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Deloitte.

# The Colonial Mutual Life Assurance Society Limited (CMLA)

## Deloitte Claims Review Program

3 February 2017

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# Glossary of terms

| Term | Detail | Term | Detail |
|---|---|---|---|
| **APRA** | Australian Prudential Regulation Authority | **IDR** | Internal Dispute Resolution |
| **ASIC** | Australian Securities and Investments Commission | **Known Error** | Refer s2.4.2 |
| **Benefit Type** | Describes benefits payable under an insurance policy | **Line of business** | Refers to the Group, Retail and Direct distribution channels |
| **CMLA** | The Colonial Mutual Life Assurance Society Limited | **Orion** | The current claims administration system |
| **Cohort** | Benefit types under review. These included RTI, GTI, RDTH, GDTH, RTPD, GTPD and RTRM. Collectively these are referred to as Lump Sum Benefit types. | **Poor Customer Outcome** | A customer has a poor outcome, either financially or through a poor customer experience in how a claim was managed |
| **Declined Claim** | A claim where CMLA completed its claims handling processes and initially declined its liability for full payment between 1 May 2011 and 30 April 2016. | **RDTH** | The Retail Death benefit type |
| **Deloitte Claims Review Program** | Two work streams, the Claims Review and the Claims Handling Review | **Retail** | Benefit types distributed through financial advisors |
| **EDR** | External Dispute Resolution | **Review Period** | 5 years running from 1 May 2011 to 30 April 2016 |
| **Eligibility** | Requirements a claimant must meet before they can claim under an insurance policy, e.g. they were employed at the time of disablement. | **RTI** | The Retail Terminal Illness benefit type |
| **Error** | Where a reviewed claim was concluded as having a customer financial impact, poor customer experience or incomplete process. | **RTPD** | The Retail Total & Permanent Disability benefit type |
| **GDTH** | The Group Death benefit type | **RTRM** | The Retail Trauma benefit type |
| **Group** | Benefit types distributed through Superannuation Funds or Employers | **Stallion** | The Claims administration system used by CMLA prior to Orion |
| **GTI** | The Group Terminal Illness benefit type | **We, our, us** | Deloitte |
| **GTPD** | The Group Total & Permanent Disability benefit type | | |

# 1. Executive Summary

## 1.1 Background

The Board of The Colonial Mutual Life Assurance Society Limited (CMLA) engaged Deloitte to design and deliver a review program to assist in its response to:

- Concerns raised about CMLA's claims management practices in various public forums; and
- Requests to insurers from ASIC and APRA relating to declined claims and claims handling processes.

The Deloitte Claims Review Program was designed by us to meet the following objectives:

> **Objective 1:** identify whether there were any systemic issues in how the claims handling processes historically declined life insurance claims; and
>
> **Objective 2:** identify whether the current claims handling processes are designed in a way which could systemically deliver poor customer outcomes, either financially because a claim is incorrectly declined or through a poor customer experience in how a claim is managed.

The Deloitte Claims Review Program included two work streams:

- Review a sample of life insurance claims declined between 1 May 2011 and 30 April 2016 to identify whether customers had claims incorrectly declined or there was a poor customer experience in how their claim was managed. This is referred to as the Claims Review.
- Review the design of the life insurance claims handling processes (both current and planned improvements) to identify any features, factors or processes that, when operated, could systemically deliver poor customer outcomes, either financially because a claim is incorrectly declined or through a poor customer experience in how a claim is managed. This is referred to as the Claims Handling Review.

Together these two work streams are referred to as the Deloitte Claims Review Program. Prior to their finalisation, the terms of engagement between Deloitte and CMLA were provided to ASIC and APRA.

## 1.2 Deloitte Claims Review Program – Overall Conclusions

| Objective | Conclusions |
|---|---|
| **Objective 1** | Our work did not identify any systemic issues relating to historically declined claims.<br><br>We have reviewed 797 Declined Claims and identified 41 claims which were referred to CMLA to undertake a reassessment of the initial decision to decline the claim. Where complete we have reviewed the reassessment outcome.<br><br>For those claims there were:<br><br>• 8 claims where there was a customer financial impact;<br>• 12 claims where the decision to decline the claim was appropriate but there was a poor experience for the customer in how their claim was managed; and<br>• 10 claims where, following CMLA's reassessment of the claim, the decision to decline was appropriate, and the customer was not impacted.<br><br>11 claims remain in the reassessment process. |
| **Objective 2** | The Review Program did not identify any evidence that the current and planned improvements to the claims handling processes are designed in a way that could systemically deliver poor customer outcomes, either financially because a claim is incorrectly declined or through a poor customer experience in how a claim is managed.<br><br>We identified a number of priority areas where we consider the execution of elements of the claims handling processes can be enhanced. We note that until these enhancements are implemented, CMLA is reliant on a strong compliance culture to ensure the risk of poor customer outcomes is minimised. |

## 1.3 Claims Review – Summary of Scope and Approach

The Claims Review covered declined claims from Retail and Group Lump Sum products for the five year period ended 30 April 2016. The Claims Review used a sample of declined claims as follows:

### Table 1.1 – Summary of claims subject to review

| Cohort | Population | Sample Size | % reviewed of Population ** |
|---|---|---|---|
| Retail Terminal Illness | 70 | 44 | 16% (Year 1, 2)<br>100% (Year 3, 4, 5) |
| Group Terminal Illness | 165 | 124 | 11% (Year 1, 2)<br>100% (Year 3, 4, 5) |
| Retail Death | 50 | 49 | 98% |
| Group Death | 322 | 138 | 43% |
| Retail TPD | 107 | 74 | 69% |
| Group TPD | 2,172 | 219 | 10% |
| Retail Trauma | 964 | 149 | 15% |
| **Total** | **3,850** | **797** | **21%** |

** Year 1 to 5 refers to the 12 month period commencing 1 May and ending 30 April. Year 1 commenced 1 May 2011.

Each sampled Declined Claim was assessed using a process designed by Deloitte with the objective of establishing whether the claim was declined in accordance with the procedures and processes in operation by CMLA at the time of the decline. This process considered the contractual obligations of CMLA, including the requirement to act in utmost good faith, give due priority to policyholders when considering each claim, and also considered good customer advocacy.

