Inquiry into the life insurance industry

Financial Ombudsman Service Australia Submission

November 2016

Contents

Executive summary

The Financial Ombudsman Service (FOS) Australia[1] is an ASIC-approved independent external dispute resolution (EDR) scheme that covers disputes across the financial sector.[2]

As well as its role in dispute resolution, FOS has responsibilities to identify and resolve systemic issues and obligations to make certain reports to ASIC. We also provide secretariat services to code monitoring and compliance committees for four industry codes of practice.

We welcome the opportunity to contribute to the inquiry. This submission[3] covers matters raised in our submission to the recent Senate inquiry into the scrutiny of financial advice[4] and comments on other issues within the current inquiry's Terms of Reference.

We recognise that life insurance products are not standard. A range of commercial factors affect the underwriting and pricing of each product and the risk products are designed to cover. Insurance policies do not cover all risks and it is appropriate for certain insurance claims to be declined.

While we acknowledge these points, we consider there is scope to introduce new consistent standards to apply to all life insurance products and services. This submission suggests that, to improve consumer protection, development of such standards be considered.

Matters addressed in this submission include:

Jurisdiction of FOS
Section 1 provides information about our jurisdiction, including an explanation of some constraints on our ability to consider certain life insurance disputes.

Dispute statistics
Section 2 sets out current statistics relevant to life insurance disputes dealt with by FOS.

[1] Information about FOS is set out in full on our website at www.fos.org.au. Section 1 of Appendix 1 summarises key points.
A review of the financial system EDR framework, including FOS, is being undertaken at present by an expert panel. An interim report on the review is due in November 2016 and the final report on the review is due in March 2017.
[2] FOS is approved by ASIC under its Regulatory Guide 139 *Approval and Oversight of External Dispute Resolution Schemes*, which is available under 'Regulatory Resources' on www.asic.gov.au.
[3] This submission has been prepared by the Office of the Chief Ombudsman and does not necessarily represent the views of the Board of FOS. It draws on the experience of FOS and its predecessor schemes in the resolution of disputes about financial services.
[4] See submission made by FOS in April 2016 to the Inquiry into the Scrutiny of Financial Advice by the Senate Economics References Committee.

Resolving disputes and handling systemic issues
Section 3 provides information about our dispute resolution processes and information that may help the inquiry to examine the effectiveness of internal dispute resolution in life insurance. It also provides details and outcomes of our systemic issues work.

Key objectives of reforms in the life insurance industry
We support the development of codes of practice and current efforts to improve remuneration structures and remove conflicted advice in the life insurance sector. Section 4 explains the need for additional reforms to ensure consumers are treated fairly in all facets of life insurance product design, service, conduct, claims handling, complaints and remediation.

Code of practice
Section 5:

- emphasises the need for all life insurance participants, products and services to be covered by a code of practice
- explains our view that a life insurance code of practice should be approved by ASIC
- comments on the code of practice launched by the Financial Services Council in October 2016 and
- suggests measures to reduce complexity and confusion in relation to medical definitions in life insurance policies.

ASIC review of life insurance claims
Section 6 outlines measures we have in place to improve fairness in the handling of life insurance disputes, addressing matters raised by ASIC.

Legislation
Section 7 suggests consideration be given to extending unfair contract terms legislation to life insurance contracts.

1 Jurisdiction of FOS

Our jurisdiction[5] is set out in Section B of our Terms of Reference and explained in detail in our Operational Guidelines. Important exclusions from our jurisdiction are noted below.

Disputes referred to in paragraph 5.1 of the Terms of Reference are excluded from our jurisdiction. To mention a few examples relevant to life insurance, FOS cannot consider:

- disputes about underwriting or actuarial factors leading to an offer of life insurance on non-standard terms
- disputes about decisions as to how the benefit of a financial product should be allocated between beneficiaries
- disputes already dealt with in a court, tribunal or another ASIC-approved EDR scheme
- certain disputes about premiums charged or
- disputes about decisions of superannuation trustees in relation to group insurance policies.

We also have discretion to exclude disputes from our jurisdiction in relation to life insurance under paragraph 5.2. We do not lightly exercise this discretion and must be satisfied it would be inappropriate for FOS to consider the dispute any further.

Under current arrangements with the Superannuation Complaints Tribunal (SCT), we generally refer disputes relating to life insurance claims where the policy is held within superannuation to the SCT as it has jurisdiction in relation to the role of the superannuation trustee. Details of some of the key similarities and differences between FOS and the SCT are set out in Appendix 2.

Our Terms of Reference set $500,000 per claim as the monetary limit of our jurisdiction. We may not consider a claim where the value exceeds $500,000. This is the 'product value' figure used as part of the retail client definition in section 761G of the *Corporations Act 2001* (Corporations Act)[6].

The current compensation cap for most disputes is $309,000. Other caps apply to disputes about income stream insurance ($8,300 per month), some disputes against general insurance brokers ($166,000), and third party motor vehicle insurance claim disputes ($5,000). A cap of $3,300 per claim also applies to awards for consequential loss or damage.

[5] In August 2016, FOS released proposals to expand our jurisdiction for small business disputes. See our consultation paper, submissions responding to it and other information about the proposals on our website.
[6] A dispute may contain multiple claims. For example if a life insurer denies both an income protection claim and a total and permanent disability claim, they are different 'claims' in a dispute.

