ASIC
Australian Securities & Investments Commission

Default insurance in superannuation: Member value for money

Report 675 | December 2020

About this report

This report shares insights from ASIC's work on metrics for measuring the value for money that members receive from default insurance offered through superannuation. Superannuation trustees should reflect on our findings to improve how they measure member outcomes.

This report forms part of ASIC's broader work on insurance in superannuation.

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About ASIC regulatory documents

In administering legislation ASIC issues the following types of regulatory documents: consultation papers, regulatory guides, information sheets and reports.

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.

Executive summary

Many Australians hold life insurance through superannuation. Almost 10 million superannuation accounts have insurance attached. Default insurance provides financial protection from death or disability to millions of Australians. It allows risks to be pooled in a way that can keep costs down and it provides cover to consumers who may not otherwise have it.

Superannuation trustees play a central role in designing default insurance and negotiating with insurers on behalf of their members. In 2019–20, trustees paid about $4.1 billion on behalf of their MySuper members for insurance. By way of comparison, trustees paid $4.0 billion in administration and investment expenses.

Note: These figures were sourced from unpublished data from the Australian Prudential Regulation Authority (APRA).

We estimate that 86% of superannuation members with insurance are on the default settings. Many superannuation members are not even aware that they have insurance through their superannuation, or that they are paying for it. Those who are aware may be deterred from engaging with their insurance because they find design features, terms and conditions, and pricing difficult to understand.

Note: See Productivity Commission, *Superannuation: Assessing efficiency and competitiveness*, report, January 2019, p. 385; Report 673 *Consumer engagement in insurance in super* (REP 673).

We are releasing this report to help superannuation trustees promote the best interests of their members with default insurance and deliver good value for money. We are sharing insights from our work and outlining what trustees can do better to meet their existing and new regulatory obligations for insurance in superannuation. Trustees are implementing the Insurance in Superannuation Voluntary Code of Practice, undertaking member outcomes assessments under APRA prudential standards, and preparing for the design and distribution obligations (from 5 October 2021). Our aim is to add to this existing momentum to improve trustees' practices around default insurance design and pricing.

Our work on insurance in superannuation

This report builds on our broader program of work on insurance in superannuation. This includes examining how the industry is adopting the Insurance in Superannuation Voluntary Code of Practice, our report on consumer outcomes from total and permanent disability (TPD) insurance claims, and our work on trustee practices relating to occupational default categories.

Note: See Report 646 *Insurance in superannuation 2019–20: Industry implementation of the Voluntary Code of Practice* (REP 646); Report 633 *Holes in the safety net: A review of TPD insurance claims* (REP 633); Media Release (20-309MR) *Trustees to improve occupational classification practices in insurance in superannuation* (3 December 2020).

Throughout this work, ASIC is challenging superannuation trustees to focus on their fundamental duty to act in the best interests of members when designing and negotiating their insurance offering.

In this report we present the findings from our project on measuring member value for money. We have explored metrics relevant to the value for money that superannuation members receive from default insurance provided by superannuation trustees. We compared value across group insurance policies, with a focus on the outcomes members are receiving – both at the trustee level and for distinct groups of members within a trustee's membership.

ASIC sourced data from a broad spectrum of the industry:

Public disclosures	Compulsory notices
20 MySuper products	**11** super trustees
Covering **82%** of MySuper accounts as at 30 June 2020	Covering **40%** of all super accounts with insurance as at 30 June 2019

We collected data to explore how to measure value for money

What **default insurance** do super members have?

How much do members pay for default insurance, and what **benefits** do they get?

We found that:

There is wide variation in the design and pricing of default insurance

Insurers expect to pay about 79 cents in claims, on average, for each dollar of premiums

Some groups of members may be receiving relatively low value for money

Trustees should reflect on our findings and consider how they can:

Collect and analyse data to monitor and review member outcomes

Refine the design and pricing of default insurance (including terms and conditions)

… to better meet their regulatory obligations and promote the best interests of their members

In this report, we focus on metrics that can help trustees better analyse and deliver good member outcomes. We have not focused on metrics that can improve decision making by consumers.

We used data on the design and pricing of default insurance obtained from public sources (covering 82% of MySuper accounts at 30 June 2020, according to unpublished APRA data). We also used data on flows of claims and premiums for a six-year period, which we obtained directly from 11 mostly large superannuation trustees (covering about 40% of superannuation accounts with insurance at 30 June 2019).

We explored three types of measures of value for money for each of default death, TPD and income protection cover (see Table 1):

- the unit price of default insurance (the annual cost per $1,000 of default insurance)
- claims ratios (the share of premiums that is returned to members as claims)
- claims-handling indicators (claims acceptance rates, rates of withdrawn claims and disputes, and claim processing times).

Each of these measures has its own strengths and weaknesses, which we have outlined in Table 1. In addition, none of these measures offers a complete picture on its own. This is because:

- most members pay for life insurance over many years or decades, and so the value for money they get over time matters more than value at a single point in time
- different members may need combinations of different types and levels of insurance cover. None of the measures we considered captures how well suited the insurance design is to an individual member
- insurance premiums can erode members' retirement income. This is not dealt with by any of the measures.

An important role for trustees is considering which trade-offs between the different facets of value are best for their insured membership, particularly when designing the default offering.

Table 1: Measures of value for money

Measure	Strengths	Weaknesses
Unit price (i.e. the annual cost per $1,000 of default insurance)	This measure: › adjusts premiums for differences in levels of default insurance › can be easily applied to specific groups of members.	This measure: › is difficult to compare across trustees because it can reflect a range of factors (e.g. differences in the average risk levels of members) › shows cost alone, which may not reflect terms and conditions that affect the likelihood of a claim being paid.

Measure	Strengths	Weaknesses
Claims ratios (accrual or cashflow methods)	This measure: › indicates value for groups of members › reflects factors that influence how much money is paid in claims.	This measure: › is complicated by claims being paid over long periods of time › can be volatile, especially for smaller groups of members › does not isolate the effect of different factors (e.g. average risk levels, policy terms and conditions) that influence how much money is paid in claims.
Claims-handling indicators (e.g. claims acceptance rates, disputes rates)	These measures: › provide a more direct measure of members' experiences when making a claim › can reflect non-financial factors, such as member understanding of the insurance policy.	These measures do not adjust for the money members pay in premiums and thus are not direct measures of value for money.

Our findings

There is wide variation in the design and pricing of default insurance

Across the 20 MySuper products we examined – as at 1 July 2020 – two identical members could receive very different cover, depending on which superannuation product they each have. At the extremes, some MySuper products in our sample offered over 20 times as much default death and TPD cover than others to the same type of member.

Some MySuper products (7 out of 20) also provided default income protection cover, which can sometimes comprise well over half the total insurance premium. These MySuper products collectively represent 43% of member accounts covered by our sample.

The cost of default insurance (i.e. the premium) also differed greatly across our sample. For example, depending on the MySuper product, a 30-year-old woman's total premium could vary by 25 times (from $29 to $732 a year) and a 50-year-old man's by 37 times (from $40 to $1,480 a year). The cost of insurance – while not directly indicative of value – is fundamental to trustee consideration of the affordability of default insurance (e.g. the effect of insurance premiums on the retirement income of beneficiaries).

Some of this variation in cost is due to trustees providing different types of cover as default, as well as the level of cover. But the unit price of cover also varied widely. A 50-year-old man could be paying almost 5 times as much per $1,000 of death and TPD cover in the MySuper product with the highest unit price, compared to the lowest. A 30-year-old woman could be paying over 12 times as much.

Because our analysis is based on comparing the insurance members would receive by default, we applied each trustee's default occupational settings. We used the trustee's light blue-collar occupational category for products where the default category is tailored by employer and no generic default was disclosed.

Many trustees allow members to provide information about their occupation, which may impact the member's premium or level of cover. However, most members do not provide such information and are provided cover on the default occupational setting.

Differences in the composition of each MySuper product's membership – such as the types of occupations members work in – may explain some of the differences in the price per unit of cover. This is because insurers may need to charge higher premiums to cover the cost of claims for a higher-risk group of members, all else being equal. Unit prices can also reflect the generosity of terms and conditions, and for income protection cover can reflect different waiting and benefit periods.

This means that value for money cannot be compared based on premiums alone. The most expensive insurance is not necessarily the worst value, nor the cheapest insurance necessarily the best value.

For more information, see the section on our findings about the variation in default insurance.

Insurers expect to pay about 79 cents in claims, on average, for each dollar of premiums

We used the more detailed data we obtained on claims and premiums over six years from 2013–14 to 2018–19, from 11 mostly large trustees, to measure claims ratios for their members with default insurance (across both MySuper and choice superannuation products). This allowed us to look in some detail at value for money across a range of insurance arrangements and groups of members.

We have primarily considered accrual claims ratios. These compare the premiums members paid in a period to the corresponding claims insurers paid, plus estimates insurers have made for expected future claim payments (for the claims incurred during the period).

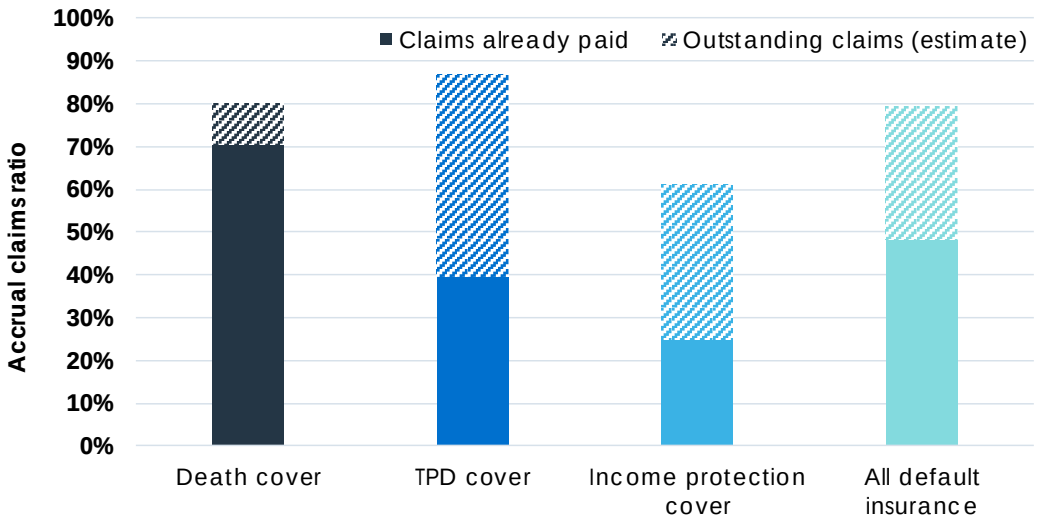
The accrual claims ratio was 79%, on average, over the six years to 2018–19: see Figure 1. This means that insurers expect that members as a whole will ultimately receive 79 cents on average in claim payments for each $1 paid in premiums. The ratio is higher, on average, for TPD cover (87%) and death cover (80%), and lower for income protection cover (61%). Income protection cover most likely has lower claims ratios than death and TPD cover because of the higher costs insurers face in managing regular income payments and periodically assessing whether beneficiaries are well enough to return to work.

Accrual claims ratios contain a degree of subjectivity because they include insurers' estimates of expected future claim payments: see Figure 1. Some claim payments can still be outstanding at the end of a period because of the policy design (e.g. income protection benefits can be paid over multiple years) or because of delays in claim notification (e.g. on average it takes 2.5 years for beneficiaries to notify trustees of TPD claims).

Insurers' estimates of outstanding claim payments, and an understanding of the factors that drive them, are important for monitoring the outcomes that members receive from default insurance. Because these estimates make up a large portion of the accrual claims ratio for recent years, we also considered a cashflow method that compares the dollar value of all premium and claim payments made in a given period.

For more information, see the section on our findings about trustees' claims ratios.

Figure 1: Accrual claims ratios, 2013–14 to 2018–19



Note: See Table 14 for the data shown in this chart (accessible version). Data and estimates are as at 30 June 2019.

Some groups of members may be receiving relatively low value for money

Trustees need to measure and understand the outcomes they are delivering to different cohorts of their members – and the factors that drive these outcomes. They should take into account this understanding when they are designing and pricing their default insurance arrangements.

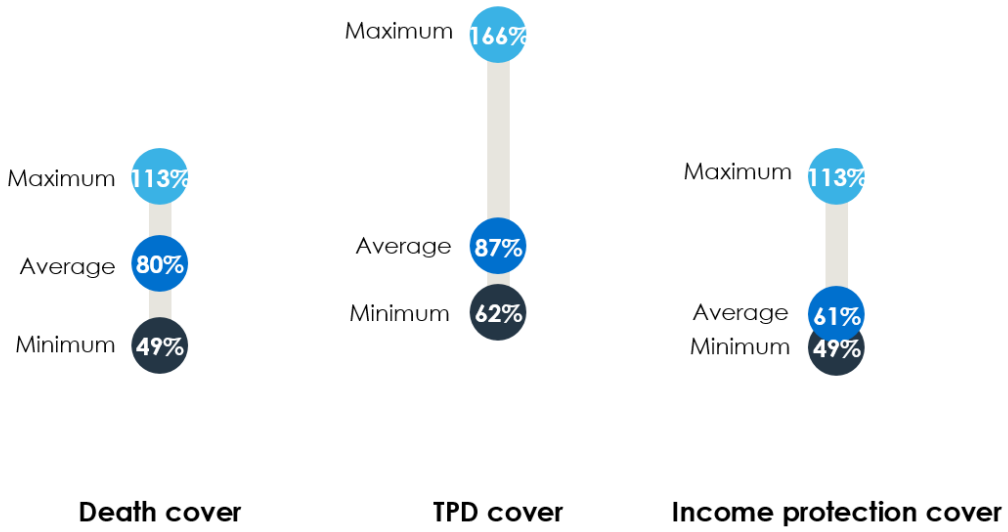
The claims ratios we observed varied significantly across trustees and insurance policies. We found accrual claims ratios that average less than 50% for some trustees, and greater than 100% for others: see Figure 2. The retail trustees in our sample tended to have lower average accrual claims ratios (74% on average) than the not-for-profit trustees (82% on average).

We also found systematic differences in the accrual claims ratio across age cohorts. On average, members aged under 30 appear to have received significantly lower value than older members over the six-year period. This may be an intentional design feature of some group insurance. However, it can also be an unintentional result of levels of risk changing over time without premiums being adjusted in response. Different outcomes between groups of members, such as these, can raise questions about fairness.

Some trustees have since made changes to address imbalances between age cohorts, prompted by the reforms in the *Treasury Laws Amendment (Protecting Your Superannuation Package) Act 2019* (PYSP Act) and *Treasury Laws Amendment (Putting Members' Interests First) Act 2019* (PMIF Act). However, some do not appear to be fully aware of the imbalances.

We also found large differences in claim incident rates across trustees and insurance policies over the six-year period. This rate measures the number of deaths or disabilities that result in a successful claim for every 1,000 members with insurance. Several factors can contribute to claim incident rates, including member demographics, claims handling processes, and aspects of insurance policy design, such as the presence of restrictive terms and conditions.

Figure 2: Range of accrual claims ratios across trustees, 2013–14 to 2018–19



Note: See Table 15 for the data shown in this chart (accessible version).

Our analysis shows that insurance policies with relatively low claim incident rates for death and TPD cover tend to also have relatively low claims ratios, on average over the six-year period. This relationship is statistically significant. There is no clear relationship for income protection cover. It suggests that members in policies with relatively low death or TPD claim incident rates may not always pay commensurately lower premiums.

For more information, see the section on our findings about outcomes across groups of members.

Claims-handling indicators provide further insights into member value and potential harm

Superannuation trustees need to consider a range of indicators of member value and potential harm when monitoring member outcomes. They should consider these indicators when designing and reviewing their default insurance arrangements. They need to look beyond the claims ratio in assessing how well an insurance policy meets the needs of their membership, and in identifying and monitoring risks of member harm.

Member harm can arise due to restrictive terms and conditions in the insurance policy that make it more difficult for some groups of default insured members to make a claim. There are also risks of harm in the way trustees and insurers handle claims. For example, a high number of withdrawn claims or disputes, or long claim processing times, could indicate frictions in the claims process. These frictions can make the claims process difficult or distressing for beneficiaries to navigate.

We found large variation in rates of declined claims, withdrawn claims, disputes and claim processing times among the 11 trustees in our sample. However, none of these indicators were systematically correlated with claims ratios.

For more information, see the section on our findings about claims-handling indicators.

Trustees have shortcomings in data and analysis

Many of our conclusions are limited because of limitations in the data we received from trustees. Most trustees we sought data from found it challenging to provide all the data we required. Those with the most complicated insurance designs and product structures tended to face the most issues. We asked for data by the end of February 2020, but many trustees required extensions. Almost all had to make resubmissions after we asked questions about their data. The process took place over several months and was extended due to the impacts of the COVID-19 pandemic.

Some trustees were unable to accurately identify default insured members – that is, members who had not opted out of (or changed) any part of the default insurance offering. Some trustees also appear not to routinely analyse the outcomes their default insured members are receiving, and some struggled to explain patterns we saw in the data they provided to us. Trustees need to be able to clearly identify which members are on default settings in order to assess whether the trustee's default arrangements are delivering value for money. This will also help them evaluate whether groups of members having different insurance arrangements are being treated fairly.

For more information, see the section on our findings about trustees' data and analysis capabilities.

How trustees can better monitor value for money

Trustees should reflect on the findings in this report. The pivotal role trustees play in designing default cover and buying insurance on behalf of their members means that they need to be accountable for the outcomes their members receive.

We have set out below a list of what trustees can do better to monitor and deliver value for money for their members with default insurance. This includes taking meaningful steps to consider the design of their default insurance and building better systems and processes. Trustees need to proactively consider how they can best provide default insurance that meets members' needs and is both affordably and sustainably priced.

We acknowledge that the industry is in a period of significant change. Trustees and insurers have recently implemented the reforms in the PSYP Act and PMIF Act. They are also dealing with the impacts of the COVID-19 pandemic.

Trustees also face new regulatory obligations. APRA's Prudential Standard SPS 515 *Strategic planning and member outcomes* came into effect on 1 January 2020. Under SPS 515, trustees are required to regularly assess the outcomes provided to members and identify opportunities for improving these outcomes. This complements their obligations to undertake annual outcomes assessments under s52(9) of the *Superannuation Industry (Supervision) Act 1993* (SIS Act).

From 5 October 2021, the design and distribution obligations (introduced under the *Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Powers) Act 2019*) will take effect. These obligations will require the industry to design fit-for-purpose products that meet consumer needs, and to take steps to ensure their products are reaching the right consumers. Trustees will need to ensure that insurance arrangements are considered when identifying the target market for a choice offering. This remains the case where the trustee has the same insurance arrangements across their MySuper and choice offerings.