As a result of this review a total of 41 claims (5.1%) were identified and were referred to CMLA to undertake a reassessment of the initial decision to decline the claim.

The following conclusions have been reached as a result of this reassessment:

### Table 1.2 – Summary of results by customer outcome

| | Decision appropriate* | Decision appropriate – poor customer experience | Customer financial impact | Reassessment in progress | Total |
|---|---|---|---|---|---|
| **Number of claims** | **766** | **12** | **8** | **11** | **797** |
| **%** | **96.1%** | **1.5%** | **1.0%** | **1.4%** | **100%** |

* Of the 41 claims defined as an Error, 10 have been reassessed and concluded as having been appropriately declined. These are included in the decision appropriate category above.

## Table 1.3 – Customer outcome by line of business and benefit type

| Cohort | Claims reviewed | Decision appropriate - poor customer experience | % | Customer financial impact | % | Reassessment in progress | % |
|---|---|---|---|---|---|---|---|
| Retail Terminal Illness | 44 | - | - | - | - | - | - |
| Group Terminal Illness | 124 | 1 | 0.8% | 1 | 0.8% | - | - |
| Retail Death | 49 | - | - | - | - | - | - |
| Group Death | 138 | 1 | 0.7% | | - | 1 | 0.7% |
| Retail TPD | 74 | 4 | 5.4% | - | - | 2 | 2.7% |
| Group TPD | 219 | 6 | 2.7% | 4 | 1.8% | 5 | 2.3% |
| Retail Trauma | 149 | - | - | 3 | 2.0% | 3 | 2.0% |
| **Total** | **797** | **12** | **1.5%** | **8** | **1.0%** | **11** | **1.4%** |

We note that:

- CMLA has made payments to the 8 customers impacted financially, totalling approximately $320,000[1].
- The reassessment process, which where complete has been subject to our review, has concluded that for the 12 claims with a poor customer experience there was no financial impact on the customer.
- CMLA management continues to complete the reassessment of 11 claims. On completion of the reassessment the categorisation of these claims will change. We acknowledge that there is considerable dependency on third parties and high complexity involved in reassessing some claims, especially given the passage of time. Whilst CMLA management has been able to complete most of this activity further time is reasonably required to complete the remaining claims.

[1] In addition, a further payment of approximately $400,000 was made in relation to the claim identified during the planning phase of the Claims Review. See Section 2.4.3

## 1.4 Claims Review Conclusion

Based on the scope of our work and the assumptions and limitations noted in this report we conclude that:

- given the level of coverage obtained by our sample we believe that the work performed is sufficient to have reasonably identified any matters that may systemically affect the declined claims population; and
- the Claims Review did not identify any systemic issues relating to historically declined claims.

We note that:

- in addition to the reassessment process CMLA is conducting a root cause analysis of the 41 claims found during the Claims Review to identify, as far as reasonably possible, whether other similar claims within the population exist;
- we observed examples of good customer advocacy during our Claims Review. These include CMLA assessing claims under a current policy definition where the old policy would not have covered the claims, consideration being given to other policies where the claimant may have coverage, and the use of ex gratia payments where appropriate; and
- during our work we identified issues related to the accuracy of the claims system records used to identify the Declined Claim population. While this has not impacted us completing our work this has limited our ability to draw statistical conclusions from our sample to that of the declined claims population as a whole. This limitation has been mitigated to some extent by the level of testing performed.

## 1.5 Claims Handling Review – Summary of Scope

The Claims Handling Review assessed the current and planned improvements to the design of CMLA's claims handling processes to determine whether these could systemically deliver poor customer outcomes, either financially because a claim is incorrectly declined or through a poor customer experience in how a claim is managed.

The Claims Handling Review covered the end to end people, processes and governance supporting Retail, Group and Direct life insurance claims management by CMLA.

## 1.6 Claims Handling Review - Conclusion

We did not identify any evidence that the current and planned improvements to the claims handling processes are designed in a way that could systemically deliver poor customer outcomes, either financially because claims are incorrectly declined or through a poor customer experience in how a claim is managed.

We note that:

- we identified a number of areas where we consider the execution of elements of the claims handling processes can be enhanced. We have summarised the priority items in this report;
- at the time of our work CMLA is in the process of implementing a number of improvements to the design of its claims handling processes. We have relied on these improvements being implemented as designed in forming our conclusion; and
- procedurally, recent developments such as the Complex Claims Committee and a pilot of a new approach to assessing claims involving potential mental health issues are also worthy of note and demonstrate an intent by management to evolve the claims handling processes.

## 1.7 Summary of Review Program observations and recommendations

We identified a number of areas where we consider the execution of elements of the claims handling processes can be enhanced.

The various recommendations can be summarised into the following core themes:

- Update and upgrade relevant training materials and provide refresher programs to all claims staff, which incorporate the learnings from our work;
- Complete root cause analysis for the identified Errors and implement recommendations arising from this analysis;
- Design and implement a standard claims assessment file structure and format to enable consistent assembly, file content, documentation of information gathering and conclusions. This should include a consistent process for identifying the most relevant policy terms applicable to customers; and
- Design and implement an enhanced data quality framework that ensures the correct classification of all claims.

