# Draft Insurance in Superannuation Code of Practice

## Submission on Discussion Paper

27 October 2017

# Contents

# 1. Executive Summary

This paper forms the Link Group (Link) response to the draft Insurance in Superannuation Code of Practice (the Code).

- In summary, Link is in support of:
- the provision of insurance via superannuation
- the development and adoption of the Code
- making the Code mandatory

Link is Australia's largest provider of administration and related services to government, industry, retail and corporate superannuation funds covering approximately 10 million accounts. This places us in a unique position to comment on the administration implications of the Code. Our submission focusses on administration efficiency, risk and implementation. In particular, we have outlined areas where we believe further prescription is required to ensure consistency, understanding and cost efficiency, whilst in other cases less prescription is needed to avoid unnecessary costs and changes. We are not commenting on product design or competitive design or advantage.

Link's key observations are that the Code will offer the following key benefits:

- improved communication and services to members
- cost efficiency
- simplicity
- consistency across the industry. This is important as variations from standard features can add implementation and maintenance cost with little or no benefit to members. Whilst we acknowledge it is not feasible to standardise across the industry, where it does not deliver value to members, standardisation should be sought.

There are however certain aspects of the Code in its current format that will considerably increase administration burden and risk for funds, their service providers and therefore members. Also, based on our experience, the proposed timeframe for funds to adopt the Code is overly restrictive and expanding this timeframe would result in a more successful overall transition. Our submission therefore proposes amendments to make the Code more practical and cost-effective to adopt. It is expected that there will be costs for Funds to implement and operate the Code. As a result of the Code, fewer members will have cover therefore it is key that any additional costs are minimised by adopting efficient processes.

We would be happy to work with the Insurance in Superannuation Working Group (ISWG) to make amendments to the draft Code with a view to achieving its key objective of improving the insurance in superannuation offered to members, improving the member experience and the processes by which insurance is delivered whilst still ensuring it is workable with minimum increased cost and risk.

### 1.1. Format of submission

This submission sets out Links' responses to feedback questions as well as additional feedback in line with the sections of the Consultation Paper. We have responded to selected questions where we believe we can offer the most significant input.

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# 2. Background

### 2.1. Link's Experience

Link is a market leading provider of technology-enabled administration solutions, continually innovating to meet clients' needs. Link Group's Fund Administration division combines its proprietary technology, process and people to deliver a quality, comprehensive service offering to its superannuation clients, supporting a stakeholder base of approximately 10 million superannuation account holders. Link supports clients across all superannuation fund sectors including government, industry, retail and corporate.

Link's core administration services:

- Data management and reporting
- Member communication
- Contribution processing
- Statement processing
- Contact centre operation
- Client accounting
- Insurance claim administration
- Online portals for members and employers
- APRA and ATO reporting.

Link's core administration business is complemented by a range of additional services to offer a comprehensive fund administration solution, including:

- Information, digital and data services
- clearing house services
- financial planning advice
- data analytics

Link's wide ranging expertise across this range of services provided to government, industry, retail and corporate positions us well to comment on the costs, risks and implementation of the administration implications of the Code.

### 2.2. Link's response to the Code

Link's main views in relation to the Code are as follows:

- We support insurance in super
- We support the development and adoption of the Code
- We support making mandatory
- Our response focusses on elements related to administration and not elements that may drive competitive advantage
- We believe that cost efficiency is important and mandating and simplifying can help to deliver this outcome
- There are some real risks around the implementation and transition arrangements and timeframes

# 3. Scope of the Code

This section covers issues raised in Section B.1 of the Summary of Key Code Standards and Section 3 of the draft Code.

### 3.1. Question 2 – Practical implications of the transition arrangements

#### 3.1.1. Timeframes

The timeframe to implement all aspects of the Code (with the exception of Appropriate and Affordable Cover) by 30 June 2019 may not be sufficient bearing in mind the extent of the systems changes required. More detailed commentary is provided throughout this submission.

