Submission to the Review of the Financial System External Dispute Resolution Framework

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1 Introduction

Since 2012, the Public Interest Advocacy Centre (**PIAC**) has been providing legal advice and representation to people who have experienced discrimination, or otherwise been treated unfairly, by general and life insurance providers on the basis of a current, historical or imputed mental health condition.

PIAC welcomes this opportunity to make submissions addressing the Terms of Reference of the 'Review of the financial system external dispute resolution framework'.

PIAC would also welcome the opportunity to speak with the Panel about this submission and our casework in further detail.

1.1 The Public Interest Advocacy Centre

PIAC is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights;
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only, broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from NSW Trade and Investment for its work on energy and water, and from the law firm Allens for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

1.2 PIAC's work on mental health and insurance

PIAC has a long history of providing legal assistance and policy analysis in the area of disability discrimination and mental health.

In 2012, Mental Health Australia (then the Mental Health Council of Australia) (**MHA**) and *beyondblue* approached PIAC detailing concerning levels of apparent unlawful discrimination on the ground of mental health in the insurance industry, in particular with regard to the provision of

general (particularly, travel) and life insurance products (including income protection, trauma and total and permanent disability insurance).

Since then, PIAC's Mental Health and Insurance Project has provided advice and legal representation in both State and Federal jurisdictions to individuals across the country who believe general or life insurance services providers have discriminated against them because of a mental health condition or purported mental health condition or who have had a policy avoided by an insurer under the *Insurance Contracts Act 1984* (Cth) (**ICA**) due to the purported non-disclosure of a mental health condition.

In the majority of cases, PIAC assists clients to make complaints of unlawful disability discrimination to State based or Federal unlawful discrimination complaints bodies. PIAC has also assisted clients to make complaints to the Financial Ombudsman Service (**FOS**).

1.3 The focus of this submission

This submission focuses on issues arising from PIAC's Mental Health and Insurance practice only, and builds on PIAC's detailed submission to the Senate Standing Committee on Economics: Inquiry into the Scrutiny of Financial Advice.[1]

The submission does not address all of the questions raised by the Panel in its Issues Paper, many of which are outside the scope of PIAC's Mental Health and Insurance practice. The submission does not examine in detail the Credit and Investments Ombudsman and the Superannuation Complaints Tribunal (**SCT**).

2 Discussion questions

2.1 How effective is IDR in resolving consumer disputes? For example, are there issues around time limits, information provision or other barriers for consumers? (Discussion Question 7)

In PIAC's experience, IDR in an insurance context is rarely effective in resolving a consumer dispute. IDR requests are sometimes ignored or 'overlooked', time frames are long, there is generally little to no contact with the consumer during this period (for example, the insurer rarely seeks further information from the consumer during this period, although it may obtain the consumer's consent to obtain further information from a third party, such as a medical practitioner), thereby limiting the consumer's ability to advocate for themselves during the IDR process. On the whole, an insurer will usually affirm its original decision following IDR. The likelihood of a different decision following IDR is only slightly increased by the involvement of a solicitor representing the consumer. PIAC has acted in only one mental health and insurance case file that successfully resolved at the IDR stage.

In view of the above, the time allowed for IDR is too long. Generally complaints bodies allow the insurer 90 days for IDR. Although 90 days might be reasonable in circumstances where an insurer is actively gathering material, speaking with the consumer and considering the consumer's complaint, in PIAC's experience 90 days is unnecessarily long, particularly in cases where the insurer already has all of the information necessary for IDR and is simply awaiting

[1] A copy of the submission can be seen at: http://www.aph.gov.au/DocumentStore.ashx?id=71ab05c6-8e18-

review by the assigned person or committee. As a result, the resolution of the consumer's complaint is usually deferred for at least three months, sometimes longer, while the consumer awaits the IDR decision.

Recommendation

That the time allowed for IDR before a consumer's complaint will be accepted by a complaints body be reduced from 90 days to 60 days.

2.2 What are the relative strengths and weaknesses of the schemes' relationships with IDR processes? (Discussion Question 8)

The process for making a complaint to FOS following IDR is generally clear. A complainant to FOS who has not engaged in IDR will generally be referred to IDR. Following IDR, an insurer will usually notify the consumer that if they are unhappy with the IDR decision, they can complain to FOS.

However, following IDR the insurer will usually only advise the consumer of their right to lodge a complaint with one complaints body, and not all of the complaints bodies that are an option for them. For example, following IDR, consumers who have insurance through their superannuation provider and have made a complaint to both the superannuation provider and the insurer are generally referred to the SCT. However, the SCT is usually the least appropriate forum for the resolution of disputes alleging unlawful discrimination, or where a person has had a policy avoided by an insurer under the ICA due to a purported non-disclosure. For example, the SCT cannot consider a complaint about the 'design' of a fund, which appears to extend to insurance that has been designed for that fund. The SCT will consider the insurer's decision against the terms of the insurance policy but will not consider whether the terms of the insurance are discriminatory.

Recommendation

That consumers be made aware of all of their options for lodging a complaint following IDR at the earliest opportunity. This should not be limited to information about the SCT and should also include information about FOS and anti-discrimination bodies.

