Inquiry into the scrutiny of financial advice

Financial Ombudsman Service Australia Submission

April 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 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 Code Compliance Committees that monitor financial services providers' compliance with four industry codes of practice.

We welcome the opportunity to comment on matters relating to life insurance included in the Inquiry's Terms of Reference on 2 March 2016.

Matters addressed in this submission[3] include:

Jurisdiction of FOS
Section 1 provides information about our jurisdiction, including an explanation of limits that prevent us from considering certain life insurance disputes.

Life insurance disputes
Section 2 sets out statistics relevant to life insurance disputes dealt with by FOS in recent years.

Resolving disputes and handling systemic issues
Section 3 provides information about our dispute resolution processes and approach and how we handle systemic issues and briefly refers to outcomes of our systemic issues work.

Key objectives of reforms in the life insurance industry
Section 4 explains the need for reforms to ensure consumers are treated fairly in all facets of product design, service, conduct, claims handling, complaints and remediation. We support the initiative for industry to develop a robust life insurance code of practice as well as codes already established and current efforts to improve remuneration structures and remove conflicted advice.

[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.
[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.

Code of practice
Section 5:

- explains the benefits that a life insurance code of practice could deliver
- comments on how a code should be designed and the areas it should cover
- discusses specific areas in which code provisions could improve consumer protection including remediation programs and definitions in insurance policies.

Legislation
Section 6 suggests consideration be given to extending unfair contract terms legislation to life insurance contracts.

1 Jurisdiction of FOS

Our jurisdiction is set out in Section B of our Terms of Reference and explained in detail in our Operational Guidelines. Section 2 of Appendix 1 summarises key information about our jurisdiction. 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 and
- certain disputes about levels of premiums.

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.

In life insurance claims disputes where the policy is held within superannuation, FOS will consider the Superannuation Complaints Tribunal (SCT) is a more appropriate forum if the SCT has jurisdiction. This is because the SCT – unlike FOS – can consider the role of and decisions made by the superannuation trustee as well as the life insurer. Details of some of the key similarities and differences between FOS and the SCT are set out in Appendix 2.

Our Terms of Reference sets $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)[4].

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.

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.

2 Life insurance disputes

2.1 Life insurance members of FOS

FOS had some 4,849 licensees and 9,258 authorised credit representatives as members as at 30 June 2015. Our records for 2014-15[5] indicate that 31 of our members were life insurers and 41 were life insurance brokers[6].

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 2014-15[7]

FOS accepted a total of 23,344 disputes across our whole jurisdiction in 2014-15. We accepted 1,227 life insurance disputes in 2014-15. This represented an increase of 6% from the previous year. Denial of claims was the most common issue in life insurance disputes referred to FOS in 2014-15. This was the primary issue in 32% of the disputes. Of the 1,227 life insurance disputes accepted in 2014-15, 55% related to income stream risk products and 45% related to non-income stream risk products.

2.2.1 Income stream risk products

Income stream risk products include:

[4] 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.
[5] This and later references to years in this submission are to years from July 1 to June 30.
[6] This information is based on how the financial services providers have described their business to us.
[7] More detailed information, including explanations of terms used, is provided in our Annual Review 2014-15, on pages 80-83.

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

FOS accepted 677 disputes about income stream risk products in 2014-15 – four fewer than we accepted in 2013-14. Of these disputes, 552 (or 82%) related to income protection insurance and 125 (or 18%) related to consumer credit insurance.

59% of these disputes were about decisions made by a life insurer. In disputes about financial services provider decisions, denial of a claim remains a prevalent complaint in relation to both income protection insurance and consumer credit insurance.

Complaints about claim amounts and incorrect premiums together with disputes over denial of claim and claim handling delays were key themes associated with income protection insurance.

In our 2014-15 Annual Review we provided examples of issues arising in disputes at FOS including:

- financial services providers not applying the correct policy provisions when denying claims and
- firms relying on more recent versions of the policy wording which can sometimes contain less beneficial terms for the consumer.

It is important that a financial services provider relies on the relevant contract terms between itself and the consumer when making decisions about whether it will or will not accept a claim.

