



ASIC
Australian Securities &
Investments Commission

Insurance in superannuation

September 2018

Report 591

About this report

This report sets out the findings from recent ASIC work on issues relevant to the consumer experience of insurance provided through superannuation.

About ASIC regulatory documents

In administering legislation ASIC issues the following types of regulatory documents.

Consultation papers: seek feedback from stakeholders on matters ASIC is considering, such as proposed relief or proposed regulatory guidance.

Regulatory guides: give guidance to regulated entities by:

- explaining when and how ASIC will exercise specific powers under legislation (primarily the Corporations Act)
- explaining how ASIC interprets the law
- describing the principles underlying ASIC's approach
- giving practical guidance (e.g. describing the steps of a process such as applying for a licence or giving practical examples of how regulated entities may decide to meet their obligations).

Information sheets: provide concise guidance on a specific process or compliance issue or an overview of detailed guidance.

Reports: describe ASIC compliance or relief activity or the results of a research project.

Contents

Overview	3
Insurance claims handling.....	8
Complaints handling.....	10
Insurance cover disclosure	13
Conflicts: Rebates and benefits	15
Default transfer arrangements	17
Appendix 1: Summary of key issues and actions for trustees	19
Appendix 2: Accessible versions of figures.....	21
Key terms	22
Related information	22

Disclaimer

This report does not constitute legal advice. We encourage you to seek your own professional advice to find out how the Corporations Act and other applicable laws apply to you, as it is your responsibility to determine your obligations.

Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

Overview

Most superannuation funds in Australia offer their members life insurance coverage in addition to retirement benefits. In fact, trustees of MySuper products are generally required to offer members death cover and total and permanent disability (TPD) cover on an opt-out basis: see s68AA of the *Superannuation Industry (Supervision) Act 1993* (SIS Act).

ASIC is committed to improving outcomes for superannuation members, including those who are less engaged with their superannuation. We looked at particular trustee conduct and disclosure issues that can affect consumer outcomes when insurance is provided through superannuation (our project). In particular, this review examined aspects of:

- **consumer understanding** – we looked at initial and ongoing disclosure about insurance cover
- **consumer access to the benefits of insurance** – we looked at the processes for claims and any complaints about claims
- **information used for setting premiums** – we looked at some particular assumptions about members that may apply in setting premiums when members are transferred between different plans in funds
- **choice of insurer and terms** – we looked at the impact of certain conflicts on trustee decisions concerning insurance.

We did not look at all issues that may impact on consumer outcomes. Many relevant consumer vulnerabilities were identified in our earlier work: see [Report 529 Member experience of superannuation](#) (REP 529). We note that there are a number of reviews and initiatives underway described in the 'Reviews and reforms' section below that are seeking to improve consumer outcomes in relation to insurance offered through superannuation.

Insurance in superannuation

Generally, superannuation funds offer one or more of the following types of life insurance cover to their members:

- **life cover** – which pays either a benefit or provides an income stream to beneficiaries when a member dies
- **TPD cover** – which pays a lump sum benefit when a member becomes injured or ill, or is unable to work again
- **income protection cover** – which provides replacement income for a period of time when a member is unable to work due to illness or injury.



70%

of all life insurance policies in Australia are held through superannuation funds. Each year about 46,000 death benefits and 17,000 disability benefits are paid through superannuation.

Note: See Rice Warner, [Insurance through superannuation](#), 20 April 2016.

Many consumers receive considerable benefit from insurance in superannuation. It can provide consumers with access to quality insurance coverage at a competitive price that may not otherwise be available.

However, the consumer experience of insurance in superannuation is not always positive. For instance:

- Many superannuation fund members do not know that they have insurance cover as part of their superannuation, meaning some people do not claim when they should. A recent survey of superannuation members identified that 24% did not know if they had insurance and 16% did not know what insurance they had: see Productivity Commission draft report, [Superannuation: Assessing efficiency and competitiveness](#), dated April 2018 and released 29 May 2018.

- Making and pursuing a claim can be time consuming and stressful. Lengthy and complex claims and complaints handling processes are likely to drive poorer outcomes for members, particularly those with lower financial capabilities. Consumers should be able to effectively claim on their insurance cover and be able to deal with any issues that may arise in relation to their claims without needing to engage lawyers.
- Retirement benefits can be unfairly eroded by insurance premiums as a result of inappropriate insurance arrangements, such as defaulting members as smokers in the absence of information about the member's smoking status, or providing insurance cover that cannot be used.

Reviews and reforms

In recent years there has been a heightened regulatory focus on the life insurance industry and the provision of insurance through superannuation. This has arisen from concerns about industry practices and whether some arrangements within the insurance industry meet best practice and the needs of members. In response, there are a number of reviews and initiatives that will affect the superannuation industry:

- The Productivity Commission is reviewing the competitiveness and efficiency of the superannuation system, and in May 2018 made draft recommendations about the offering of insurance in superannuation. Some of these are addressed in the law reform initiatives described below.
- In May 2018, the Protecting Your Super package was announced as part of the Federal Budget. The proposed reforms outlined in the package are intended to protect the retirement benefits of superannuation members from erosion by excessive fees and inappropriate insurance arrangements. The insurance-related measures will require cover to be offered on an opt-in basis in certain circumstances.

- In March 2018, the Parliamentary Joint Committee on Corporations and Financial Services (PJC) tabled a report on its inquiry into the life insurance industry. The report made a number of recommendations to improve consumer outcomes, including on life insurance offered through superannuation funds: see PJC, [Life insurance industry](#), March 2018.
- The Insurance in Superannuation Voluntary Code of Practice (Code) was launched by the superannuation industry in December 2017.

