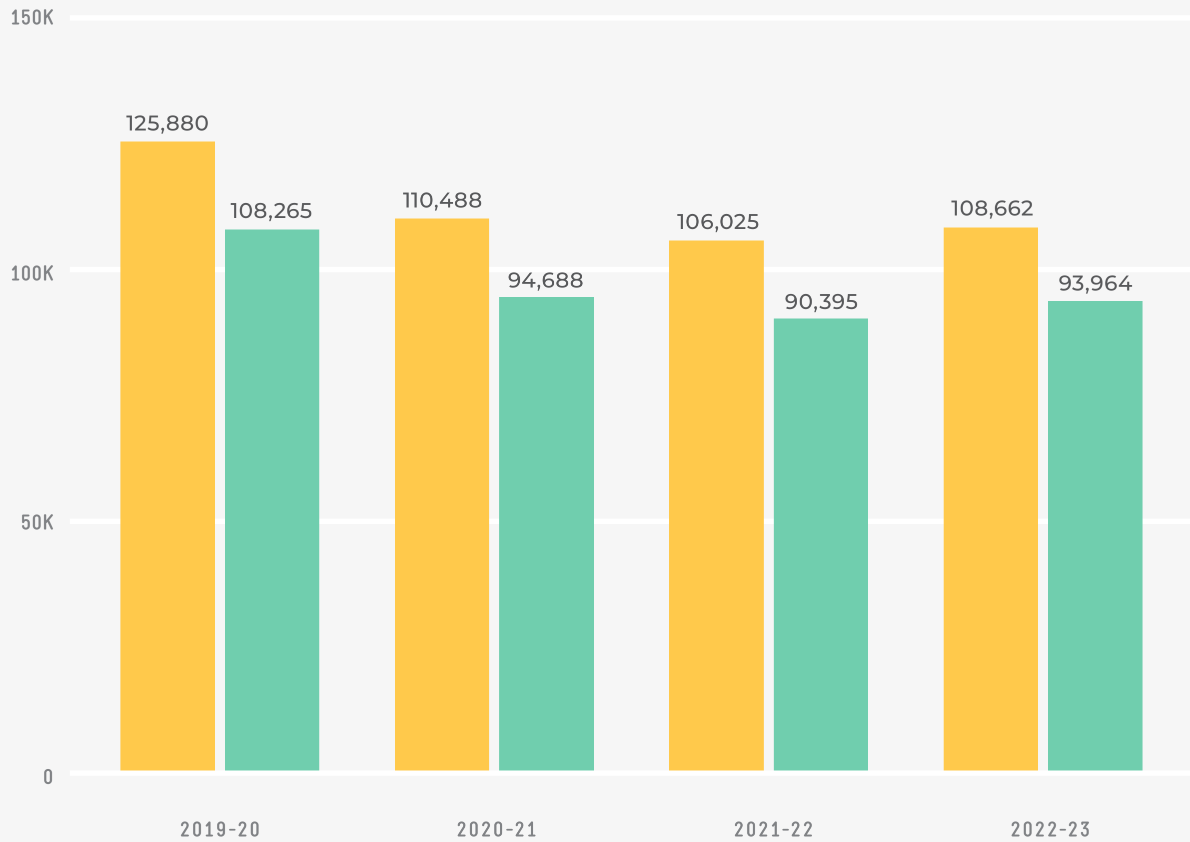


CHART 14.

Timeframes for claims decisions (not income related) in the last four reporting periods