Examples of life insurance products or services that may be the subject of disputes we consider include:

- income and non-income stream risk products sold through other risk products such as consumer credit and superannuation and
- advice by financial advisers on life insurance products.

The current review of the financial system EDR framework (the Ramsay Review) is examining, among other things, gaps and overlaps in the current arrangements among the existing three schemes along with the appropriateness of current claim and compensation limits.

2 Dispute statistics

2.1 Life insurance members of FOS

FOS had some 5,540 licensees and 8,036 authorised credit representatives as members as at 30 June 2016. Our records for 2015-16 indicate that 33 of our members were life insurers and 44 were life insurance brokers[7].

We note that many of our financial advisory members provide life insurance and risk advice to their clients, either as advice related to stand alone policies or as advice on group, industry or retail superannuation products.

2.2 Life insurance disputes accepted in 2015-16[8]

FOS accepted a total of 20,298 disputes across our whole jurisdiction in 2015-16. We accepted 1,095 life insurance disputes in 2015-16. Denial of claims was the most common issue in life insurance disputes referred to FOS in 2015-16. This was the primary issue in 26% of the disputes.

Of the 1,095 life insurance disputes accepted in 2015-16, 55% related to income stream risk products, 42% related to non-income stream risk products and the classification of 3% was not determined as at 30 June 2016. Income stream risk typically involves income protection insurance products and non-income stream risk products are typically paid on death, total and permanent disability or critical illness.

2.2.1 Income stream risk products

Income stream risk products include:

- consumer credit insurance, which is to cover loan repayments if a borrower cannot work due to an accident, sickness or involuntary unemployment or dies and

[7] This information is based on how the financial services providers have described their business to us.
[8] More detailed information, including explanations of terms used, is provided in our Annual Review 2015-16 on pages 90 to 94.

- income protection insurance, which is to pay an income if the policy holder cannot work due to injury or illness.

FOS accepted 603 disputes about income stream risk products in 2015-16. 57% of these disputes were about decisions made by a financial services provider. Of the disputes about income stream risk products we accepted, 534 (or 89%) related to income protection insurance and 67 (or 11%) related to consumer credit insurance.

Disputes about denial of a claim, delays in claim handling and claim amounts were key themes associated with income protection insurance. Common issues in income protection insurance disputes were that financial services providers:

- gave insufficient warning before ceasing benefits
- did not provide enough explanation about why benefits would cease or
- requested too much information from beneficiaries.

Our 2015-16 Annual Review provides a case study[9] based on an income protection dispute that we considered.

FOS continues to be concerned that financial services providers are relying on incorrect policy provisions and are not providing relevant documentation to us at the time of disputes.

2.2.2 Non-income stream risk products

Non-income stream risk products include:

- term life insurance
- total and permanent disability insurance
- trauma insurance
- whole of life insurance
- annuities
- endowments
- funeral plans and
- scholarship funds.

FOS accepted 462 disputes about non-income stream risk products in 2015-16. Almost half of the disputes (47%) about non-income stream risk products related to a decision made by the financial services provider.

[9] See page 93 of our Annual Review 2015-16.

Almost one third (31%) of the disputes about non-income stream risk insurance we accepted related to term life insurance products. The most common issues in disputes about these products were incorrect premium and denial of a claim.

More than one quarter (29%) of this category of disputes concerned total and permanent disability insurance. Denial of claim was the most common reason people lodged disputes about this product, followed by delay in claim handling.

We also accepted 77 disputes related to trauma insurance products in 2015-16. Denial of claim was the most common issue in those disputes.

2.3 Decisions about life insurance disputes

16% of the disputes we closed in 2015-16 were resolved by a FOS decision or assessment. Most disputes are resolved at the earlier stages of our process by the financial services provider directly with the consumer or through our processes for conciliation, negotiation or settlement. We receive some disputes that are outside our jurisdiction, including disputes that we refer to the SCT. Our 2015-16 Annual Review provides full details of the outcomes of disputes closed in that year.[10]

In 2015-16, we closed 1,327 life insurance disputes. Of these disputes, 308 (or 23%) were resolved by a FOS decision or assessment.

3 Resolving disputes and handling systemic issues

3.1 External dispute resolution

Section 2 of Appendix 1 provides information about the dispute resolution processes of FOS.

Regularly, through published material, presentations and other engagement with stakeholders, we explain our approach to dispute resolution. The material ranges from detailed 'FOS Approach' documents, decisions and case studies to easy-to-read brochures and fact sheets.[11]

3.2 Internal dispute resolution

FOS encourages early resolution of disputes. Our processes are designed to help financial services providers resolve disputes directly with consumers, without our intervention. Section 2 of Appendix 1 sets out a map of our dispute resolution process.

