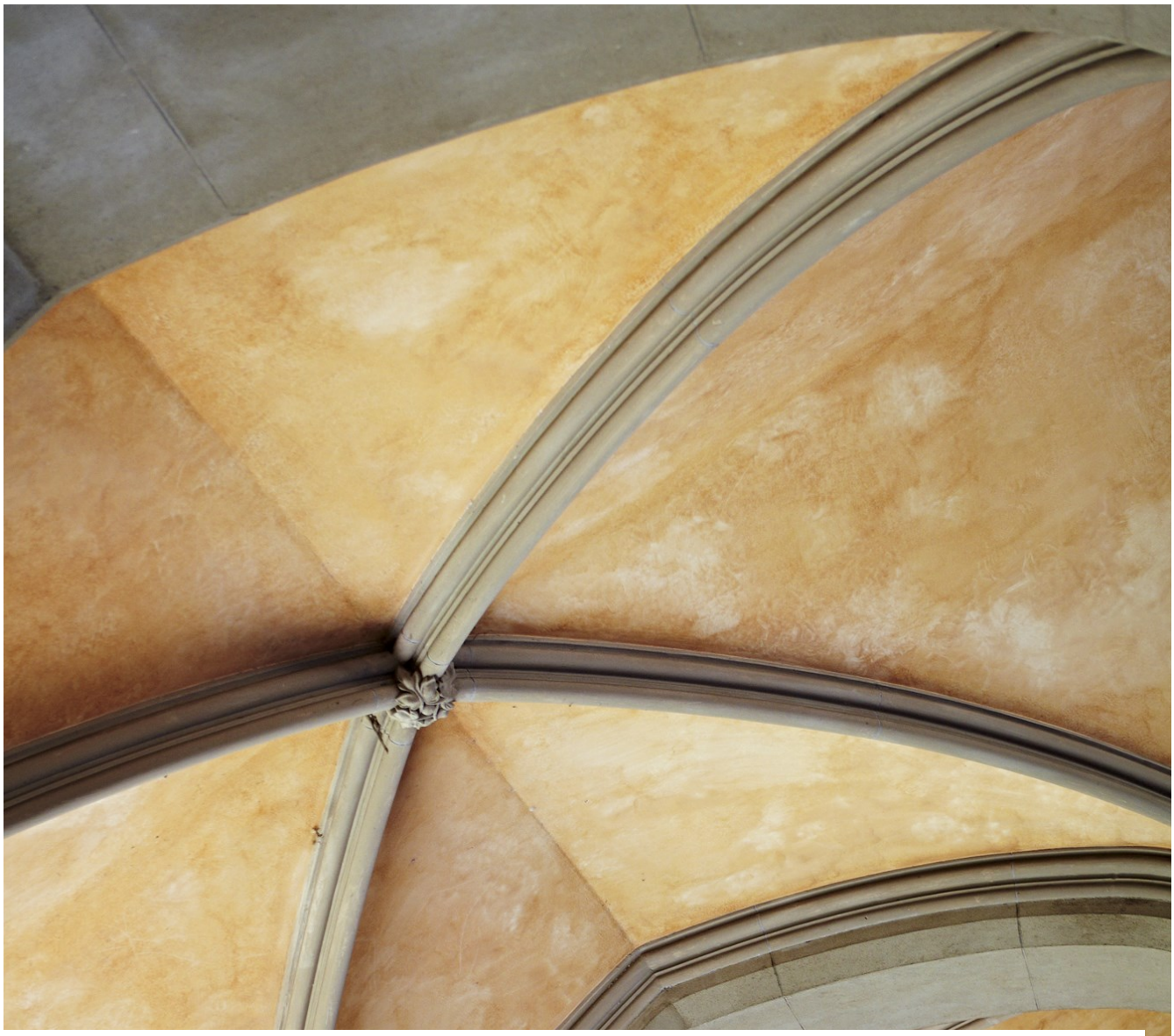
UniSuper



Consultation Paper: Insurance in Superannuation Code of Practice

Submission by UniSuper

26 October 2017

About UniSuper

UniSuper[1] is the superannuation fund dedicated to people working in Australia's higher education and research sector. With approximately 400,000 members and around $63 billion in assets under management, UniSuper is one of Australia's largest superannuation funds and has one of the very few open defined benefit schemes.