As the financial services regulator, ASIC has also been involved in issues to do with life insurance more generally:

- We recently released our report on direct life insurance [Report 587](#) *The sale of direct life insurance* (REP 587), which found that sales practices and product design are leading to poor consumer outcomes.
- We are reviewing TPD claims and will report on our results early next year. This follows our broader review of claims handling in 2016: see [Report 498](#) *Life insurance claims: An industry review* (REP 498).
- We are working with the Australian Prudential Regulation Authority (APRA) on a project that will collect and publish comprehensive data on claims outcomes relating to life insurance.

This report complements our other work in relation to insurance. Further findings and recommended actions for trustees based on these findings are set out in this report and in Table 1 (Appendix 1).

Methodology of our project

There are currently 132 superannuation trustees in Australia. For our project, we obtained information from a cross-section of superannuation trustees through a survey and a detailed review.

Survey

In 2017, we sent notices under s912C of the *Corporations Act 2001* (Corporations Act) requesting information about the insurance arrangements of 47 trustees across the retail, industry and corporate sectors for the 2015–16 financial year. In putting together our sample, we also considered factors other than the type of fund, such as the size of the fund.

Collectively, the responses to the notices provided data relating to 10.3 million members and \$525 billion in funds under management. In this report, we refer to these responses as the ‘survey results’.

The survey results indicated that, in the 2015–16 financial year:



41,101

insurance claims were collectively received by the trustees.



More than \$28 million

in rebates from insurers were received by the trustees.



11

different life insurance providers issued life insurance products to the trustees.

Note: We have rounded the findings from the survey and detailed review to whole numbers.

Review

Based on potential issues suggested by the survey results, we selected 18 (of the original 47) trustees for a more detailed review of their insurance arrangements (the review).

We sent another notice (under s912E of the Corporations Act) to these 18 trustees, requesting more detailed information and supporting documents about their insurance arrangements. We also visited some trustees to better understand their insurance arrangements.

In this report, we refer to the information we obtained from these notices and discussions as the ‘review results’.

The way forward

We have updated [ASIC’s MoneySmart](#) website to include more detailed information about insurance in superannuation for consumers.

We were pleased to find that some trustees acted to improve their disclosure and conduct following the release of [REP 529](#). However, our findings suggest that the superannuation industry has much more work to do if it is to deliver consistently good consumer outcomes. Highlighted below are some specific issues covered by our project where improvement is required.

Complaints handling

Trustees must take all reasonable steps to have arrangements to consider and deal with complaints within 90 days. While trustees may have taken steps to comply with this requirement, the arrangements were not always delivering timely outcomes for complaints about insurance claims. Around a quarter of trustees reported to us that they took longer than 90 days on average to finalise complaints about insurance claims in 2015–16. More recently, for 2017–18, almost a third reported average timeframes of more than 90 days. Consumers expect to have their complaints about insurance claims resolved in a timely manner.

We noted that a significant number of trustees reported resolving complaints about insurance claims in an average of less than 45 days, demonstrating that good complaints handling timeframes are within the control of a trustee.

We are also aware that trustees do not always provide adequate written reasons for complaint decisions, despite legal requirements to have arrangements to do so in certain circumstances. There are also clear benefits for members in understanding why a trustee made the decision it did.

Poor complaints processes can mean that members wait a long time for outcomes, which can exacerbate financial and other stresses. We are putting trustees with longer complaints handling times on notice that they need to take immediate steps to reduce these timeframes.

ASIC will be consulting on new internal complaints handling requirements after the Australian Financial Complaints Authority (AFCA) commences operation on 1 November 2018. For superannuation complaints, we will propose shorter timeframes for dealing with complaints and stronger obligations to provide reasons for decisions on complaints.

We will also review complaints handling arrangements more broadly in 2019 to see how timely and effective industry practices are for all complaint types. We will take regulatory action if we find practices that fail consumers.

Disclosure and engagement practices

Although only 11 different life insurance providers issued life insurance products to the 47 superannuation trustees surveyed, we found a very high level of variation in the TPD definitions used in the insurance products offered through superannuation funds. These variations can make it difficult for consumers to compare the insurance offerings between funds or to understand insurance offered in superannuation generally.

We also observed some inconsistencies between fund disclosure materials and the underlying insurance policies.

Work undertaken by industry in connection with the implementation of the Code should lead to the development of more standardised insurance

information for members, although this will depend on the extent of industry adoption of the Code and its adequate monitoring and enforcement. ASIC will carefully assess whether the Code results in progress on this issue.

Without significant improvement in the quality of information and reduction in complexity of insurance arrangements, it is difficult to see how consumers will be able to understand their cover, and make and implement decisions either to opt in or out of insurance cover.

Complex insurance arrangements contribute to consumer harms such as failure to claim entitlements and unnecessary balance erosion.

Other issues

In the course of our project we identified a small minority of trustees with problematic practices. These included:

- relying on disclosure in a Product Disclosure Statement (PDS) rather than notifying members that insurance cover is about to cease shortly before this occurs
- treating all members as 'smokers' in the absence of information about whether the member is a smoker when the member moves from an employer plan to a personal plan within a fund after leaving an employer.

The trustees we identified with these practices addressed our concerns or are taking steps to do so in relation to future conduct.

We also expect trustees that have engaged in these problematic practices in the past to carefully consider what action needs to be taken in relation to current members.

We have highlighted these practices to clearly articulate to trustees not covered by our project that these practices are not acceptable.

Industry efforts at self-regulation

We consider that industry codes can raise industry standards, support the complaints process and provide certainty for consumers. However, this requires broad industry commitment and effective monitoring and enforcement arrangements.

At present, there are significant weaknesses in the Code, including in its monitoring and enforcement arrangements, that limit its potential effectiveness.

