ISWG Code response

October, 2017

MLC Life Insurance welcomes the opportunity to provide comment on the Insurance in Superannuation Working Group's (ISWG) draft Insurance in Superannuation Code of Practice and selected questions raised in the consultation paper. We understand the ISWG is seeking to develop a Code of Practice that raises standards for people insured via their superannuation and we support this worthy goal.

SCOPE OF THE CODE

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

Not addressed.

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

The consultation paper states the overarching objective in developing the Insurance in Superannuation Code of Practice (the Code) is to improve insurance in superannuation offered to fund members as well as trustees' processes in providing insurance. As an insurer that provides insurance in superannuation, we expect to play a major role supporting our trustee clients to adopt the Code and meet their obligations on an ongoing basis. As the Life Insurance Code of Practice (LICOP) deals with insurance contracts in superannuation (including group contracts) and processes in relation to insurance related services, there is potential for the two Codes to result in contradiction or uncertainty in relation to the insurer's obligations. Therefore, from our point of view, a key objective in its development should be to achieve harmony between the proposed Code and LICOP.

Questions related to transitional arrangements for specific Code sections:

- Section 3.7 –We recommend the Code clearly state which insurances it applies to and further, we support that it be confined to members in respect of Automatic Insurance, as defined in the Code.
- Section 4.25 – many trustees have a minimum account balance rule that may interact with this requirement. Is it expected trustees should transition away from any such rule?
- Section 4.25 – we seek clarification on whether and how this will apply to members who have already ceased contributions and when the communications required by sections 5.23-5.25 are expected to commence? Trustees may not be in position to meet the twice notification requirements.
- Section 5.25 – the transition to this requirement needs careful consideration. How will the 'at least twice' communications apply when individuals are already past the 13 month cessation deadline?

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)?

Not addressed.

PREMIUM LIMITS

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

How the premium limit is to be applied is presently not entirely clear. There is a lack of specificity in section 4.8 that appears intended to allow trustees latitude in how the 1% premium limit is calculated. If so MLC Life Insurance welcomes the intent that sits behind it; however we believe the intent could be better delivered upon if the Code specifically recognises that permitting trustees flexibility in the application of the 1% earning premium limit is desirable and manageable.

If strict premium limits are adopted it will not cater for some arrangements that currently exist in the market and so will create problems for trustees, members and employers. We therefore recommend the Code permit trustees to deviate from the 1% premium limit where it is appropriate to do so. To ensure such flexibility is not abused we would also support an obligation for trustees to document any deliberate premium limit deviation and the rationale for the deviation in advance as a part of meeting their SPS250 obligations. Such a mechanism would permit oversight and scrutiny by APRA.

Examples of where flexibility would be beneficial are listed below:

- Some trustees have tailored insurance arrangements in place at the employer level. For example some employers request generous insurance arrangements which have higher premiums that could place them above the 1% threshold, however also contribute additional superannuation contributions above the Superannuation Guarantee to fund them. Trustees should still be able to continue to support these arrangements and the mechanism we recommend would allow this.
- Inflexible premium limits may require trustees to undertake significant benefit design modifications and cumbersome member engagement activities in circumstances where the threshold has only been marginally breached. For example if a unit based design creates a circumstance where it is marginally over the threshold, the fund has the option of:
    a. reducing the number of units, which will lead to larger falls in cover than actually required
    b. slightly reducing unit size, which works for new members but not necessarily for existing members who wish to retain cover
    c. moving away entirely from unit based model, potentially leading to a more complex design for members to understand.

  A better outcome is to permit trustees to clearly document their rationale for a higher percentage level, similarly as is permitted in section 4.10 for high risk insurance populations.
- Another consequence of a strict enforcement of the 1% premium limit may be a perverse encouragement for trustees to introduce or widen segment cross-subsidies. This is because higher earning segments can be used to cross-subsidise lower earning segments, so ensure the trustee's full population stays within the 1% premium limit. Such an outcome would appear antithetical to the spirit of the Code.

Separately, we recommend that were trustees to have in place a premium adjustment arrangement the trustees should clearly specify the impact on member premiums and how the arrangement relates to the application of the 1% premium limit.