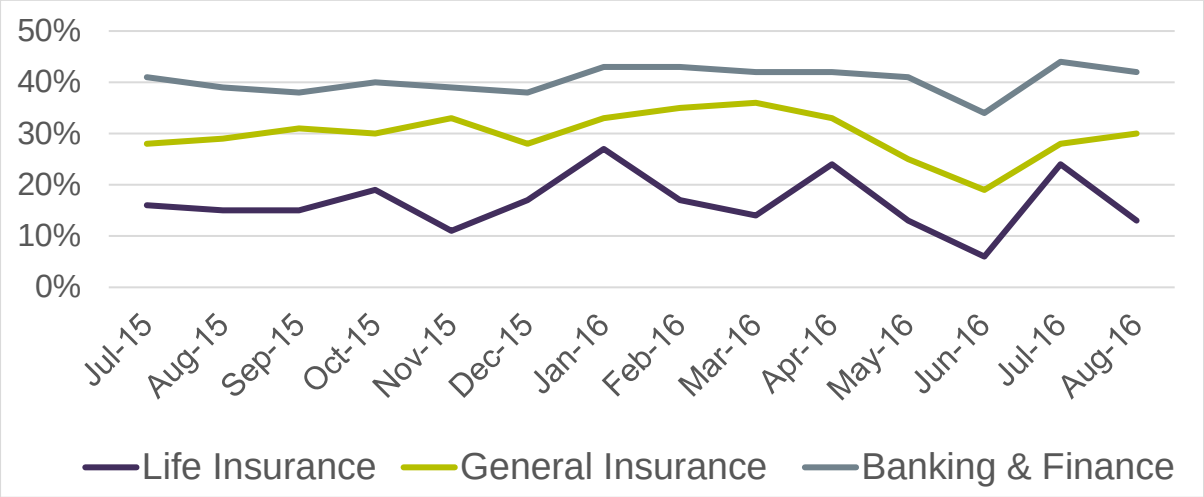
After a dispute is lodged with FOS, we refer the dispute to the financial services provider. This referral occurs during the first stage of our dispute resolution process, known as 'Registration and Referral'. We give the financial services provider a

[10] See pages 56-58 of our Annual Review 2015-16.
[11] See our decisions and case studies under the 'Resolving Disputes' tab, and material under the 'Publications' tab, on the home page of our website www.fos.org.au.

timeframe to resolve the dispute directly with the consumer and provide its response to FOS if the dispute is not resolved.

The graph below provides information on dispute resolution rates during the Registration and Referral stage. It indicates that the rate of dispute resolution at the earliest stage in our process is lower for life insurance disputes than for other disputes we consider – banking and finance disputes and general insurance disputes.

Resolution rate – Registration and Referral



It is acknowledged that certain factors may contribute to dispute resolution being slower for life insurance disputes than for other financial services disputes. Examples of these factors include:

- The involvement of underwriters:

  Resolution of a life insurance dispute may need to be agreed with an underwriter.

- The need for external evidence:

  Evidence needed for life insurance claims may take some time to obtain. For example, delays in obtaining certain medical reports may be unavoidable.

- Professional indemnity insurance:

  It may only be possible to resolve a financial advice dispute after consultation with a professional indemnity insurer.

The second stage of our dispute resolution process, known as ‘Case Management’, is designed to be a time for us to consider whether approaches such as assessment, negotiation or conciliation are appropriate, and seek to resolve the dispute. If the financial services provider in a dispute does not respond to FOS within the timeframe allowed, the dispute will still progress to Case Management, but our ability to deal with the dispute efficiently is reduced, as we do not know the financial services provider’s stance.

Further, our current statistics show that, in a substantial proportion (up to 40% in a month) of these disputes, by the time the dispute progressed, the financial services provider had not provided any response to FOS. We are currently discussing the reasons behind this trend with the firms involved as this impacts on the timeliness of EDR and can adversely affect consumers.

3.3 Systemic issues

Section 3 of Appendix 1 explains how FOS handles systemic issues. More detailed information about our work on systemic issues is published on our website and in our Annual Reviews.[12]

Information supplied by financial services providers indicates that the systemic issues identified by FOS across all disputes and resolved during 2015-16, affected over 400,000 consumers. Outcomes of these systemic issues include:

- monetary refunds of more than $12.75 million to consumers following direct involvement by FOS (or in some cases the issues identified from FOS disputes may have already been remediated by the financial services provider or been subject to ASIC involvement)
- improving business practices, such as methods used to calculate the quantum of life insurance benefits and
- addressing specific problems – for example, an insurer reviewed its decisions to decline certain travel insurance claims after we raised concerns about two claims being declined incorrectly.

One example of our work on systemic issues affecting life insurance is a matter we handled in 2014-15, in which denials of insurance claims were overturned. Another example is provided by a case study[13] set out in our latest Annual Review, where a process failure caused a life insurer to breach legal requirements for cancelling policies due to non-payment of premiums.

4 Key objectives of reforms in the life insurance industry

The central theme of our submissions to the Financial System Inquiry was that the inquiry's recommendations should encourage and support consumer trust and confidence in the financial system and the financial services providers, products and services that consumers use.

We also referred to changes in the financial sector supporting a move towards a more integrated approach to consumer protection regulation rather than one based

[12] See pages 109-114 of our Annual Review 2015-16.
[13] See page 112 of our Annual Review 2015-16.

on regulating distinct activities.[14] In life insurance, recent developments have included:

- a move to direct sales by the internet and phone
- provision of group policies through superannuation
- major and continuous medical breakthroughs, requiring policies to remain responsive to significant changes in clinical, diagnostic and medical practice and
- policies being sold as bundle products with consumer credit and other policies.

