DISCUSSION PAPER

Towards a transparent public reporting regime for life insurance claims information

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Preamble

This discussion paper outlines proposals developed jointly by the Australian Prudential Regulation Authority (APRA) and the Australian Securities and Investments Commission (ASIC) to collect and publish performance data on life insurance claims and disputes.

In relation to the matters set out in this paper, APRA has the appropriate set of powers and processes to support the proposed collection and publication of data. Accordingly, this paper makes proposals for collection and publication of data by APRA. The agencies have worked together closely to develop these proposals and they support the respective mandates of each agency.

The proposals in this paper reflect the approach that the agencies are taking to the first round of data collection. Feedback is sought on this approach, which may be adjusted in light of that feedback.

Specifically, comment is invited on:

- The overall approach to this data collection and engagement with stakeholders.
- The best way for insurers to provide data for Phase 2, having regard to the objectives of this data collection (see Chapter 3).
- Whether an alternative approach to data collection in Phase 2, such as an industry-led approach, should be considered (see Chapter 3).
- Any matters that should be taken into account when consulting on the scope and design of publications, including the expectations of different groups of data users regarding the content of publications (See Chapter 3).
- Whether the proposed data items adequately address the objectives of the data collection (see Chapter 4) and whether there are any additional data items which would assist in meeting those objectives.

Written submissions on this discussion paper should be sent by 11 August 2017, preferably by email to lifeclaimsdata@apra.gov.au. Alternatively, submissions can be mailed to:

General Manager
Policy Development
Australian Prudential Regulation Authority

The data collection template should be completed by 30 June 2017. Assistance with completing the template is available by contacting APRA at lifeclaimsdata@apra.gov.au.

Important disclosure notice – publication of submissions

All information in submissions will be made available to the public on the APRA website unless a respondent expressly requests that all or part of the submission is to remain in-confidence.

Automatically generated confidentiality statements in emails will not suffice for this purpose.

Respondents who would like part of their submission to remain in-confidence 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 *Australian Prudential Regulation Authority Act 1998* (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 only with ASIC for the purposes outlined in this paper.

Executive summary

Life insurance is an important risk management tool that supports consumers and their families during critical times in their lives including death, injury, illness and disability.

In 2016, ASIC conducted a thematic review to identify any systemic concerns with claims handling across the life insurance industry, and released its findings in October in 'Report 498 Life insurance claims: An industry review' (REP 498).

One key finding was that there is 'a clear need for better quality, more consistent and more transparent data about insurance claims'[1]. The report noted that data limitations include significant variability in the interpretation of key performance metrics related to claims handling across different insurers, cover types and distribution channels. The report recommended the establishment of a 'consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types'[2]. This recommendation was made in the context of growing community concern about the handling and payment of claims across the life insurance industry.

In performing its mandate of prudential supervision, APRA balances the objectives of financial safety and efficiency, competition, contestability and competitive neutrality and, in balancing these objectives, promotes financial system stability in Australia. This discussion paper sets out how APRA proposes to implement ASIC's recommendation that a 'consistent public reporting regime' be introduced. APRA considers that such a regime can improve competition between insurers, increase the efficiency of claims handling and reporting by insurers and generally enhance the financial safety of the life insurance sector.

There are a range of further benefits that flow from making life insurance claims and dispute data available publicly. These include benefits for:

- Consumers by allowing them to make better informed decisions based on the performance of life insurers.

- The community as enhanced transparency can drive greater accountability and improved performance. Data can also help provide useful context to facilitate an informed public debate when questions about life insurance are raised.

- Insurers by providing management with important insights into relative portfolio experience and performance, and the ability to enhance claims handling practices. The life insurance industry, through the Financial Services Council (FSC), has put in place the Life Insurance Code of Practice, with an objective of increasing trust and confidence in the life insurance industry.

[1] ASIC REP 498 'Life claims: An industry overview' at paragraph 43

[2] See note 1 at page 20

- Group insurers and superannuation trustees through higher quality of data for group business, particularly in relation to pricing and in setting appropriate levels of cover for default members that will not inappropriately erode retirement outcomes.

- Regulators by allowing them to monitor claims trends on an ongoing basis and identifying any potential issues of concern from changes in data to more appropriately target regulatory and supervisory efforts.

Credibility of data is critical. Transparency only drives accountability to improve outcomes if the comparisons being made are meaningful, based on reliable and consistent data.

The agencies are now proposing to collect data on an entity level basis. This will be done at a sufficient level of granularity as to ultimately allow for publications that support meaningful comparisons of insurer performance with sufficient context to effectively inform consumers. It will cover life insurance issued via all distribution channels, including group business issued for the benefit of superannuation members.

APRA and ASIC are working together to leverage their respective strengths in data collection and infrastructure as the data will be of use to both regulators. The data will be collected by APRA using APRA powers, and will be made available to ASIC to support the objectives of this work.

While the core purpose of the data collection is to support publication, not all data that is collected will necessarily be published. It may also be used to facilitate analysis by ASIC and APRA.

There are some key challenges to be addressed before credible, reliable and comparable data can be released. In some cases, addressing these will require changes to insurer practices and systems. In other cases, these may require further refinement of the data requested. This discussion paper is the first step in a series of steps that the agencies will take to consult with stakeholders. The scope and design of the data collection may be refined in response to stakeholder feedback.

Overall, it is expected that making the necessary investment in change will be beneficial, not only in supporting the ability of insurers to report under the data collection proposed in this paper, but also to support internal reporting and decision making by insurers.

Chapter 1 sets out background to ASIC's REP 498 and contextualises the objectives of the proposals in this Discussion Paper.

Chapter 2 discusses the currently available data on claims, the targeted end-state for data quality and availability and the key data gaps that must be addressed.

Chapter 3 outlines the overall process the agencies are undertaking in relation to this work, including an overview of the two-phase approach.

Chapter 4 discusses the initial Phase 1 data request and template in further detail.

Chapter 1 – Background and objectives

Investigations into the life insurance industry

As Australia's corporate, markets, financial services and consumer credit regulator, part of ASIC's role is to ensure that Australian financial services licensees, including life insurers, comply with the financial services laws. In 2016, ASIC conducted a thematic review to identify any systemic concerns with claims handling practices across the life insurance industry, and to understand whether particular products, insurers, distribution channels, practices or issues needed to be examined further.

ASIC's October 2016 REP 498 focused on life insurance claims by policyholders, assessing the outcome of claims and the nature of claims related disputes.

While not finding evidence of cross industry misconduct, with 90 percent of claims being paid in the first instance (a payout of about $8.2 billion over the 2015/16 financial year)[3], ASIC did identify particular areas of interest that it is exploring this year. One significant recommendation made in REP 498 was the need for consistent public reporting of life insurance claims data, claims outcomes, dispute levels and claims and dispute handling timeframes across all policy types on an industry an individual insurer basis.

ASIC found that key metrics for claims performance, such as decline rates and dispute levels, varied widely across insurers. In some cases, decline rates appeared to be very high. However, ASIC also found that there were significant issues with data quality and comparability, which made drawing firm conclusions problematic. Some insurers informed ASIC that their investment in systems and processes had fallen behind the requirements of the business, resulting in poor data quality.[4]

ASIC concluded that the problems with data have significant implications for consumers and for the industry itself. Specifically, it found that the current data limitations mean that:

- it is difficult to compare and assess declined claim rates and other key measures of claims performance across insurers;
- it is more difficult for insurers, including boards and senior management, to assess the performance of their own claims handling and claims outcomes; and
- it is very difficult for consumers and other stakeholders to assess the claims outcomes and performance of the life insurance sector, including trends over time, and this undermines insurer accountability and consumer trust.

The claims process of life insurers is largely opaque, and is often poorly understood by stakeholders. Consumers and other stakeholders cannot readily compare the claims

[3] See note 1 at para 2

[4] See note 1 at para 326

performance of different insurers. This lack of transparency has given rise to a lack of trust and confidence in the integrity of the claims assessment process and, by extension, in the life insurance industry more generally. Lack of transparency can also lead to a lack of accountability on the part of insurers.

