Review of the financial system external dispute resolution framework

Australian Government Treasury

beyondblue Submission

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Summary of key points

- For the past 15 years, *beyondblue* has been working to reduce discrimination by the insurance industry for people with mental health conditions when accessing insurance products.
- The current complainant-driven dispute resolution system can inadvertently disadvantage people, especially people with a mental health condition, as it is often costly, complicated and time-consuming.
- Depending on the nature of the complaint, relevant law and jurisdiction, a person who feels they have been unfairly treated as a result of their mental health condition, is expected to navigate a complex external dispute resolution system comprising of multiple organisations as well as traversing the internal dispute resolution system of the financial service in question.
- Very rarely does the internal dispute resolution process change the original decision.
- Disputed claims and/or lengthy delays can be extremely stressful and in some cases may exacerbate a person's mental health condition.
- Disputed claims and/or lengthy delays can increase levels of financial stress. The presence of a mental health condition significantly increases the likelihood of a person being in severe or high financial stress.
- Mental health conditions are common – in a lifetime, depression affects one in seven Australians and anxiety conditions as many as one in four.
- There is still significant stigma and discrimination associated with having a mental health condition.
- *beyondblue* welcomes reform to better support people with a mental health condition engage in insurance complaint dispute resolution in a straight-forward and timely way.

Summary of recommendations

The following recommendations are made to the Australian Government Treasury:

To reduce the level of responsibility on the person to initiate, navigate and seek resolution in a complex financial service dispute resolution process, *beyondblue* makes the following recommendations:

- Streamline the complaints mechanism by establishing a 'no wrong door' approach for people seeking financial service external dispute resolution. As part of this structure, overlay a triage system to ensure the complaints are directed to the most suitable organisation.
- Support the 'no wrong door' approach with a triage system that engages, consults and cooperates with State and Territory regulatory and complaints bodies as well as Commonwealth, State and Territory anti-discrimination dispute resolution organisations to ensure complaints that fall outside the Financial Ombudsmen Service Terms of Reference are referred to the appropriate service.
- Review and revise the Financial Ombudsmen Service Terms of Reference to include the consideration of cases where the individual has been either refused or provided non-standard life insurance cover due to pre-existing conditions including mental health.
- Any alternative dispute resolution model proposed as an outcome of this review should consider the scope of the terms of reference of organisations involved to ensure that no complaint is not addressed.
- Consider a provision to confidentially share information between different regulatory bodies or regulators to prevent repetitive information provision for the people who engage in a dispute resolution process.
- Develop, implement and monitor clear and well-defined timeframes for a complaint to be addressed by providing an average timeframe for resolution. To increase adherence to timeframes consider developing and implementing benchmarks and impose penalties for falling below these.
- Improve the public reporting practices of complaints by:
    - providing a full description of how the complaint was addressed, or inversely why it was not, and where it was referred if it was outside the Financial Ombudsman Service Terms of Reference
    - providing a description of the outcome of the complaint including adherence to timeframes
    - making complaints information prominently and publically available through either reporting to a relevant body or providing it as a public annual report.
- Consider financial incentives or penalties, or random auditing of financial services to encourage the enactment of external dispute resolution decisions by insurers.

Introduction

beyondblue welcomes the opportunity to make this submission to the Australian Government Treasury in response to the call for submissions on the *Issues Paper – Review of the financial system external disputes resolution framework*. This submission provides recommendations on how to improve the external dispute resolution framework for people engaging in the financial service sector. The focus of this submission is on the Financial Ombudsmen Service and how it could be improved to better support people with mental health conditions.

beyondblue is committed to supporting all people in Australia to achieve their best possible mental health. As a national population mental health organisation, we have a range of integrated initiatives to prevent depression, anxiety and suicide and to assist people who experience these conditions by raising awareness, increasing knowledge, decreasing stigma and discrimination, encouraging people to seek help early and improving their ability to get the right services and supports at the right time. *beyondblue's* work is supported by the Commonwealth and every State and Territory government in Australia, philanthropy and public donations.

A snapshot of mental health in Australia

Depression and anxiety are common – around one in seven Australians will experience depression in their lifetime and one quarter of Australians will experience an anxiety condition.

