RESPONSE TO SUBMISSIONS

Life insurance - public reporting of claims information - update on progress

24 May 2018

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Executive summary

The Australian Prudential Regulation Authority (APRA) and the Australian Securities and Investments Commission (ASIC) (the agencies) are working with industry to collect and publish comprehensive and reliable life insurance claims information. In this paper the agencies:

- publish granular policy, claims and disputes data at an aggregated industry level for the period 1 January 2017 to 30 June 2017;
- respond to submissions received about the Discussion Paper of May 2017; and
- set out the proposed next steps in the data collection and publication work, and seek feedback on the agencies' proposals.

The agencies encourage stakeholders to review the industry level data and provide feedback on proposals, including how the agencies plan to publish insurer specific data from 2019.

The agencies started this work on public reporting of life insurance claims information after ASIC released *Report 498 Life insurance claims: An industry review* (Report 498) in October 2016, with the aim of improving the accountability and performance of life insurers. Public reporting will mean publication of credible, reliable and comparable data at the aggregate industry level as well as individual insurer level.

The agencies are now well advanced in their progress towards public reporting of claims and disputes in the life insurance industry.

The agencies adopted a two phase approach to this work: the first involves collecting three rounds of data in a pilot process to establish an effective and consistent collection approach (pilot data collection), and the second is the ongoing collection and publication of credible, reliable and comparable data (ongoing reporting phase).

The agencies have now completed the first two rounds of the pilot data collection. The agencies have settled on common definitions to help ensure consistent and comparable data, and these have now been broadly adopted by industry. The agencies have considered and acted on feedback received to help shape the pilot data collection for example, in relation to the format of data reporting, and the manner of data publication.

The pilot data collection gathers general policy data on the underlying inforce business, data on claims received, data on claims related disputes (subject to an internal and/or external dispute resolution process, as well as those proceeding to litigation), as well as claims and dispute processing durations.

Having completed two rounds of data collection and analysis, the agencies are pleased to be able to release aggregate industry level data at a more granular level than was issued in November 2017. This more granular level data is an important step towards achieving the objectives of this work, and will materially enhance transparency and help inform public discussion. The agencies are confident that the data will be sufficiently robust to support insurer level publication by early 2019. This is due to the agencies' work with industry in developing standard definitions of claims outcomes, and insurers improving their data quality.

The industry level data published in this paper is broadly consistent with the findings of the data the agencies released in November 2017, and with the findings published in Report 498. The data shows that overall, more than 90% of claims where a decision has been made are paid in the first instance. The claims paid rates differ for the different cover types and distribution channels, as shown in the findings set out in this paper.

The data quality in the second round of data collection improved compared to the first round and the agencies found that insurers were better prepared for the second data request than the first. The limitations of insurers' legacy systems and their reliance on manual processes continue to pose challenges, particularly where data is not currently being stored in the form requested. The agencies expect the impact of these challenges will reduce as the agencies progress the next round in the pilot data collection, and then move from the pilot data collection phase into the ongoing reporting phase. Experience from the second round of the pilot data collection will inform the third and final round of the pilot data collection, which the agencies will launch shortly.

As the agencies are now starting the final round of the pilot data collection, this paper sets out next steps following the pilot: the ongoing collection and publication of credible, reliable and comparable data, both at industry aggregate and individual insurer level.

Once the pilot data collection is complete, the agencies propose that for the ongoing reporting phase:

- APRA will require insurers to provide the data under a Claims Data Reporting Standard (Reporting Standard) issued under the *Financial Sector (Collection of Data) Act 2001* (FSCODA);
- all data collected by APRA under the Reporting Standard should be determined 'non-confidential' under the *Australian Prudential Regulation Authority Act 1998* (APRA Act) on the basis of APRA's preliminary view that the public interest in access to the data outweighs any commercial detriment; and
- aggregate industry level, and insurer specific life insurance claims and disputes data will be regularly published by the agencies.

The agencies now seek stakeholder feedback on each of these proposals. A suggested model for insurer specific data publication is included in this paper for comment.

The agencies consider that robust reporting offers the life insurance industry an opportunity to better understand and communicate claims performance to the community. The industry has acknowledged this by approaching the agencies via the Financial Services Council (FSC) with a proposal to engage and fund an independent data expert to collect and analyse claims and disputes data.

Under the proposal this independent data expert would help insurers to provide the required data to the agencies, and would bolster the industry's data capabilities. Importantly, each insurer would be obliged to report data to APRA and would be responsible for the quality of their data. The agencies recognise merit in this independent expert proposal as a way to help insurers to meet their regulatory obligations and also to deliver enhancements to the industry's data analysis capability. The agencies have indicated that they support the proposal in principle. This support is subject to a number of conditions, including that the proposal can be implemented in accordance with the agencies' timetable and consistent with the agencies' objectives for the collection and publication of the data.

The agencies are continuing to work with industry to ensure that their independent expert proposal meets the objectives of the project. APRA intends to finalise the proposed Reporting Standard later in 2018, and then to collect data under that standard in late 2018. The agencies plan to publish insurer specific data as soon as practicable afterwards, in early 2019.

Feedback on the proposals for publication of life insurance claims data should be submitted to lifeclaimsdata@apra.gov.au by 5 July 2018.

Chapter 1 – Introduction

1.1 Background

This response paper sets out proposals by the Australian Prudential Regulation Authority (APRA) and the Australian Securities and Investments Commission (ASIC) (the agencies) to jointly establish public reporting on life insurance claims and disputes.[1] This work started after ASIC issued 'Report 498 Life insurance claims: An industry review' (Report 498) in October 2016.[2]

The agencies have released two previous papers to develop the public reporting regime:

- Discussion Paper 'Towards a transparent public reporting regime for life insurance claims information' (Discussion Paper) in May 2017; and
- Information Paper 'Update on steps to implement a public reporting regime for life insurance claims information' (Information Paper) in November 2017.[3]

1.2 Objectives

The objectives of the public reporting regime for life insurance claims information are to:

- improve accountability and performance of life insurers in relation to claims; and
- facilitate an informed public discussion about the performance of the life insurance industry.

These objectives will be achieved through publication of credible, reliable and comparable data. The agencies' intention is for this data to be collected and published on each insurer with sufficient granularity to allow for meaningful comparisons of insurer claims performance, and with sufficient context and accessibility to effectively inform policyholders and other interested people.

[1] APRA is the prudential regulator of the Australian financial services industry. It oversees banks, credit unions, building societies, general insurance and reinsurance companies, life insurance, private health insurance, friendly societies and most of the superannuation industry. ASIC is Australia's corporate, markets and financial services regulator.

[2] http://www.asic.gov.au/regulatory-resources/find-a-document/reports/rep-498-life-insurance-claims-an-industry-review/

[3] http://apra.gov.au/lifs/Pages/Life-Claims-Data-Collection-.aspx

Enhanced transparency can help ensure that community confidence and trust in the industry reflect insurers' performance. Transparent information about the industry and the products sold to customers helps people to hold insurers accountable for their performance, creates an environment where there is better understanding of the operation of the industry, and helps people make informed choices about life insurance products.

1.3 Project phases and status

In May 2017, the agencies started a two-phased approach to developing the public reporting regime:

- pilot data collection – this phase involves three collections of data, each followed by incremental refinements to the data requested; and
- ongoing reporting– this phase involves the regular collection and publication of credible, reliable and comparable data, with publication of aggregate industry and individual insurer data. Data will be published on each insurer, subject to criteria set out in this paper.