Note: See Regulatory Guide 274, *Product design and distribution obligations* (RG 274).

Superannuation trustees also need to improve the standard of data they collect about their members. APRA's Superannuation Data Transformation project and industry-led data initiatives should help to accelerate progress in this area.

Trustees should collect and analyse data to monitor and review member outcomes

They should proactively consider how to better:

- assess whether members' needs are being met and they are receiving value for money
- identify where risks of low-value outcomes (or member harm) may be emerging
- understand what outcomes each cohort of their membership is receiving from a group insurance arrangement and why these outcomes may differ across cohorts.

See Box 1 for ways that trustees can use data.

Trustees should proactively consider how they can refine the design and pricing of default insurance (including terms and conditions)

They should use their analysis to take action to:

- better meet members' needs
- reduce the risk of low-value insurance.

Trustees should periodically reflect on whether different arrangements with their insurer or a different insurer could:

- deliver better value for money in a way that is sustainable over time, and/or
- provide insurance that better meets members' needs.

Box 1: How trustees can use data to monitor and review member outcomes

Trustees should, at a minimum, segment their membership by whether or not members have default cover and by demographic characteristics (e.g. age, gender, occupation category and work status).

For each member cohort, they should monitor:

- the level of premiums and consequent balance erosion
- claims ratios
- other claim-related indicators (such as claim incident rates and claims handling measures).

To support this analysis, trustees should:

- collect data on their members' insurance needs, demographic characteristics (such as work status) and claim outcomes

- compare their members' outcomes to industry-wide measures (e.g. the claims-related statistics published by APRA) and to other trustees, where that data is available (e.g. through industry-led data initiatives)
- consider embedding detailed data-sharing arrangements in service-level agreements with insurers so that trustees can access the data required to monitor member outcomes
- appropriately challenge the assumptions insurers are making about their membership in the process of negotiating premiums, terms and conditions (drawing on external expertise where necessary)
- seek updates on how their insurers are improving their own data management practices. Trustees should use the expectations ASIC set out in REP 633 as a guide.

ASIC will continue to engage with trustees

Superannuation trustees often need to design default insurance with incomplete data on their members. In doing so, they must make complex trade-offs and judgements – they must balance the affordability of premiums, the level of cover and the generosity of terms and conditions. We note that many trustees have made improvements to their default insurance design or pricing in the past 18 months.

The actions set out above can help trustees make these trade-offs. They can also help trustees to comply with their existing and new regulatory obligations, including the member outcomes assessments under SPS 515 and the design and distribution obligations.

We will continue to engage with trustees across the industry during 2021. Our aim is to understand what progress is being made towards better monitoring member outcomes and value for money. We will seek information from trustees on changes they are making. We will also follow up with selected trustees where we have concerns about the clarity or consistency of their public disclosure materials and will communicate with the market to clarify requirements if necessary.

New regulatory requirements taking effect in 2021 will provide further focus for ASIC's engagement, as well as additional regulatory powers.

Default insurance through superannuation

Default insurance matters because it is so widely held

Almost all superannuation trustees provide insurance to their members. Trustees must generally offer death and permanent incapacity insurance benefits to members in a MySuper product on an opt-out basis: see s68AA of the SIS Act. Most do so by providing default death and TPD cover. Many trustees also choose to provide default income protection cover to MySuper members, as well as default insurance to members in choice superannuation products.

Many members are not aware that they have insurance through their superannuation, or that they are paying for it. While trustees give their members flexibility to change their insurance, relatively few members exercise the option to change. Some may be deterred from engaging as a result of finding design features, terms and conditions, and pricing difficult to understand. Low engagement can also be compounded by behavioural biases, and by the complexity of comparing the wide variety of default insurance offered across different superannuation funds and products.

Note: For more background information on default insurance, see REP 646 and REP 673.

Trustees play a powerful role in shaping members' outcomes from default insurance. Most members do not take active steps to select a superannuation fund or product, or make choices about the insurance attached to their superannuation product.

The law limits *how* trustees can offer insurance. In addition to the general obligation to ensure financial services are provided efficiently, honestly and fairly (see s912A(1)(a) of the *Corporations Act 2001* (Corporations Act)), trustees must:

- perform their duties in the best interests of members (see s52(2)(c) of the SIS Act)
- act fairly when dealing with classes of beneficiaries, and with beneficiaries within a class (see s52(2)(e)–(f) of the SIS Act)
- formulate, review regularly and give effect to an insurance strategy that relates to the kind and level of insurance and has regard to the demographic composition of beneficiaries (see s52(7)(a) of the SIS Act)
- only offer insurance if the cost does not inappropriately erode the retirement income of beneficiaries (see s52(7)(c) of the SIS Act)
- annually assess whether the insurance strategy for each MySuper and choice superannuation product is appropriate for the beneficiaries and whether any insurance fees charge inappropriately erode the retirement income of beneficiaries (see s52(11) of the SIS Act)

Note: This requirement was inserted into the SIS Act in 2019. It is complemented by requirements set out in SPS 515, which came into effect on 1 January 2020.

- comply with Prudential Standards made by APRA. These standards, among other things, prescribe governance requirements – this includes a board-approved insurance management framework, insurance strategy and generally the appointment of an external insurer (see Prudential Standard SPS 250 *Insurance in superannuation*).

The legal and regulatory framework affords trustees discretion in how they design default insurance for their members. They are responsible for decisions that go to the trade-offs between the type and level of cover, terms and conditions, affordability of premiums and choice of insurer. Trustees often need to make these decisions with access to only limited data on their members' personal circumstances and needs, such as their work status or financial circumstances.

Challenges the industry is facing

We recognise that the regulatory regime for insurance in superannuation has been in a dynamic phase recently. In addition to managing the impacts of the COVID-19 pandemic, superannuation trustees have been:

- responding to the findings of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Royal Commission) and Productivity Commission's inquiry into superannuation

Note: Royal Commission, *Final report: Royal Commission into misconduct in the banking, superannuation and financial services industry*, January 2019, and Productivity Commission, *Superannuation: Assessing efficiency and competitiveness*, report, January 2019.

- adjusting to changes in the structure of the life insurance industry. Some large insurers have been sold by their banking group owners and/or purchased by other large insurers
- implementing the reforms under the PYSP Act and PMIF Act. These reforms removed default insurance from a significant number of superannuation accounts – those that had been inactive for at least 16 months or where the balance was below $6,000 in November 2019 (and the member did not opt to retain insurance)
- continuing implementation of the Insurance in Superannuation Voluntary Code of Practice. This code of practice caps premiums for default insurance at 1% of estimated salary (for the membership generally and segments within it)
- making changes to some group insurance policies to remove restrictive TPD definitions. This is in response to REP 633
- commencing business performance reviews and member outcome assessments under SPS 515
- preparing for the design and distribution obligations, which will take effect from 5 October 2021.

Some of these changes have also affected the life insurers who provide group insurance to superannuation trustees.

The current period of change is an opportunity for industry to improve. Trustees can build better systems and processes to promote the best interests of superannuation members. We are sharing the insights from our project to help trustees better measure value for money in insurance in superannuation. This will in turn help trustees meet their existing and new regulatory obligations.

Value for money is about more than monetary cost

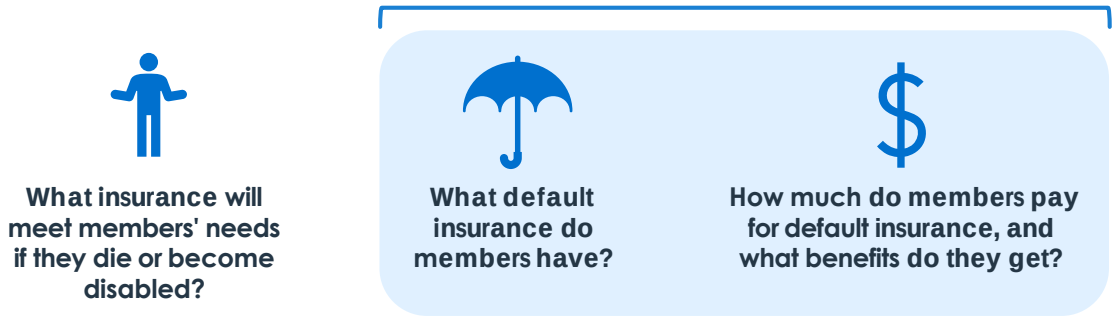
Default insurance offers value by providing members (or their dependants) financial support in the event they die or become too disabled to work. How much support an individual would need can depend on a wide range of factors. These include:

- their financial commitments (e.g. whether they have dependent children or a mortgage)
- other forms of financial support that can be accessed if they die or become disabled (such as a partner's income, government benefits or workers compensation payments).

In designing default insurance arrangements, trustees must make judgements about what cover is appropriate for their members, recognising that not all members are alike. They must make these judgements with limited information about members' individual circumstances (aside from age, gender and superannuation contributions).

In this report, we have not sought to quantify how much insurance members need. Rather, we have focused on metrics that provide insight into the **value for money** that members get from default insurance. The value members get depends on the insurance that trustees provide to them, how much they pay in premiums, and the benefits they receive.

Importantly, members do not need to receive a claim payment in order to receive value for money from their insurance in superannuation. After all, only a small proportion of members die prematurely or become disabled. Insurance is valuable because it offers protection against risks that could occur, even though those risks are unlikely to be realised for any particular individual.



We have specifically examined how value for money can be quantified and compared across different groups of members. We also looked at how value can vary over superannuation products and over time.

It is challenging to quantify value, because what members get from default insurance has many aspects. For example:

- the types of cover that are provided (e.g. death, TPD or income protection cover)
- the level (sum insured) of each type of cover
- the terms and conditions that limit when a claim can be paid (or exclude some members from being able to claim at all)
- how well trustees and insurers process claims and help members through the claims journey.

In making judgments about what default insurance to provide, trustees also need to weigh the value of insurance against the impact insurance premiums will have on their members' retirement income.

In the following sections, we explore how some aspects of value can be measured quantitatively. However, no single metric can capture every aspect that matters to members.

There is wide variation in the design and pricing of default insurance

We examined how much default insurance a set of representative members would receive and the premiums they would pay in a range of widely held MySuper products. The representative members were based on different combinations of age (25, 30, 40 and 50) and gender.

Because our analysis is based on comparing the insurance members would receive by default, we applied each trustee's default occupational settings (using the trustee's light blue-collar category for products where the default category is tailored by employer and no generic default was disclosed). This means that one of the factors that influences price, occupational risk rating, varied across the MySuper products. Many trustees allow members to provide information about their occupation, which may impact the member's premium or level of cover. However, most members do not provide such information and are provided cover on the default occupational setting. We have examined the use of occupational defaults by trustees in other recent work: see 20-309MR.

Our data is drawn from publicly available disclosures on the standard default insurance in 20 MySuper products offered by trustees of large funds: see Tables 5–10 in Appendix 1. Extracting and analysing this data was difficult. There were a variety of complex arrangements, and information about some of them was presented in a confusing way. We needed to adjust some of the data so we could compare it across MySuper products. Our methodology is set out in Appendix 1, along with the full list of products and more detailed results.

Public disclosures should be clear and consistent to help inform members about their insurance cover and to allow them to make comparisons. We will follow up with trustees if we have concerns about their public disclosure materials. We will communicate with the market to clarify requirements if necessary.

8 representative consumers in **20** MySuper products covering **82%** of all MySuper accounts at 30 June 2020

13 default death and TPD cover only

6 default death, TPD and income protection cover

1 default death and income protection cover only

6 charge a combined premium for death and TPD cover

Two identical members can get very different default insurance

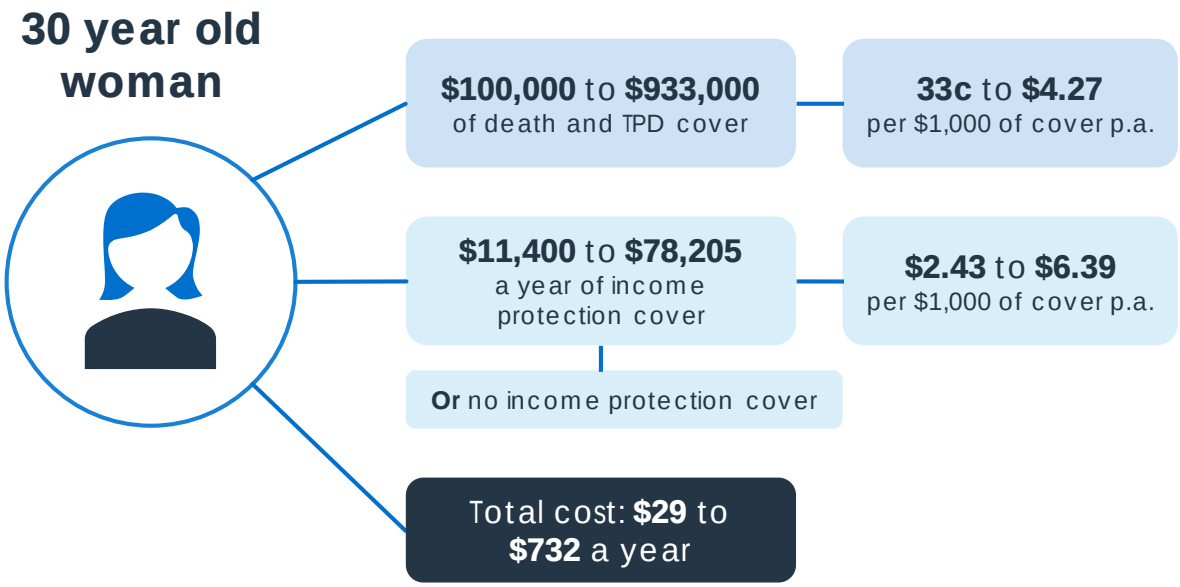
We found that two identical members can pay very different amounts of premiums for very different levels of default insurance cover, depending on which superannuation product they each have. This will often depend on which MySuper product their employer has as its workplace default.

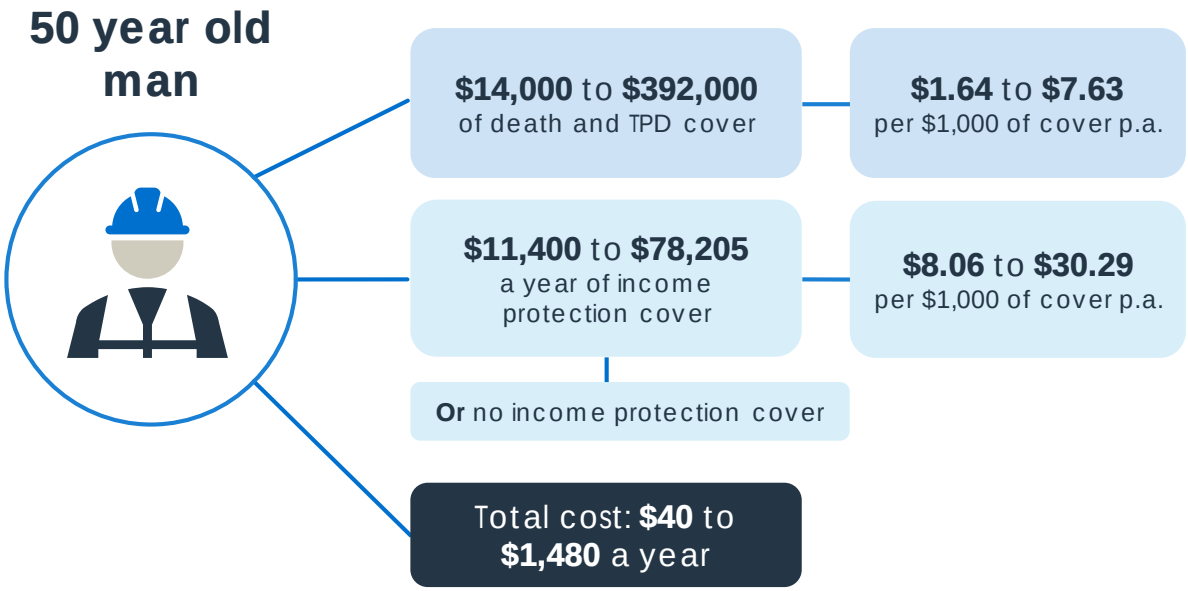
Figure 3 illustrates the range of outcomes we saw for a 30-year-old woman and a 50-year-old man. For two identical 30-year old women, the woman in the product with the highest premiums would be paying a total premium 25 times greater than the woman in the product with the lowest premiums. For two identical 50-year old men, the total premium ranges by a factor of 37. The range is of a similar magnitude for the other representative members we looked at.

Some of the differences we found arise because of the decisions trustees have made about the appropriate type and level of default insurance to provide their members:

- 7 of the 20 MySuper products in our sample provided default income protection cover (43% of member accounts covered by our sample were in these MySuper products). Having income protection cover means a wider range of life events (illnesses or disabilities) are covered by the insurance. In turn, this means members are more likely to be able to claim. However, the cost is material. Default income protection cover accounted for 18% to 73% of the total premium these members pay
- some MySuper products provided much more default death and TPD cover than others. The highest amount was 9 to 27 times the lowest amount (depending on a member's age and gender)
- half the MySuper products in the sample varied the level of default death and TPD cover by age, while half held the level of cover constant.

Figure 3: Default insurance outcomes for a 30-year-old woman and a 50-year-old man





Note: We have provided more detail in Appendix 1, including the method we used to add together death and TPD cover.

We also found considerable differences in the unit price (the annual cost per $1,000 of default insurance: see Table 1. All MySuper products in our sample charged higher unit prices to older members, and some also charged men a higher price than women. This can be justified where some types of members face higher risks of death or disability (on average) than others.

However, the unit price also varied significantly for the *same* representative member depending on which MySuper product they were in. A 50-year-old man could be paying almost 5 times as much per $1,000 of death and TPD cover in the MySuper product with the highest unit price compared to the lowest. A 30-year-old woman could be paying over 12 times as much.

All the MySuper products in our sample with default income protection cover were offered by not-for-profit trustees (although both types of trustees offer default income protection cover in other ways, such as through corporate MySuper arrangements and choice superannuation products). The amount and cost of death and TPD cover did not significantly differ based on whether the MySuper products in our sample were offered by retail or not-for-profit trustees.