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

We suggest that the Good Practice Guide (GPG) consider issues related to the following sections:

- Section 4.8 – we note the 1% limit is based off Ordinary Time Earnings. We question if this is the appropriate measure for superannuation funds with a high proportion of casually employed members. The GPG should suggest how trustees manage such issues.
- Section 4.10 – The GPG should define and standardise the meaning of "higher risk" and provide guidance for trustees in determining if their insured population meets the standard.
- Sections 4.10 and 4.25 – The GPG should clearly explain how trustees can satisfy the requirements of these sections while still meeting MySuper minimum cover obligations.
- Section 5.27 – The GPG should advise how this section applies to members who have only recently joined the fund and so have low contributions. For example the GPG might clarify to say the section only applies to members who have been in the fund for a certain time.
- Section 11.2 – There is a risk that as trustees learn more about their members they uncover large cohorts of members who were either not eligible to claim against their cover or are over-insured. This may result in the need for trustees to action mass refunds at significant financial cost. In anticipation of this possibility, the GPG should encourage trustees and insurers to develop protocols on how the costs of a mass refund are shared.

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).

Not addressed.

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?

Benefit design is very important to ensuring insurance in superannuation delivers the benefits that are so important to members should their circumstances need it. We are concerned that the introduction of a 1% premium limit will refocus benefit design around fitting into the premium limit requirement rather than providing the right benefits at the right price, based on members' needs. We therefore suggest that premium limits are better expressed as a guideline with trustees free to set premiums at a higher level where doing so is right for members.

Alternatively, trustees should be permitted to breach the premium cap in certain circumstance and with certain controls, as we have outlined as part of our response to question 4 above.

If trustees had access to better quality information about their members, in particular more accurate salary information, they would be able to work with their insurer to design better products that are appropriate to the member's circumstances, with premiums that do not improperly erode premiums. While trustees can use member's Superannuation Guarantee contributions to back-solve for salary level, this is only a proxy measure and accurate data would assist in creating good insurance outcomes. We suggest that if individual salary data collected by the Australian Taxation Office, along with member occupation and/or industry information, were to be shared with trustees then the goal of ensuring insurance is good value that does not inappropriately erode the retirement savings of members.

Questions related to specific Code sections:

- Re Sections 4.4 and 4.12(a), trustees have limited access to this data. Is it expected that trustees adapt their systems to collect and manage this sort of detail?

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?

MLC Life Insurance understands low income earners, particularly women and younger members, require special consideration so as to avoid of inappropriate account erosion. As outlined in the response to question seven, regardless of income level MLC Life Insurance suggests basing product design off individual member's salary is the most appropriate way to balance benefit design against inappropriate erosion. In the absence of such data, Superannuation Guarantee contributions can be used as a proxy, but a number of salary data points would be required before any level of confidence can be achieved.

We note the Code is silent on what represents a low income earner. An agreed definition of what represents low income members earners should therefore be developed for inclusion in either the Code or the Good Practice Guide. For example the definition might be members whose salary information or Superannuation Guarantee contribution indicates they are in the bottom quintile of all income earners.

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?

The principle that sits behind the recently announced intention of AustralianSuper to change to its insurance arrangements for younger members provides an interesting model for other trustees to examine. As we understand it AustralianSuper is intending to:

- Defer the start of death and total and permanent disability cover until the member turns 20, from which point these covers are "turned on".
- Defer income protection cover until the member turns 25.
- Cease allocating a default number of insurance units, replacing it with a needs-based cover scale.

While other trustees may opt for an alternative benefit design, such as delaying death cover to 25 and starting income protection cover earlier, the moves by AustralianSuper represent a good first step.

We note that reducing cover for some segments of a fund's membership may have an impact on other segments, including the potential for older members to face a financial shock as a result of premium restructure. To manage this, the Code should permit a transition period longer than currently envisaged so increases for these older members can be absorbed over time.

In respect of retaining original cover, trustees should be free to offer existing members the ability to retain their cover even where it exceeds the 1% premium limit. This could be offered as an opt-in or opt-out solution, subject to a potential premium adjustment or via the introduction of risk controls to reduce potential anti-selection. If an opt-in arrangement was adopted by a fund, then the members should not be classified as Automatic Insurance Member. If an opt-out arrangement was adopted by a fund, then the members should remain classified as Automatic Insurance Member.

CANCELLATION AND CESSATION OF COVER

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

We have concerns with the implication of the "13 month rule" generally as follows:

- The rule's possible inconsistency with insurance contract terms which provide that insurance cover will continue whilst funds remain in the member's account.
- The detriment to members of the proposed default position that insurances will cease unless the member instructs the trustee otherwise. The rationale for this default position appears to be that it is likely that the member has ceased to make contributions because they superannuation (and therefore automatic insurances) elsewhere. This default position would appear inappropriate for members who have consolidated their insurances from elsewhere. It may also detrimentally impact those members who have full cover but would be subject to exclusions elsewhere.

