Notice of Determination

by the Life Code Compliance Committee (Life CCC) on alleged non-compliance with the Life Insurance Code of Practice by a subscriber

Reference:	CX11246	**Date:**	24 November 2023
2016 Code[1]:	Sections 8.3, 8.4, 8.7, 8.16[2]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breaches:

The Consumer was a member of a superannuation fund (the Trustee). As part of that membership, the Consumer obtained an Income Protection (IP) policy. The IP policy was a Group Policy issued by the Subscriber and owned by the Trustee.

On 18 June 2021, the Consumer lodged an IP claim with the Subscriber. This meant that the Subscriber had two months to issue a decision on the claim, unless Unexpected Circumstances (UC) applied. As UC did not apply to the claim, the Subscriber was required to make a decision on the claim by 18 August 2021.

On 9 February 2022, the Consumer's Legal Representative (CLR) raised a Code breach allegation with the Life CCC, alleging that the Subscriber had breached its obligations under sections 8.4 and 8.16 of the Code.

The Subscriber communicated the claim decision to the CLR on 21 July 2022, more than 12 months after the Consumer lodged the claim. The Subscriber admitted that it did not request medical information promptly, which led to delays in the claim assessment.

During the investigation, the Subscriber also raised potential breaches of sections 8.3 and 8.7 of the Code. As a result, the Life CCC also investigated the Subscriber's compliance with these sections, in addition to the Consumer's Code breach allegations under sections 8.4 and 8.16 of the Code.

Expanded Investigation:

The Life CCC also expanded its investigation beyond the specific circumstances of the Consumer's complaint. This was prompted by outlier data provided by the Subscriber in its 2020-21 and 2021-22 Annual Data Compliance Programme (ADCP) submissions relating to claims where UC applied. Findings from the expanded investigation are detailed below in this Determination.

Expanded investigations differ from investigations into consumer Code breach allegations as they are not limited to the circumstances surrounding a consumer's complaint. Expanded

[1] The 2016 Life Code of Practice (Code 1.0) applied between 1 July 2017 – 30 June 2023.
[2] The Code sections are provided in full in the last section of the Determination.

investigations target more broadly how effectively Code subscribers comply with specific Code obligations and areas of risk.

Findings in accordance with Charter clause 7.4(b)(iii)[3]:

The Life CCC determined that the Subscriber was in breach of section 8.3, 8.4, 8.7 and 8.16 of the Code and that the allegations were proven in whole.

The Life CCC findings and conclusion:

Section 8.3

Section 8.3 requires subscribers to explain the following within 10 business days of claim lodgement:

- the cover and the claim process
- why certain information is requested
- any waiting periods that apply
- the subscribers contact details.

The Subscriber acknowledged that it provided the necessary information to the Consumer on 5 July 2021, one business day after the 10 business day deadline had passed. The breach was caused by human error by the assigned claims manager and was confirmed to be isolated to this case only.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.3 of the Code and that the allegation was proven in whole.

Section 8.4

Section 8.4 of the Code requires subscribers to provide consumers with updates on their claim at least every 20 business days unless otherwise agreed (element one), and to respond to requests for information about the claim within 10 business days (element two).

The Subscriber acknowledged it had breached both elements under section 8.4.

In relation to element one, the Subscriber did not provide the Consumer an update on the progress of their claim at least every 20 business days between 14 September 2021 and 10 January 2022.

In relation to element two, the Subscriber did not respond to the Consumer's request for updates within 10 business days on six occasions following requests on: 7 October 2021, 12 October 2021, 4 November 2021, 18 November 2021, 29 November 2021, and 14 December 2021.

The breach was caused by underperformance of the assigned claims manager during the period of non-compliance and was confirmed to be isolated to this case only. Regular contact with the Consumer recommenced after the period of non-compliance when the assigned claims manager ceased employment with the Subscriber and a new claims manager was assigned to the claim.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.4 of the Code and that the allegation was proven in whole.

[3] The Life CCC is bound by its Charter to use the terminology 'the reported allegation was proven in whole or in part or was unfounded.' This in essence requires the Life CCC to state if it determined there was a breach or not. The Life CCC will explain its determination in plain language in the body of the Determination.

Serious non-compliance with section 8.4

The breach of section 8.4 amounted to serious non-compliance with the Code. This was because the non-compliance continued for five months between September 2021 to January 2022 and amounted to eight individual instances where section 8.4 was breached. This meant that the Subscriber failed to meet the requirements under the Code during that period.

Given the above, the Life CCC determined, in accordance with the Charter clause 7.4(b)(iv)[4], that the Subscriber's breach of section 8.4 amounted to serious non-compliance with the Code.

Section 8.7

Section 8.7 requires a subscriber to request the information that it needs as early as possible (element one) and to avoid multiple information requests where possible (element two).

The Subscriber acknowledged it had breached element one of section 8.7 in five instances. Medical information, which was requested on 17 February 2022 and 9 March 2022 (four requests), could have been requested earlier in the claim assessment.