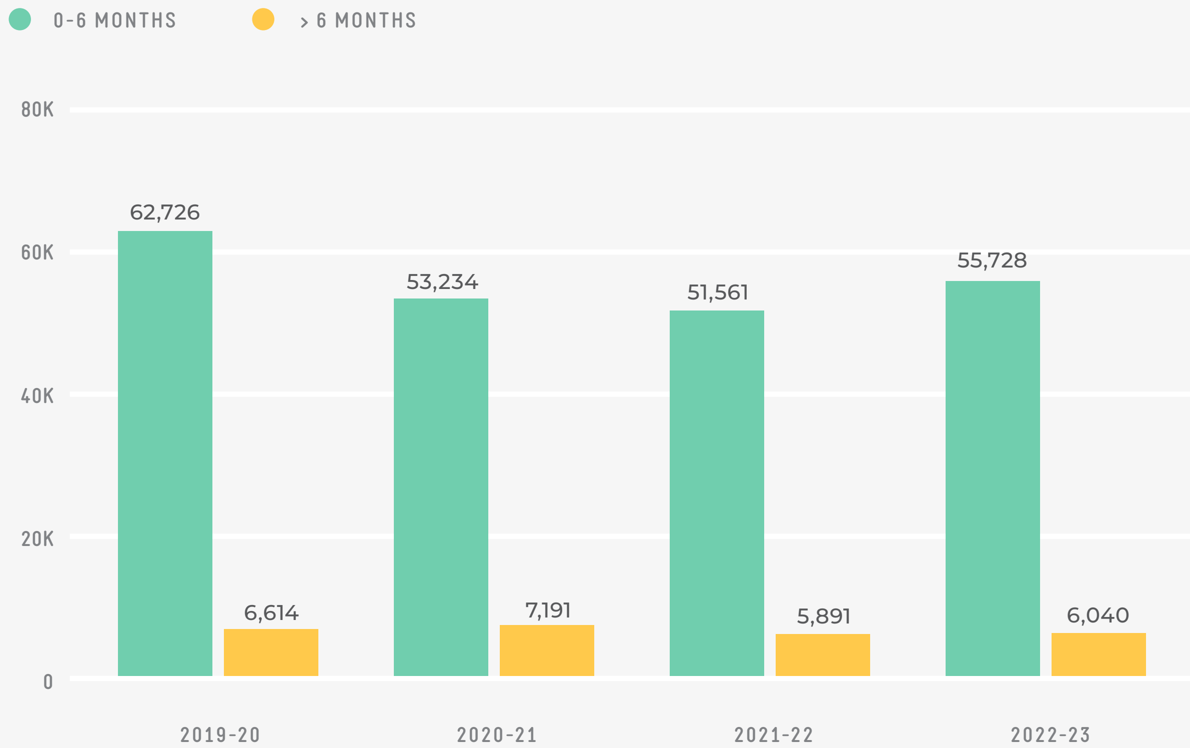
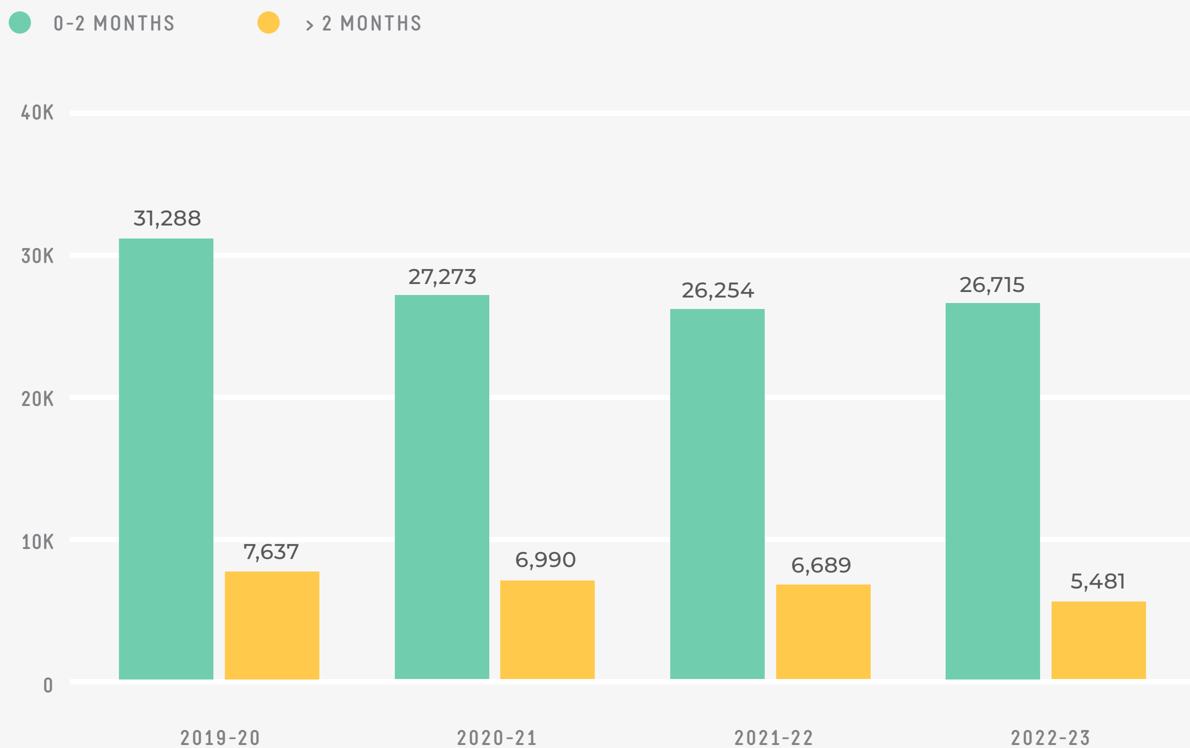


CHART 15.

Timeframes for claims decisions (income related) in the last four reporting periods



About us

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 Council of Australian Life Insurers (CALI) are required to adopt the Code.

We are independent body that monitors compliance with the Code, supports its objectives and protects the interests of customers. We do this by:

- monitoring, enforcing, and reporting on Code compliance
- working collaboratively to improve Code standards and promote good practices in the industry.

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

The Life Code Compliance Committee (Life CCC) includes three members:

- an independent Chair, Jan McClelland AM, co-appointed by CALI and AFCA
- an industry representative, Brad Clarke, appointed by CALI
- a consumer representative, Alexandra Kelly, appointed by the consumer directors of the AFCA Board.

You can read more about the Life Code Compliance Committee on its website.

Life Code Compliance Committee
lifeccc.org.au