# 2. Claims Review

## 2.1 Claims Review Background, Scope and Methodology

### 2.1.1 Claims Review Background

The Claims Review was part of CMLA's response to concerns that customers may have had life insurance claims incorrectly declined or there was poor customer experience in managing the claim.

### 2.1.2 Claims Review Scope and Methodology

Declined Claims from the following lines of business and benefit types were included in the Claims Review:

- Retail Terminal Illness;
- Group Terminal Illness;
- Retail Death;
- Group Death;
- Retail Total & Permanent Disability;
- Group Total & Permanent Disability; and
- Retail Trauma.

The final population and sample selected by line of business and by benefit type is below:

Table 2.1 - Summary of claims subject to review

| Cohort | Population | Sample Size | % reviewed of Population ** |
|---|---|---|---|
| Retail Terminal Illness | 70 | 44 | 16% (Year 1, 2)<br>100% (Year 3, 4, 5) |
| Group Terminal Illness | 165 | 124 | 11% (Year 1, 2)<br>100% (Year 3, 4, 5) |
| Retail Death* | 50 | 49 | 98% |
| Group Death | 322 | 138 | 43% |
| Retail TPD | 107 | 74 | 69% |
| Group TPD* | 2,172 | 219 | 10% |
| Retail Trauma* | 964 | 149 | 15% |
| **Total** | **3,850** | **797** | **21%** |

* For four sampled claims the documentation supporting the initial decision to decline was incomplete. Where possible, alternative claims were selected to replace them.

** Year 1 to 5 refers to the 12 month period commencing 1 May and ending 30 April. Year 1 commenced 1 May 2011.

For the purpose of the Claims Review a Declined Claim was defined as a claim where CMLA completed its claims handling processes and initially declined its liability for full payment between 1 May 2011 and 30 April 2016. This included certain withdrawn claims (being claims where the claimant did not submit

necessary claims documentation for an assessment to take place), claims with potential for a partial benefit payment, and ex gratia payments. The definition of a Declined Claim was requested by CMLA to be broad, to capture all outcomes that could be inferred as a decline. This means it includes, for example, claims that were partially admitted to ensure that customers did not get a lower payment than they were entitled to.

Each sampled Declined Claim was assessed using a process designed by Deloitte with the objective of establishing whether the claim was declined in accordance with the procedures and processes in operation by CMLA at the time of the decline. This process considered the contractual obligations of CMLA, including the requirement to act in utmost good faith, give due priority to policyholders when considering each claim, and also considered good customer advocacy. It is noted that for Group claims involving a trustee, the trustee also has a responsibility for assessing Eligibility and the claim decision reached. Procedures surrounding this were not assessed in the Claims Review.

The Claims Review had two stages:

1. A review of the initial decision to decline the claim based on our assessment process.
2. Review of CMLA's reassessment of the claims identified in stage one to determine any customer impact.

At the completion of our initial review one of four conclusions was made by us. We either agreed with the process undertaken and decision to decline the claim or had three categories which we classified as an Error.

An Error included not just claims that had been declined incorrectly and had a customer financial impact, but also those claims that had been declined appropriately however there was a poor customer experience, or at the point the claim was initially declined CMLA's process was considered incomplete. This is a deliberately broad definition, and was requested by CMLA to capture both service issues attached to the management of the claim as well as claims where there had been a financial impact/incorrect outcome.

The four outcomes were:

1. **Decision appropriate.** Agree with application of CMLA's claims handling processes and the decision to decline the claim.
2. **Decision appropriate – poor customer experience**. The process followed by CMLA in handling the claim resulted in a poor customer experience e.g. a customer had an undue delay in the decline of their claim or had unnecessary information requests from CMLA as part of managing their claim.
3. **Customer financial impact**. CMLA's decision to decline the claim was incorrect or an incorrect payment was made.
4. **Incomplete process**. Documentation supporting the application of CMLA's claims handling processes was incomplete at the date of the initial decline.

Our initial review identified 41 claims (5.1%) which met the definition of an Error.

The reassessment process described in stage two is ongoing. The current status is provided below.

## 2.2 Claims Review Summary of Results

Table 2.2 – Summary of results by customer outcome

| | Decision appropriate * | Decision appropriate - poor customer experience | Customer financial impact | Reassessment in progress | Total |
|---|---|---|---|---|---|
| **Current position** | **766** | **12** | **8** | **11** | **797** |
| **%** | **96.1%** | **1.5%** | **1.0%** | **1.4%** | **100%** |

* Of the 41 claims defined as an Error, 10 have been reassessed and concluded as having been appropriately declined. These are included in the decision appropriate category above.

We have further analysed the claims with a customer financial impact (section 2.2.1) and those with a poor customer experience (section 2.2.2), below.

### 2.2.1 Summary of claims with a customer financial impact

Table 2.3 – Summary of claims with a customer financial impact

| | Claim Paid | Claim paid based on additional information | Benefit calculation error corrected | Ex-gratia or goodwill payment | Total |
|---|---|---|---|---|---|
| **Number** | **2** | **2** | **2** | **2** | **8** |

We note the following in relation to the claims with a customer financial impact:

- Claim Paid:
  - Incorrect assessment of date of disability in the claims assessment. Upon reassessment, the date of disablement was concluded to be earlier and the claim paid with interest.
  - Inadequate assessment of mental health illness and the gravity of the diagnosis and treatment options. Upon reassessment, and with clarification of the diagnosis and treatment options, the claim has been paid with interest.

- Claim paid based on additional information:
  - One claim where the claims handling processes were incomplete at the initial decision to decline. Upon reassessment, and concurrent with a complaint being received, subsequent information was received and the claim was paid.
  - One claim where the claims handling processes were incomplete at the initial decision to decline. Upon reassessment, subsequent information was received and the claim was paid.

