INSURANCE ▪ COMMERCIAL ▪ BANKING

Welcome to the Life Insurance and Superannuation Bulletin (LSB) - December Edition, 2019

This edition delivers industry news and important case law developments.

In 'What's Happening Here and Now', we have a number of events and news items to share with you.

We hope you enjoy this edition of the LSB!

CONTENTS

CONTACT US

John Myatt
Practice Group Head
T: 02 8257 5740
Email John

Alph Edwards
Partner
T: 02 8257 5703
Email Alph

Fiona Hanlon
Partner
T: 07 3212 6703
Email Fiona

Michael Iacuzzi
Partner
T: 02 8257 5769
Email Michael

Sandra Nicola
Partner
T: 02 8257 5752
Email Sandra

Lisa Norris
Partner
T: 02 8257 5764
Email Lisa

Darryl Pereira
Partner
T: 02 8257 5718
Email Darryl

Peter Riddell
Partner
T: 03 8600 5005
Email Peter

Peter Murray
Partner
T: 03 8600 5031
Email Peter

Sofia Papachristos
Partner
T: 03 8600 5049
Email Sofia

WHAT'S HAPPENING HERE AND NOW

TurksLegal and ALUCA Mental Health and Life Insurance Panel discussion

We had a full house at our recent TurksLegal and ALUCA panel discussion on Mental Health and Life Insurance. We heard from a panel of experts; Geoff Atkins, Principal, Finity; Nick Kirwan, Policy Manager - Life Insurance, FSC; Glenn Baird, Head of Mental Health, TAL; Carly Van Den Akker, Head of Life & Health Solutions, Swiss Re; and Margo Lydon, CEO, SuperFriend, discussing ways that we can make a real difference to mental health and life insurance today and into the future. The key issues and solutions discussed in the session are detailed in the attached presentation.

2019 ALUCA TurksLegal Scholarship winner's paper

Cy Lindeberg, Health Support Consultant, BT Financial Group, was awarded this year's prestigious ALUCA TurksLegal Scholarship for her paper on 'The Role of Rehab Advisors in Improving Customer Outcomes'. In her well researched and compelling paper, Cy enlightened us to the many ways Rehab advisors operating in the life claims space can be difference makers for the better in terms of the customer experience. You can read Cy's paper here.

Life Matters Seminar - November – ASIC Report 633 on TPD

In our final Life Matters Seminar for the year Partners Alph Edwards, Darryl Pereira, Sofia Papachristos and Peter Murray unpacked R633 for our client audiences in Sydney, Melbourne and Brisbane. A summary of the key findings can be found later in this LSB.

Our Life Matters Seminar series will return in March 2020.

L-R: Alph Edwards, TurksLegal; Fiona Hanlon, TurksLegal; Nick Kirwan, FSC; Geoff Atkins, Finity; Margo Lydon, SuperFriend; Carly Van Den Akker, Swiss Re; Glenn Baird, TAL; Darryl Pereira, TurksLegal; Amanda McKernan, ALUCA and John Myatt, TurksLegal.

L-R: Jim Welsh, Chair, ALUCA; 2019 Scholarship Winner Cy Lindeberg, Health Support Consultant, BT Financial Group; Alph Edwards, Partner, TurksLegal and member of the 2019 Judging Panel.

INDUSTRY NEWS

Extending Unfair Contract Terms to Life Insurance Contracts

The unfair contract terms reforms were introduced into Federal Parliament last week under the *Financial Sector Reform (Hayne Royal Commission Response – Protecting Consumers (2019 Measures)) Bill 2019* (the Bill). Schedule 1 to the Bill gives effect to recommendation 4.7 of the Financial Services Royal Commission to extend the existing protections under the *Australian Securities and Investment Commission Act 2001* (ASIC Act) to insurance contracts governed by the *Insurance Contracts Act 1984* (ICA).

The extension of the UCT regime to life insurance contracts has been anticipated for some time. The key issue for the insurance industry has always been how the regime will apply to insurance contracts, which are a different form of contract to the typical contracts to which the UCT regime applies.

The key takeaways from the Bill[1] are summarised below.

Proposed Commencement Date

5 April 2021. The UCT regime will then apply to insurance contracts made or varied after 5 April 2021 (but only to the extent of the variation).

UCT regime under ASIC Act to apply

The draft Bill proposes to amend the ICA to enable the UCT regime under the ASIC Act to apply to insurance contracts covered by the ICA. In other words, the central elements of the existing UCT regime under the ASIC Act will apply to insurance contracts where:

- at least one party to the contract is a consumer (as defined in subsection 12BF(3) of the ASIC Act) or a small business (as defined in subsection 12BF(4) of the ASIC Act); and
- the contract is a standard form contract (as defined in section 12BK of the ASIC Act).

What types of life policies will fall under the UCT regime?

A standard form contract is essentially a contract that sets out its terms on a "take it or leave it basis" such that the consumer cannot negotiate its terms. The Explanatory Memorandum (EM) to the Bill makes it clear that an insurance contract will be a standard form contract even if a consumer can choose between several options such as levels of cover provided the consumer does not have the ability to negotiate the underlying terms and conditions.