Risk levels, terms and conditions, and waiting and benefit periods can affect the unit price of insurance

Several factors may explain the variation in the unit price of default insurance, such as:

- **the composition of a MySuper product's membership.** For example, a MySuper product covering members mainly in heavy blue-collar jobs where the risk of death or disability is high may charge members a higher unit price than a MySuper product that mostly covers office workers that do not have the same level or risk. Some trustees tailor their insurance based on occupational categories, but the classification that applies by default can differ
- **the generosity of terms and conditions.** For example, some policies do not cover pre-existing conditions for certain categories of members (whereas others do cover these conditions). Some policies provide more restrictive cover to members who are unemployed or work in high-risk occupations. Unit prices might be lower in cases such as these (compared to policies without these restrictions) because there is a lower probability of the insurer having to pay claims

- **waiting and benefit periods for income protection cover.** There were five distinct combinations of waiting and benefit periods across the seven MySuper products with income protection cover in our sample. Some MySuper products pay benefits for a maximum of two years, whereas others pay benefits until the beneficiary is aged 60 or 67. A longer benefit period may be associated with a higher unit price.

These factors imply that the most expensive insurance is not necessarily the worst value, nor the cheapest insurance necessarily the best value.

Value for money cannot be compared based on premiums alone, or even the price per unit of cover. Various factors, such as those listed above, also need to be considered. Trustees need to take these into account in considering whether the default insurance design is appropriate for different groups of their members.

Insurers expect to pay about 79 cents in claims, on average, for each dollar of premiums

In this section of the report, we explore the claims ratio. The claims ratio is the amount of benefits received by members – that is, the dollar amount of claims accepted and paid by insurers – expressed as a share of premiums charged to members. This is a measure of value for money that takes a wider range of factors into account than the unit price of insurance: see Table 1.

In this section we examine industry-level trends. In the following section we examine the outcomes for members, comparing across trustees, group insurance policies and cohorts of members.

We measured claims ratios for 11 superannuation trustees

Using ASIC's compulsory notice powers, we obtained data on the largest group insurance policies of 11 superannuation trustees. The data includes payments of premiums and claims for default insured members in both MySuper and choice superannuation products over the six years to 2018–19. This is a more detailed dataset than in the previous section, which covered a different sample of trustees and only considered the largest MySuper product of each trustee. More detail on our methodology can be found in Appendix 2.

We obtained detailed data on premiums and claims from...

11 super trustees with

32 insurance policies insured by

9 life insurers

The data covers

5 million default members

$12 billion in premiums

$7 billion in claims paid over **6** years

These insurance policies cover an estimated **40%** of superannuation accounts with insurance at 30 June 2019

We used the data from the 11 trustees to calculate claims ratios. We consider the claims ratio to be a good indicator of the outcomes members collectively receive, because it is a direct measure of the share of premiums that are returned through claim payments. It takes account of factors that influence how much insurers pay in claims, including:

- the level of insurance (sum insured) that members have
- the risk level of the membership, which influences the probability of claims being made
- the terms and conditions that restrict who can make a claim or the amount that is paid out in a range of circumstances.

We rely primarily on an 'accrual' measure of the claims ratio in our analysis. This involves lining up the premiums and claims associated with a given insurance arrangement (i.e. the number of insured members, levels of default insurance, and terms and conditions in place for a given period). Importantly, the accrual method counts claims that have already been paid, plus an estimate of claims that are still outstanding because they have not yet been notified to the trustee or not yet paid.

Significant changes occurred after the review period

We have discussed our observations on each trustee's data directly with the individual trustees. We did this to better understand their insurance arrangements and the limitations of the data they provided to us.

The data we obtained from trustees does not reflect changes to insurance arrangements that have occurred since July 2019. Some trustees have indicated to us that they have made significant changes to their insurance arrangements or are actively considering changes. We also recognise significant changes occurring across the industry – these are set out in the section on default insurance through superannuation. Most of these changes will continue to have an impact as trustees renegotiate their insurance policies and/or change their insurers.

These changes mean that current and future trends in premiums and claims may look different to those seen in the six years of data we analysed for this report. Industry and regulators will need to consider data for the period after July 2019, including additional data on insurance in superannuation that will be collected by APRA through its Superannuation Data Transformation project, to see how the patterns and trends we report on here evolve over time.

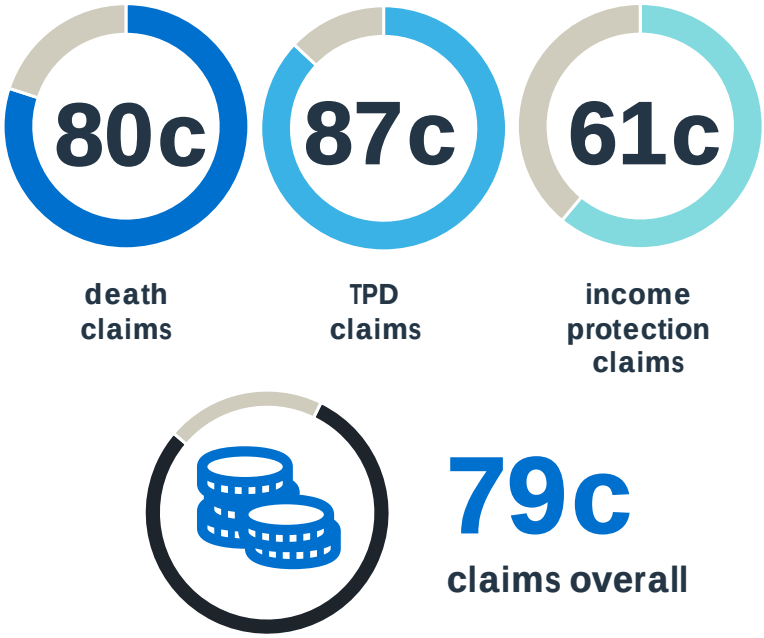
On average, claims ratios are higher for death and TPD cover than for income protection cover

We found an overall average claims ratio of 79% (using the accrual measure) looking across all 11 trustees and 6 years of data. This means that insurers predict that members as a whole will ultimately receive 79 cents in claim payments for each $1 they paid in premiums during this period, on average. The ratio is higher, on average, for TPD cover (87%) and death cover (80%), and lower for income protection cover (61%): see Figure 4.

We expected to find average claims ratios well below 100%. Insurers need to cover expenses associated with handling claims and running their business, pay stamp duties and make a profit for their shareholders. However, in practice, claims ratios can sometimes exceed 100% if claims are greater than expected.

We were also not surprised to find that claims ratios are lower on average for income protection cover. The cost of managing income protection claims may be greater than the cost of managing death and TPD claims. Death and TPD claims are generally only assessed once, whereas income protection claims involve managing regular income payments and periodically assessing whether beneficiaries are well enough to return to work.

Figure 4: Accrual claims ratios (claims per dollar of premiums), 2013–14 to 2018–19



We also found that the accrual claims ratio can vary year by year: see Figure 5. This may be due to changes some trustees made to the design of their insurance arrangements (e.g. increasing levels of cover or making terms and conditions more generous), adjustments to premiums, and trends in the rate of deaths or disabilities across the population in general. The average effect was a decrease in the claims ratio for the first few years – across all three types of cover – followed by a more recent increase.

A significant share of claims is yet to be paid

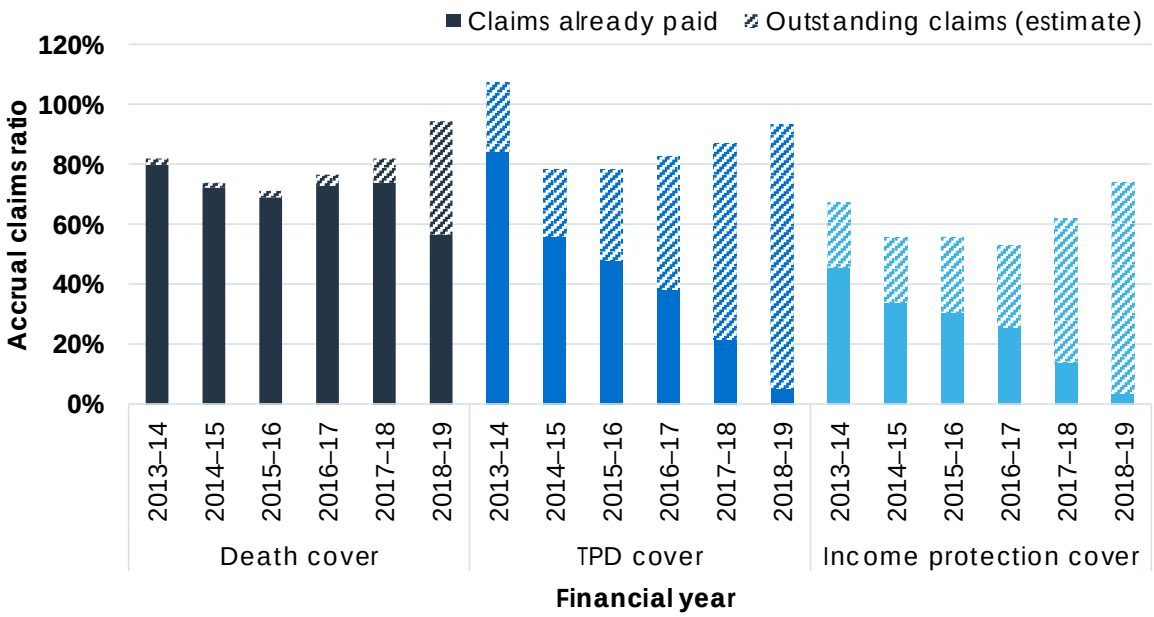
Our data also show that insurers estimate that a significant volume of claims associated with the six-year period had not yet been paid by 30 June 2019: see Figure 5. For TPD and income protection cover in particular, over half of total claims over the period are provisions – meaning that insurers have so far paid less than half the total amount of claims they expect to pay, based on the default insurance arrangements that were in place over the period.

There are two main reasons why claims are often paid out over an extended period:

- delays in claims being notified or assessed – for example, it takes an average of 2.5 years for beneficiaries to notify their trustee of a TPD claim (see Table 2)
- some insurance policies spread payments over time – for example, income protection cover typically pays a benefit each month until a beneficiary is well enough to return to work (with a cap on the total amount of time they can receive a benefit).

Estimates of outstanding claims can make up a relatively high share of claims for more recent years (where there has not been as much time for claims to be paid). This can make the accrual claims ratio prone to fluctuation as estimated claims are revised over time – in other words, the amount of money ultimately paid out in claims could be higher or lower than insurers had previously estimated. However, once a long enough period of time has passed, the share of estimated claims as a portion of the total will shrink and the accrual claims ratio will be known with more certainty.

Figure 5: Accrual claims ratios over time



Note: See Table 16 for the data shown in this chart (accessible version). Data and estimates are as at 30 June 2019.

Table 2: Estimated average delay between claims being incurred and notified to trustees

Type of cover	Average notification delay (years)
Death cover	0.7
TPD cover	2.5
Income protection cover	0.9

Note: The methodology used to estimate average notification delays is set out in Appendix 2.

There are alternative ways to calculate claims ratios, but these also have limitations:

- Cashflow claims ratios can be calculated by using financial flows of claim and premium payments each year (where the claim payments may relate to insurance arrangements in place across a number of past years). However, the cashflow method may result in significantly lower claims ratios, particularly if the level of insurance or number of insured members is increasing over time (see Box 2 and Figure 6).
- Accrual claims ratios can be calculated without the estimates of outstanding claims – that is, by using only the portion of claims that have already been paid (in relation to a given period). This will produce a lower claims ratio. Our analysis suggests that across the trustees in our sample, excluding the estimates of outstanding claims for death and TPD cover does not significantly change the ranking of most trustees relative to the others (except for 2018–19, the most recent year, where the estimated component is large).

Note: Further detail on our methodology and analysis is provided in Appendix 2.

Box 2: Claims ratios are typically lower using the cashflow method

An alternative way to calculate claims ratios is using the cashflow method. This method compares the financial flows of claim and premium payments that are made in a given period, regardless of when the deaths or disabilities giving rise to those claims occurred.

We also calculated claims ratios using the cashflow method. The ratios we calculated are similar to those published by APRA for selected years at an industry-wide level for death and TPD cover. However, they were lower for income protection cover due to methodological differences: see Appendix 2.

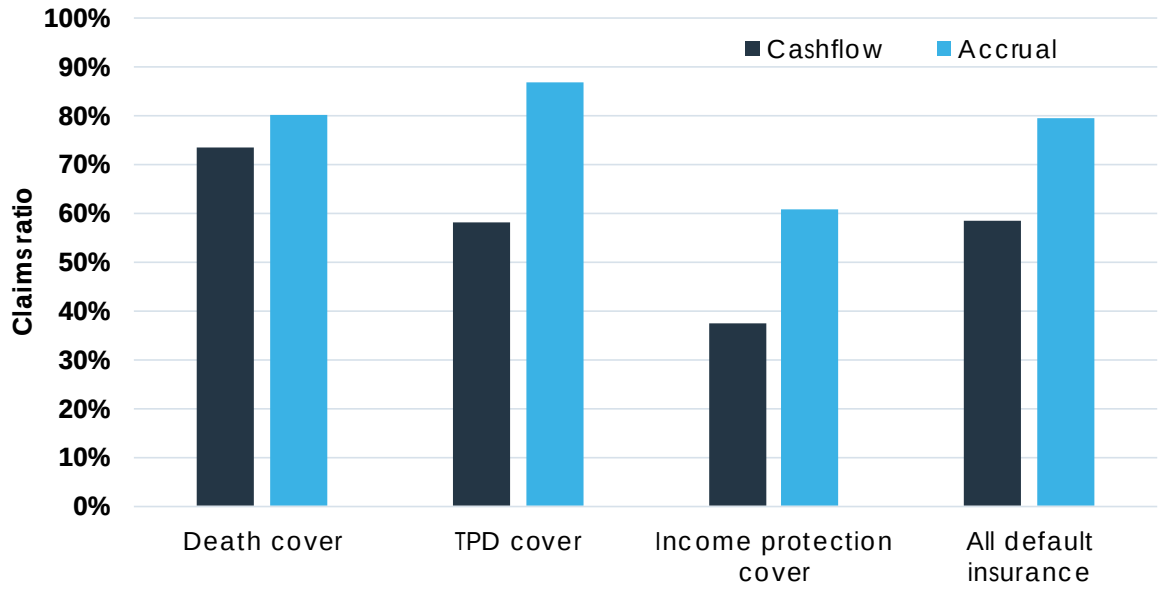
The cashflow claims ratio has the advantage of being objective (not requiring estimates) and administratively simpler to calculate because it makes use of financial flow data. It is simply the amount of money paid in claims during a given year divided by the premiums collected.

The disadvantage is that payments being made in any given year can relate to a mixture of both current and past insurance arrangements. This makes the cashflow claims ratio hard to interpret where insurance arrangements have changed over time (e.g. because of changes in the number of members, level of cover, claim incident rate or delays in beneficiaries notifying a claim).

The cashflow claims ratios we calculated using our data are lower than the accrual claims ratios, both on average and for most individual trustees. The overall average for the cashflow claims ratio is 58% across the 11 trustees and six years of data, compared to 78% for the accrual claims ratio: see Figure 6. The difference is particularly large for TPD cover and income protection cover. These have cashflow claims ratios of 58% and 37% respectively, which is 28 and 24 percentage points lower than the accrual claims ratio.

Cashflow claims ratios were lower than accrual claims ratios because of the way claim payments are measured. The cashflow method will capture claim payments made in a given year that relate to insurance arrangements in place in previous years, whereas the accrual method will capture estimates of future (outstanding) claim payments. The latter is usually greater if there are increases in default levels of cover or in the number of insured members over time. Differences can also emerge when the design of insurance arrangements has changed.

Figure 6: Accrual and cashflow claims ratios, 2013–14 to 2018–19



Note: See Table 17 for the data shown in this chart (accessible version).

Trustees need to monitor outstanding claims

As insurers are liable for outstanding claims, insurers (rather than superannuation trustees) typically calculate these estimates and make provisions to cover the cost of expected future claims. However, these estimates are necessary for calculating accrual claims ratios. Therefore, they can help trustees monitor the outcomes they are delivering for different cohorts of their members through default insurance arrangements. Trustees can use this information to understand whether current premium levels are likely to be sustainable over time. This, in turn, can help trustees in considering whether members are receiving value for money and identifying where changes may be warranted to the design of their arrangements.

It is therefore important for trustees to seek information from their insurer on the estimate of outstanding claims and to analyse factors that may impact the size of this estimate. This includes monitoring:

- changes in the timing of claim payments (e.g. due to members taking longer to notify the trustee of a claim, or spending a longer amount of time on income protection benefits due to a slow recovery from illness or injury)
- why actual claim payments may ultimately end up higher or lower than previously expected
- what assumptions insurers are making about their membership in the process of negotiating premiums, terms and conditions.

Some groups of members may be receiving relatively low value for money

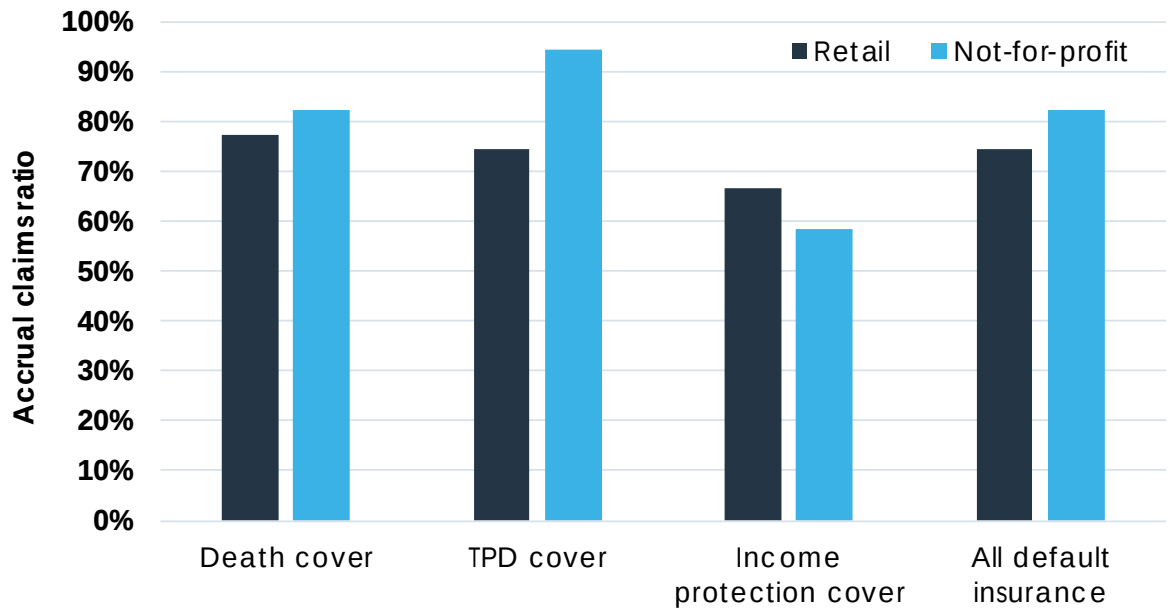
In this section, we look at how value for money (measured by the accrual claims ratio) varies across the 11 trustees in our sample and across specific groups of their members. We are presenting this analysis to emphasise the importance of trustees measuring and understanding the outcomes they are delivering to different cohorts of their members – and the factors that drive these outcomes. Trustees should take into account this understanding when they are designing and pricing of their default insurance arrangements.