Industry codes work best if they have full coverage across the industry. One way to achieve this is to make Code membership mandatory. ASIC cannot mandate a code or force industry sectors to submit a code for approval.

Noting these limitations, we will work with APRA to see how the adoption of the Code progresses. One issue that we will be interested to watch is whether the superannuation industry can collectively commit to the establishment of a properly resourced Code administrator with appropriate coverage across the industry.

Protecting Your Super package

As noted above, the announced reforms will require cover to be offered on an opt-in basis in certain circumstances. We will undertake work to promote better consumer decision making around insurance choices.

Next steps

We will:

- work with APRA to see how the implementation and coverage of the Code progresses in order to understand if it is effective in improving industry practices
- take regulatory action against trustees that consistently fail to comply with their legal obligations in relation to disclosure and complaints handling, including potential enforcement action
- ensure trustees stop treating members as ‘smokers’ by default
- undertake work to promote better consumer decision making around insurance choices
- help consumers understand insurance in superannuation by providing them with useful and independent information on [ASIC's MoneySmart](#) website that helps them engage with their superannuation.

We will consult on new internal complaints handling requirements, which will apply to superannuation and all other financial services and credit complaints. We will consult on these requirements after AFCA commences operation.

Productivity Commission draft report

A number of problems with insurance in superannuation for consumers have recently been highlighted by the draft report of the Productivity Commission, [Superannuation: Assessing efficiency and competitiveness](#).

These potential problems include significant balance erosion, insurance of no value, poor member awareness, challenges for members in comparing insurance, and difficulties in interacting with trustees in relation to insurance.

The draft report, released on 29 May 2018, recommends further work be undertaken by ASIC in relation to issues including:

- provision of meaningful information about insurance to members
- monitoring and enhancing the Code.

In addition, the Productivity Commission recommends that the Australian Government commission a formal independent review of insurance in superannuation.

ASIC firmly agrees that further work is needed to improve industry practice. We are considering the report and it will help shape our continuing work to achieve better outcomes for consumers in relation to insurance in superannuation.

Insurance claims handling

To enable members to realise genuine benefits from their insurance cover, it is important that claims handling processes are designed and operate in a way that works well for consumers. Insurance claims are made when claimants are dealing with disability, illness, injury or the death of a member, and trustees should ensure that there are no unnecessary barriers or frictions for consumers in making and pursuing a claim.

In [REP 529](#), we noted that complaints and claims were often handled collectively by trustees, external administrators and insurers. If these parties did not interact well, members risked processing delays and poor communications.

The Code states that the trustee will act in claims handling processes as follows:

'We will play a visible role in the claims process and ensure you receive regular updates as well as a decision on your claim in a reasonable timeframe.'

– Insurance in Superannuation Voluntary Code of Practice, December 2017

There are specific provisions in the Code dealing with providing easily accessible website information on claims handling, providing updates to claimants every 20 business days and responding to any query within 10 business days.

The Government has announced that it is considering removing the exemption for claims handling from the definition of 'financial services' in the Corporations Act. We support this reform and advocated for it in 2016: see [REP 498](#). This would increase the legal obligations of trustees in relation to claims handling.

Survey results

The information we collected about insurance claims handling from the 47 trustees during the 2015–16 financial year showed:

- trustees deal with a significant volume of claims on insurance (our sample of 47 trustees received 41,101 claims and finalised 40,659 claims in 2015–16)
- out of all finalised claims (including withdrawn claims), 70% were accepted in full (when withdrawn claims were excluded from finalised figures, 88% of claims were accepted in full)
- 8% of all insurance claims were declined, 1% were accepted in part and 20% were withdrawn, with a small number being resolved by ex gratia payments
- 28 trustees outsourced insurance claims handling to their external administrator
- the withdrawal rate of trustees using external administrators was on average more than twice that of trustees that handle claims internally
- regardless of whether the claims handling was administered internally or externally, decline rates were similar for each group
- industry funds receive more claims per member in comparison with retail funds
- 29 trustees provided interest to members on delayed claims, and 28 trustees had provided refunds in certain cases (totalling \$16.7 million) where there were complaints by members, errors by the trustee, or a misunderstanding or miscommunication between the trustee and its members
- approximately 27% of all complaints that trustees received were identified as being about insurance issues.

Review results

Our review of insurance claims handling found that:

- All the trustees in our sample reviewed claims denied by insurers. This was either done at the board level or by delegated authority to a committee. Where the process had been delegated, reporting protocols were established to ensure that the board was informed about the claims handling process or outcomes.
- About half of the trustees had initiated actions (either internally or externally) to review and improve their claims handling processes between 2015 and 2017. We observed reviews that were aimed at streamlining the processes, improving communications to claimants and raising standards to enhance the experience of members. Not all trustees had focused on making the lifecycle of a claims handling process available easily to members. Explaining the claims handling process is not difficult, yet it can help a member during a stressful life period.
- Material produced for members wanting to make a claim varied greatly. Some trustees advised that they referred members wanting to make a claim to the fund's PDS, insurance booklets and relevant claim forms. However, there was very little information on the actual claims handling process and the steps involved. In some cases, members had to contact trustees for more detailed information. Other trustees provided information outlining requirements once a claim was received.

The actions that we observed during the later phases of our project suggested that some trustees were preparing their internal processes in anticipation of the Code's implementation, and were actively responding to [REP 529](#) and recent adverse publicity about insurance claims handling. While these changes are positive, we expect trustees to take further steps to ensure material improvements in member experience.

Next steps

Trustees should review their claims handling processes, particularly given our findings about the number of complaints about insurance claims. Key issues to consider in any review are:

- simplicity, timeliness and transparency of the process for members
- feedback mechanisms for trustee oversight in relation to the role of administrators and insurers.