As such, the UCT regime under the Bill would generally apply to retail life contracts and direct life contracts.

The Bill will also amend the ASIC Act to allow for third party beneficiaries of insurance contracts to bring actions against insurers under the UCT regime.

However, the EM to the Bill has outlined that group insurance contracts with superannuation trustees should be exempt from the UCT regime given they are negotiated contracts and owned by a superannuation trustee i.e. these types of group contracts should not meet the threshold requirements of at least one party being a consumer or small business as well as not being a standard form contract.

Main subject matter exemption

A term which defines the "main subject matter" is exempt from the UCT regime.

The most contentious issue for the industry has been whether the UCT regime would recognise that it is in the nature of insurance that the subject matter includes terms which establish the scope of what is covered, when it is covered and the extent of coverage.

As it stands, the Bill has defined "main subject matter" narrowly as the description of what is being insured i.e. the person insured under a life policy and the sum insured. The net effect is that all terms in retail contracts will essentially be subject to the UCT regime including the insured event definitions (such as TPD, total disability) if the Bill passes in its current form.

Meaning of unfair

A term is unfair if:

- It causes a significant imbalance to the parties rights; **and**
- it is not reasonably necessary to protect legitimate interest; **and**
- it would cause detriment.

In determining whether a term is unfair based on the above factors, a Court may take into account such matters as it thinks relevant, but must take into account the transparency of the term and the contract as a whole.

The likelihood is that the main factor in determining if a term is unfair for a life insurance contract will be whether or not the term is "reasonably necessary to protect a legitimate interest." The EM to the draft Bill has provided some examples of terms of a life policy that may be considered "unfair" as well as limited commentary on factors relevant to an assessment of what is reasonably necessary to protect an insurer's legitimate interest such as if the term reflects the underwriting risk or is required to obtain reinsurance.

What happens if a term is deemed unfair?

A term will be void if it is deemed "unfair". However, this may be problematic in circumstances where the term challenged is a term which defines the insured event, such as a TPD definition. In such circumstances, declaring the term "unfair" may not provide a consumer with the remedy they seek of being paid a TPD benefit.

Duty of Good Faith

The duty of good faith will continue to operate independently of the UCT regime, despite the potential for overlap.

Implications

A narrow "main subject matter" definition means nearly all terms of a retail and direct insurance contract will be subject to the UCT regime.

Whilst the EM to the Bill provides some more guidance about the type of term in a life insurance contract which may be "unfair", there remains limited overall guidance as to the types of terms that can be considered as "reasonably necessary to protect" an insurer's legitimate interest.

Unfortunately, as such, life insurers may face periods of uncertainty from 5 April 2021 if the Bill passes in its current form regarding the extent of risk it is taking on as various exclusions, limits and restrictions could be tested against the UCT regime. It would be helpful for all if there was more certainty about the practical operation of the unfairness test in the context of insurance contracts before the Bill is passed.

[1]The Bill essentially reflects the exposure draft legislation released on 30 July 2019 by the Government in the Treasury Laws Amendment (Unfair Terms in Insurance Contracts) Bill 2019.

INDUSTRY NEWS

The Financial Services Reform Roadmap

In August 2019, the Federal Treasurer, Josh Frydenburg released the Federal Government's Implementation Roadmap which sets out a timeline for the enactment of the recommendations of the Banking, Superannuation and Financial Services Royal Commission.

In this edition of the Bulletin we will begin to give you a brief tour of some of the more significant points of interest on the roadmap and their implications for the life insurance industry.

Prior to the Federal election both the government and opposition promised a quick and comprehensive response to enacting the Royal Commission recommendations and the government undertook to act on all of Commissioner Hayne's 76 recommendations.

Treasury, which is entrusted with the implementation of the recommendations, has indicated that delivering on this commitment will amount to the biggest shake-up of corporate law since the 1990's when the current structures under which financial services are licensed were comprehensively reformed.

While the changes that will flow from the recent Royal Commission will not be so fundamental, they will be very wide-ranging and will stretch the capacity of government to formulate policy and for the industry to respond in a thoughtful and positive way.

It will also clearly be a major challenge for industry to have its voice heard through a consultation process that will see over 40 individual pieces of legislation enacted.

So far, the government credits itself with having acted on 15 of the commitments outlined in its response to the Royal Commission's Final Report, but the most meaningful of the changes affecting the life insurance industry are currently still largely in the wings or just around the corner.

The government has promised that by mid-2020 close to 90 per cent of its commitments will have been implemented or have legislation before the Parliament, so there is a period of intense change ahead which, for the reasons just outlined, will challenge the industry to respond and ultimately implement.

LICOP

One of the headline changes already underway is the move to make the Life Insurance Code of Practice ("LICOP") legally enforceable.

Treasury has already begun an accelerated consultation process in relation to this change having issued a consultation paper and concluded an initial consultation period in April 2019.

Both the LICOP and the related Insurance in Superannuation Voluntary Code of Practice were created with the aim of benefitting consumers and driving better product and process outcomes. However, neither was intended at the time to be a legally binding promise and it is reasonable to anticipate they will need to be heavily adapted with this in mind before this occurs.

