Discussion Paper Claims Handling – (Response to Working Group)

This feedback reflects the views of Mercer's Claims Advisory Service, which is a specialised team that sits within Mercer's Legal and Governance Consulting Team. Mercer's Claims Advisory Team has a unique perspective on claims handling, as the specialised staff work full time on providing detailed analysis and recommendations in relation to disability and death claims. This work includes challenging insurer decisions and attending trustee meetings to provide advice, which in turn allows the trustee to make informed decisions that are fair and reasonable.

Whilst we generally agree with the content and intent of this Paper, we would like to take the opportunity to provide some comments/suggestions. In addressing some of the specific questions the Working Group has raised in relation to each section, we provide the following feedback:

B.1 Claims Handling Principles

With specific regard to Point 2 in this Section of the Paper, we would envisage that trustees will, effective from 1 July 2017, be monitoring claims durations as specified in the Life Insurance Code of Conduct. Additionally, the trustee will need to monitor specific timeframes and service levels imposed upon the trustee and third part administrators, for the particular steps/actions they are required to undertake as part of the overall claims process.

The trustee should, however, be wary of obtaining any additional information upfront from Members, because this could lead to a false expectation of a claim being accepted, prior to a formal Trustee determination.

A further principle that could be added is around having in place the required structure/procedures to meet Member's expectations in relation to standard timeframes. For example, it is somewhat worthless having timeframes imposed by the Life Insurance Code of Conduct, if a claim is then delayed because the trustee has inadequate delegations in place and/or an infrequency of trustee meetings to determine claim outcomes.

B.2 Standard Time Frames For Superannuation Fund Claims

Commenting on the timeframe for the action of 'The superannuation fund's independent review of the insurer's decision' we raise the following points:

- Quite often this is a two-step process, with some funds requiring review from a specialist team within the third party administrator or from other independent claims specialists (particularly in relation to declined claims). In some cases funds may need to seek legal advice about the insurer's interpretation of the policy.
- Dependent on the delegations set up by each fund, certain claims will only be determined by the trustee at a Claims Committee Meeting. The timing of these meetings is often entirely inadequate with some meetings being months apart.

The timeframe will be dictated by the above factors and hence the proposed timeframe of fifteen business days is particularly unlikely to be realistic for declined claims.

With regard to the Working Group's comments that the reasons for a decline decision are provided to the claimant by the Insurer or the Trustee, we make the following comments:

- We agree that best practice would indicate providing reasons in the first instance helps facilitate better understanding. However, we note this is not currently a legislative requirement.
- If this practice is to be adopted, which we believe it should be, then for declined claims, the trustee needs to be sure that the reasons given by the Insurer are the same as the reasons it relied upon in declining the claim, as this is not always the case. This could also have implications should a complaint arise.
- If the trustee was relying on the reasons provided by the Insurer, it would also need to ensure the wording used by the Insurer was in line with the fund's communication standards (if providing the Insurer's wording as an attachment).

Some further general comments around timing are:

- Consultation would need to be made where third party administrators are involved, as any changes to time frames may be limited by things such as system constraints, staffing and cost implications.
- The time frames do not contemplate situations where a deferral is warranted. There are sometimes cases where a legitimate decision is made to defer final determination of the claim until a medical condition has resolved or further treatment has been sought.
- An exception to these timeframes should be provided where retrospective disability claims (say, more than five years after the member has ceased employment) are involved and where limited information is provided or able to be obtained.
- Standard timeframes need to be improved in conjunction with a consideration of the timeframes for reviewing complaints. We recognise the Financial System External Dispute Resolution Framework is currently under review and this is a necessary part of the overall claims process.

B.3 Enhancing Communications Throughout The Claims Journey

We certainly advocate the idea of communications being constructed in a simple and easy to understand manner. We also advocate the idea of the fund being expected to provide assistance to members, who are having trouble understanding or completing forms or what is required of them. This particularly relates to members that are not legally represented.

