INFORMATION PAPER

Update on steps to implement a public reporting regime for life insurance claims information

9 November 2017

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Executive summary

APRA and ASIC (collectively, the agencies) are working together to implement a public reporting regime for life insurance claims information, as set out in APRA's May 2017 Discussion Paper *Towards a transparent public reporting regime for life insurance claims information* [1] (Discussion Paper). This initiative commenced following the release of ASIC's Report 498 *Life insurance claims: An industry review'* (REP 498) in October 2016.

Significant progress has now been made to implement a public reporting regime for life insurance claims information. A first round of pilot data collection has been conducted and analysed, and initial results are now available. Work is proceeding in accordance with the programme set out in the Discussion Paper.

This Information Paper:

1. provides an update on progress and next steps;

2. launches the second round of the pilot data collection, with refinements made to the data template and definitions;

3. provides feedback to insurers and other stakeholders regarding common data quality issues observed in round one of the pilot data collection, to support improvements for subsequent collections; and

4. provides key initial industry aggregate results from round one of the pilot data collection to contribute to informed public debate, consistent with the intent outlined in the Discussion Paper.

The agencies have engaged extensively with stakeholders as this initiative has progressed. This has included engagement with the Financial Services Council, individual insurers, the actuarial profession and other stakeholders including consumer groups. The agencies have also kept the Parliament informed through ongoing accountability processes and appearance before inquiries, including the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry.

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

Update

This Chapter provides an update on the progress of the implementation of a public reporting regime for life insurance claims information. It sets out:

- objectives and approach;
- some initial results from round 1 of the pilot data collection;
- changes made for round 2 of the pilot data collection;
- the process for considering submissions in response to the Discussion Paper; and
- next steps.

Objectives and approach

The objectives of the public reporting regime for life insurance claims information as set out in the Discussion Paper, are to:

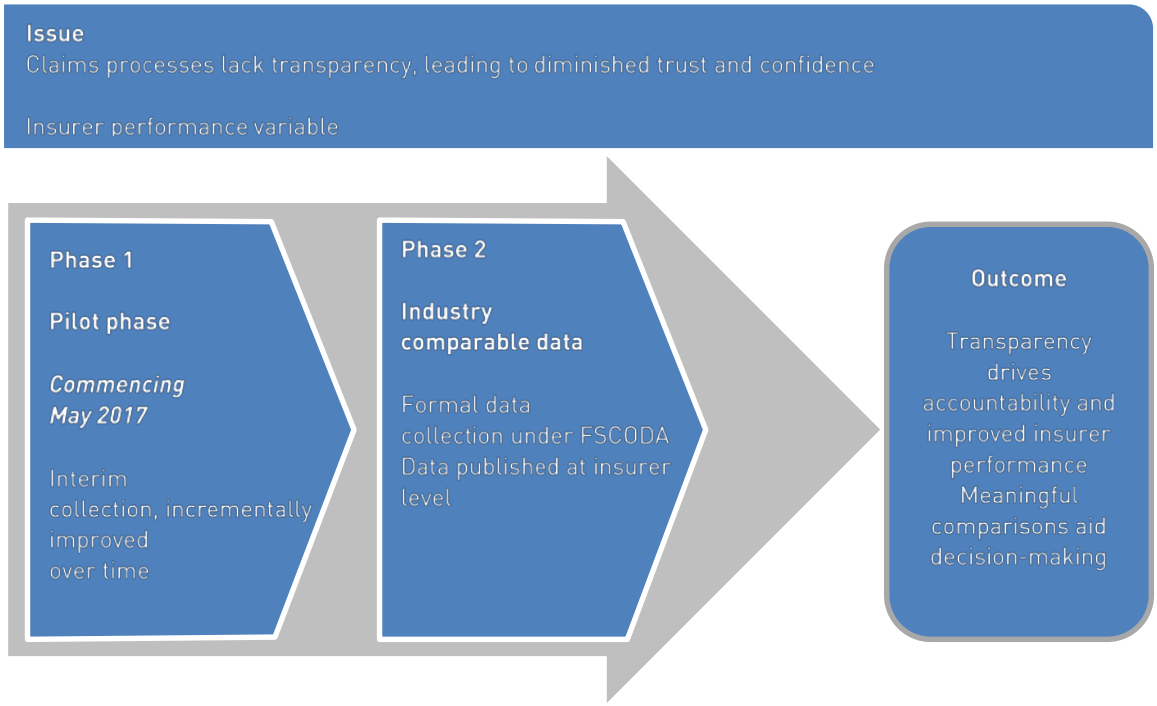
1. improve accountability and performance of life insurers in relation to claims; and
2. facilitate an informed public discussion about the performance of the life insurance industry.