In 2007, the National Survey of Mental Health and Wellbeing found that in the year prior, around 1 in 5 Australians aged 16-85 years have experienced a mental health condition at some point. The survey also found that over their lifetime, around 45 per cent of Australians reported that they had experienced some sort of mental health condition.

Despite being so common, there is still significant stigma and discrimination associated with having a mental health condition. While Australians are becoming increasingly literate about mental health conditions, there is still a level of confusion and misunderstanding associated with these conditions that leads to stigma and discrimination. This harms individuals and our community.

Like physical health conditions, mental health conditions have a range of characteristics unique to each individual. They can be recognised and treated. Most people with a mental health condition will recover and stay well. Some may experience intermittent relapses while others may experience more persistent difficulties. Individual differences must be expected and understood.

Insurance discrimination

In April 2015, *beyondblue* provided a comprehensive submission to the *Senate Economics References Committee – Inquiry into the Scrutiny of Financial Advice – Life Insurance* detailing the issue of insurance discrimination for people with mental health conditions and providing recommendations for change. *beyondblue* recommends consideration of this submission by the Australian Treasury. Found here http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Scrutiny_of_Financial_Advice/Submissions

For the past 15 years, *beyondblue* has been working to reduce discrimination by the insurance industry for people with mental health conditions when accessing insurance products.

People with a mental health condition are entitled to fair and equitable access to insurance products, to enable them to protect themselves and their families against financial stress and uncertainty. Despite this, empirical evidence and anecdotal reports demonstrate that many people with a mental health condition experience significant difficulties in obtaining and claiming on different types of insurance products, compared to the rest of the population. These difficulties occur across the general and life insurance industries for products such as travel insurance, income protection, total and permanent disability (TPD) and life insurance.

Under the Disability Discrimination Act 1992 (Cth), insurers must use actuarial and statistical data to justify any discrimination on the basis of disability where that data is available. Parts of the insurance industry claim to be using this data, although it has not been released and shared on the public record to date.

Other parts of the industry declare that robust data is not available and that other relevant information must be relied upon to make decisions. It is understood by *beyondblue* and others advocating in this space, that the insurance industry treats all mental health conditions as a single group, rather than treating each mental health condition as a unique diagnosis with relevant prevalence rates and prognostic characteristics. This could be likened to treating all physical conditions – heart disease, cancer and arthritis – as a single group of conditions, and making decisions relating to insurance accordingly.

Cases of discrimination appear to be driven by an under-reliance on available statistical and actuarial data and an over-reliance on views of the nature of mental health conditions, often based on deeply flawed understanding of these conditions. Policy wording commonly refers to symptoms (e.g. stress, insomnia) or risk factors (e.g. family history) as proxies for a diagnosed mental health condition. Evidence suggests insurers may also attribute a mental health condition to someone who has seen a counsellor or psychologist, even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling).

When an application for insurance is declined, people have reported to *beyondblue* that insurers either do not provide reasons or they offer very broad or generic reasons, which do not cite particular factors that were considered relevant to the individual. When Mental Health Australia and *beyondblue* conducted a Survey of Consumer Experiences relating to insurance discrimination, we were told:

> *"They wouldn't explain … it was just 'based on medical evidence"*
>
> *"Was told I was a risk due to 'health problems'… did not elaborate on which ones"*

Furthermore, *beyondblue* has seen no evidence that the insurance industry is basing its decisions on readily available epidemiological data that relates to the typical trajectory of each specific mental health condition and the types of risk and protective factors, including access to effective treatment that can modify these trajectories. Nor does the insurance industry appear to rely on the wealth of data from the Medical Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Australian Institute of Health and Welfare (AIHW), Independent Hospital Pricing Authority (IHPA) and other sources that would enable it to calculate the likely costs of treatment of different mental health conditions at varying severities in order to inform its risk ratings and price settings.

The consumer experience

In recognition of the importance of this issue, *beyondblue* and Mental Health Australia undertook a study into insurance discrimination in 2010 – the Survey of Consumer Experiences. The results highlighted the difficulties people with a mental health condition have in obtaining travel, life, TPD and income-protection insurance. To shed further light on this issue, since 2013 *beyondblue* has called for people to share their stories of unfair treatment or discrimination by insurers for mental health reasons. We have received hundreds of stories telling us about seemingly arbitrary decisions around access, obfuscation and lack of transparency in the management of claims.