2.2.2 Non-income stream risk products

Non-income stream risk products include:

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

FOS accepted 550 disputes about non-income stream risk products in 2014-15, which represented a 20% increase from 2013-14. Almost half of the disputes (49%) about non-income stream risk products related to a decision made by the financial services provider.

About one third (34%) of these disputes concerned total and permanent disability insurance. The number of these disputes increased to 188 in 2014-15 from 133 in 2013-14. Denial of claim was the most common reason people lodged disputes about this type of cover, followed by complaints about a delay in claim handling.

In this category, term life insurance product disputes almost doubled, to 165 (or 30% of non-income stream risk disputes) from 87 disputes (or 19%) in the previous year. The most common issues in term life product disputes were denial of claim and incorrect premiums.

We also accepted 95 disputes related to trauma insurance products in 2014-15. Denial of claim was again the most common issue in those disputes.

2.3 Decisions about life insurance disputes

Less than 14% of the disputes we closed in 2014-15 required a formal FOS decision. 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 2014-15 Annual Review provides full details of the outcomes of disputes closed in that year.[8]

In 2014-15, we closed 1,522 life insurance disputes. Of these disputes, 221 (or 14.5%) required a formal decision by FOS.

In the two earlier years, we closed fewer life insurance disputes – 1,416 in 2013-14 and 1,208 in 2012-13. The percentage of those disputes that required a formal decision was 11.8% in 2013-14 and 9.3% in 2012-13.

3 Resolving disputes and handling systemic issues

3.1 Dispute resolution

Section 4 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

[8] See our 2014-15 Annual Review, on pages 51-53.

from detailed 'FOS Approach' documents, decisions and case studies to easy-to-read brochures and fact sheets.[9]

3.2 Systemic issues

Section 5 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.[10]

In 2014-15, outcomes from our work with industry to remediate systemic issues included:

- more than 77,400 consumers were identified as being affected by systemic issues
- over $4.3 million was refunded to these affected 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) and
- improvements were made in a range of areas within the financial services provider's business, including claims handling, disclosure, complaints handling and staff training practices.

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[11] set out in our 2011-12 Annual Review, in which claims for disability benefits were denied incorrectly.

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, the financial services providers and individuals consumers deal with and the products and services they 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 on regulating distinct activities.[12] These trends can also be seen in life insurance where recent developments that require consideration and analysis by the Inquiry have included:

[9] 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.
[10] See our 2014-15 Annual Review, on pages 96-99.
[11] See page 59 of our 2011-12 Annual Review, under the 'Publications' tab on our website.
[12] See our Submission to the Interim Report of the Financial System Inquiry, August 2014, on page 8.

- 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 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'.[13]

We consider that life insurance reforms should include initiatives developed recently 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. 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.

In the context of life insurance, the duty to act in utmost good faith applies. This provides a strong base for life insurance reforms, which in our view should focus on ensuring fair treatment of consumers in all facets of product design, service, conduct, claims handling, complaints and remediation.

Life insurers should put the interests of consumers first in a way that keeps pace with consumer needs and expectations, which continue to change, and may change rapidly. This includes meeting standards of good practice as well as meeting all relevant minimum legal requirements.

5 Code of practice

We support the development of a code of practice for the life insurance industry including robust and transparent governance arrangements. Through a code, financial services providers can make commitments to consumers over and above requirements imposed by law. A code could expand obligations under the law and set standards of good practice in areas such as:

[13] See Financial System Inquiry Final Report, November 2014, on page 193.

- the timeliness, fairness and transparency of claims handling and
- decisions by life insurers to deny claims or to avoid or cancel policies.

The standards and obligations in a code would be considered by FOS as part of our role to consider good industry practice when deciding disputes.

Ideally, a code should include guiding principles that life insurers need to observe to ensure they treat consumers fairly and consistently through the whole product life cycle. Principles in a code can be applied to take into account changes in practice, technology and other developments such as those that may impact on the interpretation of policy definitions, terms and conditions. This allows a code of practice in theory to be more flexible and agile than legislation or case law.

