Mercer Consulting (Australia) Pty Ltd
ABN 55 153 168 140
Collins Square
727 Collins Street Melbourne VIC 3008
GPO Box 9946 Melbourne VIC 3001
+61 3 9623 5061
Fax +61 3 8640 0800
paul.shallue@mercer.com
www.mercer.com.au

MERCER
MAKE TOMORROW, TODAY

Insurance in Superannuation Working Group (ISWG)
Project Management Office

Via email to: **ISWG-PMO@kpmg.com.au**

26 October 2017

Subject: **Consultation Paper - Insurance in Superannuation Code of Practice**

Thank you for the opportunity to comment on the draft Code and to the ISWG for the substantial amount of work that has gone into this exercise.

Mercer is supportive of the broad thrust of the proposed Code but we have significant concerns with some of the key proposals and with the proposed timeframe for implementation.

The proposals include a whole raft of changes that will be challenging to implement operationally for fund trustees and their service providers. Whilst we understand there is time pressure, we believe it would be highly costly, disruptive and counterproductive to 'finalise' the Code and the transition timeframe before the requirements and their implications across the industry have been thoroughly thought through and fine-tuned.

There is no doubt the changes required to implement the draft code will be costly to implement (and more costly for some parts of the industry, such as corporate master trusts, than others) and this cost will be borne largely by members. The implementation cost will be significantly greater if the Code is finalised prematurely and/or with a transition period that is not workable across the industry.

In our view it is unrealistic to expect the Code can be finalised by the end of 2017, particularly in respect of the provisions relating to the default insurance cover design/premium caps and automatic cancellation (13 months with no contributions). It may be possible to achieve consensus on the other elements of the code early in 2018.

In terms of the default insurance cover design/premium caps and automatic cancellation provisions, we believe the timetable should be reviewed having regard to the responses received to this consultation. Clearly the findings of the Productivity Commission's current review (draft report due early 2018) may also have some impact.

In our view the default insurance cover design/premium caps provisions need to have greater flexibility and a much longer transition period than is proposed in the draft. The legal concerns over whether it is appropriate for trustees to voluntarily constrain the benefits they offer (along with adopting the cover cancellation provisions) in such a manner also need to be addressed.

A workable approach to get something in place in the short term may be for the Code to apply as guidance with a trustee able to decide if the guidance is applicable in their particular circumstances, with a requirement to document why they have departed from guidance if they have (i.e. work on "if not, why not" basis).

We have commented in more detail below on the draft provisions relating to:

- the default insurance cover design/ premium caps
- automatic cover cancellation
- duplicate cover.

We have also set out in the Attachments:

- our response to the Feedback questions in the Consultation Paper, and
- comments on other aspects of the draft Code.

DEFAULT INSURANCE COVER DESIGN/PREMIUM CAPS

We support the principle behind the proposed premium caps in terms of providing a common industry approach as to what level of insurance costs does not result in inappropriate erosion of retirement income.

Whilst having a different benefit design/approach for young members will add to complexity and cost, we agree with the proposed separate cap for under 25s due to the generally different insurance needs of members at young ages.

We also support the proposals that the testing of a potential insurance design against the premium caps be applied:

- using an average earnings base considered appropriate for the relevant segment by the trustee, where individual salary information is not available
- based on the average cost over a membership period or periods considered appropriate for the relevant segment by the trustee.

However we do not support the strict application of the caps as proposed in the draft Code. Our concerns with the proposed caps and their operation include the following:

- In many cases the Code would appear to require trustees to reduce cover levels for some or all default cover members when the Code is first applied. Members in poor and deteriorating health will lose cover they are likely to be unable to replace. A strict application of the caps will not leave any room for trustees to balance the reduction against the premium level taking into account the fund and member circumstances.
- If a plan's premium rates are reviewed upwards in future this may also require cover levels to be reduced, which will also be difficult for trustees.
- Strict application of the premium caps does not seem consistent with the levels of the caps being fairly arbitrary and the fact that they are to be based on average earnings across segments of membership rather than individual member earnings (we agree the latter would be unworkable in many cases)
- While the use of average earnings bases to design cover to comply with any caps is a practical necessity in many cases, it means that there will be many lower income earners (in particular) whose premiums will exceed the cap percentage applied to their own

earnings, both in a particular year and over their period of membership. Hence we think the proposal is of limited effectiveness in terms of applying an income-related cap to default premiums for lower income earners.

- The 'fine print' relating to the caps being based on 'average earnings' and 'average cost over a suitable period chosen by the trustee' is likely to be lost on members and other stakeholders such as some journalists. If the earnings caps are introduced as proposed, members are likely to expect they will apply each year based on their individual earnings for that year and/or possibly that the premium will be capped but this won't affect their cover. This is likely to lead to confusion and, over time, complaints.
- We agree with providing a longer transition period for the design/premium cap provisions as compared with the remainder of the Code (as noted above the automatic cover cancellation provisions, if implemented as proposed in the draft, may also require a special transition period). However in our view the transition period for the design/premium cap provisions would need to be much longer than proposed in order to be workable and to avoid adding substantially to the costs of transition.
    - Assuming that many funds will require changes, the proposed timeframes are far too tight for trustees to undertake design reviews, have these priced by their insurers, work with their insurers to determine the best package of benefits and cover terms, possibly conduct insurance tenders, finalise the design, then communicate these changes to members, as well as for fund administrators and insurers to implement the changes across the whole industry – pushing this though in such short time frames will significantly add to the costs for all as occurred with the MySuper timetables. The provisions requiring compliance with the caps by the first policy renewal after adoption of the code are particularly unworkable and are likely to result in many funds delaying adoption of the Code.
    - The transition issues are magnified greatly for corporate master trusts and other arrangements with multiple sub-funds each with separate default insurance designs. For example, the Mercer Super Trust has around 230 employer sub-plans, many of which have a number of benefit classes with different insurance designs, with over 800 different insurance arrangements overall. These have different default insurance arrangements tailored to the relevant workforces and segments of those workforces - each of these designs would need to reviewed against the caps and any changes agreed with the MST's multiple insurers and the relevant employers. Following this the update of all the PDS's would be at least a 12 month task in itself.
- The whole exercise would have very substantial costs and in many cases would only have a marginal positive impact on members' retirement benefits e.g. a reduction in insurance premiums from 1.1% to 1% of average earnings might save a member $60 per year (or $50 post contributions tax).

Mercer-recommended alternative approach

We recommend the following approach as a more workable alternative:

- Trustees would be required to use the 1% /0.5% caps as a guideline in designing default cover, but with some flexibility to exceed the caps e.g. to enable a sensible transition from existing cover levels, to avoid reductions being required where average premiums are not substantially higher than the caps and to assist managing premium rate increases where the trustee wishes to avoid or mitigate any cover reductions
- The transition period should be extended to 5 years and the provision requiring implementation by the first policy renewal after adoption of the Code should be removed
- If default cover insurance costs for an individual member exceeded 10% of SG contributions received over the prior year, the member's annual statements would be required to include a notice to this effect, along with other information as proposed in the current draft para 5.27 (proposals where SG contributions are less than $1,800). This requirement would apply to all members and would replace the proposed 'low or infrequent contributions' (annual SG contributions less than $1,800) requirement.