1.4 This paper

This paper:

- provides an update on the second round of the pilot data collection and publishes aggregate industry data including: policy data, claims outcome by product and distribution channel, disputes data by product and distribution channel, and claims and dispute processing durations;
- responds to submissions received in response to the May 2017 Discussion Paper;
- consults on the approach that the agencies propose to take to the ongoing reporting phase, after completion of the pilot data collection.

The agencies seek feedback on this approach, and have included a suggested approach and format for insurer specific data publication in this paper.

1.5 Balancing financial safety and other considerations

APRA's mandate includes balancing the objectives of financial safety and efficiency, competition, contestability and competitive neutrality, and, in balancing these objectives, promote financial system stability in Australia. APRA considers that, on balance, the proposals in this paper will improve efficiency and competition within the life insurance sector.

PRIMARY OBJECTIVES	
Financial safety ⟷	Financial system stability ⟷
No material change: the proposals in this paper have no material impact on financial safety.	No material change: the proposals in this paper have no material impact on financial system stability.

OTHER CONSIDERATIONS	
Efficiency ⇧	Improved: the proposals in this paper are expected to improve efficiency by making the performance of life insurers more transparent.
Competition ⇧	Improved: transparency of claims handling and dispute data may have a positive impact on competition.
Contestability ⟷	No material change: the proposals in this paper have no material impact on contestability.
Competitive neutrality ⟷	No material change: the proposals in this paper have no material impact on competitive neutrality.

Chapter 2 - Update on pilot data collection

2.1 Progress of pilot

The pilot data collection is well advanced, with two rounds of pilot data collection having been completed.

APRA's November 2017 Information Paper released initial, aggregated industry results of the first pilot data collection. The agencies expressed an intention to publish significantly more data when it became sufficiently credible, reliable and comparable.

Figure 1 – progress towards completion of pilot data collection

May 2017	June/July 2017	November 2017	Jan/Feb 2018	May 2018	July 2018	
Discussion Paper and Data Request 1	Data collected	Information Paper and Data Request 2	Data collected	Response Paper and Data Request 3	Data due to be submitted	COMPLETE
ROUND 1		ROUND 2		ROUND 3		

2.2 Results of second round of pilot data collection

Overview

The first round of data that the agencies collected was for the period 1 January 2016 to 31 December 2016 (12 months). The second round of data was for the period 1 January 2017 to 30 June 2017 (6 months).

The first round included the following products: Death, Total and Permanent Disability (TPD), Trauma and Disability Income Insurance (DII). The second round included all the products collected in the first round, plus Consumer Credit Insurance (CCI), Funeral and Accidental Cover.

The data that the agencies collected included:

- policy statistics, including number of lives insured, policy contracts, annual inforce premium and sums insured;

- detail on claims reported, including outcomes and claims processing durations; and
- detail on claims related disputes, including outcomes and dispute processing durations.

Information was collected across a number of data dimensions, including cover type (covering the products listed above), insurance type (individual vs group insurance), advice type (advised vs non-advised for individual insurance), on-sale status (open vs closed for new business) and dispute type (internal, external and litigated disputes).

The collection covered the majority of insurance risk products in the Australian life insurance market. Table A.1 in Appendix A contains a summary of the business covered by the collection.

The agencies found that the reliability and comparability of the data improved in the second round of the pilot data collection, and is now sufficiently robust to release significantly more data than was possible in the November 2017 Information Paper. Publication of this additional, granular aggregate level data is an important step towards achieving the objectives of this work, and will materially enhance transparency and inform public debate.

Overall, the results of the data collected in the second round of the pilot are consistent with the results released in the November 2017 Information Paper, and with the finding in Report 498, that more than 90% of claims where a decision has been made are admitted in the first instance.

In interpreting these results, it is important to understand that there will always be a portion of claims received by insurers that are legitimately declined by insurers. These include instances where claimants do not meet the contractual policy definition, or where claims are submitted on a fraudulent basis. For this reason, the decline rate and withdrawal rate are not expected to be zero. Indeed, it is important to the prudential soundness of an insurer that sound claims management processes are in place to identify which claims are valid in accordance with the terms of the policy and ensure those claims are paid.

Additionally, types of cover have different characteristics, and the claims and dispute outcomes are expected to differ. For example, it is inherently more difficult to assess trauma and TPD claims than death claims; and so decline rates could reasonably be expected to be higher for trauma and TPD than for death claims. The agencies assessment is that the data findings set out in this paper reflect these differences and are therefore consistent with expectations.

Results

This section contains a summary of the results from the claims and dispute data collected in round two of the pilot. Appendix A includes additional data.[4]

The following table sets out a number of definitions and explanations of the data published in this paper. Where an item is defined, that definition applies to all subsequent instances of that item, unless indicated otherwise. This includes the additional detail in Appendix A.

Claims reported	Claims reported is the sum of claims that were reported to insurers during the reporting period, claims that insurers re-opened during the reporting period, and claims that were undetermined at the start of the reporting period.
Ratios	The ratios for claims finalised, claims withdrawn and claims undetermined at end reflect the share of reported claims in each of these categories. These should normally add up to 100%, but due to rounding this will not always be the case. The ratios for claims admitted and claims declined reflect the share of finalised claims in respect of each of these categories.
Claims admitted	Claims admitted include all outcomes where the contractual benefit has been paid, including where this was done on an ex-gratia basis.
Claims declined	Claims declined include all outcomes where no benefit was paid, or where a partial payment was made on an ex gratia basis but lower than had it been admitted.
Disputes lodged	Disputes lodged is the sum of disputes that were lodged during the reporting period and disputes that were undetermined at the start of the reporting period.
Disputes with original decision maintained	Disputes where the original decision is maintained reflect those instances where the original claims outcome is maintained, usually to the benefit of the insurer.
Disputes with original decision reversed	Disputes where the original decision is reversed reflect those instances where the original claims outcome is reversed or amended, usually to the benefit of the claimant.

[4] The results include all information collected from insurers, with the exception of:

- subsets of CCI business (all benefits other than death cover) and Accidental cover (Accidental Injury) where there is a significant overlap with products offered by general insurance (GI) writers. Given the similarity of products sold by life and general insurers in these categories, there is a risk that results may not be understood and interpreted in a consistent way.
- Accidental death business, where a number of challenges with data quality, combined with a very low volume of claims submitted meant results were not deemed to be sufficiently credible for publication at this time.

Distribution channel	Individual insurance sold with personal advice (typically through financial advisors), individual insurance sold without personal advice (typically direct) and group insurance (where personal advice is not relevant at a member level) are shown separately.

Table 1: Second pilot round summary and comparison with first pilot round

Claims Outcomes	Pilot round 1 (1 Jan '16 to 31 Dec '16)		Pilot round 2 (1 Jan '17 to 30 Jun 17) (same products as round 1)		Pilot round 2 (1 Jan '17 to 30 Jun 17) (All products)	
	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	126,300		64,217		71,170	
Claims Finalised	103,100	82% of reported	40,739	63% of reported	47,069	66% of reported
-Claims Admitted	*95,000*	*92% of finalised*	*37,694*	*93% of finalised*	*43,920*	*93% of finalised*
-Claims Declined	*8,100*	*8% of finalised*	*3,045*	*7% of finalised*	*3,149*	*7% of finalised*
Claims Withdrawn	6,400	5% of reported	4,514	7% of reported	4,604	6% of reported
Claims Undetermined at End	16,800	13% of reported	18,964	30% of reported	19,497	27% of reported

Table 1 summarises the results from the second round pilot data collection and provides a comparison with the results from the first round pilot collection. Results are compared using a subset of products consistent with the first round of the pilot data collection, as well as the expanded set of round two products. Compared to the first round results, there has been a significant reduction in the proportion of reported claims finalised within the reporting period. This is mostly the result of the second round having a much shorter reporting period, with a commensurately lower number of reported claims. Adjusting for this effect, the portion of finalised claims increases to 77% (based on the full set of round two products).