2.3 How accessible are the EDR schemes and complaints arrangements? Could their awareness be raised? (Discussion question 15)

There is a good level of awareness of FOS in the community, however, there is less understanding of FOS's Terms of Reference (that is, the types of disputes that FOS will and will not consider). In PIAC's experience there is an even lesser understanding of the differences between the various schemes (such as FOS and the SCT) and the anti-discrimination bodies. PIAC has heard many examples of consumers who have made complaints to FOS, only to find that the consumer's complaint is not within FOS's Terms of Reference. Despite many of these consumers having grounds to lodge a complaint of unlawful discrimination, FOS did not refer any of these consumers to an anti-discrimination body.

Recommendation

That FOS (and other complaints bodies) refer consumers who may have grounds to lodge a claim of unlawful disability discrimination for legal advice and/or to an anti-discrimination body, such as the Australian Human Rights Commission.

2.4 To what extent do EDR schemes and complaints arrangements provide an effective avenue for resolving consumer complaints? (Discussion question 17)

Strengths of the FOS scheme include the conciliation process, which should continue to be offered to consumer complainants wherever possible, and the low risk to consumers to engage in the FOS dispute resolution process (for example, in the ability to 'decline' to accept a decision that is not in the consumer's favour, without detriment to other legal avenues that may be available to the consumer).

2.5 Are the jurisdictions of the existing EDR schemes and complaints arrangements appropriate? If not, why not? (Discussion question 19)

FOS will not consider a dispute about underwriting or actuarial factors leading to an offer of a Life Insurance Policy on non-standard terms[2], nor will it consider a dispute about a decision to refuse to provide insurance cover, except where the dispute is that the decision was made indiscriminately, maliciously or on the basis of incorrect information[3]. The significance of this is best understood in the context of disability discrimination legislation, where the insurer must rely on underwriting and actuarial factors, amongst other things, to satisfy the insurance exemption[4].

However, this can be problematic for consumers who have been declined insurance or offered insurance on non-standard terms following the disclosure of a mental health condition, when the consumer suspects that this decision is contrary to insurer's underwriting guidelines. A consumer who suspects that there has been an error in the insurer's application of its underwriting guidelines, will not be able to lodge a dispute in FOS. FOS does not accept that a decision to decline to offer insurance or to offer insurance on non-standard terms would fall within its Terms of Reference. Certainly, s5.1(d) of the Terms of Reference appear to support FOS's position. However, PIAC's view is that s5.1(f)(i) of the Terms of Reference permit FOS to examine an insurer's underwriting guidelines for the purpose of determining whether they have been applied correctly according to the insurer's own practices.

As a result of FOS's position, consumers must lodge a complaint of unlawful disability discrimination to a State or Territory anti-discrimination Board or Commission. Unlike FOS, which has some decision-making powers, a complaint of unlawful disability discrimination initially depends on the goodwill of both parties to resolve the dispute. If an insurer is unwilling to provide a copy of underwriting guidelines and/or evidence of the actuarial and statistical data on which those guidelines are based during the course of a complaint of unlawful discrimination and a resolution cannot otherwise be achieved, the consumer's only option is to consider seeking a referral of their discrimination complaint from the relevant Board or Commission to a Tribunal or Court.

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[2] FOS Terms of Reference s5.1(d).

[3] FOS Terms of Reference s5.1(f)(i).

[4] The insurance exemption is set out in section 46 of the *Disability Discrimination Act 1992* (Cth) (**DDA**) and similar exemptions can be found in State and Territory discrimination legislation. The exemption under the DDA provides, in terms, that it is not unlawful to discriminate against a person by refusing insurance or in respect of the terms or conditions on which insurance is offered or may be obtained, if the discrimination is based on actuarial and statistical data on which it is reasonable for the insurer to rely and is reasonable having regard to any other relevant factors. If no actuarial or statistical data is available and cannot reasonably be obtained, the discrimination must be reasonable having regard to other relevant factors.

The time limit to lodge a disability discrimination claim (generally 12 months from the date of the discriminatory conduct) is shorter than the time limits to lodge a dispute in FOS (which generally start at 2 years and go up to 6 years in some cases). It is therefore important that all consumers who attend a complaints body be provided with information about the time limits that apply to the discrimination claim and referral options.

Recommendation

That FOS provide to all consumers whose dispute includes a discrimination claim or raises a discrimination issue, information about the complaints procedures in the disability forums (for example, by referring them to the Australian Human Rights Commission in the first instance) and the time limit for making a discrimination claim in those forums (generally 12 months from the date of the discriminatory conduct).

FOS's current terms of reference exclude discrimination complaints, however, PIAC notes this is contrary to statements made publicly by FOS following the decision in *Ella Ingram v QBE Insurance (Australia) Ltd* [2015] VCAT No H107/2014 (18 December 2015)[5]. Further information is needed from FOS about the manner in which it will consider these complaints and the remedies that will be available, noting that the relief offered by FOS and the discrimination forums is also different.