The above alternative approach would:

- Avoid expensive changes being required where average premiums are not substantially higher than the caps;
- Provide greater flexibility for trustees to rejig current arrangements to the proposed caps over time if they believe that would be in members' best interests
- Address the potential erosion issue with members whose annual SG contributions exceed $1,800 but are significantly lower than the average earnings assumed in the insurance design
- Avoid (or significantly reduce) the number of situations where the premium cap code requires the trustee to reduce a member's cover without their consent and the member is subsequently disadvantaged at claim time
- Reduce transition costs and provide a more realistic transition period

However the legal concerns over whether it is appropriate for trustees to voluntarily constrain their discretion to design their benefits to best suit their members' needs will still need to be addressed. Clearly this could be overcome by a legislative mechanism requiring trustees to abide by the Code.

CANCELLATION AND CESSATION OF COVER

Opt out proposals

We support the proposals relating to making it straightforward to opt out of cover.

Please refer to the 'Refund Proposals' section below for our high-level comments about the proposals regarding premium refunds on cancellation of cover, and to Q10 in Attachment 1 for our detailed comments.

Cancellation of cover due to lack of contributions

Whilst we agree that the intent of the draft policy is reasonable, we have a number of serious concerns with it.

Firstly, the proposed requirements are very challenging administratively in terms of requiring multiple member communications and a strict cut-off at 13 months at the latest.

For some funds/divisions (e.g. retained members), it may be impossible to identify whether a member has default cover, whether they have chosen it, or whether they have a mix of default and chosen. For example, many employer funds or sub-funds provide salary-related insurance cover, which has the advantage of automatically tailoring the level of cover - and hence the related premiums - to the member's level of income. On leaving the employer and retaining their benefit in the fund, a salary-related benefits is no longer practical and hence the member's current $ level of cover is continued unless they choose otherwise. Historically there has been no reason to identify whether (or what portion of) this cover was default cover. How will the Code require trustees to deal with circumstances such as these? We have a number of concerns with the draft definition of Automatic Insurance Member – see Attachment 1 Q10 for our detailed comments.

More importantly, the cancellation of cover will inevitably result in claims against the trustee that cover was cancelled when the member wanted it to be retained and did not receive or understand the notices about cancellation for a variety of reasons. If the definition of Automatic Insurance Member and other circumstances for cancellation of cover are not absolutely watertight, this will open up a further area of potential challenge. We note that, in many cases it will be either impossible or impractical to turn off cover at exactly 13 months so under the code trustees would have to do it earlier, opening up another potential point of challenge.

Taking into account the legal concerns over whether it is appropriate for trustees to voluntarily constrain their discretion to provide cover they consider best suits their members' needs, in our view it would not be appropriate for trustees to be required to cancel cover as proposed in the draft Code, in the absence of legislation requiring it and providing protection for trustees who do so.

Mercer-recommended alternative approach

Pending any legislation requiring cancellation of cover and providing protection for trustees who do so, we suggest that this issue would be adequately dealt with by our proposal above that the members' annual statements include a notice if insurance costs for that individual member exceeded 10% of SG contributions received over the prior year. The intent would be to prompt members to consider the issue and make an informed decision, not to make the decision for them.

DUPLICATE INSURANCE COVER

Proposed new member requirements

Paragraph 4.31 of the draft Code requires that trustees seek permission from each new member to find out whether they have insurance in other funds, then requires the trustee to find that information and communicate it to the member. We consider that this service will be of limited effectiveness given that SuperMatch will only show whether or not the member has insurance in other funds, not the type or amount of cover, as is noted in the Consultation Paper.

We would not support this requirement extending to trustees being required to ascertain more information than is available from SuperMatch, such as the type or amount of cover, as this would be a highly manual process and very costly for trustees to implement.

We do not understand the reference in the Consultation Paper to potentially extending Single Touch Payroll 'to provide real-time view of existing accounts and insurance and allow members to consolidate their existing accounts'. Our understanding is that the Employee Commencement Service component of Single Touch Payroll is already planned to provide as near as possible to a real-time view of existing accounts, as well as whether or not each account has insurance, and to facilitate members consolidating their existing accounts.

If the extension proposed is to allow myGov/ATO Online to show the type and/or amount of cover, we note that this would require this information to be added to SuperStream reporting. SuperStream related changes are not able to be completed quickly and are significant system/data reporting builds.

We believe the Welcome Pack letter should highlight what the automatic cover is and that the member should consider whether they have cover in other funds and if so, whether they need both of them (it should also cover the potential inability to claim on multiple income protection benefits). It could also draw attention to the availability of super information (including whether it includes insurance) on *myGov.*

We believe that availability of superannuation information on myGov/ATO Online is an important development which will assist members manage their super and that utilisation of this information and the associated consolidation service will increase significantly over time. Members can now easily see if they have insurance cover in more than one fund. This can be expected to reduce the prevalence of multiple unwanted accounts and duplicated multiple insurance as consumers become more aware of this facility.

If considered appropriate by the Government, myGov could be modified to send messages to members who are identified as having insurance cover in more than one fund e.g. as a once-off to all existing members with multiple cover and then each time a new account with insurance cover is added to myGov for a member who already has an account with insurance cover.

REFUND PROPOSALS

The refund proposals relating to both duplicate cover and opt-out of default cover involve the same tensions as arise for many of the other proposals in the Code – looking from the viewpoint of the individual members affected they are clearly reasonable and have merit, yet they are administratively cumbersome and quite demanding for funds, so that the cost of implementation and ongoing compliance with the proposed refund measures may well exceed the benefit to the members concerned, while increasing the costs borne by all members.

Accordingly we have serious reservations about the proposals regarding premium refunds due the administrative burden they would entail. However on balance we support the proposals, subject to strong consideration of any refinements that would make the refund process more efficient. Please refer to Q10 and Q24 in Attachment 1 for our detailed comments.

We presume that the insurers are comfortable with the refund proposals, as funds will not be able to make refunds to members if they cannot obtain a corresponding refund from their insurer.

SERVICE STANDARDS

While the recommended timeframes provide a reasonable benchmark for a good practice guide, if the Code is to be mandatory there needs to be greater flexibility in the service standards to allow for contingencies and difficult circumstances, particularly when a direct to member service model is not in place with the insurer.

Accordingly we would like to see more recognition in Code that many of the timeframes specified are fairly tight and that trustees are unlikely to be able to meet these in all instances, particularly in the period immediately following adoption when new systems and procedures and the associated resourcing needs may still be in the process of being established and bedded down. We suggest there should be a clear statement in the Code to the effect that trustees will use their best endeavours to ensure that the timeframes specified are met in the majority of cases but that workflow peaks or other reasons may mean that these timeframes are not met in some instances.

Who is Mercer?

Mercer is a global consulting leader in talent, health, retirement and investments. Mercer helps clients around the world advance the health, wealth and performance of their most vital asset – their people.

Mercer Australia provides customised administration, technology and total benefits outsourcing solutions to a large number of employer clients and superannuation funds (including industry funds, master trusts and employer sponsored superannuation funds). We have over $150 billion in funds under administration locally and provide services to over 2.4 million super members and 15,000 private clients. Our own master trust in Australia, the Mercer Super Trust, has around 230 participating employers, 220,000 members and $22 billion in assets under management.