Table 2: Claims outcomes by cover type

Cover / Product Type	Claims Finalised % of reported	*Claims Admitted* *% of finalised*	*Claims Declined* *% of finalised*	Claims Withdrawn % of reported	Claims Undetermined at End % of reported
Death	71%	*97%*	*3%*	3%	26%
TPD	49%	*84%*	*16%*	7%	44%
Trauma	72%	*87%*	*13%*	6%	23%
DII	68%	*95%*	*5%*	9%	23%
CCI Death	73%	*92%*	*8%*	2%	25%
Funeral	95%	*99%*	*1%*	1%	4%
All	**66%**	***93%***	***7%***	**6%**	**27%**

Table 2 summarises the claims outcomes by cover type. The lower admittance rate in respect of TPD and Trauma reflects the complexities of assessing these claims, as well as clarity on what constitutes a valid claim. Given their complex nature, TPD claims usually take longer to assess, as is reflected in the higher proportion of undetermined claims. Conversely, funeral claims are normally relatively simple and processed reasonably quickly.

Table 3: Admittance rate by cover type and distribution channel

Cover / Product Type	All	Individual Advised	Individual Non-Advised	Group
Death	97%	98%	88%	98%
TPD	84%	86%	67%	84%
Trauma	87%	87%	84%	*
DII	95%	95%	83%	96%
CCI Death	92%		92%	*
Funeral	99%		99%	
All	**93%**	**93%**	**95%**	**93%**

* Small volumes of claims reported, but masked for reasons of confidentiality.

Table 3 summarises the claims admittance rate by cover type and distribution channel. Trauma and CCI Death claims in respect of Group business has been masked for reasons of

confidentiality. The numbers of reported claims for these categories are however very low. TPD claims in respect of Individual Non-Advised business also reflect relatively low volumes of claims, which would typically contribute to more volatility in results. Whilst individual non-advised business has a higher aggregate admittance rate, it is worth noting that this is mainly a result of the contribution of funeral business.

More detailed information on claims outcomes by cover type and distribution channel is provided in tables A.2 to A.5 in Appendix A.

Table 4: Claims processing duration by cover type

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0-2 weeks	52%	15%	33%	33%	62%	76%
> 2 weeks to 2 months	22%	18%	42%	41%	15%	20%
> 2 months to 6 months	17%	31%	21%	19%	13%	3%
> 6 months to 12 months	5%	20%	3%	4%	4%	0%
> 12 months	4%	15%	2%	3%	6%	0%

Table 4 summarises claims processing durations in respect of finalised claims. This is the period of time from when a claim is reported to when it is finalised. The table shows, for each cover type, the distribution of finalised claims between different duration categories. A breakdown of this information by distribution channel is reflected in Tables A.6 to A.9 in Appendix A.

Table 5: Disputes outcomes by cover/product type

Cover / Product Types	Disputes Resolved % of lodged	*Original decision maintained* *% of resolved*	*Original decision reversed* *% of resolved*	*Other decisions* *% of resolved*	Disputes Withdrawn % of lodged	Disputes Undetermined % of lodged
Death	60%	*40%*	*31%*	*30%*	5%	35%
TPD	46%	*32%*	*17%*	*52%*	3%	52%
Trauma	68%	*60%*	*21%*	*19%*	1%	30%
DII	62%	*47%*	*25%*	*28%*	4%	34%
CCI Death	84%	*50%*	*31%*	*19%*	-	16%
Funeral	93%	*29%*	*7%*	*64%*	-	7%
All	54%	*41%*	*22%*	*38%*	3%	43%

Table 5 summarises disputes outcomes by cover type. It includes all disputes in the data collection, namely internal, external and litigated disputes. A total of 2,833 disputes were lodged during the reporting period, including those undetermined at the start of the period. TPD and DII make up the vast majority of disputes, representing 50 per cent and 37 per cent of the total disputes respectively.

Additional detail on disputes outcomes, including a breakdown by distribution channel is included in Tables A.10 to A.13 of Appendix A. Appendix A also includes information on dispute processing durations, similar to that provided for claims in Table 4 above – see Tables A.14 to A.17.

Feedback question 1

Industry level data publication	Are there any aspects of the data tables in this paper, including in Appendix A, that could be improved for the ongoing publication of aggregated industry data? Are there any data items which should be added or removed?

Data quality assessment

The quality of submissions in the second round was generally an improvement on the first round, and most of the issues identified in the first round were addressed or significantly improved. The agencies simplified the template and insurers have increased their familiarity with the concepts introduced in the first round, which likely also contributed to the quality of the second round submissions. However, many submissions still included a number of common errors, which may indicate the absence of a robust quality control and oversight process. The agencies have followed up with insurers to ask for missing data, clarify data anomalies, correct data errors and seek responses on why certain types of data were not provided. The agencies encourage insurers to focus on data quality processes and to transparently indicate issues or concerns they have with their data, ahead of the agencies identifying these matters through analysis.

Many insurers adapted their systems, processes and formulae to enable them to provide data on items previously requested in the first round. This has improved the overall reliability of those data items. Whilst a significant portion of data items and definitions were unchanged from the first round, the aspects that were changed presented some insurers with a challenge, especially where they had developed processes to deliver data consistent with the first round specifications.

The agencies encourage insurers to strike an appropriate balance between improving their systems and processes to enhance the collection and storage of relevant data items, and retaining sufficient flexibility to accommodate further changes and additions that may be necessary.

2.3 Next round of the pilot data collection

The agencies will shortly launch the next and final round of the pilot data collection. The agencies will contact insurers shortly and will provide the revised data template and definitions. The reporting form will be similar to the second round. The agencies are considering changes to the definitions and data template including:

- adding Business Expense Insurance to the collection;
- refining the way that CCI data is collected, e.g. distinguishing between lump sum and monthly benefits and/or between products related to loans (more fixed in nature) vs credit cards (potentially volatile in nature); and
- refining the treatment of a range of matters, including ex-gratia payments, re-opened claims, multiple benefits, premium refunds, claim and dispute scenarios, and claim and dispute processing durations.

The agencies will cover these refinements in more detail when the next round requirements are released. They are expected to improve data quality, address areas of ambiguity and enhance clarity.[5]

The next round of collection will be the final under the pilot phase. From the results of the round three collection some further refinements may be necessary. It is, however, the agencies' view that the collection requirements and related definitions are largely settled, with further changes not likely to be significant. With this in mind, insurers and other stakeholders are encouraged to use the round three collection to share:

- views on the appropriateness of the products covered under this collection and whether any additional products should be considered for inclusion. Views on products where there is an overlap with products offered by general insurers (such as non-death CCI and Accidental Injury) would be of particular interest;
- any significant concerns with the approach and definitions as they currently stand. Views on changes that would improve the consistency of data received would be of particular interest.