The experiences that are reported to *beyondblue* suggest that dismissive and/or obstructive conduct within the insurance industry is common, and is particularly concerning given the negative impact that this can have on vulnerable people. Some survey respondents indicated that insurance companies appeared to automatically categorise mental health conditions as high risk regardless of the person's individual circumstances. Insurers made broad assumptions about a person's ability to maintain employment and their general level of functioning, which in turn had negative implications for their application. Several respondents mentioned the embarrassment, humiliation and insensitivity surrounding interactions with an insurance provider. Several also mentioned how their interactions with insurance providers have impacted negatively on their mental health.

> *" … I decided not to take up the product for the time being, because I felt discriminated against and deeply affected by the stigma and shame the whole process (answering the questions etc.) made me feel."* - Respondent to Survey of Consumer Experiences

The flow on effects of this discrimination contribute to stigma, which produces considerable harm at the individual, community and economic level. While there are some protections offered by legislation and

regulation, this appears insufficient to stop behaviour that is legal, but potentially unethical, and which does not reflect contemporary knowledge and attitudes to mental health conditions. This has impacts on some of the more vulnerable members of the community.

Many people described dealing with the insurance industry's internal dispute resolution processes as a battle. Case studies have also reported that it is rare that an insurer will overturn a decision already made. Of particular concern, some people described experiencing a prolonged claims process that sometimes spanned a number of years.

> *"The claim was accepted after about 5 years – they lost the original claim, then lost the next one, then delayed whilst sending me to a lot of specialists at my cost. Whenever the specialist reported in my favour they would send me to another at my cost. I never recovered the cost of specialists."* – Respondent to Survey of Consumer Experiences

Disputed claims and/or lengthy delays can be extremely stressful and in some cases may exacerbate a person's mental health condition. Respondents in the Survey of Consumer Experiences spoke of the increased stress that the claims process inflicted, particularly the impact of prolonged processes with extensive evidence required, and examinations undertaken by unfamiliar medical professionals working for insurers. The issues in relation to claiming were recently exposed in a joint Fairfax-Four Corners investigation, which highlighted evidence that insurers (in this case CommInsure) are unfairly denying people coverage or rejecting and/or delaying claims, often based on weak diagnoses and outdated attitudes about mental illness. The current co-regulatory framework, which is reliant on industry compliance with standards and codes of conduct monitored and enforced by statutory bodies is not working.

Legislative and regulatory considerations

The Insurance Contracts Act 1984 (Commonwealth)

The *Insurance Contracts Act 1984 (Cth)* (ICA) sets out relevant law governing insurance contracts in Australia and aims to strike a fair balance between the interests of the insurer and the insured consumer. Section 13 of the ICA requires each party to act towards the other party with the utmost good faith. Section 75 of the ICA requires an insurer to outline in writing their reasons for refusing to enter into a contract of insurance, cancelling or not renewing a contract, or for offering insurance cover on less advantageous terms, if requested to do so in writing by the policy holder or applicant. If the reasons, or one of the reasons, concerns the state of health of the policy holder/applicant, the written reasons may be provided to a medical practitioner on behalf of the policy holder/applicant.

It is unclear whether the conditions of the Act are adhered to on a consistent basis, with anecdotal evidence suggesting many people, especially those with a mental health condition do not fully understand why they are rejected for a policy or when a claim is made.

Financial Ombudsman Service

The Financial Ombudsman Service (FOS) provides dispute resolution services between consumers and financial service providers, including insurers.

The FOS is guided by Terms of Reference (ToR), last updated in 2015. In relation to insurance, the FOS ToR only provide a complaints service to people who have a current life insurance policy. As such, they do not provide dispute resolution services to consumers who have been refused life insurance cover or have been provided a non-standard life insurance cover, which would exclude certain medical conditions or will have higher premiums as the consumer has pre-existing medical conditions. In essence, this means consumers with mental health conditions are often unable to receive any assistance from FOS.

Australian Human Rights Commission

For persons who have been refused life insurance or have been issued a non-standard life insurance policy, a complaint about a financial service must be lodged through the Australian Human Rights Commission under the *Disability Discrimination Act 1992 (Cth)*. While this may result in a positive outcome for the

consumer if the matter is resolved, it does little to raise awareness and build understanding of mental health conditions in the broader insurance industry.