Treasury has however made it clear to stakeholders that the government will be seeking to ensure that any legislation to make any industry code enforceable will achieve the objectives in recommendation 1.15 of Commissioner Hayne's final report which were;

- that ASIC's power to approve codes of conduct should extend to all APRA-regulated institutions (and clearly therefore life insurance product issuers and superannuation trustees);
- that industry codes of conduct approved by ASIC may include 'enforceable code provisions', which, if they are not followed, will constitute a breach of the law;

- that ASIC may take into account what provisions are intended to be enforceable in a proposed code when determining whether to approve that code;
- that there will be remedies, modelled Part VI of the *Competition and Consumer Act 2010* (CC Act), for breach of an 'enforceable code provision'; and
- for the imposition of mandatory financial services industry codes, if needed.

Treasury sees the introduction of an enforceable code as an opportunity "*to self-regulate and set standards on how to comply with and exceed what is required by the law*" and would prefer industry to manage this process for itself, as "*Industry codes may develop and evolve over many years, coming to encapsulate industry norms in a way that a code prescribed from outside, even by a closely engaged regulator, would not*".[i]

However, obtaining the approval of ASIC will clearly play a critical role in exactly what parts of any code will ultimately become enforceable.

Clearly another major change that will take place when the LICOP becomes enforceable will be the consequences for breaches and the provision of appropriate remedies. The reference to the remedies in the current CC Act clearly also indicates the model Treasury will be working towards.

The CC Act provides for both civil penalties, the issuing of public warnings about parties in breach and orders for compensation. Breaches may also form a basis for a claim for relief by affected parties.

Though companies already treat their responsibilities under the LICOP seriously, the enforceability of the code will clearly be transformative for the industry.

The Roadmap is available on the Treasury website.

We will look at other important "hotspots" for the life insurance industry in the next edition of the Bulletin.

[i] Enforceability of financial services industry codes - Taking action on recommendation 1.15 of the Banking, Superannuation and Financial Services Royal Commission Consultation Paper - The Australian Government the Treasury 2019.

INDUSTRY NEWS

ASIC Report 663 on TPD – Analysis and Implications

Background

In Report 498 (2016), ASIC promised a standalone investigation of TPD after finding an average 16% TPD decline rate, which in their view, was unacceptably high.

That review is now complete and has resulted in report 633 'Holes in the safety net: A review of TPD insurance claims'.

The review involved an investigation of seven life insurers representing 65-70% of TPD market in the target calendar years of 2016 and 2017.

As part of the review, ASIC consulted reinsurers, superannuation trustees, the legal community, consumer advocates and also academics. In addition to this, it collected substantial data from the subject life insurers and commissioned research with 20 consumers who had made TPD claims.

Issues identified by ASIC

ASIC identified four issues that the life insurance industry needed to address, namely:

1. ADL definitions deliver poor consumer outcomes – ASIC suspects that these definitions have 'junk' tendencies.
2. The withdrawn claim rate (12.5%) is too high and unexplained by data. ASIC suspects that the challenging and onerous claims processes are driving up the withdrawn claim rate.
3. Insurers have significant deficiencies in their ability to record and search for relevant claims data. Without data, problems in products and processes will go unnoticed and consumers will suffer.
4. Decline rates for certain insurers and for certain types of TPD claims are higher than predicted decline rates – this may be a sign of unfair claims practices.

ADL - Poor consumer outcomes

ASIC noted that the decline rate for claims under ADL cover (which accounts for 4% of TPD claims) was 60%.

ASIC considered that this was too high and that decline rates above 70% make ADL definitions junk (in this regard, two insurers had decline rates over 70%). It also noted that 89% of ADL claims in the review related to group insurance.

ASIC found that this caused a risk of harm to consumers because:

- most insureds will unlikely be able to make a successful claim;
- yet they still pay the same premium as those with 'any occupation cover';
- vulnerable consumers are most affected because of the 'funnel' effect of ADL. That is, those most likely to get it are casual, contract or seasonal employees; and
- it is unsuitable for a range of common illnesses and injuries such as mental illness and musculoskeletal injuries.

ASIC made the following recommendations for group insurance in response to its concerns, to be implemented by 31 March 2020:

- all insurers and super trustees to review all products with ADL definitions and consider removing them or improving the terms so they have demonstrable value;
- if new terms are to be introduced they must be road tested on various cohorts to show that they are not junk;
- improve data collection on outcomes for ADL claims;
- improve communications with consumers about the type of TPD cover they will receive and warn them when cover

could change to ADL; and

- super trustees must consider ASIC's ADL findings when negotiating new group contracts.

For retail insurance, ASIC recommended that by 31 March 2020 insurers review all ADL definitions and explain why they are staying or how they are being modified.

ASIC's recommendations raise the following implications:

1. Should ADL TPD definitions be removed?
2. Is no cover rather than ADL cover, permissible?
3. Is there an alternative to current ADL cover?
4. Is disclosure of ADL cover enough?
5. Assuming the ADL issue is sorted going forward, what of the past claims?

The report highlighted ASIC's enhanced focus on trustees' insurance strategy/best interest duties in the context of TPD offerings. This balancing exercise requires consideration of phasing out ADL definitions versus pricing impact, and also MySuper requirements versus having no cover.