Claims ratios vary significantly across trustees, insurance policies and groups of members

We found significant variation in the accrual claims ratios (averaged over the six years) across trustees, their individual group insurance policies, and groups of members within them. Even among our sample of mostly large trustees, we found accrual claims ratios that averaged less than 50% or greater than 100% over the six years from 2013–14 to 2018–19: see Figure 2 in the Executive Summary.

On average, we also saw higher accrual claims ratios for death and TPD cover among the not-for-profit trustees in our sample compared to the retail trustees, on average over the six years. We found that retail trustees had higher accrual claims ratios for income protection cover, on average, but with more variation year to year. Across all default insurance, the accrual claims ratio is slightly higher for not-for-profit trustees in our sample, on average: see Figure 7.

Figure 7: Accrual claims ratios for retail and not-for-profit trustees, 2013–14 to 2018–19



Note: See Table 18 for the data shown in this chart (accessible version).

The range of claims ratios is even larger when we looked at individual group insurance policies held by each trustee: see Figure 14 in Appendix 2. Group insurance policies often represent distinct groups of members, such as those associated with a specific superannuation product or large corporate arrangement. We found many examples of above-average claims ratios, suggesting that members in these insurance policies were collectively receiving good value for money. However, in a handful of cases we found claims ratios consistently exceeding 100%. This implies that the insurance design or pricing may be unsustainable.

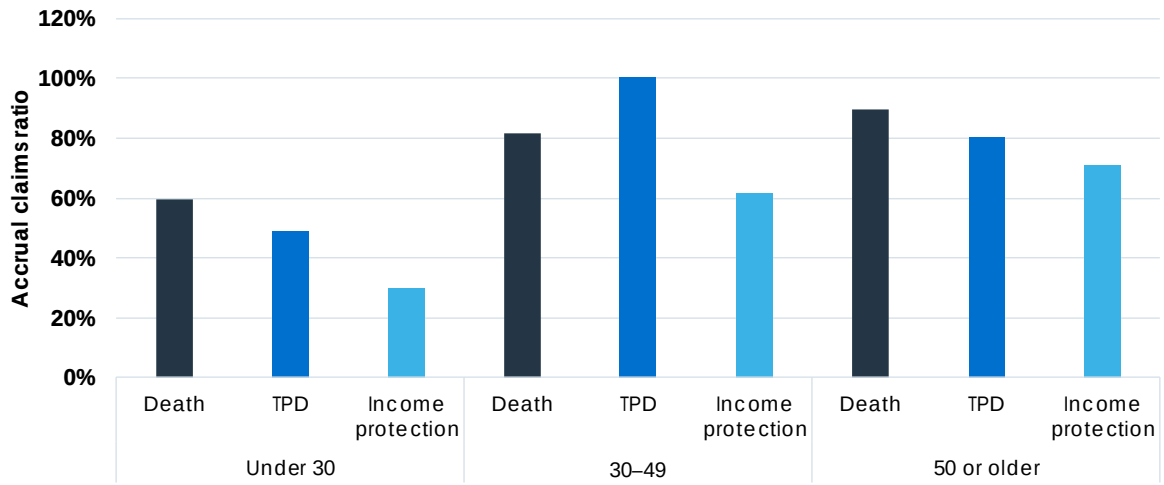
We also found evidence that some groups of members may have been receiving poor value for money from default insurance. Specifically, we found several instances of claims ratios that are consistently and significantly lower than average, for certain group insurance policies, or for specific groups of members.

We found that members aged under 30 received much lower value than older members, on average, over the six years to 2018–19. We found significant differences between age cohorts across many individual policies and in aggregate: see Box 3 and Figure 8.

Trustees need to monitor outcomes across groups of their members. A systematically lower claims ratio can be an indication that an insurance design may not be appropriate for a specific group (e.g. because few members are able to successfully claim on it) or that the premiums are persistently high compared to the amount of money that is expected to be paid out in claims.

If a group insurance arrangement is structured so that one group of members is charged higher premiums that effectively pay some of the cost of claims for other groups of members, this raises questions about fairness. This is especially the case where there are alternative ways in which the arrangement could be structured.

Figure 8: Accrual claims ratios by age cohort



Note: See Table 19 for the data shown in this chart (accessible version).

Box 3: Fairness between groups of members

Superannuation trustees provide default insurance for large and diverse groups of their members. In doing so, most differentiate the premiums they charge or level of cover they provide to individual members by age, gender and/or type of occupation.

Questions about fairness between groups of members can arise when one group has a systematically lower claims ratio than others. This indicates that premiums are high compared to the dollar amount of claims that insurers will pay (a proxy measure for the level of risk). It also indicates that the members are effectively paying some of the cost of claims for other groups of members. This is an intentional design feature of some group insurance. However, it can also be an unintentional result of levels of risk changing over time without premiums being adjusted in response.

We asked trustees to disaggregate their data into three broad age cohorts: members aged under 30, members aged 30–49, and members aged 50 or older (this included also disaggregating the estimates of outstanding claim payments). Our analysis shows that members aged under 30 have systematically lower accrual claims ratios, on average, than those aged over 50 – and thus are receiving less value for money based on this measure: see Figure 8. Most, but not all, of the trustees in our sample had claims ratios that systematically differed between age cohorts.

Some trustees explained that they have recently sought to address imbalances between different age cohorts. Many were prompted to do so by the reforms in the PYSP Act and the PMIF Act. However, other trustees did not appear to be fully aware of the imbalances between groups of their members.

Claim incident rates may explain some of the differences

We have considered factors that may help explain why some groups of members receive lower value for money than others, as measured by the accrual claims ratio over the six years to 2018–19. We do not have detailed information on the demographic composition of each trustee's members (other than the age cohort data discussed above). However, we do have data on the claim incident rate – that is, the number of deaths or disabilities that result in a successful claim each year for every 1,000 members with insurance.

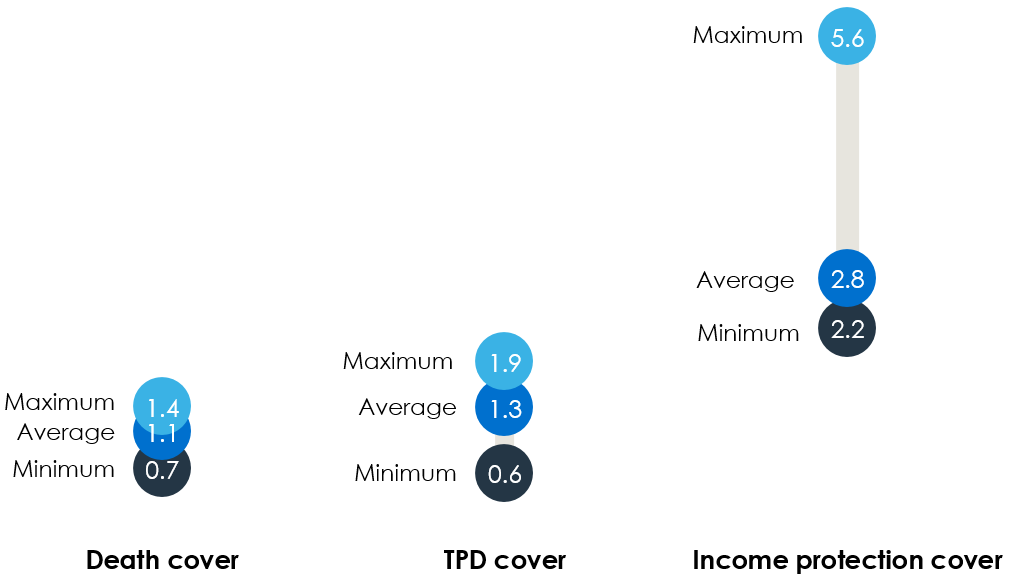
Claim incident rates are typically higher in our data for income protection cover (averaging 2.8 claims each year for every 1,000 insured members) than for death cover (1.1 claims per 1,000 members) and TPD cover (1.3 claims per 1,000 members). We had expected to see more claims made against income protection cover because temporary disabilities are more common than deaths or total and permanent disabilities.

We found large differences in claim incident rates across trustees and insurance policies: see Figure 9. On average, not-for-profit trustees in our sample had higher death and TPD claim incident rates, and retail trustees in our sample had higher income protection claim incident rates. We have focused on the full six-year period in this analysis because there can be some volatility on a year-to-year basis, especially for smaller group insurance policies.

Our discussions with trustees suggest the differences we found in claim incident rates across trustees and group insurance policies could be due to differences in:

- the risk level of the membership, which reflects demographic factors such as average age and the mix of occupations
- the terms and conditions in the insurance policy – for example, more restrictive conditions for members in high-risk occupations that prevent them from making a successful claim, or exclusions for deaths and disabilities related to a pre-existing condition
- for income protection cover, the length of the waiting period that must elapse before a claim can start being paid (during which time some beneficiaries may recover).

Figure 9: Range of claim incident rates (number of claims per 1,000 insured members per year) across trustees, 2013–14 to 2018–19



Note: See Table 20 for the data shown in this chart (accessible version). The range of claim incident rates across group insurance policies is shown in Figure 15 in Appendix 2.

Our analysis also shows that insurance policies with relatively low claim incident rates for death and TPD cover tend to also have relatively low claims ratios, on average over the six-year period.

Specifically, we found a statistically significant relationship between the claim incident rate and the accrual claims ratio for death and TPD cover on average, but not for income protection cover. This may reflect the wider range of designs for income protection cover, which complicate comparisons. We did not find evidence of a relationship between accrual claims ratios and the average size of claims.

The relationship between claim incident rates and accrual claims ratios for death and TPD cover suggests that members in policies with relatively low claim incident rates (i.e. where relatively few members make a successful claim) do not always pay commensurately lower premiums. It also implies that insurance policies covering members with higher average risks tend to have higher accrual claims ratios, on average.

However, it is possible that the relationship may also reflect other factors. For example, how often trustees and insurers adjusted premiums over the six-year period, or alternatively, the presence of fixed costs that trustees and insurers need to pay in addition to paying claims (such as some claims handling expenses).

Trustees need to have a detailed understanding of factors that may lead to higher or lower claim incident rates, such as member demographics or the terms and conditions of the insurance policy. This is especially the case where these change significantly – for example, following a merger or insurance redesign. This understanding can help trustees to assess whether the insurance policy is appropriately designed to meet the needs of their members who rely on the default insurance, as well as whether the premiums are fair and sustainable.

A range of factors influence value for money over time

Most members pay for life insurance over many years, and so the value for money they get over time matters more than at a single point in time. Trustees need to consider value for money over the length of time a member is expected to be in the fund.

We found significant year-to-year variation in the value for money that a trustee's default insured members receive, measured by the accrual claims ratio. This could partly be due to volatility in the number of claims each year, especially when looking across smaller groups of members. Over longer periods, however, such volatility generally evens out or is reflected in pricing.

Claims ratios can also change when trustees and insurers renegotiate premiums. If claims ratios rise significantly higher than expected, the insurer may no longer find it sustainable to continue offering the insurance at current premiums (e.g. a claims ratio exceeding 100% would imply the insurer is making a loss). This means that accrual claims ratios can fall following an adjustment to premiums.

We also saw many instances of accrual claim ratios trending up or down due to changes in claim incident rates over time. Trustees identified several reasons for these changes, including:

- changes to terms and conditions in the policy, such as the removal of pre-existing condition exclusions
- an increasing average age of the insured membership, because new members were not being defaulted into the insurance
- other changes in member demographics (such as average age or the mix of occupations) due to large transfers of members into or out of the policy (e.g. due to product consolidation or a merger with another superannuation fund)
- changes to underlying rates of death or disablement
- changes to workers compensation arrangements in some states that led to more members making a TPD claim
- increased member awareness of insurance in superannuation, especially following the announcement of the reforms in the PYSP Act in 2018
- changes to insurers' estimates of outstanding claims – for example, if insurers revise upwards their estimates of how many claims are still yet to be paid because recent experience suggests that beneficiaries are making more claims than originally expected.

However, some trustees did not appear to have a clear understanding of the changes that had been occurring for their members, or the reasons for these changes: see the section on our findings about trustees' data and analysis capabilities.

Trustees need to monitor changes in the value for money different groups of their members receive and consider the drivers of these changes. An understanding of how outcomes are changing over time can help to distinguish structural trends from volatility. While some change may be due to external factors, beyond the control of trustees, others may be more amenable to influence through insurance design, member engagement or claims handling processes.

Claims-handling indicators provide further insights into member value and potential harm

The claims ratio is a robust measure of the value for money members receive from default insurance in superannuation, but it does not capture everything. Superannuation trustees need to monitor a range of indicators of member value and potential harm in monitoring member outcomes, and in designing and reviewing their default insurance arrangements.

The claims ratio on its own is not well suited to assessment of how well an insurance policy meets the needs of a trustee's membership – for example, whether it will provide the 'right' amount of financial protection in the event of a death or disability, or whether the premium is affordable. This assessment will require other types of member data and analysis.

Trustees need to look beyond the claims ratio in identifying risks of member harm. For example, an insurance policy could have relatively low premiums and a high claims ratio. This could be because it has restrictive terms and conditions that make it more difficult for some groups of default insured members to make a claim. It could also be because it excludes those members entirely for being able to claim (e.g. if they are unemployed or have a pre-existing condition).

Trustees also need to monitor risks of harm in the way trustees and insurers handle claims. For example, high rates of declined claims could indicate that members do not fully understand when they are eligible to receive a claim payment. A high number of withdrawn claims or disputes, or long claim processing times, could indicate frictions in the claims process. These frictions can make the claims process difficult or distressing for beneficiaries to navigate.

Note: ASIC's expectations for how superannuation trustees and life insurers should use claims-handling data to improve member outcomes are set out in REP 633.

We obtained data on rates of declined claims, withdrawn claims, disputes and claim processing times from the 11 trustees in our sample. We found a large amount of variation across all the measures we looked at: see Table 3.

Our analysis also suggests little or no systematic correlation between these claims-handling measures and accrual claims ratios. This emphasises the importance of trustees monitoring a range of indicators when assessing the outcomes they are delivering for their members.

Table 3: Claims-handling indicators

Indicator	Death cover	TPD cover	Income protection cover
Claims acceptance rate (share of finalised claims that are accepted)	**98%**	**88%**	**97%**
Range across trustees	*85–100%*	*66–94%*	*90–99%*
Withdrawn claim rate (share of received claims that are withdrawn)	**1.8%**	**4.5%**	**4.7%**
Range across trustees	*1–10%*	*2–8%*	*2–12%*

Indicator	Death cover	TPD cover	Income protection cover
Average claim time (i.e. processing time)	**0.8 months**	**5.3 months**	**1.4 months**
Range across trustees	*0.2–3.1 months*	*1.6–10.0 months*	*0.7–13.6 months*
Disputes per 100,000 lives insured	**0.5**	**6.2**	**7.5**
Range across trustees	*0.1–16.0*	*1.7–20.1*	*2.1–39.9*

Note: Data for claims acceptance rates is for 2013–14 to 2018–19. Data for the other three indicators is for 2017–18 and 2018–19 only.

Trustees have shortcomings in data and analysis

We obtained data directly from trustees because not all the data we sought was available from other sources (such as APRA data collections). We had expected that trustees would already have much of the data we sought or would be able to access it if necessary. Before issuing compulsory notices, we held a technical roundtable with the trustees to seek feedback on the types of data we were seeking.

Most trustees found it challenging to provide all the data we required. We asked for data by the end of February 2020, but many trustees required extensions. Almost all had to make resubmissions after we asked questions about their data. The process took place over several months and was extended due to the impacts of the COVID-19 pandemic.

Some of the challenges trustees encountered in providing data to ASIC were:

- identifying premiums and claims for default insured members. We defined 'default insured members' as those who are provided insurance that they have not changed (by increasing or decreasing the level of cover, or opting out of part of it) other than by reporting their occupation to the trustee
- challenges or delays in obtaining data from administrators and insurers. This was especially difficult for trustees that had changed their administrator or insurer during the six-year period
- splitting premiums between death and TPD cover for some members (where death and TPD cover were bundled)
- providing data on claim payments that had been provided to a beneficiary (in addition to, and distinct from, data on claim payments provided from the insurer to the trustee).

The trustees with the most complicated insurance designs and product structures tended to face the most issues.

Some trustees were only able to provide estimates of data points or were unable to provide some data points at all. This means that many of our conclusions are limited to the data the trustees provided to ASIC.

We have concerns about trustees' understanding of their own data. Some trustees struggled to provide explanations for trends we saw in the data they provided to us, such as low claim incident rates or rates of declined claims.

Many trustees told us that they do not routinely analyse insurance outcomes for their members with default insurance separately to their other members. Some also told us their own internal analysis is mostly focused on looking at outcomes jointly across death and TPD cover, or jointly across several large group insurance policies. This is concerning, because it suggests trustees may not be monitoring the risks that the default insurance they are providing could be inappropriate or low-value for groups of their members. It may also mean they are unable identify the drivers of outcomes for groups of their members, such as specific terms and conditions in the insurance policy.

Trustees need to be able to clearly identify which members are on default settings in order to assess whether the trustee's default arrangements are delivering value for money, and to evaluate whether groups of members having different insurance arrangements are being treated fairly.

Appendix 1: Methodology for analysis of MySuper products using public data sources

Data sources and methodology

We collected data, from public sources, on the default level of cover (for each type of applicable cover: death, TPD and income protection) and the annual premium for a set of eight representative superannuation members: a woman and a man for each of the ages 25, 30, 40 and 50. We chose these ages to provide a snapshot of default insurance across the age distribution.

We collected data directly from publicly available disclosures (Insurance Guides and Product Disclosure Statements (PDSs)) for the default insurance that was in place as at 1 July 2020. Any changes that trustees have made to their default insurance arrangements since this date are not reflected in our data.

Our data covers large MySuper products offered by 20 large trustees: see Table 4. For each trustee, we used the default insurance that is offered to its MySuper members. For trustees with more than one MySuper product, we selected the largest product (by number of members) for which default premiums and levels of cover were disclosed.