Industry context

A life insurance policy protects the policyholder or another beneficiary by paying a lump sum or income stream in the event of death, disablement (temporary or permanent) or specified trauma.

Like all insurance contracts, the premium charged by the insurer for a life insurance policy needs to reflect the insurer's estimate of the expected claims that will be paid plus expenses that will be incurred and a profit margin. The insurer takes into account the terms and conditions of the policy and other known information and undertakes actuarial analysis to determine the expected claims. A life insurer needs to charge an appropriate premium in order to be sustainable into the future.

The policy terms and conditions are drivers of expected claims and the premium charged. An insurer administers the policy consistently with the policy terms, so that its actual experience aligns as closely as possible with the experience that was assumed in setting the premium. This is an important aspect of the prudent management of an insurer and supports the ability of the insurer to remain sufficiently capitalised to keep the financial promises that they make to policyholders.

Insurers sometimes do receive a claim that falls outside the scope of the policy terms and legitimately decline such claims. For this reason, the decline rate is not expected to be zero. Ultimately, if claims are paid that do not meet the terms and conditions of the policy, then premiums will need to be higher in the future to ensure that the insurer remains financially sound and can meet its financial promises to policyholders. The insurer balances the interests of claimants in having their legitimate claim paid, and the interests of other policyholders in the financial stability of the insurer, and in not having their premium increased to fund claims outside the terms and conditions of the policy.

As noted above, in some instances, life insurers receive a claim which does not fall within the terms of the policy contract but which the consumer and/or the community expects to be paid.[5] In these instances, insurers are, technically, entitled to rely on a strict legal application of the terms and conditions. In the past, insurers may have declined such claims. Community expectations regarding claims handling have changed. Insurers now face reputational risks from declining these types of claims. Some insurers have developed a claims philosophy which makes increasing use of ex gratia payments to policyholders to meet consumer and community expectations. The agencies' understanding is that ex gratia payments represent a small proportion of total payments, however further data is necessary to fully understand the use of ex gratia payments by insurers.

[5] See note 1 at paras 23-24

Unlike many other types of insurance, life insurance policies are guaranteed renewable. As long as the policyholder continues to pay the premium, the life company must continue to renew the policy. This, combined with a range of systems, operational, taxation and legal constraints, has contributed to the existence of a large number of legacy products and systems. The resulting complexity is an ongoing challenge for the life insurance industry, and one that will require careful attention to be addressed. APRA has noted its expectation that further progress must be made on the issue of legacy products.[6]

The life insurance industry has recently responded to concerns about the sale of life insurance by launching a Life Insurance Code of Practice with which insurers need to comply by 1 July 2017.

The data collection and reporting objectives

To give effect to ASIC's recommendation in REP 498, the agencies have commenced a joint initiative to collect and publicly report on life insurance claims and disputes data. The data will be collected by APRA, and will be made available to ASIC to support the objectives of this work.

The agencies' objectives in this endeavour are to:

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

The aim is to achieve these objectives through publication of credible, reliable and comparable data. The agencies' intention is for this data to be collected and published on an entity-level basis, at a sufficient level of granularity to allow for meaningful comparisons of insurer performance and with sufficient context to effectively inform consumers and other stakeholders.

Enhanced transparency can help ensure that public levels of confidence and trust in the industry will reflect the actual performance of the life insurance industry. A transparent industry enables stakeholders to hold insurers accountable for their performance. This creates an environment where stakeholders can observe the performance of the industry and form their own judgements. These objectives will be met through meaningful comparisons based on reliable data.

[6] http://apra.gov.au/MediaReleases/Pages/16_51.aspx

Chapter 2 - Life insurance claims data

This Chapter discusses the currently available data on life insurance claims, sets out some international comparisons, and outlines the key data gaps and challenges that must be addressed to achieve the data collection and reporting objectives.

What do we know so far?

Data collected by APRA

APRA has broad data collection powers under the *Financial Sector (Collection of Data) Act 2001* (FSCODA) and has determined a number of reporting standards under that Act to require submission of specific data from insurers and superannuation funds. This data is used to support APRA's prudential supervision of these entities, to support policy making by Government and for publication.

APRA's existing data collection and publications include a very significant amount of insurer-specific and industry-aggregate data.[7] APRA's life insurance data collection has been primarily developed for the purposes of supporting APRA's prudential supervision of life insurers. In addition, some of the data is published. While it provides useful contextual information, it does not include data that can help to fully understand the claims processes of insurers.

APRA also collects a significant amount of data from superannuation funds regarding their insurance offerings. Again, this data collection is used extensively by APRA to support prudential supervision of superannuation funds. This data provides useful insights into insurance premiums and claims in superannuation, but is not sufficient to meet the objectives of this collection as it doesn't comprehensively cover claims processes and disputes.

A summary of the key features of APRA's current data collection for life insurers and superannuation funds, including analysis of the data, is included in Attachment A.

Over recent years, APRA has substantially increased the amount of data that it publishes. In relation to group business, both APRA and the superannuation and insurance industries have made significant enhancements to the quality and extent of data collected. This has been in response to regulatory developments and also to assist in better pricing and monitoring of group business following significant losses caused by mispricing in that market segment. Further industry initiatives are in train, and it is expected that these will assist insurers in completing the data request discussed in this paper.

[7] See http://www.apra.gov.au/lifs/Publications/Pages/quarterly-life-insurance-statistics.aspx and http://www.apra.gov.au/lifs/Publications/Pages/Life-Insurance-Institution-level-statistics.aspx

Other sources of data

Other sources of data are also available. For example, the Financial Ombudsman Service (FOS) publishes data regarding disputes about financial services providers that are members of FOS.[8] This data provides useful context, particularly regarding dispute levels for life insurance relative to other financial products, but does not comprehensively address dispute outcomes and timeframes.

Separately, ASIC will also collect life insurance data about policy replacements, lapses, clawback amounts, premium changes and policies for the purposes of monitoring and enforcement, of the life insurance remuneration reforms, and also to inform the 2021 review of these reforms. That data collection and the collection discussed in this paper are separate, and the two agencies will work to minimise duplication and inconsistency between the two collections where possible.

A number of commercial and industry data collection processes include data relevant to the objectives of this project. However this data is not commonly publicly available and, does not comprehensively address life insurance claims from the perspective outlined in this paper.

Internationally, claims data is collected and published in a number of countries, either by a regulator or an industry association. For example, the Association of British Insurers collects and publishes life insurance claims data annually.[9]

Where are the key gaps and challenges?

As discussed above, a significant volume of data on life insurers is already available, but there are important data gaps that need to be addressed to resolve the problems outlined above and to meet the objectives.

Some key areas where currently available data is deficient to meet the objectives are:

- Clear data on the number of claims received, and how those claims have been dealt with by the insurer (for example, withdrawn, declined, paid in full, ex gratia payment made).
- Data on claims that were disputed, whether subject to internal dispute resolution, external dispute resolution, litigation or a combination of these.
- Timeframes for dealing with claims and disputes.

In order to comprehensively understand these matters, the agencies propose to collect the data by key product type, by key distribution channel and include not only numbers of policies, claims and disputes but also dollar totals for premiums, claims and sums insured. To facilitate consistency, the aim is for all data items to have clear and unambiguous definitions.

[8] http://www.fos.org.au

[9] https://www.abi.org.uk/News/News-releases/2016/04/Protection-Claims-2015-QA

The agencies recognise that there will be challenges in addressing these deficiencies, but that the capacity of insurers to meet these challenges will improve over time. Some key challenges are:

- Different insurers currently record the necessary data in different ways, in part because they have differing claims and complaints practices. Insurers also adopt different terminology and data definitions. This makes achieving comparability difficult, and can also give rise to data quality issues as data may need to be manually extracted and manipulated.