Bearing in mind the number of designs that need to be reviewed and priced by insurers and configured in systems by administrators, it may be challenging for all Funds to implement the Appropriate and Affordable Cover requirements by 30 June 2021.

### 3.1.2. Cost

If the Fund does not implement the Appropriate and Affordable Cover changes at the same time as the other changes to comply with the code, there are likely to be additional costs due to making two sets of changes to system configuration, processes and documentation.

Further clarification is needed to ensure funds, service providers and members can easily understand which aspects of the code apply only to Automatic Insurance Members (AIM) and which apply to non-AIM and which apply to all members.

### 3.1.3. Identifying AIM

We believe the AIM definition requires further prescription to ensure clarity for members and to assist funds to correctly identify and categorise them. Also, there is a risk that a restrictive definition may result in fewer AIM members and therefore fewer members protected by the Code. The Code appears to imply that any choice made would mean the member is not an AIM, for example having elected to transfer in cover from another fund or increasing cover due to a life stages event such as marriage or birth of a child.

Further, there will be issues in accurately classifying members on adoption of the code. For example, funds may not hold the detail to determine whether someone obtained their current level of cover automatically or by choosing to vary it. These records may not exist because the changes were made many years earlier when the benefit design may have differed from the current design, possibly in a different fund or on a different administration system, and because records may have not been kept to allow a clear trail as they were not required.

We suggest that it may be appropriate to have an addition to the definition along the lines of “where we do not have records to enable us to determine whether you should be classified as an Automatic Insurance Member, we will classify you as an Automatic Insurance Member”.

For clarity, if a member has been classified as non-AIM is it possible for them to be re-defined as AIM, e.g. if they have previously made a decision to maintain cover on maternity leave but on return to employment have the default cover level.

We recommend that members be advised whether or not they are classified as an AIM.

### 3.1.4. Treatment of existing members’ cover

Additional administration work will be required to identify and maintain benefits for existing members. For members who wish to retain current levels of benefits this may require “grandfathered categories” to maintain this, which will mean differing processes and communication. From an administration viewpoint, any grandfathering brings additional complexity and cost and if possible is best avoided.

### 3.1.5. Benefits of scale, industry collaboration

Where changes can be made consistently across all funds this will provide greater clarity to members generally and also give a benefit of scale, and therefore minimise the costs

of implementation. More detailed prescription of some aspects of the Code could facilitate this, i.e. preventing each fund from selecting a different method of complying with the Code, prescribing reporting and Key Fact Sheet formats are other examples where efficiency benefits can arise.

It will be important for all parties involved in servicing members' needs (i.e. fund, administrator, insurer) to collaborate closely to ensure effective implementation which minimises costs and timeframes.

## 3.2. Question 3 – Flags required in systems

In order to meet the Code's proposed requirements, systems will require additional flags or status codes and effective dates for application of the prescribed requirements, reporting purposes and to maintain audit history.

Flags and/or status codes we have identified that may be required are:

- whether a member is an Automatic Insurance Member
- the reason for not being an automatic member e.g.
    - An application for cover has been made
    - request by a member to maintain existing cover on introduction of new benefit design
    - request by a member to maintain cover after 13 months of no contributions
    - possibly having transferred cover in or having elected life events cover increase
    - Cover cancelled
    - Cover fixed
    - Benefit or waiting period changed
    - member request for cover to be reinstated
- vulnerable members
- high risk member
- consent provided to assist in locating insurance in other funds
- provided communication 1 and 2 in relation to ceasing cover (after six months of no contributions) and possibly form of communication

We expect that other flags or status codes may be identified when working through the required systems changes in detail and it is important that these are all identified as part of the requirements gathering phase as to introduce later will incur additional cost and complexity. It will also be necessary to set up processes to monitor and update the flags and codes when appropriate.

# 4. Appropriate and Affordable Cover

This section covers issues raised in Section B.2 of the consultation paper and Section 4 of the draft Code.