Note 1: The 20 trustees are those with the most MySuper member accounts listed in APRA's annual MySuper statistics publication for 2018–19, with two exceptions. We excluded one trustee and its MySuper product because the product has since merged with another in the sample. We excluded another trustee because its MySuper product is only offered through corporate arrangements where the default design is tailored to each employer and there is no standard default.
Note 2: See APRA, Annual MySuper statistics, June 2019 (released 16 December 2019).

We used the default settings that the trustee applies when it does not have information on a member's occupation or salary (either from the member or their employer), as described in the publicly available disclosures.

To do this, we applied each trustee's default occupational settings. For trustees that tailor the default occupational category by employer, we used the generic default (i.e. applying where the employer has not disclosed the member's occupation or selected a default category). In cases where no generic default was disclosed, we used the trustee's light blue-collar occupational category.

One trustee (QSuper) based the level of default income protection cover on a member's individual salary. In this instance, we assumed an annual salary of $89,123, which is the annualised value of full-time adult average weekly ordinary time earnings at May 2020 (which was $1,713.90).

Note: See Australian Bureau of Statistics, Average Weekly Earnings, Australia, May 2020, Cat. 6302.0 (released 13 August 2020).

Table 4 lists the trustees, MySuper products and any assumptions we needed to make for individual products.

Table 4: MySuper products used in the analysis

Trustee	MySuper product name (on PDS)	Assumptions
AMP Superannuation Limited (AMP) – see note 1	AMP Flexible Super	Light blue-collar occupation
AustralianSuper Pty Ltd (AustralianSuper)	AustralianSuper	Not applicable
BT Funds Management Limited (BT)	BT Super	Light blue-collar occupation Premium for TPD cover is equal to premium for death and TPD cover less the premium for death only cover
CARE Super Pty Ltd (CareSuper)	CareSuper Employee Plan	Not applicable
United Super Pty Ltd (CBUS)	CBUS Industry Super	Not applicable
Colonial First State Investments Limited (CFSIL)	First Choice Employer Super	Light blue-collar occupation
Commonwealth Superannuation Corporation (CSC)	Public Sector Superannuation accumulation plan	Not applicable
FSS Trustee Corporation (First State Super) – see note 2	First State Super Employer Sponsored	Light blue-collar occupation
H.E.S.T. Australia Ltd. (HESTA)	Core Pool	Not applicable
Host-Plus Pty. Limited (Hostplus)	Balanced option	Not applicable
I.O.O.F. Investment Management Limited (IOOF)	IOOF Employer Super	Light blue-collar occupation
Motor Trades Association of Australia Superannuation Fund Pty. Limited (MTAA)	MTAA Super	Not applicable
Nulis Nominees (Australia) Limited (NULIS)	MLC MasterKey Business Super	Not applicable
OnePath Custodians Pty Limited (OnePath)	ANZ Smart Choice Super for employers and their employees	Not applicable
QSuper Board (QSuper)	Accumulation Account	Salary of $89,123
Retail Employees Superannuation Pty. Limited (REST)	REST Super	Not applicable

Trustee	MySuper product name (on PDS)	Assumptions
Statewide Superannuation Pty Ltd (Statewide)	Statewide Super	Not applicable
Sunsuper Pty. Ltd. (Sunsuper)	Sunsuper for life	Not applicable
Unisuper Limited (UniSuper)	UniSuper – Balanced	Not applicable
VicSuper Pty Ltd (VicSuper) – see note 2	VicSuper FutureSaver	Not applicable

Note 1: On 15 May 2020, AMP Flexible Super was transferred from AMP Superannuation Limited to N. M. Superannuation Proprietary Limited.
Note 2: On 1 July 2020, VicSuper Pty Ltd merged with FSS Trustee Corporation. On 14 September 2020, FSS Trustee Corporation became Aware Super Pty Ltd.

Bundled death and TPD cover

Some trustees bundle default death and TPD cover together so that there is a combined premium and/or level of cover disclosed. Others disclose separate levels of cover and premiums. To make comparisons across our sample, we constructed 'standardised' (combined) measures of death and TPD cover for the 19 trustees that offer both death and TPD cover by default.

In comparing bundled death and TPD cover with standalone death and TPD cover, we doubled the level of bundled cover (e.g. we treated $50,000 of bundled cover as identical to $50,000 of death cover plus $50,000 of TPD cover). We considered this the most straightforward way to make direct comparisons, even though it may not reflect differences in terms and conditions that exist between standalone and bundled cover.

To compare the price of cover, we adjusted premiums by the level of cover. To do this we constructed a measure of the annual cost of $1,000 of death and TPD cover (unit price), calculated as the cost of $1,000 of death cover plus the cost of $1,000 of TPD cover. For bundled cover, this is simply the bundled premium divided by the bundled level of cover (with the latter divided by 1,000). For standalone cover, we performed the calculation separately for death and TPD cover (i.e. premium divided by level of cover), then added these results together.

This method avoids distortions that can arise when the unit price of death and TPD cover is different. For example, had we simply divided the sum of the premiums by the sum of the levels of cover, we would effectively be imposing an assumption that the unit price of death and TPD cover is equal.

Treatment of tax rebates and stamp duties

We understand that some trustees in our sample do not disclose insurance premiums before adjustment for tax rebates (associated with the deductibility of insurance premiums from the 15% contributions and earnings tax). For these trustees' MySuper products, we divided the disclosed insurance premiums by 0.85. The trustees are indicated with an asterisk in Table 5.

Practices also varied for the disclosure of insurance premiums gross or net of state and territory stamp duties (which are modest for death cover but can be up to 10% of premiums for TPD and income protection cover in some states). We did not adjust our data for the treatment of stamp duties.

Further results

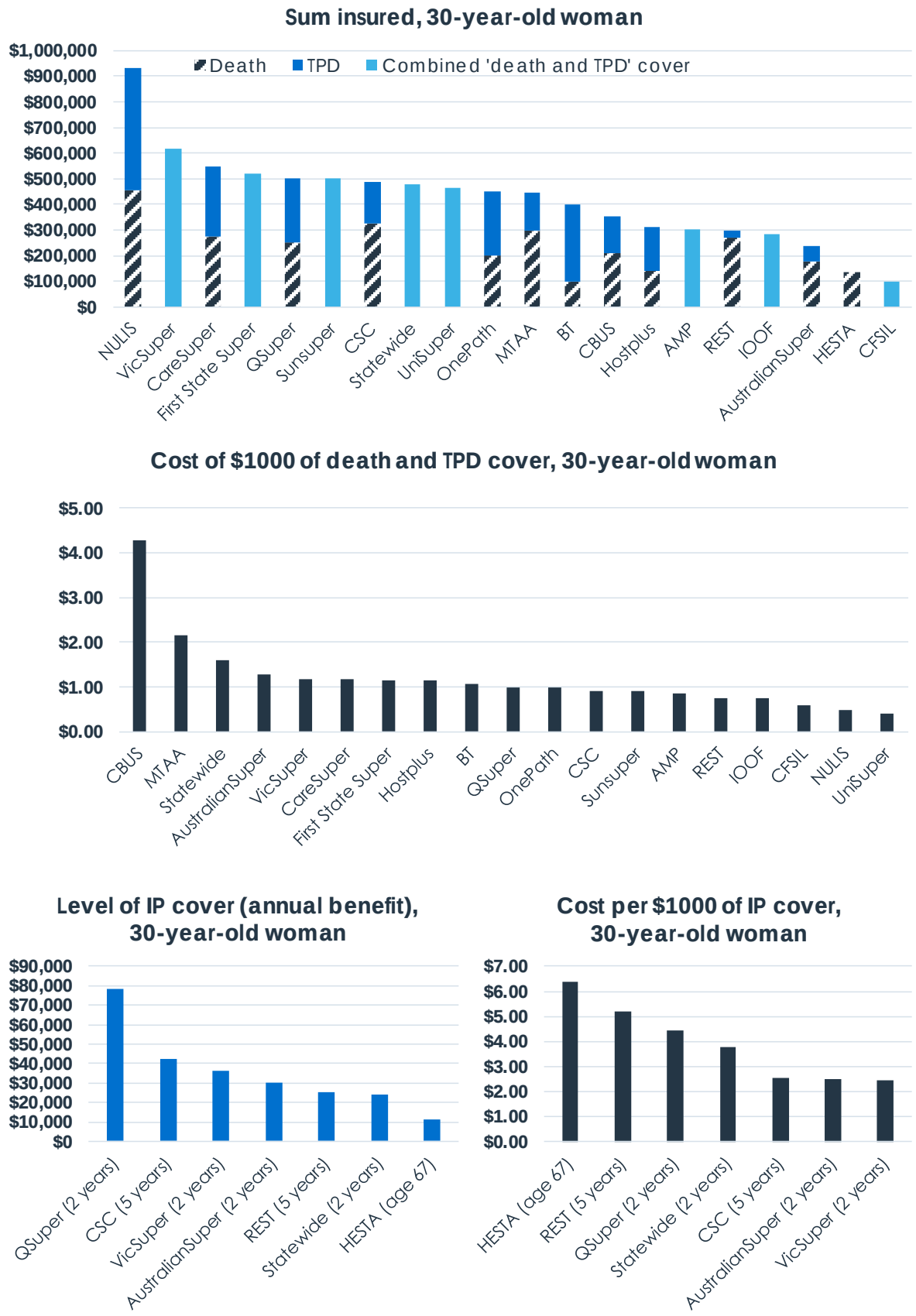
Figure 10 and Figure 11 respectively show the level of default death and TPD cover, and the cost per $1,000 of that cover, for the 30-year old female and 50-year old male representative members. We highlighted these two members in the main report to illustrate the range of outcomes that members in default arrangements can face. The full set of results is in Table 5–Table 10.

As discussed in the main report, differences in the unit price across trustees can be driven by a range of factors. For example, the average risk level of a MySuper product's membership, the generosity of terms and conditions, or waiting and benefit periods for income protection cover.

We also observed that:

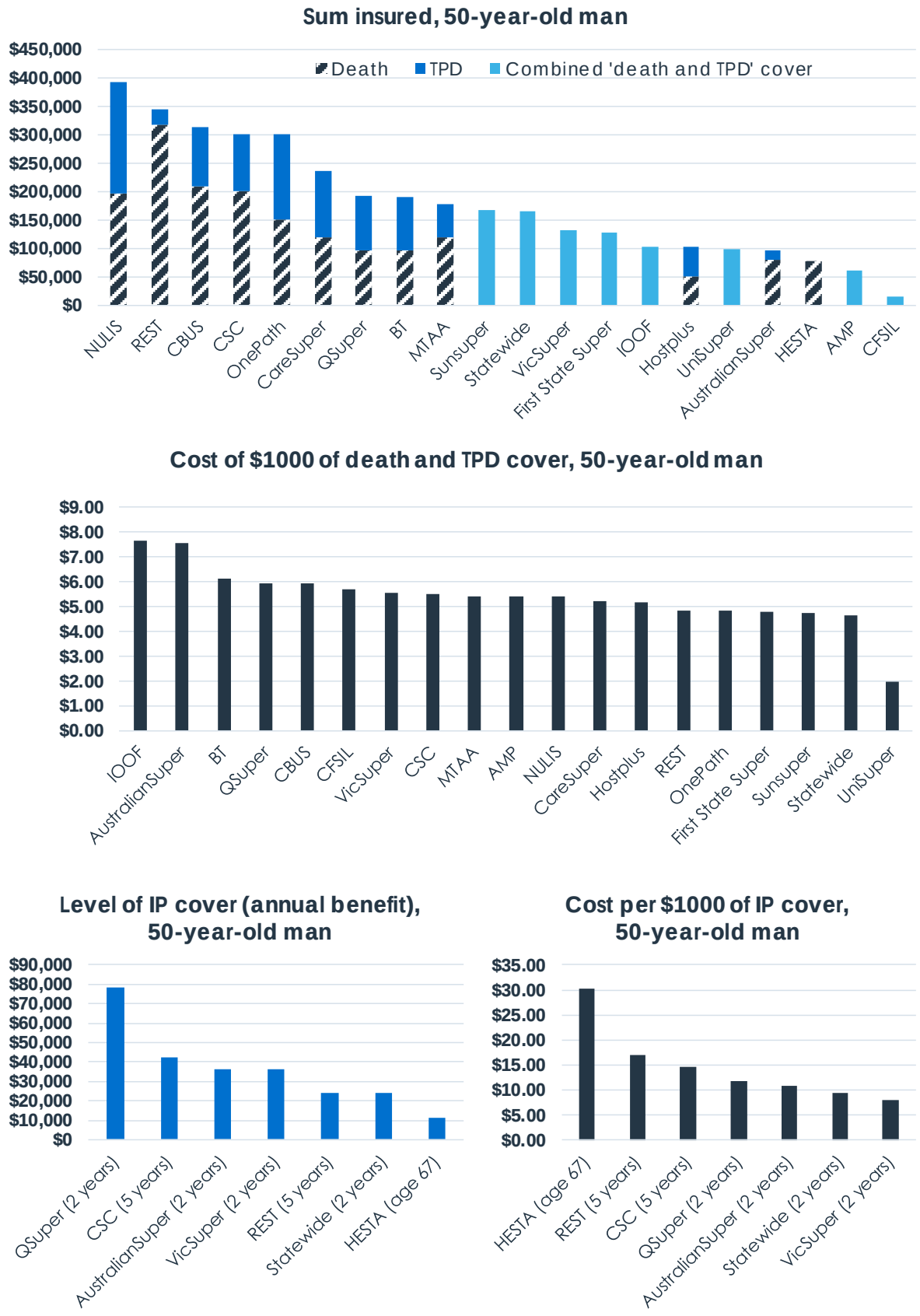
- 11 MySuper products in our sample provided different levels of default death and TPD cover to younger members (aged 25 or 30). About half (6) provided more death cover and the rest provided more TPD cover
- six MySuper products provided more death cover than TPD cover for older members (aged 40 or 50). The remainder provided the same level of death and TPD cover
- four MySuper products charged the same total death and TPD premium to all four ages. Eight charged different unit prices for death and/or TPD cover to men and women (with the unit price almost always higher for men)
- of the seven MySuper products with default income protection cover, none differentiated the level of cover or the premium by gender.

Figure 10: 30-year-old woman



Note 1: See Table 5, Table 7, Table 8 and Table 10 for the data shown in these charts (accessible version).
Note 2: The benefit period for income protection cover is in parentheses. Waiting periods also differ – see Table 8.

Figure 11: 50-year old man



Note 1: See Table 5, Table 7, Table 8 and Table 10 for the data shown in these charts (accessible version).
Note 2: The benefit period for income protection cover is in parentheses. Waiting periods also differ – see Table 8.

Table 5: Level of default death and TPD cover (default death sum insured plus default TPD sum insured)

Trustee	25-year-old	30-year-old	40-year-old	50-year-old
AMP*	$300,000	$300,000	$182,400	$60,800
AustralianSuper	$164,000	$239,000	$203,000	$97,000
BT	$370,000	$400,000	$570,000	$190,000
CareSuper	$273,000	$546,000	$487,500	$236,000
CBUS	$364,000	$353,600	$332,800	$312,000
CFSIL*	$100,000	$100,000	$40,000	$14,000
CSC	$300,000	$487,500	$487,500	$300,000
First State Super*	$508,716	$521,874	$429,000	$126,546
HESTA (death cover only)	$134,900	$134,900	$170,000	$76,800
Hostplus	$282,730	$311,003	$269,620	$101,824
IOOF – men*	$244,496	$333,717	$340,368	$102,200
IOOF – women*	$264,547	$281,584	$334,378	$96,915
MTAA	$236,400	$445,500	$369,000	$177,300
NULIS	$883,000	$933,000	$774,000	$392,000
OnePath	$340,000	$450,000	$600,000	$300,000
QSuper	$450,000	$500,000	$500,000	$192,000
REST	$129,800	$296,200	$425,100	$345,100
Statewide*	$366,000	$476,000	$332,000	$164,000
Sunsuper*	$350,000	$500,000	$372,000	$166,000
UniSuper*	$464,000	$464,000	$298,000	$98,000
VicSuper*	$618,000	$618,000	$486,000	$132,000
Average	**$343,952**	**$420,515**	**$383,414**	**$179,179**
Median	**$320,000**	**$447,750**	**$370,500**	**$165,000**
Minimum	**$100,000**	**$100,000**	**$40,000**	**$14,000**
Maximum	**$883,000**	**$933,000**	**$774,000**	**$392,000**
Maximum as multiple of minimum	**8.8**	**9.3**	**19.4**	**28.0**

Note 1: Figures are rounded to the nearest dollar. Trustees marked with an asterisk provide bundled death and TPD cover in their MySuper product. The disclosed level of cover has been doubled for these trustees. Only IOOF differentiated the level of default cover between men and women. Some trustees with standalone death and TPD cover offer different levels of each type of cover by default.
Note 2: This is the data shown in Figure 10 and Figure 11.

Table 6: Annual premium for default death and TPD cover

Trustee	25-year-old man	30-year-old man	40-year-old man	50-year-old man	25-year-old woman	30-year-old woman	40-year-old woman	50-year-old woman
AMP	$164	$164	$164	$164	$127	$127	$127	$127
AustralianSuper	$87	$154	$252	$279	$87	$154	$252	$279
BT	$165	$272	$660	$580	$83	$183	$602	$501
CareSuper	$168	$458	$617	$617	$100	$321	$529	$505
CBUS*	$732	$732	$754	$820	$732	$732	$754	$820
CFSIL	$66	$61	$41	$40	$25	$29	$36	$33
CSC	$147	$247	$447	$748	$147	$247	$447	$748
First State Super	$303	$303	$303	$303	$303	$303	$303	$303
HESTA (death cover only)	$45	$45	$111	$126	$45	$45	$111	$126
Hostplus	$170	$183	$164	$262	$170	$183	$164	$262
IOOF	$190	$220	$390	$390	$80	$105	$300	$300
MTAA	$201	$471	$471	$471	$201	$471	$471	$471
NULIS	$431	$504	$749	$1,056	$143	$230	$509	$716
OnePath	$214	$302	$616	$723	$161	$234	$534	$589
QSuper*	$127	$250	$566	$570	$127	$250	$566	$570
REST	$35	$131	$394	$569	$35	$131	$394	$569
Statewide	$286	$381	$381	$381	$286	$381	$381	$381

Trustee	25-year-old man	30-year-old man	40-year-old man	50-year-old man	25-year-old woman	30-year-old woman	40-year-old woman	50-year-old woman
Sunsuper	$183	$333	$393	$393	$123	$225	$308	$308
UniSuper	$96	$96	$96	$96	$96	$96	$96	$96
VicSuper	$365	$365	$365	$365	$365	$365	$365	$365
Average	**$209**	**$284**	**$397**	**$448**	**$172**	**$241**	**$362**	**$403**
Median	**$169**	**$261**	**$392**	**$392**	**$127**	**$228**	**$373**	**$373**
Minimum	**$35**	**$45**	**$41**	**$40**	**$25**	**$29**	**$36**	**$33**
Maximum	**$732**	**$732**	**$754**	**$1,056**	**$732**	**$732**	**$754**	**$820**
Maximum as multiple of minimum	**20.7**	**16.4**	**18.5**	**26.5**	**29.6**	**25.0**	**21.1**	**25.1**

Notes: Figures are rounded to the nearest dollar. Trustees marked with an asterisk reported default premiums only after adjustment for tax rebates. Disclosed premiums were divided by 0.85 for these trustees. Some trustees with standalone death and TPD cover offer different levels of each type of cover by default.

