THOMSON GEER
LAWYERS

Superannuation Case Law Update

June 2017

Contents

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Thomson Geer thanks
Scott Charaneka (Head of Superannuation and Wealth Management) and Stanley Drummond (Adjunct Head of Superannuation and Wealth Management) for their assistance in preparing this publication.

1. TPD claim – effect of termination of employment – *MLC Nominees Pty Ltd v Daffy* [2017] VSCA 110

The Victorian Court of Appeal (Beach and McLeish JJA; and Keogh AJA) has upheld an appeal by an insurer and a superannuation trustee which concerned the effect of termination of a superannuation fund member's employment during the qualifying period for a total and permanent disablement (TPD) benefit on the member's entitlement to the benefit. The trial judge had held that in the circumstances of the case, a benefit had already accrued to the member by the time his employment was terminated, and so termination of his employment did not affect that entitlement and he was accordingly entitled to the TPD benefit of about $1.5 million. The Court of Appeal disagreed. The appeal decision is *MLC Nominees Pty Ltd v Daffy* [2017] VSCA 110.

Background

The member was the general manager of a company. He also held shares in the company's parent company.

Throughout his employment by the company, he was a member of a superannuation fund. The trustee of the fund held a group life policy.

Employees of participating employers came under the First Schedule to the policy. Upon leaving their employment with a participating employer, a person was automatically transferred from the First Schedule to the Sixth Schedule. The definition of TPD in the Sixth Schedule was more onerous than that in the First Schedule.

As an employee of a participating employer, the member came under the First Schedule.

In 2010 the member suffered a prolapsed disc while lifting a large sliding door at work. He was hospitalised and absent from work for approximately 4 weeks. Following his return to work, he worked reduced hours and was not able to perform his usual general manager duties. He suffered from pain and experienced significant difficulties during this time in both the workplace and with his daily living activities. However, he continued to work reduced hours for a further 6 months.

The member's last day at work was 20 May 2011.

On 24 May 2011 (being 4 days later and during the 6 month qualifying period for a TPD benefit under the policy) the member attended a meeting with fellow directors of the company and the parent company. He attended this meeting in his capacity as a shareholder of and investor in the company, and not in his capacity as general manager. The meeting arose out of a demand by the majority shareholder of the parent company that the company owed it $1.2 million, and should repay this money. The member objected to this and during the course of the meeting, his employment was terminated. The termination was related to this dispute about repayment of the debt, and not the member's injury.

In 2012 the member claimed a TPD benefit of approximately $1.5 million under the First Schedule to the policy, or alternatively under the Sixth Schedule.

The policy

The definition of TPD in the First Schedule to the policy read in part:

> (b) the Member having been absent from their Occupation solely through Injury or Illness for six consecutive months and after which time the Member has become in MLC's opinion, after consideration of all evidence obtained, incapacitated to such an extent as to render the Member unlikely ever to engage in any gainful profession, trade or occupation for which the Member is reasonably qualified by reason of education, training or experience ...

The definition of TPD in the Sixth Schedule read in part:

> (d) a Member who is not actively employed and in MLC's opinion would have been absent from their previous or any similar occupation solely through Injury or Illness for a period of six consecutive months and after which time the Member has in MLC's opinion, after consideration of all evidence obtained, suffered a total irreversible inability to perform at least two of the Activities of Daily Living.

The court noted that the definition of TPD in the Sixth Schedule was more onerous than that in the First Schedule. The court said:

> The TPD criteria prescribed by the Sixth Schedule are significantly more onerous than those prescribed by the First Schedule ... A claim for a TPD benefit under the Sixth Schedule by a Member who is not actively employed requires the Member to establish, not only that he/she would have been absent from their previous Occupation solely through injury or illness for a period of six consecutive months, but also that the Member has suffered a total irreversible inability to perform a least two of the Activities of Daily Living.

Another relevant section of the policy was clause 27.1(e), which provided:

> 27.1 Notwithstanding any other provision contained in this Policy, MLC's liability to pay any Benefits which have not already accrued in respect of a Member shall cease on the occurrence of the earlier of any of the following events:
>
> …
>
> (e) on the date the Member ceases to be an employee of a Participating Employer, unless the Member is covered under Schedule 3 or continues to be covered under Schedule 4 of the Policy, or with respect to a Family Member on the date the Family Member no longer meets the "Family Member" eligibility conditions unless the Family Member continues to be covered under Schedule 6 of the Policy.

The claim is declined

The insurer declined the member's claim. The trustee agreed with the insurer's decision.

The proceedings

The member commenced proceedings against the insurer and the trustee in the Supreme Court of Victoria.