In 2019, ASIC intends to see whether claims handling processes have been reviewed by trustees in the three years before this check. This will involve testing a sample of these reviews to see if they have resulted in genuine improvements to consumers. We will also do further work to understand why the withdrawal rate for trustees using external administrators was higher than that of trustees that handle claims internally.

Complaints handling

The complaints handling requirements for trustees of superannuation funds are in s101(1) of the SIS Act. The current requirements are to take all reasonable steps to ensure there are arrangements in place:

- to consider and deal with complaints within 90 days
- for death benefit complaints:
 - to give written reasons for decisions on complaints when giving notice of the decision
 - if no decision is made within 90 days, to provide reasons for this on written request from the complainant
- for all other complaints, to provide written reasons for a decision on a complaint, or the failure to make a decision within 90 days, on written request from the complainant.

Note: There have been changes to s101 of the SIS Act since the project was started. Although there is a new s101, the obligations are still currently operative because they have been saved: see [Regulatory Guide 165](#) *Licensing: Internal and external dispute resolution* (RG 165) at RG 165.88 and the *Treasury Laws Amendment (Putting Consumers First – Establishment of the Australian Financial Complaints Authority) Act 2018*.

In our project we looked at the timeframe it took trustees to consider and deal with complaints during the 2015–16 and 2017–18 financial years.

Note: The results for this issue are based on a sub-set of the 47 trustees, due to industry changes or reports of nil complaints in relation to insurance claims. For the 2015–16 year the sample size is 43 trustees; for the 2017–18 financial year the sample size is 41 trustees. We are following up with those trustees that reported nil complaints in relation to insurance claims because this raises questions about whether this reflects good claims handling processes or weaknesses in their complaints handling records.

Recent amendments in the *Treasury Laws Amendment (Putting Consumers First – Establishment of the Australian Financial Complaints Authority) Act 2018*, establishing AFCA, will significantly change trustees' internal dispute resolution (IDR) obligations.

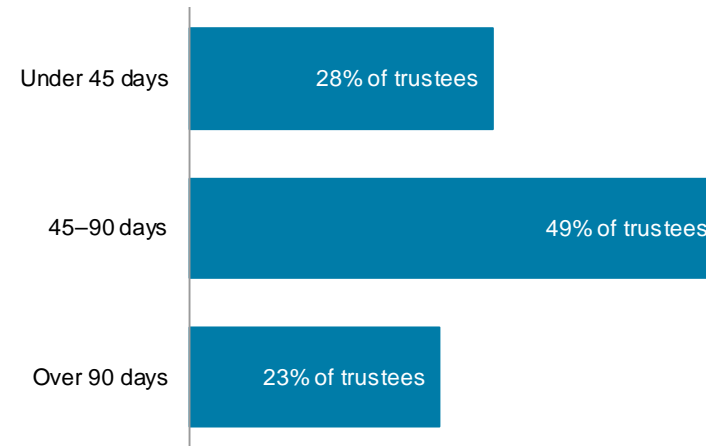
We will be consulting on new IDR requirements and changes to [RG 165](#). This will include reviewing the definition of complaint, consulting on reducing the timeframe for dealing with superannuation and other complaints, and stronger obligations for trustees to provide written reasons for decisions. We note that the Code has already moved to a 45-day timeframe to in which trustees must provide members with a final response to an insurance-related complaint.

Survey results

The information we collected about the handling of insurance complaints in the survey showed:

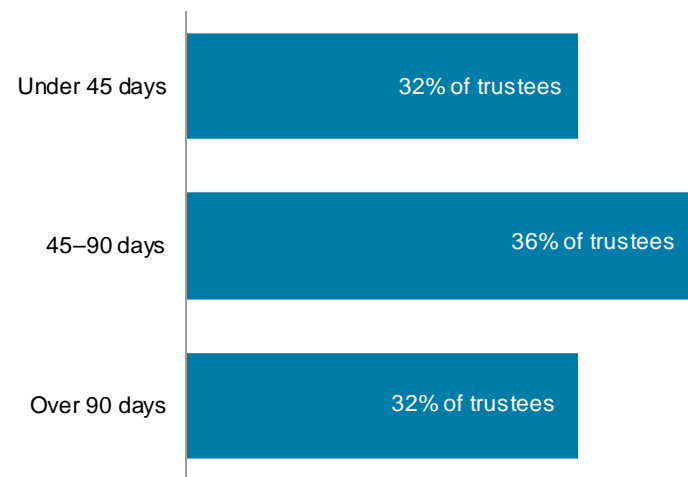
- while some trustees were able to finalise insurance-related complaints within a 45-day period on average, around a quarter of trustees in our sample exceeded 90 days in 2015–16 (see Figure 1)
- nearly half of trustees took longer to deal with insurance-related complaints in 2017–18 compared with 2015–16 (see Figure 2).
- 36% of all insurance-related complaints were about TPD policies. This is consistent with ASIC's previous work in [REP 498](#), where we found decline rates were highest for TPD claims. This suggests that TPD insurance may have characteristics, such as complexity, that make it harder for consumers to understand and claim on their cover. ASIC is doing further work on TPD claims and we will report on our results early next year.

Figure 1: Average time taken by trustees to finalise complaints relating to insurance claims (FY 2015–16)



Note: See Table 2 in Appendix 2 for the data shown in this figure (accessible version).

Figure 2: Average time taken by trustees to finalise complaints relating to insurance claims (FY 2017–18)



Note: See Table 3 in Appendix 2 for the data shown in this figure (accessible version).

The Code says that trustees dealing with insurance complaints will generally meet a 45-day timeframe:

'We will provide a final response to your complaint in writing within 45 calendar days of receiving your complaint. In exceptional cases, we will need more time to investigate and respond to your complaint. In these cases, we will tell you that we need more time, and will clearly communicate our revised expected timeframe, which will not exceed 90 calendar days.'