The breach was caused by the underperformance of the initial claims manager who failed to request the required information as early as possible. The required reports were requested following a new claims manager being assigned to the claim. The claims manager responsible for the non-compliance ceased employment with the Subscriber. The breach was confirmed to be isolated to this case only.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.7 of the Code and that the allegation was proven in whole.

Serious non-compliance with section 8.7

The breach of section 8.7 amounted to serious non-compliance. This was because there were five occasions where the Subscriber failed to comply with section 8.7 of the Code which contributed to lengthy delays in the claim assessment.

These delays had the potential to cause harm and financial detriment to the Consumer. The delays in requesting the information ranged from 4 to 4.5 months for each of the above requests.

Given the above, the Life CCC determined that the Subscriber's breach of section 8.7 amounted to serious non-compliance with the Code.

Section 8.16

Section 8.16 of the Code requires a subscriber to provide its decision on income related claims within two months unless UC applies. If UC applies, the subscriber has 12 months to provide its decision on the claim.

The Consumer lodged the IP claim on 18 June 2021 and the Subscriber was required to issue the decision on the claim by 18 August 2021, unless UC applied.

The Subscriber confirmed that UC did not apply due to the individual claims assessor's oversight which resulted in a delay in requesting necessary medical information. The Subscriber confirmed that it issued the decision on the claim on 21 July 2022, after the two month timeframe had expired.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.16 of the Code and that the allegation was proven in whole.

[4] The Life CCC is bound by its Charter to state, where applicable, whether it finds that a subscriber is responsible for serious and/or systemic non-compliance with the Code.

Serious and systemic non-compliance with section 8.16

The breach of section 8.16 amounted to serious non-compliance with the Code. This was due to the significant delay caused to the claims assessment because of the breach of section 8.7. The delays unnecessarily prolonged the claim assessment duration causing consumer financial harm and subsequently resulting in subscriber making additional interest payments to the consumer.

The breach of section 8.16 also amounted to systemic non-compliance with the Code as the Subscriber confirmed that breaches of 8.16 were not limited to this matter. Details have been noted in the expanded investigation section below.

Given the above, the Life CCC determined that the Subscriber's breach of section 8.16 amounted to serious and systemic non-compliance with the Code.

Expanded Investigation – Unexpected Circumstances

The Life CCC expanded its investigation beyond the Consumer's allegations in CX11246. This was based on the Subscriber's 2020-21 and 2021-22 ADCP submissions where the Subscriber reported:

- the highest number of claims amongst subscribers where UC applied but could not be classified by a UC definition (**Issue One**)
- the highest number of claims amongst subscribers where UC applied due to UC Definition (d) (**Issue Two**).

Issue One – Reporting error

The Subscriber reviewed Issue One of our Expanded Investigation and identified an ADCP reporting error.

The Subscriber noted that due to a defect in the reporting mapping process, breaches of sections 8.16 and 8.17 were reported as "Unknown" under UC rather than as a breach within the Subscriber's 2020-21 and 2021-22 ADCP submissions. This resulted in the underreporting of approximately 166 breaches over the two previous reporting periods in relation to sections 8.16 and 8.17 of the Code.

The Subscriber reported these 166 breaches in its 2022-23 ADCP submission and confirmed that the issue has been rectified by its Insurance Analytics team and will not impact any future reporting periods or ADCP data collections.

Issue Two – Misinterpretation of UC definition (d) and inconsistent application of UC

The Subscriber noted a misinterpretation of "Policy Owner" under UC definition (d) in some claims since the introduction of the claims management system in October 2019. The misinterpretation occurred because some claims assessors incorrectly recorded that UC definition (d) applied to claims where the delays were caused by the Subscriber rather than the Trustee. In those cases, UC should not have applied.

The misinterpretation was due to the arrangement the Subscriber has with its Trustee whereby the consumer lodges the claim directly with the Subscriber rather than the Trustee as the Policy Owner. This resulted in some claims assessors interpreting the Subscriber as the "Policy Owner" rather than the Trustee.

The Subscriber estimated underreporting of approximately 101 breaches in 2020-21 and 105 breaches in 2021-22 within its ADCP submissions across sections 8.16 and 8.17 due to this misinterpretation. These breaches were reported in the 2022-23 ADCP submission, and the Subscriber implemented remediation actions (outlined below) to address this issue.

Remediation

The Subscriber undertook the following actions to remediate the breaches related to the Consumer's allegations:

- Paid $1,910.03 in interest to the Consumer for delays in the claim assessment.
- Ceased the employment of the individual claims assessor responsible for the non-compliance in the matter.
- Created a Workforce Manager role to improve oversight of claims timeframes and minimise risks caused by changing claims managers.
- Emphasised the imperative for claims managers to self-identify and report non-compliance.
- Made improvements to system controls for more accurate exception reporting.
- Enhanced oversight through compliance dashboards.
- Reviewed all 251 breaches of sections 8.3 and 8.4 reported in its 2021-22 ADCP submission to confirm no systemic issues.