- Benefit calculation error corrected:
  - Two Trauma claims were identified where the decision to pay a partial benefit was correct but there was an error in how this benefit amount was calculated. Upon reassessment, the benefit has been recalculated and the difference paid with interest.

- Ex-gratia or goodwill payment:
  - While the decision to decline was appropriate based on the claimants non-disclosure of pre-existing conditions, the handling of the non-disclosure was not completed in accordance with CMLA's standard processes. As a result, CMLA has reinstated the policy and a partial benefit has been paid.
  - Medical evidence existed to support a range of potential life expectancy. CMLA should have clarified this evidence prior to the initial decline. Additional medical certifications were obtained 16 months later and the claim was paid. While it is not possible to determine if these medical certifications supported payment of the claim at the initial decline, CMLA has paid an additional benefit amount as if it was, with interest.

CMLA has made payments to the 8 customers impacted financially totalling approximately $320,000[2].

### 2.2.2 Summary of claims with a poor customer experience

Table 2.4 – Summary of claims with a poor customer experience

| | Decline Appropriate | | Claim Paid | |
|---|---|---|---|---|
| | CMLA identified and closed process gaps | Undue delay in decision to decline | CMLA identified and closed process gaps | Total |
| **Number** | **5** | **5** | **2** | **12** |

CMLA has reviewed the 12 claims where there was a poor customer experience in managing the claim. We note the following in relation to these claims.

- Decision appropriate – CMLA identified and closed process gaps:
  - Prior to the initial decision to decline, CMLA should have performed further procedures on five claims. For the five claims the process gaps in the assessment of the claims were identified and closed by CMLA prior to the Deloitte Claims Review. Closure of these gaps continued to support a decision to decline the claim but indicate a poor experience for the claimant in managing the claim. The five claims included:
    - Two claims where further enquiries confirmed that the claimant was ineligible to claim;
    - One TPD claim where both the Death and TPD benefits were voided due to non-disclosure of pre-existing conditions, when only the TPD benefit should have been. CMLA subsequently reinstated the death benefit
    - One claim where additional information should have been obtained and clarified. This was subsequently addressed as a result of escalation from the Trustee; and

[2] In addition, a further payment of approximately $400,000 was made in relation to the claim identified during the planning phase of the Claims Review. See Section 2.4.3.

        - One claim where further information confirmed the claimant was unable to claim due to a pre-existing condition.

- Decision appropriate - Undue delay in decision to decline the claim:
  - In five cases the CMLA claims handling processes were not executed in a timely manner. Delays ranged between five and eleven months. The five claims included:
    - Two claims where Eligibility was not assessed promptly because the assessment process initially focused on the medical assessment;
    - Two claims where the communication of the claims decision was not timely; and
    - One claim where procedural errors in the interpretation of the policy terms caused a delay to the handling of the claim.

- Claim Paid – CMLA identified and closed process gaps:
  - Two claims were paid by CMLA subsequent to the initial decision to decline. Process gaps in the initial assessment were identified and closed prior to the Deloitte Claims Review. The two were:
    - One claim where CMLA initially declined a claim without contacting the fund administrator to confirm Eligibility. On clarification of Eligibility the claim was subsequently resubmitted and paid within a two week period; and
    - In one Terminal Illness claim CMLA failed to follow up on a request for additional information from the external administrator. Once this was received the claim was paid.

### 2.2.3 Summary of claims pending reassessment

CMLA management continues to complete the reassessment of 11 claims. On completion of the reassessment the categorisation of these claims will change. We acknowledge that there is considerable dependency on third parties and high complexity involved in reassessing some of the claims, especially given the passage of time in some circumstances. Whilst CMLA management has been able to complete most of this activity further time is reasonably required to complete the remaining claims.

## 2.3 Analysis of Claims Review findings

We have further analysed the results of our review by benefit type and line of business and year. Both are presented below.

Table 2.5 – Customer outcome by line of business and benefit type

| Cohort | Claims reviewed | Decision appropriate - poor customer experience | % | Customer financial impact | % | Reassessment in progress | % |
|---|---|---|---|---|---|---|---|
| Retail Terminal Illness | 44 | - | - | - | - | - | - |
| Group Terminal Illness | 124 | 1 | 0.8% | 1 | 0.8% | - | - |
| Retail Death | 49 | - | - | - | - | - | - |
| Group Death | 138 | 1 | 0.7% | | - | 1 | 0.7% |
| Retail TPD | 74 | 4 | 5.4% | - | - | 2 | 2.7% |
| Group TPD | 219 | 6 | 2.7% | 4 | 1.8% | 5 | 2.3% |
| Retail Trauma | 149 | - | - | 3 | 2.0% | 3 | 2.0% |
| **Total** | **797** | **12** | **1.5%** | **8** | **1.0%** | **11** | **1.4%** |

As can be noted from the above table, the benefit types with the highest error rates are Retail TPD, Group TPD and Retail Trauma. Completion of the reassessment of the remaining 11 claims will alter the final categorisation.

Table 2.6 – Errors by Year of Decline

| | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | Total |
|---|---|---|---|---|---|---|
| Customer financial impact | 1 | 2 | - | 2 | 3 | 8 |
| % | 1.2% | 1.7% | 0.0% | 0.9% | 1.5% | 1.0% |
| Poor customer experience | - | 4 | 1 | 4 | 3 | 12 |
| % | 0.0% | 3.4% | 0.6% | 1.7% | 1.5% | 1.5% |

NB – Years run from 1 May to 30 April

There was no consistent theme in relation to the Errors by year.