- Legacy products and systems (with varying constraints and complexities) present challenges to the extraction of data and are complex and expensive to update to support new data collections. They increase the level of complexity in the system, and in particular cause significant administrative challenges. Legacy products are commonly administered on out-of-date legacy systems which, amongst other concerns, are typically less able to produce accurate and timely data to support insurer decision-making. Such systems also challenge the ability of insurers to provide reliable and timely data for regulatory purposes, such as in responding to ASIC review data requests such as for REP 498 and the proposed life insurance claims data collection.

- Life insurance products are inherently complex and the operating environment (including distribution channels) is also complex, with a wide range of different structures and products in existence. This makes like-for-like comparability a challenge.

Chapter 3 - Overview of the process

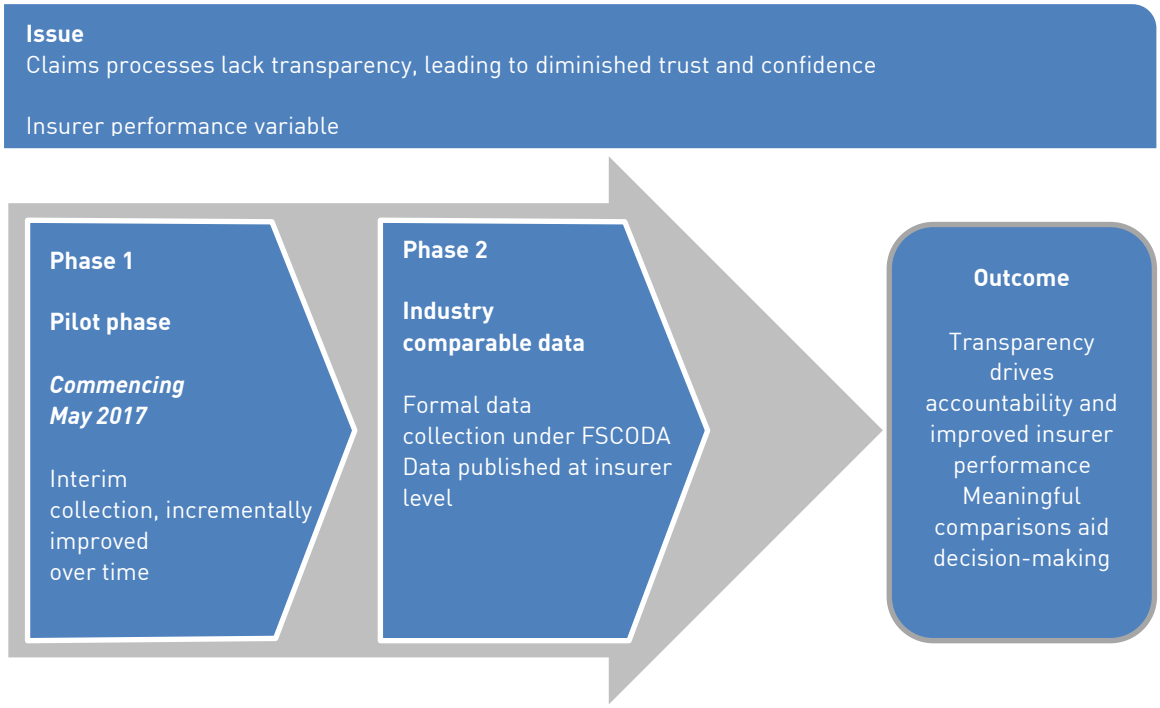
The agencies have adopted a two-phase approach to developing the data collection:

1. Phase 1 – pilot collection of data - will likely continue until 2018. It is a pilot phase with multiple collections, each followed by incremental refinements to the data requested.

2. Phase 2 – ongoing collection and publication - the targeted end-state of credible, reliable and comparable data, with publication of entity-level data.

These phases are represented in Diagram 1 and this Chapter provides further details on each Phase.

Diagram 1 – Phases of Consultation Process



Feedback question 1

The agencies welcome feedback on the overall approach to this data collection and engagement with stakeholders.

Phase 1

In Phase 1, the agencies' current intention is to undertake three rounds of data collection, however this may be longer or shorter depending on how the process develops. Each round will include the release of a data template with data definitions, a specified reporting period

to be covered and a due date for insurers to provide the completed template by. The data will be submitted to APRA by insurers, APRA will share the data with ASIC for the purposes outlined below.

After each round of data is received, the agencies will analyse it and, where appropriate, share learnings about the process and outcomes with insurers and other stakeholders. The agencies will also consider whether further improvements should be made to the template or data definitions for the next round of collection.

Timeframes for Phase 1

At this stage, the agencies anticipate the following schedule:

Phase/round	Period covered	Release date for template	Due date for data
Phase 1, Round 1	January – December 2016	May 2017	30 June 2017
Phase 1, Round 2	January – June 2017	September 2017	October 2017
Phase 1, Round 3	July – December 2017	February 2018	May 2018

Objectives of Phase 1

Phase 1 has the following objectives:

- to pilot test the data template and spreadsheet to identify areas for further development; and

- to provide a transitional period for insurers to align their data recording to the new definitions. This will ensure progress towards the overall objective of credible, reliable and comparable data.

The Phase 1 template draws on the work undertaken by ASIC to collect data for REP 498. ASIC identified concerns with the data collected during that review and accordingly the agencies have refined and improved the template in a number of key ways. This includes expanding the number of items to allow for additional analysis and enhancing the definitions for the data items to clarify areas of ambiguity and to drive improved comparability between reporting by different insurers. Further detail on the information requested in the initial template is contained in Chapter 4.

The agencies recognise that not all insurers will initially be able to complete all the data items according to the prescribed definitions. The agencies ask that insurers use their best

endeavours to complete the template[10] and explain the approach taken. Information about areas where insurers are not able to complete the template in full will assist future refinement of the template. Relevant staff at the agencies are also available to assist insurers in understanding the template and responding to queries.

The agencies are particularly interested in qualitative information on:

- areas where the template or definitions could be improved; and
- data items where insurers were unable to report according to the instructions. An outline of key assumptions, simplifications or estimations used to complete the data template should be provided in those cases.

It is expected that insurers will progressively improve their ability to report consistently with the data template and definitions over time. The agencies recognise that, at least initially, reporting is likely to require manual processing in some areas and that this gives rise to risks to the timeliness, quality and accuracy of the data. It is also recognised that it can give rise to reporting burden on insurers, at least initially. The agencies expect that insurers will, over time, systematise their reporting of this data and that the collection will be formalised into a standard APRA reporting collection. It is anticipated that these developments will alleviate reporting burden over time.

Use of Phase 1 data

APRA and ASIC will use the Phase 1 data in two key ways:

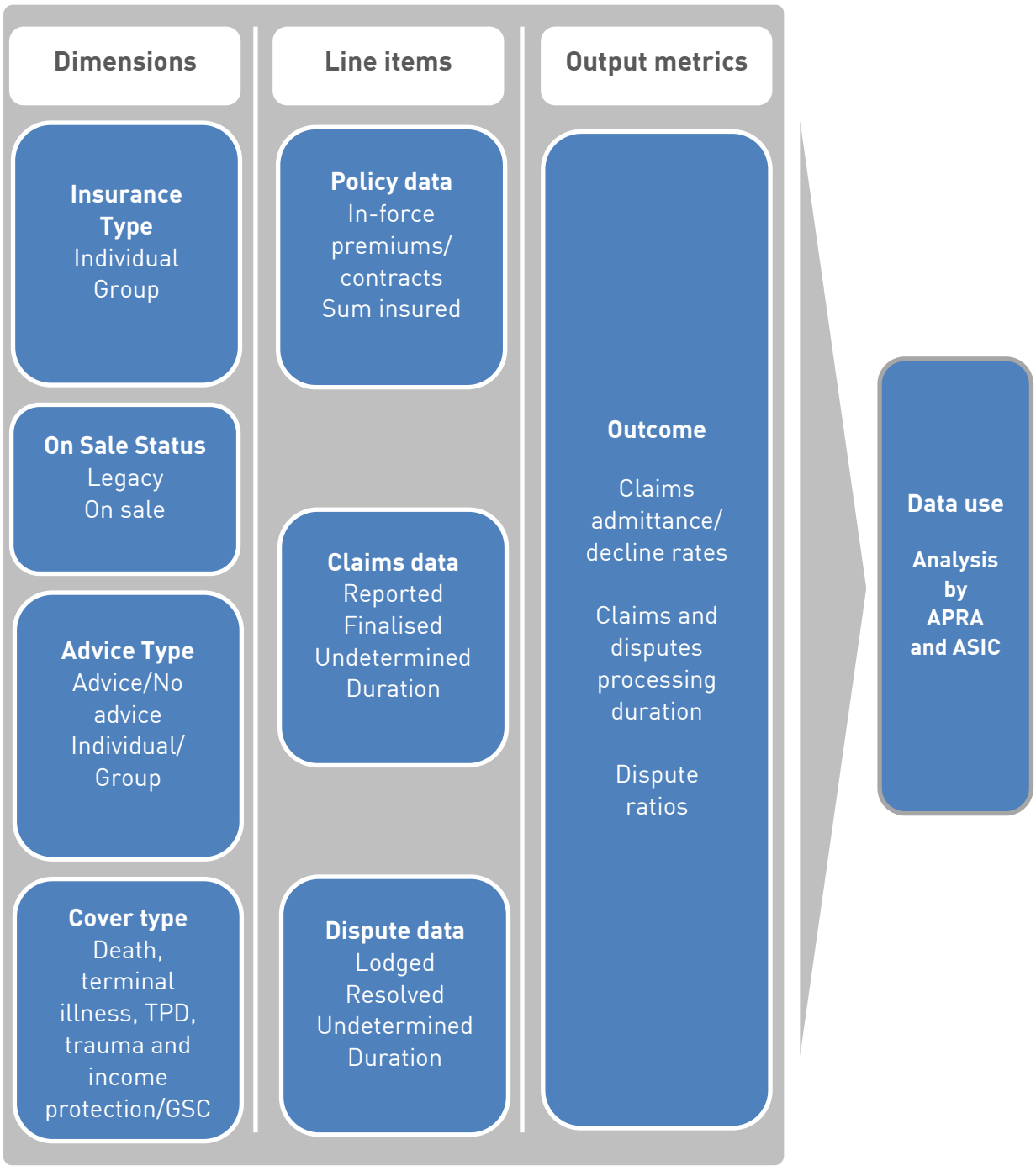
- to support further development of the data template and of Phase 2; and
- where appropriate and only at an industry level, to facilitate informed public discussion of insurance.

ASIC and APRA will also make use of the data, in both Phase 1 and Phase 2, to support their supervision of insurers, within each agency's distinct mandate. Entity-level data will not be published at any stage of Phase 1.

The data being collected will allow calculation of metrics such as claims admittance and claims decline rates, claims and disputes processing duration and dispute ratios to inform supervision. High-level, industry-aggregate results from the collection may also be used by the agencies to facilitate informed public debate.

[10] Best endeavours reporting means to complete as many of the data items as possible, and adhere as closely as possible to the prescribed definitions. Where this is not possible, assumptions, simplifications and estimations can be made.

Diagram 2 – Round 1, Phase 1 data collection and data use



Phase 2

Objectives of Phase 2

The objective of Phase 2 is to collect and publish data at a sufficient level of granularity to allow for consistent and meaningful comparisons of insurer performance regarding claims handling and determinations, with sufficient context to effectively inform consumers.

This will involve two related but separate processes:

1. determining a formal, legally enforceable data collection; and

2. publishing relevant and useful data on a regular basis following consultation with entities and other interested parties.

Data collection

Through the Phase 1 process, including the feedback from industry, it is expected that a settled data collection will emerge that can form the basis for consultation on a permanent formal collection.

It is proposed that the Phase 2 collection will follow a similar approach to other collections administered by APRA. In broad terms, the expected approach involves:

- reporting standards determined by APRA under the FSCODA;

- each reporting standard to include reporting forms with clearly defined instructions, and specified reporting periods, due dates and data quality arrangements; and

- use of existing APRA data submission processes under D2A, including data quality checks.

The agencies are exploring various options for the way in which insurers could provide data in the future, for example, one possibility is to eventually collect at the level of individual claims and disputes using what is known as a 'flat file' approach. The agencies will consult further with insurers before reaching a final decision on this question.

Feedback question 2

The agencies welcome feedback on the best way for insurers to provide data for Phase 2, having regard to the objectives of this data collection.

Alternative approaches to Phase 2 data collection

The above approach has the benefit of minimising costs by making use of existing industry and APRA processes. A central source of statistics assists users of the data.

However, comments are invited on whether another approach can better meet the objectives of the data collection. A possible alternative could be the collection and publication of data by the industry itself.

Feedback question 3

The agencies welcome feedback on whether an alternative approach to data collection in Phase 2, such as an industry-led approach, should be considered.

When proposing an alternative, stakeholders are encouraged to articulate how the alternative would meet the data collection objectives, together with any efficiency gains and cost savings that would flow from the alternative.

Publication

While the core purpose of the data collection is to support publication, not all data that is collected will necessarily be published. It may also be used to facilitate analysis by ASIC and APRA. A formal process of consultation on publication will commence as part of Phase 2 on the publication of data at an industry-level and an entity-level. Industry level publication is on an aggregate basis, and can enhance understanding of industry performance and structure at an aggregate level. Entity-level data is published on an insurer-by-insurer basis, and helps support transparency and accountability regarding the performance of individual insurers. It is also consistent with ASIC's use of data to analyse emerging risks and consumer harms.

The agencies anticipate that different users will have different expectations of the content of the publications. For example, the level and character of data published for the benefit of consumers may differ from the level and character of data published for the benefit of market analysts. The publication will need to be carefully designed so that it can support the objectives and not drive unintended behaviour by either customers or insurers.

In advance of the formal process of consultation on publication, the agencies invite preliminary comment from stakeholders regarding the publication of data.

Feedback question 4

The agencies welcome 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.

Confidentiality of data

Under section 56 of the APRA Act, data submitted to APRA under FSCODA is protected information. The section 56 protection applies to all data submitted to APRA under both Phase 1 and Phase 2. APRA can release data to ASIC, as necessary to achieve the objectives of this collection, but the data will continue to be protected information under section 56.

APRA is generally able to publish aggregate industry-level data without restriction. Given that the objectives of this data collection include improved accountability of the industry and a more informed public discussion about the performance of the life insurance industry, it will ultimately be necessary to publish data at an entity level.

Under section 56 of the APRA Act, data is generally not able to be released at an entity level unless APRA determines the data to be non-confidential under the process outlined in section 57 of the APRA Act or the release falls within another exception under section 56 of that Act.

Under section 57 of the APRA Act, before determining any data to be non-confidential, APRA is required to assess whether the benefit to the public from the disclosure of the data outweighs any detriment to commercial interests that the disclosure may cause. APRA must allow interested parties an opportunity to make representations on these matters before making its decision.

In order to release publications that meet the stated objectives, it will be necessary to determine some or all of the data provided by insurers to be non-confidential.

APRA anticipates, in due course, consulting with insurers regarding the potential commercial detriment of disclosure, to support decision-making about confidentiality. Data which APRA determines to be non-confidential will identify individual insurers but will not identify individual claimants or breach the privacy of individuals.

APRA will continue to apply its confidentiality protection measures to data that has not been determined non-confidential. APRA will ensure that information relating to an individual institution cannot be derived where the data are not otherwise publicly available.

Consultation

As part of the process to implement Phase 2, the agencies will:

- consult with stakeholders by releasing a discussion paper, together with draft reporting standards, forms and instructions; and
- consult on the design of the publication(s) and on data confidentiality as necessary to facilitate the publication.