## 4.1. Benefit Design

Our preference is that any segmentation occurs at a benefit design and premium level rather than a requirement for segmentation information to be recorded at a member level. Being required to hold details of any segmentation at a member level within an administration platform will potentially add considerably to the cost of administration and could be seen to undermine the principles of group life insurance. Where funds choose to segment the members further e.g. to allow for different treatment of "high-risk" members this will add to costs and the time to implement. Any segmentation for member interactions needs to be clearly defined. If additional data is needed to be stored, consideration needs to be given on how this data is maintained and updated.

Our understanding is that salary information will not need to be collected and stored for all members. For most funds that do not require or collect salary information today, any change to now require collection would be significant in terms of both cost and effort to achieve.

We note the suggestion of collecting further information from employers. Based on our experience, we are concerned that the quality of some employer data will not be of the required standard and may be difficult to verify. Privacy concerns will need to be addressed to ensure that employers are able to provide the data. It is also important that any additional information required by employers should be considered in relation to Superstream data and payment standards and the minimum/mandatory data elements to be collected. This therefore may require a legislation/regulation change.

It is expected that most funds (and sub-plans) will require benefit redesign over the next three years. This will be costly for funds, particularly if the benefit changes are complex and the timeframes to implement for all funds may be an issue considering the need for systems, process and disclosure changes.

## 4.2. Premiums

We understand that Trustees of different funds can choose to calculate maximum premiums using a range of methods and assumptions. Trustees will also have the flexibility to determine how different segments will be identified. We assume that this would be done through benefit design and premiums at a fund level and would not involve member level calculations, as this would add considerably to administration effort and costs.

There is likely to be an increase in significant event notification activity which has the ability to add to costs.

It is not clear how frequently a Trustee will need to review the compliance with premium limits. If we see an increase in the frequency of premium updates being required to administration platforms this will ultimately result in increased costs.

### 4.2.1. Question 9 – Managing members who want to retain their original cover

Our recommendation is that members who want to retain their original cover are not classified as AIM as they have made a choice to retain cover. This will put them in line with all other members who have made an election. We recommend that this is communicated to members.

## 4.3. Cancellation and cessation of cover

### 4.3.1. Question 10 – Views on cancellation, cessation and reinstatement of cover

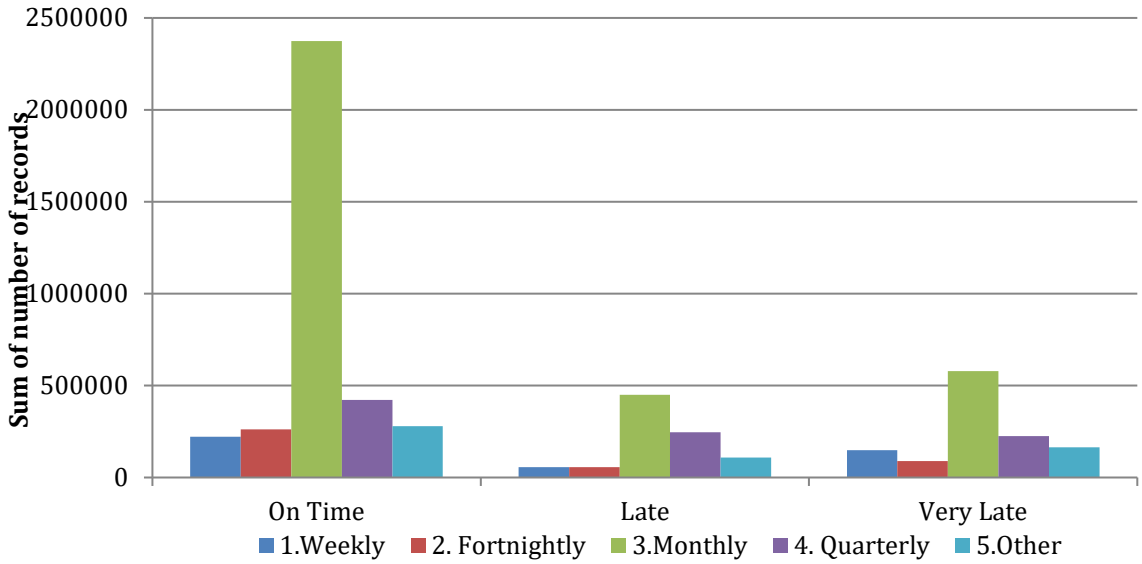
We recommend that further prescription is given to simplify and standardise lapsing rules across the industry, to reduce risk and increase understanding. Areas to address include:

- How to measure commencement of 20 days cooling off period as set out in Section 4.24 of the Code. E.g. date of letter, date of member access or download of app. We suggest adopting general insurance cooling off period rules.
- Are the reinstatement rules just for members who make a request?
- What are the rules for reinstatement of cover if a member re-joins a new employer?

