CTP Insurer Claims Experience and Customer Feedback Comparison

31 March 2021

State Insurance Regulatory Authority (SIRA)

NSW GOVERNMENT

Why does SIRA publish insurer data?

As part of its regulatory oversight, SIRA closely monitors insurers' performance through data-gathering and analysis. SIRA helps to hold insurers accountable by being transparent with this data, enabling scheme stakeholders and the wider public to have informed discussions about the performance of the industry.

Additionally, access to insurers' data will help customers make meaningful comparisons between insurers when purchasing CTP insurance. People injured in motor accidents may also benefit from knowing what to expect from the insurer managing their claim.

In this report, SIRA compares seven key indicators of customer experience across the five CTP insurers in NSW: AAMI, Allianz, GIO, NRMA and QBE. A sixth insurer, Youi, joined the scheme from 1 December 2020. Once a significant number of claims are received by Youi, it will then also be included in this report.

The following indicators measure insurer performance over the course of a claim journey:

- the number of statutory benefits claims accepted by insurers
- how quickly insurers pay statutory benefits
- the outcome and time taken to review claim decisions by insurers through the insurers internal review unit
- the number and outcome of claims referred to the Dispute Resolution Service
- the number and type of compliments and complaints received by SIRA about insurers
- the number and type of issues considered for enforcement and prosecution action
- customer experience and outcomes, as measured by SIRA's independent survey

This issue of the report presents data for the first three measures above, over two time periods: 1 April 2019 to 31 March 2020 (the 2020 year) and 1 April 2020 to 31 March 2021 (the 2021 year).

Where the data relates to disputes about insurers, it is measured from December 2017 to 28 February 2021. From 1 March 2021, SIRA dispute resolution functions transferred to the Personal Injury Commission and the Independent Review Office was established to respond to complaints about insurers.

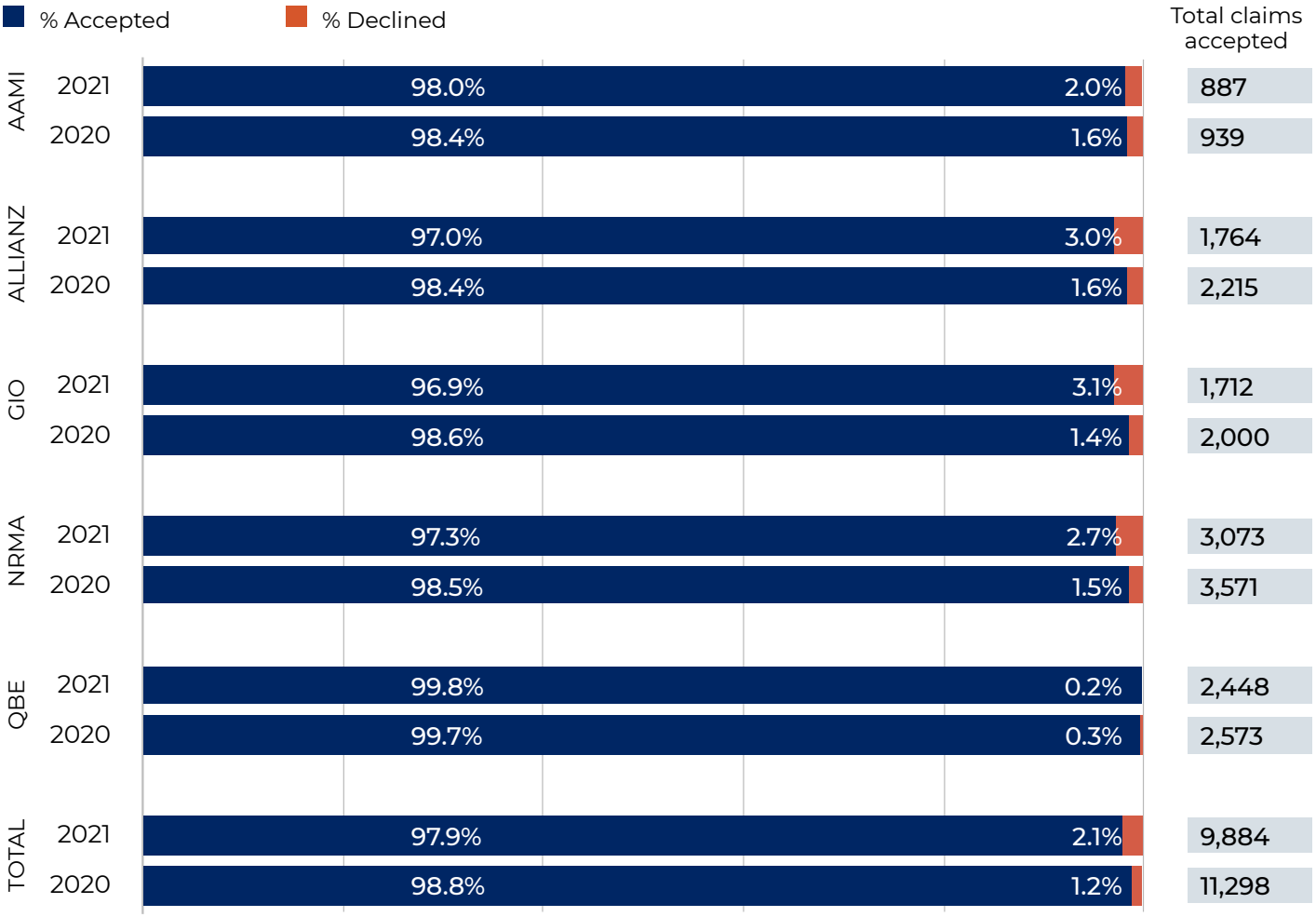
The other measures are presented as per the periods described in the respective sections of the report.

The CTP Insurer Claims Experience and Customer Feedback Comparison results are published each quarter. Generally, these results and the indicators measuring insurer performance remain relatively stable quarter to quarter.

How many claims* did insurers accept?

Insurers accepted most claims from injured people and their families. During the 2021 year, 97.9% of claims were accepted compared to 98.8% in the year 2020. More detail on the rejected claims is provided on the following page.

CHART 1: Claims* acceptance rates (%)



* Statutory benefits claims.

Why were claims declined?

Insurers decline claims in certain circumstances under NSW legislation.

The most common reasons for claim denial included:

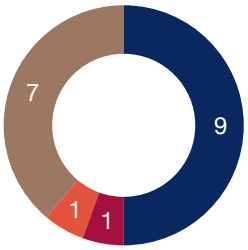
- late claim lodgement (more than 90 days after their accident),
- the claim did not involve a motor vehicle accident.
- the claim involved an uninsured, unregistered or unidentified vehicle

2.1% of claims were declined by insurers in the 2021 year, compared with 1.2% in the 2020 year. There were 9,884 total claims accepted in the 2021 year, down from 11,298 in the 2020 year.

CHART 2: Reasons why claims* were declined

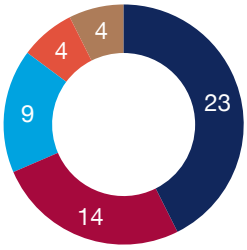
Year ending 31 March 2021

AAMI



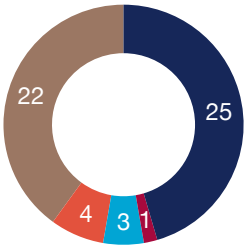
Rejected claims: 18

ALLIANZ



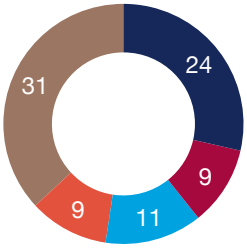
Rejected claims: 54

GIO



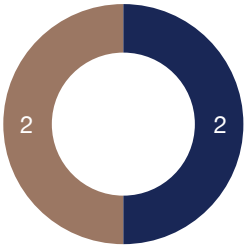
Rejected claims: 55

NRMA



Rejected claims: 84

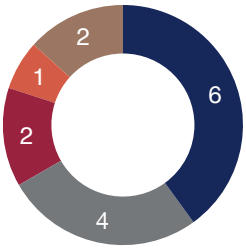
QBE



Rejected claims: 4

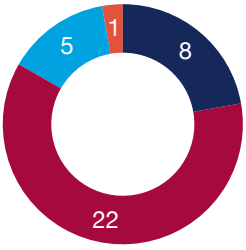
Year ending 31 March 2020

AAMI



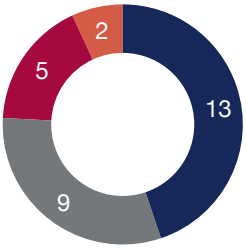
Rejected claims: 15

ALLIANZ



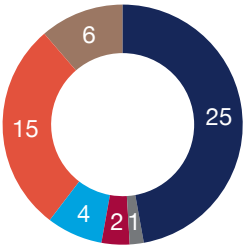
Rejected claims: 36

GIO



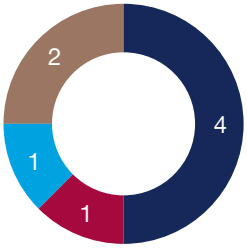
Rejected claims: 29

NRMA



Rejected claims: 53

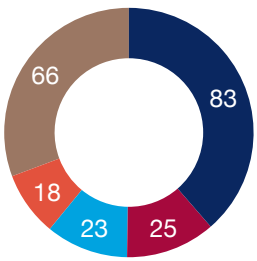
QBE



Rejected claims: 8

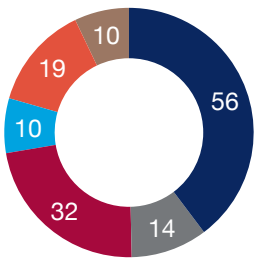
Totals 2021 vs 2020

TOTAL 2021



Rejected claims: 215

TOTAL 2020



Rejected claims: 141

- Late claim (lodged >90 days after accident)
- Insufficient information provided to insurer
- Claim did not involve a motor vehicle accident
- Claim involved an uninsured, unregistered or unidentified vehicle
- Claim related to a serious driving offence
- Other**