Under the First Schedule

The insurer's position was that upon termination of the member's employment, he was transferred from the First Schedule of the policy to the Sixth Schedule (which, as mentioned above, had a more onerous TPD definition than the First Schedule). The member had no right to have his TPD claim determined under the First Schedule, as he had ceased to be an employee. The insurer's liability was therefore excluded under clause 27.1(e) of the policy.

The insurer further contended that upon termination of the member's employment, he ceased to have an occupation. Without an occupation, the member could not satisfy the requirement in the First Schedule of being "absent from his occupation through injury for 6 consecutive months".

Under the Sixth Schedule

In relation to the member's alternative claim under the Sixth Schedule, the insurer said that the member had not satisfied the definition of TPD as he had not "suffered a total irreversible inability to perform a least two of the Activities of Daily Living".

The decision at first instance

At first instance, the court (McDonald J) rejected the arguments of the insurer and the trustee (who were jointly represented) and held that the member was TPD under the First Schedule: *Daffy v MLC Nominees Pty Ltd*: [2016] VSC 606.

First or Sixth Schedule?

The court held that the member was automatically transferred from the First Schedule to the Sixth Schedule upon termination of his employment. Accordingly, the Sixth Schedule governed his entitlements to benefits in respect of illness or injury occurring after termination of his employment.

However, the member's right to make a TPD claim under the First Schedule in respect of the injury he had sustained before the termination of his employment was an "accrued benefit" for the purposes of clause 27.1 of the policy, and was thereby preserved.

Considering the medical evidence available to the insurer, the insurer should have

formed the view that the member was incapacitated to such an extent as to satisfy the definition of TPD in the First Schedule. The member's termination of employment did not extinguish his right to claim a TPD benefit under the First Schedule, given that the injury giving rise to the claim had occurred prior to termination of employment.

Cause of absence from occupation

The court also considered whether the member's absence from work had been due to his injury or due to the termination of his employment following the meeting with representatives of the parent company. The court said that the relevant question to ask was whether, if the member's employment had not been terminated, he would have been absent from work for the next 6 months. The court concluded that the member would probably have continued to work for a short period of time after the meeting with representatives of the parent company, had his employment not been terminated. However, given that the member's physical condition had deteriorated following that meeting, he would have been able to work for no more than a few months, irrespective of whether his employment had been terminated after the meeting.

The insurer and the trustee appealed to the Victorian Court of Appeal.

The decision of the Court of Appeal

The Court of Appeal allowed the appeal.

The Court of Appeal noted that on any view of the facts, the 6 month qualifying period in the TPD definition had not elapsed (or occurred) prior to the termination of the member's employment.

The court further noted that it had not been suggested by the member that the word "accrued" should be given other than its ordinary meaning.

Under the Sixth Schedule, a member, in addition to having to establish an absence from an occupation solely through injury or illness for a period of 6 consecutive months, also had to establish that they had suffered "a total irreversible inability to perform at least two of the Activities of Daily Living". The court went on:

> [82] No doubt this additional requirement is not one that is easily satisfied, even for a person absent from his or her occupation solely through injury or illness for a period of six consecutive months. That, however, is not a sufficient basis upon which one might torture the language of cl 27.1 of the policy so as to hold that in a particular case of injury, a TPD benefit that might subsequently be payable (and paid) under the policy is an accrued benefit at the time of injury, and no matter what part any such injury might ultimately be found to play in any subsequently determined disability. That would deny the requirement in the First Schedule and the Sixth Schedule that the member had been absent from an occupation for six consecutive months. While Mr Daffy pointed to ways in which that requirement could easily work unfairness, it cannot simply be ignored.

The construction primarily contended for by the member could not have universal application. A person who might ultimately satisfy paragraph (b) of the First Schedule TPD definition may not be able to point to any date upon which it might be contended that a disorder first commenced or came into existence. Moreover, such injustice as might be capable of being inferred from the termination of a member's employment with a participating employer at some time during the 6 consecutive month period equally could not be a ground for giving the policy (and in particular clause 27.1) a construction which its text will not bear.

It followed that the trial judge erred in concluding that there existed a relevant accrued benefit as at the termination of the member's employment. The First Schedule TPD benefit that was required, by clause 27.1 of the policy, to be accrued at the time of the member's termination was not a benefit that had accrued within the meaning of clause 27.1 of the policy.

The trial judge had found that member had been absent for 6 consecutive months commencing from late July 2011. The member had filed a notice of contention that the trial judge should have found that he had been absent for 6 consecutive months commencing from 20 May 2011. The court said that there was "no substance" in the contention. (Given that, as mentioned above, the member's last day at work was 20 May 2011, this aspect of the judgment seems curious.)

The result

In the result, the appeal by the insurer and the trustee was allowed and the orders made at first instance were set aside.