5.1 Design of code

FOS has extensive experience in code compliance and monitoring. A separate business unit of FOS administers and monitors compliance with four industry codes of practice that operate at present in the financial services sector.[14]

We consider that the design of a life insurance code of practice should be based on some key principles. An effective code of practice should:

- be developed through a transparent, consultative process
- be well known and supported widely across the industry
- build upon rather than replicate mandatory minimum standards – whether by setting higher standards, covering additional issues or supporting compliance with practical elaboration and guidance
- have an effective governance structure that allows for meaningful independent monitoring of code compliance
- provide consumers with access to a clear, simple mechanism for raising code breach concerns and
- be subject to independent review at regular intervals.

5.2 Areas code should cover

Current codes of practice within the financial services sector provide an indication of the types of key areas that may be included in a code of practice for life insurers. These key areas include commitments about:

- definitions in policies

[14] For more detail, see pages 101 to 105 of our 2014-15 Annual Review.

- claims handling - setting standards around timeliness, fairness and transparency of decision making
- service standards to govern direct and intermediary sales of insurance policies
- accountability for the conduct of agents, including assessors and investigators
- dealing with consumers with special needs or from culturally and linguistically diverse backgrounds or in financial hardship and
- timely, fair and efficient internal complaints handling.

5.3 Definitions in insurance policies

Fairness needs to underpin the design of policies and policy definitions and not just the sales and claims handling processes of financial services providers.

It is our experience that disputes often arise as a result of policy definitions or interpretations where the definition is ambiguous, unclear in its meaning, outdated or has not kept pace with current clinical, medical or diagnostic tools or community expectations.

A concern is that consumers may be misled to expect that certain events or medical conditions are covered by the policy when they are not. For example, marketing of a policy by a life insurer or an agent that the policy responds to heart attack when in fact only a low proportion of claims will be paid due to the definition of heart attack within a policy may be potentially misleading.

5.3.1 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 fact sheet for consumers about life insurance products and standard definitions for key terms that could be adopted by the life insurance industry.

A key 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 life policy will apply. Most consumers do not have this knowledge.

This should be addressed by requiring definitions in insurance policies to be based on standard cover, expressed as clearly and simply as possible, with the use of technical language kept to a minimum.

For certain types of insurance cover 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 apply to life insurance. We consider it should do so.

To enhance any legislative or regulatory reforms in this area, we believe the industry can also play a role. 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.

We recognise that initiatives in relation to standardising policy definitions may encroach on the traditional role of insurers to set underwriting guidelines on the basis of actuarial and other data associated with risk. We also acknowledge that not all risk is supposed to be covered by any insurance policy.

5.3.2 Keeping definitions up to date

Existing case law does not impose on financial services providers a clear legal obligation to keep definitions in insurance policies up to date. 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.[15]

This means that update practices across firms can vary and assessment of claims based on current legal principles can sometimes result in adverse outcomes for consumers.

We consider that an industry mechanism to enable definitions in insurance policies to keep current, to reflect developments in practices, medicine, technology or other matters relevant to the definitions, is required. Examples of such developments include advances in medical knowledge and improved diagnostic tests.

This could be achieved by a requirement in the code for a consistent updating mechanism to respond to medical and diagnostic developments. This should involve a consistent industry standard on the timing, evidence of and approach to updating rather than leaving this as a matter for each individual firm to determine.

These changes would both help avoid disputes arising in the first place and when they do arise would enable FOS to take into account the standards set out in the code when resolving individual disputes under our Terms of Reference. At present, unless there is some ambiguity or a general provision in policy definitions, case law can limit our ability to go beyond the terms of the policy definitions under a life insurance contract.[16]

5.4 Remediation programs

ASIC has recently consulted on guidelines on remediation programs conducted by financial services providers. FOS has responded setting out our views on ASIC’s consultation paper. While the ASIC guidance was primarily designed for the financial

[15] See *MLC Ltd v O’Neill* [2001] NSWCA 161.
[16] See *MLC Ltd v O’Neill* [2001] NSWCA 161

planning and advice sectors, we consider it should apply to redress and remediation programs in other financial service areas, such as life insurance.

We set out in our submission[17] that any program should be based on the current framework for internal dispute resolution and EDR, avoid undue complexity and tiering of internal dispute resolution arrangements, and lead to timely review and outcomes for consumers. We consider it important to make clear that where an external person is appointed to review individual client matters by the firm they do so as an agent of the licensee, and are therefore part of the internal review process put in place by the licensee.