Accordingly, we welcomed the clear recognition by the Financial System Inquiry in its final report that the key to building consumer confidence and trust is the fair treatment of consumers by financial firms and that the regulatory framework needs to broaden its focus beyond point of sale. The final report concluded that 'alignment needs to start at the point of product design, and then be strengthened through distribution and advice'.[15] We go further and say it should also include claims handling, complaints and remediation programs.

We support recent life insurance reforms including initiatives to improve remuneration structures and address conflicted commission based advice. These measures should form part of a suite of reforms to cover all stages from product development to sales and distribution.

In the context of life insurance, the duty to act in utmost good faith articulated in section 13 of the *Insurance Contracts Act 1984* (Insurance Contracts Act) applies. This provides a strong base on which life insurance reforms can be built. In our view, the reforms should focus on ensuring fair treatment of consumers in all facets of product design, service, conduct, claims handling, complaints and remediation.

We also note the importance of current practice standards that apply in relation to advice on life insurance products, such as the Financial Planning Association of Australia's Code of Professional Practice and its 'Member Guidance Series' on life insurance advice.[16]

When deciding a dispute, FOS does what it considers fair in all the circumstances, having regard to factors including good industry practice and codes. For example, our decisions in life insurance disputes take into account the standards and obligations in any applicable code of practice.

Life insurers should put the interests of consumers first in a way that keeps pace with consumer needs and community expectations, which continue to change, and may

[14] See our Submission to the Interim Report of the Financial System Inquiry, August 2014, on page 8.
[15] See Financial System Inquiry Final Report, November 2014, on page 193.
[16] Financial Planning Association of Australia *Member Guidance: Life Insurance Advice*, September 2015.

change rapidly. This includes improving, then meeting, standards of good practice as well as meeting all relevant minimum legal requirements.

In addition, we suggest consideration be given to increasing the awareness of existing consumer protection provisions in the Insurance Contracts Act. These provisions include section 13, stating the duty to act in utmost good faith, and limitations on:

- the right to avoid policies for non-disclosure (section 29)
- denying claims based on pre-existing conditions (section 47) and
- refusing claims in certain circumstances (section 54).

The inquiry could consider whether these provisions should, for example, be reinforced through better internal compliance arrangements, possible specific provisions in the next iteration of the code along with steps by the industry and firms to increase consumer awareness of importance of these provisions.

5 Code of practice

5.1 Need for consistent overarching industry standards

FOS considers that all services provided by life insurers, including insurance under superannuation group policies, should be covered by a code of practice.

We support the work done by the Financial Services Council (FSC) to produce the initial Life Insurance Code of Practice launched on 11 October 2016 (FSC Code). We note that the FSC in its statements of 11 October 2016 and 2 November 2016 has set out the further work it is doing to address some of the gaps in its initial code. The statements include:

1. **Life cover in group superannuation:** The FSC is committed to working collaboratively with the superannuation industry to deliver end to end commitment to the insurance experience for superannuation members. These discussions with the superannuation industry will continue. To this end, the FSC has released a Statement of Intent with organisations representing all superannuation trustees, ASFA, AIST, ISA and IFF, which commits to working together to lift standards for group insurance, including the role of super trustees.

2. **Advisers:** The code's first iteration is a code for consumers. The relationship between insurers and financial advisers is an important but different one, and we are committed to working with the peak adviser organisations to address mutual obligations.

3. **Funeral insurance and consumer credit insurance:** In response to recent ASIC reports on funeral insurance and consumer credit insurance, the industry will address the issues raised including through limitations on sales and premium

structures. These standards would require the second iteration of the code to be submitted for ACCC approval.

4. **Enforcement:** In response to feedback from stakeholders, the FSC will consider making an application for ASIC approval of the second iteration of the code.

5. **Products and definitions:** Building on the work done to date on draft minimum standard medical definitions, the FSC will investigate whether further standardisation or updating of definitions is required. The industry will discuss the possibility of putting in place a standardised process for policy upgrades for existing customers.

6. **Mental health specific standards:** The next iteration of the code will seek to increase obligations on insurers when interacting with consumers suffering mental health issues. The FSC will work with groups like Beyond Blue, Lifeline, Mental Health Australia and the Public Interest Advocacy Centre to determine how to better serve those consumers with mental health issues.

We support this further work outlined above. In our view, while the initial code is a useful starting point, gaps do remain in its scope and coverage for certain key areas. We note the FSC has committed to addressing a number of these issues for the second iteration of the FSC Code over the coming months.

We comment further on a number of these pieces of work below.

5.1.1 Group insurance

The relevant industry bodies have established the 'Insurance in Superannuation Industry Working Group' to develop a code of practice for life insurance in superannuation.[17] We support this initiative which will address the gap in the coverage of the current code and improve industry practice to benefit consumers in all sectors.[18]

5.1.2 ASIC approval of the second iteration of the FSC Code

We note the FSC has stated it will consider seeking ASIC approval of the second iteration of the Code. Important issues relating to code coverage, adequacy of code provisions and multiple codes are matters addressed in ASIC's Regulatory Guide 183 *Approval of financial services sector codes of conduct*. We support ensuring that the second iteration of the FSC Code, and any other code of practice developed for life insurance, be approved by ASIC under Regulatory Guide 183. Approval of a code by ASIC would be a strong signal to consumers that they can have confidence in the code.