UniSuper is a default fund in numerous enterprise agreements across the higher education sector. Full time employees in the higher education sector are defaulted into our defined benefit option but have up to 24 months to choose our accumulation option. Defined benefit ("DB") members receive death and disability benefits that are partly provided via self-insurance within the DB and via an external insurance arrangement.

We also manage two defined contribution ("DC"), accumulation-style accounts: Accumulation 1, for members who are not entitled to DBD membership and Accumulation 2 based on the same 14% employer contributions paid by participating employers for those who opt out of DBD membership.

The Fund's insurance strategy has different levels of default cover (which are offered without the need to submit health evidence) 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 offered to permanent employees (who are generally in receipt of 17% employer contributions) likely to earn higher salaries and have longer tenure in their roles, leading to higher account balances.

We believe the Code does not adequately address some of the issues that arise from the interaction of DBs and out-sourced insurance and the related issue of above-SG employer support. In the following submission, we highlight the key issues that we believe require further consideration.

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

[1] 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).

Key issues from UniSuper's perspective

UniSuper supports the ISWG's aim of lifting standards across the industry. In developing any code, there are going to be trade-offs between prescription and flexibility. We favour prescription and standardisation in some areas (e.g. definitions of key terms) provided that it is matched with sufficient flexibility for trustees to respond to the needs of their own membership (e.g. different insurance offering for different membership categories based on level of contributions).

A move to codify standards across the industry is, however, not without costs. One of the implementation challenges for the Code is how the new norms will interact with many existing (and worthwhile) practices already in place. While we are supportive of uplifting standards across the industry, we maintain that a flexible approach is warranted based on the recognition of the diversity of funds and their memberships as well as the unique approaches that funds have taken to address these needs.

From our perspective, the four key issues that we believe need further consideration are:

1. Recognition that higher levels of employer support via EBAs and awards lead to different insurance offerings which require different premium caps than those in the proposed Code.

2. Insurance design is a trade-off between protecting against account erosion and protecting members in the event of their from death or disability. It should be recognised that the proposed cessation of cover rules would result in the cancelling of valuable automatic insurance cover - without member consent - even in situations where there is no risk to account balance erosion. We do not support the proposed cessation rule; in its place, we propose fund-based rules, such as account balance size rules, to determine whether or not to cancel a member's insurance.

3. Diverse communication strategies and customer service offerings need to be recognised rather than codified. Trustees should use the most appropriate communication method for the job. When it comes to claim enquiries, for example, we believe the best method for UniSuper is not online (as proposed in the Code) but direct contact with our highly-trained Claims Assist team whose primary function is to "on-board" new claimants.

4. Enforceability of the Code remains the key unanswered question but the Code's authority and enforceability are central to its success.

The following submission focusses on two things: firstly, issues particular to UniSuper that result from our unique position in Australia, i.e. offering a large open defined benefit scheme as well as two accumulation options, one attracting employer contributions of 17%. Secondly, we highlight issues that we believe require clarification, most of which are likely to be broader industry issues.

Appropriate and affordable cover will differ across funds

Premium limits

We do not support the establishment of maximum premium levels for automatic insurance. There are already existing rules and regulations, including insurance covenants in the SIS Act, that require the trustee of an RSE to consider the cost to all members when offering insurance and whether particular levels of cover inappropriately erode the retirement balances of members.

While we do not support limits in principle, if the ISWG were to develop a policy of maximum premium levels, we strongly encourage flexibility rather than prescription. Flexible rules should recognise that different insurances will need to be matched to different membership cohorts e.g. members who receive SG contributions only vs members who receive higher contributions under awards, EBAs and related industrial agreements. In fact, the proposed Code recognises this in Clause 4.4f which identifies employer contribution levels as a key consideration when designing automatic insurance.

If the proposed 1% cap were, for argument's sake, to be the appropriate cap for SG recipients, it does not follow that this is the right cap for all superannuation members, particularly those with higher levels of employer support. Higher levels of employer superannuation support are typically based on a broader conception of superannuation support whereby the ancillary benefits of death, TPD and income protection insurance are incorporated into that level of support.