The Sixth Schedule, and not the First Schedule, applied to the member's claim. The member had not disputed that he did not satisfy the TPD definition in the Sixth Schedule. Therefore, no TPD benefit was payable.

2. TPD claim – further material requiring reconsideration of claim – *Gomez v Board of Trustees of the State Public Superannuation Scheme* [2017] QSC 98

The Queensland Supreme Court (Boddice J) has ordered the trustee of a superannuation scheme to reconsider a member's claim to a total and permanent disablement (TPD) benefit, having regard to further material provided by the member. The case is *Gomez v Board of Trustees of the State Public Superannuation Scheme* [2017] QSC 98.

Background

The member was born in the Philippines in 1972. He obtained his nursing qualifications in the Philippines. He worked, pursuant to those qualifications, as a nurse and as a tutor prior to emigrating to Australia in 2003.

In Australia, the member predominantly worked as an intensive care nurse. He did not undertaken any work in Australia as a tutor. He was employed with Queensland Health from 2007 until being made voluntarily redundant in 2013. That employment, at the Princess Alexandra Hospital, was as an intensive care nurse.

In September 2011, the member was employed as an intensive care nurse at the Princess Alexandra Hospital. Whilst undertaking that employment he sustained an injury to his right shoulder, resulted in increasing pain and limitation of movement. He subsequently developed anxiety and depressed mood.

The member lodged a claim for compensation with WorkCover Queensland and was paid weekly compensation benefits. He undertook an alternative light duties programme for a period of time. However, the member's return to work on light duties was unsuccessful. He further injured his shoulder in March 2012. The member ceased reliance on WorkCover in May 2012. At that time he made application for income protection benefits from the superannuation scheme.

Attempts at finding alternate employment at the hospital which the member could perform were unsuccessful. He last performed duties at the hospital in April 2013. The member's employment with the Princess Alexandra Hospital ceased on 12 August 2013 when the member accepted a voluntary redundancy pursuant to an offer made by his employer.

The offer of a voluntary redundancy was made in circumstances where the employer had advised the member that as a consequence of a restructure of employment arrangements there was no suitable position available having regard to the member's ongoing restrictions in his employment capabilities.

In May 2012, the member lodged a claim for income protection benefits pursuant to the terms of the superannuation scheme. In August 2012, he lodged a claim for payment of a TPD benefit from the scheme.

The member's claim for payment of income protection benefits was initially allowed but subsequently declined by the trustee of the scheme. The trustee also declined the

member's claim for payment of the applicable TPD benefit. The decision to decline to pay income protection benefits was overturned on review in March 2014.

The member's first claim for payment of a TPD benefit was lodged on 7 August 2012. That claim was rejected by letter dated 9 January 2013 by a delegate of the trustee on the basis the information available was not sufficient to establish the requirements for a TPD benefit (first decision).

By letter dated 10 February 2014, the member sought a review of that decision. The member provided submissions and new material for consideration by the trustee. On 26 June 2014, the trustee determined that the member did not satisfy the definition of TPD and affirmed its delegate's earlier decision (second decision).

On 15 April 2016, the member made a further request for review of the decision to decline his claim for a TPD benefit. Again, that request was accompanied by submissions and additional new material.

In particular, the member provided reports from Dr English, orthopaedic surgeon, and Dr Shaikh. Dr English opined that with appropriate treatment the member would remain fit for work as a nurse supervisor, pre-admission nurse, telephone nurse, practice nurse, nurse educator, pathology collector, medical receptionist or general practice nurse.

Dr Shaikh, who had examined the member on 23 March 2016, noted the member reported ongoing constant pain of varying severity depending upon the activities undertaken by him. his pain disturbed his sleep leading to daytime fatigue which affected his concentration and memory. He required ongoing medication. Dr Shaikh opined that the member's sleep disturbances, impaired cognition and reduction in recreational pursuits were primarily due to physical complaints, not a psychiatric disorder.

The member also provided a supplementary report from Ms Hague, occupational therapist. Ms Hague had conducted a telephone consultation with the member. In her opinion, the member's accent would be a barrier to employment as a telephone triage nurse as would his lack of experience and additional qualifications. Further, as the member did not hold the requisite certificates for the occupation of pathology collector/venepuncture, the member was not reasonably qualified or experienced for work in that occupation. Similarly, as the member had no prior experience or formal qualifications as a ward clerk or a medical receptionist and no knowledge of specialised software programmes, he was not reasonably suited for this type of work by virtue of his education, training and experience. Ms Hague opined the position of health promotion officer was a profession with a recognised undergraduate qualification in Australia requiring an applicant to possess the understanding of public health sector policies and requirements. The member did not possess either the qualifications or the skills to allow him to work in this field.