Complaints and enforcement

The current complainant-driven process can inadvertently disadvantage complainants as the process is often considered complicated, costly and time-consuming. The external disputes resolution system is complex comprising of multiple bodies who can hear complaints regarding insurance, depending on the nature of the complaint, relevant law and jurisdiction. This includes the Australian Human Rights Commission, Financial Ombudsman Service, Superannuation Complaints Tribunal, and State and Territory based human rights, anti-discrimination or equal opportunity bodies. This makes the system difficult to navigate and deters consumers from taking action, particularly if they are currently unwell as a result of their mental health condition, or feeling vulnerable and stigmatised as a consequence of their interaction with insurers.

There are a number of avenues in which complaints and appeals of insurers' decisions can be made. Many complaints are resolved through conciliation. While conciliation processes provide an opportunity for satisfactory resolution for the individual, most cases settle on a confidential basis without an admission of liability on the part of the insurer. As a result, the opportunity to set firm legal precedents, or to influence longer-term practice change, has been considerably constrained. In the current approach the burden falls on individuals to invest considerable time, money and effort in pursuing a complaint. This can be extremely stressful and in some cases may exacerbate a person's mental health condition and levels of financial stress, which may already be high.

Case Study: Ingram v QBE Insurance (Australia) Ltd (Human Rights) [2015] VCAT 1936

Ella Ingram, now 21 years old, was issued with a travel insurance policy by QBE for a school study trip to New York when she was 17. After commencing Year 12, prior to the departure of the school trip, Ella became unwell and was diagnosed by a psychiatrist with depression, and was subsequently voluntarily admitted to an adolescent psychiatric inpatient unit. This was the first time in her life that Ella had experienced depression. On doctors' advice, Ella decided she would be unable to go on the trip to New York, and then claimed under the policy for the cancellation costs of $4292.

Ella's claim was refused by QBE internal dispute resolution process, who relied on a general mental illness exclusion clause, which excluded coverage of any claims relating to mental illness. Ella subsequently took her complaint to the Victorian Equal Opportunity and Human Rights Commission and challenged QBE's denial of the claim in the Victorian Civil and Administrative Tribunal (VCAT); in December 2015 VCAT found in Ella's favour. VCAT found that QBE discriminated against Ella twice, firstly by issuing a policy which contained the mental illness exclusion clause, and secondly by refusing her claim based on that exclusion.

The Tribunal found that QBE did not produce sufficient evidence to prove that the discrimination was based on actuarial or statistical data. QBE accepted that it had no actuarial data on which to rely in respect of the mental illness exclusion in the policy. QBE presented a range of prevalence data, however they also acknowledged that there was a 'paucity of evidence' to show that there was a link between the statistical data and the decision to include a general exclusion for mental illness in the travel insurance policy.

QBE was found by the Tribunal as not being able to produce sufficient evidence that it would have suffered an unjustifiable hardship by removing the mental illness exclusion clause. The Tribunal member noted that "There is an absence of sufficient material for me to determine that it would be an unjustifiable hardship for QBE to be unable to rely on the mental illness exclusion. The scales weigh in favour of people like Ms Ingram being able to be properly assessed on their policy claims in the same way people with physical disabilities are assessed."

Although the finding is limited to the circumstances of Ella's case, which concerns travel insurance, being the first test-case concerning insurance discrimination on the basis of mental illness in Australia, the case highlights critical issues in relation to broad, blanket mental health exclusions, and the importance of policy terms being informed by robust actuarial and statistical data and analysis.

Ella's case was the first test case heard by a court or tribunal in relation to insurance discrimination and mental illness in Australia. Ella Ingram's case was unique, in that she chose to pursue her dispute with QBE to a hearing for the broader public benefit despite the toll of protracted litigation. It **took almost four years** for Ella to find out whether QBE's discrimination against her was unlawful. In the time that it takes to pursue a complaint, an individual may be uninsured and unprotected, or suffer financially.

