

from ASIC

Lifting the bar

ASIC is urging trustees to prioritise member interests when handling insurance claims and complaints. JANE ECCLESTON explains why change is necessary and how small improvements can make a big difference for members.

Many Australians hold life insurance cover through their superannuation. When making a claim on their insurance cover, consumers are often in the middle of difficult personal circumstances. So, any complaints about claims can raise complex and sensitive matters.

Against this backdrop, it is essential that consumers who are dissatisfied with the treatment of their claim have access to a transparent, fair and timely complaints process.

Last year, ASIC released *Report 591 Insurance in Superannuation*. Our review of data from 46 trustees highlighted specific areas for improvement in relation to complaints about insurance claims. We found that:

- 29 per cent of the trustees took more than 90 days on average to resolve insurance complaints;
- the average time taken by trustees was over 67 days with half taking more than 55 days;
- a number of trustees were failing to provide adequate written reasons for their decisions.

These issues highlight some deficiencies in the Internal Dispute Resolution (IDR) processes of superannuation trustees.

IDR IS KEY TO CONSUMER PROTECTION

IDR is the first step in financial dispute resolution and plays a vital role in consumer protection. ASIC considers that super trustees' approach to IDR provides a meaningful measure of the way trustees treat their members and whether they act in their members' best interests.

With this in mind, ASIC visited a number of super trustees to better understand what they have done in relation to key drivers of insurance complaints and to address the issue of lengthy resolution times. We focused our work on total and permanent disability (TPD) claims.

TRUSTEES CAN DO BETTER

ASIC identified several common failures among trustees, which if addressed, could lead to significant improvements for members. These are:

1. Limited identification of complaint drivers

Trustees often undertook inadequate analysis of the drivers of complaints and appeared to rely on speculation rather than fact. There seemed to be an underlying assumption that the member had complained because their claim had been denied and that this was to be expected in a number of cases. However, a deeper analysis would have presented opportunities for improvements in both member experience and efficiency.

A common driver seemed to be a failure to have processes in place to ensure all relevant medical information was gathered at the outset of a claim.

2. Limited attempts to change the way complaints are managed

Among some trustees, there seemed to be an assumption that complaints relating to insurance claims would take longer to resolve because they were more complex, and trustees have limited ability to influence this. However, ASIC found that other trustees were able to manage complex complaints in a timely manner.

3. Over-reliance on insurers' processes for claims and complaints

Many trustees seemed to rely too heavily on their insurer when managing claims-related complaints. For instance, some trustees had limited involvement in reviewing the initial decision or managing timeframes for responses to a complaint. To fulfil their duty to members, trustees should provide oversight and input into insurance complaints management.

4. Lack of member-centric view for the claims and complaints process

Trustees' approach to complaints handling tended to be process-centred, focusing on the actions of trustees and their service providers. This approach was not balanced with a member-centric view, which would have highlighted the members' experience.

Most trustees had not undertaken member-testing of insurance claim-related materials such as application forms, due process letters and insurance guides. They could not judge whether their membership understood what was required of them. To be confident that they are acting in the best interests of members, trustees must ask themselves: are we dealing with complaints promptly? Are we being responsive to members? Are we giving them information about the complaints process and how long it is likely to take? Are we providing high quality written reasons for decisions?

5. Quality of data

The quality of record keeping for claims and complaints varied across trustees, and this had an impact on a trustee's ability to monitor complaints, including the duration, contact with affected parties and status of the complaint. Good data is key to effective complaints management and is a strong focus of ASIC's consultation proposals about the new mandatory IDR data reporting requirements.

TRUSTEES RECOGNISE THAT THEIR PROCESSES NEED TO CHANGE

ASIC observed that those trustees seeking to improve outcomes for their members were introducing new initiatives to enhance their insurance claims and complaints management. Some of the initiatives are:

1. Separation of responsibilities and better oversight

A number of trustees have introduced a claims management officer or group to oversee all complaints raised by their members, including complaints managed by their insurers.

2. Trustee interest and commitment to reviewing declined claims

Some trustees have established a panel that meets regularly to review declined claims before a final decision is presented to the trustee board. Appropriate oversight at this stage could lead to a reduction in claims-related complaints.

An effective relationship between the trustee and the insurer is important. Trustees need to work with their insurers to ensure that their members are provided a fair outcome.

Claims that are initially denied by the insurer may be overturned during the claims or complaints processes because a trustee has taken steps to query the insurer's decision.

3. Appropriate record keeping and analysis

Some trustees have taken steps to record all the complaints they receive, including those that are 'immediately resolved'. This additional information may assist them with a thorough analysis of the drivers of complaints and in transitioning to the new data reporting regime.

These trustees also track members who request claim forms and have useful information on the proportion of members who ultimately proceed with a claim. This information may assist trustees in a more thorough analysis of members' needs and barriers to action.

4. Recognition of the need to be member champion

Trustees are starting to recognise the importance of improving their member experience. Some trustees are improving engagement with the claims and complaints process by implementing a single point of contact. Others are reviewing agreements with service providers in order to improve service-level timeframes and deliverables.

Additional initiatives to improve member experience include: tele-claims, where a member lodges the initial information over the phone; case management, where the member has a dedicated case manager; and clear explanation to a member about the claims process and the documentation required. Some trustees, in formalising their internal policies on claims and complaints handling identified areas for improvement.

5. Triaging claims can reduce complaints

Trustees with a lower ratio of TPD complaints to claims often undertook more detailed analysis of the claim when it was first lodged. Some trustees also triaged the claim – before lodging

the claim with the insurer, they contacted members if any information was missing. This reduced the possibility of the claim being declined due to lack of supporting information and a subsequent complaint from the member.

Early intervention is important to members' claim experience, and trustees recognise the benefits of a triage process during the assessment stage. Obtaining relevant information early in the claims process can help avoid delays later.

One trustee provided an example of a claim where a member's general practitioner (GP) recommended an examination by a specialist, which was not completed prior to lodging the claim. It was only after the claim was denied that the GP recommendation was noticed, and the examination carried out. A triage process could have picked up on the recommendation earlier and prevented unnecessary delay or even denial of the initial claim.

MEMBERS WON'T HAVE A BETTER EXPERIENCE IF TRUSTEES DON'T CHANGE THEIR APPROACH

It is unreasonable for trustees to expect members to be able to navigate the unfamiliar and potentially confusing process of lodging a claim without assistance. A process tailored to member needs will reduce the likelihood of a valid claim being withdrawn or declined because members didn't fully understand the requirements. This should also help reduce the number of member complaints.

Complaints handling is an ongoing area of focus for ASIC, and we look forward to feedback from industry on our proposals in CP 311. Last year, we undertook research into the obstacles consumers face when navigating the complaints processes of financial services providers. Our report (REP 603) also offers a roadmap for how providers can improve the way they handle complaints.

ASIC will also continue to meet with super trustees to gain further insights into the implementation of the Insurance in Superannuation Code of Practice, which aims to improve member experience and reduce timeframes for trustees' resolution of complaints. At the time of writing this article, 62 trustees had adopted the code.

Super trustees can make worthwhile improvements that not only deliver better member outcomes but also help meet the obligation of providing services in the best interests of their members and build trust in their brands. **SF**

Jane Eccleston is senior executive leader – superannuation, ASIC