It also gives rise to a potential increase in disputes for ADL declines. Trustees may therefore need to review the basis upon which ADL TPD definitions were provided to specific cohorts. The report no doubt accelerates the desire for standardisation of TPD definitions.

Withdrawn claims – claims frictions

ASIC noted the withdrawn claim rate was 12.5%. This was an important statistic for ASIC as it is a measure of potential consumer harm. Further, ASIC believes that insurers and trustees are poor at capturing the real reasons for withdrawn claims so the real measure of consumer harm cannot be measured.

ASIC identified frictions in the claims process which likely contributes to withdrawn claims including:

- poor insurer communication;
- the requirement for multiple medical assessments;
- threatening behaviours– including surveillance and allegations of fraud;
- delay;
- 'fishing' for non-disclosure; and
- changes to claims staff.

ASIC made the following recommendations in relation to these issues:

- Insurers and trustees to enhance their voluntary codes to incorporate enhanced obligations around proactive communication, streamlined claims lodgment, daily activity diaries, limiting IMEs, appropriate use of desktop surveillance and documented guidelines for claims staff training;
- By 31 March 2020 insurers should report to ASIC on progress towards implementing recommended changes to claims handling practices;
- Trustees to also review their claims handling procedures;
- Insurers not to enter into inconsistent treaties with reinsurers;
- Financial targets/claims scorecards for claims staff to be removed;
- Claims training needs to be robust enough to handle high turnover rates in staff; and
- ASIC spot checks on certain insurers – reports to ASIC required.

The implications of these recommendations include:

- How will the trustee's role in TPD claims change following REP 633?
- Are there differences between the Court's approach and ASIC's approach on delay?
- Could multiple medical examinations breach the duty of utmost good faith?

The above recommendations raise the following future considerations:

- Reduction in initial claims lodgment requirements and paperwork.
- Claims philosophies may need to address issues such as withdrawn claims.
- Both codes of conduct will be updated to further address claims friction issues identified by ASIC.

- Potential introduction of caps on medical assessments before a decision is made subject to exceptional cases.

Poor Data

The issue with respect to this aspect of the report was that consumer harm cannot be detected in real time. All seven insurers failed ASIC's criteria for 'good data' on TPD claims. The specific issues were as follows:

- too slow in providing data;
- critical data was not in searchable form or not available at all;
- data contained errors;
- no standard definitions for key data i.e. when a claim began etc;
- claims in super – insurers had no data on what occurred before a claim was forwarded to them by the trustee.

ASIC responded to these issues with the following recommendations:

- Insurers to invest in resources to improve quality of data
- Collect data which assists insurers to:
  - Assess conduct risk and consumer harm
  - Better measure reasons for withdrawn claims
  - Product value
  - Consumer satisfaction
  - Claims assessment practices
  - Involvement of third parties

ASIC noted that:

No insurer had a holistic, up-to-date picture of potential consumer harm arising from TPD claims handling and outcomes.

The implication on this is that too much focus has been on claims data, and not enough on membership data. Additionally, it is worth noting the possible benefits of improved data in the context of legislative obligations.

Data will become more important for trustees to establish compliance with SIS and other duties in context of group insurance. It will also become more of a focus in defending litigated and AFCA complaints.

Additionally, ASIC's findings may have impacts on which terms meet the 'reasonably necessary to protect legitimate interests' test for the unfair contracts terms regime.

Decline Rates

ASIC found that some characteristics of claims handling unfairly lead to poorer claim outcomes.

These characteristics were present in increased decline rates – this may be due to claims handling procedures which may be operating unfairly for these claimants (ASIC expressed no concluded view on this):

- Mental health and factures
- Youth
- Age of the policy at claim date
- Delay in lodging claim

Decline rates varied significantly between insurers. TAL had the lowest with 9%, Asteron had 28%.

ASIC's response to the above was to recommend the following:

- All Insurers to undertake a targeted review of a 'statistically significant sample' of declined claims for period 1 January 2016 to 31 December 2018 with the following characteristics:
  - Late notified claims
  - Claims made where the insurer no longer holds the risk for the fund
  - Mental illness claims made by young insureds
- Review claims practices especially those with factors with high decline rates and confirm practices are fair and appropriate.

These recommendations raise the following implications:

- How much weight should be placed on age in assessment of TPD claims?
- Should the difficulties associated with assessing claims lodged late lead to higher decline rates?

They also raise the question of what to consider when

determining an appropriate sample of declined claims for the period 1 January 2016 to 31 December 2018.

ASIC's findings also suggest that there should be an increased propensity for tripartite arrangements for assessment of takeover claims following change of insurer.

CASES AND TRIBUNAL DECISIONS

AFCA Group – Avoidance by later in time insurer

In August 2019, AFCA published decisions (613562 and 619820) which considered the scenario of whether underwritten cover initially entered into by the earlier group insurer but now sitting with a later insurer, could be subject to a s29 of an ICA avoidance or variation, by the later insurer.

