ASIC

Australian Securities & Investments Commission

Review of the financial system external dispute resolution framework

Supplementary submission by the Australian Securities and Investments Commission

November 2016

Background

1 In May 2016, the Government established a review of the external dispute resolution (EDR) and complaints framework in the financial services sector. ASIC lodged a submission to this Review in October 2016.

2 In October 2016, ASIC also released Report 498 *Life insurance claims: An industry review* (Report 498), which set out the results of our industry-wide review of life insurance claims practices and outcomes.

3 ASIC did not find evidence of cross-industry misconduct, however, we did identify specific areas of concern in relation to declined claims rates and claims handling procedures associated with particular types of policies, particular insurers and particular causes for consumer disputes. These concerns will be the subject of further surveillance work by ASIC.

4 We identified some areas of action, with a view to improving claims handling outcomes for consumers, one of which is recommending that consumer dispute resolution for claims handling be strengthened. Both the Financial Ombudsman Service (FOS) and the Superannuation Complaints Tribunal (SCT) deal with retail disputes about life insurance, and the overlapping and contrasting jurisdiction of FOS and the SCT are raised in the Issues Paper and also discussed in ASIC's main submission.

5 The recommendations in Report 498 relating to complaints handling were to:

(a) ensure better and more effective consideration of issues of fairness to supplement the existing EDR jurisdiction, particularly in relation to outdated medical definitions in trauma policies; and

(b) give better access to consumers with complaints about delays in claims handling and ensure better remedies when these complaints are found in favour of the consumer.

6 The purpose of this supplementary submission is to provide some further background to these recommendations, so that the Panel may consider these in the context of the current review.

Ensure better and more effective consideration of issues of fairness to supplement the existing jurisdiction

How FOS applies "fairness"

7 The FOS Terms of Reference (TOR) require it to make decisions having regard to legal principles, applicable industry codes or guidance, good

industry practice and its previous relevant decisions (although not binding), while reaching a conclusion that in its opinion is "fair in all the circumstances" (FOS TOR cl 8.2).

8 Under its operating guidelines, FOS states that it will "take into account industry codes, practice guides and good industry practice. However, FOS will not necessarily be bound by the minimum standard that may be set in a particular industry code. FOS will try to do what is fair in all the circumstances for both parties to the dispute and this may involve deciding that an FSP should have met a higher standard than the minimum industry standard set in a particular industry code including good practice expressed by ASIC or other relevant regulators."

9 This highlights the critical role that industry codes play in setting standards that can directly improve consumer outcomes at industry based EDR schemes.

10 In ASIC's primary submission at paragraph 102, we described the strengths of the current co-regulatory model of EDR. The following strengths are particularly relevant to our review of life insurance claims:

(a) a decision making approach which includes having regard to the law, relevant industry codes, good industry practice and what is fair in all the circumstances;

(b) public guidance on how a scheme will approach particular types of disputes or fact scenarios to guide industry on good practice and make decision making more predictable;

(c) identification and resolution of systemic issues;

(d) role in lifting industry standards by incorporating the standards in industry based codes of conduct into assessment of disputes and resolution of systemic issues; and

(e) processes which support the parties to achieve quick, earlier resolutions of disputes.

11 The life insurance industry has launched a new Life Insurance Code of Practice which is mandatory for members of the Financial Services Council (the Code). The Code will help to establish minimum standards for the industry. The industry has committed to further enhancements to the Code to help to raise industry standards across the issue of life insurance policies, including in relation to claims handling. This includes developing a set of standard definitions of medical definitions for trauma policies.

Fairness and outdated medical definitions

12 The terms of a life insurance policy generally define the insured risk (e.g. that a benefit is only payable for a condition defined in the policy). Where a policy term has been properly disclosed, and is not misleading or ambiguous, then an EDR scheme is unlikely to be able to find that an insurer's decision to deny a claim was unlawful or not consistent with good industry standards (assuming there is no conflict with an industry code of practice).

13 For instance, a life insurance policy may define a serious heart attack according to specific diagnostic criteria. As medical practice evolves, the diagnostic criteria for serious heart attacks may change, which means that a consumer may suffer a serious heart attack without being tested according to the diagnostic criteria which was specified in their life insurance policy.

14 In a recent dispute, FOS found that, while a person had suffered a heart attack which seriously affected their life, the insurer was only required to pay the benefit in accordance with the policy where the person met the definition of heart attack in the policy.

15 In instances where an insurer's decision to decline a claim is made by reference to the terms of the policy (for example, not meeting a technical medical definition) but may not align with the 'spirit' or 'intent' of the policy, we consider that EDR schemes should have the ability to consider what is 'fair' in the circumstances, and not be limited to a strict interpretation of the terms and conditions of the policy. This is because a fair outcome is not always achieved when the consumer's condition or circumstances do not meet the technical policy definition; even if they have suffered a trauma, and the condition has negatively impacted their life in the way that the insurance policy was intended to address. This is in circumstances where the consumer has not engaged in activities contrary to the intent of the policy (e.g. engaging in illegal activity).