Table 7: Annual cost per $1,000 of death and TPD cover

Trustee	25-year-old man	30-year-old man	40-year-old man	50-year-old man	25-year-old woman	30-year-old woman	40-year-old woman	50-year-old woman
AMP	$1.09	$1.09	$1.80	$5.39	$0.85	$0.85	$1.40	$4.19
AustralianSuper	$1.01	$1.28	$2.90	$7.57	$1.01	$1.28	$2.90	$7.57
BT	$1.26	$1.76	$2.32	$6.10	$0.64	$1.07	$2.11	$5.27
CareSuper	$1.38	$1.68	$2.53	$5.23	$0.79	$1.18	$2.17	$4.28
CBUS	$4.11	$4.27	$4.84	$5.93	$4.11	$4.27	$4.84	$5.93
CFSIL	$1.32	$1.22	$2.04	$5.70	$0.50	$0.59	$1.79	$4.67
CSC	$0.81	$0.92	$1.86	$5.49	$0.81	$0.92	$1.86	$5.49

Trustee	25-year-old man	30-year-old man	40-year-old man	50-year-old man	25-year-old woman	30-year-old woman	40-year-old woman	50-year-old woman
First State Super	$1.19	$1.16	$1.41	$4.78	$1.19	$1.16	$1.41	$4.78
HESTA (death cover only)	$0.33	$0.33	$0.65	$1.64	$0.33	$0.33	$0.65	$1.64
Hostplus	$1.16	$1.16	$1.22	$5.15	$1.16	$1.16	$1.22	$5.15
IOOF	$1.55	$1.32	$2.29	$7.63	$0.60	$0.75	$1.79	$6.19
MTAA	$1.70	$2.15	$2.60	$5.41	$1.70	$2.15	$2.60	$5.41
NULIS	$1.02	$1.09	$1.94	$5.39	$0.34	$0.50	$1.31	$3.65
OnePath	$1.31	$1.33	$2.05	$4.82	$0.86	$0.99	$1.78	$3.93
QSuper	$0.57	$1.00	$2.27	$5.94	$0.57	$1.00	$2.27	$5.94
REST	$0.48	$0.75	$2.38	$4.84	$0.48	$0.75	$2.38	$4.84
Statewide	$1.56	$1.60	$2.30	$4.65	$1.56	$1.60	$2.30	$4.65
Sunsuper	$1.05	$1.33	$2.11	$4.74	$0.70	$0.90	$1.66	$3.71
UniSuper	$0.41	$0.41	$0.65	$1.96	$0.41	$0.41	$0.65	$1.96
VicSuper	$1.18	$1.18	$1.50	$5.53	$1.18	$1.18	$1.50	$5.53
Average	**$1.22**	**$1.35**	**$2.08**	**$5.19**	**$0.99**	**$1.15**	**$1.93**	**$4.74**
Median	**$1.17**	**$1.20**	**$2.08**	**$5.39**	**$0.80**	**$0.99**	**$1.79**	**$4.81**
Minimum	**$0.33**	**$0.33**	**$0.65**	**$1.64**	**$0.33**	**$0.33**	**$0.65**	**$1.64**
Maximum	**$4.11**	**$4.27**	**$4.84**	**$7.63**	**$4.11**	**$4.27**	**$4.84**	**$7.57**
Maximum as multiple of minimum	**12.4**	**12.9**	**7.5**	**4.7**	**12.4**	**12.9**	**7.5**	**4.6**

Note 1: Figures are rounded to the nearest cent.
Note 2: This is the data shown in Figure 10 and Figure 11.

Table 8: Level of default income protection cover (annual benefit)

Trustee	25-year-old	30-year-old	40-year-old	50-year-old	Waiting period (days)	Benefit period
AustralianSuper	$22,800	$30,000	$37,200	$36,000	60	2 years
CSC	$42,488	$42,488	$42,488	$42,488	60	5 years
HESTA	$11,400	$11,400	$11,400	$11,400	90	To age 67
QSuper	$78,205	$78,205	$78,205	$78,205	90	2 years
REST	$25,500	$25,500	$25,500	$24,000	60	5 years
Statewide	$24,000	$24,000	$24,000	$24,000	60	2 years
VicSuper	$36,000	$36,000	$36,000	$36,000	90	2 years
Average	**$34,342**	**$35,370**	**$36,399**	**$36,013**	Not applicable	Not applicable
Median	**$25,500**	**$30,000**	**$36,000**	**$36,000**	Not applicable	Not applicable
Minimum	**$11,400**	**$11,400**	**$11,400**	**$11,400**	Not applicable	Not applicable
Maximum	**$78,205**	**$78,205**	**$78,205**	**$78,205**	Not applicable	Not applicable
Maximum as multiple of minimum	**6.9**	**6.9**	**6.9**	**6.9**	Not applicable	Not applicable

Note 1: Figures are rounded to the nearest dollar. No trustee in the sample differentiated between males and females for the level of default income protection cover. This table shows the annual benefit only and excludes any additional payments that some members may be eligible to receive in certain circumstances (for example, lump sum payments after a period of time).
Note 2: This is the data shown in Figure 10 and Figure 11.

Table 9: Annual premium for default income protection cover

Trustee	25-year-old	30-year-old	40-year-old	50-year-old
AustralianSuper	$35	$74	$203	$385
CSC	$104	$107	$208	$624
HESTA	$73	$73	$212	$345
QSuper*	$265	$348	$657	$910
REST	$52	$133	$364	$408
Statewide	$76	$91	$224	$224
VicSuper	$78	$87	$175	$290
Average	**$98**	**$130**	**$292**	**$455**
Median	**$76**	**$91**	**$212**	**$385**
Minimum	**$35**	**$73**	**$175**	**$224**
Maximum	**$265**	**$348**	**$657**	**$910**
Maximum as multiple of minimum	**7.7**	**4.8**	**3.8**	**4.1**

Note: Figures are rounded to the nearest dollar. Trustees marked with an asterisk reported default premiums only after adjustment for tax rebates. Disclosed premiums were divided by 0.85 for these trustees. No trustee in the sample differentiated between males and females for default income protection premiums.

Table 10: Annual cost per $1,000 (annual benefit) of income protection cover

Trustee	25-year-old	30-year-old	40-year-old	50-year-old
AustralianSuper	$1.52	$2.47	$5.46	$10.70
CSC	$2.46	$2.53	$4.90	$14.68
HESTA	$6.39	$6.39	$18.61	$30.29
QSuper	$3.39	$4.45	$8.41	$11.64
REST	$2.04	$5.20	$14.27	$17.01
Statewide	$3.18	$3.78	$9.33	$9.33
VicSuper	$2.17	$2.43	$4.85	$8.06
Average	**$3.02**	**$3.89**	**$9.40**	**$14.53**
Median	**$2.46**	**$3.78**	**$8.41**	**$11.64**
Minimum	**$1.52**	**$2.43**	**$4.85**	**$8.06**
Maximum	**$6.39**	**$6.39**	**$18.61**	**$30.29**
Maximum as multiple of minimum	**4.2**	**2.6**	**3.8**	**3.8**

Note 1: Figures are rounded to the nearest cent. The figures for each trustee in this table were calculated by dividing the relevant value in Table 9 by the corresponding value in Table 8 (and multiplying by 1,000).
Note 2: This is the data shown in Figure 10 and Figure 11.

Appendix 2: Methodology for analysis of data obtained from trustees

Process

Using ASIC's compulsory notice powers, we obtained data from 12 trustees: five large retail trustees, five large not-for-profit trustees, and two smaller not-for-profit trustees. These trustees held 49% of member accounts in APRA-regulated superannuation funds at 30 June 2019. One of the smaller trustees faced considerable difficulties in providing the required data and was later exempted from providing much of the data.

This is a more detailed dataset than that described in Appendix 1, which covered a different sample of trustees and only considered the largest MySuper product of each trustee.

The data we obtained under notice is about default insured members: members who are provided insurance that they have not changed (by increasing or decreasing the level of cover, or opting out of part of it), other than by reporting their occupation to the trustee. This is not a perfect overlap with MySuper products because:

- some members in choice superannuation products may receive default insurance provided by the trustee
- some members in MySuper products may have changed their insurance.

Some trustees have separate insurance designs for different groups of members (e.g. those in MySuper versus choice superannuation products, or those in large employer plans), and so have multiple group insurance policies.

This process involved several steps:

- In October and November 2019, we engaged with expert industry stakeholders to inform our initial consideration of whether and how to collect data from industry.
- In December 2019, we held a technical roundtable with the trustees to seek feedback on the feasibility of our approach to collecting data.
- In late December 2019, we served notices with a due date of 28 February 2020.
- Most trustees provided initial data between late February and late March 2020.
- We engaged directly with trustees during the process to respond to questions. Many trustees provided internally inconsistent data or became aware of errors following our discussions with them about their data. Resubmissions took place over several months, with the process extended due to the impacts of the COVID-19 pandemic.

Data

We required trustees to provide:

- a single Excel workbook ('**Workbook 1**') containing data on claim payments for default insured members. The data was grouped by incident date (i.e. the date of death or disability) and notification date (i.e. the date the claim was notified to the trustee). It was also grouped in six-monthly periods between June 2013 and December 2019 (inclusive). The data came from all the trustees' group insurance policies. All 12 trustees provided this workbook

- a separate Excel workbook ('**Workbook 2**') containing data on the number of default insured members, the premiums members paid, the claim payments insurers made and claims-handling indicators. The data was for the six financial years 2013-14 to 2018-19 (inclusive), for each externally insured group insurance policy with greater than 10,000 default insured members in any one of these years. Eleven trustees provided one or more of these workbooks
- a copy of each of the group insurance policies covered by **Workbook 2**.

The group insurance policies covered by Workbook 2 collectively represent about 40% of all member accounts with insurance in APRA-regulated superannuation funds at 30 June 2019 (for each of death, TPD and income protection cover). Our data excludes some smaller group insurance policies held by the trustees.

The data spans changes that trustees have made to their insurance arrangements over the six-year period. In some cases, this includes the commencement or termination of group insurance policies, changes of insurer, and significant transfers of members into or out of particular insurance policies.

We required trustees to restrict the data to default insured members. We defined 'default insured members' as members who are provided insurance that they have not changed (by increasing or decreasing the level of cover, or opting out of part of it), other than by reporting their occupation to the trustee. On average, 86% of insured members met this definition: see Table 11.

Table 11: Proportion of all insured members who are default insured members

Type of cover	Weighted average	Minimum (across trustees)	Maximum (across trustees)
Death	85%	61%	95%
TPD	86%	67%	96%
Income protection	86%	62%	95%
All	**86%**	**63%**	**95%**

We required the data in each workbook to be separately recorded for default death cover, lump-sum TPD cover, TPD cover paid by instalment, and income protection cover (where relevant). The policy-level workbooks required most data to be separately recorded on a cashflow and accrual basis (explained below). They also required data to be separately recorded for all default insurance members, plus the following four cohorts (which are not mutually exclusive):

- members aged under 30 (based on their age at the start of the financial year)
- members aged 30–49
- members aged 50 or older
- members in the default occupation category, where such a category exists – defined as the occupation group(s) used (for the purposes of determining premiums and/or level of cover) if the trustee does not have information from the member or employer about the occupation of the member. This cohort will also include members who have provided occupation information and whose occupation falls into the same category.

Only six trustees had a default occupation category for some or all of their group insurance policies. The others did not have any occupation categories, or did not have a default category. Nearly three quarters of default insured members in our sample (72%) were in funds operated by these trustees in 2018–19. Of those, 83% were in the default occupation category. However, we have not presented analysis on members inside and outside of the default occupation category. This is because most of these trustees had a very high or very low proportion of their default insured members in this category, and because the results are skewed by a single large trustee.

To aid comparability, we required that trustees report:

- premiums and claims before any tax deductions (e.g. for stamp duties or income taxes), tax rebates, reinsurance arrangements or profit-sharing payments between trustees and insurers
- premium amounts on an earned basis that include any fees or costs incurred by the trustee in administering the insurance, as well as any component of the premiums paid by employers
- claim numbers and dollar amounts that include any *ex-gratia* payments to members and any terminal illness payments made under the insurance policy. Terminal illness payments could be paid under death and/or TPD cover, depending on the insurance policy
- claim amounts that are discounted to the incident date (excluding cashflow data), to account for the time value of money
- estimates of the dollar amount of outstanding claim payments (i.e. claims incurred but not reported or still in the course of payment) for each of the six incident years, as at 30 June 2019.

The claims handling related data we collected included:

- the number and dollar amount of finalised claims admitted and declined
- the number of claims received, withdrawn and undetermined (2017–18 and 2018–19 only)
- average claim time, in months (2017–18 and 2018–19 only)
- disputes per 100,000 lives insured (2017–18 and 2018–19 only).

The claims-handling data was collected based on when claims and disputes were received (regardless of when the underlying death or disability occurred). We applied the following definitions:

- **claims acceptance rate –** The percentage of claims an insurer accepted for payment out of all claims that went to a final decision during the period
- **withdrawn claims –** Instances where a received claim is withdrawn and closed before being assessed and finalised. This includes beneficiaries returning to work before the expiry of a waiting period (where applicable)
- **average claim time –** The average amount of time, in months, between claims being received by the trustee and finalised
- **disputes per 100,000 lives insured –** The number of claims-related disputes lodged during the reporting period per 100,000 lives insured. The number of lives insured is the average for the reporting period.

We aggregated these measures over insurance policies. We weighted trustees by the number of claims received (for claims acceptance rates, withdrawn claim rates and claim times) or by the number of default insured members (for disputes).

This was an ad-hoc data collection that included data trustees have not previously been required to report to regulators. Many trustees faced challenges in providing data in the format we required. This was especially the case where they did not have good records of which members had made changes to their insurance cover: see the section on our findings about trustees' data and analysis capabilities. To assess the reliability of the data, we engaged directly with each trustee to understand the challenges they faced and to verify our interpretation of their data. We also tested our findings with an external actuarial consultant.

Calculations: claim incident rates and ratios

For **Workbook 2**, we performed the calculations set out in Table 12.

Table 12: Metrics calculated for the analysis

Measure	Formula
Number of insured members	The average of the number of members at the start of the period and the number of members at the end of the period
Average premium	The dollar amount of premiums divided by the number of insured members
Claim paid rate – cashflow	The number of all claims paid in a period on a cashflow basis divided by the number of insured members. This includes claims relating to all past periods of insurance, not just the six-year period from 2013–14 to 2018–19.
Claim incident rate – accrual	The number of claims incurred during a period for which a claim payment has already been made, plus the estimated number of claims yet to be paid for that period, divided by the number of insured members
Claims ratio – cashflow	The dollar amount of all claims paid in a period on a cashflow basis divided by the dollar amount of premiums
Claims ratio – accrual	The dollar amount of claims incurred during a period for which a claim payment has already been made, plus the estimated dollar amount of claims yet to be paid for that period, divided by the dollar amount of premiums
Number of claims yet to be paid	**For death and lump-sum TPD cover** The sum of the number of claims incurred in the period that have been: › reported but not admitted* › admitted but not yet paid › incurred but not reported (estimate). **For TPD paid by instalment and income protection cover** The sum of the number of claims incurred in the period that have been reported but not admitted and incurred but not reported (estimate).
Dollar amount of claims yet to be paid	The sum of the dollar amount of claims incurred in the period that have been: › reported but not admitted* › admitted but not yet paid (including any claims still in course of payment) › incurred but not reported. These items include estimates of the dollar amount of future payments that have not yet been made.

Note: * We multiplied the number and dollar amount of claims reported but not admitted by a measure of the claims acceptance rate for the relevant period (using data on the number and dollar amount of claims admitted and declined in each year).

We did not impose a methodology for how to calculate estimates of claims yet to be paid, but required trustees to provide the best available estimate they could. In practice, this meant obtaining these estimates from their insurer(s).

When making calculations across multiple insurance policies or trustees, we used weighted rather than simple averages to avoid small but unusual policies distorting the aggregate results. We used the denominator as the weight where fractions or ratios were being calculated, and otherwise used the number of default insured members.

For death and TPD cover, data on claim payments that have already been made relates to payments that the trustee has received from the insurer. We also collected data on claim payments made to beneficiaries. We considered this a more appropriate measure of member value because it would reflect where trustees had already passed the benefit on to beneficiaries. (This distinction is not relevant for income protection benefits, which are typically paid directly by the insurer to the beneficiary.) However, many trustees faced difficulties providing data on this basis. Some were unable to provide it at all, or only able to provide an estimate. Accordingly, our analysis uses data on claim payments received from the insurer, which we consider be more reliable and comparable across the sample.