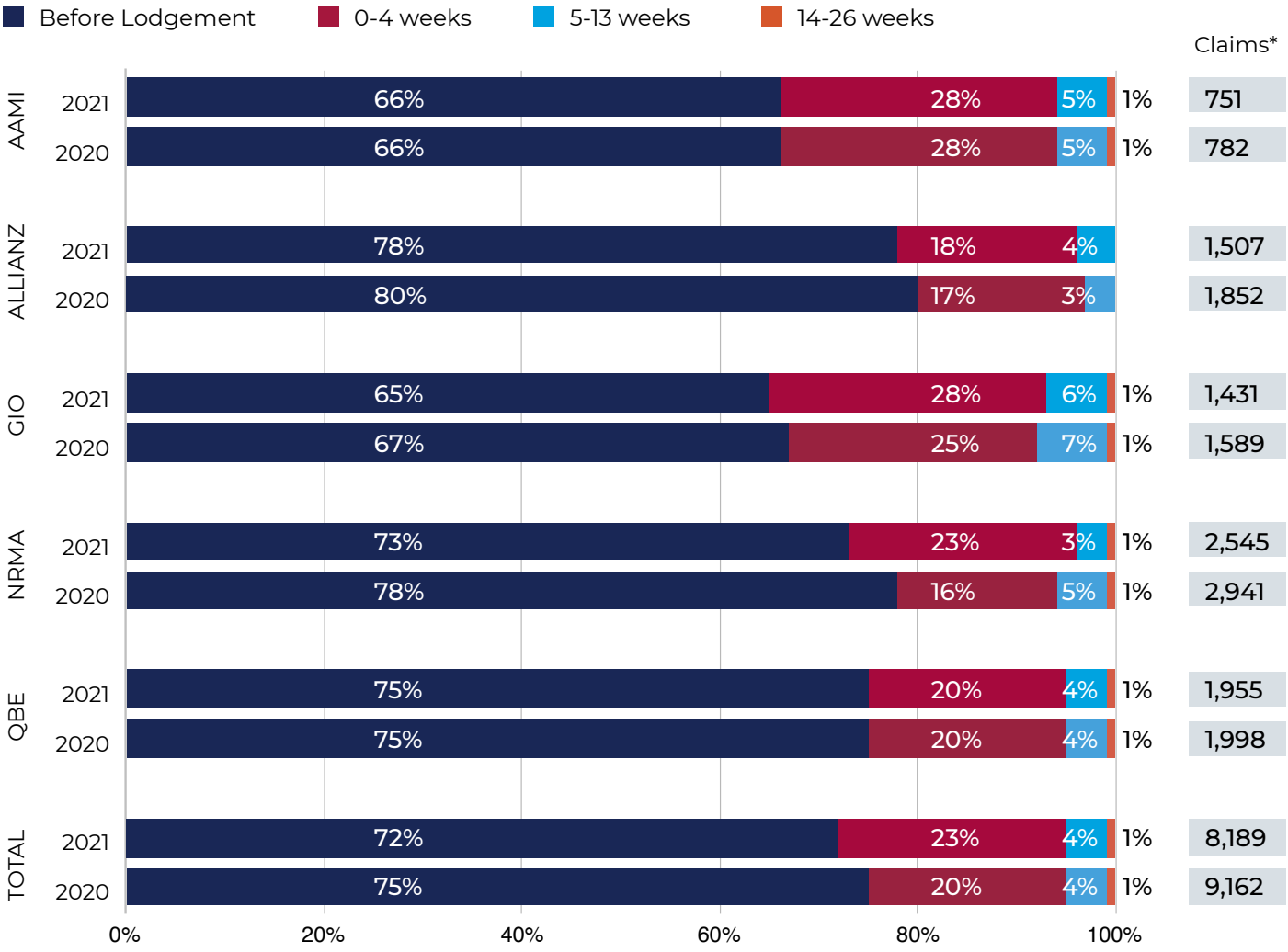
* Excludes claims which were declined because customers were covered by other scheme/insurer.
** Includes: injury non-existent, or not covered under the legislation.

How long did it take to receive treatment and care benefits?

Receiving treatment immediately after an accident is critical for making a full recovery. That is why insurers cover initial medical expenses for most people before they lodge a formal claim. This is when customers access treatment and care services after notifying the insurer, but before lodging a formal claim.

72% of injured people received 'pre-claim support' in the 2021 year, with a further 23% accessing treatment and care services within the first month after lodging a claim. During the 2020 year, 75% of injured people received 'pre-claim support' with a further 20% accessing treatment and care within the first month of lodging a claim.

CHART 3: Time it takes to receive treatment and care benefits (in weeks)



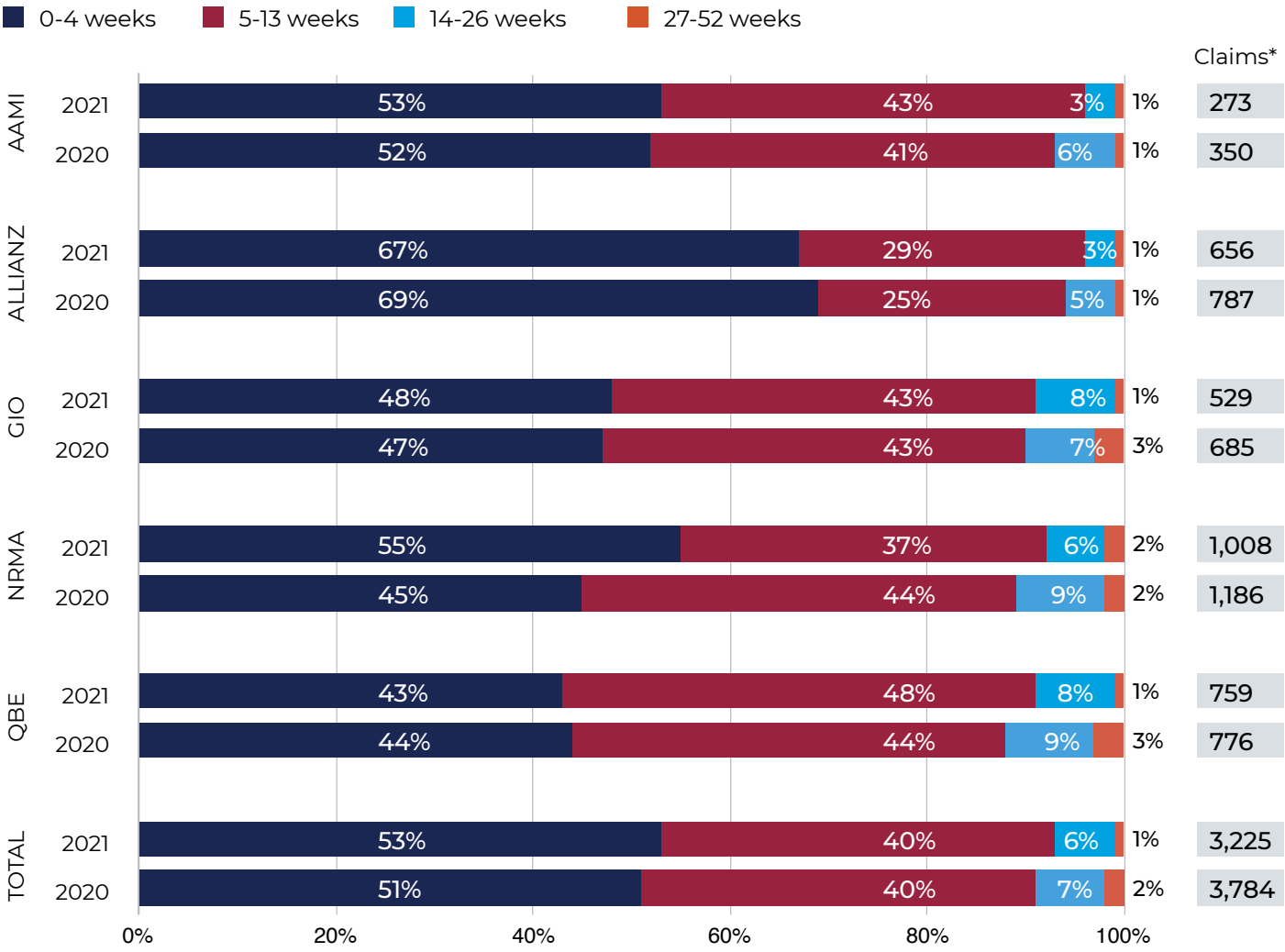
*Of the total 9,884 accepted statutory benefits claims in the 2021 year, 8,189 had treatment and care services. For the 2020 year, of the total 11,298 accepted statutory benefits claims, 9,162 had treatment and care services.

How quickly did insurers pay income support to customers after motor accidents?

Some people need to take time off work after an accident. That is why it's important for insurers to provide income support in the form of weekly payments to people while they are away from work. Over half of customers entitled to income support payments received it within the first month of lodging a claim, with the vast majority receiving the income support payments within 13 weeks.