## 2.4 Other Errors

### 2.4.1 Overview

The Claims Review anticipated there being the potential for other errors to exist. It was anticipated that these may arise from two sources:

- First, management identified errors, or Known Errors which could come from matters escalated through, for example, IDR and EDR, litigation, previous incident management and remediation exercises, performed during the Review Period. See Section 2.4.2.
- Second, via other claims reviewed but not part of the Deloitte sample. For example, the files reviewed during the process to refine the proposed methodology to be used in the Claims Review. See Section 2.4.3.

Where identified these were considered by us in forming our conclusion as to whether there were any systemic issues in how the claims handling processes historically declined life insurance claims.

### 2.4.2 Known Errors

Known Errors were defined as a claim that has already been identified by CMLA as being declined in error and subsequently remediated.

For the period of the Claims Review CMLA's claims handling and risk management systems did not routinely or systematically collect information on Known Errors. Therefore, in order to identify Known Errors within the Review Period management adopted a top-down approach, relying on existing data sources.

Management concluded that there were eight Known Errors in the benefit types under the scope of the Claims Review. Details of these claims are summarised below:

Table 2.7 – Known Errors

| | Retail Terminal Illness | Group Terminal Illness | Retail Death | Group Death | Retail TPD | Group TPD | Retail Trauma | Total |
|---|---|---|---|---|---|---|---|---|
| Known Errors | - | 2 | - | - | - | 4 | 2 | 8 |

It is noted that claims subject to a further review following the backdating of Heart Attack and Severe Rheumatoid Arthritis (SRA) definitions to May 2014 have not been included as Known Errors as these claims were not considered to have been declined in error under the policy terms that existed at that point in time.

### 2.4.3 Other Errors

During the pilot phase of the Claims Review we completed an assessment of 25 claims outside of Terminal Illness. This work was primarily performed to assist in concluding on the homogeneity of the claims handling processes and was completed prior to the selection of the sample of claims to be reviewed. Consequently, some of these claims did not ultimately fall into the final sample selected but have been assessed by us using our Claims Review methodology.

For one such Group TPD claim we found that further procedures should have been completed before declining the claim. This claim has been subsequently paid with interest (approximately $400,000).

## 2.5 Claims Review - Consideration of root cause and nature of Errors

### 2.5.1 Overview

To assess the cause and potential impact of each of the Errors management are completing a review considering:

- **Process** – was the CMLA process followed, or appropriately evidenced? Was this a matter of fact or judgement?
- **Systems** – did the CMLA claims handling processes operate as intended?
- **People** – was there a potential performance issue with the individual or individuals assessing the case?
- **Governance** – did the delegated authority and wider performance monitoring frameworks operate as intended?

Following the completion of this exercise an analysis of the reasons which would mitigate there being other similar errors in the population, or reasonably prevent such an error from occurring in future, is being performed.

Where the results of this exercise find that the cause of an Error could potentially impact other claims in the population, management intends to undertake a broader review of the root cause and to complete any other activities that may be required.

### 2.5.2 Areas identified for further investigation

The above exercise has identified the following issues which are subject to ongoing review by management:

A) **Performance of Trauma calculations**

The Retail Trauma policy places a $25,000 cap on claims where a specified injury and/or illness type has occurred. Where another injury and/or illness type exists the payment received should not be capped at this amount, but calculated in line with the broader policy terms. There is the potential that more than the two claims identified by us in this category could exist.

Initial findings suggest that the system control used to calculate the partial benefit payable under this policy cap has not operated as designed. The incorrect calculation was not identified by the system control or mitigating peer review or delegated authority sign offs. Management is identifying any other potentially impacted claims.

Management has informed us that the correct payments due on each of the identified errors have been calculated, and the additional amounts due plus interest have been paid to claimants.

B) **Case Manager Error**

In analysing the Errors it has been identified that in limited instances individual case managers and delegated authority holders had made more than one error.

CMLA management are in the process of reviewing claims assessed by these case managers, and delegated authorities, during the Review Period to identify other claims, if any, that should also be reassessed. CMLA management has indicated that they will make any necessary changes to the delegated authority framework and quality assurance process as a result of this review.

C) **Documenting assessment of policy terms**

In analysing the Errors it has been identified that for 10 claims it was not possible to identify the policy, policy endorsements or addendums, or policy upgrades used in the assessment of the claim. Whilst none of the claims identified in this category have resulted in a customer impact, management is considering what more should be done to document the consideration of relevant policy, policy endorsements or addendum, or policy upgrades within the claims handling processes.

D) **Process guidance and training**

Management has recognised the opportunity to enhance the way that elements of the claims assessment process are executed. In particular, management is reviewing the process guidance and training materials for the claims teams in the areas where Errors have been identified and is considering if the current guidance may have resulted in other claims being treated in the same way as any of the Errors.

### 2.5.3 Other potentially impacted claims

In addition to the matters noted above, management continues to complete the underlying root cause analysis of the identified Errors. This work is ongoing but has indicated other potential areas for consideration, including for example, completeness of assessment of secondary causation (with a focus on psychiatric conditions) in the TPD cohorts.

## 2.6 Data Validation Procedures on Declined claims population

The Claims Review relied on data extracted from the CMLA claims handling systems to identify the population of declined claims. Extraction of this data required a number of definitions (e.g. "what is a declined claim" and "which time period is the review covering") to be agreed. Certain procedures were performed by both Deloitte and CMLA over the completeness and accuracy of this population.

These procedures were designed to ensure that:

- the design of the process followed in extracting the data set was robust; and
- the results arising from the execution of that process captured all relevant customer claims.