The agencies anticipate commencing formal consultation on the draft reporting standards, forms and instructions in early 2018. The work on the draft standards, forms and instructions will be extensively informed by experiences in undertaking the Phase 1 collection.

Voluntary disclosure by insurers

APRA wrote to insurers in June 2015, setting out its expectations for enhanced public disclosure of prudential information.[11] Public disclosures better inform market participants such as investors, analysts, policyholders, other insurers and rating agencies. This provides for a more informed assessment of the soundness of each insurer, including assessment of each insurer's capital adequacy with respect to its risks, governance and risk management practices.

[11] http://www.apra.gov.au/CrossIndustry/Pages/Public-disclosure-for-prudential-purposes-for-insurers-June-2015.aspx

The key benefits of public disclosure for prudential purposes include:

- reducing information asymmetries between insurers and other market participants, thus giving market participants greater ability to make informed assessments of the relative strength of insurers;

- creating strong incentives for insurers to conduct their business in a safe, sound, prudent and efficient manner; and

- enhancing market information available to the board and senior management, including, for example, peer remuneration practices.

This in turn can lead to increased confidence in the soundness of insurers, and the promotion of stability in the insurance industry and financial system.

Public disclosure for prudential purposes includes information published by the insurer, for example in its annual report or on its website. Such information supports market discipline and is an important component of prudential regulation.

ASIC's findings were de-identified in the public report REP 498, however, ASIC shares APRA's view that insurers could make public certain claims information, in order to inform consumers about matters affecting the underlying value of their life insurance policies.

Claims information of the sort contemplated in this discussion paper is a further example of a disclosure that can support market discipline. Voluntary disclosure of further information on claims, where insurers are confident regarding the reliability of their data, would be an appropriate step to take to increase transparency and would be consistent with the objectives of this project.

Chapter 4 - Initial Phase 1 data request in detail

This table summarises the key features of the initial Phase 1 collection:

What is required?	Use best endeavours to complete the reporting template according to the instructions
Reporting entities	All life insurers that write death, TPD, trauma and/or income protection/group salary continuance.
Reporting period	1 January 2016 – 31 December 2016
Due date	30 June 2017 or such later date as agreed with APRA
Cover types	Death (with and without terminal illness), TPD, trauma, income protection/group salary continuance 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 business, such as traditional business, consumer credit insurance and funeral business are excluded from the first collection 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

Overview of data requested

The agencies are collecting data in three key areas:

A. Policy data on the in-force numbers of policies, in-force premium income and in-force sums insured. This data is requested because it provides context to the claims and dispute data collected.

B. Claims data which will include detailed information on the claims received, how they were handled by the insurer, as well as associated claims processing durations. This is the core of the data request, and is of a sufficient level of detail to enable analysis of claims patterns in the sector.

C. Dispute data in respect of those claims which are subject to an internal and/or external dispute resolution process. For this purpose, 'dispute' includes those claims

which proceed to litigation. This data will be used to analyse the level and nature of disputed claims.

Submission of data

All life insurers that write death, TPD, trauma and/or income protection/group salary continuance, other than life insurers that write only reinsurance business, are expected to submit data by completing the reporting template, according to the instructions.

The agencies will accept the data on a 'best endeavours' basis in Phase 1, as it is appreciated that insurers may need time to adjust their systems to enable them to provide reliable data. It is expected that the quality of data will improve in subsequent rounds. Insurers should indicate any assumptions or approximations used to complete the reporting template.

Reporting parameters

The reporting period for round 1 will be the 2016 calendar year. Future reporting periods will likely be for shorter periods.

The unit of reporting is policy benefits rather than policy contracts or insured lives. This is because policy contracts may cover multiple insured lives, and insured lives could have multiple products each of which could have a different claims outcome. High level data will be collected on insured lives and policy contracts, to enable analysis of the relationship between policy contracts, insured lives and policy benefits.

Data request in detail

A. Policy Data

Detailed information is sought on the in-force book of business to which reported claims pertain, including premium income, and sum insured.

Policy data being collected includes:

- The number of benefits, policy contracts and lives insured in-force at the start and end of the reporting period, as well as the number of benefits sold and discontinued during the reporting period.
- The amount of in-force annual premium at the start and end of the reporting period, as well as the amount of premium sold and discontinued during the reporting period.
- The amount of sums insured at the start and end of the reporting period, as well as the amount of sum insured sold and discontinued during the reporting period.

The policy data is to be provided by the following dimensions:

- Insurance type, distinguishing between individual insurance (split between business sold outside super and inside super) and group insurance.

  Rationale: This is required to make distinction between individual and group insurance contracts, given that these two types have very different underwriting and claims processing practices.

- On sale status, distinguishing between products which are open for new business and legacy (closed for new business).

  Rationale: This data is required in order to understand different generations of products, potentially driven by different policy definitions and/or claims practices.

- Advice type, distinguishing between individual insurance business sold with and without advice.

  Rationale: This data is required to establish the relationship between the distribution channel and claims experience.

- Cover type, categorised as death (both with and without terminal illness), TPD, trauma and income protection/group salary continuance.

  Rationale: This data will be used to analyse claims experience by cover type.

B. Claims data

Detailed information on claims and claims handling is sought. Claims data being collected includes:

- Total number of claims reported, finalised and withdrawn, as well as the number of claims that are undetermined at the end of the reporting period.

  Rationale: This data will be used to assess claims outcomes.

- Finalised claim counts are further categorised between:

  - Claims admitted with full benefit payable;
  - Claims declined, but an ex-gratia payment made;
  - Claims declined but admitted under a different cover type;
  - Claims declined, with policy benefit or policy contract cancelled and premiums refunded; and
  - Other claim outcomes.

  Rationale: This data will be used to assess claims outcomes.

- In addition to claim counts, the detail above will also be collected for claims sums insured and claims amount.
- Claims processing durations, will be collected in respect of finalised claims. Duration detail will be collected separately for claim counts and claim sums insured.

  Rationale: This will provide insight into the time frames insurers require to process claims.
- The claims data should be provided by the following dimensions:
  - For claims data the dimensions will be the same as for policy data, namely insurance type, advice type, on sale status and cover type.
  - For claims processing durations, the dimensions will be insurance type, advice type and cover type.

C. Dispute data

Detailed data is required to understand how disputed claims are handled.

- Total number of disputes lodged, resolved and withdrawn, as well as the number of disputes that are undetermined at the end of the reporting period.
- Resolved disputes are further categorised between:
  - Resolved with no further payment made;
  - Resolved with full benefit payment;
  - Resolved with a partial benefit payment;
  - Resolved with payment made on an ex-gratia basis;
  - Resolved with a non-cash benefit;
  - Resolved with payment made under another cover type;
  - Resolved with claim declined, with contract cancelled and premiums refunded; and
  - Resolved through any other means.
- In addition to dispute counts, the detail above will also be collected for the associated claim (or dispute) sums insured and claim (or dispute) amount.
- Dispute processing durations will be collected in respect of resolved disputes. Duration detail will be collected separately for dispute counts and dispute sums insured.

  Rationale: This data will provide insight into the time frames insurers require to process disputes.

- The dispute data should be provided by the following dimensions:
    - Dispute type, categorised as internal disputes, external disputes and litigated disputes.
    - For dispute counts, further dimensions will be the same as for policy data, namely insurance type, advice type and cover type.
    - For dispute processing durations, further dimensions will be insurance type, advice type and cover type.

      Rationale: This data is required to provide insight into the relationship between disputes (and their outcome) and claim size.

Feedback question 5

The agencies welcome feedback on whether the proposed data items adequately address the objectives of the data collection and whether there are any additional data items which would assist in meeting those objectives.