Finally, the member provided a statement dated 15 April 2016 in which he indicated that over the previous three years he had attempted to look for alternate work and had submitted approximately 200 job applications without success. The member had only basic computer skills and spoke English with an accent and could not be described as highly fluent.

On 10 June 2016, the member was advised that the senior delegate of the trustee had determined that a review of that additional material did not indicate a reasonable possibility of a different result to the trustee's earlier decision and therefore affirmed the trustee's refusal to pay a TPD benefit to the member (third decision).

The issue said to disentitle the member to the payment of a TPD benefit was that there were occupations the member could undertake for which the member was reasonably qualified by his education, training or experience.

The member commenced proceedings against the trustee in the Queensland Supreme Court.

The decision

The court said that the trustee's first decision became of no practical effect once it made the second decision (at [42]).

The court held that the second decision was a decision reasonably open to the trustee (at [44]).

In relation to the third decision, the court referred to the principle stated in *Gilberg v Maritime Super Pty Ltd* [2009] NSWCA 325 at [25]-[28] and said that here, the further

material provided by the member called for a reconsideration of his claim. The court said:

> [52] The further material provided to the [trustee] addressed not merely the availability of other occupations for which the [member] was qualified by relevant education, training or experience. That material addressed the likelihood of the [member] having such transferrable skills, having regard to the need for particular educational requirements and the ability to undertake certain types of communication. They were matters which had not been specifically considered by Ms Stewart [a rehabilitation adviser] or any of the medical practitioners who had earlier provided opinions to the [trustee].

and:

> [54] The [trustee], consistent with its obligations and duties under the [governing rules of the scheme], had to consider whether, having regard to the [member's] particular circumstances, the identified alternate occupations were occupations the [member] had the capacity to engage in having regard to his education, training or experience. That consideration had to be more than a theoretical exercise removed from reality. The additional material gave rise to that very consideration. It put forward sufficient material to show there was a case to be investigated further. That case justified the seeking of further opinions from Ms Stewart and the relevant medical practitioners.

The result

In the result, the court ordered the trustee to reconsider the member's claim to a TPD benefit.

3. Pension payments – Edwards v Commonwealth Superannuation Corporation [2017] FCA 375

The Federal Court (Mortimer J) has dismissed an appeal from a determination of the Superannuation Complaints Tribunal under the *Superannuation (Resolution of Complaints) Act 1993* (Cth) and an application for judicial review under the *Administrative Decisions (Judicial Review) Act 1977* (Cth) in relation to pension payments following the death of a member of a superannuation scheme. The applicant, Mr Edwards, did not himself claim any relationship with the deceased member. Rather, he claimed to represent his former partner and to be entitled to press claims on behalf of his two children. The case is *Edwards v Commonwealth Superannuation Corporation* [2017] FCA 375.

Background

The deceased member was a member of the Commonwealth Superannuation Scheme Fund (CSS Fund), which was managed by the Commonwealth Superannuation Corporation (CSC).

Following the member's death, Ms Carol Harris, who claimed to have been in a spousal relationship with the member, applied for spousal pension rights for herself and her two children, Mr Ashley Harris and Mr Adam Harris. CSC refused the application. Mr Edwards, on behalf of Ms Harris, complained to CSC and then the Superannuation Complaints Tribunal (SCT), which determined that benefits were payable to Ms Harris and the children (the second SCT determination). That necessitated a calculation of the amount of back payments, and the matter was remitted to CSC for determination in accordance with the SCT's reasons.

CSC decided to pay 67% of the pension to Ms Harris, and 11% of the pension to each of Ashley and Adam, who were twins. It took CSC some time to calculate the amount of the back payments.

Mr Edwards agitated a position that the pension payments to Ashley and Adam should be paid to him. There was also a question of interest on the back payments.

CSC reconsidered the matter. It rejected Mr Edward's claim for the pension payments to be made to him rather than to Ashley and Adam, and decided that no interest on back payments was payable. Mr Edwards complained to the Commonwealth Ombudsman, and then lodged a second complaint with the SCT. The SCT affirmed the decisions of CSC (the second SCT determination).

The appeal to the Federal Court

Mr Edwards, Ms Harris, Ashley and Adam filed two applications in the Federal Court against CSC appealing from the first and second SCT determinations, under the *Superannuation (Resolution of Complaints) Act* and the *Administrative Decisions (Judicial Review) Act.* Ms Harris, Ashley and Adam all withdrew from the proceedings, leaving Mr Edwards as the sole applicant.