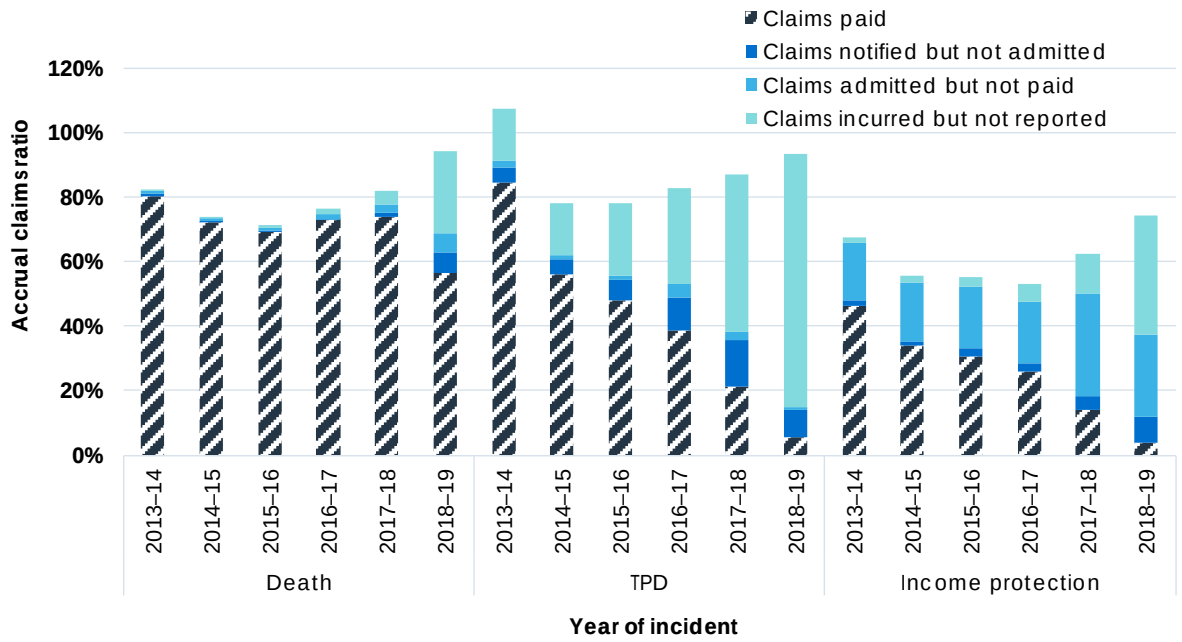
Further results

This section provides further detail on the charts and analyses presented in the main report.

We excluded one large trustee from our aggregate results for income protection claim incident rates and ratios – this trustee is excluded from Figure 12–Figure 15. This is because this trustee had an unusual design and claim incident rates over five times higher than the overall average. Including it would materially affect the aggregate results and distort the overall level and trend of most key measures we looked at for income protection cover. This would make the results less representative of the wider industry. Aside from this example, our aggregate results are not materially sensitive to the inclusion or exclusion of individual trustees.

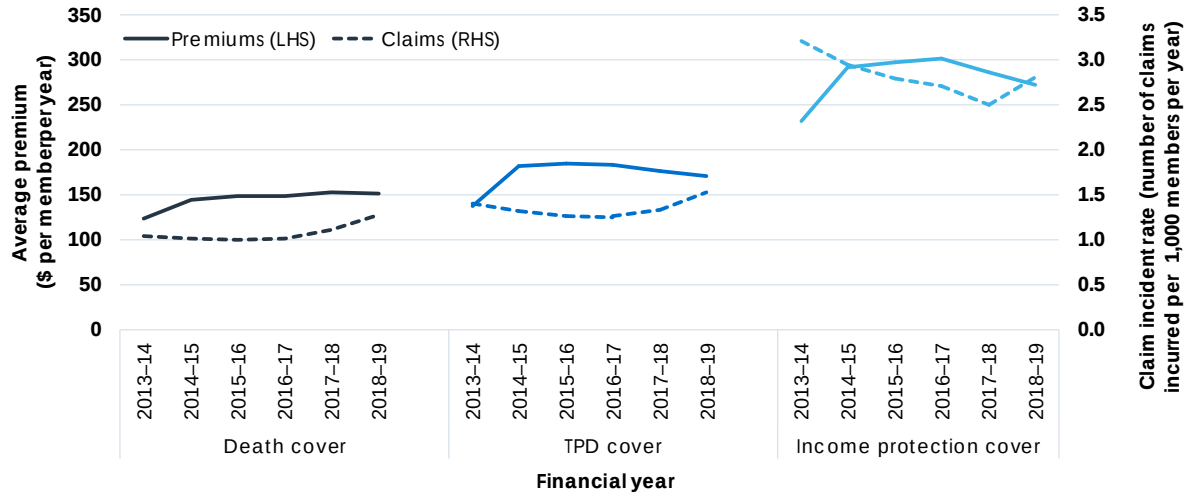
Figure 15 below also excludes this trustee (for income protection cover) and one relatively small insurance policy for another trustee (both for TPD and income protection cover) which also had a claim incident rate about five times higher than the average. These data points are outliers and their inclusion would significantly limit the readability of the figure.

Figure 12: Components of accrual claims ratios, 2013–14 to 2018–19



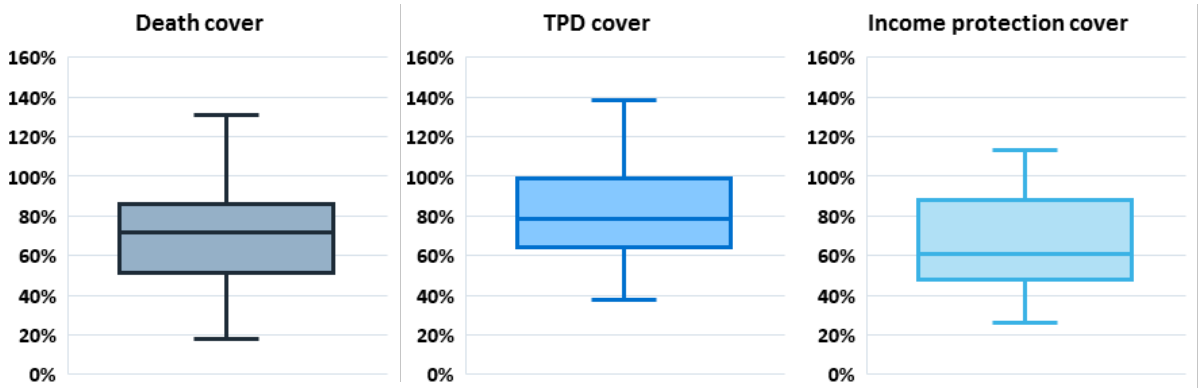
Note: See Table 21 for the data shown in this chart (accessible version). Data and estimates are as at 30 June 2019.

Figure 13: Average premiums and claim incident rate, 2013–14 to 2018–19



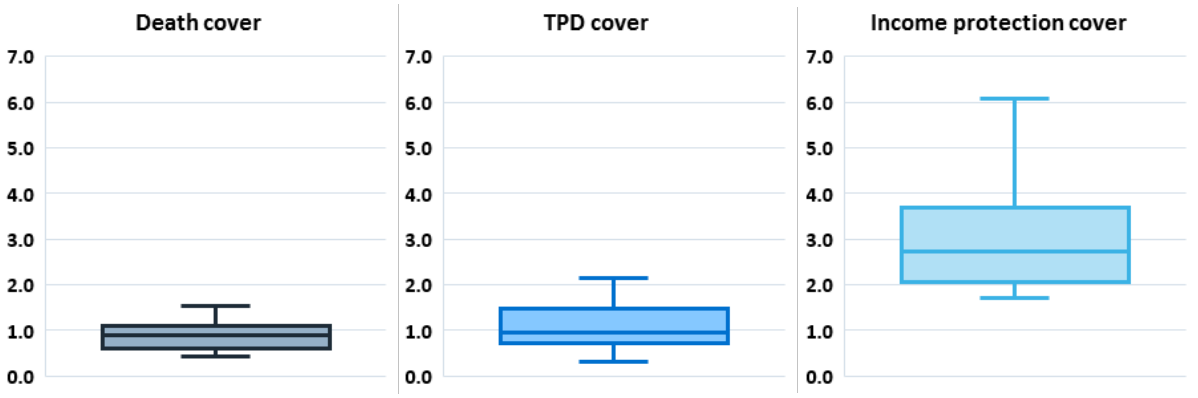
Note: See Table 22 for the data shown in this chart (accessible version).

Figure 14: Distribution of accrual claims ratios across group insurance policies, 2013–14 to 2018–19



Note 1: See Table 23 for the data shown in this chart (accessible version).
Note 2: The lower and upper bars represent the minimum and maximum observations respectively. The shaded bars show the first quartile, median and third quartile (from bottom to top). Very large outliers have been removed from the charts.

Figure 15: Distribution of claim incident rates (number of claims incurred per 1,000 insured members per year) across group insurance policies, 2013–14 to 2018–19



Note 1: See Table 24 for the data shown in this chart (accessible version).
Note 2: The lower and upper bars represent the minimum and maximum observations respectively. The shaded bars show the first quartile, median and third quartile (from bottom to top). Very large outliers have been removed from the charts.

Correlation between accrual claims ratios and claim incident rates

We examined whether accrual claims ratios are correlated with claim incident rates (i.e. the number of deaths or disabilities that result in a successful claim each year per 1,000 insured members) across each type of cover.

We found evidence of a positive relationship for death and TPD cover, but not for income protection cover. We observed this relationship in the data both at the trustee level and insurance policy level, over the full six years of data (on a combined basis, although some trustees and insurance policies had fewer years of data), as well as using annual observations.

Table 13 shows the regression coefficients, derived using simple Ordinary Least Squares models. We excluded the outlier observations of claim incident rates for income protection and TPD cover, as noted above for Figure 15.

The results indicate that an increase in the claim incident rate by 0.1 claim per 1,000 members is associated with a 4.9 percentage point increase in the claims ratio for death cover *on average*, and a 4.0 percentage point increase in the claims ratio for TPD cover *on average* (for the analysis by insurance policy using 6-year averages). This reflects the large differences we see across the sample in both the claim incident rates and accrual claim ratios. However, the model provides only a partial fit for the data, with much variation around the trend.

Table 13: Regression coefficients for accrual claims ratios and claim incident rates

Analysis	Death cover	TPD cover	Income protection cover
By trustee, using 6-year averages			
Regression coefficient	0.33	0.35*	0.04
R^2	Not statistically significant	0.38	Not statistically significant
By insurance policy, using 6-year averages			
Regression coefficient	0.49***	0.40***	0.04
R^2	0.41	0.40	Not statistically significant
By insurance policy, using annual data			
Regression coefficient	0.54***	0.46***	0.04**
R^2	0.42	0.31	0.04

Note: * statistically significant at the 10% level. ** statistically significant at the 5% level. *** statistically significant at the 1% level.

The relationship between claim incident rates and accrual claims ratios for death and TPD cover suggests that members in policies with relatively low claim incident rates (i.e. where relatively few members make a successful claim) do not always pay commensurately lower premiums. It also implies that insurance policies covering members with higher average risks tend to have higher accrual claims ratios, on average.

However, it is possible that the relationship may also reflect other factors. It may reflect how often trustees and insurers adjusted premiums over the six-year period. It may also reflect the presence of fixed costs that trustees and insurers need to pay in addition to paying claims (e.g. some claims handling expenses).

We also looked at whether accrual claims ratios are correlated with the average size of claims. We did not find evidence to support this.

Correlation between accrual claims ratios with and without estimated claims

We compared the accrual claims ratio, separately for death and TPD cover, to a modified version that excludes the estimate of outstanding claims (i.e. claims that are 'incurred but not reported'). Specifically, for each year, we looked at whether trustees with a relatively high total claims ratio also had a relatively high value of claims that have already been paid with respect to that year (relative to the total premium).

We did not undertake this analysis for income protection cover. Much of the estimate would comprise the value of claims that are still in the course of payment. This value is significantly influenced by the benefit period of the cover, which varied significantly across the sample. This makes it difficult to meaningfully compare the size of the estimates across the sample.

For most years, we found a high degree of correlation for both death and TPD cover (statistically significant at the 5% level).

For death cover, we found almost perfect (100%) correlation between the claims ratios with and without the estimates for all years. We ranked the trustees from highest to lowest claims ratio, both with and without the estimates. There were only very minor changes in the ranking of trustees each year.

For TPD cover, we found a very high degree of correlation for most years, and small to modest changes in the ranking for each year. The exception is 2018–19, for which there was no statistically significant correlation between the claims ratios with and without estimates.

Comparison to APRA data

We have compared our aggregate results to APRA data collected from life insurers for group insurance in superannuation. Since the APRA data is collected on a cashflow basis, we compared it to our cashflow data for claim incident rates and claim rations.

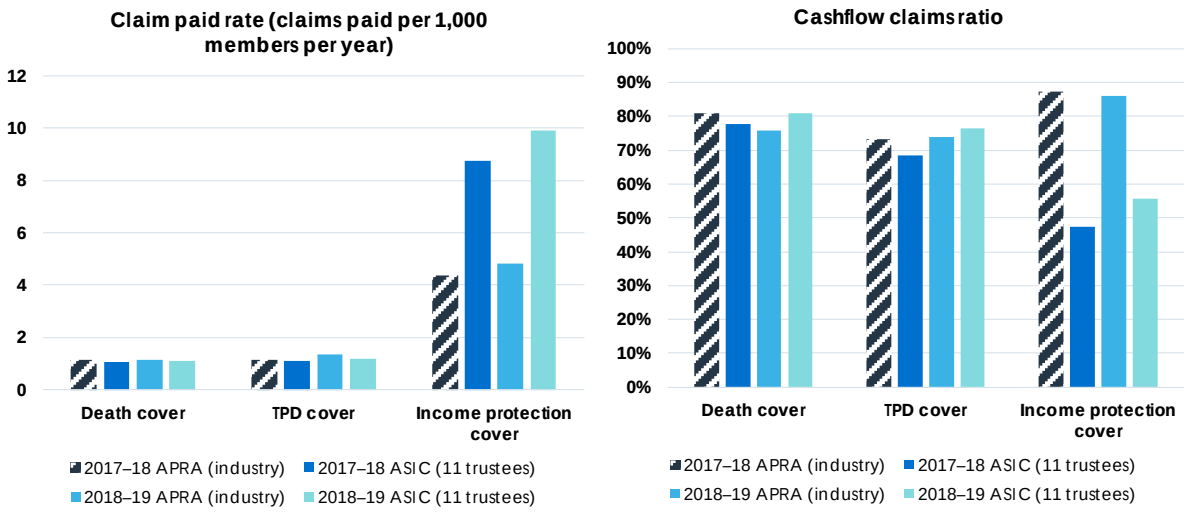
Note: see APRA, Life insurance claims and disputes statistics (released 20 October 2020).

The measures for death and TPD cover are similar, which likely reflects that our data cover a significant share (an estimated 40%) of member accounts with insurance in APRA-regulated superannuation funds: see Figure 16.

There are large differences for income protection that arise from differences in methodology:

- Our estimates of cashflow claim incident rates are much higher. In our data, an income protection claim that has payments made over multiple years will be recorded against each of those years.
- We calculated claims ratios using the dollar amount of actual claim payments that are made. APRA estimates the dollar amount of claims by assuming that each claim has 24 monthly payments. While many default insured members with income protection cover in our sample have a two-year benefit period, not all beneficiaries will be receiving benefits for a full two years.

Figure 16: Claim paid rate and cashflow claims ratios compared to APRA industry-level data



Note: See Table 25 for the data shown in this chart (accessible version). ASIC figures for income protection claim paid rates count a single claim against each year in which a payment is made, whereas APRA figures count a single claim only against the first year.

Notification delays

Using the data from **Workbook 1**, we measured the amount of time that elapses between claims being incurred and notified to a trustee (the notification delay). We looked at this across each type of cover (death, TPD and income protection) and by the number and dollar amount of claims.

These results are estimates because only some events occurring in the period will have been notified to a trustee – in other words, there are 'outstanding' claims for some incident years that have not yet been notified to the trustee. We estimated the number of these claims using a simple version of the 'chain-ladder method'. This involves calculating the ratio of claims notified at each duration (e.g. two year delay) to claims notified in the previous duration (e.g. one and a half year delay) and using this to estimate how many claims will be notified for incident years that have not yet reached that duration (in this example, the two year delay duration).

Note: See Actuaries Institute, *Discussion Note: IBNR* (PDF 407 KB), Life Insurance & Wealth Management Practice Committee, December 2014.

This method assumes that the duration pattern of delays is stable from year to year. Our analysis using the raw data supports the validity of this assumption: see Figure 18. The method also assumes that the insurance design (average sum insured and terms and conditions) is stable.

To estimate the number of claims notified after six and a half years (the time period of the data we obtained), we made projections by applying a negative exponential curve (i.e. decay function) to the data.

We used an analogous method to estimate the dollar amount of claims. We did these calculations for individual trustees and on the aggregated data.

To calculate the average duration of notification delays, we weighted the duration associated with each period by the share of total estimated claims notified during that period. This average is higher when we used the estimates of incurred but not reported claims, but the difference is small (e.g. 2.3 years for TPD cover using the raw data only, and 2.5 years when the estimates are included).

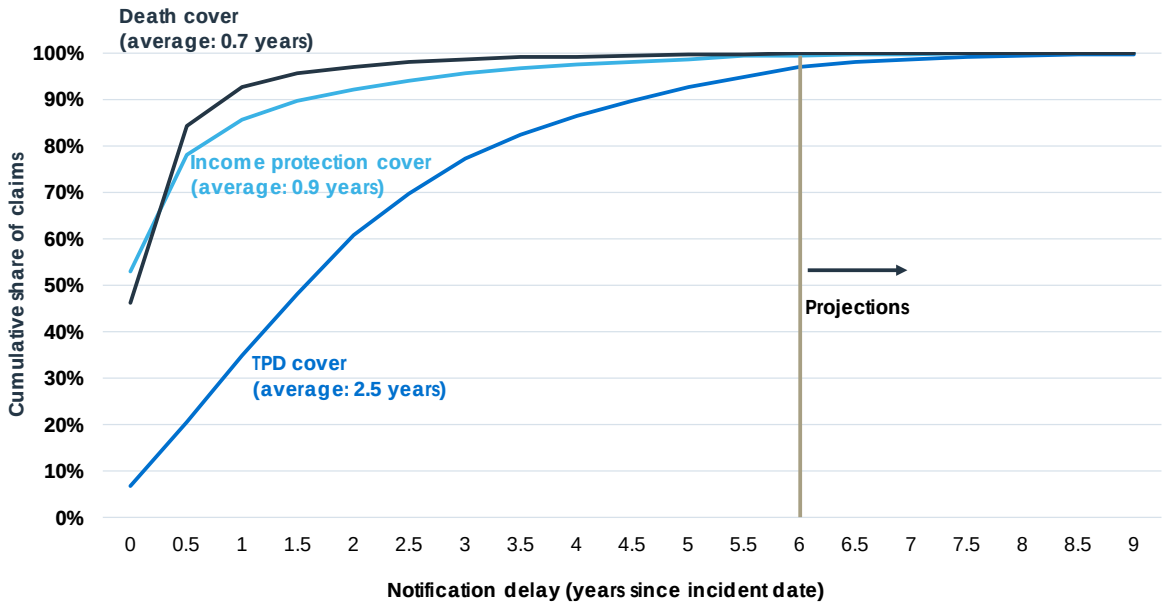
Using this analysis, we estimated that:

- only 15% of death claims are notified more than a year after the event, with an estimated average delay of 8 months
- only 26% of income protection claims are notified more than a year after the event, with an estimated average delay of 10 months
- 77% of TPD claims are notified more than a year after the event, with an estimated average delay of 30 months (or 2.5 years), and about 5% of claims taking more than 5 years to be notified.