Please contact me on 03 9623 5061 or paul.shallue@mercer.com if you would like to discuss this submission.

Yours sincerely

Paul Shallue
Manager, Research & Policy

MERCER
MAKE TOMORROW, TODAY

ATTACHMENT 1

MERCER RESPONSES TO CONSULTATION QUESTIONS

B.1 Feedback questions

SCOPE OF THE CODE

1. How should the ISWG ensure that all trustees are bound by the Code?

In our view this would require some sort of legislative compulsion. This could be via:

- A Prudential Standard issued by APRA
- A mandatory Code approved by ASIC if a supporting framework is legislated (along the lines of the ASIC Enforcement Review Taskforce's proposal as discussed in their *Industry codes in the financial sector* Consultation Paper)
- Specific legislation

As an interim arrangement funds could voluntarily adopt the Code. If this is to occur, the legal concerns over whether it is appropriate for trustees to constrain their discretion in some areas (e.g. insurance benefit design) by voluntarily adopting such a Code need to be addressed. Please refer to the Law Council submission for details of these concerns. Further, the contents of the finalised Code may affect a trustee's willingness to voluntarily adopt the Code.

A workable approach to get something in place in the short term may be for the Code to apply as guidance with a trustee able to decide if the guidance is applicable in their particular circumstances and being required to document why they have departed from guidance if they have (i.e. work on "if not, why not" basis).

2. What are the practical implications of the transition arrangements?

Please refer to our comments in the body of the letter. We caution against rushing finalisation of the Code. 1 July 2018 might be a practical target date for finalisation.

We think it will take something like 12 months from finalisation of the Code to implement the systems and procedural changes, along with associated policies, staff training, preparation of member communications material, staff training and website work. However it is difficult to be confident because of the many facets of the changes required and that there is still uncertainty about the details of some of the proposals.

We note that, as a major Fund Administrator, we will need to work with a large number of funds to implement the changes. Therefore so we think it is prudent to recognise that it may in practice take significantly longer than 12 months to implement the changes across the industry. Accordingly we propose that an 18-24 month transition period should be permitted.

MERCER
MAKE TOMORROW, TODAY

This does not include the proposed premium cap/benefit design component. As set out in the body of the letter, for this component the transitional arrangements proposed are nowhere near long enough for a multi-employer fund with multiple different insurance arrangements. We have recommended modified proposed premium cap/benefit design provisions with a 5 year transitional period.

Summary of Mercer's transition recommendations:

- Set 1 July 2018 as a practical target date for finalisation of the Code
- Allow an 18-24 month transition period for funds to adopt the Code, excluding the premium cap/benefit design provisions
- The transition period for the premium cap/benefit design provisions should be extended to 5 years and the provision requiring implementation by the first policy renewal after adoption of the Code should be removed
- If the decision is to proceed with the 13 months cover cancellation provisions, the transition period should allow this to apply only from a date from which it will be a legal requirement for all funds.
- Transitional provisions may also be needed for existing members – for example providing flexibility for trustees to decide how they will deal with existing members whose cover is not capable of being identified (in an efficient manner) as being default cover or not.

3. What flags will be required to be built into a trustee's (or their administrator's) system as a result of the Code requirements (for example, whether a member is an Automatic Insurance Member, whether they have chosen to retain their cover even when not making contributions, whether they require assistance as a vulnerable consumer)?

We agree all these flags will be needed and very likely others to facilitate management of the re-designed cover arrangements across the different segments of membership determined by the trustee.

Further information is needed for us to understand the practical implications of the proposed requirements regarding vulnerable consumers, including the interaction with privacy requirements.

The fact that many of these flags do not currently exist results in a further significant transition issue – how do we deal with existing members who do not have these flags?

A very important example of this is that many funds may have no way of identifying whether the cover for some or all existing members is default insurance or not – for example some retained member sections as discussed in the body of this letter.

Will trustees be required to apply the default member rules to all such members? We would be very uncomfortable with doing this given there would be a significant proportion of such members who deliberately selected their cover levels. Not only will they be annoyed that we are threatening cancellation of their selected cover, there are also likely to some who fail to respond and lose that cover when they didn't want to e.g. if they are away when we write to them.

MERCER
MAKE TOMORROW, TODAY

We believe transitional provisions are needed for existing members in circumstances as such as these – for example providing flexibility for trustees to decide how they will deal with existing members whose cover is not capable of being identified (in an efficient manner) as being default cover or not.

B.2 Feedback questions

PREMIUM LIMITS

4. Are there alternative proposals for setting maximum premium levels that the ISWG should consider?

   Yes - please refer to our recommendations in the body of the letter.

5. Are there particular measures of earnings that the ISWG should include in Good Practice Guidance?

   Many employer funds or sub-funds collect salary information form the employer/s and use this to determine the member's insurance cover. This has the advantage of automatically tailoring the level of cover - and hence the related premiums - to the member's level of income.

   Hence any guidance should recognise salary information as a reasonable basis for determining earnings. It should also recognise that basing insurance cover on salaries may render the use of average earnings unnecessary i.e. the cover design may be such that the cost of cover as a % of a member's salary is independent of their salary level.

6. For superannuation funds – how would you approach the design principles, including the premium limits? Do your current premiums fall within or outside of the maximum limits provided? (Note that this information will be treated confidentially).

   As explained elsewhere in this submission, it would be a huge exercise to undertake such an assessment for all Mercer's funds and sub-funds. However our initial analysis for a small sample of funds suggests we will have significant numbers of members who exceed the limits by small amounts.

   The MST's approach to ensuring premiums are not excessive is set out in Attachment 2.

7. What impacts are the premium limits likely to have on benefit design and premiums? Are there financial impacts that the ISWG should take into account?

   As explained elsewhere in this submission, it would be a huge exercise to undertake such an assessment for all Mercer's funds and sub-funds. We have responded to the ISWG Survey for a small sample of corporate plans within the MST. If the limits are to be strictly applied, we expect we would have to make changes to the design of many plans which will be very costly and have a very small impact on the member outcomes.

MERCER
MAKE TOMORROW, TODAY

We have recommended in the body of this letter that a more flexible approach be applied, along with a longer transition period.

8. To what extent will the premium limits achieve the goal of targeting inappropriate account erosion for low income earners, particularly women and younger members?

   They will assist to some extent.

   However the use of average earnings bases to design cover to comply with any caps, while a practical necessity in many cases, means that there will be many lower income earners (in particular) whose premiums will exceed the cap percentage applied to their own earnings, both in a particular year and over their period of membership. Hence we think the proposal is of limited effectiveness in terms of applying an income-related cap to default premiums for lower income earners.

   To address this, we have recommended in the body of this letter that the following approach be adopted (in combination with more flexible premium caps):

   > *If default cover insurance costs for an individual member exceeded 10% of SG contributions received over the prior year, the member's annual statement would be required to include a notice to this effect, along with other information as proposed in the current draft para 5.27 (proposals where SG contributions are less than $1,800). This requirement would apply to all members and would replace both the proposed 'low or infrequent contributions' (annual SG contributions less than $1,800) requirement and the 13 month cancellation of cover proposal.*

   Different views about what is 'inappropriate erosion' will continue. For example some will be of the view (and some trustees may decide) that members under 25 (or some other age) should have no default insurance cover, whereas others may take the view that TPD or income protection cover is no less important for members under 25, noting that default cover accessed at early ages can be a lifesaver for those that either have serious accidents (more common in this age group) or develop conditions that preclude them from accessing retail cover.