The sooner the insurer receives the relevant information from the customer, the sooner the insurer can begin to pay income support payments.

CHART 4: Time it takes to receive income support (in weeks)



Some insurers begin paying income support faster than others. Among the five insurers, Allianz had the highest proportion of customers who received income support within the first month of lodging a claim.

*Of the total 9,884 accepted statutory benefits claims in the 2021 year 3,225 had payments for loss of income. For the 2020 year, of the total 11,298 accepted statutory benefits claims, 3,784 had payments for loss of income.

What happened when customers disagreed with the insurer's decision?

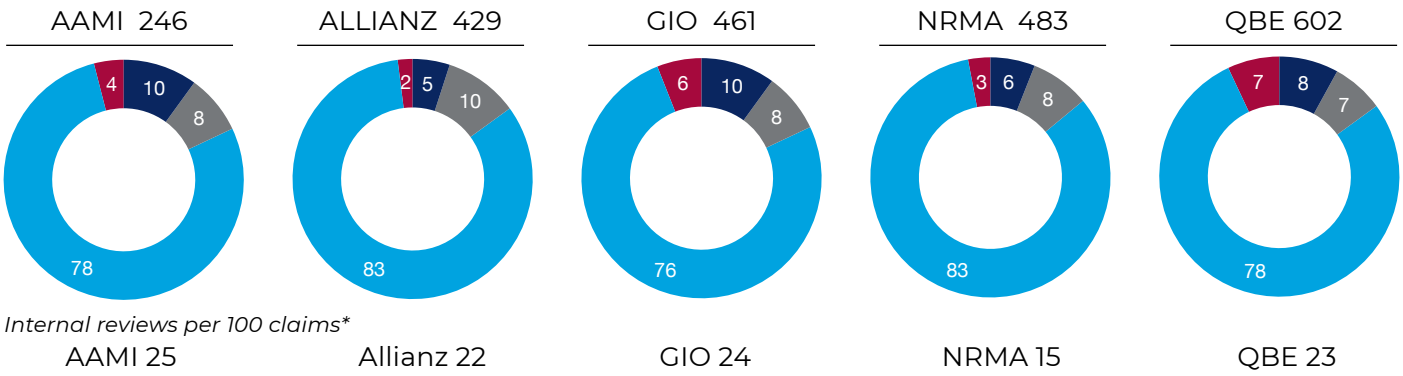
Customers who disagree with the insurer's decision can ask for a review. The decision will be reconsidered by the insurer's internal review team, who did not take part in making the original decision. Insurers accepted most applications for internal reviews. However, some applications were declined because:

- the request was submitted late and the customer did not respond to requests for reasons why it was submitted late, or
- the insurer determined it did not have the jurisdiction to conduct an internal review of that decision.

Customers sometimes also withdraw their application for an internal review.

CHART 5: Internal reviews by insurers and status (%)

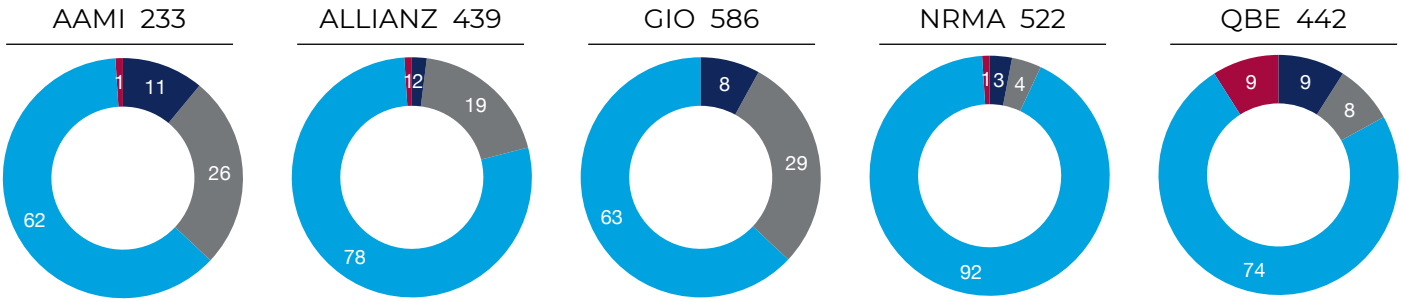
Year ending 31 March 2021



*Internal reviews per 100 claims**

AAMI 25	Allianz 22	GIO 24	NRMA 15	QBE 23

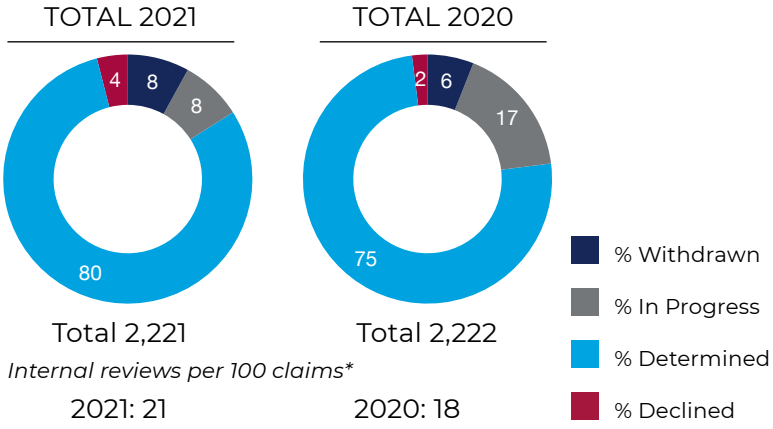
Year ending 31 March 2020



*Internal reviews per 100 claims**

AAMI 23	Allianz 18	GIO 27	NRMA 14	QBE 16

Totals 2021 vs 2020

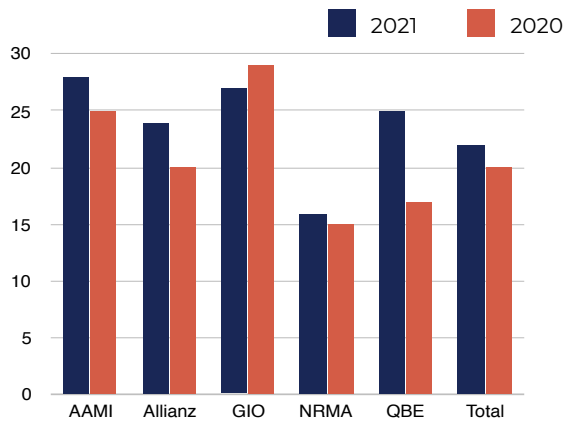


Total 2,221	Total 2,222

*Internal reviews per 100 claims**

2021: 21	2020: 18

Internal reviews to accepted claims ratio

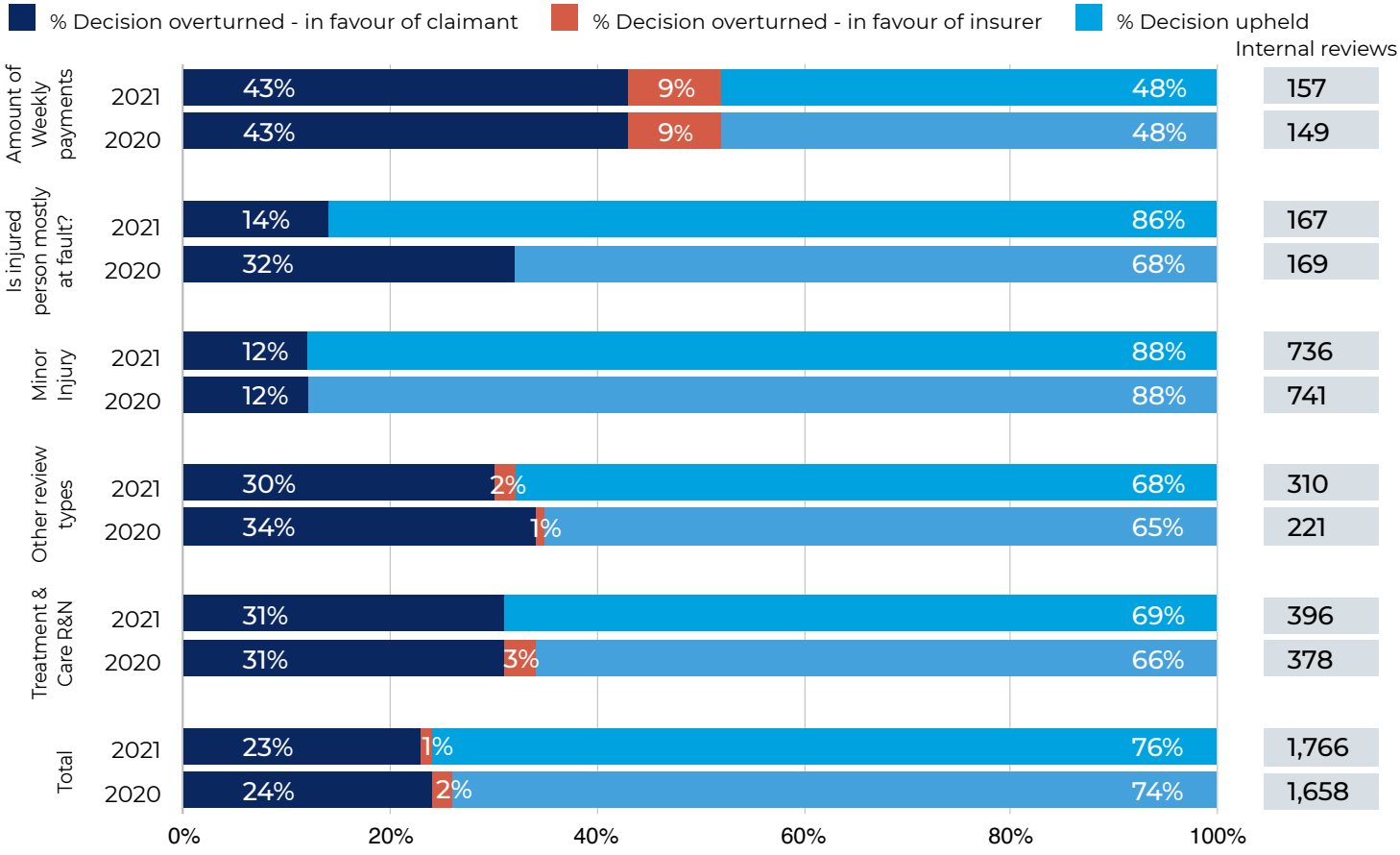


*The number of internal review requests received by insurers depends on how many claims have been received. Insurers with more reported claims are more likely to receive a greater number of internal review requests. By measuring insurer internal reviews per 100 claims received, SIRA can compare insurers' performance regardless of how many customers they have.