The Subscriber took the following actions to remediate both issues identified in the expanded investigation:

- The Subscriber upgraded its claims management system to support the compliance with its claims handling obligations under the 2023 Code[5], allowing accurate mapping of UC claims and providing alerts for timely decision-making. The claims management system is also designed to facilitate compliance with additional claims related obligations outlined in the 2023 Code. For instance, it generates reminders and tasks for claims managers to update consumers when the 20th business day is approaching, aligning with section 8.4 of the 2016 Code (clause 5.6 of the 2023 Code). This updated system effectively resolves the legacy issues identified in the prior claims management system implemented in October 2019.
- The Subscriber provided group-wide training to all claims employees, teaching them how to use the claims management system correctly and accurately identify reasons for UC. The Subscriber also updated training materials and documents for UC, introducing a system to report breaches through its Governance, Risk, and Compliance system. This breach reporting process captures claims that are finalised outside the two or six months' timeframe due to the Subscriber's delay as well as breaches that are identified through its internal monitoring, and generates a letter which advises the consumer of the breach.
- The Subscriber enhanced its internal monitoring and oversight process through its weekly risk and compliance reporting. In addition to the graphical monitoring of the trends on the Code obligations that were introduced in 2021-22, the Subscriber further enhanced the graphical summary in 2022-23 to detail breaches by occurrence date. This allows the Subscriber to easily monitor both current and historical breaches. Additional enhancements in February 2023 also include requiring sign off on all UC reasons by a team leader prior to advising the consumer and updating the system data.
- The Subscriber recruited additional employees for caseload management and promoted more experienced employees to the Claims Management team.
- The Subscriber continued a focus on employee training and accountability to consistently meet compliance obligations and deliver positive consumer outcomes.

Given the above, the Life CCC is satisfied that the Subscriber has adequately remediated the breaches and process issues in this matter.

[5] The 2023 Life Code of Practice (Code 2.1) applies from 29 September 2023 onwards.

Key learnings

This investigation initially found that breaches were attributed to human error by a claims assessor over a prolonged period. While the Subscriber outlined several actions to remediate these breaches, it is crucial for the Subscriber to ensure that its monitoring and detection mechanisms are sufficiently reliable and robust to identify breaches promptly in the future and provide prompt remediation action to minimise the impact on consumers. Subscribers must establish robust checks and balances to pinpoint and address breaches at the initial occurrence, minimising the impact of ongoing non-compliance and detriment to impacted consumers.

Moreover, our expanded investigation revealed issues with inadequate training and staff supervision and monitoring. It is imperative for subscribers to guarantee that their employees receive proper training to adhere to the Code as well as strong supervision and guidance to assist them in conducting their roles. Additionally, subscribers need to ensure that their checks and balances are sufficient, keeping employee training and monitoring current, well-suited for their purpose, and correctly implemented.

Relevant Code Sections/Definitions

2016 Life Code of Practice

Section 8.3:

Within ten **business days** of being notified about **your** claim, **we** will explain to **you your** cover and the claim process, including why **we** request certain information from **you** and any waiting period before payments will be made. **We** will give **you** contact details that **you** can use to get information about **your** claim.

Section 8.4

Prior to making a decision on **your** claim, **we** will keep **you** informed about the progress of **your** claim at least every 20 **business days** unless otherwise agreed with **you** or the **Group Policy-owner**. **We** will respond to **your** requests for information about **your** claim within ten **business days**.

Section 8.7:

We will request the information **we** need as early as possible and will avoid multiple information requests where possible.

Section 8.16:

For income-related claims, **we** will let **you** know **our** initial decision no later than two months after **we** are notified of **your** claim or two months after the end of **your** waiting period (whichever is later), unless **Unexpected Circumstances** apply. Where **Unexpected Circumstances** apply, **our** decision will be made no later than 12 months after **we** are notified of **your** claim. **We** will let **you** know the reasons for the delay, and if **you** disagree **we** will review this. If **we** cannot make a decision within 12 months, **we** will give **you** details of **our Complaints** process.

Unexpected Circumstances means:

a) your claim has been notified to us more than 12 months after the later of the date of disability or the end of your waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of your claim from the intervening period;

b) for a claim for total and permanent disability, we cannot reasonably satisfy ourselves on the basis of the information provided in the six months after the end of your waiting period that your condition meets the requirements of your Life Insurance Policy;

c) we have not received reports, records or information reasonably requested from an Independent Service Provider, your doctor, a government agency or other person or entity (including a Reinsurer);

d) the Policy-owner or Group Policy-owner has disputed or taken a protracted period to consider our decision;

e) you or your Representative have not responded to our reasonable enquiries or requests for documents or information concerning your claim;

f) there are difficulties in communicating with you in relation to the claim due to circumstances beyond our control;

g) there is a delay in the claims process that you have requested; or

h) the claim is fraudulent or we reasonably suspect fraud or non-disclosure that requires further investigation.

The Life CCC is the independent body responsible for the administration and enforcement of the Life Insurance Code of Practice (the Code). It acts in accordance with the Life CCC Charter, which sets out the powers, duties, functions and responsibilities of the Committee, subject to any provisions in the Code. This Determination is issued in accordance with clause 7.4 of the Life CCC's Charter in order to facilitate agreement between the Life CCC and the Subscriber on corrective measures and the relevant timeframes for their implementation.