The appointment of these external experts or panels in a review needs to be described in a way that does not confuse this internal assurance role with FOS's role as the independent EDR scheme in resolving disputes.

Firms should discuss any proposed remediation program with FOS at an early stage so we can ensure a consistent and streamlined process for disputes that may come to FOS as the independent dispute resolution body.

As the largest ASIC-approved EDR scheme in Australia, FOS will play a key role in review and remediation programs of licensees under the proposed ASIC guidance.

When a licensee that is a member of FOS establishes a program, FOS and the member will need to agree on documentation, timelines and other arrangements for the program and FOS will conduct any external independent reviews of decisions sought by clients.

In our submission to ASIC we emphasised that, when a licensee establishes a review and remediation program, it will be most important for the licensee to engage constructively with FOS in early discussions and agree satisfactory arrangements for the program. The agreement between the licensee and FOS will need to provide for matters including:

- how the review and remediation program interacts with internal dispute resolution and EDR
- establishing streamlined and efficient mechanisms to refer matters requiring external review to FOS
- any waiver of limits on the jurisdiction of the scheme, such as time and monetary limits and compensation caps, and any alternative limits agreed
- timeframes and
- measures to address concerns of affected clients about the operation of the program such as delays in considering a case.

[17] See our Submission to ASIC's Consultation Paper 247, March 2016.

6 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.[18] We consider that the Inquiry should review whether the basis of this exemption remains relevant given the importance the Financial System Inquiry placed on ensuring fair treatment of customers by life insurance and other financial sector firms.

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

Appendix 1 - About FOS

1 Overview

FOS was formed in 2008 from the merger of three predecessor schemes organised largely along industry sector lines. The original participants were:

- the Banking and Financial Services Ombudsman
- the Financial Industry Complaints Service and
- the Insurance Ombudsman Service.

On 1 January 2009, two other schemes joined FOS, namely:

- the Credit Union Dispute Resolution Centre and
- Insurance Brokers Disputes Ltd.

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.

2 Jurisdiction

Our jurisdiction is set out in Section B of our Terms of Reference and explained in detail in our Operational Guidelines. Section B sets out:

- who can access our services
- the types of disputes we can consider
- the types of dispute that are excluded, and our power to exclude a dispute if it is inappropriate for FOS to consider that dispute
- the monetary limit of our jurisdiction and caps on compensation we may award and
- time limits to lodge a dispute.

Our jurisdiction is designed to meet the requirements in ASIC's Regulatory Guide 139[19].

[19] See 'Regulatory Resources' on www.asic.gov.au. ASIC's Regulatory Guide 139 sets out requirements for an approved EDR scheme, including its jurisdiction and who can access it.

2.1 Access to our services

Individual consumers of 'financial services' may be eligible to lodge disputes with FOS.[20]

'Small businesses' may also be eligible. A 'small business' is a manufacturing business with less than 100 employees, or a non-manufacturing business with less than 20 employees[21].

The policy holder of a group life insurance policy may be able to bring a dispute to FOS on behalf of anyone insured under the policy. An example would be where a superannuation trustee disagrees with its insurer's decision to deny a fund member's claim for benefits.

2.2 Types of disputes we can consider

We can consider a dispute if it falls within, and is not excluded from, our jurisdiction. The following is a summary.

Disputes within our jurisdiction

For FOS to consider the dispute it must relate to:

- a contract or obligation arising under Australian law
- a particular type of collective investment offered in Australia or
- an investment in a product offered through a platform in Australia.

The subject matter of the dispute must be about one of the following:

- a 'financial service' provided by the financial services provider to the applicant[22]
- a guarantee, security or repayment provided by the applicant
- an entitlement a person may have under an insurance contract
- an interest arising out of an investment product or a facility to manage financial risk
- a third party motor vehicle insurance claim (subject to certain limits)
- a service provided for a mutual financial services provider

[20] See paragraph 4.1 of our Terms of Reference and the guideline to that paragraph in our Operational Guidelines for more detail on eligibility requirements.
[21] See paragraph 20.1 of our Terms of Reference. This definition is derived from the Corporations Act.
[22] This includes financial services provided by representatives or agents of the financial services provider. The Terms of Reference define financial services more broadly than the Corporations Act, to include any product service that is financial in nature.