The arrangements for the next round of the pilot data collection are summarised in the following table:

What is required?	Use best endeavours to complete the reporting template according to the instructions. The agencies expect insurers to continue to liaise with relevant superannuation fund trustees and other external administrators to ensure that they are aware of, and are able to provide the data required for this collection. The template and definitions will be provided to each relevant insurer shortly and will also be made available on the APRA website.
Reporting entities	All life insurers with directly written business of the types defined for inclusion in the third round of the pilot data collection.
Reporting period	1 July 2017 – 31 December 2017
Due date	Friday 27 July 2018 or such later date as agreed with APRA.
Cover types	Death (with and without terminal illness), TPD, trauma, income protection/group salary continuance, business expense insurance

[5] See also Chapter 4. The agencies consider that the data template and instructions to be used for the third round of the pilot data collection are now sufficiently developed to form the basis of the ongoing reporting phase.

	life insurance component of CCI, funeral insurance, accidental death/injury cover. Investment products such as annuities (lifetime or term certain), investment linked business and investment account business are excluded, but rider benefits of the cover types listed above are included. Other types of business, such as whole of life and endowment policies are excluded. Reinsurance business is excluded, but other business written by reinsurers that comes within the scope outlined above is included.
Where to submit?	Via email lifeclaimsdata@apra.gov.au

Chapter 3 – Response to submissions on the ongoing reporting phase

3.1 Consultation issues

In May 2017 the agencies published a Discussion Paper, and sought feedback on several questions relating to the ongoing public reporting phase. Nine submissions were received from insurers, consumer groups and service providers. Six were public, three confidential.

3.2 Overview of submissions

All submissions acknowledged the value of an ongoing reporting phase and recognised that there is a clear need for public reporting on life insurance claims outcomes at an industry and individual insurer level. The overall approach was welcomed, with general support for the scope of data requested. Some respondents proposed data be collected on a wider range of products. Others, however, suggested that the level of granularity could be onerous for industry. There was some support for data being collected on a line-by-line 'flat file' basis rather than by template or standard reporting forms. A range of views were received on whether the agencies or another organisation should collect data in the ongoing reporting phase.

3.3 Submissions and response

Collection scope – data items

The agencies sought feedback on whether the proposed data items collected in the pilot data collection adequately addressed the objectives of the public reporting regime and whether there additional data items should be collected to help meet those objectives.

Submissions

Overall, it was submitted that the majority of proposed data items addressed the objectives of the public reporting regime. Several submissions suggested that additional data should be collected on claims, such as data relating to cause of claim, circumstances where potential claimants have decided not to lodge a claim or to withdraw their claim, and the circumstances that led to that decision. It was also submitted that more granular data should be collected on the reasons for denied claims so that denial rates could be more comparable across varying conditions and products. A number of submissions also called for the collection of claims and disputes data relating to CCI and funeral insurance.

Additionally, it was suggested that a broader scope of data be collected. For example, it was submitted that data that went beyond claims and disputes data such as systemic issues, serious misconduct reporting (breach reports) to ASIC, refusal of insurance, fraud, investigations and surveillance practices of the industry should be collected.

Some submissions concentrated on specific types of data that should be excluded from the data collection. It was submitted that the policy data, in particular, was requested at a greater level of detail than necessary and contributed to the complexity of the template. It was also submitted that ex-gratia payment data should not be collected on the basis that these are commercial decisions made by insurers. Concern was expressed about the prospect of collecting overturned dispute decisions on the grounds that there are a range of complex reasons that a dispute decision may have been overturned (including incorrect claims decisions, commercial settlements and the receipt of further information), many of which do not imply deficient claims processes.

Some concern was expressed with respect to the timeframes proposed in the May 2017 Discussion Paper. For example, it was submitted that the tight timetable for the pilot data collection would not allow sufficient time for the system changes required to meet the ongoing reporting phase timetable.

Response

The November 2017 Information Paper addressed a number of these issues and the agencies incorporated many of them into the second round of the pilot data collection.

The agencies significantly simplified the policy data collected in the second round. However, the agencies consider that there is value in capturing the data categories used in the first round – such as open/legacy products and whether the product was sold with or without advice.

Taking into account the submissions on the Discussion Paper and the data submitted in the first round, the following additional data was collected in the second round:

- additional products– funeral, life insurance component of CCI, accidental death/injury;
- claim declined reasons;
- claim withdrawn reasons;
- dispute lodged reasons;
- dispute withdrawn reasons; and
- detail on disputes resulting in an overturned claims decision.

The addition of new products to the collection meant several new insurers were added to the second round as their main products were now included in the collection scope.

In addition, refinements were made to clarify the data request and a range of qualitative information was collected to inform possible future template changes. A number of other data items suggested in the submissions fell outside the objectives of the public reporting regime and so have not been included.

Collection method – flat file

The agencies sought feedback on the best way for insurers to provide data having regard to the objectives of this data collection. The agencies indicated that various options were being considered for the way in which insurers could provide data in the future, including collecting data at the level of individual claims and disputes using what is known as a 'flat file' approach.

Submissions

Feedback on this question was mixed, with several respondents considering flat file collection of individual policy data to have significant advantages over collection of aggregated information via a template, whilst others favoured a traditional reporting form. It was submitted that the advantages of 'flat file' collection included the ability to analyse additional data dimensions and different relationships. It was also submitted that the collection of individual records was appropriate as it would be in line with the industry's growing capability to handle large data. Others submitted that the key criteria for a collection method was one which minimises the compliance burden on business.

Response

The agencies have continued to explore the potential for a flat file approach to collection, including collection of further information about the costs and benefits from industry. The agencies consider the key benefit of a flat file collection method is that it allows for collection of more granular information, particularly across multiple dimensions, which is difficult to collect in an aggregated template. The agencies acknowledge that there are potentially significant cost implications associated with developing and implementing the necessary processes and systems.

The agencies note that the industry's proposed independent data expert approach would make use of a flat file collection approach, which could have substantial value in assisting insurers to meet their reporting obligations to APRA and could deliver some of the benefits outlined above. The agencies will continue to explore these matters as part of the ongoing engagement with industry. At this stage, the agencies are not proposing to collect data on a flat file basis for the next round of the pilot data collection or for the ongoing reporting phase.

Publication

The agencies sought feedback on any matters that should be taken into account when consulting on the scope and design of publication, including feedback from data users on their expectations regarding the content of the publications.

The data collection is intended to support two levels of publication in the ongoing reporting phase:

- industry publication on an aggregated basis; and
- insurer level publication with insurers named to facilitate transparency and promote accountability relating to claims performance.

Submissions

It was submitted that different stakeholders, being consumers and market analysts, would have different needs and that the published data should reflect those differences. With respect to market analysts, it was submitted that the public reporting regime would be valuable for financial advisors working with clients and for superannuation trustees working with their members. Publications, it was submitted, should be sufficiently detailed for the different users. Finally, there was broad agreement that published data should include a variety of analytical and visual stimuli for consumers, using where possible, interactive tools.

While it was widely agreed that publication should be accessible online, views on the online location of publications varied widely. Some submitted that publications should be available to consumers at the point of sale to assist them to make decisions, while others submitted that the best location for insurer level data would be the website of each individual insurer.

Responses to the agencies' intention to publish data at an insurer level were broadly supportive. Other comments on the scope of data to be published proposed that data be published by product type, and on claims frequency, acceptance rate and average claims pay-out.

Concerns were expressed across a number of submissions that data could be misinterpreted, warning that it was possible that consumers could cancel or change their insurance cover on an uninformed basis. To mitigate this risk, it was submitted that any publication should contextualise the data. It was also submitted that stakeholder engagement throughout the development of the publication, user testing prior to publication and a consumer education program, could mitigate the risk of misinterpretation.

Response

The agencies have taken the above submissions into consideration in setting out how they will progress to insurer level publication. A suggested model of an insurer level publication is set out in Appendix B of this paper. The above submissions have contributed to the principles

that any publication must be tailored to its audience, readily accessible online and provide sufficient contextualisation around data to minimise the risk of misinterpretation.