9. What are the likely impacts of a trustee reducing cover for some segments of its membership in order to reduce premiums? How would the trustee manage a member who wanted to retain their original cover? Could this member remain an Automatic Insurance Member?

   Funds would need to write to all affected members (which may not just be default insurance members, for the reasons discussed above Q3 above), telling them their cover would be reduced. There would be an anti-selection risk in allowing members to elect to retain their higher cover. We understand that insurers have been unwilling to permit this (at least without underwriting) in some recent instances where default cover has been reduced across the board in response to premium increases.

MERCER
MAKE TOMORROW, TODAY

Other Comments

Clause 4.14 ***We*** *may limit the type or level of cover offered to* ***you*** *as an* ***Automatic Insurance Member*** *if* ***we*** *believe that cover cannot be provided at a reasonable cost; for example, if* ***you*** *are employed in a hazardous occupation.*

This suggests circumstances where the premium rates that the trustee would be charged by an insurer are higher than reasonable for the level of risk. We suggest that the wording be modified to refer to 'that a worthwhile level of cover cannot be provided at an affordable cost ' or 'that the standard level of cover cannot be provided at an affordable cost ' – or both, depending on what this clause is intended to mean.

Clause 4.15 **We** will not automatically include **you** in a division of **our** fund that is higher risk than the membership generally due to smoker status or occupation (where such a designation exists) without sufficient evidence.

We have no problem with the smoker status but in regard to occupational rating this clause seems to be unworkable for funds that are not able to collect reliable occupation information. In the absence of such information, we do not see how this clause can be applied without disadvantaging members who are of lower than average risk.

Is it envisaged that there will be a cover adjustment clause that will reduce the sum insured where someone is in a higher-than average risk category at the time of claim and did not disclose this? Would this represent an improvement on current practices?

We believe this clause should be removed unless it can be explained how this could work equitably in practice.

CANCELLATION AND CESSATION OF COVER

We query the proposal in the Consultation paper for a legislative change to require employers to communicate reasons for ceasing contributions, for example terminated employment, to assist funds with more targeted communications. We note this is unlikely to be workable for casual employees and that a change would need to be implemented by adding to the information collected via SuperStream reporting. SuperStream related changes are not able to be completed quickly and are significant system/data reporting builds.

10. What are your views on the proposed cessation and reinstatement mechanisms?

We support the proposals relating to making it straightforward to opt out of cover.

Premium refunds on opt-out

As per our comments in the body of this letter, the refund proposals relating to both duplicate cover and opt-out of default cover involve the same tensions as arise for many of the other proposals in the Code – looking from the viewpoint of the individual

MERCER
MAKE TOMORROW, TODAY

members affected they are clearly reasonable and have merit, yet they are administratively cumbersome and quite demanding for funds, so that the cost of implementation and ongoing compliance with the proposed refund measures may well exceed the benefit to the members concerned, while increasing the costs borne by all members.

Operationally premium refunds are inefficient, impractical and create record-keeping inconsistencies. Not only is it cumbersome to process the refund on the affected member's account, the transaction also affects:

- the accuracy of records captured and reported (to APRA, Member annual reports, Insurer plan experience, etc.)
- reconciliation of employer sponsor paid, member paid and/or plan paid premiums
- recouping of amounts / obtaining approvals from the Fund's respective insurers.

We presume that the insurers are comfortable with the refund proposals, as funds will not be able to make refunds to members if they cannot obtain a corresponding refund from their insurer.

On balance we support the proposals, subject to strong consideration of any refinements that would make the refund process less burdensome administratively.

Cancellation of cover due to lack of contributions

We do not support the 13 month automatic cover cancellation proposals in the absence of legislation requiring it and providing protection for trustees who do so. Please refer to our comments and recommendations in the body of the letter.

Definition of Automatic Insurance Member

We have significant concerns about the lack of clarity in the draft definition of Automatic Insurance Member. This is defined in section 16 as:

> **Automatic Insurance Member** means **you** are a superannuation fund member who holds insurance under an automatic acceptance limit, issued when **you** joined the fund, or **your** employer has ceased funding all or part of **your** premiums, such as when **you** leave the employer. **You** are not regarded as an **Automatic Insurance Member** if:
>
> a) **you** make an application for cover (including cover that is underwritten or the recommencement of previous cover);
> b) **you** vary the cover in any way, such as cancelling, fixing cover or changing the benefit or waiting period;
> c) **your** insurance premiums are wholly paid for by **your** employer or not paid by deduction from **your** account; or
> d) **you** are a defined benefit member.

We do not understand the intent of the highlighted words. We presume the highlighted words are intended to refer to the insurance, not the automatic acceptance limit.

MERCER
MAKE TOMORROW, TODAY

Intended meaning of 'issued when you joined the fund'

We note for unitised cover the $ cover per unit usually changes as the member ages – is whatever the current cover is regarded as being 'issued when you joined the fund'? Further, it is not uncommon to reset default cover levels from time to time after a member joins a fund e.g. for unitised cover the cover per unit at a particular age may have increased and/ or decreased since a member joined – this does not seem to fit with 'issued when you joined the fund'. Similarly, for salary-related cover, this usually increases with increases in the member's salary and is generally automatically accepted – it is difficult to see how any such increase in cover could be regarded as insurance issued when you joined the fund', however it is automatically accepted cover.

What is the situation of members who have insurance cover transferred in from a prior fund (e.g. by successor fund transfer)?

- Is this cover regarded as being issued when they joined the fund?
- If the member applied for cover as per (a) or (b) in the prior fund and this existing cover was automatically accepted on transfer to the current fund, does that mean they then become an Automatic Insurance Member? We presume this is not intended.

Intended meaning of 'issued when …. your employer has ceased funding all or part of your premiums, such as when you leave the employer

We are unsure what this is trying to get at. It is now uncommon for employers to pay all or part of a member's premiums. However it is common for employer funds or sub-funds to provide salary-related insurance cover while the member is an employee. On leaving the employer and retaining their benefit in the fund, a salary-related benefits is no longer practical and hence it is common for the member's current $ level of cover to be continued unless they choose otherwise. Are the above words intended to capture this sort of cover? Does it depend on whether some or all of the cover was default cover prior to leaving service? Is it accurate to regard this as cover issued 'when you leave the employer'?

Exclusions (a) and (b)

Why is the present tense used? Presumably it is intended that members who have taken those actions in the past not be regarded as Automatic Insurance Members?

What happens where member's status in uncertain?

Historically there has been no reason to identify whether (or what portion of) some or all members' cover was default cover.

Assuming the definition is suitably amended to provide clarity on all the above points, how will the Code require trustees to deal with circumstances where they cannot identify

MERCER
MAKE TOMORROW, TODAY

(in a reasonably efficient manner) whether or not a member's cover is (100% if applicable) default cover?

We also suggest there should be a provision that if the member has given the trustee an indication in any way that they are happy with the current amount of cover, they are excluded from being an Automatic Insurance Member.