[17] See media release on 2 November 2016 for details.
[18] Appendix 4 outlines key considerations that should be taken into account in the development of any new life insurance code of practice.

While we appreciate there are a number of technical difficulties in establishing a single code given the different entities involved, we suggest that, if achievable, a single life insurance code is preferable to multiple codes which may add to complexity for consumers and difficulties in ensuring consistent standards across the industry for subscribers.

5.2 Further improvements for the second iteration of the FSC Code

Below, we outline how the next iteration of the FSC Code could be enhanced. Our views were explained to the FSC during its consultation to develop the current code.[19] We are continuing to engage with the FSC in relation to enhancements of the FSC Code.

5.2.1 Coverage of FSC Code

As a matter of principle, we consider the second iteration of the FSC Code should aim to cover all services provided by life insurers, whether sold directly or through intermediaries, including group life insurance through superannuation.

In our experience, codes of practice are more effective when they also hold subscribers accountable for the actions and conduct of their employees, agents and subcontractors in the provision of services to consumers. We would support initiatives by the FSC to ensure this occurs.

5.2.2 Customer focus

We would support enhancements to ensure, for example, that:

- clear timelines are set for the handling of claims and consumer complaints
- any concerns about the relevance and frequency of requests for information by life insurers are addressed
- mechanisms for the review, application and interpretation of medical definitions in policies are standardised across industry. Currently each code subscriber can have its own system to update medical definitions. For further detail, see section 5.3.
- a single uniform approach to the cancellation of policies for non-payment of premiums is established and
- consumers can easily access EDR.

[19] See submission by FOS to FSC on second consultation draft of Life Insurance Code of Practice in September 2016.

5.2.3 Accessibility, fairness and accountability

We consider there are opportunities for the second iteration to be easier for consumers to read and understand. The FSC Code should simply state each standard, how it should be met and what happens if it is not met.

Each section of the FSC Code should begin with a commitment to fair service and treatment of consumers throughout the life cycle of an insurance product.

The FSC Code should commit subscribers to open and transparent decision-making and conduct at all stages from marketing to claims and complaints handling.

The FSC Code should establish a clear and simple framework for the monitoring and oversight of compliance and accountability of subscribers against the code's standards.

Subscribers should also be held accountable against the 'key code promises' published on the FSC website. These promises should be considered part of the obligations that are monitored and enforced by the Life Code Compliance Committee. FOS will take the key code promises into account when making decisions relating to conduct of a subscriber after their transition to the code.

5.3 Medical definitions

The FSC is currently consulting on standardised medical definitions. Our approach to such definitions is based on the underlying principle that fairness needs to underpin the design of policies, including policy terms and conditions such as medical definitions.

It is our experience that disputes often arise as a result of the application and interpretation of policy definitions where the definition is overly restrictive, ambiguous, unclear in its meaning, outdated, has not kept pace with current clinical, medical or diagnostic tools and where community expectations about what the definition will cover is different to the elements in the definition that must be satisfied in order for a claim to be successful. We have a real concern that consumers may be misled to expect that certain events or medical conditions are covered by a policy when they are not.

A major challenge for consumers is that definitions in life insurance policies can require detailed medical knowledge to fully understand when and under what circumstances the cover under a policy will apply. Most consumers do not have this knowledge.

Options to reduce complexity and confusion are discussed below. Our suggestions are designed to both help avoid disputes arising in the first place and, when they do arise, enable FOS to take into account the standards set out in the FSC Code in resolving individual disputes under our Terms of Reference.

5.3.1 Extending new standards to all medical definitions

The current provision in the FSC Code for medical definitions, section 3.2, applies only to definitions in 'on-sale' policies. This limitation amounts to a substantial 'carve out' from the code and we consider that such carve outs detract from the effectiveness of a code. We suggest consideration be given to extending section 3.2 so that it applies to policies other than 'on-sale' policies.

5.3.2 Making definitions easier to understand

As with the standard definition of 'flood' for general insurance policies, which has been adopted industry wide, there may be scope to consider the development of a key facts sheet for consumers about the cover contained within some standard life insurance products.

Definitions should also be written in plain English, expressed as clearly and simply as possible, with minimal use of technical language and jargon.

5.3.3 Standardising against a minimum benchmark

We recognise that initiatives to standardise policy definitions may need to balance pricing considerations for risks covered, amongst other things. We also acknowledge that not all risks are supposed to be covered by every insurance policy and that not all claims will be successful.

For certain types of general insurance such as home and contents insurance, an insurer is required to provide standard cover and can only depart from that cover if it clearly informs consumers about the variation. Standard cover does not currently apply to life insurance, but there may be an opportunity to work towards standardising some common definitions for key illnesses and trauma within certain policies.

We consider that the industry can play a role here. When a life insurance policy uses a commonly understood term, such as 'major heart attack', 'cancer' or 'stroke', a code of practice could require the policy to give the term its ordinary meaning or one that is consistent with current medical practice and clinical diagnostic tests.

5.3.4 *Keeping definitions up to date with community expectations and diagnostic practice*

Existing case law does not impose on financial services providers a clear legal obligation to regularly review definitions in insurance policies. The leading cases in this area suggest that a claim under a policy is to be treated as a matter based solely on contract, even if a crucial definition in the policy is out of date and this affects the insured adversely.[20] At present, this case law can in some instances limit our ability to go beyond the terms of the policy definitions under a life insurance contract.[21]

[20] See *MLC Ltd v O'Neill* [2001] NSWCA 161.
[21] See *MLC Ltd v O'Neill* [2001] NSWCA 161.