The agencies do not accept that it is sufficient for each individual insurer to publish their own data on their website, on the grounds that this would not meet the aim of 'comparable' data and would not be 'readily accessible'. Similarly, the agencies do not intend to prescribe the provision of data at 'point of sale', but consider that advisors, consumer advocates, regulators and the industry itself carry responsibility for assisting consumers to understand the data where needed. The agencies strongly encourage the industry to take the data collection as an opportunity to better educate consumers about the reasons for, and features of, products.

Alternative approaches to data collection

The agencies sought feedback on whether the objectives of the public reporting regime could be met by an alternative to the proposed collection and publication of data by the agencies.

Submissions

Submissions varied considerably on this question. While many supported the Discussion Paper approach, it was also submitted that data collection undertaken by an industry body would be preferable, provided the whole industry could be compelled to provide data.

One submission proposed that the industry finance an independent data collection organisation. Through the Financial Services Council (FSC), industry proposed an alternative approach to meet the need for public reporting on life insurance claims outcomes. Under their proposal the independent data expert would help insurers to provide the required data to the agencies, and would bolster the industry's data capabilities.

Response

The agencies recognise merit in the independent expert proposal as a way to help insurers to meet their regulatory obligations and deliver enhancements to the industry's data analysis capability. On that basis, the agencies support the industry's proposal to engage an independent data expert in principle, subject to meeting the objectives of the project and complying with the timetable.

The agencies are continuing to work with the industry to ensure that the independent expert proposal meets the objectives of the project. To assist all stakeholders in understanding how an independent data expert could contribute to meeting the objectives of the project, the agencies have set out, in Chapter 4, the pathway and timetable towards the ongoing reporting phase.

Chapter 4 – How the agencies will deliver insurer level data publication

4.1 Overview

The agencies propose that the public reporting phase will be undertaken in the following way:

- insurers will be required to provide APRA with data under a Claims Data Reporting Standard (Reporting Standard) determined by APRA under FSCODA;
- all data collected by APRA under the Reporting Standard will be determined to be 'non-confidential' under the APRA Act; and
- regular publication of granular industry-aggregate and insurer level life insurance claims and disputes data will be undertaken by APRA, ASIC or both.

The agencies intend that the proposed Reporting Standard will be determined in 2018, with a first round of data collected under that Standard in late 2018 and a first round of insurer level data published as soon as practicable afterwards. This timeframe is appropriate as the industry is well prepared given the extended pilot data collection phase.

The agencies seek feedback on all aspects of this proposal, and specific consultation questions are contained in this chapter.

4.2 Reporting standard

The proposed Reporting Standard will create a legal obligation on each insurer to submit the required data to APRA in an appropriate form and to appropriate standards of quality.

Having undertaken the pilot data collection phase of this project, the agencies consider that the data template and instructions to be used in the last round of the pilot data collection are sufficiently well developed to form the basis of the ongoing reporting phase. If insurers have a differing view they should provide feedback on the template when completing the last round of the pilot, to be launched shortly.

The structure of the proposed Reporting Standard is set out in the following table:

Authority	The Standard is made under section 13 of FSCODA.
Purpose	For the purpose of APRA's prudential supervision, assisting ASIC to perform its functions and for publication.
Application	All life insurers with directly written business of the types defined for inclusion in the prescribed template.
Commencement	The first reporting period would be 1 January to 30 June 2018. The final round pilot data collection covering 1 July 2017 to 31 December 2017 will be repeated.
Information required	A life company must provide APRA with the information required by the prescribed template for each reporting period. The prescribed template is proposed to be the template used in the last round of the pilot data collection, subject to any further changes resulting that exercise, and is to be completed according to the associated instructions.
Forms and method of submission	The information required by this Reporting Standard must be given to APRA in electronic format using the prescribed template, or by another method notified by APRA prior to submission.
Reporting periods and due dates	A life company must provide the information required by this Reporting Standard in respect of each six-monthly reporting period as prescribed. If, having regard to the particular circumstances of a life company, APRA considers it necessary or desirable to obtain information more or less frequently than set out above, APRA may, by notice in writing, change the reporting periods, or specify reporting periods, for the particular life company.
Quality control	The information provided by a life company under this Reporting Standard must be the product of systems, processes and controls that have been reviewed and tested by the life company.
Authorisation	An officer of a life company submitting information under this Reporting Standard must be authorised by either: (a) the Principal Executive Officer of the life company; or (b) the Chief Financial Officer of the life company.
Variations	APRA may, by written notice to a life company, vary the reporting requirements of the Reporting Standard in relation to that life company.

Transition	The first data collection is proposed to be due by 15 November 2018 and cover data for the periods 1 July 2017 to 31 December 2017 and 1 January 2018 to 30 June 2018. The next two rounds of data collection (being for the periods 1 July 2018 to 31 December 2018 and 1 January 2019 to 30 June 2019 will be due two months after the end of the relevant period. Thereafter, submission timeframes of six weeks are proposed.

Feedback question 2

Proposed Reporting Standard	Are there any aspects of the proposed Claims Data Reporting Standards which require modification? If so why?

4.3 Confidentiality of data

Confidentiality of insurer level data

To meet the objectives of this data collection, it will be necessary to publish data at an insurer level. Accordingly, it is necessary to address the question of data confidentiality under the APRA Act.

Under section 56 of the APRA Act, data is generally not able to be released at an insurer level unless APRA determines the data to be non-confidential under the APRA Act, or if one of the other conditions under that Act have been met. Section 57 of the APRA Act provides that APRA may, by legislative instrument, determine whether data submitted to it by life companies under section 13 of the FSCODA contains non-confidential information.

APRA may determine data to be non-confidential if, after taking into account representations made by entities, it considers that the benefit to the public from the disclosure of the data outweighs the detriment to commercial interests that the disclosure may cause. APRA must not make a determination unless it has given all relevant life insurers a reasonable opportunity to make representations as to whether information of the kind that is proposed to be released is confidential; and has taken any such representations into account. Where APRA makes a determination, APRA may release insurer level data under subsection 56(5C) of the APRA Act.

Further to the opportunity provided in the Discussion Paper, this response paper provides life insurers with the opportunity to make representations regarding data confidentiality.

Proposed non-confidentiality determination

APRA proposes to determine under section 57 of the APRA Act that all data collected under the Reporting Standard is non-confidential.

Data which APRA determines to be non-confidential will identify individual insurers but will not identify individual claimants or breach the privacy of individuals. Not all data that is proposed to be determined to be non-confidential would necessarily be published. The scope of a proposed insurer level publication is discussed in this chapter.

Reasons for proposed determination

APRA has formed the preliminary view that all data collected under the Reporting Standard be determined to be non-confidential because on balance, the benefit to the public from the disclosure would outweigh the detriment to the commercial interests that the disclosure might cause. APRA has reached this preliminary view on the basis set out in the following paragraphs.

Evidence of the public interest includes:

- the announcement made by Minister for Revenue and Financial Services, The Hon Kelly O'Dwyer MP welcoming the agencies work to 'collect and publish data provided by insurers on an ongoing basis, showing rates of declined, approved and withdrawn claims, timeframes for claims decisions and details of insurance-related disputes';[6]

- the view expressed by the Parliamentary Joint Committee on Corporations and Financial Services) that it welcomes the collaboration between ASIC and APRA on the public disclosure regime and 'looks forward to the findings from the next stage of the joint data project';[7]

- submissions received by the agencies in support of publication of identifiable insurer level data;

- alignment with the Australian Government Data Policy on releasing of data to the public;[8]

- general public interest in this data collection and the issue of transparency of life claims and disputes data; and

[6] Media Release: Release of ASIC report on claims handling in life insurance industry (12 October 2016) at http://kmo.ministers.treasury.gov.au/media-release/092-2016/

[7] Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Industry (March 2018) at 10.29.