Facts

- Claim for an underwritten insured death benefit on the fund by the beneficiary.
- Cover applied for in November 2009 when the cover was issued by the earlier insurer. The later in time insurer assumes the risk in December 2011.
- The life insured died in December 2016.
- Post December 2016 the cover was avoided by the later in time insurer under s29(2) of the ICA using a retro underwriting opinion of the earlier insurer.

Decision

AFCA found:

1. There was relevant fraudulent misrepresentation by the life insured in the application for the underwritten cover AND the previous insurer's retro underwriting opinion was sufficient for it to avoid the cover.
2. However, because the relevant pre-contractual misrepresentation was not made to the later in time insurer (it was made to the earlier insurer – which is '*the insurer*' for the purposes on s29) the later in time insurer could not avoid the cover.

AFCA rejected the following arguments:

- The 'insurer' in s29 is a floating concept – given a purposive construction, it must mean 'the insurer holding the risk at the relevant time' in circumstances of a take over on the same terms of an existing book of cover.
    - AFCA rejected this argument and stated '*There is nothing in the wording of section 29 to treat a misrepresentation made to one insurer as a misrepresentation made to another insurer*'.
- The 'insured' in s29 includes a legal personal representative so it follows that 'the insurer' should include a successor in title (to all intents and purposes, the later insurer is a successor in title to the earlier insurer).
    - AFCA rejected this argument and stated '*the later insurer is not a successor in title to the previous insurer*'.
- Section 29 should be interpreted so that insurers do not lose rights when a trustee changes insurance cover. To do so would encourage fraudulent misrepresentation.
    - AFCA rejected this argument and stated '*It is for Parliament to change the law, not AFCA*'.
- The FSC supports seamless cover for members transferring cover when a trustee switches insurers. A narrow interpretation of '*insurer*' is therefore not consistent with good industry practice.
    - AFCA rejected this argument and stated '*there is nothing in the FSC guidance note dealing with assignment of one insurer's rights to another insurer. Insurers may negotiate such arrangements*'.

Implications

These findings by AFCA potentially conflict with FOS determination 378061 wherein the FOS stated:

…it is common practice for superannuation trusts to change insurers for group life policies. This can offer important benefits to their members. One of the premises of the ability to move from one group policy provider to another is that insurance companies are willing to take the risk for existing members under a previous policy with a previous insurer. This would support the FSP's submission that "the insurer" in s.29(2) should be interpreted, with this practice in mind, as the insurer holding the risk at the relevant time.'

In any event, the AFCA decisions carry the following implications:

- Avoidances by later in time insurers in similar scenarios to the present will likely be overturned by AFCA, however, at least where fraud is proven there is still an argument that the benefit should still not be paid consistent with the reasoning of FOS 378061.
- Avoidance/variation needs to be undertaken by earlier in time insurer (there is nothing stopping this even though the earlier insurer is no longer on risk) but note this may not necessarily invalidate the cover under the new policy – NB will need to check the provisions of the transfer terms with the trustee.
- Moving forward assignment of rights between old and new insurers may be required.
- Or transfer terms of new insurer need to carve out cover which could be avoidable or varied. The result being that cover which could be avoidable or varied by the old insurer, never comes across to the new insurer.

INSURANCE ▪ COMMERCIAL ▪ BANKING

CASES AND TRIBUNAL DECISIONS

TPD - Imperfect Decline Reasoning

MX v FSS Trustee Corporation as Trustee of the First State Superannuation Scheme & Anor [2018] NSWSC 923

Link to decision

Background

You will recall that we have previously discussed the 2018 NSWSC TPD decision of *MX v FSS & MetLife*.

In that case, being a split TPD case dealing with stage one only, the NSWSC held that the insurer's two separate TPD declines failed because:

- The reasoning demonstrated in the relevant decline letters left '*pertinent questions unanswered*' and that '*the gaps in this reasoning are such that they do not satisfy the test stated by Ball J in* Ziogos … *and one cannot discern why*… the insurer… *reached the conclusion that it did*'.
- The insurer was influenced by its reinsurer in exercising its opinion and this breached its obligations under the primary insuring clause.
- The second decision was also set aside by the Court on the primary basis that when making this second decision, the insurer did not start *de novo* but rather approached it on the basis as to whether it should change its mind from its first decision to decline.

The insurer appealed and was unsuccessful.

NSWCA's Findings

Dealing with the extent to which the provisions of reasons by an insurer are relevant to stage one TPD declines, the NSWCA dismissed the potential tension between *Newling (No2)* and earlier NSWSC decisions and confirmed the view of Parker J (in *Newling No2*) that if reasons were given, they required no more than an explanation of '*the actual path of reasoning*' by which the conclusion was arrived at.

Moving to the substance of the appeal, the NSWCA dismissed the grounds of appeal in relation to the initial decline because '*It was well open to the primary judge to conclude that the Insurer's reasons for its first decision were inadequate and that the Insurer in breach of its contractual duty had failed to act fairly and reasonably in considering the respondent's claim*'.

That is, the NSWCA found that the insurer's reasons did not explain the '*actual path of reasoning*' for arriving at its decision, and cited competing medical evidence without explaining why it preferred one medical opinion over the evidence of treating doctors.