Further comments:

- Flexibility is needed in the ability to measure the 13 month period with no contributions as it is not practical to carry out a run every day to determine whether contributions have been received for every member. A monthly investigation should be permitted which could mean that cover is not switched off until nearly 14 months for some members.
- Note that many members may lose their cover due to late contribution payments by employers. We have carried out an analysis of nearly 5.7 million employer contribution payments over the 2016-17 financial year. A summary of the timing is set out below. Of most concern is that over 20% of contributions were paid more than 42 days after the end of the period to which they relate.
    - On time is defined as within 28 days of the end date of the contribution.
    - Late is defined as between 29 and 42 days.
    - Very late is > 42 days.

**Graph 1. Employment payment punctuality**




- There is a high risk that members on parental leave will inadvertently lose cover. Many members on maternity leave will have no contributions for more than 13 months and for many of these members superannuation and insurance may be overlooked during this time due to the priorities of becoming a parent.
- The need as set out in section 4.28 of the Code to determine if a member is capable of active employment for cover to be reinstated will be too difficult to administer. It would be better to have clear wording that "if it is determined that you were not capable of active employment at the time your cover was reinstated then the cover will be treated as if it were not reinstated and premiums will be refunded".
- Cancellation and reinstatement are high risk. There will currently be a number of funds who will need to introduce these components to their benefit designs. There is a risk of members inadvertently having cover removed for example if communication is missed or the member does not understand the implications.
- There is additional complexity if an AIM is close to losing cover due to no contributions and then suddenly engages, thereby becoming a non-AIM. If they subsequently lose cover under a non-AIM rule (e.g. minimum account balance) – they may get very confused. Systemically this will be challenging to ensure members have and are paying for the level of cover they are entitled to.
- With regards to reinstatement of cover within 60 days of it ceasing, it is important that consistent rules apply to all funds. For example, the cover could be treated as continuous (i.e. reverse the cancellation, with premiums deducted to cover the 60 day period).
- There is real administration complexity associated with maintaining two sets of lapsing and reinstatement rules within one fund – 1 for AIM members and one for non-AIM members and ensuring members are able to understand their situation and make informed decisions.

## 4.4. Duplicate Insurance cover

### 4.4.1. Question 11 – What more could Code do to help members identify duplicate insurance cover and whether it is appropriate

We have a strong preference to provide tools which make it easier for the member to take charge of their own cover rather than the ATO collecting more member information. This alternative would be simpler and provide more education for members, possibly with links to contact their previous fund. It would make sense to link this with consideration of transferring in balances from other funds rather than looking at insurance in isolation.

Some of our concerns relating to central collection of data across the industry are set out below.

The funds will have limited capability to assist members unless improvements are made to data sharing by funds. The current limitations of 'Supermatch' are:

- whilst it advises if a member has cover it gives no detail on the type or eligibility to claim
- it is not used by all funds
- for funds that do use it, it is run on a cyclic basis e.g. monthly, quarterly etc.
- data may not be current - this will be improved with the introduction of MAAS and MATS

Other options to Supermatch include enhancement to Supertick or some other method to access ATO records. However, if data provided by ATO is used, it is possible that the member may be provided the wrong/out of date information, which will add risk for the fund. It will be important to advise the member that this could be the case and to recommend they contact their other funds to obtain details.

A common, real-time data base across all funds would be required in order for this to work effectively but note this would still ignore other cover a member might have e.g. employer-provided cover or retail cover.