Alternative models for dispute resolution

The issues paper that accompanies the Inquiry provides a number of options for consideration if an alternative model for dispute resolution in the system was adopted.

beyondblue strongly supports the recommendation of a 'no wrong door' approach with a triage system to address the issues encountered when engaging in the financial services dispute resolution system. This system reform should aim to reduce the burden and responsibility on an individual to navigate the complex external disputes resolution system. As part of this reform, the Australian Government Treasury should also consider consulting a broader group of members than those contained in the current inquiry – extending to the Australian Human Rights Commission and State or Territory-based human rights, anti-discrimination or equal opportunities bodies.

While the ToR for the FOS remain as they are currently, many people who are discriminated against by insurers are precluded from engaging FOS' support to review their case. As such, *beyondblue* believes that any alternative model to support people engaging the external dispute resolution service for financial service needs to:

- Consider the scope of the terms of reference of involved organisations to ensure that no person's complaint falls through the gaps between different organisations involved in the external dispute resolution system.
- Consider a provision to confidentially share information between different regulatory bodies or regulators to prevent the repetitive information provision for a person engaging in the system.
- Develop, implement and monitor clear and well-defined timeframes for a complaint to be addressed providing an average timeframe for resolution. To increase adherence to timeframes consider developing and implementing benchmarks and impose penalties for falling below these.
- Improve the public reporting practices of complaints by:
    - providing a full description of how the compliant was addressed or inversely why it was not accepted and where the person was referred if needed;
    - providing a description of the outcome of the complaint including adherence to timeframes;
    - making complaints information prominently and publicly available through either reporting to a relevant body or providing it as a public annual report.
- Consider financial incentives or penalties and random auditing of financial services to encourage the enactment of external dispute resolution decisions by insurers.

Other inquiries that the Australian Government Treasury should consider when developing its recommendations are:

- *Senate Economics References Committee – Inquiry into the Scrutiny of Financial Advice – Life Insurance recommendations and submissions.*

Conclusion

This submission outlines the significant challenges and issues that people with mental health conditions experience when using the dispute resolution services for financial services in Australia. The case studies

which are shared with *beyondblue* cite interactions and experiences with a variety of different insurance companies. This suggests that the complexity of the current complaints resolution system is preventing people from resolving a legitimate complaint and putting undue responsibility and stress on the complainant to get a fair and enforceable resolution. Although the law contains protections for people with a disability (including a mental health condition), complaints practices appear to be skewed towards the interests of insurers, at the expense of the rights of insurance policy holders and applicants. *beyondblue* is keen to work in collaboration with the government on concrete actions to change this so that all people using the system, especially those with a mental health condition get a fair and timely resolution to their insurance complaint.

Summary of recommendations

The following recommendations are made to the Australian Government Treasury:

To reduce the level of responsibility on the person to initiate, navigate and seek resolution in a complex financial service dispute resolution process, *beyondblue* makes the following recommendations:

- Streamline the complaints mechanism by establishing a 'no wrong door' approach for people seeking financial service external dispute resolution. As part of this structure, overlay a triage system to ensure the complaints are directed to the most suitable organisation.
- Support the 'no wrong door' approach with a triage system that engages, consults and cooperates with State and Territory regulatory and complaints bodies as well as Commonwealth, State and Territory anti-discrimination dispute resolution organisations to ensure complaints that fall outside the Financial Ombudsmen Service Terms of Reference are referred the appropriate service.
- Review and revise the Financial Ombudsmen Service Terms of Reference to include the consideration of cases where the individual has been either refused or provided non-standard life insurance cover due to pre-existing conditions including mental health.
- Any alternative dispute resolution model proposed as an outcome of this review should consider the scope of the terms of reference of organisations involved to ensure that no complaint is not addressed.
- Consider a provision to confidentially share information between different regulatory bodies or regulators to prevent repetitive information provision for the people who engage in a dispute resolution process.
- Develop, implement and monitor clear and well-defined timeframes for a complaint to be addressed by providing an average timeframe for resolution. To increase adherence to timeframes consider developing and implementing benchmarks and impose penalties for falling below these.
- Improve the public reporting practices of complaints by:
    - providing a full description of how the complaint was addressed or inversely why it was not and where it was referred if it was outside the Financial Ombudsman Service Terms of Reference;
    - providing a description of the outcome of the complaint including adherence to timeframes;
    - making complaints information prominently and publically available through either reporting to a relevant body or providing it as a public annual report.

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