- an investment offered under a foreign recognition scheme or
- a traditional trustee company service.

The financial services provider in the dispute must be a current member of FOS when the dispute is lodged.

Exclusions

Disputes referred to in paragraph 5.1 of the Terms of Reference are excluded from our jurisdiction. To mention a few examples that can be 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 in which the only issue is the performance of investments
- 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 and
- certain disputes about levels of premiums.

Power to exclude inappropriate disputes

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

Examples of situations in which we may exercise this discretion include:

- there is a more appropriate forum for the dispute, such as a court or the SCT
- the applicant is not a retail client as defined in the Corporations Act and
- the dispute is frivolous, vexatious or lacking in substance.

In life insurance claims disputes where the policy is held within superannuation, FOS will consider the SCT is a more appropriate forum if the SCT has jurisdiction. This is because the SCT – unlike FOS – can consider the role of the superannuation trustee as well as the insurer.

2.3 Our monetary limits and compensation caps

Paragraph 5.1o) of our Terms of Reference sets $500,000 per claim as the monetary limit of our jurisdiction. We may not consider a claim the value of which exceeds

$500,000. This is the ‘product value’ figure used as part of the retail client definition in section 761G of the Corporations Act[23].

Within that jurisdictional limit, our power to award financial compensation is also limited by the ‘compensation caps’ which are the maximum limits on compensation FOS can award per claim (not including costs or interest).

The compensation caps are set out in the Schedules to our Terms of Reference. The amount of the applicable compensation cap will depend on the nature of the financial service involved and when the dispute was lodged. The caps are indexed every three years.

The current 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.

2.4 Time limits

Paragraph 6.2 of our Terms of Reference sets out the time limits within which a dispute must normally be lodged. FOS can extend these time limits but only if there are exceptional circumstances.

Disputes about a variation of a credit contract as a result of financial hardship, an unjust transaction or unconscionable interest and other charges under the National Credit Code, must be lodged within two years of the following (whichever is later):

- the date when the credit contract is rescinded, discharged or otherwise comes to an end or
- the date the applicant received an IDR response[24] in relation to the dispute from the financial services provider.

All other disputes including life insurance disputes must be lodged within the earlier of the following time limits:

- within six years of the date when the applicant became aware or should reasonable have become aware of the loss that the dispute is about and
- within two years of the date the applicant received an IDR response in relation to the dispute from the financial services provider.

[23] 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.
[24] An IDR response is the financial services provider’s written response to the applicant’s complaint. For the time limit to apply, the IDR response must include the financial services provider’s final response to the complaint after it goes through internal dispute resolution, the right to take the dispute to FOS, our contact details, and the applicable time limit.

3 Statistics

3.1 Main activities

To very briefly note our main activities, we provide these statistics, which relate to the year from 1 July 2014 to 30 June 2015[25]:

Total disputes received	**31,895** (up by 1% from 2013-14)	
Total disputes closed	**34,714** (up by 4% from 2013-14)	
Financial difficulty disputes accepted	**4,134** (down by 12% from 2013-14)	
Systemic issues resolved	**52**	
Investigations of alleged breaches of industry codes of practice	**347**	
Members	Licensees: **4,849**	Authorised credit representatives: **9,258**
Phone calls handled by FOS contact team	**210,420** (down 5% from 2013-14)	
Visits to FOS website	**602,542** (up by 3% from 2013-14)	

3.2 Comparative tables

Annually, FOS publishes comparative tables, which provide statistics on disputes involving financial services providers that are members of FOS. The tables are published on our website under the 'Publications' tab.

The Inquiry may be interested in the comparative tables showing outcomes of life insurance disputes. This link connects to the 2014-15 table for life insurance disputes and relevant material including explanatory notes and a glossary.

More statistics can be found in our Annual Review 2014-15.

4 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

[25] For more detail, see our 2015-16 Business Plan.

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.