In our experience the review and update of medical definitions across firms currently varies considerably and the reliance by insurers on restrictive legal principles to interpret and apply medical definitions can result in adverse outcomes for consumers.

We therefore support the industry's commitment to regular three year reviews of medical definitions in on-sale policies, for benefits that are payable after a defined medical event. In our view this will go some way toward ensuring these definitions reflect developments in medical practice and diagnosis and keep pace with community expectations. We appreciate that insurers cannot alter an insurance contract unilaterally and agree the obligation to let consumers know when medical definitions in their life insurance policy are updated is important.

However, we think the industry can do more in this regard. First, we encourage industry to consider whether the commitment to review definitions in on-sale policies can be extended to other policies. We also encourage industry to reflect on the need to give consumers clear and simple information so they understand not only that a review has taken place, but how and when an updated medical term might apply to their policy.

Where there are consumer safeguards already in place, further compliance mechanisms may be needed to ensure the safeguards operate effectively. Two examples drawn from our dispute resolution experience for the inquiry to consider are:

- **Promises to 'upgrade' policies:** A common feature of guaranteed renewable life insurance is the promise by the insurer to upgrade the policy from time to time.

  Recent disputes about the currency and coverage of definitions of critical illness may be evidence that the insurer has not upgraded the policy as promised.

- **Section 54 of the Insurance Contracts Act:** Section 54 may prevent an insurer from relying on a medical definition to refuse a claim.

  Insurers should routinely consider their obligation to take into account section 54 in the handling of a claim and not simply rely on the terms of the policy.

Further, we believe that transparency is key and we encourage industry to report annually to the Life Code Compliance Committee on reviews conducted in any reporting year under this provision, including outcomes of the reviews undertaken, number of policies affected, nature and type of amendments made to definitions and consultations undertaken.

6 ASIC review of life insurance claims

In October 2016, ASIC released the findings of its recent industry-wide review of claims handling in the life insurance industry – Report 498. The report recommends[22] that:

- the consumer dispute resolution framework for claims handling should be strengthened and
- the coverage of life insurance claims by dispute resolution schemes should be considered as part of the current EDR review[23].

The report states that it is necessary to:

- ensure better and more effective consideration of issues of fairness to supplement the existing jurisdiction and
- 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.

ASIC has followed its report with a submission[24] to the EDR review Panel and recommended that there be greater clarity around, and strengthening of, the consideration of fairness in the handling and determinations of disputes by EDR schemes, including FOS.

ASIC suggests that in the instances where an Insurer's decision to decline the claim is made by reference to the terms of the policy (for example, not meeting the technical medical definition) but may not align with the 'spirit' or 'intent' of the policy, 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.

Further, ASIC has suggested that that the limits affecting EDR for life insureds should be reviewed given the different monetary limits operating across the financial services EDR sector and to promote consistent access to justice. FOS supports this recommendation.

FOS and ASIC have discussed these recommendations and we look forward to ongoing work with ASIC and the EDR review panel to progress the recommendations.

In addition, we have already developed a range of relevant initiatives, which include working with industry to:

- further develop our approach to fairness in EDR decision making on life insurance disputes

[22] Paragraphs 45 and 49 of Report 498 set out these recommendations.
[23] Footnote 1 provides information about the EDR review.
[24] ASIC supplementary submission November 2016.

- improve service delivery and practice through the identification and remediation of systemic issues and
- strengthen internal dispute resolution arrangements within life insurers.

7 Legislation

National unfair contract terms (UCT) laws generally apply to contracts for financial services under the *Australian Securities and Investments Commission Act 2001*. The UCT laws do not apply to life insurance and general insurance contracts however.

A proposal to extend the UCT laws to general insurance contracts was considered in 2013, but did not proceed.[25] We consider that the inquiry should review whether the basis of the exemption remains relevant for life insurance given the importance the Financial System Inquiry placed on ensuring fair treatment of customers by life insurers and other financial sector firms.

[25] See information on the Treasury website about its consultation for this proposal.

Appendix 1 - About FOS

1. Overview

FOS is an ASIC-approved independent EDR scheme that covers disputes across the financial sector. Our service is free to consumers and is funded through a combination of levies and case fees paid by our members, which are financial services providers.

Our operations are governed by our Terms of Reference that form a contract with our members. The Terms of Reference are available on our website.

FOS and its predecessor schemes have over 20 years' experience in providing dispute resolution services in the financial services sector. FOS provides services to resolve disputes between member financial services providers and consumers, including certain small businesses, about financial services such as:

- banking
- credit
- loans
- general insurance
- life insurance
- financial planning
- investments
- stock broking
- managed funds and
- pooled superannuation trusts.

As well as its functions in relation to dispute resolution, FOS has responsibilities to identify and resolve systemic issues and obligations to make certain reports to ASIC.

FOS also provides code monitoring, administration and secretariat services to committees that monitor financial services providers' compliance with these industry codes of practice:

- the Code of Banking Practice
- the Customer Owned Banking Code of Practice
- the General Insurance Code of Practice and
- the Insurance Brokers Code of Practice.