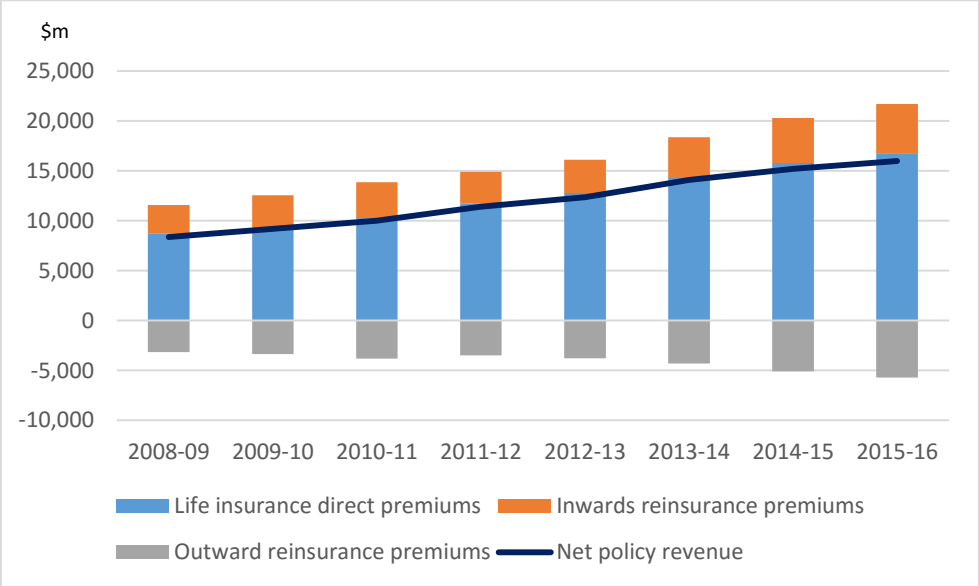
Attachment A – Observations from APRA's existing data collection

Insurance information collected from life insurers

APRA collects the value of premium received (by premium type) and claims expenses (by expense type) at individual statutory fund level and by business geography (Australian business and overseas business) in *LRF_310_1: Income Statement (SF and SF Eliminations)*

APRA publishes policy revenue and expenses statistics at total statutory fund, investment linked and non-investment linked statutory fund levels in the *Quarterly Life Insurance Performance Statistics* publication, and at an entity-level in *Life Insurance Institution level Statistics* publication. The charts below provides time series snapshots of insurance policy revenue and insurance policy expenses breakdowns for non-investment linked statutory funds.

Life insurance policy revenue by insurance type (non-investment linked)

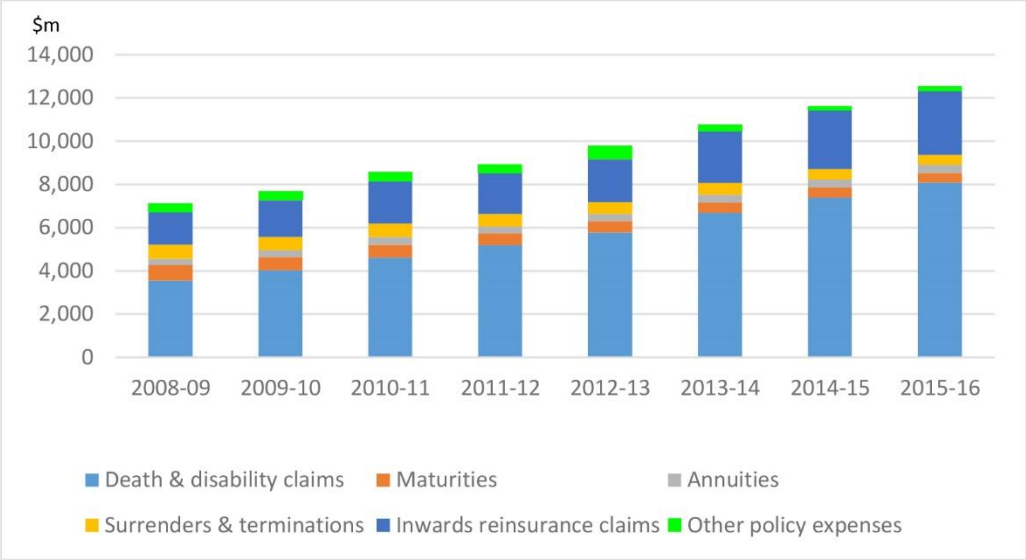


Life insurance policy expenses by expense type (non-investment linked)

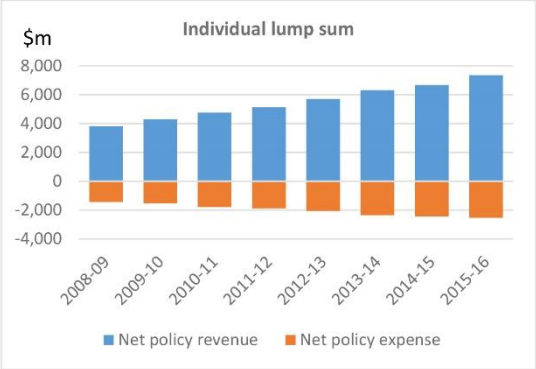
APRA also collects policy revenue and policy expenses data by product group and class of business in *LRF_330_0: Summary of Revenue and Expenses* for each statutory fund.

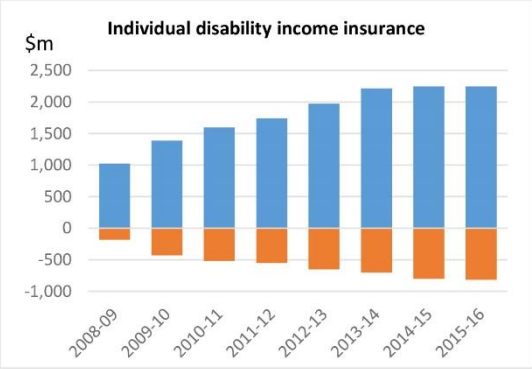
APRA publishes the collected policy revenue and policy expenses data by product group and class of business. The chart below shows net policy revenue and net policy expenses of the four risk product groups. It depicts the recent increases in net policy expenses relative to net policy revenue in group risk products.

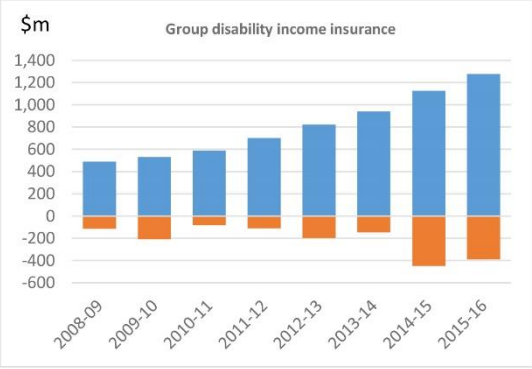
Life insurance policy expenses by expense type (non-investment linked)



Net policy revenue and net policy expenses for risk products







Insurance information collected from superannuation funds

APRA implemented a range of prudential requirements for the superannuation industry as part of the Stronger Super reforms. As part of these reforms, APRA released a new reporting framework in June 2013. The revised reporting requirements, which commenced progressively from 1 July 2013, replaced the reporting requirements that had been in place

since 2004. APRA commenced collecting annual detailed insurance information as part of the superannuation reporting framework for periods ending on or after 1 July 2013.

Self-insurance information is collected on *SRF 161.0 Self-Insurance* and acquired insurance information is collected on *SRF 250.0 Acquired Insurance*. The data are collected primarily for use by APRA for the purpose of prudential supervision, including assessing compliance with *Prudential Standard SPS 250 Insurance in Superannuation* (and *Prudential Standard SPS 160 Defined Benefit Matters* in the case of SRF 161.0, which contains additional requirements applying to RSE licensees that are permitted to self-insure insurance benefits). The data are also collected for publication.

Insurance agreements

The following information is collected:

- Insurance agreement details for each of a fund's largest group insurance policies, defined as group insurance policies that cover five per cent or more of the total number of member accounts with insurance cover. This includes for each policy the name of the insurer, whether they are an associate and (by insurance type – life insurance, TPD, income protection and other) the number of member accounts covered and aggregate cover.
- Summarised agreement details for a fund's remaining group insurance policies. This includes the details above aggregated for each individual insurer.
- Summarised agreement details for a fund's individual insurance policies, aggregated for each individual insurer. This includes for each insurer, whether they are an associate and (by insurance type) the number of member accounts covered and aggregate cover.