Outcomes of determined internal reviews

Of the total 1,766 determined internal reviews in the 2021 year, 76% had the initial claim decision upheld. In the 2020 year, 74% determined internal reviews had the decision upheld.

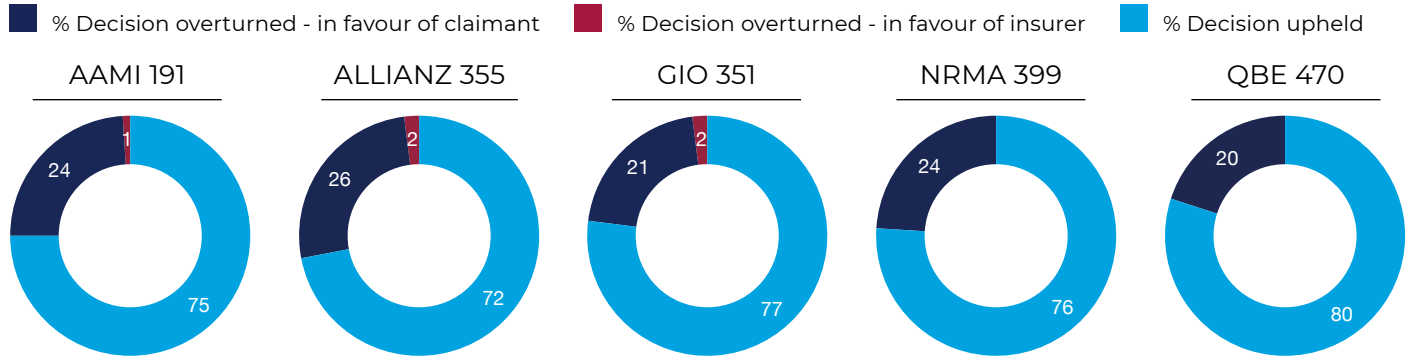
CHART 6A: Outcomes of determined internal review by review type (%)



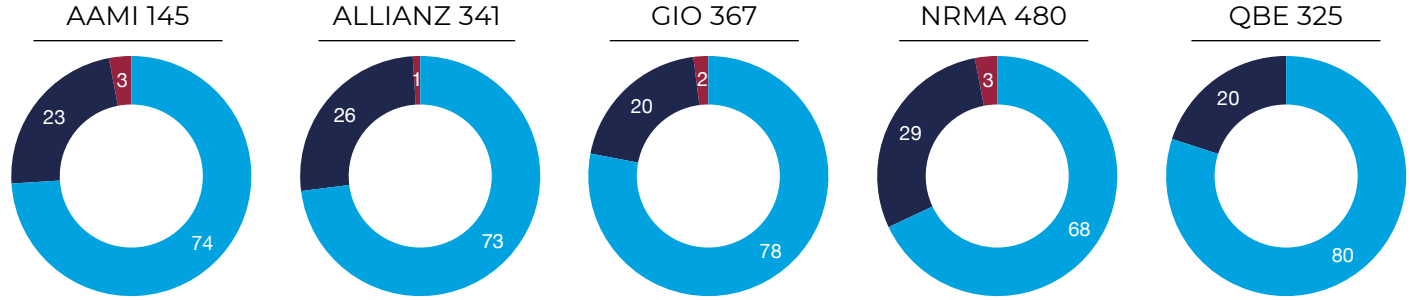
Note: Figures are rounded to the nearest whole percentage

CHART 6B: Outcomes of determined internal reviews by insurer %

Year ending 31 March 2021



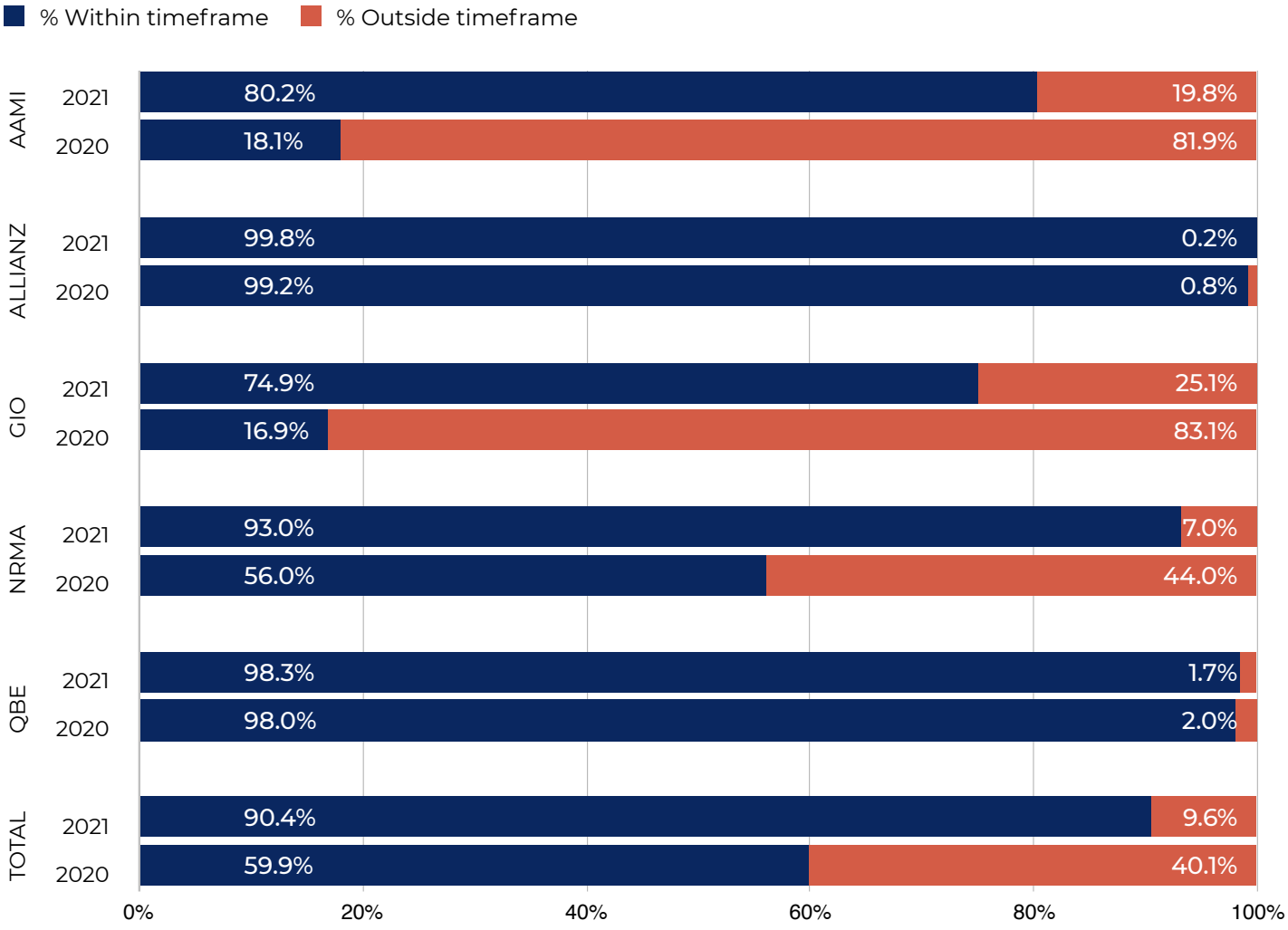
Year ending 31 March 2020



Internal review timeframes

The insurers internal review team must assess the claim within legislated timeframes.
The data shows the performance of each insurer in meeting those timeframes in the 2021 and 2020 year.

CHART 7A: Internal reviews completed by timeframe %



In response to SIRA's regulatory action, AAMI, GIO and NRMA have significantly improved their compliance with internal review decision timeframes, particularly in the second half of 2020.