[8] https://www.pmc.gov.au/resource-centre/data/australian-government-public-data-policy-statement

- potential interaction with other data collection programs, such as that undertaken by the Life Code Compliance Committee.

To date, the agencies have not received evidence from any interested party that disclosure might cause detriment to commercial interests. In APRA's assessment, commercial detriment is unlikely to arise given the nature of the data being collected.

Feedback question 3

Public benefit of a non-confidentiality determination	What would be the potential benefit to the public of the proposed determination that all data collected under the Reporting Standard is non-confidential?

Feedback question 4

Detriment to commercial interests of a non-confidentiality determination	Would potential detriment to commercial interests arise from disclosure of data collected under the Reporting Standard? Submissions that seek to have the data remain confidential should: • specify which data items should remain confidential; and • include specific information on how the disclosure of that information would cause detriment to commercial interests, and the extent to which that could occur.

4.4 Data publication

The ultimate success of the public reporting phase will be measured by the usefulness of the publication to consumers.

The agencies consider that any publication should meet the objective of promoting well-informed decision-making and assisting public discussion on policy issues about the financial sector by regulators, policymakers, and the public.

Data publication should promote transparency and accountability of the financial institutions that the agencies regulate.

Publication principles

The agencies intend that the publication of data will meet the following principles for the public reporting phase for life insurance claims information:

- credible, reliable, comparable data;
- coverage of all direct writers of included insurance products;
- industry-aggregate and insurer level publication allowing for comparisons;
- sufficient granularity to allow for meaningful comparisons;
- accessible to the community, including consumers; and
- sufficient context to effectively inform the community.

Feedback question 5

Publication principles	Are there any aspects of publication principles which could be improved?

Proposed data to be published at insurer level

Appendix B sets out an example of the proposed insurer level publication of data. To support these quantitative results, it is proposed that educational material be developed to help people to understand and interpret the results.

Depending on the quality and timeliness of data collected, the agencies aim to publish a first round of insurer level data in early 2019. The agencies propose that, when the initial round of insurer level publication of data is undertaken, an information paper will accompany the release. The information paper will contain additional contextual information to assist the community to understand the data and how it may be relevant for decision making.

Feedback question 6

Education materials on insurer level publication	What educational material would help people to understand and interpret the results?

Some of the key considerations which underpin insurer level publication are set out in the following table.

Whether the six-monthly publication should be based on discrete six-monthly data, or on a rolling 12-month (or longer) period of data	The agencies propose that a rolling 12 month period is appropriate to reduce short-term volatility in the results.
The number of claims and disputes that represent a statistically credible number for publication purposes	The agencies consider that 50 finalised claims on a rolling 12-monthly basis is an appropriate threshold. All proposed insurer level statistics would be published for each product with at least 50 finalised claims for the rolling 12-month period, including disputes data.
The minimum industry coverage before insurer level publication would occur	The agencies consider that, if more than 30 per cent of all claims finalised for a product are excluded because they relate to insurers that individually fall below the threshold of 50 finalised claims, no data would be published for that product in that reporting period.
The minimum number of insurers required before publication occurs	The agencies consider that the above limit on minimum industry coverage is sufficient to protect commercial interests. For example, if only one insurer exceeds the threshold of 50 finalised claims and its share of all claims finalised exceeds 70 per cent, this insurer's results would be published. The agencies consider that the public benefit of publication outweighs any potential commercial detriment, as no profitability data is released.
The appropriate level of granularity	The agencies consider that publication of results for each combination of product and distribution channel (i.e. individual advised, individual non-advised and group) would be appropriate.
Whether ranges of claims or exact numbers of claims are more appropriate for publication	The agencies propose that exact numbers are appropriate rather than ranges

Feedback question 7

Proposed insurer level publication	Are there any aspects of the proposed insurer level publication in Appendix B which could be improved? Should the assumptions for insurer level publication be changed? If so, why?

Chapter 5 - Information on consultation and cost-benefit analysis

5.1 Request for submissions and feedback questions

The agencies invite written submissions on the proposals set out in this discussion paper. Written submissions should be sent to lifeclaimsdata@apra.gov.au by 5 July 2018, addressed to:

General Manager, Policy Development
Policy and Advice Division
Australian Prudential Regulation Authority

Stakeholders are invited to comment on all aspects of this paper. Specifically, comment is invited on:

Industry-level publication	Are there any aspects of the data tables in this paper, including in Appendix A, that could be improved for the ongoing publication of aggregated industry data? Are there any data items which should be added or removed from this publication?
Proposed Reporting Standard	Are there any aspects of the elements of the proposed Claims Data Reporting Standards which require modification? If so why?
Public benefit of a non-confidentiality determination	What would be the potential benefit to the public of the proposed determination that all data collected under the Reporting Standard is non-confidential?
Detriment to commercial interests of a non-confidentiality determination	Would potential detriment to commercial interests arise from disclosure of data collected under the Reporting Standard? Submissions that seek to have the data remain confidential should: • specify which data items should remain confidential; and • provide specific information on how the disclosure of that information would lead to detriment to commercial interests, and the extent to which that could occur.
Publication principles	Are there any aspects of publication principles which could be improved?

Education materials on insurer level publication	What educational material would help people to understand and interpret the results?
Proposed insurer level publication	Are there any aspects of the proposed insurer level publication in Appendix B which could be improved? Should the assumptions for insurer level publication be changed? If so, why?

5.2 Important disclosure notice – publication of submissions

All information in submissions will be made available on the APRA website unless a respondent expressly requests that all or part of the submission is to remain confidential. Automatically generated confidentiality statements in emails will not suffice for this purpose. Respondents who would like part of their submission to remain confidential should provide this information marked as confidential in a separate attachment.

Submissions may be the subject of a request for access made under the *Freedom of Information Act 1982* (FOI Act). APRA will determine such requests, if any, in accordance with the provisions of the FOI Act. Information in the submission about any APRA-regulated institution which is not in the public domain and which is identified as confidential will be protected by section 56 of the APRA Act and will be ordinarily exempt from production under the FOI Act.

Please note: this disclosure notice relates only to submissions on the consultation questions outlined in this paper. Submissions of completed data templates will be treated as confidential and shared with ASIC for the purposes outlined in this paper.

5.3 Cost-benefit analysis information

To improve the quality of regulation, the Australian Government requires all policy proposals undergo a preliminary assessment to ascertain whether it is likely that there will be new material business compliance costs arising out of any proposed change. Compliance costs are defined as direct costs to businesses of performing activities associated with complying with government regulation.

If an insurer considers that compliance costs will increase significantly as a result of the proposals, it should provide in its submission an assessment of the impact of the proposed Reporting Standard. In particular, APRA is interested in estimates of new costs associated with upgrading existing frameworks to comply with the requirements of the proposed Reporting Standard.

Consistent with the government's requirement, APRA will use the methodology in the regulatory burden measurement framework to assess any increase in compliance costs identified by submissions.[9] This framework is designed to capture the relevant costs in a structured way, including a separate assessment of upfront and ongoing costs. Life insurers are encouraged to use this methodology to estimate any increase in compliance costs as this will enable the data supplied to APRA to be aggregated and used in an industry-wide assessment.