These objectives will be achieved through publication of credible, reliable and comparable data. The agencies' intention is for this data to be collected and, eventually, 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 reflect the performance of the insurers. A transparent industry enables stakeholders to hold insurers accountable for their performance and creates an environment where stakeholders can understand the operation of the industry.

The agencies are following a phased approach to this initiative, as outlined in Figure 1.

Figure 1



Results of the phase 1, round 1 data collection

The first round of the phase 1 pilot data collection was launched in May 2017, covering data for the 2016 calendar year. Data was submitted on a best endeavours basis by the 16 insurers that were requested to participate. The submission deadline of 30 June proved challenging for some insurers, and the agencies granted extensions of up to four weeks to allow for submission of data that was of the highest standard possible.

Overall, the first round of the pilot data collection has been successful. The pilot has formalised common definitions for key data items for the first time. The agencies are focusing on the ability of insurers to report according to the common definitions.

Data quality

The data submissions were reasonably complete and the majority of items were considered either fair or good in terms of the quality of data received.

As outlined in the Discussion Paper, the agencies expected that some insurers would find it challenging to report all the requested data according to the specified definitions. The experience during round 1 was consistent with that expectation. Insurers reported a range of systems constraints and other issues that resulted in data submissions that were not completely consistent with the data definitions and this reduced the comparability of the data. The agencies anticipate that this will improve over time but recognise that this will continue to be a challenge for many insurers.

The most common data items that presented insurers with problems included notified claims, passive and active withdrawals, some claims and dispute outcome categories, claim and dispute amounts paid and processing durations. Data analysis also showed that more specific consideration and clarity was required with respect to income protection insurance (also known as disability income insurance (DII)), reopened claims, voluntary discontinuances, and multi-benefit policies that are both inside and outside superannuation. The agencies are continuing to engage with insurers to clarify identified data issues. To assist in improving the quality of future data submissions, Attachment A includes a summary of common issues encountered during the review of the data submissions.

Initial results

While the data from the first round of pilot data collection is not of sufficient reliability and comparability to support entity-level publication, the agencies are of the view that components of it are sufficiently robust to release publically at an aggregate industry level. Publication of aggregate level data is an important step towards achieving the objectives of this initiative, and will materially enhance transparency and inform public debate.

The life claims data collection made use of a detailed, multi-dimensional template. Data was collected from 16 insurers across three broad data categories of policy statistics, claims data and dispute data.[2] The collection covered the four main cover types of death, total and permanent disability (TPD), trauma and DII. There were four additional data dimensions included in the collection, namely insurance type, advice type, on sale status and dispute type. A variety of measures were utilised across each dimension and category, such as lives insured, policy counts, premiums and sums insured. The combination of various data dimensions, categories and measures resulted in approximately 12 500 unique potential data points per insurer.

The detailed level of data collected will, once an appropriately reliable standard of data quality is achieved, allow for granular analyses of various items. Importantly, the various data dimensions will allow for more insight into what may drive potential differences in observed results. For example, trauma and TPD claims are typically more complex for insurers to assess than death claims; decline rates could reasonably be expected to be higher for the former than the latter. Similarly, fully underwritten policies entered into with advice may be less likely to result in a declined claim than a policy entered into directly, without advice. The agencies will continue to assess the effectiveness and adequacy of the current data dimensions and introduce further changes as appropriate.

Table 1 below sets out some key metrics derived from the data, aggregated across all insurers, cover types and distribution channels. The data items in Table 1 are defined in the data definitions document for the round 1 collection.[3] When considering these results, it

[2] Data was collected from insurers that write death (with and without terminal illness), TPD, trauma and disability income insurance. Investment products were excluded, as were traditional business, consumer credit insurance and funeral business. Reinsurance business was excluded, but other business written by reinsurers that comes within the scope above was included. A small number of insurers that had underwritten business included in the categories above, but that were no longer writing new business, were also excluded.

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

should be noted that insurers reported a range of systems constraints and other issues that resulted in data submissions that were not completely consistent with the data definitions.

In interpreting these results, it is important to note that a portion of claims received by insurers fall outside the policy terms. Insurers can and do legitimately decline such claims, and some policyholders will withdraw their claim when it becomes apparent that it is outside the terms of the policy. For this reason, the decline rate and withdrawn 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 within the terms of the policy and ensure those claims are paid.