The court's decision

The court held that Mr Edwards did not have standing under the *Superannuation (Resolution of Complaints) Act* to appeal from the second SCT determination, as he was not "party" to that determination. The court said:

> [44] Whatever relationship may exist on a social or day to day level between Mr Edwards, and Adam, Ashley and Ms Carol Harris, so far as the law is concerned Ms Carol Harris, Ashley and Adam are autonomous individuals who are the persons directly affected by the decisions made by CSC and the Tribunal about the payments of benefits to them. Mr Edwards cannot adopt some generalised representative role in relation to them in either of these proceedings, especially since each of them decided to withdraw.

Mr Edward's challenge to the first SCT determination was rejected principally because the CSC's first decision was set aside by that determination, and another decision was substituted.

The court accepted that Mr Edwards had standing to bring the application under the *Administrative Decisions (Judicial Review) Act*. However, the court rejected his submissions.

Mr Edwards also asserted claims in contract and tort. These were also rejected. In particular, there was no contractual relationship between Mr Edwards and CSC.

The result

In the result, the court rejected Mr Edwards' challenge to the SCT determinations, and ordered him to pay CSC's costs.

4. Excess non-concessional contributions – *Pitts and Commissioner of Taxation* (Taxation) [2017] AATA 685

The Administrative Appeals Tribunal (AAT, Senior Member CR Walsh) has affirmed an objection decision of the Commissioner of Taxation which disallowed, in full, a taxpayer's objection against an excess non-concessional contributions tax assessment for the year ended 30 June 2013, totalling $94,542. The decision is *Pitts and Commissioner of Taxation* (Taxation) [2017] AATA 685.

Background

The taxpayer made the following non-concessional contributions in the financial years ended 30 June 2011, 30 June 2012 and 30 June 2013.

Year ended 30 June	Non-concessional contributions
2011	$328,316.18
2012	$0.00
2013	$325,000.00
Total	**$653,316.18**

In March 2015 the Commissioner wrote to the taxpayer advising him that:

> ***You may have to pay excess***

contributions tax – 2012-13 financial year

For your information and action

…

Based on our current information, you have exceeded at least one of the superannuation contribution caps and you may have to pay excess contributions tax.

…

Concessional Contributions	Your concessional contributions cap	Your excess concessional contributions
$24,189.00	$25,000	$0.00

Non-concessional contributions	Your non-concessional contributions	Your excess non-concessional contributions
$325,000	$121,683	$203,316.18

The taxpayer's non-concessional contributions cap of $121,683 was calculated by subtracting the amount of the contribution he made on 21 October 2010 (ie $328,316.18) from the relevant three year contributions cap of $450,000.

In June 2015 the taxpayer wrote to the Commissioner requesting, pursuant to section 292-465(2) of the *Income Tax Assessment Act 1997* (Cth) (ITAA 1997) that the Commissioner make a written determination under s 292-465(1) of the ITAA 1997 to disregard his excess non-concessional contributions for the 2013 financial year (of $203,316.18) or to allocate them to another financial year.

In August 2015 the Commissioner notified the taxpayer that he refused to make a written determination under s 292-465(1) of the ITAA 1997 to disregard the taxpayer's excess non-concessional contributions for the 2013 financial year (of $203,316.18) or to allocate them to another financial year. The Commissioner's letter read in part:

> Whilst we recognise you did not intend to exceed your contributions cap, such intent alone does not establish 'special circumstances'. [Excess contributions tax] is simply a consequence of your financial transactions and is not unjust, unfair or inappropriate in and of itself.

In November 2015 the Commissioner issued the taxpayer with an excess non-concessional contributions tax assessment for $94,542 for the year ended 30 June 2013, which represented $203,316.18 (being the excess non-concessional contribution for the 2013 financial year) multiplied by 46.5% (being the maximum marginal rate of tax) (Assessment).

On 9 January 2016, the taxpayer objected to the Assessment on the ground that he was dissatisfied with the Commissioner's refusal to make a written determination under section 292-465(1) of the ITAA 1997 to disregard or allocate to another financial year part or all of his non-concessional contributions for the 2013 financial year (Objection).

In March 2016 the Commissioner disallowed the Objection in full (Objection Decision).

The taxpayer applied to the AAT for a review of the Objection Decision, relying on a number of arguments.

The AAT decision

The AAT affirmed the Commissioner's Objection Decision

On the question of whether there were "special circumstances" that would support the Commissioner exercising his discretion under section 292-465 of the ITAA 1997 to disregard all of part of the contributions, the AAT noted the following principles (at [108]):

> From the cases which have considered what constitute "special circumstances" for the purpose of s 292-465 of the ITAA 1997, the following general principles emerge:
>
> - Ignorance of the existence or effect of the law does not, by itself, amount to "special circumstances";
> - "Special circumstances" does not extend to an error on the taxpayer's part, even if the error was innocent and made in good faith;
> - An error on the part of a third party will not, of its own force, amount to "special circumstances";

- Incorrect or deficient financial advice from a third party professional will not, on its own, satisfy the requirement for “special circumstances";
- While the effect of the circumstances on a taxpayer may be described as unfortunate and unforeseen, this is insufficient to render the imposition of the excess contributions tax unjust, unreasonable or inappropriate and to constitute “special circumstances; and
- It is the circumstances that must be “special”, not the individual’s experience of them.