When submitting cost assessments to APRA, stakeholders should include any assumptions made and, where relevant, any limitations inherent in their assessment. Feedback should only address additional material costs incurred as a result of complying with APRA's requirements or expectations, not activities an insurer would undertake regardless of regulatory requirements in their ordinary course of business.

[9] https://pmc.gov.au/regulation/best-practice-regulation

Appendix A – Detailed industry-aggregate results

Table A.1 Policy statistics

All business	Death	TPD	Trauma	DII**	CCI	Funeral	All**
Industry Aggregate							
Lives insured ('000) ***	15,998	14,181	1,266	6,279	1,470	780	*21,024*
Annual premium ($million)	6,069	3,385	1,365	4,646	378	434	16,276
Sum insured ($million)	3,515,181	2,630,938	232,133	*26,605pm*	55,048	12,292	*6,445,592*
Individual Advised							
Lives insured ('000) ***	2,121	1,199	853	929	-	-	*2,996*
Annual premium ($million)	3,082	1,120	1,304	2,395	-	-	7,901
Sum insured ($million)	1,250,571	708,605	214,527	*6,717pm*	-	-	*2,173,703*
Individual Non-Advised							
Lives insured ('000) ***	586	75	*	112	*	780	*2,863*
Annual premium ($million)	533	23	*	138	*	434	1,560
Sum insured ($million)	183,784	15,200	*	*476pm*	*	12,292	*278,976*
Group							
Lives insured ('000) ***	13,291	12,907	*	5,238	*	-	*15,165*
Annual premium ($million)	2,454	2,242	*	2,112	*	-	6,815
Sum insured ($million)	2,080,826	1,907,133	*	*19,413pm*	*	-	*3,992,913*

* Data masked to maintain confidentiality.

** DII is expressed as a monthly benefit, and is excluded from the total sum insured across all products (final column).

*** Total lives insured represents the number of unique lives, with duplication across products eliminated. However, the duplication of lives between individual and group insurance, as well as between insurers, remains.

Table A.2: Claims outcomes by cover type – all distribution channels

Claims Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	14,750		18,288		3,800		27,379	
Claims Finalised	10,493	71%	8,896	49%	2,717	72%	18,633	68%
- Claims Admitted	*10,184*	*97%*	*7,490*	*84%*	*2,353*	*87%*	*17,667*	*95%*
-Claims Declined	*309*	*3%*	*1,406*	*16%*	*364*	*13%*	*966*	*5%*
Claims Withdrawn	454	3%	1,339	7%	222	6%	2,499	9%
Claims Undetermined at End	3,803	26%	8,053	44%	861	23%	6,247	23%

Claims Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	1,157		5,796		71,170	
Claims Finalised	849	73%	5,481	95%	47,069	66%
-Claims Admitted	*779*	*92%*	*5,447*	*99%*	*43,920*	*93%*
-Claims Declined	*70*	*8%*	*34*	*1%*	*3,149*	*7%*
Claims Withdrawn	23	2%	67	1%	4,604	6%
Claims Undetermined at End	285	25%	248	4%	19,497	27%

Table A.3: Claims outcomes by cover type – individual advised business

Claims Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	3,972		1,799		3,246		9,353	
Claims Finalised	2,122	53%	567	32%	2,272	70%	6,203	66%
-Claims Admitted	*2,078*	*98%*	*487*	*86%*	*1,978*	*87%*	*5,880*	*95%*
-Claims Declined	*44*	*2%*	*80*	*14%*	*294*	*13%*	*323*	*5%*
Claims Withdrawn	191	5%	255	14%	197	6%	1,109	12%
Claims Undetermined at End	1,659	42%	977	54%	777	24%	2,041	22%

Claims Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	-		-		18,370	
Claims Finalised	-		-		11,164	61%
-Claims Admitted	-		-		*10,423*	*93%*
-Claims Declined	-		-		*741*	*7%*
Claims Withdrawn	-		-		1,752	10%
Claims Undetermined at End	-		-		5,454	30%

Table A.4: Claims outcomes by cover type – individual non-advised business

Claims Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	1,213		112		*		1,914	
Claims Finalised	681	56%	43	38%	*	80%	1,183	62%
-Claims Admitted	*598*	*88%*	*29*	*67%*	*	*84%*	*981*	*83%*
-Claims Declined	*83*	*12%*	*14*	*33%*	*	*16%*	*202*	*17%*
Claims Withdrawn	53	4%	19	17%	*	5%	257	13%
Claims Undetermined at End	479	39%	50	45%	*	15%	474	25%

Claims Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	*		5,796		10,736	
Claims Finalised	*	73%	5,481	95%	8,673	81%
-Claims Admitted	*	*92%*	*5,447*	*99%*	*8,201*	*95%*
-Claims Declined	*	*8%*	*34*	*1%*	*472*	*5%*
Claims Withdrawn	*	2%	67	1%	444	4%
Claims Undetermined at End	*	25%	248	4%	1,619	15%

* Data masked to maintain confidentiality.

Table A.5: Claims outcomes by cover type – group insurance business

Claims Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	9,565		16,377		*	*	16,112	
Claims Finalised	7,690	80%	8,286	51%	*	*	11,247	70%
-Claims Admitted	*7,508*	*98%*	*6,974*	*84%*	*	*	*10,806*	*96%*
-Claims Declined	*182*	*2%*	*1,312*	*16%*	*	*	*441*	*4%*
Claims Withdrawn	210	2%	1,065	7%	*	*	1,133	7%
Claims Undetermined at End	1,665	17%	7,026	43%	*	*	3,732	23%

Claims Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Claims Reported	*	*	-		42,064	
Claims Finalised	*	*	-		27,232	65%
-Claims Admitted	*	*	-		*25,296*	*93%*
-Claims Declined	*	*	-		*1,936*	*7%*
Claims Withdrawn	*	*	-		2,408	6%
Claims Undetermined at End	*	*	-		12,424	30%

* Data masked to maintain confidentiality.

Table A.6: Claims processing duration by cover type – all distribution channels

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0-2 weeks	52%	15%	33%	33%	62%	76%
> 2 weeks to 2 months	22%	18%	42%	41%	15%	20%
> 2 months to 6 months	17%	31%	21%	19%	13%	3%
> 6 months to 12 months	5%	20%	3%	4%	4%	0%
> 12 months	4%	15%	2%	3%	6%	0%

Table A.7: Claims processing duration by cover type – individual advised business

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0-2 weeks	16%	9%	27%	33%		
> 2 weeks to 2 months	38%	11%	45%	44%		
> 2 months to 6 months	31%	27%	22%	19%		
> 6 months to 12 months	9%	25%	4%	3%		
> 12 months	6%	28%	2%	2%		

Table A.8: Claims processing duration by cover type – individual non-advised business

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0-2 weeks	17%	23%	58%	16%	62%	76%
> 2 weeks to 2 months	27%	7%	25%	45%	15%	20%
> 2 months to 6 months	33%	23%	14%	31%	13%	3%
> 6 months to 12 months	10%	23%	2%	5%	4%	0%
> 12 months	13%	23%	2%	3%	6%	0%

Table A.9: Claims processing duration by cover type – group insurance business

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0-2 weeks	65%	16%	*	35%	*	
> 2 weeks to 2 months	17%	19%	*	39%	*	
> 2 months to 6 months	12%	31%	*	19%	*	
> 6 months to 12 months	4%	20%	*	5%	*	
> 12 months	2%	14%	*	3%	*	

* Data masked to maintain confidentiality.