FOS is governed by a board with an independent chair and:

- four ‘industry directors’ appointed based on their expertise in and knowledge of the financial services industry, independence and capacity and willingness to consult with the industry and
- four ‘consumer directors’ appointed based on their expertise in consumer affairs, knowledge of issues pertaining to the industry, independence and capacity and willingness to consult with consumer organisations.

More information can be found on our website and in our Annual Review 2015-16.

2. Dispute resolution processes

Our dispute resolution processes are explained fully on our website www.fos.org.au. Information about the processes can be accessed easily through the ‘Resolving Disputes’ and ‘Consumers’ tabs on our home page.

Our dispute resolution process map, noting timeframes, is set out at the end of this section. The process map shows that determinations may be made by an Ombudsman, an adjudicator or a panel. The guideline to paragraph 8.5 of our Terms of Reference explains factors we consider when deciding who should determine a dispute.

In some cases, an Ombudsman or adjudicator will have particular expertise and the ability to readily access any industry or consumer advice required to resolve a matter. In other cases, it will be important to involve consumer or industry experts in the actual decision making, which can be done by using a panel. An example of this may be where it is not clear what good industry practice should be for the circumstances of a dispute and it would be more effective to involve an industry representative in the decision making.

ASIC’s Regulatory Guide 139 requires FOS to undertake an independent review every 5 years and specifies how the reviews must be conducted. Independent reviews, which assess an EDR scheme’s performance in qualitative as well as quantitative terms, are designed to provide feedback on how the scheme should evolve and highlight any need for change or improvement.

The first independent review of FOS was conducted in 2013. It examined:

- the accessibility, independence, fairness, accountability, efficiency and effectiveness of our services
- our jurisdiction and
- our dispute resolution processes.

The key recommendations of the independent review focussed on the need for FOS to increase the pace of its efforts to eliminate dispute backlogs and reshape its

processes to reduce the time taken to resolve new disputes. The recommendations are set out in full on our website together with our responses.[26]

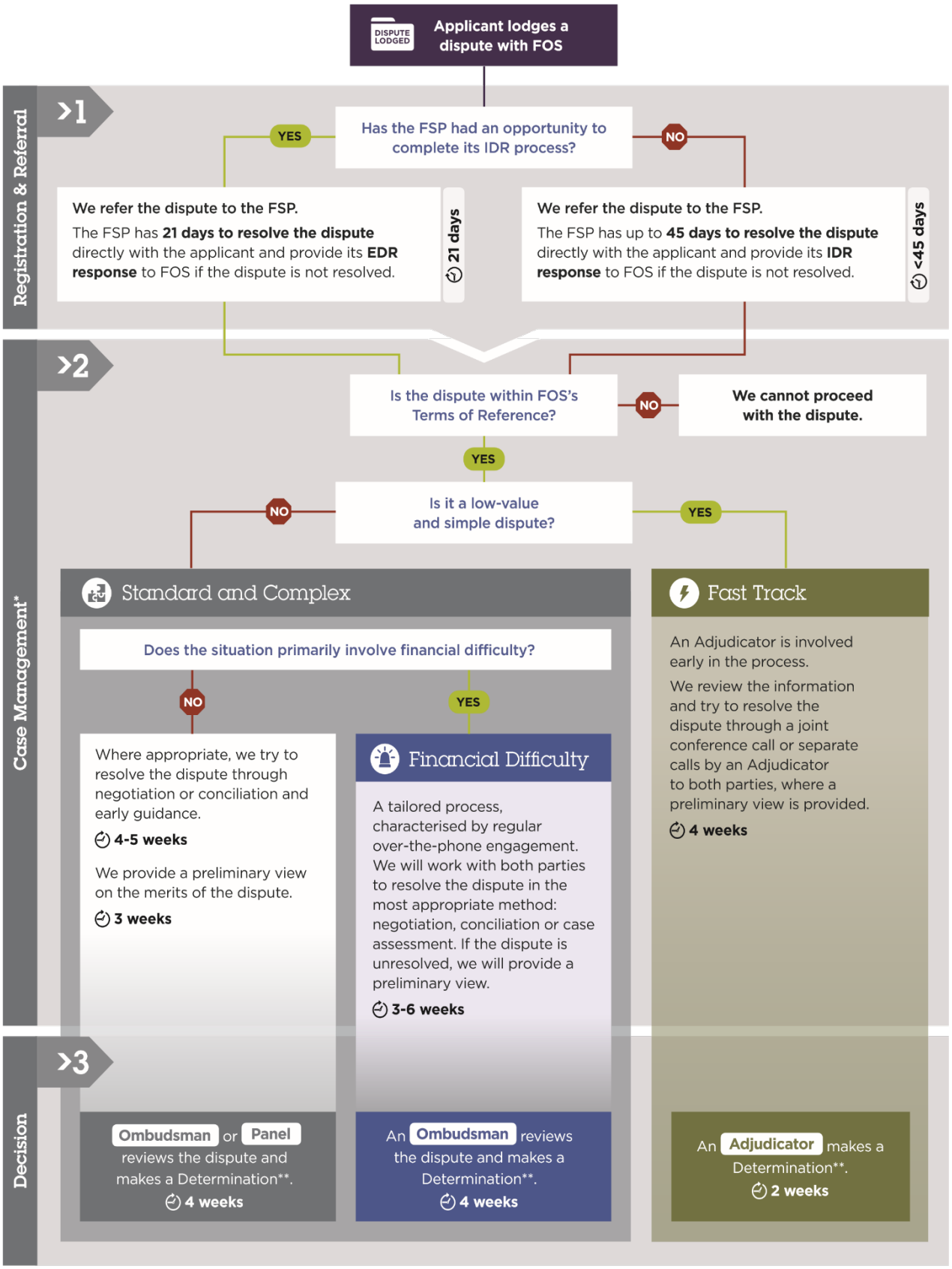
The independent review examined our dispute resolution work in all areas, including life insurance. The review did not recommend any changes relating specifically to life insurance disputes. However, recommendations to improve all dispute resolution operations, and other general matters such as publications, were relevant to life insurance disputes.