The AAT found that the circumstances surrounding the contribution of $328,316.18 (ie ill-health and poor financial advice) were not, in themselves, “special circumstances” because they were not so unusual or different as to take them out of the ordinary course.

As for the later contribution of $325,000, the AAT said that the taxpayer had not provided any information or evidence to suggest that his decision to make this contribution was impacted by any medical condition at that time.

The result

In the result, the taxpayer was liable to pay excess non-concessional contributions tax of $94,542.

5. Mental illness and disability discrimination – FOS Determination 428120

The Financial Ombudsman Service (FOS) has determined that a travel insurer's denial of a claim in reliance on a clause in the policy that excluded claims arising from or in any way related to "depression, anxiety, stress, mental or nervous conditions" constituted unlawful discrimination in the provision of insurance, under the *Disability Discrimination Act 1992* (Cth). The Determination is case number 428120 (31 March 2017).

Although this determination is about insurance, in has important implications for superannuation trustees.

Legislative framework

Section 24 of the *Disability Discrimination Act* prohibits discrimination in the provision of goods, services and facilities on the ground of a person's "disability", in the following terms:

> **24 Goods, services and facilities**
>
> It is unlawful for a person who, whether for payment or not, provides goods or services, or makes facilities available, to discriminate against another person on the ground of the other person’s disability:
>
> (a) by refusing to provide the other person with those goods or services or to make those facilities available to the other person; or
>
> (b) in the terms or conditions on which the first mentioned person provides the other person with those goods or services or makes those facilities available to the other person; or
>
> (c) in the manner in which the first mentioned person provides the other person with those goods or services or makes those facilities available to the other person.

"Services" is defined as including services relating to insurance and superannuation.

"Disability", in relation to a person, is defined in broad terms which relevantly include:

> (a) total or partial loss of the person’s bodily or mental functions;

and:

> (g) a disorder, illness or disease that affects a person’s thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour;

Disability discrimination can be either "direct" or "indirect".

Section 29A creates a general exemption where "avoiding the discrimination would impose an unjustifiable hardship on the discriminator".

In the case of insurance and superannuation, s 46 creates two exemptions referable to actuarial and statistical data, in the following terms:

46 Superannuation and insurance

(1) This Part does not render it unlawful for a person to discriminate against another person, on the ground of the other person's disability, by refusing to offer the other person:

(a) an annuity; or

(b) a life insurance policy; or

(c) a policy of insurance against accident or any other policy of insurance; or

(d) membership of a superannuation or provident fund; or

(e) membership of a superannuation or provident scheme;

if:

(f) the discrimination:

(i) is based upon actuarial or statistical data on which it is reasonable for the first mentioned person to rely; and

(ii) is reasonable having regard to the matter of the data and other relevant factors; or

(g) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the discrimination is reasonable having regard to any other relevant factors.

(2) This Part does not render it unlawful for a person to discriminate against another person, on the ground of the other person's disability, in respect of the terms or conditions on which:

(a) an annuity; or

(b) a life insurance policy; or

(c) a policy of insurance against accident or any other policy of insurance; or

(d) membership of a superannuation or provident fund; or

(e) membership of a superannuation or provident scheme;

is offered to, or may be obtained by, the other person, if:

(f) the discrimination:

(i) is based upon actuarial or statistical data on which it is reasonable for the first mentioned person to rely; and

(ii) is reasonable having regard to the matter of the data and other relevant factors; or

(g) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the discrimination is reasonable having regard to any other relevant factors.

Whereas s 46(1) is about a *refusal* to offer insurance or superannuation, s 46(2) is about the *terms or conditions* on which insurance or superannuation is offered. In each case, two exemptions are potentially available. The first exemption is where the discrimination "is based upon actuarial or statistical data on which it is reasonable for the first mentioned person to rely" and the discrimination "is reasonable having regard to the matter of the data and other relevant factors": s 46(1)(f) and (2)(f). The second exemption is where "no such actuarial or statistical data is available and cannot reasonably be obtained' and "the discrimination is reasonable having regard to any other relevant factors": s 46(1)(g) and (2)(g).

Reliance on either exemption involves searching for relevant and reliable actuarial or statistical data before the disability discrimination occurs, and not "after the event".