These procedures included but were not limited to, a review of the SQL script used to extract the claims data from the claims handling systems, review of declined claims identified as declined but not actually a decline, and a review of a sample of admitted claims.

As a result of these procedures we noted issues in the underlying data set. This was primarily because of the following:

- CMLA migrated between two different claims handling systems within the Review Period. The business now uses Orion, having previously used Stallion. The migration commenced in 2015 and completed in June 2016. The Orion and Stallion systems have different data fields and classifications and the functionality of the systems have been used differently within the various CMLA claims teams;
- A manual adjustment, impacting some but not all of the Review Period, was made to the population after the extraction process in respect of Retail Death claims to further align the data to the definition of a declined claim; and
- Certain other claims (e.g. ex-gratia payments) agreed to be within the Claims Review but for which there was no specific data flag in the claims handling system to reliably identify these claims. A combination of other data flags were identified to mitigate the likelihood of these claims being omitted from the population. A residual exposure has been accepted on the grounds of materiality to the Claims Review.

Due to these issues additional validation procedures were performed by Deloitte and CMLA without further issue. It is accepted that there is a risk from the above limitations and assumptions, in combination with findings arising from the completion of the data validation work, that there are claims that do not meet the definition of a Declined Claim in the population and also that not all claims intended to be within the population having been captured. Given the results of the additional procedures performed this risk was not deemed significant to prevent us from using the extract as the basis from which to select a sample of Declined Claims.

In addition to data validation procedures our work included procedures to assess the completeness of the documentation on a sample of the claims files subject to the assessment process. This involved reconstructing the claims file provided to us by CMLA from the underlying systems. No exceptions were identified in this testing.

## 2.7 Claims Review Limitations

In addition to the matters identified in Section 2.6, we were limited in our review due to the following:

- management has performed a top down approach to identifying Known Errors. Management believes this to have identified the majority of such claims but since there is no tracking of Known Errors there is a possibility others exist;
- the extracted population included claims arising from Accidental Death policies but these are outside of the scope of this report; and

- the data issues have restricted our ability to make statistical conclusions in relation to the Claims Review.

## 2.8 Claims Review Conclusion

Based on the scope of our work and the assumptions and limitations noted in this report we conclude that:

- given the level of coverage obtained by our sample we believe that the work performed is sufficient to have reasonably identified any matters that may systemically affect the declined claims population; and
- the Claims Review did not identify any systemic issues relating to historically declined claims.

We note that:

- in addition to the reassessment process CMLA is conducting a root cause analysis of all Errors identified to identify, as far as reasonably possible, whether other similar claims within the population exist;
- we also observed examples of good customer advocacy during our Claims Review. These include CMLA assessing claims under a current policy definition where the old policy would not have covered the claims, consideration being given to other policies where the claimant may have coverage, and the use of ex gratia payments where appropriate; and
- during our work we identified issues related to the accuracy of the claims system records used to identify Declined Claim population. While this has not impacted us completing our work this has limited our ability to draw statistical conclusions from our sample to that of the declined claims population as a whole. This limitation has been mitigated to some extent by the level of testing performed.

High priority recommendations relating to our work have been incorporated into Section 5.

# 3. Claims Handling Review

## 3.1 Claims Handling Review Background and Scope

We were engaged by CMLA to undertake a review of the current and planned improvements to the life insurance claims handling processes. The review, known as the Claims Handling Review, was aimed at identifying whether claims handling processes are designed in a way that could systemically deliver poor customer outcomes, either financially because claims are incorrectly declined or through a poor customer experience in how a claim is managed.

The Claims Handling Review covered the end to end people, processes and governance supporting Retail, Group and Direct life insurance claims management at CMLA. This included the Internal Dispute Resolution (IDR) and External Dispute Resolution (EDR) processes relevant to life insurance claims.

For the purpose of the Claims Handling Review, life insurance claims management covered the whole of CMLA's business, comprising life, trauma, terminal illness, income protection and total and permanent disability benefit types across Group, Retail and Direct lines of business.

Our review focused on the current and planned improvements to the systems and processes used by CMLA. Our scope was limited to assessing the design of current and planned improvements to the processes and not their implementation or operating effectiveness. Our review was also informed by the findings arising from the Claims Review.

## 3.2 Claims Handling Review Methodology

The Claims Handling Review was conducted using our claims management and IDR diagnostic tool. This tool uses a three-lens approach of people, process and governance to understand and evaluate the claims handling processes against generally observed market practice. It is supported by a database of industry claims management controls and enables comparison of the processes of organisations of a similar size and complexity.

In performing the Claims Handling Review our approach was informed by the following:

- The Financial Services Council Life Insurance Code of Practice (FSC Life Insurance Code of Practice) finalised October 2016 and effective 1 July 2017, which sets out a range of commitments covering many aspects of a customer's relationship with their insurer from buying insurance to making a claim;
- ASIC Report 498, released 12 October 2016, on its industry review of life insurance claims which delivered a range of potential implications for organisations;
- The Australian Standard AS ISO 10002–2014 Customer satisfaction—Guidelines for Complaints Handling in Organizations;

- Deloitte's maturity model for claims and complaints controls processes; and
- Deloitte insights on practice across the industry, including the results of the Claims Review.

## 3.3 Claims Handling Review Limitations

Our scope did not include consideration of the following:

- testing of the implementation or operational effectiveness of the controls, assessment of process efficiency, or re-performance of case manager work;
- system related controls and processes, for example for Orion (the CMLA claims handling system); and
- remuneration or remuneration related KPI's covering the claims and IDR personnel.

## 3.4 Summary of Claims Handling Review Conclusions

Based on the scope of our work and assumptions and limitations detailed in this report we did not identify any evidence that the current and planned improvements to the claims handling processes are designed in a way that could systemically deliver poor customer outcomes, either financially because claims are incorrectly declined or through a poor customer experience in how a claim is managed.