Reinstatement of Cover

Clause 4.28 reads as follows:
*4.28 If **your** cover has ceased due to a lack of contributions in accordance with section 4.25,[7] it can be reinstated in the following circumstances without any health assessment being required or break in cover, provided **you** are capable of active employment and **your** account has adequate funds to pay the premium owed for the intervening period:*
*a) if **you** tell **us you** want to reinstate **your** cover within 60 calendar days of the cessation date; or*
*b) if sufficient **eligible contributions** are made within 60 calendar days of the cessation date.*

The condition that '***you** are capable of active employment '* is important and we presume this process has been agreed with the major group insurers. We think this condition deserves greater prominence and that the 'adequacy of account balance' condition should be combined with (b). We suggest clause 4.28 should be re-worded as follows:

*4.28 If **your** cover has ceased due to a lack of contributions in accordance with section 4.25,[7] it can be reinstated in the following circumstances without any health assessment being required or break in cover:*
*a) if **you** are capable of active employment; AND*
*b) if **you** tell **us you** want to reinstate **your** cover within 60 calendar days of the cessation date; AND*
*c) if **your** account has adequate funds to pay the premium owed for the intervening period or sufficient **eligible contributions** to enable payment of the relevant premiums are made within 60 calendar days of the cessation date.*

However we still have a concern that the condition that '***you** are capable of active employment '* is somewhat inconsistent with the impression given by the words '*without any health assessment being required'* – implicitly an assessment is required that the member's health is such that they are capable of active employment.

Furthermore, this condition raises the stakes of the cover cancellation - a member whose health is such that that they are not *capable of active employment* will not be able to have their cover reinstated. We are not surprised that insurers would want to apply such a condition due to the anti-selection risk, however this condition only firms our view that cover cancellation should only occur if required by legislation that also provides adequate protection for trustees.

MERCER
MAKE TOMORROW, TODAY

DUPLICATE INSURANCE COVER

11. What more could the Code do more to help members identify whether they have duplicate insurance, and determine whether this is appropriate for them?

    Please refer to our comments and recommendations in the body of the letter.

B.3 Feedback questions

HELPING MEMBERS TO MAKE INFORMED DECISIONS

12. Which parts of the Code require particular attention for consumer testing?

    As per our comments on the proposed premium caps in the body of the letter, in our view the 'fine print' relating to the caps being based on 'average earnings' and 'average cost over a suitable period chosen by the trustee' is likely to be lost on members and other stakeholders such as some journalists. If the earnings caps are introduced as proposed, members are likely to expect they will apply each year based on their individual earnings for that year and/or possibly that the premium will be capped but this won't affect their cover. This is likely to lead to confusion and, over time, complaints.

    Hence we consider any wording in the Code relating to premium caps should be consumer-tested to ensure it does not give a misleading impression of how the caps might affect an individual member's premiums.

    We also have concerns about clause 5.1:

    ***5.1 We** will help **you** to make better informed decisions by giving **you** appropriate and easy-to understand information when **we** provide **you** with cover and on an ongoing basis.*

    Whilst we will give members some information that can reasonably be regarded as 'easy to understand information', we will also have to give them detailed information which we do not think can be reasonably described as easy to understand. We think we should be up-front about this and add something like:

    > *We will also give you more detailed information which sets out the important features, terms and conditions associated with the insurance cover provided or available to you.*

    We suggest the wording here be consumer-tested.

13. How could the Key Facts Sheet template better assist members to understand and compare their cover?

    We suggest that:

    - The waiting period for income protection benefits should be included (along with the benefit period)
    - A 'change in your working hours' should be added to the list of circumstances that may change your cover.

MERCER
MAKE TOMORROW, TODAY

14. Do the communication requirements in the Code achieve the right balance between prescription and trustee flexibility?

Please refer to our comments in the body of the letter that a longer transition time is needed for the changes to be implemented across the industry, including for multi-employer funds which generally need at least 12 months to change all their communications materials.

15. What further steps could be taken to engage members who are making no contributions or low or infrequent contributions? (No comment)

Other comments

*5.15 Where **we** offer **you** insurance arrangements that are different to **our** automatic cover (for example, tailored cover for an employer), **we** will ensure that **you** are provided with information on **your** specific cover.*

Does this imply tailored cover for an employer is not automatic cover? For example in the Mercer Super Trust all cover is tailored for different employer groups, with different automatic insurance levels for different employer groups. It is completely unclear what 5.15 means in this context.

Communication of low or infrequent contributions
*5.27 If at the end of **our** financial year **we** have received contributions for **you** that are less than $1,800 in **Superannuation Guarantee** in the previous 12 months, **we** will contact **you** to let **you** know:*
*a) the cost of **your** premiums and general information about the impact of insurance premiums on retirement savings when there are low contributions; and*
*b) **your** options to retain cover, cancel immediately, or reduce cover.*
*5.28 This communication will be provided to **you** at least once a year if we continue to receive contributions that are less than $1,800 in **Superannuation Guarantee** in each 12-month period.*

There seems to be duplication here with the annual statement contents (para 5.19). Presumably this information can be included on/with the annual statement. To allow flexibility, para 2.27 should not require this annual check to tie in with the fund's financial year in case this does not line up with the annual statement timing.

Accessing information
*5.29 **We** will include the following information easily accessible on **our** website:*
*a) the Key Facts Sheet for **our** automatic cover;*
b) the product disclosure statement for our automatic cover;
c) information about the benefits and costs of insurance in superannuation;
*d) information on how to cancel **your** insurance and the consequences of cancelling;*
e) how to make a claim; and
f) how to make a complaint.

Why isn't voluntary cover mentioned?

MERCER
MAKE TOMORROW, TODAY

B.4 Feedback questions

CLAIMS HANDLING

16. What are the practical implications of the obligations that are placed on trustees? How can any practical difficulties be overcome in a way that improves members' experience of the claims process?
17. Will the requirements at section 6.28 of the Code to provide a person claiming with information about a decline (including all documents obtained during the assessment) and the ability to provide further information in all cases cause delays and/or cost to the claims process? If there are concerns with these requirements, can specific examples be provided of the difficulties these requirements cause?
18. What are the implications of the requirements on trustees to oversee and review ongoing income protection payments?

Response to Qs 16-18

On the face of it these seem reasonable provided funds are given a reasonable time to put in place the additional processes and resources to achieve the new requirements (see our comments in the body of this letter that a longer transition time is needed to allow this) and there is clearly acknowledged flexibility in the service standards (also see related comments in the body of this letter).

One possible exception is the requirements around "vulnerable consumers" – please refer to our comments at B5.

Other comments

(i) We query why it is proposed (under draft para 3.17) that the Code does not apply if a member commences legal proceedings – a trustee (and insurer for that matter) are generally required to keep undertaking the claims assessment process at first instance or due to reconsideration of claims, notwithstanding legal proceedings are on foot.

(ii) In this section the Consultation Paper acknowledges suggestions the industry should work with the legal representative bodies to develop protocols for the engagement of legal practitioner in insurance claims and communication protocols between the various parties. It indicates the ISWG has not had time to progress this work and that it should be considered for the second iteration of the Code.

This is an important piece of the puzzle - currently there are legal firms advocating for work assisting members with superannuation claims, where in the majority of cases they are not required. It is not in the member's best interests to be losing a portion of their benefit because solicitors are unnecessarily engaged. As set out in the body of the letter, we suggest it is more realistic to adopt 1 July 2018 rather than the end of 2017 as the target date for finalisation of the first iteration of the Code. We hope that this later time frame will allow time for protocol with the legal industry to be developed and included in the first iteration.