We also share similar concerns to those raised elsewhere, that for some funds, particularly those with a higher proportion of members that are more likely to take extended breaks from paid employment, 13 months is too short and runs the risk of seeing otherwise payable claims denied. To cater for this we suggest the Code permit trustees to deviate from the 13 month standard by documenting the rationale for the deviation as a part of meeting their SPS250 obligations. Such a mechanism would permit oversight and scrutiny by APRA.

Notwithstanding the above, we also raise the question as to whether it would be appropriate for income protection cover to be ceased earlier than 13 months after the receipt of last receipt of a contribution, for example at the six month point. This is because the lack of a contribution suggests a high likelihood the member has ceased employment either permanently or temporarily, including the possibility of having moved to new employment and commenced making contributions to different superannuation fund. Regardless of the reason, the member is highly unlikely to be able to claim so it is appropriate for premiums to cease being deducted as soon as possible. In addition, the higher cost associated with income protection cover means that earlier cessation will have a greater impact on account balance preservation, perhaps to the extent of allowing the time limits on death and total and permanent disability cover to be lengthened as a trade-off.

In respect to reinstatement, while we understand the customer service goals that sit behind the reinstatement mechanism, we are concerned it may lead to an increased anti-selection risk. If this risk materialised, it could have an impact on premiums for existing members of the fund and our preferred option is to reduce the timeframe for members to reinstate their cover to a 30 day maximum period for members to reinstate their cover.

Questions related to specific Code sections:

- Section 4.20 – we seek clarification whether this sections means all communications options must be available, or is it sufficient if at least one of these methods are available? We further note that cancelling via website is not available currently in many funds and some trustees may be unable to implement this change by 1 July 2018.
- Section 5.25 – we support the proposed communications but suggest an additional communication that is sent immediately after cessation of cover informing of the consequences of cessation and of the reinstatement window.
- Of more significant concern however is that the cessation of cover as envisaged here may be inconsistent with the cancellation terms or the insurer's obligations under the insurance contract. Section 5.25 at this time does not deal with possible contractual inconsistency.

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?

Core to the problem of account balance erosion is the issue of multiple accounts, which leads to the occurrence multiple insurance and other fees. MLC Life Insurance supports moves to prevent the incidence of multiple insurance

fees as outlined in section 4.31. However we caution that trustees may find the obligations under section 4.31 burdensome and suggest the ISWG provide guidance on a number of points:

- What is the intended mechanism for trustees to use to establish the insurance status of members?
- Should trustees find multiple covers, what is the course of action expected of trustees?
- What should trustees do if they find more than one duplicate cover?

The other aspect of multiple accounts is in respect of dealing accounts already in existence. We urge the ISWG to consider a separate mechanism to help solve this problem, possibly by way of cooperation with the Australian Taxation Office to auto-consolidate funds on a member opt-out basis, or alternatively by making clear in annual member communications where the member has multiple superannuation accounts the impacts of this.

An issue of some public interest is how insurers determine who should pay when an insured person has multiple income protection policies, and whether premiums for a second or more income protection policy should be refunded when it doesn't pay (or upon request). We suggest the ISWG consider addressing this issue in the Code.

HELPING MEMBERS TO MAKE INFORMED DECISIONS

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

Cessation of cover in 13 months. This is a significant change and consumer testing should be undertaken to understand whether consumers see this as reasonable, what type of communication is effective, and how consumers would likely react if cessation were to occur.

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

Not addressed.

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

While MLC Life Insurance agrees with the approach of explaining key definitions in plain language, we do not support a further push to create standardised definitions. It is unlikely standardised definitions would materially improve consumer understanding, while being likely for such a requirement to stifle innovation and competition around disability products and in particular returning claimants back to wellness or work sooner.

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

Not addressed.

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?

Where a trustee and their insurer operate a direct to member claims model, is it intended for the trustee's claims obligations to be transmitted to the insurer?

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?

Not addressed.

18. What are the implications of the requirements on trustees to oversee and review ongoing income protection payments?

The reference in the Code to the trustee having "oversight" of the conduct of the insurer (in 6.4) and specifically 6.34 in relation to income protection payments appears to give the trustee powers and rights in relation to the assessment by the insurer of a claim that may be outside of its purview. Trustees have no right to determine what the insurer can do in relation to claims assessment. We suggest that the word "monitoring" would be the more appropriate terminology.