In relation to the subsequent decline, the NSWCA rejected the lower court finding that the second decision '*was not a genuine reconsideration of the respondent's claim*' on the basis that *'to characterise the second decision as simply whether the Insurer should "change its mind", ignored the substance of the Insurer's reasons'.*

Nonetheless, the NSWCA still agreed with the lower court that the second decline was flawed and could not stand on the basis '*that the reasons given by the Insurer did not purport to weigh the significance of what the respondent had said about his vocational prospects or the nature and reasons for his activities at the Club, and the support for the respondent's account in the affidavit of AX.*

Significantly, the striking feature of the original decision, being the novel finding that reinsurer influence on the insurer (and lack of disclosure of same) was a ground to vitiate the opinion based decline, simply fizzled out before the NSWCA. Specifically, the NSWCA, noting that the respondent had sought to uphold the relevant vitiation findings on grounds other than the reinsurance issues, sidestepped this issue given it '*cannot affect the outcome of the appeal.*'

Implications

- **Giving reasons:** Reasons given by the insurer (in decline letters) must display the '*actual path of reasoning*.' This has now been confirmed in two NSWCA decisions, being *Newling* and this case. The '*actual path of reasoning*' would appear to mean providing explanations as to why decisions are made the way they are, outlining the evidence on which they are based on and why in circumstances of conflicting evidence, one view is preferred over another.
- **TPD decline letters and reasoning:** Generally, being the only evidence submitted by insurers demonstrating the *'actual path of reasoning'* behind a decline, decline letters remain the crucial plank in any decline decision.

This decision confirms they will continue to be placed under the microscope by the courts in stage one TPD hearings. Despite the courts saying they do not expect such letters to be in the nature of judgments ('a judicial standard of reasoning is not required'), the relentless criticism of such letters suggests that they actually do. Insurers should prepare accordingly.

It is useful to note the specific areas in which the decline decisions in this matter were found to be wanting as they are areas which are common to many contentious TPD declines (learnings can flow from this). That is:

- Not considering or not adequately considering, exculpatory evidence from both the respondent and his treating doctors, which explained the potentially damaging surveillance evidence (which indicated work activity).
- Not seeking clarification of qualified views by doctors on the surveillance evidence i.e. the exculpatory evidence was not put to them.
- Not seeking further medical responses from doctors supporting a decline, on the impact of exculpatory evidence on their views.
- Not seeking to explain how the activities observed in the surveillance footage '*bore any relationship to the activities the respondent would be required to undertake in paid employment*.'
- Relying on vocational evidence which does not consider the respondent's psychological condition and restrictions on his job prospects.
- Not stating why one medical view was preferred over another.

- **The Reinsurance Issue:** The NSWCA's finding that it did not need to deal with the reinsurance issue technically means the lower court's novel finding on the impact of reinsurer influence on the primary insurer's decision, stands undisturbed.

That said, it should be noted that as mentioned above, the respondent did not seek to press its appeal on the reinsurance findings and the NSWCA stated 'Counsel (for the respondent) candidly acknowledged that the "reinsurance" issues were unnecessarily the focus of argument on the hearing of the separate question.'

On this basis one may conclude that the reinsurance grounds for vitiation raised by the lower court in this matter, will in time be seen as an idiosyncratic outlier shaped by the specific point in time reinsurance arrangements that applied to these facts, rather than a universal TPD principle.

CASES AND TRIBUNAL DECISIONS

TPD - Delay in Assessing Claims

Sargeant v FSS Trustee Corporation [2018] NSWSC 1997

Link to decision

Background

The TPD claim by the life insured, a former police officer, was brought in relation to both physical and psychiatric injuries. The life insured ceased work in February 2010 and her six months qualification period ended in October of that year. The claim was lodged in June 2011 and a decline decision was issued seven years later, in May 2018 (whilst court proceedings were on foot).

In the meantime, proceedings were commenced firstly in the Industrial Relations Commission in March 2014 but were transferred to the NSWSC by September 2015.

The decline was issued one month before the scheduled hearing date in June 2018 but for reasons unknown, the life insured chose not to challenge this decision but rather continued to assert that the insurer by reasons of its delay, had long since lost the right to make a decision on the opinion based TPD insuring clause and therefore, the May 2018 decision was invalid. Specifically, she urged the Court should make a finding that the failure to make a decision before proceedings were commenced in September 2015 or one year later in September 2016, was a breach under the policy i.e. a breach of its obligations of good faith and reasonableness in handling the claim (first stage).

These issues were determined as a separate preliminary determination by Parker J. The life insured conceded that if she failed on these questions, her claim should be dismissed i.e. the legitimacy of the final 2018 decline was not subject to a challenge.