There is broadly equivalent legislation in the States and Territories, such as the *Anti-Discrimination Act 1977* (NSW) and the

Equal Opportunity Act 2010 (Vic).

Background

The insurer issued a travel insurance policy which excluded claims relating to mental illness in the following terms:

> We will not pay under any circumstances if …
>
> 25] your claim arises from or is any way related to depression, anxiety, stress, mental or nervous conditions.

(It is to be noted that this exclusion applied both to pre-existing conditions and conditions which first became apparent after the policy was issued.)

At the time when the policy was issued, this insured did not have any prior history of depression, anxiety, stress, mental or nervous conditions. After the policy was issued and during the course of the insured's trip, he developed a condition which was variously diagnosed as a psychotic episode, manic episode, bi-polar disorder and an acute psychosis. There was no dispute between the parties that this condition was a mental illness. It was described as a "first presentation" (as opposed to a pre existing) mental illness.

While in Vancouver, Canada the insured suffered a manic episode during which he was involved in a motor vehicle accident resulting in damage to a friend's vehicle. He was hospitalised for a week. While in hospital he broke through magnetic locked doors in the psychiatric area on two occasions. He was kept locked in a quiet room and was considered a flight risk. He also exhibited other unusual behaviour. His parents travelled to Vancouver and accompanied him home. The rest of his trip was cancelled.

The insured lodged a claim for various cancellation fees, additional expenses and medical expenses.

The insurer denied the claim on the basis that the mental illness exclusion set out above applied.

(The insured also claimed compensation for personal liability arising from the damage to his friend's vehicle during the insured's manic episode. However, FOS upheld the insurer's denial of this part of the claim as the insured had not provided proof of this loss, and in any event the policy excluded loss of or damage to property while in the insured's care or control and as the vehicle was damaged while in the insured's care or control, this exclusion would have applied.)

The member complained to FOS.

The insurer's defences

From the FOS determination it appears that the insurer did not dispute that:

- the insured's mental illness was a "disability" for the purposes of the Disability Discrimination Act;
- the mental illness exclusion in the policy discriminated against a person who lodged a claim for loss or damage arising from mental illness; and
- the mental illness exclusion offended the prohibition in s 24 and was unlawful, unless an exemption applied.

In any event, FOS was satisfied as to these matters.

The insurer sought to rely on:

- the "unjustifiable hardship" exemption in s 29A;
- the exemption based on actuarial or statistical data upon which it is reasonable to rely, in s 46(2)(f); and
- alternatively, the exemption based on "other factors", in s 46(2)(g).

The FOS determination

FOS rejected the insurer's defences.

Unjustifiable hardship exemption

The insurer argued that to require it to change its whole travel insurance business to cover pre-existing and first presentation mental illnesses including those of a severe nature could cause it unjustifiable hardship.

How FOS dealt with this is worth reproducing at length:

> … the information supplied by the [insurer] relating to unjustifiable hardship is of limited assistance. The [insurer] says:
>
> (a) coverage for mental illness would have a significant

effect on the [insurer's] combined operating ratio. The [insurer] does not explain how this can be determined if it does not have the actuarial data

(b) it does not have sufficient in house actuarial data or claims experience relating to mental illness which would permit it to accurately price the additional risk. This contradicts the [insurer's] defence under section 46(2) of the [Disability Discrimination Act]. The [insurer] claims this exclusion has been in place since 1991. On that basis it would be reasonable to expect the [insurer] would have had significant experience in dealing with mental illness claims and data as to the number and value of claims rejected based on mental illness.

(c) there would be a greater number and greater complexity of claims with associated greater costs. No evidence has been provided by the [insurer] to establish that this would occur or that there would be increase in insurance costs

(d) the increased difficulties in verifying claims. No relevant medical data has been provided by the [insurer] to prove this would be the case

(e) likelihood of increasing premiums which would place the [insurer] in an uncompetitive position. No evidence has been provided to establish this

(f) cost of amending all policy wording. No estimation has been provided. Given that policies are issued at different times for relatively short durations and regularly updated this would not seem to be an extraordinary cost.

The [insurer] has argued that in an industry where competition is strong and profit margins marginal, to remove the mental illness exclusion without the benefit of following a measured and incremental approach would immediately be out of step with the industry. The [insurer] has not been clear about the relevance of this submission when considering unjustifiable hardship.

The panel notes that the [insurer] has variously described having issued over 750,000 policies and insuring in excess of 1.2 million travellers each year. It has calculated that if it were to cover mental illness, 7% of the 1.2 million insured travellers would potentially suffer such an illness. The [insurer] has not broken this category down by pre-existing or existing mental illness or first presentation mental illness.