We would suggest a clearer and more defined parameters of what the trustee is able to do at claim time would be preferable. For example:

- service timeframes under service agreements with the trustee are met
- approved claims result in timely payment of the benefit
- trustees to be informed in a timely manner of the proposed decline by the insurer of the claim and ensure reasons provided
- trustees will test any determination of the insurer, including by reference to policy terms that apply.

Generalised statements (such as "we will be responsible for overseeing the conduct of the insurer" or "we will have oversight processes in place to ensure the information you are required to provide is reasonable) in our view could result in uncertainty in relation to trustee obligations and rights and also intervene in insurer processes which are outside of the purview of the trustee. Further the trustee's and insurer's rights and obligations in relation to a claim are well set out in law and generalised statements such as the above can result not only in inconsistency and uncertainty but also set unreasonable expectations on the part of the consumer on what the trustee can or ought to do in relation to the insurer's assessment of a claim.

VULNERABLE MEMBERS

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

Not addressed.

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?

The Code could prescribe the alignment of the terminal illness definition to 24 months, but this will impact benefit outlays, with consequential impact on premiums, leading to further pressure on trustees meeting the 1% premium threshold.

Clear communications from funds is the preferred mechanism to ensure that members who are granted release of funds for terminal illness do not lose their insurance cover or a minimum account balance rule is prescribed. In addition, members should not be flagged as an Automatic Insurance Member otherwise insurance cover may cease if no Superannuation Guarantee contributions are received for 13 months.

PREMIUM ADJUSTMENTS

21. Are the premium adjustment arrangements sufficiently transparent?

The Code should prescribe a format to ensure full transparency of these arrangements, including statements regarding the impact on premium levels to members today and potential premium variations in the future.

22. What further detail could the Code include?

Not addressed.

PROMOTING OUR INSURANCE COVER AND CHANGES TO COVER

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

Not addressed.

REFUNDS

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

MLC Life Insurance recommends refunds as an area where more clarity is needed. There is a significant degree of uncertainty in the proposed refund provision of the Code.

Foremost, members reading the Code may believe they are able to be refunded whenever they are unable to claim on their cover.

In respect of section 11.1, “Premiums” are the cost of the insurance and is charged by the insurer to the trustee in respect of the member. The reference to “we will refund your premiums to your account” is incorrect or unclear as it suggests that the trustee will refund premiums. The trustee does not refund premiums, it is the insurer who does this. There needs to be certainty that it is not the insurer who will be bound by the proposed obligation to refund premiums as foreshadowed in 11.1

We do not agree with any obligation imposed on the insurer to refund premiums as might be intended under this provision. This is particularly so as the insurer in most cases will not have any knowledge of or control in relation to the covers the member may have.

- Does the obligation to refund premiums to a maximum of six years if claims are offset apply to terminated plans?

- Where there has been a change of insurer within the six years, will the trustees be required to request a refund from the previous insurer?
- Members often look for compensation for lost earnings where premiums have been improperly deducted. Will refunds be limited to the premium amounts deducted only, or will there be a requirement for the refund to also cover interest foregone?

A more sophisticated process would see trustees identifying members with multiple accounts. If trustees had access to improved data they should be able to identify individuals at high risk of being unable to claim some or all of their benefit. More generally trustees could then take appropriate steps to regularly communicate to members in relation to the impact of offset where the member has multiple insurances (particularly group salary continuance insurance).

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

Not addressed.

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

Not addressed.

STAFF AND INDEPENDENT SERVICE PROVIDERS

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

Not addressed.

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

Not addressed.

ENQUIRIES AND COMPLAINTS

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

The code might consider the experience of consumers in relation to engagement of legal practitioners to assist with making a claim.

The engagement of legal practitioners to assist with claims or complaints may be important for the customer. The involvement of lawyers may be empowering and assist claimants at the time when they feel least able to cope with the requirements of a claim.

However, legal services are costly. Further, the engagement of legal services may be unnecessary particularly where there is a very high proportion of claims accepted and insurers are increasingly making available services and enhancing claims processes that helps ease the customer's claims experience. The LICOP already sets out a

significant number of provisions intended to make the claims processes easier. The proposed Code might give consideration to how trustees might inform members about the necessity for legal services, limited to perhaps only after the insurer has made a determination about the claim.

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?

Not addressed.