Findings

The Court found that the insurer had not breached its policy by not making it decision before the 2015 and the 2016 dates. The key reasons were:

- A constructive decline finding is not merely based on the passing of time. There may be acceptable reasons for an insurer taking some time to assess a claim (para 105) per *Hellessey*.
- A life insured or trustee needs to give a clear warning if they are going to deem a claim as constructively declined or 'make time of the essence'. That is, 'it may be difficult for a trustee or a claimant to establish constructive rejection if they have not, so to speak, made time of the essence by giving an appropriate notice' to the insurer (para 105 and 126).
- Questions were raised even in the life insured's own evidence regarding the underlying legitimacy of the claim. Investigation was hence required and the insurer was not obliged to accept her (the life insured's) assertions and the opinions of her doctors at face value. It was entitled to test those assertions and opinions by reference to independent evidence (para 124).
- The insurer received implicit confirmation from both the claimant and trustee that they were satisfied with the progression of the claim when they did not take up the invitation to lodge a complaint with FOS or the internal complaint mechanism about the time taken to determine the claim (para 113).
- The ongoing service of further medical reports by the life insured throughout the proceedings and production of voluminous subpoenaed material (which the parties had

agreed could be used for the purpose of claim assessment) opened up further lines of enquiry which needed to be investigated – '… it was not just a question of reviewing any further material which came forward. Properly addressing the new material might require [the insurer] to reconsider views it had already formed, suggest lines of further enquiry, or require fresh reports from [its experts] (para 115). Further, in this regard the life insured solicitors did not make it clear that the multitude of further reports were only being served for stage 2 (para 121).

Implications

Clearly community and judicial expectations are for life claims to be determined more rapidly than they have in the past. Promises on time frames in this regard have been made in the present Life Code and the draft 2.0 version.

Be that as it may, as this case demonstrates, it is not the headline elapsed time between claim lodgement and claim decision which will be determinative of whether an insurer has delayed to an extent it has breached its policy (or the Code for that matter). Rather, it is underlying claim conduct of the parties to the claim which is determinative.

The facts in this matter are somewhat idiosyncratic and clearly taking seven years to determine a claim is not the norm. Nonetheless, one can draw some conclusions from this decision as to the type of matters which can anchor a defence to a constructive decline allegation in an aged claim context. Namely:

- the absence of a warning from the claimant that 'time is of the essence' in determining the claim;
- a medical matrix which is complex, multi-layered, controversial and warrants further investigation;
- the ongoing service or production via court process of relevant medical reports and material which requires ongoing investigation and absent clear direction that such material is not to be considered in the claim determination;
- the failure to accept an offer to pursue IDR or EDR remedies in relation to the alleged delay ; and
- contributory delay by the claimant in failing to respond to requests for information.

If some or all of these matters are present, then it would seem that an insurer has an arguable case against an assertion of delay in claim assessment.

INSURANCE ▪ COMMERCIAL ▪ BANKING

CASES AND TRIBUNAL DECISIONS

TPD - *Hearne v Street* Orders No longer Necessary

Gavan v FSS Trustee Corporation [2019] NSWSC 667

Link to decision

Background

The increased frequency with which life insurers are sued before reaching a TPD decision has in recent times created a dilemma as to how insurers, who are simultaneously defending proceedings as well as trying to make a decision on TPD, should treat documents they seek under subpoena or other compulsory court process.

That is, can the insurer, as well as using such documentation in its defence of the proceedings, also consider such material in forming its opinion on TPD?

The current approach is to use documents for these dual purposes but only after obtaining so called *Hearne v Street* orders from the court.

Obtaining such orders however, appears to be no longer required (at least in NSW) having regard to a recent decision by the Chief Justice in Equity of the NSWSC, Ward CJ, who found that the usual TPD *Hearne v Street* orders are not necessary when a life insurer wishes to use documents produced to the court to assist it in making a decision on TPD.

See link to case **here**.

Facts

The insurer and the insured had initially agreed on *Hearne v Street* orders in consent orders, which were made by the court, which allowed the insurer to use material produced by subpoena and other process, in the assessment of the TPD claim (a decision on TPD had not yet been made by the insurer).

The insured subsequently had a change of position and in the context of motions filed by both parties dealing with various matters, relevantly asserted that the insurer would be in breach of the *Hearne v Street* undertakings were it to use documents produced to the court, to assess the TPD claim.

Relevantly in response, the insurer argued that it could use court produced documents to assess the TPD claim without the leave of the Court, thus dispensing of the need to obtain the usual *Hearne v Street* orders in the first place.

Findings

His Honour found for the insurer on this *Hearne v Street* point. In short, it was found that in cases where a TPD decision has yet to be made, using documents produced to the court by compulsory process for the purpose of assessing the TPD claim is not a '*purpose unconnected with the litigation in the course of which the documents have been required to be produced*'.

Further, because the proposed use was not unconnected, the usual *Hearne v Street* orders did not need to be obtained.

The relevant comments from the judgment on this point are as follows:

> *91: I consider that, in the circumstances of the present case, use of the documents produced under the notice to produce (or under any earlier subpoena issued in the proceedings for that purpose), in order for the insurer to consider and make a determination as to Ms Gavan's claim to a TPD benefit will not infringe the Harman undertaking because it is not use for a purpose unconnected with the litigation in the course of which the documents have been*

required to be produced….