FOS implemented changes that eliminated our dispute backlogs by June 2015 and streamlined our processes. The changes included:

- introducing a new process to fast-track decisions for simpler and low-value disputes and a triage stage to classify life insurance disputes as ‘Fast Track’, ‘Standard’ or ‘Complex’ as shown in the process map below
- altering processes to give financial services providers an additional opportunity to resolve disputes directly with consumers
- allowing specialist expertise to be used earlier in disputes and reducing multiple ‘touch points’ and procedural stages
- developing a more efficient financial difficulty dispute resolution process with earlier contact, flexible pathways and consistent decision making and
- more effectively communicating outcomes of disputes through the plain English drafting of preliminary views and determinations.

[26] See Independent Review Recommendations action table on our website.

FOS dispute resolution process map



These are average expected timeframes.

*A single case worker will manage the dispute wherever possible.

**A financial services provider is bound by a determination if an applicant accepts it.

3. Systemic issues

FOS has an obligation to ASIC as an EDR scheme to identify, resolve and report on systemic issues and to notify cases of serious misconduct. A systemic issue is defined in our Terms of Reference as an issue that will have an effect on other people beyond the parties to the dispute. Several disputes of the same type may indicate a systemic problem; however, issues may also be identified out of the consideration of one single dispute where it is clear that the effect of the problem will extend beyond the parties to the dispute. Serious misconduct is defined as conduct that may be fraudulent or grossly negligent or may involve willful breaches of applicable laws or obligations.

To ensure that we continue to grow the trust, credibility, consistency and confidence required to perform our systemic issues function for financial services providers and for ASIC, we have established clear processes to deal with:

- identification of possible systemic issues
- referring a possible systemic issue to the financial services provider for comment
- assessing whether a matter represents a definite systemic issue and
- if definite –
    - through collaboration, resolving the issue identified as systemic and
    - reporting de-identified systemic issue investigation agreed outcomes to ASIC.

The aim of a systemic issue investigation is to achieve an agreed outcome between FOS and the financial services provider. This includes, where appropriate, action to ensure that:

- the financial services provider identifies all affected consumers
- all identified affected consumers are compensated fairly for losses
- the problem is rectified so that it does not occur again in the future and
- any other consumers affected will be compensated for losses in the same way as identified affected consumers.

Appendix 2 – Some key similarities and differences between FOS and the SCT

<table>
<tr><th>Similarities</th><th>Differences</th></tr>
<tr><td>Are established as independent forums to resolve disputes.</td><td>The SCT is a tribunal created by legislation and FOS is an EDR scheme approved by ASIC. The SCT is governed by legislation whereas FOS is governed by its Terms of Reference (although the content of the two governing documents is very similar).</td></tr>
<tr><td>Are funded by the industry (through a levy for the SCT and by the participating financial services providers for FOS)</td><td>The basis of decision-making differs. The SCT determines whether a decision under review is fair and reasonable in its outcome. FOS decides on the basis of what is fair in all the circumstances, having regard to the law, good industry practice, relevant codes of practice and previous FOS decisions (which are not binding). The tests are similar but there are two main differences:
The SCT must determine whether the decision in dispute – at the time it was made – was fair and reasonable in its outcome. FOS determines what outcome it considers to be fair at the time of the determination.
The SCT must affirm a decision that it considers was fair and reasonable in its outcome. There is no equivalent provision for FOS.</td></tr>
<tr><td>Are required to deal with disputes in a cooperative, efficient, timely and fair manner (for the SCT, this is expressed as fair, economical, informal and quick)</td><td rowspan="3">The SCT can deal with decisions of superannuation trustees. FOS cannot.</td></tr>
<tr><td>Are not bound by the rules of evidence</td></tr>
<tr><td>Are required to comply with the rules of natural justice</td></tr>
<tr><td>Are not able to deal with disputes that relate to management of the fund (or scheme) as a whole</td><td rowspan="3">The amount of compensation that FOS can award is limited but there is no financial limit on the compensation the SCT can award. FOS’s limit is $309,000 per claim for most disputes. Its other limits include $8,300 per month for a claim about income stream insurance. Any award of interest or costs is in addition to these amounts. Appendix 1 provides more information about FOS’s limits.</td></tr>
<tr><td>Can refuse to consider claims if they are frivolous, vexatious or lacking in substance</td></tr>
<tr><td>Are free of charge for applicants</td></tr>
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