We identified a number of areas where we consider the execution of elements of the claims handling processes can be enhanced. We have summarised the priority items in this report.

At the time of our work CMLA is in the process of implementing a number of improvements to the design of its claims handling processes. We have relied on these improvements being implemented as designed in forming our conclusion. In our opinion effective implementation of these controls and processes will be critical to ensuring that the design of the claims handling processes are implemented and operate as expected.

Procedurally, recent developments such as the Complex Claims Committee and a pilot of a new approach to assessing claims involving potential mental health issues are also worthy of note and demonstrate an intent by management to evolve the claims assessment process. Our conclusion has assumed these design changes will occur as intended.

High priority recommendations relating to our work have been incorporated into Section 5.

# 4. Other Observations

## 4.1 Background

We have identified a number of matters which, owing to the nature of the concerns raised about CMLA's claims management practices in various public forums, we consider it relevant to highlight as a result of our work.

## 4.2 Upgraded policy definitions

As announced on 10 March 2016, CMLA decided to accelerate the planned upgrade to its definitions for heart attack and severe rheumatoid arthritis for all policies. These definitions were retrospectively applied to relevant claims events from May 2014.

Declined claims under the old policy definitions remain in the population under review. If sampled, these claims were checked to ensure that they have been identified and, where appropriate, paid by management. The decision to decline the claim was also reviewed to ensure that the claims handling processes required to make this decision had been appropriately followed.

Claims of this nature reviewed by us were appropriately identified by management for re-consideration under the new policy definition. Where sampled, we concurred with the original decision to decline based on the policy definitions in force at that time.

## 4.3 Terminal Illness – consideration of organ transplant

Within terminal illness claims there were three claims in the sample where it was possible to consider organ transplant in concluding on whether to accept or decline the claim.

We have not identified any instances in our sample where we disagree with the decision to decline a claim as a result of considerations given to the success of organ transplant.

## 4.4 Terminal Illness – timeliness of claims handling

There were 69 claims that commenced as TI claims but were settled as Death claims (as the claimant passed away whilst the TI claim was considered). In such instances, the claims were included within the scope of the Claims Review, with the focus of our review being on the timeliness of consideration of the TI claim by CMLA.

One of these claims took an undue length of time (around four months) to complete the claims assessment as a result of a lack of follow up by CMLA of the external Administrator. This was an isolated incident.

We have not identified any systemic delays in considering claims by CMLA. Across the population of TI claims there were isolated instances of internal procedural delay caused by absence, departure of a case manager, awaiting further information or similar, however these do not appear to be systemic.

## 4.5 Customer advocacy and legal concept application

As part of the scope of the Claims Review we have been asked to consider matters of customer advocacy and relevant legal concepts within how CMLA's claim handling processes operate. These concepts are captured within our review methodology and our case managers were provided guidance on them.

We have not identified any systemic concerns arising from the application of these concepts in the performance of the claims handling processes by CMLA.

Two examples of good customer advocacy that we have noted are:

- For certain old policies, where the current product includes a better outcome for a claimant and there is a relevant reason to do so, CMLA has assessed claims under the current product definition and paid claims which would not have been covered by the old policy; and
- Generally, we have observed that CMLA seeks to identify if claimants may be eligible to claim under another benefit type if the claimant is ineligible under the policy initially claimed.

## 4.6 Ex gratia payments

We observed that CMLA make a number of ex gratia payments. There are various reasons where, depending on the individual circumstances, management has concluded such an outcome is appropriate. Such ex gratia payments indicate a willingness to look for reasons to pay particular claims.

## 4.7 Claim Committees

CMLA have recently introduced a number of claims escalation forums to handle and deal with complex or sensitive claims. These include the Claims Review Panel, Complex Claims Committee and the Operational Claims Committee. The composition of these various committees is primarily management however the Claims Review Panel comprises a majority of independent members. The charters for these committees have also been recently updated to explicitly reference customer advocacy principles supporting their operation.

## 4.8 Mental Health Income Protection claims process

During the Claims Handling Review we observed that CMLA are in the process of piloting a refinement of the claims handling processes for Group income protection claims where the claimant is exhibiting indicators of mental illness. If identified then the claims handling processes are altered to become more of a telephone based assessment with the evidence and assessment of this evidence being handled in a way more sensitive to the needs of the claimant. We note that this is a pilot but support the actions of CMLA management in undertaking this type of initiative.

# 5. Recommendations

## 5.1 Background

We have identified a number of findings where we consider the execution of elements of the claims handling processes can be enhanced.

These have been rated as either, high, medium, or low priority, based on our understanding of the potential to deliver poor customer outcomes.

The ratings are defined as follows:

**High** – These are the findings which if not addressed we consider have the potential to lead to a poor customer outcome.

**Medium** – These are observations and recommendations which will enhance the claims handling processes to be in line with what we would expect for an organisation of the size and complexity of CMLA's insurance operations.

**Low** – These are procedural recommendations which we suggest are considered to enhance the claims handling processes.

We recognise that management has a number of initiatives underway which may already capture some of our recommendations and we understand that management will undertake a full business impact analysis of implementing these recommendations.

## 5.2 Summary of priority findings and recommendations

The following represents a summary of the six high priority findings and recommendations arising from the Claims Review and Claims Handling Review.