It should be noted that the date of insurance activation is often different to the date of joining the fund. Procedures will need to be put in place by funds at a time that will be meaningful for the member.

The Code suggests consideration of extending Single Touch Payroll. We do not see any value in this, firstly because the employer does not hold insurance information. Secondly, this reporting goes to the ATO and for the reasons detailed above we do not believe that relying on the ATO is the best alternative to assisting members.

Note that a flag may be needed to capture member's consent to search for other insurance and privacy needs to be covered.

# 5. Helping members to make informed decisions

This section covers issues raised in Section B.3 of the consultation paper and Section 5 of the draft Code.

It is important that the insurance detail can be provided separately to the welcome pack as in some cases insurance starts at a later date (e.g. on 1st eligible contribution).

We won't always know when employment arrangements have changed and remain reliant on employer information, giving rise to some concerns about the quality and timeliness of data. As mentioned above, this may require consideration in regards to Superstream data and payment standards.

With regards to the preferred communication method, this should be the same method as used for all other fund communications, not just insurance. Note that some funds do not offer a member a preference for standard communications and they are not required to do so. The requirement to issue communications through two different channels should only be necessary if a bounce back was received. We recommend more flexibility be permitted in the Code to prevent additional costs for funds who wish to continue to use one standard method of communication.

We note that many funds are aiming to get more members to engage and communicate via self-service web-enabled technology, and the Code needs to acknowledge this rather than requiring more manual communication methods.

We would suggest Section 5.27 requirements be reworded to enable compliance as follows:

- $1,800 in Employer contributions (and not just SG contributions) as many employers do not split up SG and other employer contributions.

This should be permitted to be included with or on an annual statement to prevent excessive communications. Is it intended that a pro-rata calculation be done for members who have joined during the year? If not, members who have recently joined could be confused by the message.

# 6. Claims Handling

This section covers issues raised in Section B.4 of the consultation paper and Section 6 of the draft Code.

Funds' workflow processes and claim governance will need to be enhanced to monitor and ensure that all timeframes are met. The extent of the changes will vary from fund to fund depending on the claims operating model used by the fund. Responsibilities for particular

aspects of the claims handling may sit with the administrator, the insurer and the trustee office which may make some timeframes difficult to achieve.

We believe that changes need to be made in the following areas to make the Code workable:

- In relation to the decision to decline a claim, fifteen days may not be long enough to negotiate with the insurer where the Trustee disputes the insurers' decision.
- The timetable does not give the time to ask the claimant if they wish to submit further evidence before a decision is made (procedural fairness when based on the evidence, the claim would be denied).
- The timetable also does not allow time for claims staking for death claims. This step is critical in ensuring all stakeholders are appropriately communicated to and advised of their rights.
- With regards to the primary contact, for different models this could be with the administrator, insurer or trustee office. This could impose a significant cost for funds where claims administration resources may currently be shared across funds. The individual may also change throughout the process of the claim for various reasons so it is important that a contact model be defined that is able to be met across all claim handling operating models and takes into consideration the communication preferences of the member or their representatives.
- More transparency to ensure claimants understand the full process and what it means for them
- The level of information needing to be provided to claimants is more onerous than at present and is likely to require considerable manual intervention e.g. reasons for decline. Less prescription is preferred.

# 7. Vulnerable Customers

This section covers issues raised in Section B.5 of the consultation paper and Section 7 of the draft Code.

We recommend that a vulnerable member only be identified as such during the claims or underwriting purpose. However, it is important that once a member is identified as a vulnerable member, this should apply to all interactions with the member, not just insurance related. This may have implications for other aspects of customer servicing. It is not clear as to whether members are able to identify themselves as vulnerable?

Further prescription is required on how a member will be determined as being vulnerable for consistency across the industry to ensure if a member is a member of multiple funds then they are treated 'consistently' across those funds. Privacy issues in relation to vulnerable customers and the information held in respect of them need to be considered. Can this information be shared with other organisations and if so, in what circumstances?

Systems may need to change in relation to access for vulnerable customers...