MERCER
MAKE TOMORROW, TODAY

(iii) The use of 'We':

Principles for claims handling
6.1 ***We*** *acknowledge that claim time can be difficult.* ***We*** *will treat* ***you*** *with compassion and respect.* ***We*** *will make the claims process as straight-forward as possible for* ***you****.*
6.2 ***We*** *will help* ***you*** *identify any cover held within* ***our*** *fund under which* ***you*** *may be entitled to claim.* ***We*** *will not discourage* ***you*** *from making a claim.*
6.3 ***We*** *will oversee the claims process, and help* ***you*** *to navigate the process.*
6.4 ***We*** *will be responsible for overseeing the conduct of the insurer and any* ***Independent Service Provider we*** *engage in the claims process, in accordance with the standards in Section 12 of the* ***Code****.* ***We*** *will proactively engage with other parties in the claims process, such as any representative that* ***you*** *engage, in order to minimise delays and remove unnecessaryduplication from the process.*
6.5 ***We*** *will put in place appropriate governance arrangements for* ***our*** *claims handling.*
6.6 ***We*** *will publish* ***our*** *claims philosophy on* ***our*** *website, and* ***we*** *will assess the claims philosophies of* ***our*** *insurers to ensure they align with* ***our*** *own philosophy.*

The use of 'we' is a bit problematic as presumably in some of the above (e.g. 6.1 – 6.3 and the second sentence of 6.4) 'we' needs to be read as including any Independent Service Provider 'we' engage in the claims process, whereas in the first sentence of 6.4 and 6.5 and 6.6 it presumably just refers to the trustee. In para 6.8 'we' presumably means the trustee and the insurer. In the second sentence of para 6.20 'we' presumably could mean the trustee or the insurer under some arrangements.

Further confusion arises as para 1.2 says 'we' means trustees of super funds but in the definitions section it refers to entities bound by the code.

(iv) Clause 6.9 notes the member will be given contact details for the primary contact during the claims process. We would oppose this if it is intended to require an individual case manager for each claim, as this would not be cost efficient. This clause should be modified to make clear that the primary contact is not required to be an individual.

(v) Clause 6.21 reads:

> *6.21 If* ***we*** *become aware of any errors or mistakes in the claim or in the information requested, these will be addressed promptly.* ***We*** *may request additional information to correct errors or mistakes.*

Is there a difference between errors and mistakes?

(vi) Clause 6.28 specifies a 15 day maximum period for declined claim reviews. Given that this period will be insufficient for complex cases, we believe Clause 6.28 should draw attention to clause 6.23 which says the time standards may be exceeded in exceptional cases.

MERCER
MAKE TOMORROW, TODAY

(vii) Clause 6.28 also specifies information to be provided to all declined claimants. Is the intent here for the Trustee to afford another level of procedural fairness? We think it would be better and more efficient for the Trustee to ensure the insurer provides procedural fairness pointing out what is adverse and why likely to decline. Secondly this should cross-refer to clause 13.5 which says information may not be provided in some circumstances. Thirdly, does clause 13.5 cover the circumstance of information provided by a Medical Practitioner that is labelled as 'not to be provided to patient', as occurs sometimes e.g. in mental health cases? Last, the claims handling timetable on page 17 of the draft code indicates the information will be provided if requested, which is different from Clause 6.28

(viii) Clause 6.29 relates to further representations and new material submitted to the trustee during its review of a declined claim. Our understanding is that any further representations and new material submitted would first have to go to the insurer for reconsideration. Therefore, this step should reflect material going to the insurer and then the timeframe commences from insurer's new decision.

(ix) Clause 6.30 (Review of Insurer's Decision) undertakes to keep the member informed should the trustee decide to query the insurer's decision and/or advocate on their behalf. This would be a change from current practice and we believe it would be problematic. Whilst this would demonstrate the trustee is doing everything possible if the claim has a reasonable prospect of success, it may also raise false expectations with the member and make the trustee relationship with the insurer somewhat challenging, especially where legal representation is involved.

(x) Clause 6.31 relates to notification of approval of a claim and payment of the benefit. We suggest payment of death benefits be explained separately, as usually this has little to do with the insurer paying. As it stands, it could be construed as misleading because the "provided that" applies to the vast majority of cases and, in our view, provides insufficient qualifications around the likely timeframe taking into account claim-staking and disputes.

(xi) In fact, we think this whole section needs to be re-written to provide greater clarity about the different provisions for death, TPD and income protection (IP) claims. The draft reads as if it has been written for TPD claims (e.g. clause 6.27 re checking release requirements) and then some points about death claims and IP claims have been added in later. For example, the 15 day review period in clause 6.28 for declined claims does not appear to be restricted to TPD claims and yet clause 6.35 has a 5 day review period for the cessation of an IP claim. Or does the 15 day review period in clause 6.28 apply for IP claims declined at first instance and the 5 day review period for the cessation of an IP claim? In any event we think the 5 days is too short and the 15 day review period should also apply in these circumstances.

(xii) A further example of the foregoing point is clause 6.32. We trust it is not intended that this section apply to aggrieved beneficiaries who have missed out in the distribution of a death benefit, which is not an insurance issue at all. However as it stands it does read as applying to such beneficiaries. We believe this would be problematic and that the Insurance Code should not impose additional obligations on trustees in respect of death benefit distributions.

MERCER
MAKE TOMORROW, TODAY

B.5 Feedback questions
VULNERABLE CONSUMERS

19. Does the Code require more prescription as to how trustees will support vulnerable consumers?

    No, but further information is needed for us to understand the practical implications of the proposed requirements regarding vulnerable consumers, including the interaction with privacy requirements and existing trustee and superannuation law.

20. What more can be done to ensure that members who are granted release of funds for terminal illness do not lose their insurance cover?

    We are not convinced that any industry protocols are needed to achieve this. Trustees should be able to put in place their own procedures to achieve this in a fairly straightforward manner.

B.6 Feedback questions
PREMIUM ADJUSTMENTS

21. Are the premium adjustment arrangements sufficiently transparent?
22. What further detail could the Code include?

No comments.

B.7 Feedback questions
PROMOTING OUR INSURANCE COVER, CHANGES TO COVER

23. What are the practical implications of the Code obligations for trustees?

(i) Clause 9.3 reads:

*9.3 When **we** promote insurance cover additional to **our** automatic cover, **we** will target any promotion to the segments of **our** membership for whom **we** have identified the additional cover is appropriate, affordable and of value.*

We query whether it is possible to comply with this. In our view the trustee cannot identify that 'additional cover is appropriate, affordable and of value' for any particular member.

Also, what does 'promote' mean?

(ii) Clause 10.5 requires the member to be given contact details for the primary contact during the cover application process. We would oppose this if it is intended to require an individual case manager for each application, as this would not be cost efficient. This clause should be modified to make clear that the primary contact is not required to be an individual.