Table 1

	Number (to nearest hundred)	%
Claims reported during 2016 (1)	126 300	
Claims finalised during 2016 (2)	103 100	81.6% of reported claims
- Claims admitted during 2016	95 000	92.1% of finalised claims
- Claims declined during 2016	8 100	7.9% of finalised claims
Claims withdrawn during 2016	6 400	5.1% of reported claims
Claims undetermined at the end of 2016	16 800	13.3% of reported claims
Disputes lodged during 2016 (3)	4 400	3.5% of reported claims (4)

Notes

(1) Reported claims include claims reported during calendar year 2016, as well previously reported claims that were undetermined at the start of calendar year 2016.

(2) Finalised claims are those where a claims decision was reached during calendar year 2016.

(3) Comprise claims related disputes lodged during calendar year 2016, as well as claims related disputes that were undetermined at the start of calendar year 2016. This includes a degree of double counting because multiple disputes can relate to the same underlying complaint and disputes may have been recorded under multiple dispute types by some insurers: internal (lodged with and reported by insurers), external (lodged with external dispute resolution schemes and reported by insurers) and litigated disputes (lodged in court and reported by insurers). This does not include disputes lodged only with superannuation fund trustees and not referred to insurers.

(4) Given a possible time lag between claims decisions and related disputes, disputes lodged during calendar year 2016 could also relate to claims reported and finalised before calendar year 2016.

Round 2 of the pilot data collection

The agencies will shortly launch round 2 of the phase 1 pilot data collection. Insurers will be contacted directly in the coming weeks and will be provided with the revised data template and definitions.

As noted in the Discussion Paper, the agencies anticipated using the pilot phase of this work to incrementally refine the data template and definitions. Consistent with that intention, refinements have been made for round 2.

Some of the changes to the definitions and data template being implemented by the agencies for round 2 are summarised in Attachment B. These are still being finalised and will be covered in more detail when the round 2 requirements are released. They are expected to improve data quality, address areas of ambiguity and enhance clarity.

The arrangements for round 2 are summarised in the following table:

Table 2

What is required?	Use best endeavours to complete the reporting template according to the instructions. The agencies expect that data submissions will be of higher overall quality than those for round 1 and that insurers will begin the necessary updates to automate the provision of data and reduce systems constraints. The agencies expect insurers to liaise with relevant superannuation fund trustees and other external administrators to ensure that they are aware of, and able to provide the data required for, this collection. The template and definitions will be provided to each relevant insurer in the coming weeks 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 round 2.
Reporting period	1 January 2017 – 30 June 2017
Due date	Wednesday 31 January 2018 or such later date as agreed with APRA.
Cover types	Death (with and without terminal illness), TPD, trauma, income protection/group salary continuance, life insurance component of consumer credit insurance, 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 traditional business, are excluded from the round 2 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

Discussion paper

In addition to launching the first round of the pilot data collection, the Discussion Paper sought input on a number of specific consultation questions, including the design of the collection, the data definitions, and the approach to publication and confidentiality of data. It sought feedback on whether other approaches to this initiative could be pursued, including whether:

3. data should be collected at the level of individual claims and disputes using what is known as a 'flat file' approach (collecting individual data on a claim-by-claim and dispute-by-dispute basis); and

4. an 'industry-led approach' to collection and publication of data is feasible.

APRA received ten submissions from a range of stakeholders: several consumer groups, representatives and a member of the life insurance industry and other private sector service-providers. Submissions were broadly supportive of the objectives underpinning this initiative, with particular emphasis on the importance of transparency for consumers.

Submissions expressed some support for further exploration of an industry-led approach. The agencies are assessing the merits and feasibility of such a proposal and engaging further with stakeholders. There was also some support in submissions for the collection of data in 'flat file' form. This would enable more granular data to be collected than can be accommodated by the current template structure. The agencies will actively explore alternative data collection approaches in upcoming collection rounds.

APRA will release a full response to submissions and publish non-confidential submissions when the agencies release proposals on phase 2 of the public reporting regime for life insurance claims information in 2018.

Next steps

Following the completion of round 2 of the pilot data collection, the agencies intend to conduct at least one further pilot data collection round. Table 3 reflects the agencies' current intentions regarding timeframes for the remaining rounds in the pilot.

Table 3

Phase/round	Period covered	Release date for template	Due date for data
Phase 1, round 2	January – June 2017	November 2017	31 January 2018
Phase 1, round 3	July – December 2017	May 2018	June 2018

The Discussion Paper also outlined in some detail the intended approach to phase 2 of this initiative. As part of the process to implement phase 2, the agencies intend to:

5. consult with stakeholders by releasing a discussion paper, together with draft reporting standards, forms and instructions; and

6. 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 the first half of 2018. The work on the draft reporting standards, forms and instructions will be extensively informed by the experience of undertaking the phase 1 pilot data collection.