Note that SRF 250.0 also captures the name of any previous insurer from the last five years and the type of policy provided.

Premiums

Note that unlike insurance agreement details and claims information, premium information is not collected by type of insurance.

The following information is collected:

- Individual premium information for each of a fund's largest group insurance policies, defined as group insurance policies that cover five per cent or more of the total number of member accounts with insurance cover. This includes the premium collected, a breakdown of the insurance premium paid to insurers (paid by fund, paid by licensee, paid by employer sponsor, paid in previous period) and insurance premium rebates received.
- Summarised premium information for a fund's remaining group insurance policies. This includes the details above aggregated for each individual insurer.
- Summarised premium information for a fund's individual insurance policies. This includes the premium collected, a breakdown of the insurance premium paid to insurers (paid by fund, paid by licensee, paid by employer sponsor, paid in previous period) and insurance premium rebates received.

Claims

The following information is collected:

- Claims in progress by insurance type (number of claims reported (not admitted), number of claims admitted (not yet paid) and value of claims admitted (not yet paid).
- Claims paid by insurance type (number claims paid, admitted this year/admitted in previous years and value of claims paid, admitted this year/admitted in previous years).

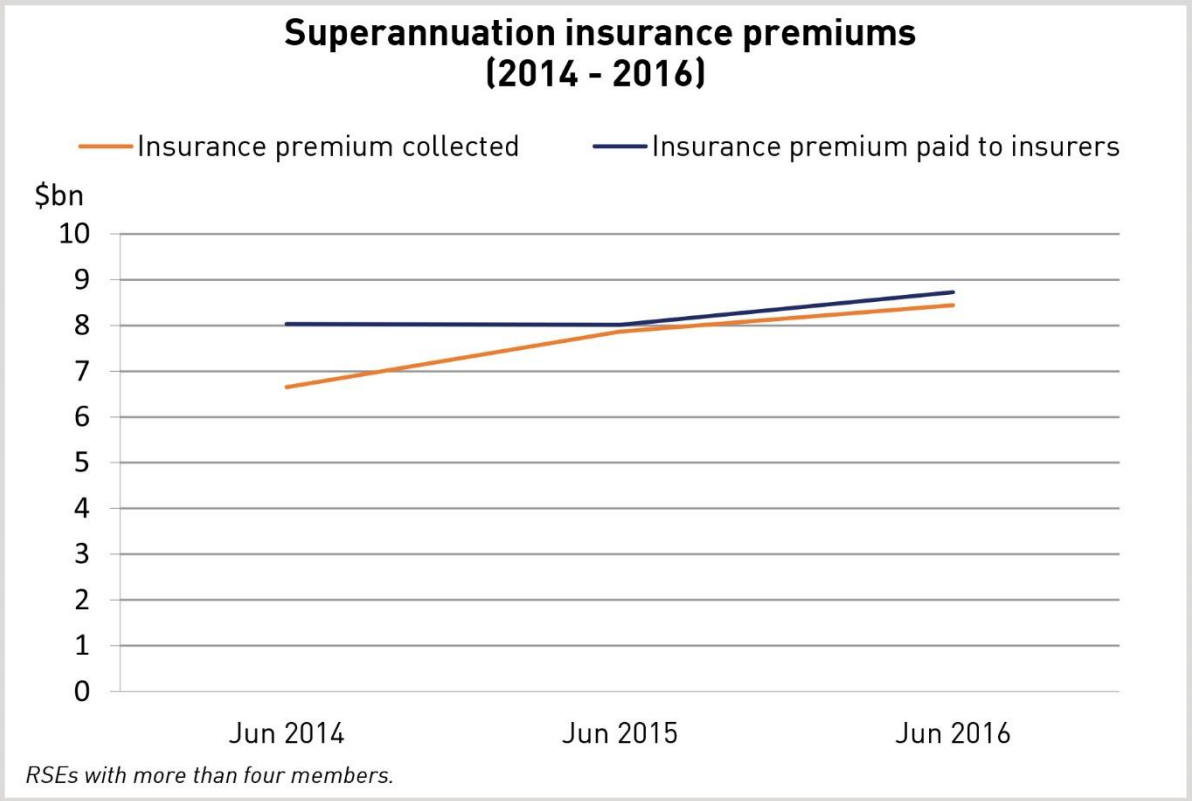
APRA publishes industry-level insurance statistics on a selection of the data collected annually in the *Annual Superannuation Bulletin* for entities with more than four members, including exempt public sector superannuation schemes. Table 1 below contains key insurance statistics for 2014 to 2016, showing insurance premium information, as well as insurance coverage and claim information by insurance type. The statistics include self-insurance and acquired insurance.

Table 1: Superannuation insurance premiums, coverage and claims by insurance type

Entities with more than four members

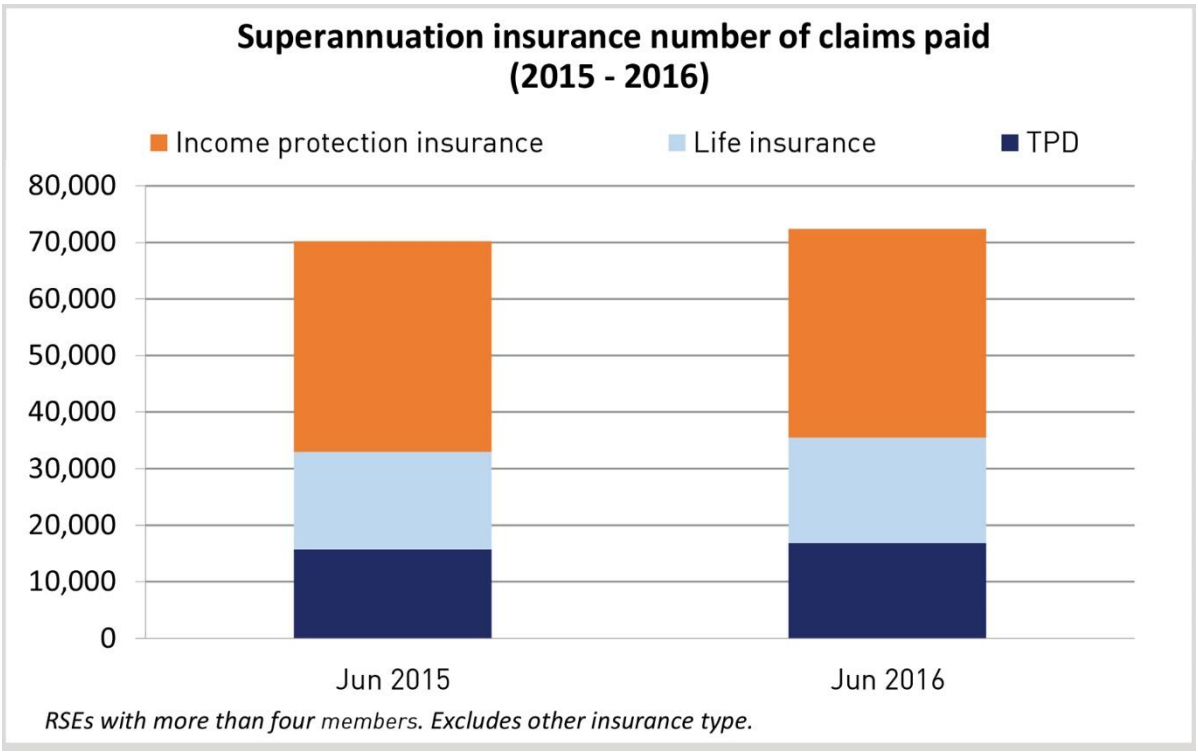
	Jun 2014	Jun 2015	Jun 2016
Insurance premiums collected ($m)	**6,651**	**7,867**	**8,442**
Insurance premiums paid to insurers ($m)	**8,031**	**8,013**	**8,727**
Life insurance			
Number of member accounts with insurance ('000)	15,243	15,296	14,853
Number of claims reported	2,091	2,134	2,131
Number of claims admitted	1,028	1,035	1,089
Number of claims paid	17,447	17,258	18,593
Value of claims paid ($m)	1,955	2,270	2,419
Total and permanent disability insurance			
Number of member accounts with insurance ('000)	13,196	13,235	12,922
Number of claims reported	8,921	8,188	7,186
Number of claims admitted	1,071	595	784
Number of claims paid	16,348	15,716	16,873
Value of claims paid ($m)	*	1,448	1,698
Income protection insurance			
Number of member accounts with insurance ('000)	5,240	5,308	5,280
Number of claims reported	4,776	4,368	3,957
Number of claims admitted	700	578	808
Number of claims paid	28,408	37,222	36,908
Value of claims paid ($m)	610	662	820
Other insurance			
Number of member accounts with insurance ('000)	69	58	52
Number of claims reported	41	79	57
Number of claims admitted	*	91	*
Number of claims paid	778	370	*
Value of claims paid ($m)	*	45	35