MERCER
MAKE TOMORROW, TODAY

B.8 Feedback questions

REFUNDS

24. What are the practical and administrative implications of the refund requirements provided?

> *11.1 If at claim time **we** identify that **you** have multiple automatic insurance covers in superannuation and **your** benefit is offset, which means that no payment is made to **you** under the cover **you** hold with **us** because **you** have been paid a benefit under another similar policy, **we** will refund **your** premiums into **your** account for the duration of the overlap of covers, to a maximum of six years.*
> *11.2 If **we** identify that **you** were not eligible to claim against **your** cover for any event from the start of the cover, **we** will refund **your** premiums to **your** account for the period **you** were ineligible.[16]*
> *11.3 If **you** make a claim that is accepted, **we** will refund **your** premiums back to the date **you** became eligible to claim.*

Administrative issues

Many of the comments on premium refunds in Q 10 response also apply here, although we expect that refunds due to duplicate cover under the proposed clause would be far less common than refunds when a member opts out of default cover on joining a fund.

However for refunds in respect of duplicate cover, there would potentially be further administrative issues:

- Determining whether or not the cover concerned is 'duplicate cover' as defined
- Calculation of the amount of the refund will be more complex where it covers an extended period
- policy offset conditions which may need to be adjusted to be inapplicable subject to the other policy being retrospectively cancelled for the overlap period. (It is noted that this may conflict with Life Insurance conditions around non-cancellable policies).

Risk of scope creep

We note that the refunds are proposed to be limited to cases where there is a full offset. Does the ISWG believe that this will not result in pressure for refunds where there are partial offsets?

Wording of 11.1

The offset conditions do not appear to take into consideration features such as the whether the benefit periods of IP polices match. The adverse consequence of refunding premiums may mean cancelling a policy with better provisions such as a longer benefit period, not ceasing on admission of TPD or even SG contributions being included in the insured benefit.

We recommend that the clause be refined to clarify that (for example) premium refunds will not be provided for a 'to age 65' IP benefit because it is offset against a 2 year benefit period policy. More generally, refunds should only apply to income protection

MERCER
MAKE TOMORROW, TODAY

policies that are inferior or similar but of the same benefit period, waiting period, TPD benefit cessation conditions and benefit basis (i.e. not inclusive of SG contributions),

Reimbursement from insurers

We presume that the insurers are comfortable with the refund proposals, as funds will not be able to make refunds to members if they cannot obtain a corresponding refund from their insurer.

25. Are there any issues with the maximum time limits for the duration of refunds?

Yes, the longer the time period, the more difficult it will be of determine the period for which duplicate cover has applied, the more complex the calculation of the refund amount and the more likely it is that there will have been a change of insurer which may make it difficult for the trustee to be re-claim the full refund from their insurer.

In our view the maximum duration should be 3 years. We believe this would strike a suitable balance between the trustee's responsibility in terms of providing default cover which duplicates other cover and the member's role in allowing the duplicate cover to continue.

26. For superannuation funds – what are your current practices for refunding premiums, and the duration of any refunds?

No comment.

B.9 Feedback questions
STAFF AND INDEPENDENT SERVICE PROVIDERS

We consider that the term 'Independent Service Providers' is inappropriate and likely misleading. The term 'Independent Service Providers' implies the service provider is independent from the trustee, whereas in many cases the service provider concerned will be a related party to the trustee e.g. the service provider will be a subsidiary of the trustee or they will both be subsidiaries of the same parent company.

We suggest the term be modified to 'Trustee Service Providers'.

27. Do the standards for training and monitoring staff require further detail?

No, the Code is already quite prescriptive as currently drafted. Any further guidance should be outside the Code.

28. What are the practical implications of requiring trustees to ensure Independent Service Providers comply with the Code?

We are concerned that this may lead to costly exercises such as detailed reporting and 'independent' audits/reviews. Para 12.10 as drafted reads:

MERCER
MAKE TOMORROW, TODAY

12.10 **We** will monitor the activities of any **Independent Service Providers** that **we** engage to ensure that they are complying with the relevant standards of the **Code**. This can include requiring regular reporting, putting in place quality assurance measures, and analysing data such as claim decisions and complaints.

The 'can include' in the second sentence is likely to be read as implying that there would be all these processes and more. We recommend that second sentence be removed. Any further guidance on good practice to meet this requirement should be outside the Code.

B.10 Feedback questions

ENQUIRIES AND COMPLAINTS

29. Do the processes for making enquiries and making complaints require further detail?

Although headed 'How to make an enquiry/complaint' this section doesn't literally say how.

B.11 Feedback questions

GOVERNANCE, ENFORCEMENT AND SANCTIONS

30. Is the governance framework appropriate, taking into account ASIC's requirements for approval of the Code, and the governance provided by existing financial services codes?

We defer to the Law Council's comments on this aspect.

MERCER
MAKE TOMORROW, TODAY

ATTACHMENT 2
SETTING DEFAULT INSURANCE LEVELS IN THE MST

Mercer's flagship superannuation product is the Mercer Super Trust (MST), which has 220,000 members and $22 billion of assets.

The majority of members have death and TPD cover. There are a number of different default insurance arrangements for different employer plans within the MST.

Rather than discuss them all we will focus on the process adopted for determining default cover levels for new individual MySuper members applying to join the MST for the first time.

However before doing so it is worth noting that similar processes are followed for setting default cover levels in other parts of the MST, but in the employer plans the insured benefits are generally salary-related, as we collect current salary information from employers and this allows the cover to be better tailored to the members' needs.

Table 1 below provides an overview of sums insured by age as well as average salary information for the Corporate Superannuation Division (employer plans) of the MST.

Table 1 - Average Sum Insured by Age
Mercer Super Trust Corporate Superannuation Division (CSD)

Age	# of CSD Members	Death Cover	TPD cover	TTD cover	Average Death	Average TPD	Average Salary
15-19	300	$48,495,147	$48,495,147	$1,675,816	$161,650	$161,650	$33,693
20-24	5,051	$1,382,010,098	$1,368,652,980	$32,643,605	$273,611	$270,967	$48,833
25-29	13,488	$4,584,816,305	$4,516,278,924	$136,526,550	$339,918	$334,837	$67,133
30-34	19,714	$7,114,903,254	$6,962,263,130	$262,538,320	$360,906	$353,163	$86,829
35-39	21,455	$7,776,076,214	$7,511,555,268	$344,737,521	$362,437	$350,107	$99,072
40-44	21,784	$7,564,952,194	$7,273,935,589	$408,112,416	$347,271	$333,912	$111,884
45-49	19,636	$5,810,969,100	$5,572,179,942	$380,717,721	$295,934	$283,774	$110,204
50-54	16,435	$3,599,051,610	$3,427,891,423	$339,233,219	$218,987	$208,573	$112,984
55-59	12,471	$1,792,574,416	$1,690,010,978	$283,036,987	$143,739	$135,515	$113,525
60-65	7,917	$504,052,799	$445,363,600	$159,484,349	$63,667	$56,254	$96,515
66+	2,640	$21,164,899	$11,905,527	-	$8,017	$4,510	-

Notes:

1. Most members have death and TPD cover but only a minority have TTD cover (income benefits payable for a period on total and temporary disablement). The TTD cover shown is the annual benefit payable while TTD.
2. Also note that the table shows the insured cover component only, which would be payable in addition to the member's balance on death or TPD.

MERCER
MAKE TOMORROW, TODAY

Determination of default cover levels for new individual MySuper members

Let us now turn to the process adopted for determining default cover levels for new individual MySuper members applying to join the MST Trust for the first time.