The agencies remain committed to publishing further data as early as possible. Given the objective of a public reporting regime for life insurance claims information which allows consumers and other stakeholders to make meaningful comparisons, it is critical that the data is credible, reliable and comparable to avoid consumers and other stakeholders being misled.

A structured process is being followed to carefully consider the release of data, with a view to releasing data as early as possible while ensuring that it is fit for purpose. The agencies will consult further with stakeholders regarding publication of entity-level data, including how that data should be presented to support the objectives of this initiative and the confidentiality of the data.[4]

[4] Under section 56 of the *Australian Prudential Regulation Authority Act 1999* (APRA Act), data submitted to APRA under the *Financial Sector (Collection of Data) Act 2001* (FSCODA) is protected information. The section 56 protection applies to all data submitted to APRA under both Phase 1 and Phase 2. 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.

Attachment A – data quality from phase 1, round 1

Overall assessment

- *Instructions.* Concepts and definitions, including more complex issues, such as the allocation of claims to claims incidence years, were generally well understood. There were some instances of misinterpretation or instances where the definition proved to be insufficient, but the effect of these was generally not significant. These issues, together with other definitional refinements, will be addressed in phase 1, round 2.

- *Completeness of submission.* The submissions of most insurers were generally complete. A small number of insurers had gaps in their submissions, usually related to information that they were not able to include and/or that was split across the data dimensions requested.

- *Data granularity.* Many insurers encountered challenges with the level of granularity requested. This usually occurred in relation to subsets of their business and specific systems with certain data limitations or gaps, or where data was held in a format different from what was requested. Most insurers dealt with this by using assumptions.

- *Databases and systems.* Many insurers had to resort to significant manual efforts to complete the template. Most indicated that they were looking at ways to address shortcomings in their initial submissions in round 2 of the pilot data collection, including better data capture and sometimes more automated processes. Depending on the specific data request, for some insurers improvements might be a difficult exercise without significantly overhauling or updating systems.

To illustrate the impact of these issues on the quality of data Table 4 below provides an overall assessment of the general quality of data received.

Issues and comments related to policy statistics data

- Policy statistics were generally complete and of a reasonable quality for most insurers.

- Policy contracts with benefits both inside and outside of superannuation funds presented some obstacles, as the template did not allow for such complexity. Interpretation of the template was not consistent across insurers.

- There were some inconsistencies in the treatment of employer-owned contracts, with some insurers classifying these as group insurance, despite the underlying contracts being individual insurance contracts with individual underwriting.

- There were some inconsistencies with the allocation of business between benefit categories, particularly where it related to business with terminal illness.

- Especially with group insurance, there were often inconsistencies between insurers with their interpretation of the concepts of policy contracts, policy benefits and lives insured.

- Detail in respect of the sum insured for DII was not always provided in accordance with the definition, often appearing to reflect an annual rather than a monthly income.
- There were some instances where insurers could not distinguish insurance claims from voluntary discontinuances. There were also a number of related items not treated consistently by insurers, such as lapses during the cooling off period, or items classified as new business.

Issues and comments related to claims data

- Claims data was generally complete and of a reasonable quality for most insurers.
- Many insurers were not able to provide information on claims notified, as defined for the round 1 data collection. This issue is mainly the result of most insurers currently not capturing this information in an accessible form.
- There were often inter-template inconsistencies in relation to the detail of claims reflected on the claims processing duration sheets and corresponding items in other sections of the template. The duration profiles submitted could potentially change when this detail is aligned with other claims data.
- The treatment of claims that are re-opened during the reporting period was not dealt with in the definitions and likely resulted in some inconsistencies in the treatment of this item.
- Not all insurers were able to provide detail in respect of all the defined claims outcome categories. Whilst the main categories of accept and decline generally appeared sensible, other categories proved problematic for some insurers (for example, ex-gratia payments, or benefits cancelled with premiums refunded). In most cases this was the result of the insurer not capturing the information at the relevant time or in the requested format.
- Consistent with the issue listed under Policy Statistics, the claim sum insured and claim amount paid in respect of DII contracts was often not expressed as a monthly benefit.
- Some insurers were unsure how to deal with the claim amount paid when it came to undetermined and declined claims.
- Many insurers were unable to differentiate between active and passive claim withdrawals.

Issues and comments related to dispute data

- Dispute data appeared to present most insurers with a greater challenge. Whilst most insurers were able to report on the total number of disputes lodged, there were limitations in their ability to report on the outcomes. Obstacles experienced by insurers generally related to dispute information being fragmented across different administration systems and often processed on a manual basis.