Our view is that far too many communications, particularly those relating to following up outstanding material, are carried out by written communication, rather than verbal communication over the phone. Having properly trained staff contact members by phone should, in most instances, reduce timeframes, it would also alleviate the issues noted above in relation to claimants not understanding what is required and personalise the process. Whilst we recognise many funds already use some phone contact and in fact have separate call centres set up specifically to deal with claims, it is important that funds recognise they must be staffed with properly qualified and experienced people.

In terms of minimum communication standards being developed, our preference is that they initially be good practice guidance, rather than mandatory. However, if having good practice guidance fails to improve outcomes, mandatory standards should then be imposed.

B.4 Claims Handling Governance

We agree with the development of guidance in relation to governance standards for superannuation in relation to claims handling. We particularly see this as necessary for the review of declined disability claims and fulfilment of the trustee obligations under Section 52 of the SIS Act, where the trustee must do everything reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success. To enable this to happen the trustee must either have an in depth technical knowledge of claims and the associated legal precedents and decisions from the SCT, or rely on a third party to provide this expertise prior to it making a determination.

It is our view that a minimum mandatory requirement is already in place because of the legislation that currently exists, so good practice guidance would then demonstrate how this is achieved.

Whilst we agree that procedural fairness must be provided in relation to any material that has been relied upon by the Insurer in its assessment and not previously sighted by the claimant, we question the comment about providing procedural fairness 'throughout the process', rather than once, after the Insurer has collected all the information and is about to make its decision. This practice could in fact lengthen the time taken to assess a claim.

C. Further Considerations

How can superannuation funds better access and use data and technology to improve the claims handling journey to customers?

Whilst data and technology is useful in many facets of superannuation administration, probably what is of more importance with claims administration, is the recognition by trustees of the sensitivity and care that is required with these cases. Claims administration is unique because of the sensitivities involved. It requires personalised service and each claimant should be allocated with a dedicated case manager rather than dealing with multiple people over different stages of the claims process.

Do you support the reporting of claims data by funds for publications? If so, what information should be reported / published?

While it is unlikely a member would base their choice of fund on claims data, this approach could potentially encourage trustees to improve its processes and timeframes. This sort of information is only useful however, if we are comparing like with like and it is simple and easily understood by members. However, we consider that more granular data than just 'accept/decline' numbers should be provided; for example deferral numbers could also be reported, together with average times taken to consider claims and reasons for claims falling outside the standard timeframes.

Should the current exemption of claims handling from being considered a financial service be removed?

Our view is that it is better for industry to self -regulate rather than having regulators intervene. The industry is best placed to understand the environment in which claims reviews are being made and to provide workable standards. Our suggestion would be to see whether a code improves outcomes and only resort to removing the exemption if it fails to do so.

Is there merit in considering the establishment of an industry-funded claims assistance service to assist people claiming who are having difficulty in understanding the claims process? If so, how would such a service operate and be funded?

Our view is that it is more likely individual funds would want to consider offering their own service. In fact, many funds would argue they already provide this service with specialised call centre staff dedicated to assisting with claims. Each fund will have a different claims philosophy. Additionally, there would be different views on how much each fund would have to contribute in relation to an industry-funded assistance service, if it was to be paid for by the funds. It is also unlikely there would be any government funding given the lack of funding that already exists for external dispute resolution.

Further comment about involvement of law firms

While there has been a significant increase in the proportion of claims that involve legal representation, the reality is that in most cases legal representation will not assist in the claim outcome. We believe that enhanced fund communications are required to avoid early engagement of lawyers. Perhaps funds should be providing statistics to members upfront on the percentage of claims that are successful (without legal representation). This, combined with the fund having specialised services in place to assist members, would in our view reduce the number of members engaging lawyers early in the process. This information could be communicated in a variety of ways including sending reminders to members with their annual statements, advising them to contact the fund directly in the first instance in relation to lodging a claim.

Consideration could also be given to including in a protocol with legal representative bodies, that a lawyer will not accept engagement in disability claims that have not yet been determined, except in cases where the timeframes in the code are not being observed.