Premium limits in the Code must take into account these situations. Clause 4.10 allows for an exception to the fee capping rules for higher risk occupations, provided that the Code administrator is satisfied that the cover is appropriate and affordable. We maintain that a mirroring clause is required for situations where employers make contributions at rates higher than the SG level.

Cessation of automatic cover

We do not support the proposed rules for ceasing a member's insurance after 13 months without an eligible contribution.

Developing the right insurance offering for members includes a trade-off between the competing objectives of preserving member account balances, with the strong desire to cancel compulsorily the insured benefits of as few members as possible.

Under UniSuper's current rules, automatic cover ceases for accumulation members after 12 months of inactivity for those with account balances under $2,000. We think this strikes the right balance.

We are also concerned that there could be legal issues with cancelling the insurance of members, particularly those with larger balances where there is little or no chance of premiums eroding their account balances. For example, a 45 year old Accumulation 1 member of UniSuper with a $500,000 account balance, but no eligible contributions, could have his or her insurance cancelled. The annual premium of $1.68 per week (for $85,000 of cover) is less than 0.0175% of the account balance, while the benefit is valued at, say, one

year's salary. Cancelling automatic insurance in this instance, without member consent, would be a poor outcome.

The 13-month rule also needs to consider the potential consequences for those on parental leave, long-service leave and, common in the higher education sector, sabbaticals.

We think any push to reduce the cessation time period from 13 months to four months, would raise serious concerns about whether a letter posted after no eligible contributions have been received for three months could be relied on to arrive within the four-month period. A four-month timeframe would be far too short and impractical.

Duplicate cover

There are a variety of reasons why members choose to have duplicate cover (e.g. sometimes to serve out waiting periods, top-up strategies) and we would be concerned if the Code lead to instances of valuable cover being cancelled without member consent.

Effective communication is, therefore, going to be central to the success of some of the key parts of the Code. As a principle, we believe that the best communication method for the job at hand should be used. The proposed Code has, at times, a preference for traditional communication methods e.g. written letters. While letters continue to be an important way to communicate, we believe that some newer communication methods are equally or more useful when advising members of insurance options, potential duplicate cover, etc.

We believe notifications such as email, member portal messages and apps should be viable alternatives to written letters when notifying members about duplicate cover (and potential balance erosion, etc.).

Claims handling & communication strategies will differ across funds

UniSuper is broadly supportive of the timeframes proposed in the discussion paper as minimum standards to be met. UniSuper is confident that it can meet 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. However, UniSuper believes that these measure transactional timeframes only and do not promote the effective management of the life cycle of a claim.

UniSuper is therefore also supportive of the implementation of industry standards measuring key milestones within claims, for example:

- Notification to Lodgement
- Lodgement to Initial Assessment
- Initial Assessment to Insurer Decision
- Insurer decision to Trustee determination
- Trustee determination to Payment
- Notification to Payment

One of the challenges in measuring these timeframes however, is that there is no uniform definition of what triggers each of these milestones. Therefore, UniSuper recommends that these milestones become defined terms across the industry, for example:

- Notification – formal (verbal or written) advice of intent to claim. This would not necessarily include enquiries from members and/or their representatives regarding the claims process and/or level of cover held.
- Lodgement – the receipt of minimum required information. This will be claim-type dependent e.g. IP – Member claim form/application and/or minimum medical report and/or employer information.
- Initial Assessment – the ability to commence a formal medical assessment against the various definitions and/or in the case of death claims, the minimum information to commence the insurance assessment e.g. Death certificate & proof of age.
- Decision – Insurer decision
- Trustee Determination – the date the recommendation and/or distribution of benefits has been ratified by the trustee or its delegates
- Payment – actual release of benefit to the member/claimant/beneficiary or on payment advice from the member.

UniSuper acknowledges that these issues will need to be further discussed and that individual requirements may need to be accommodated, as well as defined and disclosed.

(NB. The above definitions may differ when applying to the different claim types).

Online forms should not be a member's first experience

Clause 6.12 would require funds to offer digital forms to members to commence a claim. We do not think that is best practice. UniSuper has developed a highly personalised service designed to minimise the levels of uncertainty and stress that often accompany 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 is to "on-board" new claimants via highly skilled trained assessors and consultants.

