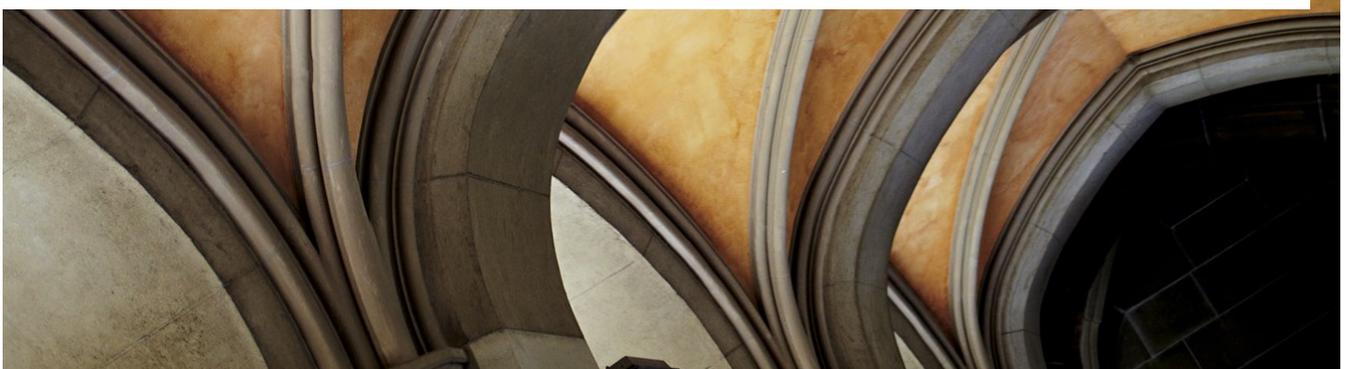




# ISWG Discussion Paper: Claims handling

Submission by UniSuper

12 May 2017



## About UniSuper

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UniSuper<sup>1</sup> is the superannuation fund dedicated to people working in Australia's higher education and research sector. With approximately 400,000 members and around \$60 billion in assets under management, UniSuper is one of Australia's largest superannuation funds and has one of the very few open defined benefit (DB) schemes.

Death and disability benefits for DB members are currently self-insured. Benefits for Accumulation account members are externally insured. In addition to self-insured benefits, DB members also have access to externally insured death and disability cover.

Different levels of default cover (which are offered without the need to submit health evidence) are offered to different cohorts of members, e.g. a lower level of default cover offered to SG members (casuals, contractors), and a higher level of cover is offered to permanent employees (generally in receipt of 17% employer contributions) who are likely to earn higher salaries and have longer tenure in their roles, leading to higher account balances.

UniSuper Management Pty Ltd would welcome the opportunity to discuss the submission further and to provide additional information in respect of the comments made in this submission. Should you have further queries, please contact Benedict Davies, Public Policy Manager, on 03 8831 6670 or [benedict.davies@unisuper.com.au](mailto:benedict.davies@unisuper.com.au)

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<sup>1</sup> This submission has been prepared by UniSuper Management Pty Ltd (ABN 91 006 961 799), which acts as the administrator of the Trustee, UniSuper Limited (ABN 54 006 027 121).

## Feedback

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### **The member experience at claim time**

UniSuper is strongly committed to making a difference at a member's greatest time of need: claim time. Our claim service is a highly personalised service designed to minimise the level of uncertainty that often accompanies insurance claims. To that end, all claims enquiries are directed to the claims area where there is a dedicated Claims Assist team whose primary function it is to "on-board" new claimants via highly skilled trained assessors and consultants.

All initial claim contacts, which are usually by phone, are directed via a dedicated IVR to the Claims Assist Consultants (CACs). This initial contact involves discussion with members about their current circumstances and the cover (or types of cover) that they hold with the fund. A preliminary eligibility check is conducted to determine claiming options available to the member. A key function of the CAC team is to explain the claims process to members as part of this initial contact and provide them with realistic time expectations on how long it will take for a decision to be made about the claim. At this point, and if determined to be appropriate, the member is also offered the option of lodging their claim via tele claim or paper.

The Consultants then create an initial claim notification file and send out the appropriate claim documents to members. This usually happens on the same day. Once the claim is loaded onto our system, it is followed up by Consultants at regular intervals with the first follow up as more of a check-in to make sure the member received the claim documents and see if they need any assistance as the documents can seem overwhelming to begin with.

UniSuper prefers that its Consultants deal directly with members; therefore, while we do have insurance facts on our website, the insurance claim forms are not available without speaking to a Consultant. We think it is far better that members deal directly with a Consultant prior to making a claim to ensure that the initial eligibility checks are done upfront which helps members understand the likelihood of a claim being successful. If unsuccessful claims can be avoided, members are better off and they save time and money (e.g. getting medical reports).

It is important to note that a key feature of the Claims Assist function is that the claim is case managed by the same person until the claim is ready to be assessed, at which point the assessor takes over the claim and becomes the primary /sole contact person. Once a claim is assigned to an assessor the member will be provided with a direct line to that assessor for the duration of the claim.

We strongly believe that dedicated Claims Consultants, with functions similar to those described above, are a key part of ensuring good member outcomes. Some funds in the industry also follow similar "best practice". We strongly believe that having dedicated Claims Consultants in-house is preferable to having an industry-funded claims assistance service (Question 14) which will always have less expertise than in-house experts.

### **Standard timeframe for superannuation fund claims (Question 3)**

UniSuper is broadly supportive of the timeframes proposed in the discussion paper as a minimum standard that has to be met. UniSuper already meets the standards, having in place a service level agreement requiring, for example, 95% of all initial internal claims handling actions to be completed within two days and 100% within five days.

We should point out that in claims where the member has legal representation, on average these cases are slower and the communications are potentially less effective where we do not have direct contact with our member. We also note that it is not uncommon for a member with legal representation to be contacting the fund directly to find out what is happening with their claim as all communications are being sent to their representative.

An option may be to copy in the member or the legal representative so that both parties are kept up to date. However given the nature of claims, a one size fits all approach to this may not be advisable as there will be claimants who would not cope well with receiving all correspondence and benefit from having the 3<sup>rd</sup> party involvement.

### **Reporting of claims data (Question 12)**

If claims data were to be reported publicly, it should be done no more than annually. The data would need to be standardised for measurement and comparability. While claims paid data, on first blush, might appear to be useful information for consumers, comparing data across schemes is extremely difficult. Comparisons are often unlikely to give rise to meaningful patterns because of the diversity of schemes, the age and profile of their memberships.

For example, the average time for a claim to be settled is a key internal metric; however, this would give some members false hope and unrealistic expectations about the claims process because each individual claim will ultimately depend on the complexity of a claim and there is no average claimant. Time-based frequency tables should be preferred to simple averages.

Claims paid data could also lead to increased risk of self-selection for some schemes. For example, if comparisons across schemes were done by members or their advisers to see which schemes approved the most TPD claims.

While we are broadly supportive of the reporting of high-level claims data, there are increased risks of this information being misused or misunderstood. We think these issues need to be addressed in more detail in a later paper.