# 8. Premium adjustments

This section covers issues raised in Section B.6 of the consultation paper and Section 8 of the draft Code.

Our assumption is that premium adjustments would be made through future premium rates. It will be important for funds to identify the scenarios where this may occur and plan appropriately to ensure sufficient focus on the administrative efficiency of this process.

# 9. Promoting our insurance cover and changes to cover

This section covers issues raised in Section B.7 of the consultation paper and Sections 9 and 10 of the draft Code.

## 9.1. Question 23 – What are practical implications of Code obligations?

The need for a primary contact is unnecessary in most instances where a member applies for cover via a web application/portal. Where the member applies on-line using an underwriting application, generally more than half will be accepted automatically making the timeframes meaningless. The Code needs to acknowledge that this is the way that most applications for cover will be dealt with in the future.

Section 10.16 has a requirement to contact members about insurance cover if they have been transferred to another division. Where a member's cover doesn't change on a change of division then we would suggest a separate insurance communication requirement should not be necessary.

# 10. Refunds

This section covers issues raised in Section B.8 of the consultation paper and Section 11 of the draft Code.

### 10.1. Question 24 – Refunds – what are the practical implications of requirements

We believe that this section refers to IP only as members are able to receive death, TPD and terminal illness benefits from multiple funds. The only exception may be for very large sums insured.

There needs to be clear rules around which policy should pay the benefits. One possibility would be to use the fund that the member joined first unless the member chooses to claim via another fund (e.g. because the benefits are more generous or payable sooner). Clear rules need to be set out as to the circumstances when a refund would be payable as most policies do not have identical terms. E.g. if IP waiting period or benefit period differs, policy offsets or exclusions differ would a refund be payable?

We note that no refunds are payable if the member is unable to claim due to benefits being payable from a non-superannuation life policy or a worker's compensation policy. For the benefit of member understanding it may be worth stating this in the Code.

We also note that refunds will only occur at claim time. A member who is not eligible to claim who realises they have duplicate cover cannot request repayment of premiums. To avoid conflict in the future this should be made clear as the inconsistency could cause problems for funds seeking to treat all members fairly and consistently.

Preferably the cut-off period for working out the premiums to be refunded would be shorter (perhaps three years before the event date) to minimise the need for the fund to obtain refunds of premiums from several insurers.

For members who have made a very late claim it may be difficult to obtain premium information and proof of overlap over numerous historic years where records may not have been retained.

In summary, we believe Section 11 of the Code requires much more consideration and detail as administrative complexity and ultimately the degraded customer experience may be greater than desired benefit.

# 11. Staff and Independent Service Providers

This section covers issues raised in Section B.9 of the consultation paper and Section 12 of the draft Code.

### 11.1. Question 28 - Staff and Independent Providers practical implications

We note that there is likely to be a need for more formal training and assessment to demonstrate competency.

# 12. Question 29 - Enquiries and Complaints

This section covers issues raised in Section B.10 of the consultation paper and Section 13 of the draft Code.

We do not believe that further detail is required here and do not have any concerns or comments on this area of the code.

# 13. Question 30 – Governance, enforcement and sanctions

This section covers issues raised in Section B.11 of the consultation paper and Sections 14 and 15 of the draft Code.

It is important that the Data reporting is standardised across all funds to minimise costs to develop and comply and to ensure consistency of reporting for compliance monitoring and for comparative purposes.

It is important that there is an opportunity for the fund's service providers (administrators, insurers) to have the opportunity to respond to any issues. A clear standard process for all funds should be set up for this otherwise we consider this will be a risk for service providers.

We have concerns around how will the code get enforced. If funds choose to opt out, this may reduce the benefits of scale available if there is full adoption.

# 14. Definitions

## 14.1. Automatic Insurance Member

As previously mentioned, we believe this definition requires further prescription to ensure clarity for funds and members. This is detailed in Section 3.1.3.

## 14.2. Eligible Contributions

As previously mentioned, this should include all employer contributions as many employers do not provide breakdowns by type to enable Superannuation Guarantee contributions to be identified.