- The dispute amount in respect of resolved disputes was not interpreted and completed on a consistent basis across insurers. This issue should however be seen in the context of a complex and possibly counter-intuitive round 1 data collection definition.
- Similar to claims, there were some inter-template inconsistencies with some dispute items reflected on the dispute processing duration sheets and corresponding items in other sections of the template. The duration profile could potentially change when this detail is aligned with other dispute data.
- Similar to claims, insurers were not always able to provide detail in respect of all the defined dispute outcome categories. Some insurers were not able to classify significant portions of their lodged disputes, due to the required information not being available.
- As with other data sections, the DII sum insured presented some difficulties. This was further complicated by the fact that settlements were often of a lump sum nature, something that the round 1 data collection template and definitions did not address.
- Many insurers were unable to differentiate between active and passive dispute withdrawals.

Table 4

	Data type	Overall quality rating
A	**Policy Statistics**	
1	Benefit Categories/Cover Types	Some quality issues
2	Policy Benefits/Policy Contracts/Lives Insured	Some quality issues
3	Annual Premium	Good
4	Sum Insured	Some quality issues
5	New Business	Good
6	Voluntary Discontinuances	Good
7	Other Movement	Some quality issues
8	Claims Finalised	Good
9	Various Claims Outcomes	Some quality issues
10	Group vs Individual	Some quality issues
11	Individual Inside Super vs Outside Super	Some quality issues

	Data type	Overall quality rating
B	**Claims**	
1	Benefit categories/cover types	Good
2	Claim Counts	Good
3	Claim Sum Insured	Some quality issues
4	Claim Amount Paid	Some quality issues
5	Claim Incidence Year	Good
6	Claims Notified	Significant quality issues
7	Claims Reported	Some quality issues
8	Claims Finalised	Good
9	Various Claims Outcomes	Some quality issues
10	Claims Withdrawn	Some quality issues
11	Claims Undetermined	Good
12	Claims Processing Durations	Significant quality issues
13	Open vs Legacy	Good
14	Advised vs Non-Advised	Good
15	Group vs Individual	Some quality issues
16	Individual Inside Super vs Outside Super	Good
C	**Disputes**	
1	Benefit categories/cover types	Good
2	Dispute Counts	Good
3	Dispute Sum Insured	Some quality issues
4	Dispute Payment Amounts (Resolved)	Significant quality issues
5	Disputes Notified	Significant quality issues
6	Disputes Lodged	Some quality issues
7	Disputes Resolved	Good

	Data type	Overall quality rating
8	Various Disputes Outcomes	Significant quality issues
9	Disputes Withdrawn	Some quality issues
10	Disputes Undetermined	Good
11	Disputes Processing Durations	Significant quality issues
12	Dispute Types	Some quality issues
13	Advised vs Non-Advised	Good
14	Group vs Individual	Some quality issues
15	Individual Inside Super vs Outside Super	Good

Notes

In Table 4, overall quality ratings should be interpreted as follows:

"Good": Generally completed well although there may have been an issue for a small number of insurers providing full or accurate data that could not be resolved.

"Some quality issues": Many or most insurers had a one or more difficulties or issues completing the item fully that could not be resolved.

"Significant quality issues": Most insurers had significant issues providing any data or reliable data.

Attachment B – refinements to the data template and definitions for phase 1, round 2

This Attachment summarises:

- additional data to be collected in round 2;
- data items to be removed or significantly simplified in round 2; and
- other proposed changes for round 2.

Additional data to be collected in round 2

The following are examples of the new data items which will be included in round 2:

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

A number of insurers have been added for round 2, as their main products will now be included in the collection template.

Round 2 will also collect qualitative information to inform possible future template changes. Qualitative information will include:

- detail on sub-benefit types, e.g. own vs any occupation TPD;
- detail on DII claims management practices; and
- detail on collection capabilities and preferences, including the use of a flat file.

Data items to be removed or significantly simplified in round 2

The following are examples of the data items which will be removed or significantly simplified in round 2:

- simplification of policy benefits, policy contracts and lives insured;

- benefit categories simplification, including the removal of terminal illness in the policy statistics;
- simplification of the claim sum insured and claim amount paid detail (claims data); and
- simplification of the dispute sum insured and dispute amount paid detail (dispute data).

Other changes for round 2

Whilst no significant changes to definitions are planned, there will be a number of refinements to address areas of ambiguity. These include:

- the definition for DII sum insured;
- dealing with re-opened claims; and
- claims processing durations, specifically dealing with waiting periods.

Other changes include a recalibration of the duration categories used for claims and dispute processing durations.

APRA