The [insurer] has calculated the anticipated extra medical costs that would result in a claims burden of over 2.5 million dollars and the anticipated extra cancellation costs an additional 1.7 million dollars for both first presentation and pre-existing conditions.

The 4.2 million dollars in extra claims costs would be, according to the [insurer] spread over 750,000 policies or 1.2 million insured travellers. In the [FOS] panel's calculations, this would amount to an additional $5.60 per policy or $3.50 per insured added to a premium.

FOS said that this information did not establish unjustifiable hardship.

Actuarial or statistical data exemption

The insurer also maintained that it had considered relevant statistical and actuarial data upon which it was reasonable to rely. In particular:

- each year, since at least 2011, it had considered the publically available data;
- it had prepared a briefing note in September 2011 justifying the exclusion for mental illness;
- it had considered Australian Bureau of Statistics and Australian Institute of Health and Welfare websites including the 2010 National Survey of People Living with Psychotic Illness; and
- it had considered data in relation to the frequency of mental illness.

How FOS dealt with this is also worth reproducing at length:

> The panel has considered the briefing note. The briefing note, whilst acknowledging the complexity of the issues associated with mental illness, does not reference relevant actuarial or statistical data to justify the position.
>
> The [insurer] has referred to studies indicating mental illness is one of the leading causes of disability in Australia. The data and studies on which the [insurer] relies: do not reference the risk undertaken by the [insurer]; were not in existence in 1991 when the exclusion was first applied being the relevant date under the [Disability Discrimination Act]; were not accompanied by any evidence, as required by the [Disability Discrimination Act] that the [insurer] actually relied on the data and studies in introducing and maintaining the exclusion.
>
> No data has been provided by the [insurer] as to the assessment of the insurance risk. The [insurer] suggests the data indicates that 7% of its insureds would potentially suffer a mental illness. It has not provided data to show the risk associated with pre-existing or existing mental illness and first presentation mental illness.
>
> The [insurer] referred to data indicating the likely total extra claims cost of 4.2 million dollars spread over 750,000 policies or 1.2 million travellers. If this is an accurate figure, it is difficult to see how the mental illness exclusion could be justified.
>
> Given the data relates to all mental illness and not just first presentation mental illness, it is difficult to see how the blanket exclusion including first presentation mental illness is justified. Overall, the data referred to by the [insurer] is mostly about the prevalence, diagnosis and treatment of mental illness, not data, required by the [Disability Discrimination Act], about the assessment of the insurance risk or incidence data.

FOS said it was not reasonable for the insurer to rely on the actuarial or statistical data referred to by the insurer.

Other factors exemption

Finally, FOS considered the insurer's reliance on the exemption based on "other factors".

FOS accepted that an exclusion that limits cover for a pre-existing medical condition or mental illness may, in certain circumstances, be reasonable given the greater likelihood of a claim. Here, however, the exclusion relied upon by the insurer was a blanket exclusion.

The insurer had provided information on general studies into mental health and the prevalence of the condition. However, no other relevant factors submitted by the insurer justified the exclusion. The insurer could not rely on the exemption based on other factors.

The result

In the result, FOS determined that the insurer should pay the insured a total of $8,877.37 as cancellation fees, additional expenses and medical expenses, and $1,500 compensation for non-financial loss.

Comments

Back in 2003, the decision of the Federal Magistrates Court (Raphael FM) in *Bassanelli v QBE Insurance* [2003] FMCA 412 (on appeal *QBE Travel Insurance v Bassanelli* [2004] FCA 396; (2004) 137 FCR 88 (Mansfield J)) (involving metastatic breast cancer) sent shockwaves throughout the insurance industry. That case shattered the myth that an insurer who engages in discriminatory underwriting on the basis of an individual's disability can simply gather supporting actuarial and statistical data after the event (and only if a complaint is made).

More recently, in 2015 a similar outcome ensued in the Victorian Civil and Administrative Tribunal (A Dea, Member) in *Ingram v QBE Insurance (Australia) Ltd* (Human Rights) [2015] VCAT 1936 (involving depression). That case also highlighted the difficulties insurers face in relying on the unjustifiable hardship exemption.

This recent FOS determination shows that when it comes to complying with the *Disability Discrimination Act*, insurers are still facing difficult challenges.

These anti-discrimination provisions apply equally to superannuation trustees. Given that they can only be reasonably expected to have access to less, rather than more, actuarial and statistical data than insurers, the challenges for them can only be greater.

Our superannuation expertise

We act for a broad range of superannuation clients located around Australia. Our clients include some of the country's largest industry, corporate and public sector schemes, with most of our client relationships going back many years. Our Superannuation team operates as a "seamless team" across our Sydney, Melbourne, Brisbane and Adelaide offices.

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