The chart below shows insurance premium collected from superannuation member accounts, as well as insurance premium (gross of any rebates) paid to insurers for 2014 to 2016. The insurance premium paid to insurers includes the premium paid by the superannuation fund, paid by the trustee and paid by an employer-sponsor.

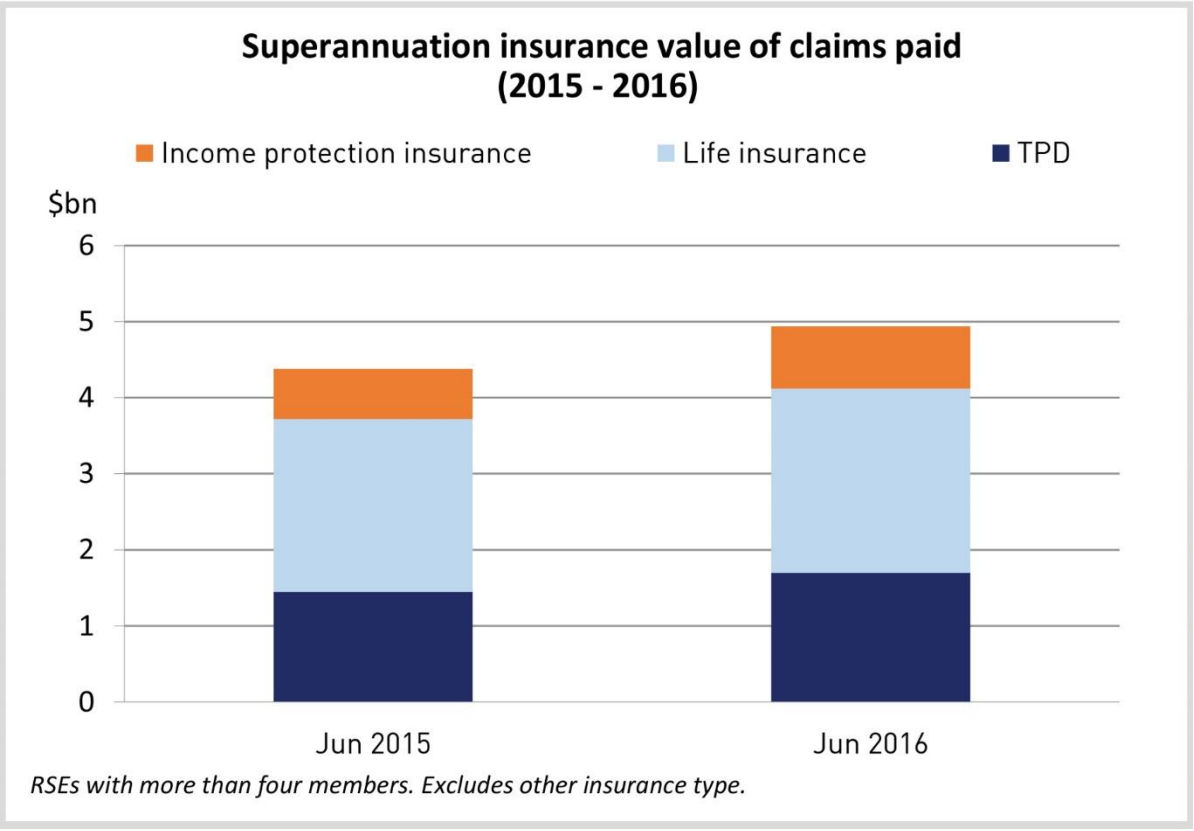


RSEs with more than four members.

The charts below show the number and value of claims paid by insurers for 2014 to 2016. The information is presented by type of insurance for life insurance and TPD. The category 'non-life insurance and TPD' includes income protection insurance and other insurance.



RSEs with more than four members. Excludes other insurance type.



RSEs with more than four members. Excludes other insurance type.

Glossary of terms used in Attachment A

Claims admitted	Claims admitted represents claims where a final decision to admit the claim has been made by the insurance provider but payment has not yet been made by the insurance provider to members and/or their beneficiaries. For each insurance type (other than income protection insurance), claims admitted represents the value of claims admitted but not yet paid. For income protection insurance, the value of claims admitted represents the aggregate monthly amount of claims.
Claims paid	Claims paid represents where an insurance provider makes a payment with respect to a claim made by an RSE licensee. Includes: rehabilitation costs or benefits that minimise claims experience or potential prepayment of insured amounts. For income protection insurance, claims paid include the total amount paid during the reporting period and includes claims that are in the course of payment but are subject to regular assessment.
Claims reported (not admitted)	Claims reported (not admitted) represents potential claims which have been notified to an insurance provider but for which a decision to accept the claim has yet to be made.
Income protection insurance	Income protection insurance represents the temporary incapacity cover provided to members, where temporary incapacity insurance cover has the meaning given in the SIS Regulations, r. 6.01.
Insurance premium	Insurance premium represents an amount paid for the provision of insurance under an insurance policy. Excludes: legacy insurance arrangements where no insurance premium is payable because the insurance policy is based on a surrender value.
Life insurance	Life insurance represents a benefit, in respect of each member, that is payable only in the event of the death of the member and which is provided by taking out insurance. Includes: life insurance policies offered through superannuation only and insurance premiums are commissions. Reference: SIS Act, s. 68AA(1)(b).
Life insurance direct premiums	Life insurance direct premiums comprises life insurance direct premiums, policy conversions-inwards and non-life insurance premiums.
Member account	Member account represents a distinct entry recorded in the register of member accounts (or other equivalent mechanism).
Net policy expenses	Net policy expenses means policy expenses net of outward reinsurance claims.

Net policy revenue	Net policy revenue is policy revenue net of outward reinsurance premiums.
Other insurance	Other insurance represents insured benefits that are not otherwise categorised as life insurance, total and permanent disability insurance or income protection insurance. Includes: permissible insurance types as outlined in the SIS Act, types of insurance which have been grandfathered under law and legacy insurance arrangements where no insurance premium is payable by the member because the insurance policy is based on a surrender value. Reference: SIS Act, s. 68AA, s. 10(1), SIS Regulations, r. 6.01.
Product group	Product group is as defined in Reporting Standard LRS 001 Reporting Requirements
SIS Act	SIS Act means *Superannuation Industry (Supervision) Act 1993*.
SIS Regulations	SIS Regulations means Superannuation Industry (Supervision) Regulations 1994.
Superannuation entity	A superannuation entity is a regulated superannuation fund, an approved deposit fund or a pooled superannuation trust.
Total and permanent disability insurance	Total and permanent disability insurance represents a benefit, in respect of each member, that is payable only if the member is suffering permanent incapacity. Reference: SIS Act s. 68AA, s. 10(1).

APRA