UniSuper prefers that our staff deal directly with members and we prefer that the insurance claim forms are not available without first 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. This 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).

The Code should explicitly accommodate this approach to servicing members. We suggest the following alternative wording (in italics):

> 6.12 If you tell us that you wish to make a claim, we will *assist you to complete or* direct you to the appropriate forms or information online or email these to you within one business day.

Effective methods of communicating with members

The Code rightly aims to recognise the diverse communication options that are available today. For example, 4.20 lists options for cancelling cover to be via the website or digital application, over the phone, in writing by email or post.

Rather than proscribe references to numerous communication options, we suggest a broader but wide-reaching principle should be established in the Code that trustees should use the most appropriate communication method for the job. In some areas, it is becoming increasingly common for written correspondence to be less effective than, say, communication via a website log-in which the site owner can then monitor to determine if the message has been read.

Issuing standalone insurance statements outside of annual statement packs

It is broadly accepted across the industry that a large number of members do not read, or only pay cursory attention to, their benefit statements, with large numbers of members only checking their balances and not much else.

Based on that industry-wide experience, we are somewhat sceptical of the benefits of posting out an insurance statement separately to all members when readership levels would likely be equally as low (or lower) than benefit statements.

While this approach is the norm for general insurance, we question the actual effectiveness of this correspondence for the insurance industry. We would encourage evidence-based policy in this area and empirical evidence of the effectiveness of this method of communication would need to be established to impose new costs on members.

We would, however, support a more flexible alternative to communicate with members via less expensive (and more measurable) channels to provide these statements, such as SMS, email, member portal pop-ups and app notifications that require a member response, e.g. acknowledgement of notification, warning via check box, Yes/No response to SMS etc.

Enforceability and scope of the Code

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

While the Code is intended to bind all trustees that offer insurance within an APRA-regulated superannuation fund, the Consultation Paper leaves open the question of how to enforce the proposed Code.

If the Code were not mandatory as a matter of law (i.e. via prudential or operating standard or some other form of legislative codification), trustees would then be required to conduct an assessment as to whether to adopt the Code based on the costs and benefits of doing so.

In doing so, trustees will look to existing duties under statute and common law (such as the best interests duty), statutory prescriptions (such as the MySuper default requirements and prescribed disclosures), and the terms of its trust deed in making a decision about whether (or how) to comply with the Code.

The enforceability of the Code will, therefore, be particularly relevant for any prescribed Code requirements, such as those relating to benefit design, premium limits and cover terms (i.e. the 13 months cancellation of cover requirement).

From a fund's perspective, the Code needs authority and enforceability if it is to be effective. Exactly how it is enforced and by whom are difficult questions for any one fund to answer. We believe this fundamentally important question needs to be addressed by an industry roundtable, along with relevant regulators, and be done in a process after the ISWG has finalised the Code.

What are the practical implications of the transition arrangements?

Clauses 3.9 and 3.10 of the proposed Code outline a transition period of 12 months *plus* two years for *new* or *updated* policies. It is not clear what type of change to an existing policy would make it a new or updated policy. Rather than try to resolve what is meant by new or updated policies, we think it would simplify the transitional arrangements if the Code's two-year period were simplified to a trustee opt-in at any stage in those two years with a hard time limit at the end.

Creation of a parallel dispute handling regime

The proposed Code would create a new dispute resolution regime which would sit alongside existing complaints handling processes and dispute handling regimes (both of which are currently being redesigned). We have concerns that parallel regimes are likely to lead to inefficiencies in the handling of disputes as well as the potential for forum shopping and delays to decision-making. Further, navigating these dispute channels is likely to be confusing and complex for consumers.

We also believe there is uncertainty of application. For example, the same dispute could be taken at the same time to both the SCT as well as the dispute handling regime proposed under the Code. If it is intended that a dispute could be raised regarding a matter that is currently excluded from review by the SCT, for example, where a decision relates to:

1. the membership of the fund as a whole or
2. where a complaint would otherwise have been excluded by reason of the claim staking exemption for SCT matters

Is it intended that a dispute may be excluded under the Code and that it be taken to the SCT instead?

Another issue we believe that needs clarification is that under the proposed Code only a member or a 'beneficiary' may raise a dispute regarding cover. This may not be broad

enough to enable those who may be eligible to be considered in a decision regarding the distribution of a death benefit (such as an LPR for an estate).