Recommendation

That, if indeed FOS now proposes to accept discrimination claims, it should:

- *work with state and Federal anti-discrimination bodies to develop a protocol in respect of these disputes; and*
- *provide information to users and consumers of the service as to how FOS will consider these disputes, including by updating its Terms of Reference.*

2.6 Are the current monetary limits for determining jurisdiction fit-for-purpose? If not, what should be the new monetary limit? Is there any rationale for the monetary limit to vary between products? (Discussion Question 20)

The current monetary limits in FOS should be increased. The current monetary limits in FOS operate, not to exclude a dispute from FOS's Terms of Reference, but to limit the remedies that FOS can offer to successful complainants.

For example a consumer with a life insurance policy with a monthly benefit exceeding $8,300, will only be able to recover $8,300 per month or alternatively a maximum of $309,000 if the total amount payable does not exceed this amount and satisfies the criteria in Schedule 2 of FOS's Terms of Reference. By making a complaint to FOS, which is generally a more efficient and cost-effective option than pursuing a civil claim through litigation, because of the caps applied to the remedies that FOS can decide, a consumer electing to take advantage of the FOS service may also be giving up their ability to fully recover their financial loss if they are successful in their complaint.

[5] See for example page 68 of FOS's Annual Review 2015/2016 in which it is reported that Lead Ombudsman John Price told audiences at industry forums that these types of discrimination cases are within its Terms of Reference and that if issues of discrimination are raised, FOS will ask insurers to provide actuarial and statistical data and satisfy FOS that information was relied on.

Recommendation

The current monetary limits in FOS should be increased[6]*:*

- *(1) From $8300 per month to $10,000 for a claim on a Life Insurance or General Insurance Policy;*
- *(4) From $309,000 to $500,000 – Other (according to the current Terms of Reference, this limit applies if a claim is in excess of the monthly limit above but within this amount).*

These limits are proposed on the basis of the average value of the life insurance policies that PIAC has seen as part of its mental health and insurance practice. The Panel might as part of this Inquiry obtain data from the insurers about the average value of these policies that will further inform its findings in relation to new monetary limits.

2.7 Do the existing EDR schemes and complaints arrangements possess sufficient powers to settle disputes? Are any additional powers or remedies required? (Discussion Question 22)

In most jurisdictions, a complainant who has achieved a successful outcome may apply to the same body for an order to enforce the terms of any remedy ordered and rely on that enforcement order to achieve a remedy.

However, there is no such enforcement process in FOS. A consumer who has achieved a successful outcome in FOS is unable to enforce the remedies decided by FOS directly against the financial services provider. A consumer can raise a financial service provider's failure to comply with a remedy ordered and, as a result, FOS *may* engage with the financial service provider on the issue and *may* decide to take enforcement action against the financial service provider in the Courts. Such enforcement action is effectively to enforce the terms of FOS's contractual relationship with the financial services provider and thereby to enforce the remedy that FOS has decided in any particular case.

2.8 To what extent are there gaps and overlaps under the current arrangements? How could these best be addressed? (Discussion Question 30)

A consumer who has insurance through a superannuation provider will rarely benefit from having their dispute considered by the SCT due to the limited scope of the SCT's enquiries in respect of complaints of that nature. Consumers with insurance complaints should be directed to FOS in the first instance, irrespective of whether the consumer holds the insurance in connection with a superannuation policy, or to a State or Territory discrimination Board or Commission.

For consumers who have been declined insurance or offered insurance on non-standard terms, generally the appropriate complaints body will be a State or Territory anti-discrimination Board or Commission.

However, for consumers who have existing insurance policies and have a complaint about an insurer's decision in respect of that existing policy, for example in relation to an application to adjust the terms of that policy or in relation to a claim made by the consumer against the policy or to a decision by the insurer to avoid the policy on the basis of non-disclosure of a mental health

[6] See page 46 of FOS Terms of Reference for current monetary limits.

condition (either current, historical or imputed by the insurer), a consumer will be faced with a choice between making a complaint of unlawful disability discrimination or lodging a dispute in FOS. Although FOS will accept a dispute that has also been lodged with an anti-discrimination body due to the impending expiration of the limitation period and only if that dispute has been stayed, it will not accept a dispute that has otherwise been lodged with an anti-discrimination body. This can be problematic as the focus of the inquiries made by an anti-discrimination body and FOS are different. Generally consumers also require assistance to negotiate with FOS in relation to the acceptance or staying of proceedings.

2.9 Would a triage service improve user outcomes? (Discussion Question 35)

A triage service has the potential to improve user outcomes, for example, by telling consumers of the various complaints bodies that could consider the consumer's dispute, providing the consumer with or directing them to the terms of reference for those complaints bodies and providing referral options for legal advice and assistance (which could be best managed by referring to existing referral services for more detailed referral options).

2.10 What should any triage service look like? (Discussion Question 36)

Ideally, a triage service would be serviced by individuals who are trained in the jurisdiction and terms of reference for each complaints body and can then provide information about those complaints bodies, as well as referral to one of those bodies where appropriate. In house legal staff and/or decision makers who are actively involved in decision-making for the respective complaints bodies should support the individuals working in the triage service.