Note: The time taken to review an internal review is sourced from data provided by each insurer

Internal review timeframes by dispute type

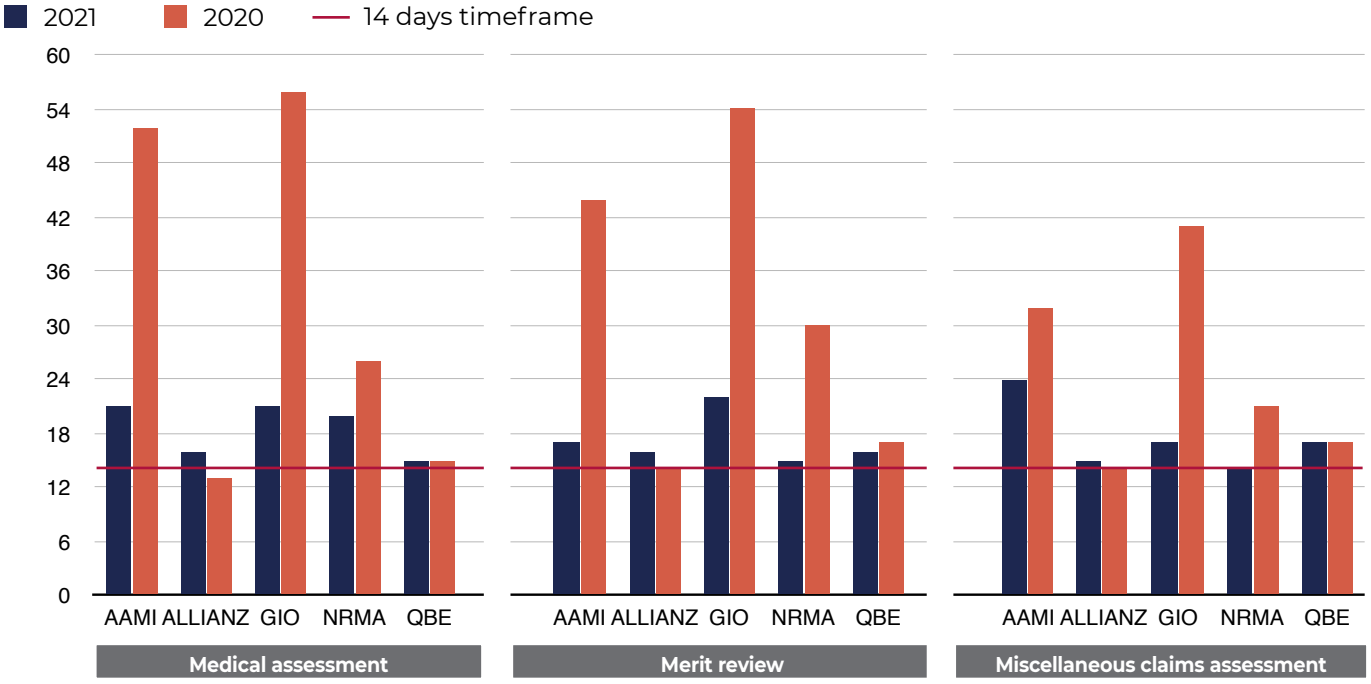
There are three types of internal reviews:

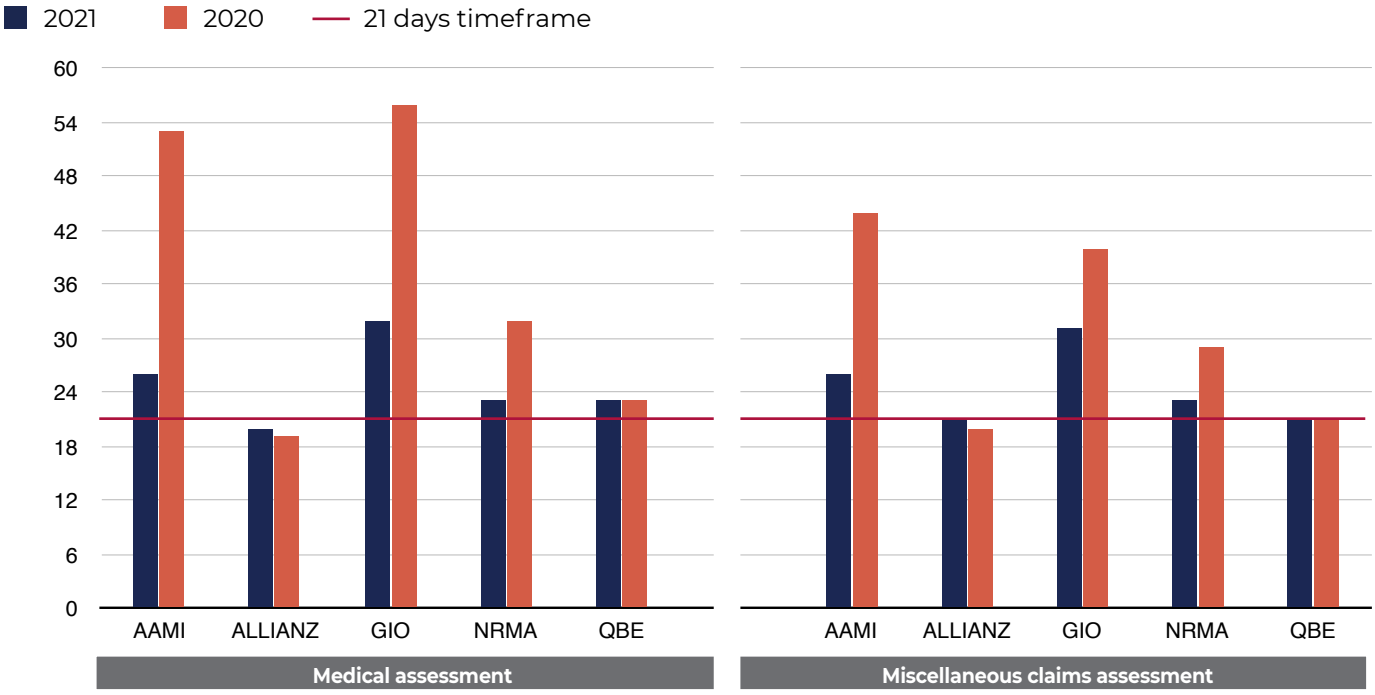
1. Merit review (e.g. the amount of weekly benefits)
2. Medical assessment (e.g. permanent impairment, minor injury or treatment and care)
3. Miscellaneous claims assessment (e.g. whether the claimant was mostly at fault).

For most internal reviews, the insurer must provide their internal review decision within 14 days of receiving the request for internal review. However, there are some medical assessment and miscellaneous claims assessment matters where this timeframe is extended to 21 days.

The maximum timeframe for all internal reviews is 28 days if further information is required.

CHART 7B: Internal review duration shown by dispute type and timeframe (days)





What if customers still disagreed with the reviewed decision by the insurer?

If the customer continues to disagree with the insurer about their claim after the insurer internal review, customers may apply to the Personal Injury Commission for an independent determination of the dispute.

The Personal Injury Commission was established on 1 March 2021 as a new tribunal that handles both motor accident and workers compensation disputes in NSW. Prior to this, SIRA managed motor accident dispute resolution functions through its Disputes Resolution Service (DRS).

The figures below provide dispute resolution data for SIRA's DRS until 28 February 2021, prior to this function being transferred to the Personal Injury Commission.

CHART 8: Dispute resolution cases by insurer and status (%)*

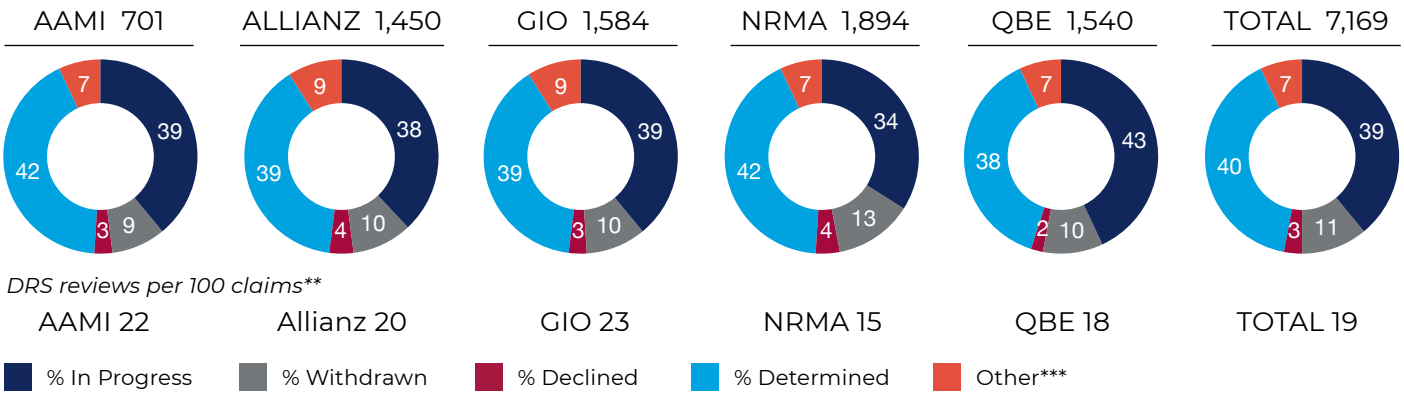
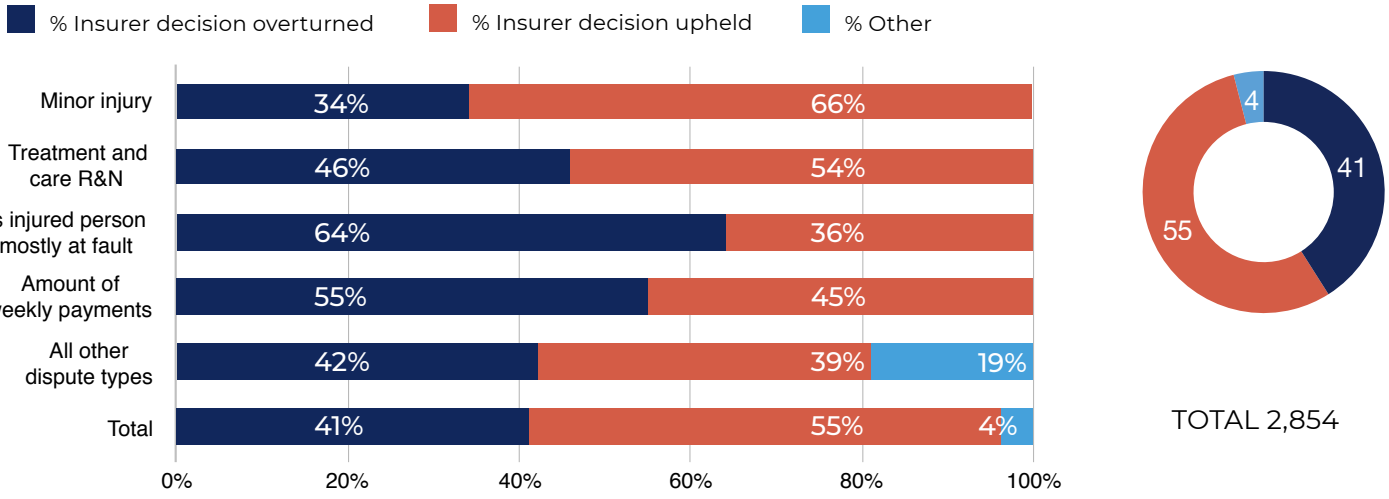