16 Although FOS has regard to more than legal principles, cases such as *MLC v O'Neil* ([2001] NSWCA 161) and *Larwint Pty Ltd v Norwich Union Life Australia Ltd* [2007] VSCA 21 set out the legal approach. In these cases the Courts found in favour of the insurer (which had denied the life insurance claims) despite the life insureds suffering a heart attack according to contemporary medical testing or diagnosis, however, not meeting the symptoms and out of date diagnostic tests for suffering a heart attack specified in the life insurance policy.

17 In *Larwint*, Ashley JA said that "The purpose of the policy is to give indemnity not where a person suffers a heart attack in lay or medical parlance, but where a person suffers a heart attack as defined. The evidence in this case showed that it is not uncommon for a person who has suffered a

heart attack to have a normal ECG. It follows that a medical man may diagnose a heart attack in reliance upon clinical presentation and having regard to other test results. But that is no occasion to manipulate the language of the definition of to make it accord with modern day medical practice".

18 In the vast majority of cases the terms of the policy accurately reflect the intent and spirit of the policy and what is intended to be covered. It is thus appropriate to focus on the strict wording of those terms in determining claims. However, as evidenced in a small number of cases, due to changing medical understanding or practice, the legal approach set out in cases like *Larwint* can generate an outcome that does not reflect the emphasis on fairness in FOS's decision making criteria.

19 The primary responsibility for addressing this problem rests with insurers. We made this clear in Report 498 where we stated[1]:

> *We identified that fairness should be given greater consideration by insurers. Not all insurance claims will be successful, but an issue arises when a policyholder's reasonable expectations about policy coverage do not align with the technical wording in the policy.*
>
> *On this point, a key challenge for the life insurance sector is how to deal with that small number of claims that may not technically be covered under the 'fine print', but under any reasonable consumer or community expectation should be paid. We found that ex-gratia payments were inconsistently applied across the sector.*
>
> *Poor and/or inconsistent management of these relatively small number of claims can lead to very poor outcomes for consumers and significant reputational damage for insurers. This issue highlights the importance of an insurer's 'claims philosophy' and how that philosophy aligns with the need to put policyholders first.*

20 This challenge also needs to be taken up at the level of EDR. As noted above, under its terms of reference, FOS can and does take fairness into account in its current decision making. However, our view, based on what we found in Report 498, is that in a small number of cases the outcome suggests that there needs to be greater clarity around, and a strengthening of, the consideration of fairness in FOS's handling and determination of the dispute. This may be achievable through a practice note or guidance rather than a change to the terms of reference.

[1] Report 498 *Life insurance claims: An industry review* (Report 498), October 2016, paragraphs 21-23

Give better access to consumers with complaints about delays in claims handling and ensure better remedies when these complaints are found in favour of the consumer

21 The new Code provides for an overall time frame of 12 months for claims decisions. However, insurers are permitted to go beyond 12 months in making a decision for a range of reasons. If a claim does go beyond 12 months, the Code only requires insurers to provide the consumer with information about how to make a complaint. We are concerned that this step alone may be inadequate to encourage consumers who have already been through a protracted claims process to then pursue a complaint about this delay. We consider that access to IDR and EDR by consumers has an important role to play, not only in reviewing the final decision of an insurer, but also to assist consumers who have concerns about delays in insurers making a decision about a claim.

Compensation for consequential loss

22 We recommend that additional compensation be payable to consumers where insurers have unreasonably delayed the determination of a claim. The purpose of life insurance is to pay a benefit at a time of need, and this is not achieved where there is unreasonable delay in determining a claim. We have seen examples where delays involve multiple requests for the same or extensive evidence, which also adds stress to a claimant.

23 Where a clear link to consequential damage (due to delay) can be demonstrated by the consumer, and in the event of an ultimately successful claim (wholly or partially), FOS or the SCT should be allowed to consider consequential loss to the consumer as part of the remedy, and not merely full or partial payment of the claim plus interest. The calculation of 'consequential loss' could be (as an example) made by reference to proofs submitted by the consumer. Alternatively (or additionally), the interest rate could be increased to reflect a 'punitive' amount attributed to the unreasonable delay

24 This is consistent with approaches taken overseas – for example, in the UK, compensation is payable for unreasonably declined claims. In the USA, high interest charges apply in many states where there are delays in (ultimately successful) claims payments.

25 FOS can currently make an award of up to $3,000 for consequential financial loss or damage, including where "an unusual degree or extent of physical inconvenience, time taken to resolve the situation or interference with the Applicant's or Other Affected Party's expectation of enjoyment or peace of mind has occurred". ASIC supports a review of the adequacy of this limit in the context of life insurance claims handling.

26 We note that FOS can also apply interest to decisions made in the consumer's favour where there has been an inappropriate delay in making a decision by the insurer, in accordance with FOS's terms of reference and in line with provisions in the Insurance Contracts Act. However these rates are limited and we think consumers' access to dispute resolution and beneficial outcomes can be enhanced by enabling full consideration of consequential loss and /or to reflect a punitive amount.

Monetary limits

27 In our primary submission, ASIC identified the different monetary limits operating across the financial services EDR sector, including the difference between the FOS and SCT jurisdiction. ASIC believes it is appropriate to review the limits affecting EDR for life insureds to promote consistent access to justice.