Step 1 is to analyse the demographics of the membership. In this particular case members typically join between ages 18 and 65 and can come from a wide range of occupations and insurance risk profiles, representing a broad cross section of the population.

Step 2 is to analyse the members' insurance needs. In doing this we partner with our insurer who in turn partnered with Rice Warner, who have done a significant amount of research in this area. The research indicated as expected that insurance needs vary by age, marital status and whether the member has children. Death cover needs differ from TPD cover needs. By and large insurance needs are lower at younger and older ages, and peak at around ages 35-45.

The MST does not generally have information about individual section default members' marital and dependant status or their salary, and so the trustee needs to set default cover levels based on the key variable it does have, which is age.

The trustee decided to set the *shape* of the default cover by age based on the Rice Warner needs analysis. In Step 2 the trustee needs to take account of any constraints its insurer may impose. For example at young ages members typically need more TPD cover than death cover, however some insurers are not prepared to offer a TPD benefit which is higher than the death benefit.

Step 3 is to carry out actuarial calculations to determine what *level* of cover (based on the *shape* of the cover by age determined by Step 2) strikes a reasonable balance between:

a) Providing cover which goes a reasonable way towards meeting the member's insurance needs; and

b) Ensuring that premium rates do not unreasonably erode members' retirement balances.

Regarding (b), Table 2 below shows an example of our analysis based on the projected reduction in retirement benefits using 9.5% as the contribution level, 65 as retirement age, 2.5% pa real investment return and the default level of insurance cover (default cover scale and cost provided in Table 3 below). With these assumptions, our projections indicated that the higher the salary, the higher the contributions and therefore the cost of this type of cover (i.e. dollar-based rather than salary-related) has less impact on retirement accumulation which is demonstrated in Table 2 below.

To ensure the cost is fair and reasonable, we took the view that the cost of default insurance should not generally erode the member's retirement benefits by more than 15% for most members. While the table below shows that some members on lower salaries would have a higher than 15% impact on their retirement accumulations, the member demographics of the MST generally show that the average salaries are in the higher ranges so few members will exceed the 15% level. Members may choose higher levels of cover to suit their personal circumstances and can balance the cost against their needs.

MERCER
MAKE TOMORROW, TODAY

Table 2 - Percentage Reduction in Retirement Benefits

Entry Age / Salary	20000	30000	40000	50000	60000	70000	80000	90000	100000
15	10.6%	7.1%	5.3%	4.3%	3.5%	3.0%	2.7%	2.4%	2.1%
20	12.1%	8.1%	6.1%	4.9%	4.0%	3.5%	3.0%	2.7%	2.4%
25	13.7%	9.2%	6.9%	5.5%	4.6%	3.9%	3.4%	3.1%	2.7%
30	15.7%	10.5%	7.9%	6.3%	5.2%	4.5%	3.9%	3.5%	3.1%
35	18.3%	12.2%	9.1%	7.3%	6.1%	5.2%	4.6%	4.1%	3.7%
40	21.2%	14.1%	10.6%	8.5%	7.1%	6.0%	5.3%	4.7%	4.2%
45	23.6%	15.8%	11.8%	9.5%	7.9%	6.8%	5.9%	5.3%	4.7%
50	25.0%	16.7%	12.5%	10.0%	8.3%	7.1%	6.3%	5.6%	5.0%
55	25.1%	16.7%	12.5%	10.0%	8.4%	7.2%	6.3%	5.6%	5.0%

Of course, it should be recognised that at the lower and middle income levels, many individuals will have a lower superannuation balance and are therefore likely to receive a higher age pension. This outcome reduces the ultimate effect on these members' retirement income of the higher reduction in superannuation retirement benefits.

Step 4 is to design additional cover, for which members can apply on a voluntary basis. This is generally available without underwriting if requested within a window period or through occurrence of a significant life event such as marriage, birth or adoption of a child, taking out a mortgage, etc. Otherwise, election for higher amounts of cover can be made at any time subject to underwriting.

It is also worth noting that all super funds are required to have an Insurance Management Framework which requires them to have policies and procedures governing how they set default cover levels, but we believe additional regulator guidance along these lines may be useful.

Table 3 – Default cover levels for individual MySuper members

The following table 3 shows the default cover levels that have been formulated using a dollar based approach and the methodology set out above. Maximum insurance cover is between ages 30 and 50, when a member generally has the greatest insurance needs. The equivalent of 3 units of cover is above the average insurance needs determined from Rice Warner's research at the younger and middle years when cover is accessible at a reasonable cost and slightly below at older ages when premiums are more expensive.

Members can generally opt out or reduce their cover at any time to align the amount of cover with their needs.

MERCER
MAKE TOMORROW, TODAY

Table 3

Age Next Birthday	Cost of Cover (Light Blue Collar)		Whole of Life Bell Curve (Default Cover Levels)	
	Dth only	Dth & TPD	Death & TPD ($) (1 Unit)	Death & TPD ($) (3 Units)
15	0.240	0.300	50,000	150,000
16	0.240	0.300	50,000	150,000
17	0.288	0.348	50,000	150,000
18	0.336	0.420	50,000	150,000
19	0.360	0.480	50,000	150,000
20	0.372	0.492	50,000	150,000
21	0.372	0.492	55,000	165,000
22	0.372	0.480	60,000	180,000
23	0.360	0.468	65,000	195,000
24	0.336	0.432	70,000	210,000
25	0.324	0.420	75,000	225,000
26	0.300	0.396	75,000	225,000
27	0.300	0.396	75,000	225,000
28	0.300	0.396	75,000	225,000
29	0.300	0.408	75,000	225,000
30	0.300	0.408	77,500	232,500
31	0.324	0.432	77,500	232,500
32	0.336	0.444	80,000	240,000
33	0.336	0.456	80,000	240,000
34	0.336	0.480	82,500	247,500
35	0.360	0.516	82,500	247,500
36	0.360	0.528	85,000	255,000
37	0.372	0.564	87,500	262,500
38	0.408	0.612	90,000	270,000
39	0.420	0.660	92,500	277,500
40	0.456	0.720	95,000	285,000
41	0.504	0.792	100,000	300,000
42	0.540	0.888	100,000	300,000
43	0.612	0.984	97,500	292,500
44	0.660	1.092	95,000	285,000
45	0.708	1.212	92,500	277,500
46	0.780	1.368	90,000	270,000
47	0.852	1.536	85,000	255,000
48	0.936	1.728	80,000	240,000
49	1.020	1.932	75,000	225,000
50	1.116	2.160	70,000	210,000
51	1.236	2.436	65,000	195,000
52	1.356	2.736	60,000	180,000
53	1.476	3.072	53,000	159,000
54	1.644	3.480	47,000	141,000
55	1.800	3.924	41,500	124,500
56	2.004	4.476	36,500	109,500
57	2.244	5.136	31,500	94,500
58	2.496	5.892	27,500	82,500
59	2.784	6.744	24,000	72,000
60	3.120	7.764	20,500	61,500
61	3.492	8.928	18,000	54,000
62	3.936	10.308	15,500	46,500
63	4.416	11.868	13,500	40,500
64	4.992	13.680	11,500	34,500
65	5.604	15.780	10,000	30,000