CHART 9: Outcomes of determined DRS review* (%)



*Data from 1 Dec 2017 to 28 February 2021.
**The number of dispute resolution cases received by DRS depends on how many claims individual insurers have received. Insurers with more claims are more likely to receive a greater number of dispute resolution applications. By measuring dispute resolution cases per 100 claims reported, SIRA can compare insurers' performance regardless of how many customers they have.
*** Open in error, invalid or dismissed disputes.

Compliments and complaints

From 1 March 2021, the Independent Review Office was established to hear complaints from injured people about their insurer. Prior to this, SIRA dealt with this type of complaint.

SIRA closely monitored the compliments and complaints it received about insurers. Compliments helped to identify best practice in how insurers manage claims, while complaints highlighted problems with insurers' conduct which could have required further investigation.

SIRA's compliments and complaints data from 1 April 2020 to 31 March 2021 was collected through SIRA's complaints and operational systems. Please note that customer complaints about insurer claims management are not included for the period 1 to 31 March 2021 due to the transition to the Independent Review Office SIRA will now only handle insurer claims management complaints when they are regulatory in nature.

Compliments and complaints received directly by the insurers are not included in the data below.

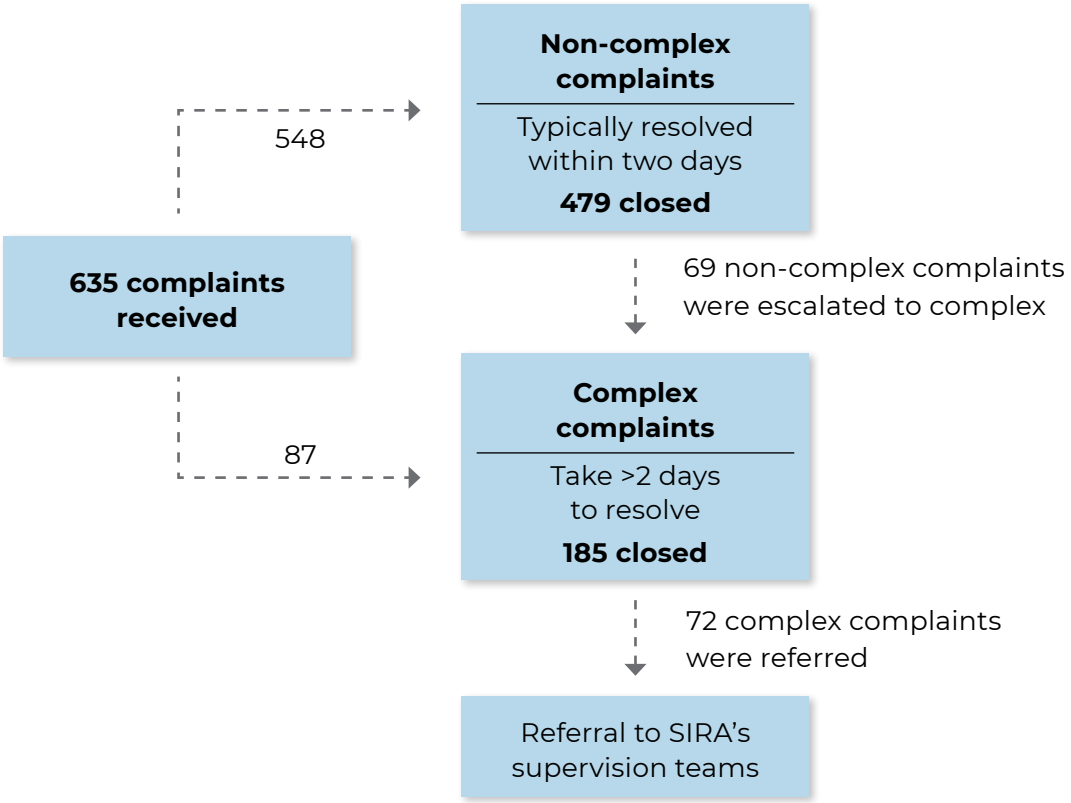
How SIRA handles complaints

Customers can lodge complaints through any of SIRA's channels. Non-complex complaints are handled by SIRA's CTP Assist service and usually take less than two working days to close.* Complex complaints are referred to SIRA's complaints handling experts and take more than two working days to close, depending on their complexity. Potential cases of insurer misconduct are escalated to SIRA's supervision teams for further investigation and possible regulatory action.

Customers who are unhappy with the outcome of SIRA's review can resubmit their complaint for further consideration. If customers disagree with how SIRA handled their complaint, they can contact the NSW Ombudsman for assistance.

Snapshot of resolved complaints process

Customers are encouraged to talk to their insurer in the first instance; insurers have their own complaints handling process.

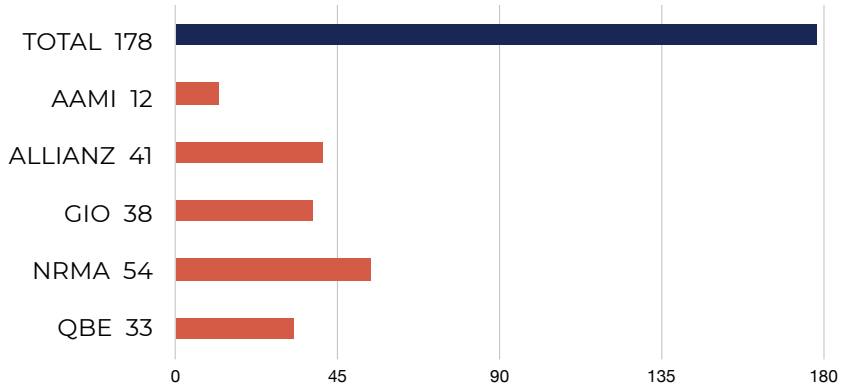


This information was collected from 1 April 2020 to 31 March 2021.

How many compliments and complaints about insurers did SIRA receive?

CHART 10: Compliments & Complaints (1 April 2020 - 31 March 2021)

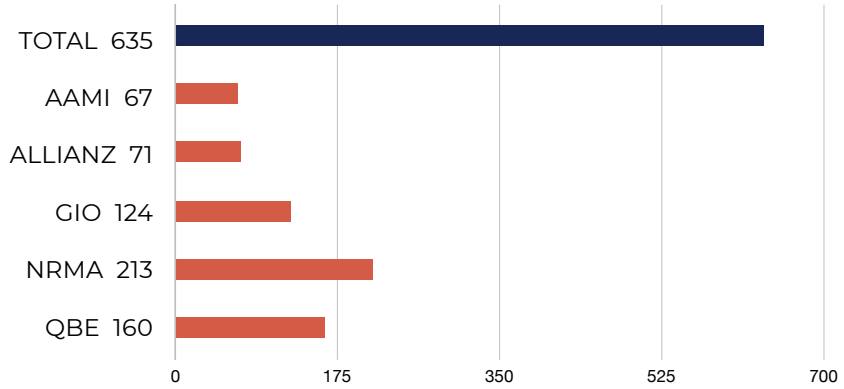
Compliments



Compliments
per 100,000 Green Slips*

TOTAL	3
AAMI	2
ALLIANZ	4
GIO	4
NRMA	3
QBE	2

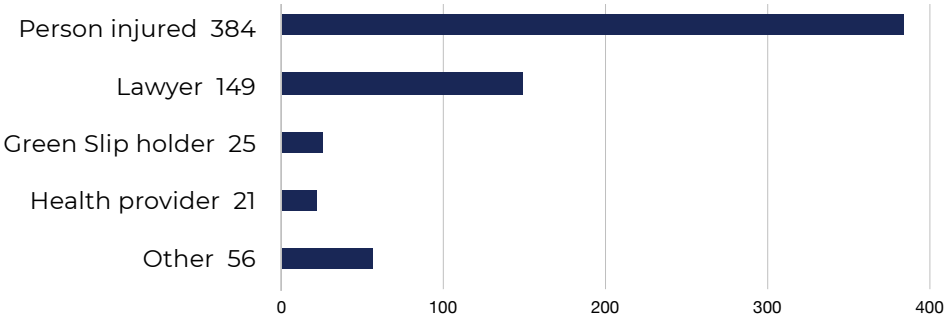
Complaints



Complaints
per 100,000 Green Slips*

TOTAL	11
AAMI	12
ALLIANZ	7
GIO	13
NRMA	11
QBE	11

Who made the complaint?