The Code is silent on the issue of the standard by which compliance with the Code, or the discretionary conduct of the Trustee, will be judged by the Code administrator.

For discretionary decisions reviewed by the SCT, fairness and reasonableness is the measure; no such standard is specified within the Code but we think it should be.

The Code is also silent on the review process for decisions of the Code administrator (as currently exists with the Federal Court for the SCT). We believe such a process needs to be incorporated into the Code.

Areas where we suggest further clarification is required

There are a number of areas in the Code which we believe require clarification or further consideration. These are industry-wide issues based on our reading of the Code and understanding of how the Code is likely to interact with existing procedures, policies, practices and norms.

The Code is almost completely silent on defined benefit schemes and related issues

There are only two references to "defined benefit" in the Code. While we understand that the Code is not proposed to apply to defined benefits (many of which have in-built benefits that look like insurance), we believe that it should explicitly state up-front that the Code does not apply to defined benefit interests.

We also believe the following DB- and UniSuper-related issues need further consideration.

- UniSuper's DB members may have the option to convert to an Accumulation account. On doing so, their self-insured benefit is converted to an externally-insured benefit. This benefit will often exceed the maximum caps. It is unclear under the Code if this will be caught under the definition of Automatic Insurance Members as the member has not made a decision around insurance levels.
- Erosion of account balances, in our experience, is more closely linked to employment patterns as opposed to age. If there is to be a lower level of cover offered to some members (as a lower fee cap for those under 25 implies), we believe it should be based on a member's employment category, such as causal or part-time, rather than age. This approach is more likely to get to the core issue, i.e. size of member account balance (age is not always the best proxy for having a small account).
- The proposed definition of eligible contribution (definitions Clause of the Code) does not cover the full range of contributions that a fund, such as UniSuper, receives. The definition refers only to SG contributions. This ignores the fact that some funds receive above-SG contributions, e.g. 17% or 14% contributions under awards and EBAs. This becomes particularly relevant where a member has chosen another fund for SG contributions but their employer continues to pay the difference between SG and the EA/Award rate to UniSuper. These amounts can and do cover the member insurance costs even though this it is not specifically made to the funds for this purpose.
- Clause 3.7b is not broad enough to cover all product options. UniSuper currently has a TPD benefit that provides a true income stream - not a lump sum - payable by instalments. As such, this definition would prevent our ability to offer this valuable cover and could future product designs.
- Clause 5.27 is unclear. Should this read as employer contributions as opposed to SG? For some members, UniSuper receives employer contributions above the SG with the SG going to another fund (see point above).
- We also have a Personal Account product in which members may make personal contributions to the fund without any employer contributions. This product is considered a MySuper product with default insurance. The Code is silent on whether the insurance offered under a personal product is automatic insurance. This needs to be clarified; preferably, excluding Personal Accounts which are essentially choice products.

Fair and respectful or fair and reasonable?

An objective of the Code is that funds dealings with members need to be 'fair and respectful' (2.2.(b)). While being respectful is central to good customer service, from a legal perspective we would prefer 'fair and **reasonable'** as the standard by which the exercise of discretion is judged. There are precedents for this with the SCT and other areas of law.

Supporting vulnerable members

We agree that cohorts of vulnerable members deserve appropriate support; however, the practicalities of how we identify vulnerable members would be problematic. How would we identify, and subsequently capture and record these vulnerabilities to enable us to address their needs appropriately? These issues will need to be further explained for the Code to be effective.

Claims processing issues

- Clause 6.13 refers to a "submission". It is unclear what this means. Does this mean a completed application or a partly incomplete application etc?
- Clause 6.28 requires a review of a decision but does this relate to a review of the insurer's decline based on eligibility or medical grounds? These are two different things.
- Clause 6.31 is unclear on the timeframes around death benefits. Is the timeframe five days after the end of a claim-staking process?
- Clause 6.36 is unclear on offsetting arrangements. Is the premium refund to an insurer or the member? If it is to the insurer, what about an exited insurer?
- Clause 4.28 is silent on the issue of whether or not (or how) pre-existing conditions (and waiting periods) would apply. Does a PEC waiting period restart?