We found little evidence that delays have been getting systematically longer or shorter, though there has been a slight increase in TPD delays. There is a modest degree of variation in the delays across trustees, particularly for income protection and TPD claims.

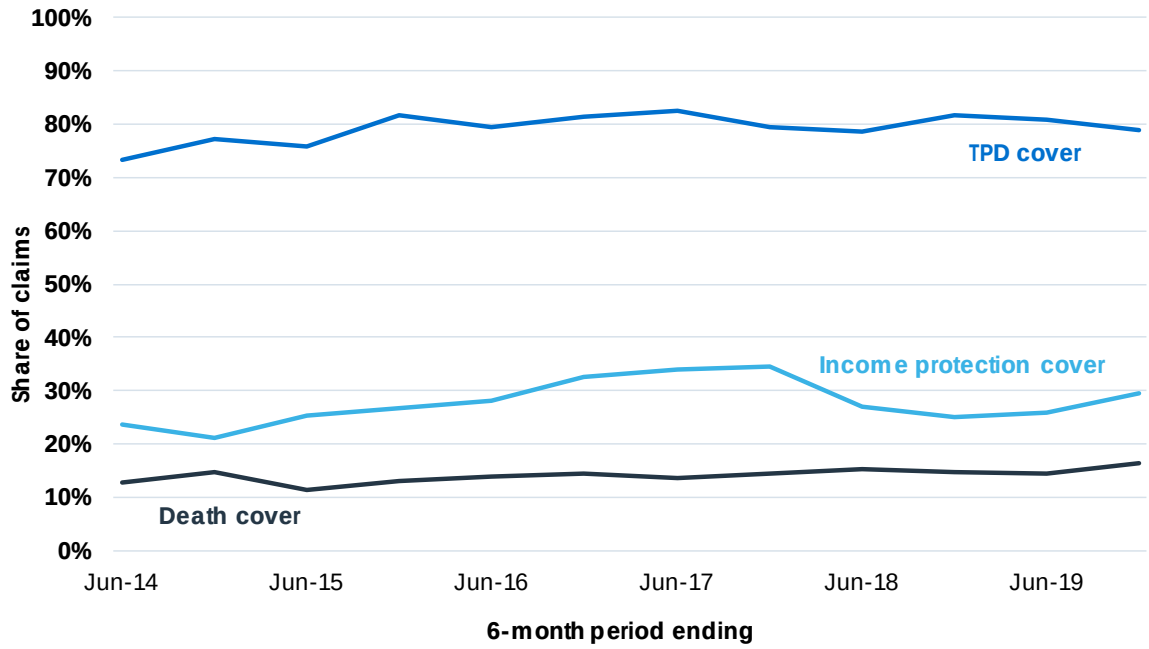
Further results are shown in Figure 17 and Figure 18.

Figure 17: Estimated cumulative share of claims by length of notification delay



Note: See Table 26 for the data shown in this chart (accessible version).

Figure 18: Share of claims notified each year that relate to incidents more than one year prior



Note: See Table 27 for the data shown in this chart (accessible version).

Appendix 3: Accessible versions of figures

Table 14: Accrual claims ratios, 2013–14 to 2018–19

Type of cover	Claims already paid	Outstanding claims (estimate)
Death cover	70%	10%
TPD cover	40%	47%
Income protection cover	25%	36%
All default cover	48%	31%

This is the data shown in Figure 1. Data and estimates are as at 30 June 2019.

Table 15: Range of accrual claims ratios across trustees, 2013–14 to 2018–19

Type of cover	Minimum	Average	Maximum
Death cover	49%	80%	113%
TPD cover	62%	87%	166%
Income protection cover	49%	61%	113%

Note: This is the data shown in Figure 2.

Table 16: Accrual claims ratios over time

Financial year	Claims already paid	Outstanding claims (estimate)
Death cover		
2013–14	80%	2%
2014–15	72%	1%
2015–16	69%	2%
2016–17	73%	4%
2017–18	74%	8%
2018–19	57%	38%
TPD cover		
2013–14	84%	23%
2014–15	56%	22%
2015–16	48%	30%
2016–17	38%	44%
2017–18	21%	66%
2018–19	5%	88%
Income protection cover		
2013–14	46%	21%
2014–15	34%	22%
2015–16	30%	25%

Financial year	Claims already paid	Outstanding claims (estimate)
2016–17	26%	27%
2017–18	14%	48%
2018–19	4%	70%

Note: This is the data shown in Figure 5. Data and estimates are as at 30 June 2019.

Table 17: Accrual and cashflow claims ratios, 2013–14 to 2018–19

Type of cover	Cashflow	Accrual
Death cover	73%	80%
TPD cover	58%	87%
Income protection cover	37%	61%
All default cover	58%	79%

Note: This is the data shown in Figure 6.

Table 18: Accrual claims ratios for retail and not-for-profit trustees, 2013–14 to 2018–19

Type of cover	Retail	Not-for-profit
Death cover	77%	82%
TPD cover	75%	94%
Income protection cover	67%	59%
All default cover	74%	82%

Note: This is the data shown in Figure 7.

Table 19: Accrual claims ratios by age cohort

Age cohort	Death	TPD	Income protection
Under 30	60%	49%	30%
30–49	82%	100%	61%
50 or older	90%	80%	71%

Note: This is the data shown in Figure 8.

Table 20: Range of claim incident rates (number of claims per 1,000 insured members per year) across trustees, 2013–14 to 2018–19

Type of cover	Minimum	Average	Maximum
Death cover	0.7	1.1	1.4
TPD cover	0.6	1.3	1.9
Income protection cover	2.2	2.8	5.6

Note: This is the data shown in Figure 9. The range of claim incident rates across group insurance policies is shown in Figure 15 in Appendix 2.

Table 21: Components of accrual claims ratios, 2013–14 to 2018–19

Financial year	Claims paid	Claims notified but not admitted	Claims admitted but not paid	Claims incurred but not reported
Death cover				
2013–14	80%	1%	1%	0%
2014–15	72%	0%	1%	0%
2015–16	69%	0%	1%	1%
2016–17	73%	0%	1%	2%
2017–18	74%	1%	3%	5%
2018–19	57%	6%	6%	26%
TPD cover				
2013–14	84%	5%	2%	16%
2014–15	56%	4%	1%	16%
2015–16	48%	6%	2%	22%
2016–17	38%	11%	4%	30%
2017–18	21%	14%	3%	49%
2018–19	5%	9%	1%	79%
Income protection cover				
2013–14	46%	2%	18%	2%
2014–15	34%	1%	18%	2%
2015–16	30%	2%	19%	3%
2016–17	26%	2%	19%	5%
2017–18	14%	4%	32%	12%
2018–19	4%	8%	25%	37%

Note: This is the data shown in Figure 12. Data and estimates are as at 30 June 2019.

Table 22: Average premiums and claim incident rate, 2013–14 to 2018–19

Financial year	Average premium (dollars per member per year)	Claim incident rate (number of claims incurred per 1,000 members per year)
Death cover		
2013–14	$124	1.0
2014–15	$145	1.0
2015–16	$148	1.0
2016–17	$148	1.0
2017–18	$152	1.1
2018–19	$151	1.3
TPD cover		
2013–14	$137	1.4
2014–15	$182	1.3
2015–16	$184	1.3

Financial year	Average premium (dollars per member per year)	Claim incident rate (number of claims incurred per 1,000 members per year)
2016–17	$183	1.3
2017–18	$176	1.3
2018–19	$170	1.5
Income protection cover		
2013–14	$232	3.2
2014–15	$291	2.9
2015–16	$297	2.8
2016–17	$301	2.7
2017–18	$286	2.5
2018–19	$271	2.8

Note: This is the data shown in Figure 13.

Table 23: Distribution of accrual claims ratios across group insurance policies, 2013–14 to 2018–19

Type of cover	Minimum	First quartile	Median	Third quartile	Maximum
Death cover	18%	52%	71%	86%	131%
TPD cover	38%	64%	78%	99%	139%
Income protection cover	26%	48%	61%	88%	113%

Note: This is the data shown in Figure 14. Very large outliers have been removed.

Table 24: Distribution of claim incident rates (number of claims incurred per 1,000 insured members per year) across group insurance policies, 2013–14 to 2018–19

Type of cover	Minimum	First quartile	Median	Third quartile	Maximum
Death cover	0.4	0.6	0.9	1.1	1.5
TPD cover	0.3	0.7	1.0	1.5	2.2
Income protection cover	1.7	2.1	2.7	3.7	6.1

Note: This is the data shown in Figure 15. Very large outliers have been removed.

Table 25: Claim paid rate and cashflow claims ratios compared to APRA industry-level data

Data source	Death cover	TPD cover	Income protection cover
Claim paid rate (claims paid per 1,000 members per year)			
2017–18 – APRA (industry)	1.2	1.2	4.4
2017–18 – ASIC (11 trustees)	1.1	1.1	8.7
2018–19 – APRA (industry)	1.2	1.4	4.8
2018–19 – ASIC (11 trustees)	1.1	1.2	9.9

Data source	Death cover	TPD cover	Income protection cover
Cashflow claims ratio			
2017–18 – APRA (industry)	81%	73%	87%
2017–18 – ASIC (11 trustees)	78%	68%	47%
2018–19 – APRA (industry)	76%	74%	86%
2018–19 – ASIC (11 trustees)	81%	76%	56%

Note: This is the data shown in Figure 16. ASIC figures for income protection claim paid rates count a single claim against each year in which a payment is made, whereas APRA figures count a single claim only against the first year.

Table 26: Estimated cumulative share of claims by length of notification delay

Notification delay (years since incident date)	Death	TPD	Income protection
0	46%	7%	53%
0.5	84%	21%	78%
1	93%	35%	86%
1.5	96%	48%	90%
2	97%	61%	92%
2.5	98%	70%	94%
3	99%	77%	96%
3.5	99%	82%	97%
4	99%	87%	98%
4.5	99%	90%	98%
5	100%	93%	99%
5.5	100%	95%	99%
Projections from this point forward			
6	100%	97%	100%
6.5	100%	98%	100%
7	100%	99%	100%
7.5	100%	99%	100%
8	100%	99%	100%
8.5	100%	100%	100%
9	100%	100%	100%

Note: This is the data shown in Figure 17.

Table 27: Share of claims notified each year that relate to incidents more than one year prior

6-month period ending	Death	TPD	Income protection
June 2014	13%	73%	24%
December 2014	15%	77%	21%
June 2015	11%	76%	25%
December 2015	13%	82%	27%
June 2016	14%	79%	28%
December 2016	14%	81%	33%
June 2017	14%	83%	34%
December 2017	15%	79%	34%
June 2018	15%	79%	27%
December 2018	15%	82%	25%
June 2019	14%	81%	26%
December 2019	16%	79%	29%

Note: This is the data shown in Figure 18.

Key terms and related information

Key terms

accrual claims ratio	A claims ratio calculated using the premiums members paid in a period and the corresponding claims insurers paid, plus estimates insurers have made for expected future claim payments (for claims incurred during the period)
annual benefit (income protection cover)	The maximum level of income protection insurance benefit a member is eligible to receive per year
APRA	Australian Prudential Regulation Authority
APRA-regulated superannuation fund	A superannuation fund regulated by APRA
ASIC	Australian Securities and Investments Commission
average claim time	The average claim processing time, in months
beneficiary	A person who has a beneficial interest in a superannuation fund, or to whom an insurance claim is paid
benefit period	The maximum period of time over which an income protection benefit is payable
bundled cover	Insurance cover where there is a combined premium and/or level of cover for death cover and TPD cover
cashflow claims ratio	A claims ratio calculated using financial flows of claim and premium payments each year (where the claim payments may relate to insurance arrangements in place across a number of past years)
choice superannuation product	A superannuation product that is not a MySuper product
claim incident rate	The number of claims incurred during a period for every 1,000 members with insurance
claim incurred	An insurance claim that an insurer is liable to pay arising from a death or disability
claim paid rate	The number of claims paid during a period for every 1,000 members with insurance
claim processing time	The time between the trustee receiving a claim and finalising it
claims acceptance rate	The percentage of claims an insurer accepted for payment out of all claims that went to a final decision during the period

claims finalised	Claims where the insurer has made a final decision on the claim (e.g. whether to admit or decline the claim) and this decision has been accepted by the trustee
claims-handling indicators	Measures of how superannuation trustees and insurers process insurance claims, such as claims acceptance rates, dispute rates and withdrawn claim rates
claims ratio	The dollar value of insurance claims divided by the dollar value of insurance premiums
claims received	Claims for which the first piece of information (not necessarily all information) has been received
Corporations Act	*Corporations Act 2001*, including regulations made for the purposes of that Act
death cover	A type of life insurance that pays a lump sum if the consumer dies
declined claim	Claims that are declined, with no benefit paid (or payable) to the claimant
default insurance	Cover provided through group insurance policies to default insured members that is not individually underwritten insurance cover
default insured member	A member who is provided insurance that they have not changed (by increasing or decreasing the level of cover, or opting out of part of it), other than by reporting their occupation to the trustee
default occupation category	The occupation group(s) used (for the purposes of determining premiums and/or level of cover) if the trustee does not have information from the member or employer about the occupation of the member
default occupational setting	The level and cost of default insurance cover for members in the default occupation category
design and distribution obligations	The obligations contained in Pt 7.8A of the Corporations Act
dispute	A dispute relating to an insurance claim
dispute rate	The number of claims-related disputes lodged during the reporting period per 100,000 lives insured
group insurance policy	A life insurance policy issued to a third party (e.g. a superannuation trustee) that policyholders can access through their membership of the third party's fund
incident date	The date on which a death or disability occurs
income protection cover	A life insurance policy that replaces the income lost if the policyholder is unable to work for a certain amount of time due to injury and/or illness
insurance arrangement	A group insurance policy or set of group insurance policies
Insurance in Superannuation Voluntary Code of Practice	A voluntary code of practice for the superannuation insurance industry. The code gives effect to guiding principles on appropriate and affordable design, member communications, and claims and complaints handling services.

insurer	The company that issues the life insurance policy.
level of cover	See *sum insured*
life insurance	An insurance policy that pays either a lump sum or income stream payment in the event of death, illness or disability. Life insurance policies can include cover for death, total and permanent disablement, trauma and income protection
life insurance policy	A life insurance contract as defined in s9 of *the Life Insurance Act 1995*, excluding investment or annuity-related contracts
member (superannuation)	A member of a superannuation entity, and includes a prospective member
member outcomes assessments	Assessments of outcomes provided to superannuation members. Superannuation trustees must undertake these assessments annually under SPS 515 and s52(9) of the SIS Act
MySuper product	A default superannuation product provided under Pt 2C of the SIS Act
not-for-profit superannuation trustee	A superannuation trustee whose business operations are not a source of income, profit or other financial gain to the trustee owners, or associates of the trustee owners, that establish, control or finance the legal entity
notification date	The date on which an insurance claim is notified to a superannuation trustee by a beneficiary
notification delay	The time between an insurance claim being incurred and being notified
occupational risk rating	A factor applied to insurance premiums based on a member's occupation
outstanding claims	Insurance claims that are incurred in a given period for which an insurer expects to be liable to pay a claim, but have not yet paid the claim. Includes claims that are reported but not admitted, incurred but not paid, admitted but not yet paid, or still in the course of payment
PMIF Act	*Treasury Laws Amendment (Putting Members' Interests First) Act 2019*
PYSP Act	*Treasury Laws Amendment (Protecting Your Superannuation Package) Act 2019*
retail superannuation trustee	A superannuation trustee that is not a not-for-profit superannuation trustee
SIS Act	*Superannuation Industry (Supervision) Act 1993*
SPS 515 (for example)	An APRA prudential standard (in this example numbered 515)

standalone cover	Insurance cover where there are separate premiums and levels of cover for death cover and TPD cover
sum insured	The contractual benefit payable under the life insurance policy, should the insured event occur
superannuation fund	Has the meaning given in s10(1) of the SIS Act
superannuation trustee	A person or group of persons licenced by APRA under s29D of the SIS Act to operate a registrable superannuation entity (e.g. a superannuation fund) (also known as an 'RSE licensee')
TPD	Total and permanent disability
TPD cover	A type of life insurance that pays a lump sum if the consumer becomes totally and permanently disabled
trustee (superannuation)	A person or group of persons licensed by APRA under s29D of the SIS Act to operate a registrable superannuation entity (e.g. superannuation fund) (also known as an 'RSE licensee')
type of cover	death cover, TPD cover or income protection cover
unit price (insurance)	The annual cost per $1,000 of insurance cover
waiting period	A period during which the insured must be absent from work to qualify for a life insurance benefit
withdrawn claim	Instances where a received claim is withdrawn and closed before being assessed and finalised. This includes claimants returning to work prior to the expiry of a waiting period (where applicable)
withdrawn claim rate	The number of withdrawn claims as a share of all claims received during a period
Workbook 1	A data collection, for this report, containing data on claim payments for default insured members grouped by incident date and notification date for six-monthly periods between June 2013 and December 2019 inclusive
Workbook 2	A data collection, for this report, containing data on the number of default insured members, premiums, claim payments and claims handling indicators for the six financial years 2013-14 to 2018-19 inclusive, for each externally insured group insurance policy with greater than 10,000 default insured members in any one of these years

Note: Additional definitions are provided in Table 12 in Appendix 2.

Related information

Headnotes

claims handling, claims ratio, design and distribution obligations, group insurance, data resources, default insurance, income protection, insurance in superannuation, loss ratio, life insurance, members' best interest, member harm, member outcomes assessments, MySuper, product design, superannuation, superannuation trustees, total and permanent disability, TPD, value for money

Legislation

Corporations Act, s912A(1)(a)

SIS Act, s52(2)(c), 52(2)(e)–(f), 52(7)(c), 52(9), 52(11), 68AA

PMIF Act

PYSP Act

Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Powers) Act 2019

ASIC documents

REP 591 *Insurance in superannuation*

REP 633 *Holes in the safety net: A review of TPD insurance claims*

REP 646 *Insurance in superannuation 2019–20: Industry implementation of the Voluntary Code of Practice*

REP 655 *Review of member communications: Protecting Your Superannuation Package (PYSP) reforms*

REP 673 *Consumer engagement in insurance in super*

RG 274 *Product design and distribution obligations*

20-180MR *Superannuation trustees compensate members wrongly classified as 'smokers'*

20-309MR *Trustees to improve occupational classification practices in insurance in superannuation*