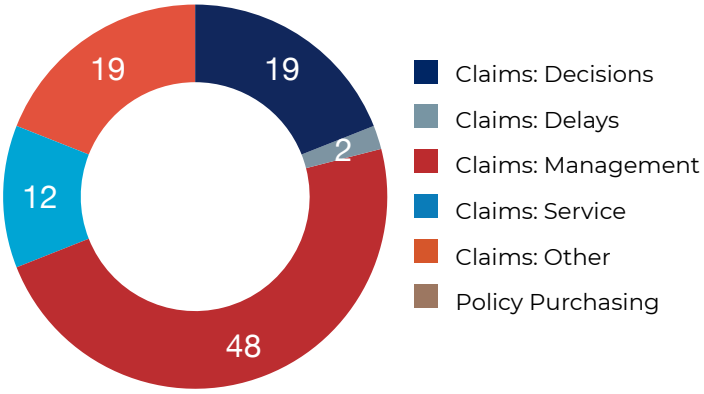


* The number of compliments and complaints insurers receive depends on how many customers they have. Insurers with more customers will receive more compliments and complaints, and vice versa. Therefore, by measuring compliments and complaints per 100,000 Green Slips sold, SIRA can compare insurers' performance regardless of how many customers they have.

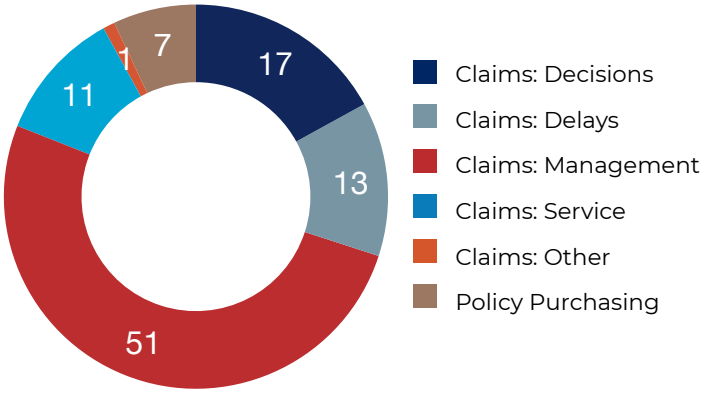
What were the complaints about?

CHART 11: Complaints categories (%)

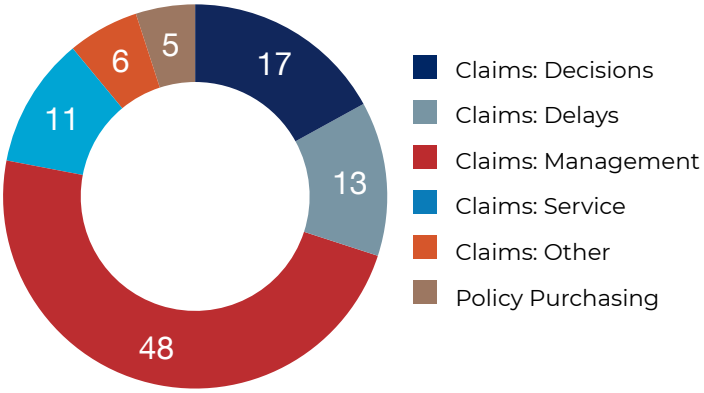
AAMI



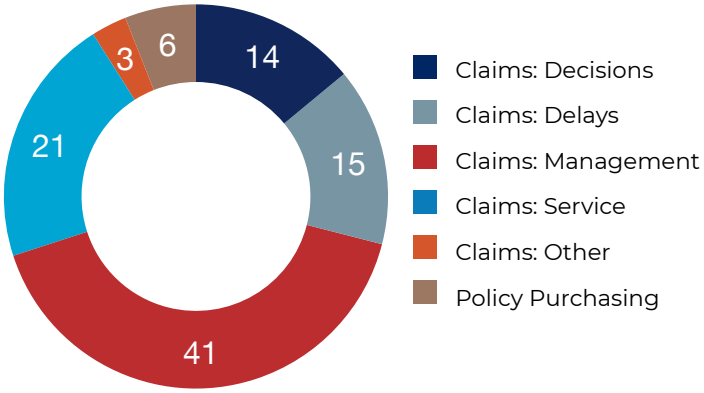
ALLIANZ



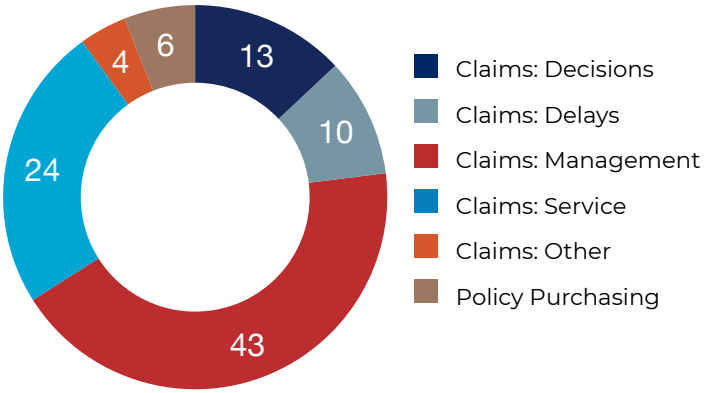
GIO



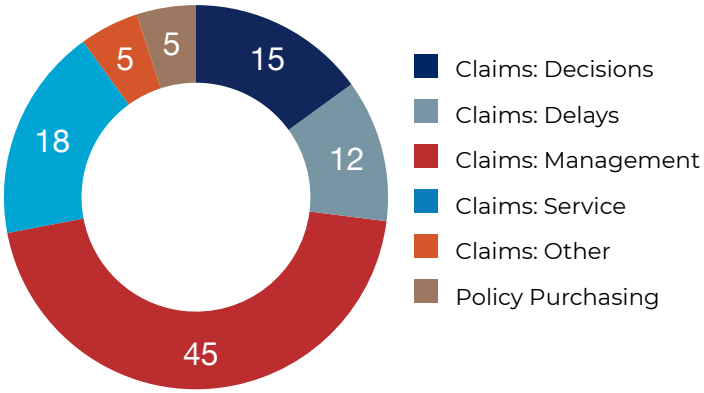
NRMA



QBE



ALL INSURER RELATED COMPLAINTS



This information was collected from 1 April 2020 to 31 March 2021.

Enforcement and Prosecutions (E&P)

SIRA is committed to making strong, consistent and evidence-based decisions on enforcement action. SIRA engages with law enforcement agencies, particularly the NSW Police Force, to deter and investigate fraudulent activity in the CTP scheme. SIRA is also developing fraud detection, scanning and provider management analytics software and services to help with regulatory monitoring.

SIRA's regulatory activities are focused on areas of highest risk. Firm and fair enforcement action is taken as needed, based on the severity of harm or potential harm, the degree of negligence, and/or the need for deterrence.

The regulatory activities outlined below are supported by SIRA's education and support initiatives. Together, these ensure that the motor accidents scheme is fair, affordable, and effective, and achieves public outcomes.

SIRA receives information on matters for potential enforcement and prosecution action through a range of regulatory monitoring activities. The following enforcement and prosecution options are available to SIRA:

Education	Notification of breach	Letter of censure	Penalty provisions	Criminal prosecution & licensing withdrawal	Publication of information on breaches or poor performance

For more information about how SIRA approaches its compliance and enforcement activities, please refer to SIRA's Compliance and Enforcement Policy.

From 1 April 2020 to 31 March 2021, SIRA had 45 active matters under investigation relating to alleged insurer breaches of their obligations under the Motor Accidents Compensation Act 1999 (1999 Scheme) and the Motor Accident Injuries Act 2017 (2017 Scheme) and guidelines. A total of 25 matters were finalised during this period, which includes matters received prior to April 2020. The remaining are under investigation.

	Completed Investigations	1999 Scheme	2017 Scheme
ALLIANZ	—	—	—
AAMI	8	5	3
GIO	9	3	6
NRMA	7	3	4
QBE	1	—	1
TOTAL	25	11	14

	Regulatory Action	Total	1999 Scheme	2017 Scheme
ALLIANZ	Regulatory notice	-	-	-
	Notification of Breach	-	-	-
	Letter Of Censure	-	-	-
	Civil Penalty	-	-	-
AAMI	Regulatory notice	1	-	1
	Notification of Breach	4	2	2
	Letter Of Censure	7	4	3
	Civil Penalty	-	-	-
GIO	Regulatory notice	1	-	1
	Notification of Breach	9	1	8
	Letter Of Censure	6	1	5
	Civil Penalty	-	-	-
NRMA	Regulatory notice	1	-	1
	Notification of Breach	10	1	9
	Letter Of Censure	1	-	1
	Civil Penalty	2	2	-
QBE	Regulatory notice	2	-	2
	Notification of Breach	5	1	4
	Letter Of Censure	1	-	1
	Civil Penalty	-	-	-
TOTAL		50	12	38

Of those matters where an insurer breach was substantiated, the following issues were identified, and insurers subsequently notified:

- Failure to endeavour to resolve claims in a just and expeditious manner in line with their obligations and licence conditions under the Act and Guidelines;
- Failure to complete and notify the results of their internal reviews within timeframes stipulated under the Act and Guidelines.
- Failure to respond or late response to a treatment and care request by the claimant or their representative;
- Inappropriate management of CTP claims.