– *Insurance in Superannuation Voluntary Code of Practice, December 2017*

Review results

Our detailed review of the complaints handling arrangements of 18 trustees found that:

- The documented procedures of five trustees did not reflect the requirement to establish arrangements to provide written reasons for decisions relating to death benefit complaints.
- All 18 trustees provided information to members about how to make a complaint, and most trustees offered multiple lodgement methods. The Corporations Act requires a PDS to contain information about the complaints process. In addition to the PDS, many trustees also provided information about the complaints process in members' periodic statements, in the fund's annual report, on the trustee's website or in separate documents, such as factsheets or booklets. In general, the disclosures we reviewed adequately explained the complaints process to members.
- Eleven trustees demonstrated that their IDR procedures had been internally or externally reviewed in the last two years and four of these indicated they had implemented recommendations made following the review.

- Of the trustees that had reviewed their IDR procedures, less than half indicated that the board had oversight or involvement in the review.

Further, while the documented IDR procedures of all trustees required superannuation complaints to be considered and dealt with within 90 days, around a quarter of trustees in the wider survey did not meet this timeframe as an average when dealing with insurance-related complaints in 2015–16 and nearly a third did not meet this average timeframe in 2017–18.

Regular review and monitoring by trustees of their complaints processes and subject matter is important. It provides a measure of performance and facilitates the identification of opportunities for improvement. Analysis of complaints can also be particularly useful for trustee boards in understanding risk areas within the trustee's operations and culture.

Additional related work

In a separate piece of work also looking at complaints handling, we engaged with 10 trustees about their failure to provide adequate written reasons in response to complaints about death benefit claims. The trustees reviewed represented a cross-section of the superannuation funds in Australia, and some of these trustees were also part of our project.

This review work uncovered more than 1,000 instances of trustees failing to provide consumers with adequate written reasons for a decision. This suggests trustees' arrangements for providing reasons may not be working effectively. All of the 10 trustees have revised the responses they provide regarding complaints about death benefit claims and implemented new procedures for handling these claims, including updating template letters and providing additional staff training.

Providing written reasons improves trustee accountability and promotes confidence in their decision making. It is also essential in helping members decide whether to escalate their complaint through to an external dispute resolution scheme.

Next steps

Trustees that have complaints handling times greater than a 45-day average need to act now to improve the timeliness of their processes.

ASIC's priority is to see that those trustees with averages over 100 days have reduced their complaints handling timeframes. If immediate action is not taken by trustees, ASIC will take further regulatory action, including considering enforcement options, against those trustees.

Trustees should also ensure that their arrangements for giving written reasons are working effectively and should endeavour to provide reasons for all complaints, even if not specifically requested.

After AFCA commences operation, ASIC will consult on new internal complaints handling requirements. For superannuation complaints, we will propose shorter timeframes for dealing with complaints and stronger obligations to provide reasons for decisions on complaints.

Insurance cover disclosure

Superannuation members need timely, accurate and consumer-focused information to be able to understand and make informed decisions about the insurance products offered by trustees.

Important information about when insurance cover will cease is not salient if only provided in the PDS given to members when they first join a fund. Trustees should consider the timing and approach used to communicate and engage with members on insurance-related matters.

The Code provides that:

'Our communications to you will be clear, timely and in plain language, to assist your understanding of the role of insurance in superannuation and the details of your insurance cover.'

– Insurance in Superannuation Voluntary Code of Practice, December 2017

Survey results

The information we collected about insurance cover disclosure in the 2015–16 financial year showed:

- all trustees provided disclosure in the fund's PDS about when insurance cover would cease
- 96% of trustees notified members shortly before their insurance cover ceased, meaning that two trustees did not
- 11 different life insurance providers issued life insurance products to the 47 trustees.

Review results

Our review of trustees' disclosures about insurance cover found:

- Two trustees did not notify members shortly before cover ceased. One has since addressed this issue, and now provides notification just before cover ceasing. The other endeavours to notify members shortly before their insurance cover ceases and now has arrangements in place to ensure insurance claims are dealt with if cover ceases without specific notification being made shortly before the cessation.
- There is a high level of variation in the TPD definitions used in the insurance products offered through superannuation funds. The variations were based on a member's employment status, including whether the member was full time or part time, permanent or casual, unemployed or engaged in home duties. Variations were also based on the age of the member (e.g. whether they were older than 65). Although a high level of variation in TPD definitions used in insurance products is not prohibited by law, it poses significant challenges for members in understanding and comparing insurance cover.
- There were some inconsistencies between the statements made by trustees about insurance cover in their disclosure documents and other materials, and the actual insurance policies.

Next steps

There is scope for many trustees to improve their insurance disclosure and member engagement practices. We highlight, in particular, standardisation of concepts, cessation information, ease of engagement to vary or opt out of cover and ability to use tools other than text-based disclosure to engage members. ASIC will monitor and assess industry initiatives to standardise definitions and terminology in relation to insurance in superannuation.

ASIC will also undertake further work to promote better consumer decision making around insurance choices.

Conflicts: Rebates and benefits

The trustees of some of Australia's largest superannuation funds receive rebate payments or other benefits from their insurance providers. Rebates are typically paid when the insurance claim levels for the fund's members are less for a period than a benchmark agreed with the insurer.

These arrangements can raise conflict issues. Do trustees minimise member claims so as to receive rebates? Do trustees choose an insurer based on the benefits the insurer provides to the trustee or to the members?

In our work we found that rebates or benefits from insurers to trustees were received in around 35% of cases. These arrangements were not always disclosed. We found no evidence that rebates led to lower claims success for members.