Table A.10: Detail on dispute outcomes by cover type – all distribution channels

Disputes Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	181		1,426		146		1,046	
Disputes Resolved	108	60%	651	46%	100	68%	644	62%
-Original decision maintained	*43*	*40%*	*206*	*32%*	*60*	*60%*	*303*	*47%*
-Original decision reversed	*33*	*31%*	*109*	*17%*	*21*	*21%*	*163*	*25%*
-Other decisions	*32*	*30%*	*336*	*52%*	*19*	*19%*	*178*	*28%*
Disputes Withdrawn	9	5%	37	3%	2	1%	47	4%
Disputes Undetermined	64	35%	738	52%	44	30%	355	34%

Disputes Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	19		15		2,833	
Disputes Resolved	16	84%	14	93%	1,533	54%
-Original decision maintained	*8*	*50%*	*4*	*29%*	*624*	*41%*
-Original decision reversed	*5*	*31%*	*1*	*7%*	*332*	*22%*
-Other decisions	*3*	*19%*	*9*	*64%*	*577*	*38%*
Disputes Withdrawn	-	-	-	-	95	3%
Disputes Undetermined	3	16%	1	7%	1,205	43%

Table A.11: Detail on dispute outcomes by cover type – individual advised business

Disputes Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	68		180		126		510	
Disputes Resolved	42	62%	92	51%	83	66%	330	65%
-Original decision maintained	*11*	*26%*	*25*	*27%*	*51*	*61%*	*153*	*46%*
-Original decision reversed	*16*	*38%*	*19*	*21%*	*15*	*18%*	*81*	*25%*
-Other decisions	*15*	*36%*	*48*	*52%*	*17*	*20%*	*96*	*29%*
Disputes Withdrawn	-	-	5	3%	2	2%	12	2%
Disputes Undetermined	26	38%	83	46%	41	33%	168	33%

Disputes Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	-		-		884	
Disputes Resolved	-		-		547	62%
-Original decision maintained	-		-		*240*	*44%*
-Original decision reversed	-		-		*131*	*24%*
-Other decisions	-		-		*176*	*32%*
Disputes Withdrawn	-		-		19	2%
Disputes Undetermined	-		-		318	36%

Table A.12: Detail on dispute outcomes by cover type – individual non-advised business

Disputes Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	52		12		20		131	
Disputes Resolved	40	77%	8	67%	17	85%	96	73%
-Original decision maintained	*21*	*53%*	*2*	*25%*	*9*	*53%*	*36*	*38%*
-Original decision reversed	*6*	*15%*	*6*	*75%*	*6*	*35%*	*23*	*24%*
-Other decisions	*13*	*33%*	-	-	*2*	*12%*	*37*	*39%*
Disputes Withdrawn	2	4%	1	8%	-	-	6	5%
Disputes Undetermined	10	19%	3	25%	3	15%	29	22%

Disputes Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	19		15		249	
Disputes Resolved	16	84%	14	93%	191	77%
-Original decision maintained	*8*	*50%*	*4*	*29%*	*80*	*42%*
-Original decision reversed	*5*	*31%*	*1*	*7%*	*47*	*25%*
-Other decisions	*3*	*19%*	*9*	*64%*	*64*	*34%*
Disputes Withdrawn	-	-	-	-	9	4%
Disputes Undetermined	3	16%	1	7%	49	20%

Table A.13: Detail on dispute outcomes by cover type – group insurance business

Disputes Outcomes	Death		TPD		Trauma		DII	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	61		1,234		-		405	
Disputes Resolved	26	43%	551	45%	-		218	54%
-Original decision maintained	*11*	*42%*	*179*	*32%*	-		*114*	*52%*
-Original decision reversed	*11*	*42%*	*84*	*15%*	-		*59*	*27%*
-Other decisions	*4*	*15%*	*288*	*52%*	-		*45*	*21%*
Disputes Withdrawn	7	11%	31	3%	-		29	7%
Disputes Undetermined	28	46%	652	53%	-		158	39%

Disputes Outcomes	CCI Death		Funeral		Total	
	Number	Ratio	Number	Ratio	Number	Ratio
Disputes Lodged	-		-		1,700	
Disputes Resolved	-		-		795	47%
-Original decision maintained	-		-		*304*	*38%*
-Original decision reversed	-		-		*154*	*19%*
-Other decisions	-		-		*337*	*42%*
Disputes Withdrawn	-		-		67	4%
Disputes Undetermined	-		-		838	49%

Table A.14: Dispute processing durations by cover type – all distribution channels

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0 - 45 days	67%	29%	58%	68%	50%	64%
> 45 days to 90 days	10%	12%	26%	12%	14%	29%
> 90 days to 6 months	10%	17%	8%	8%	7%	-
> 6 months to 12 months	4%	23%	3%	6%	14%	7%
> 12 months	9%	18%	4%	7%	14%	-

Table A.15: Dispute processing durations by cover type – individual advised business

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0 - 45 days	77%	42%	56%	63%		
> 45 days to 90 days	5%	16%	25%	12%		
> 90 days to 6 months	5%	18%	10%	11%		
> 6 months to 12 months	-	11%	4%	6%		
> 12 months	13%	13%	5%	8%		

Table A.16: Dispute processing durations by cover type – individual non-advised business

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0 - 45 days	47%	25%	67%	82%	50%	64%
> 45 days to 90 days	17%	38%	33%	13%	14%	29%
> 90 days to 6 months	22%	13%	-	-	7%	-
> 6 months to 12 months	6%	13%	-	4%	14%	7%
> 12 months	8%	13%	-	1%	14%	-

Table A.17: Dispute processing durations by cover type – group insurance business

Duration Category	Death	TPD	Trauma	DII	CCI Death	Funeral
0 - 45 days	75%	27%		70%		
> 45 days to 90 days	8%	11%		11%		
> 90 days to 6 months	4%	17%		7%		
> 6 months to 12 months	6%	25%		6%		
> 12 months	6%	19%		7%		

Appendix B – Draft insurer level publication tables

The agencies request feedback on the table below, which sets out the proposed insurer level publication of data on a product basis.

	Product & distribution channel	Insurer A	Insurer B	...	Industry total
	Policy statistics				
A.1	Market share (by annual premium, as a %)				
A.2	Average sum insured ($)				
	Claims				
B.1	Open claims (number)				
B.2	Finalised claims (number)				
B.3	Claims admittance rate (%)				
B.4	Average claim amount paid ($)				
B.5	Claims withdrawn rate (%)				
B.6	Claims undetermined rate (%)				
B.7	Mean (or median) claims processing duration (months)				
	Disputes				
C.1	Open disputes (number)				
C.2	Disputes resolved (number)				
C.3	Share of disputes resolved in favour of the consumer (%)				
C.4	Average dispute resolved payment amount ($)				
C.5	Dispute withdrawn rate (%)				

	Product & distribution channel	Insurer A	Insurer B	…	Industry total
C.6	Dispute undetermined rate (%)				
C.7	Mean (or median) dispute processing duration (months)				

Notes:

- Subject to the constraints outlined in section 4.4, it is proposed that this table will be published for each product, and within each product for each distribution channel (i.e. individual advised, individual non-advised and group).
- Claims: Open claims (item B.1) is calculated as the sum of Claims undetermined at start of the period, Claims reported during the period and Claims re-opened during the period. Item B.3 is as a percentage of B.2, and items B.5 and B.6 are as a percentage of B.1.
- Disputes: Open disputes (item C.1) is calculated as the sum of Undetermined disputes at start of the period and Disputes lodged during the period. Item C.3 is as a percentage of C.2, and items C.5 and C.6 are as a percentage of C.1.

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