The other matters finalised during this period were determined to be insurer practice issues of a minor nature. For these matters, SIRA has undertaken education initiatives to improve compliance and has continued to closely supervise the insurer.

SIRA Customer Experience Survey

SIRA engaged the Social Research Centre (SRC) to conduct independent research into the customer experience and outcomes of people with claims in the compulsory third party and workers compensation schemes.

The participants selected were representative of the general population of people making claims in the schemes. A total of 893 people with CTP claims participated in the baseline survey online or over the phone. These people had dealings with an insurer between 1 April 2019 and 31 March 2020.

This study went well beyond standard customer satisfaction tests to measure customer experience with insurers, trust in the schemes, perceptions of justice, return to work and other activities, and health and social outcomes.

The study also considered the extent to which insurers are delivering services in line with SIRA's *Customer Service Conduct Principles*. The principles are:

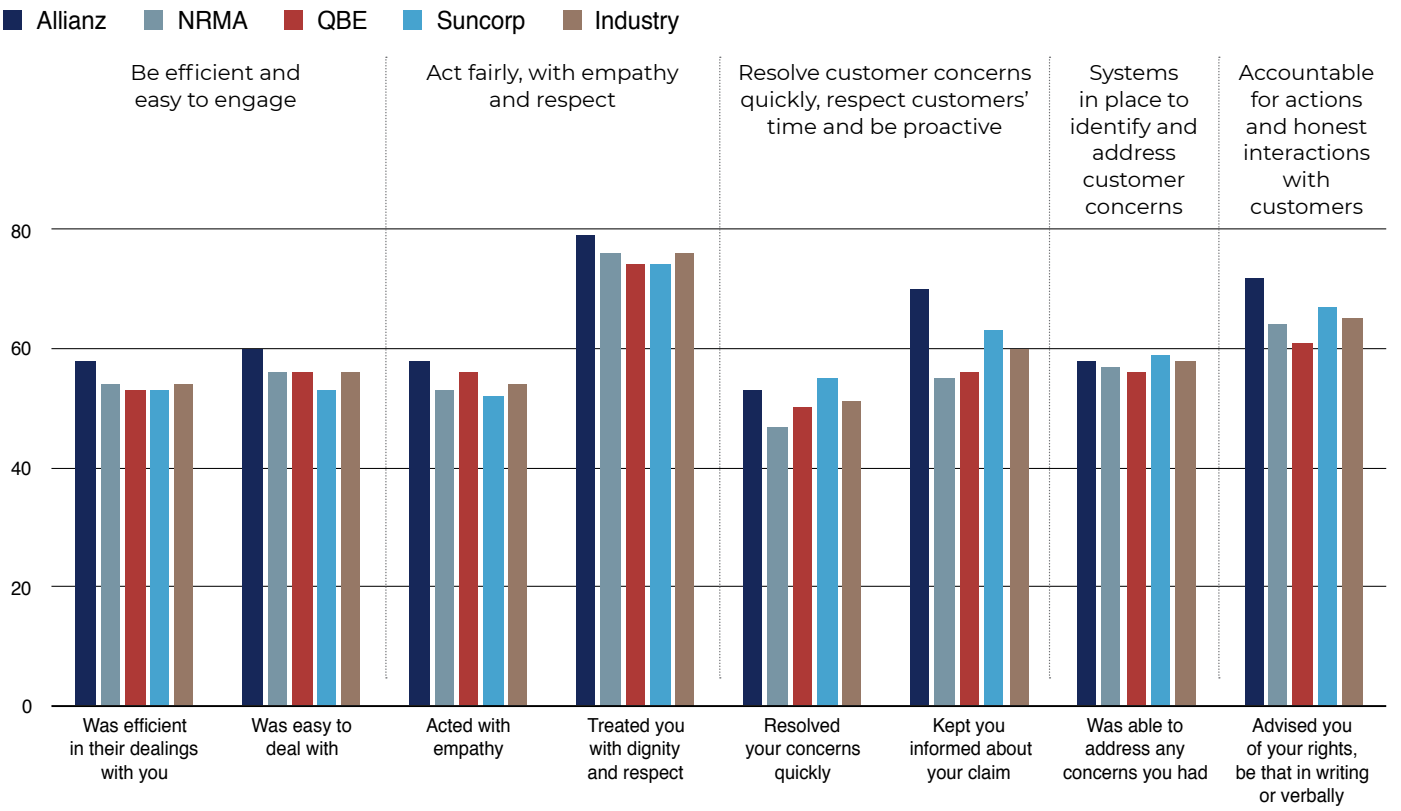
1. Be efficient and easy to engage
2. Act fairly, with empathy and respect
3. Resolve customer concerns quickly, respect customers' time and be proactive
4. Have systems in place to identity and address customer concerns
5. Be accountable for actions and honest in interactions with customers.

These principles were measured by asking claimants to agree or disagree with a series of statements about their customer service with their insurer. Each of the statements was mapped to one of the five *Customer Service Conduct Principles*.

The following table displays the percentage of claimants who agreed or strongly agreed with each statement. SIRA will use the results from this research to inform its regulatory strategies and activities. Results will also be shared with insurers at the insurer level, as part of SIRA's commitment to measure and require insurers to attest to the *Customer Service Conduct Principles*.

The full research report and a summary of the findings are published on the SIRA website.

CHART 12: Customer service conduct principles (% strongly agree/agree)



Note: In this survey the Suncorp brands of AAMI and GIO were grouped.

Glossary

Accepted claims - The total number of statutory benefit claims where liability was not declined during the first 26 weeks of the benefit entitlement period.

Claims acceptance rate - The percentage of statutory benefit claims where liability was not declined during the first 26 weeks of the benefit entitlement period. It is the total count of statutory benefit claims lodged, less declined claims, divided by total statutory benefit claims.

Claim - A claim for treatment and care or loss of income regardless of fault under the Act. It excludes early notifications (before a full claim is lodged), as well as interstate, workers compensation and compensation to relatives claims.

Complaint – An expression of dissatisfaction made to or about an organisation and related to its products, services, staff or the handling of a complaint, where a response or resolution is explicitly or implicitly expected or legally required.

Complaints received - The number of complaints that have been received in the time period.

Compliment - An expression of praise.

Declined claims - The total number of statutory benefit claims where the liability is rejected during the first 26 weeks of the benefit entitlement period.

Determined DRS dispute - A dispute which has been through the DRS process and of which a decision has been made.

Dispute Resolution Service (DRS) - A service established under Division 7 of the Act to provide a timely, independent, fair and cost effective system for the resolution of disputes.

Income support payments - Weekly payments to an earner who is injured as a result of a motor accident, and sustains a total or partial loss of earnings as a result of the injury.

Insurer - An insurer holding an in-force licence granted under Division 9.1 of the Act.

Internal review - When requested by a person, the insurer conducts an internal review of decisions made and notifies the person of the result of the review, usually within 14 days of the request.

Internal review types:

- Minor injury - Whether the injury caused by the motor accident is a minor injury for the purposes of the Act.
- Amount of weekly payments - Whether the amount of statutory benefits payable under section 3.4 (Statutory benefits for funeral expenses) or under Division 3.3 (Weekly payments of statutory benefits) is reasonable.
- Reasonable and necessary treatment and care - Whether any treatment and care provided to the person is reasonable and necessary in the given circumstances or whether it relates to the injury caused by the motor accident for the purposes of section 3.24 of the Act (Entitlement to statutory benefits for treatment and care).
- Was the accident the fault of another - Whether the motor accident was caused mostly by the injured person. This influences a person's entitlement to statutory benefits (sections 3.28 and 3.36 of the Act).
- Other insurer internal review types:
  - accident verification
  - earning capacity impairment
  - whether death or injury from a NSW accident
  - variation of weekly payments
  - weekly benefits outside Australia
  - recoverable statutory benefits
  - reduction for contribution negligence
  - serious driving offence exclusion
  - permanent impairment

Internal reviews to accepted claims ratio - the proportion of internal reviews to accepted statutory benefit claims. This will remove the influence of the insurer market share and give a comparable view across insurers.

Payments - Payment types may include income support payments, treatment, care, home/vehicle modifications or rehabilitation.

Referrals to Enforcement and Prosecutions (E&P) - Where a breach of guidelines or legislation is detected through the management of a complaint or other regulatory activity undertaken by SIRA in accordance with the SIRA compliance and enforcement policy.

Service start date - The date when treatment or care services are accessed for the first time.

Total number of policies - This figure represents the total (annual) number of policies written under the new CTP scheme with a commencement date during the reporting period. The measure represents the count of all policies, across all regions in NSW.

About the data in this publication:

Claims data is primarily sourced from the Universal Claims Database (UCD) which contains information on all claims received under the NSW Motor Accidents CTP scheme, which commenced on 1 December 2017, as provided by individual licensed insurers.

SIRA uses validated data for reporting purposes. Differences to insurers' own systems can be caused by:

- a delay between claim records being captured in insurer system and data being submitted and processed in the UCD
- claim records submitted by the insurer being blocked by data validation rules in the UCD because of data quality issues.

For more information about the statistics in this publication, contact MAIRstakeholder@sira.nsw.gov.au

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