1. **Staff Training.** We recommend that staff training sessions are developed covering the associated updates to CMLA policies and procedures arising from the Deloitte Claims Review Program.
2. **Completion of CMLA reviews.** As a result of the findings from the Claims Review CMLA is continuing to perform a number of activities, including root cause analysis on each of the claims and review of trauma partial payments. We recommend these reviews are closed out and the associated outworking's from these are embedded in business as usual processes.
3. **Documenting conclusions on medical information used in the assessment process.** As a result of our Claims Review and Claims Handling Review we recommend improvements in how case managers document how they have concluded on their assessment of differing medical evidence, and consideration of claimants with complex Mental Health conditions, including psychiatric conditions, in the claims assessment process.
4. **Enhancements to customer correspondence, including decline letters.** As a result of our Claims Review and Claims Handling Review we recommend enhancements to the documents used to communicate with claimants in the claims handling processes. We recommend these are all considered as part of the ongoing improvements being implemented by management. In particular consideration should be given to the consistency and standardisation of decline

and procedural fairness letters, and the body of evidence presented in decline letters to claimants.

5. **Assessment of Eligibility to claim under a policy.** As a result of our Claims Review we identified an opportunity for CMLA to make documentation and procedural improvements in how Eligibility assessments are performed. These recommendations include, for example, increased training and guidance in particular for Group Eligibility assessments, and consistently documenting considerations around key policy details such as detail of the policy schedule definition in Retail Eligibility assessments.
6. **Enhancements to process of conducting claimant interviews.** As a result of our Claims Review and Claims Handling Review we identified an opportunity for CMLA to improve the process currently followed in performing claimant interviews to increase the consistency of customer experience and the evidence CMLA have to then support their claim decision. This covers, for example, providing context to the claimant prior to the interview, offering an invitation for a support person to attend, including legal representation, and agreeing expected times for completion of documentation. We note CMLA are currently implementing an updated interview and surveillance guideline which was planned at the time of our review.

## 5.3 Other recommendations

In addition to the above customer outcome focussed matters, we recommend that CMLA design and implement an enhanced data quality framework that ensures the correct classification of all claims.

This includes implementing a standard data dictionary for data fields used in the claims system, training to enhance the consistent use of these data fields by claims teams, and data validation checks to be performed by the delegated authority or quality assurance processes.

# 6. Limitations and Independence

## 6.1 Independence

Deloitte was required to maintain independence through adherence to Accounting Professional and Ethical Standards ("APES") 110 Code of Ethics for Professional Accountants in relation to the entities covered by this report and through confirmation of independence by team members.

Deloitte also implemented training and procedures so that if a potential personal conflict was identified during the performance of the Claims Review this would be disclosed to CMLA and our team member or members reassigned, with an individual of equivalent experience and seniority being allocated to review the claim or claims in question.

## 6.2 Specific limitations

- Management has performed a top down approach to identifying Known Errors. This is believed to have identified the majority of such claims but since there was no tracking of Known Errors there is a possibility others exist.
- The Data issues have restricted our ability to make statistical conclusions in relation to the Claims Review.
- Owing to limitations relating to underlying claims data there remains a possibility that:
    - not all claims intended to be within the population have been captured; and
    - there are claims in the population that do not meet the definition of a declined claim.
- In addition, whilst the extracted population included claims arising from Accidental Death policies these are outside of the scope of this report.
- When assessing poor customer experience we have not interviewed the claimants related to claim and have based this assessment on the evidence within their supporting claim file.
- In performing our Claims Handling Review we did not test:
    - the implementation or operational effectiveness of the controls, assessment of process efficiency, or re-performance of case manager work;
    - system related controls and processes, for example for Orion; and
    - remuneration or remuneration-related KPI's covering the claims and IDR personnel.

## 6.3 General limitations

Our work for CMLA was limited to the specific scope outlined our statements of work dated 1 June 2016, 14 July 2016 and 23 September 2016.

Our work is performed on a sample basis; we cannot, in practice, examine every activity and procedure, nor can we be a substitute for management's responsibility to maintain adequate controls over all levels of operations and their responsibility to prevent and detect irregularities, including fraud.

This report is solely for the use of CMLA. The report is not intended to and should not be used or relied upon by anyone else and we accept no duty of care to any other person or entity.

We understand that CMLA will provide a copy of our report to ASIC and APRA. We agree that a copy of our Report may be provided to ASIC and APRA and for release publically on the basis that it is published for general information only and that we do not accept any duty, liability or responsibility to any person (other than CMLA) in relation to this Report. Recipients of this Report should seek independent expert advice.

To the maximum extent permitted by law, we are not responsible to you or any other party for any loss you or any other party may suffer in connection with the access to or use of this report.

Our assessment is based on the documents provided to us as part of our work. We did not consider other controls and/or systems within CMLA more broadly which may impact the results or change the outcomes of our findings.

Deloitte assumes that any information provided by CMLA for this report is true, complete and not misleading, and confirms that if the information is untrue, incorrect or misleading then the report may be incorrect or inappropriate for its purpose. The decision-making responsibility in response to the findings of this report resides solely with CMLA.

Our work does not constitute a reasonable assurance (audit) or limited assurance (review) engagement in accordance with the Auditing and Assurance Standards Board (AUASB) standards. The scope of our work does not extend to obligations not specifically detailed in the Engagement Schedule and the work described above, and any interpretation of law. No legal opinions are provided or can be assumed.

Because of the inherent limitations of any internal control structure, it is possible that errors or irregularities may occur and not be detected. The matters raised in this report are only those which came to our attention during the course of performing our procedures and are not necessarily a comprehensive statement of all the weaknesses that exist or improvements that might be made.

We believe that the statements made in this report are accurate, but no warranty of completeness, accuracy, or reliability is given in relation to the statements and representations made by, and the information and documentation provided by CMLA. We have not attempted to verify these sources independently unless otherwise noted within the report.

This document and the information contained in it are confidential and should not be used or disclosed in any way without our prior consent.

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