The provisions of the Code recognise the need for transparency about rebates and benefits and for these to be applied for the benefit of members. Adoption of the standards of the Code would improve current practices.

We note [Prudential Standard SPS 250 Insurance in Superannuation](#) explicitly deals with conflicts arising in insurance arrangements and further requirements regarding conflicts management are set out in [Prudential Standard SPS 521 Conflicts of Interest](#).

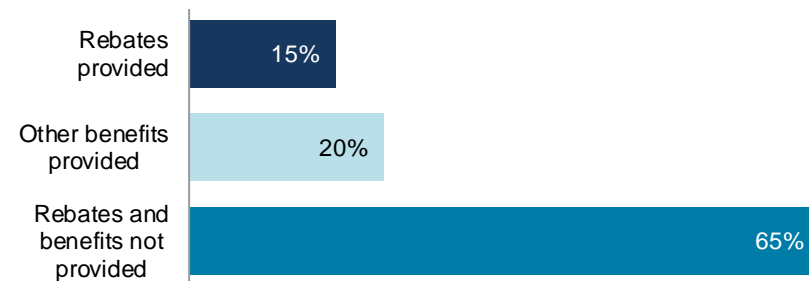
Survey results

The information we collected about rebates and benefits during the 2015–16 financial year showed:

- Approximately 15% of trustees reported having rebate arrangements with their insurers (see Figure 3).

- Rebates received from insurers by the relevant trustees totalled approximately \$28 million.
- Nearly 20% of trustees reported receiving other benefits from insurers, such as corporate hospitality.
- Disclosure of both rebates and benefits was made in some, but not all, cases. This includes disclosure in PDSs and on websites as part of the transparency requirements under s29QB of the SIS Act. There was only one instance of a trustee reporting receiving a rebate in the relevant time period of our notice but not disclosing it.
- On average, the trustees that received rebates were three times the size of other superannuation funds by both value of assets and number of members. However, there was insufficient evidence to demonstrate a connection between fund size (based on assets or members) and the amount of any rebate received.

Figure 3: Insurer rebates and benefits



Note: See Table 4 in Appendix 2 for the data shown in this figure (accessible version).

Review results

Our review of rebate and benefit arrangements found that:

- Of the trustees that reported receiving rebates, around 40% advised that they had considered insurer rebates and the potential effect of rebates on insurance premiums charged to members when selecting

an insurer. Tender documents used in the selection of insurers generally included descriptions of potential rebates. One trustee noted that, in the course of its latest tender process, all tendering insurers had proposed models for the payment of rebates.

- All trustees that reported receiving rebates indicated that these were applied for the benefit of members. The rebates were allocated to an insurance reserve, which was then used to reduce premiums payable by members or meet insurance costs. The insurance reserves were noted in the financial statements.
- Around 70% of trustees made some form of disclosure about their rebate arrangements to their members despite there being no specific requirement to do so.
- One trustee disclosed the corporate hospitality they received from their insurer under transparency requirements in s29QB of the SIS Act as part of their register of relevant interests and register of relevant duties.

Note: Prudential Practice Guide [SPG 222](#) *Management of reserves* provides guidance on the use of reserves. APRA is proposing to replace SPG 222 with a new Prudential Practice Guide [SPG 221](#) *Strategic and business planning* (draft new SPG 221). Draft new SPG 221 includes updated and amended guidance on the use of reserves, including specific guidance on insurance premium adjustment mechanisms. Where such mechanisms are in place, the guidance outlines APRA's expectations that the proceeds would be operated through a specific insurance reserve and would generally only be used to meet insurance premium costs (not generally for insurance services or other purposes), and that the insurance reserve policy would ordinarily ensure appropriate and timely use of the insurance reserve to adjust member premiums.

As noted above, we found no evidence that rebates led to lower claims success for members.

Trustees with no rebate arrangements

Although insurance rebates are used to benefit members in the form of subsidised premiums, some trustees have decided not to enter into such arrangements with their insurance providers.

One trustee noted the following:

The premiums in the fund are predominately paid for by deductions from member accounts. An approach with rebates would require higher upfront premiums and cost for members. Where rebates are eventually paid by the insurer, they may well be after the effective date to which the premiums relate. Therefore, with turnover of members, it becomes extremely difficult and costly to members to allocate the rebate to members in an equitable way.

Next steps

Trustees should be transparent about any rebates or benefits received from insurers and how receipt of these is consistent with acting in the best interests of members. This should not be burdensome because close monitoring by trustees of these payments or other benefits should be part of the trustee's usual arrangements to deliver good member outcomes.

Default transfer arrangements

Some employers organise for a trustee to offer its employees special terms and conditions in a fund (employer plans). Fund rules often require members of employer plans to be current employees of sponsoring employers. As a result of these rules, when a member leaves the employment of the sponsoring employer they are often transferred to another division (such as a personal division) within the fund.

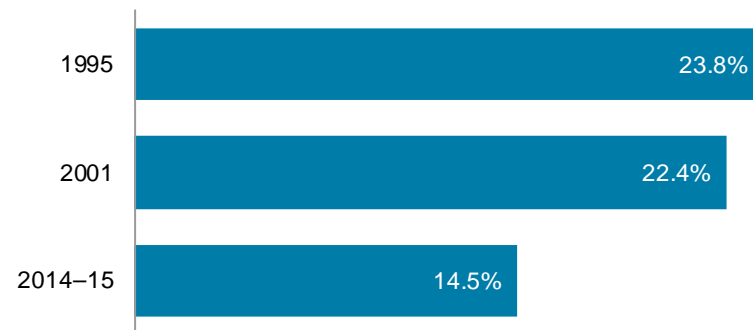
The cost and coverage of insurance cover offered within the superannuation fund is often different between employer plans and personal plans. Typically, members experience premium increases on transfer to a personal plan because insurance costs are often discounted by insurers, or subsidised by employers, in employer plans.