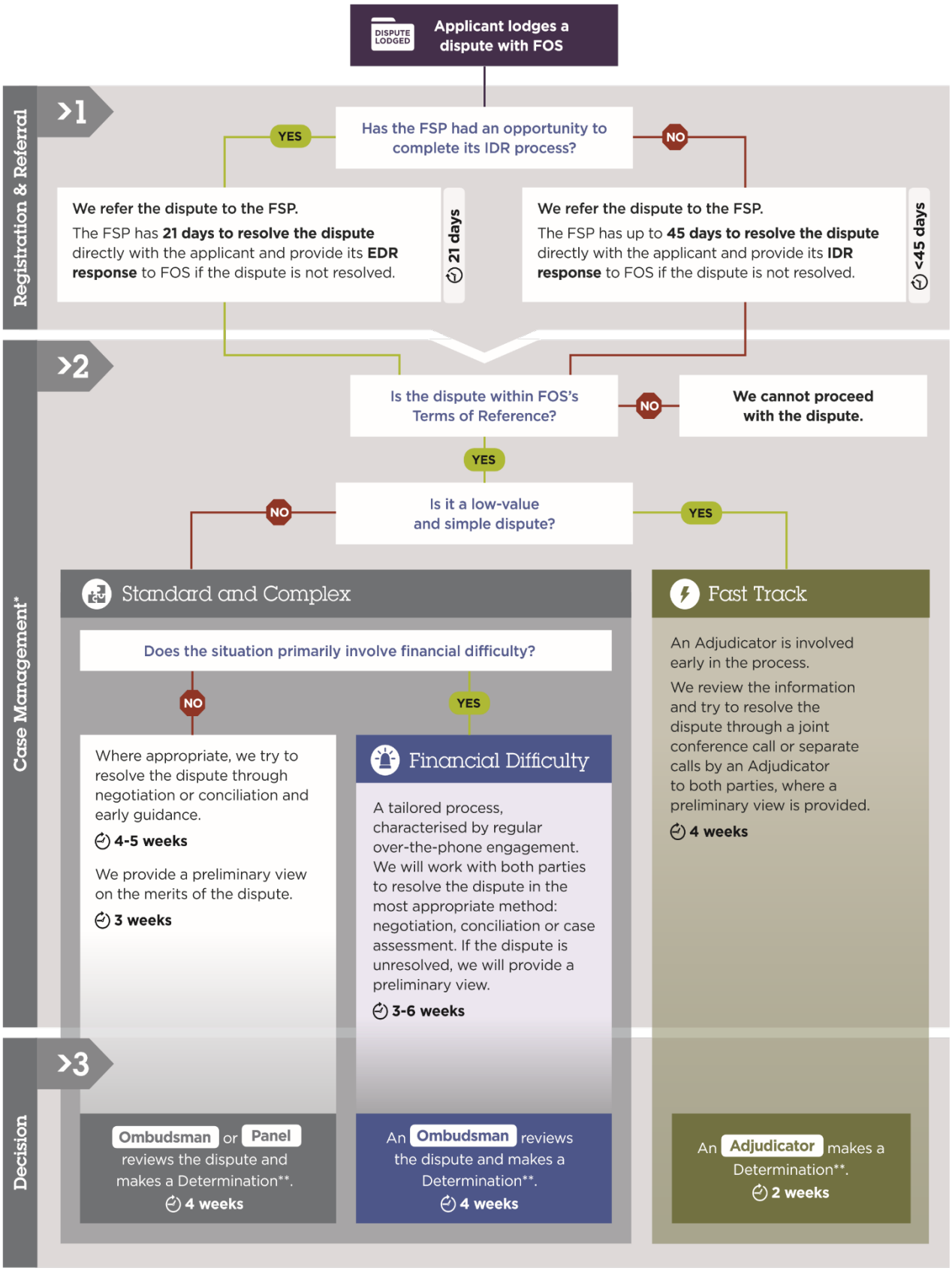
FOS implemented changes that eliminated our dispute backlogs by June 2015 and streamlined our processes. The changes included:

- 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

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

- 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.

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.

5 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, creditability, consistency and confidence required to perform our systemic issue 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 – 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, and FOS decides on the basis of what is fair in all the circumstances. 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="7">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>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></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>
</table>