When members are transferred from an employer plan to a personal plan within the same superannuation fund, some trustees automatically classify members as smokers or blue-collar workers unless specific information to the contrary is received from the member. If the member is not a smoker or blue-collar worker, these default transfer settings can unfairly increase insurance premiums and therefore significantly affect the size of the member's superannuation benefit.

We consider that defaulting all members to 'smoker' status on leaving their employer is unacceptable, particularly as recent data indicates that only around 14.5% of the adult population smoke daily: see Figure 4. We do not consider that disclosure of defaults will address all the harm the application of defaults can cause.

Similarly, recent data indicates that only around 26% of all workers are engaged in blue-collar work: see ABS, [Labour force region: SA4 data](#), May 2018.

Figure 4: Percentage of adults who are daily smokers



Source: Australian Bureau of Statistics (ABS), [4364.0.55.001 National health survey: First results, 2014-15](#)

Note: See Table 5 in Appendix 2 for the data shown in this figure (accessible version).

As explained in [REP 529](#), trustees must perform their duties and exercise their powers in the best interests of the beneficiaries of the superannuation fund: see s52(2)(c) of the SIS Act. It is important for trustees to develop and update their records, and understand the composition and different needs of their membership, to assess and justify why these default settings are in the best interests of their membership. This is particularly so for disengaged members who are less likely to be aware of a transfer, any default and its consequences.

As noted in [REP 529](#), there are Superannuation Complaints Tribunal (SCT) determinations relevant to this subject, including an SCT determination setting aside a trustee's refusal to refund premiums charged at smoker rates when the member was not, and had never been, a smoker. In that case, a decision was substituted that the trustee refund approximately \$77,000 in extra premiums paid: see SCT, [Determination D14-15/236](#), 6 May 2015.

The use of default transfer settings is also addressed in the Code:

'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 relevant evidence.'

– Insurance in Superannuation Voluntary Code of Practice, December 2017

All trustees that had smoker defaults at the time our project started have now either ceased, or are implementing changes to cease, this practice.

We will contact trustees to ensure appropriate arrangements are made for members who may already be paying higher premiums based on inappropriate default transfer arrangements.

Survey results

The information we collected about default transfer settings during the 2015–16 financial year showed:

- around 9% of trustees defaulted members as smokers
- around 6% of trustees defaulted members as blue-collar workers.

Review results

Our review of default transfer settings found that:

- All trustees disclosed the existence of default transfer settings to members at the time they joined the superannuation fund.
- Almost all trustees informed members when they were moved from an employer plan to a personal plan. Some trustees sought updated member details at the time of transfer, including the member's smoker status and occupational capacity. One trustee advised that updated details were sought from members whenever they made

contact with the fund, and the smoker status and occupational capacity of members was disclosed on periodic statements.

- One trustee did not inform some members of their default status and the potential effect on insurance premiums when they were moved between plans within the fund, other than in the PDS.
- One trustee advised that it defaulted its members as smokers to ensure that members' claims were not denied if they declared smoker status sometime in the future. We consider defaulting members as non-smokers and clearly communicating the consequences of not declaring smoker status, where applicable, a better practice.

Next steps

Trustees should avoid applying defaults classifying members as smokers or blue-collar workers in the absence of other information about a member or group of members.

ASIC will seek confirmation from trustees that appropriate changes to default transfer arrangements are being made. This includes ensuring that trustees:

- change arrangements for members who are already paying premiums based on inappropriate default settings
- communicate the effect of these changes
- review current and past practices to determine if they need to take any action regarding existing members.

Appendix 1: Summary of key issues and actions for trustees

Table 1: Summary of key issues and actions for trustees

Issue	Impact on consumers	Action
<p>Insurance claims handling</p> <p><i>Access to information about claims handling processes</i> – In order to realise benefits from insurance cover, claims handling processes must be clearly explained and easy to navigate.</p>	<p>At the time of making a claim, consumers may be vulnerable and may experience financial and other stresses. If processes are unduly complex, it can make it very difficult for consumers to navigate and manage their claim effectively.</p>	<p>Trustees should review their claims handling processes, particularly given our findings about the number of complaints about insurance claims. Key issues to consider in any review are:</p> <ul style="list-style-type: none"> – simplicity, timeliness and transparency of the process for members – feedback mechanisms for trustee oversight in relation to the role of administrators and insurers. <p>In 2019, ASIC intends to see whether claims handling processes have been reviewed by trustees in the three years before this check. This will involve testing a sample of these reviews to see if they have resulted in genuine improvements to consumers. We will also do further work to understand why the withdrawal rate for trustees using external administrators was higher than that of trustees that handle claims internally.</p>
<p>Complaints handling</p> <p><i>Providing written reasons for decisions about complaints</i> – Trustees must give written reasons to members and others for all complaints about death benefit claims or on request for other types of complaints.</p> <p><i>Dealing with complaints within the required timeframes</i> – Trustees currently have a legislative requirement to properly consider and deal with superannuation complaints and inquiries within 90 days.</p>	<p>Consumers are disadvantaged if they do not receive written reasons for a decision. Not understanding the reasons for a decision will limit the complainant's ability to make an informed choice about whether to contest or escalate the decision.</p> <p>Consumers are disadvantaged by significant delays in having their complaints addressed. This is particularly the case with complaints relating to claims for benefits under insurance policies. Delays for extended periods can create financial uncertainty and other stresses for consumers.</p>	<p>Trustees should ensure that their arrangements for giving written reasons are working effectively and should endeavour to provide reasons for all complaints, even if not specifically requested.</p> <p>Trustees that have complaints handling times greater than a 45-day average need to act now to improve the timeliness of their processes. ASIC's priority is to see that those trustees with averages over 100 days have reduced their complaints handling timeframes. If immediate action is not taken by trustees, ASIC will take further regulatory action, including considering enforcement options, against those trustees.</p> <p>After AFCA commences operation, ASIC will consult on new internal complaints handling requirements. For superannuation complaints, we will propose shorter timeframes for dealing with complaints and stronger obligations to provide reasons for decisions on complaints.</p>

Issue	Impact on consumers	Action
<p>Insurance cover disclosure</p> <p><i>Timely, accurate and consumer-focused disclosure</i> – Superannuation members need timely, accurate and consumer-focused information to be able to make informed decisions about the insurance products offered by trustees.</p>	<p>Consumers who are unaware of their insurance ceasing are unable to make a timely decision to take action if they wish to retain the coverage. This can leave them in a vulnerable position if they need to make a future claim.</p> <p>Consumers may find it difficult to compare TPD definitions in insurance in superannuation, hindering their ability to select coverage appropriate to their circumstances. They may also be unclear when a TPD event is triggered, due to the complexity of the definitions.</p>	<p>There is scope for many trustees to improve their insurance disclosure and member engagement practices. We highlight, in particular, standardisation of concepts, cessation information, ease of engagement to vary or opt out of cover and ability to use tools other than text-based disclosure to engage members. ASIC will monitor and assess industry initiatives to standardise definitions and terminology in relation to insurance in superannuation.</p> <p>ASIC will also undertake further work to promote better consumer decision making around insurance choices.</p>
<p>Conflicts: Rebates and other benefits</p> <p><i>Managing conflicts of interest</i> – Insurance arrangements may be negotiated based on considerations other than members' best interests.</p>	<p>The insurance available to consumers through the superannuation fund may not meet their needs.</p>	<p>Trustees should be transparent about any rebates or benefits received from insurers and how receipt of these is consistent with acting in the best interests of members. This should not be burdensome because close monitoring by trustees of these payments or other benefits should be part of the trustee's usual arrangements to deliver good member outcomes.</p>
<p>Default transfer arrangements</p> <p><i>Use and disclosure of default transfer settings</i> – Some trustees automatically classify members as smokers or blue-collar workers when they are transferred from employer plans to personal plans within the same superannuation fund.</p>	<p>Consumers may be defaulted into higher cost insurance when they are transferred from employer plans to personal plans within the same superannuation fund.</p> <p>The returns on members' superannuation balances may be eroded by higher premiums. Members may pay premiums at rates that do not reflect their risk.</p>	<p>Trustees should avoid applying defaults classifying members as smokers or blue-collar workers in the absence of other information about a member or group of members. ASIC will seek confirmation from trustees that appropriate changes to default transfer arrangements are being made. This includes ensuring that trustees:</p> <ul style="list-style-type: none"> – change arrangements for members who are already paying premiums based on inappropriate default settings – communicate the effect of these changes – review current and past practices to determine if they need to take any action regarding existing members.

Appendix 2: Accessible versions of figures

This appendix is for people with visual or other impairments. It provides the underlying data for each of the figures included in this report.

Table 2: Average time taken by trustees to finalise complaints relating to insurance claims (FY 2015–16)

Average time	Percentage
Under 45 days	28%
45–90 days	49%
Over 90 days	23%

Note: This table sets out the data in Figure 1.

Table 3: Average time taken by trustees to finalise complaints relating to insurance claims (FY 2017–18)

Average time	Percentage
Under 45 days	32%
45–90 days	36%
Over 90 days	32%

Note: This table sets out the data in Figure 2.

Table 4: Insurer rebates and benefits

Rebates and benefits	Percentage
Rebates and benefits not provided	65%
Other benefits provided	20%
Rebates provided	15%

Note: This table sets out the data in Figure 3.

Table 5: Percentage of adults who are daily smokers

Year	Percentage
1995	23.8%
2001	22.4%
2014–15	14.5%

Note: This table sets out the data in Figure 4.

Key terms

AFCA	Australian Financial Complaints Authority
Code	Insurance in Superannuation Voluntary Code of Practice
Corporations Act	<i>Corporations Act 2001</i> , including regulations made for the purposes of that Act
IDR procedures	The internal dispute resolution procedures/ processes that meet the requirements and approved standards of ASIC under RG 165
PDS	Product Disclosure Statement – A document that must be given to a retail client for the offer or issue of a financial product in accordance with Div 2 of Pt 7.9 of the Corporations Act Note: See s761A for the exact definition.
rebate	A payment, premium adjustment or profit-sharing arrangement between a trustee and insurer based on the claims experience of the superannuation fund
REP 529 (for example)	An ASIC report (in this example numbered 529)
RG 165 (for example)	An ASIC regulatory guide (in this example numbered 165)
s101 (for example)	A section of the SIS Act (in this example numbered 101), unless otherwise specified
SIS Act	<i>Superannuation Industry (Supervision) Act 1993</i>
superannuation fund	Has the meaning given in s10(1) of the SIS Act
TPD insurance	Total and permanent disability insurance – A life insurance policy that pays a lump sum benefit if the policy holder becomes injured or ill or is unable to work again
trustee	The trustee of a registrable superannuation entity

Related information

Headnotes

claims handling, complaints handling, default transfer arrangements, disclosure, insurance, rebates, superannuation

Legislation

Corporations Act

SIS Act

ASIC documents

[RG 165](#) *Licensing: Internal and external dispute resolution*

[REP 498](#) *Life insurance claims: An industry review*

[REP 529](#) *Member experience of superannuation*

[REP 587](#) *The sale of direct life insurance*