92: …I accept that there are parallel processes but I see them as connected in the sense that the documents sought will inform and be relevant to the same primary issue. The administrative process (of the insurer determining whether to its satisfaction the TPD definition in the Policies has been met in the present case) is not divorced from the claim to be determined by this Court if the insurer's determination is not in favour of Ms Gavan; and the same material has the capacity to inform both processes. The interconnectedness of the two processes is reflected by the potential for dispute arising from the likely difficulty of MetLife divorcing, from its consideration of Ms Gavan's TPD claim, information already gleaned from the present conduct of its defence of the proceedings instituted by Ms Gavan (noting that, as observed above, the principle extends beyond the documents themselves to use of the information contained in the documents). The potential for dispute down the track, if it be asserted that some information obtained through the compulsive processes of the Court was used improperly for the determination of Ms Gavan's TPD claim (particularly in circumstances where there has hitherto been apparent consent to the use of such information for those purposes), highlights the connection between the two processes.

As indicated above, the judgment also dealt with some other matters but not matters which are presently of any great moment to life insurers.

Implications – *Hearne v Street* Orders No longer Required

The general cautious approach to date has been for insurers to use documents produced to the court for both purposes but only if leave of the court is first obtained to do so, via *Hearne v Street* orders.

Seeking *Hearne v Street* orders, however has created an additional layer of judicial red tape on what are already highly technical two stage proceedings as well as an additional source of angst between insured and insurer.

Whilst this current decision does not carry appellant weight, it is by the chief judge in equity and its intellectual rigour is self-evident. Additionally, the current recent practice of seeking *Hearne v Street* orders in unmade TPD decision cases seems to be based on a cautious view of *Hearne v Street* rather than any TPD specific case law.

On this basis, insurers should feel comfortable in dispensing with the need to obtain *Hearne v Street* orders in circumstances where they wish to use documents produced to the court by way of compulsory process (such as Subpoena, Notice to Produce or discovery) in the assessment of a TPD claim.

Further, whilst this is a NSW decision, given the universal TPD concepts it deals with, it provides at the very least a basis for revisiting whether *Hearne v Street* orders are required in jurisdictions other than in NSW.

CASES AND TRIBUNAL DECISIONS

Crossing the "important and clear line" between general and personal advice

Australian Securities and Investment Commission v Westpac Securities Administration Limited [2019] FCAFC 187

Link to decision

Background

The licensees were licenced to provide general advice. They wrote to the members of their respective superannuation funds offering a free search for other superannuation accounts the customer might hold. A dedicated "Super Activation Team" then made telephone calls during which the customers, who may or may not have accepted the free search offer, were offered a further service of arranging a rollover of external accounts to consolidate their funds.

ASIC alleged the licensees had crossed "*an important and clear line*" and had given personal advice.

The licensees agreed that the initial mail out campaign, which successfully increased funds under management by $650M, contained marketing material intended to promote their funds, but denied that customers had received personal advice in the subsequent individual telephone calls.

At first instance, the Federal Court did not conclude the line had been crossed and considered that the telephone calls contained only general advice. However, the Court also concluded that the licensees had nevertheless acted unfairly and hence were in breach of the general obligation to do all things necessary to ensure that the financial services covered by the licence were provided efficiently, honestly and fairly.

ASIC appealed to the Full Court of the Federal Court, and the licensees cross appealed.

The Judgment

Personal Advice

In a detailed series of judgments from the Court, which consider the architecture of section 766B of the Corporations Act 2001 very closely, some themes are apparent.

His Honour Chief Justice Allsop observes for instance at paragraph 17 of his judgment that;

"The protection of people from potentially selfishly motivated advice is not advanced by making fine logical distinctions based on overly precise linguistic choices about words of a general kind employed by Parliament in furtherance of the protective purpose."

His Honour consequently commended the reasoning of the primary judge in adopting the approach of Sackville AJA in *ASIC v Park Trent Properties Group Pty Ltd* (No 3)[1] that a person may be influenced to make a decision about a financial product *"in ways other than by express recommendations or explicit statements of opinion."*

There were no or explicit statements of opinion by the licensees in the calls. However, in a passage from the same judgment approved by his Honour, Justice Sackville observed that someone may commend a course of action without saying so explicitly and it may simply be implied "*that the contemplated course of action is likely to be beneficial to the client".*

The judges of the Court were generally of the view that there was an assumption implicit in the phone calls that consolidation would be a beneficial personal objective for the

customer because they would save management fees as a result of eliminating the fees for their other accounts.

Under scrutiny by the Court the basis of this assumption was immediately called into question and the members of the Court did not consider it could simply be accepted at face value without a thorough and detailed product comparison.

The Court also looked closely at the licensees Quality Monitoring or QM framework which was both designed to ensure that only general advice was ever given and to encourage customers to ultimately agree to consolidate their superannuation accounts, including using relevant information to overcome customer objections and "*seeking a commitment for action that moves the customer closer to the sale*".

Chief Justice Allsop concluded that taken as a whole the purpose of the QM structure was "*intended to influence a decision in relation to a particular financial product*"[2] and ultimately it was to increase the licensees' funds under management.[3]

The Full Court diverged from the views expressed in the judgment at first instance over whether a reasonable person might have expected the licensees to have considered one or more of the customer's objectives, financial situation and needs, within the meaning of section 766B (3)b of the Corporations Act, rendering the representations personal advice.

Significant in the Full Court's reasoning on this point was its view that the customer's interests should have been considered where the licensees knew it was in their own interests that the funds be rolled over, increasing their funds under management, but did not know all of the matters relevant to whether it would be in the customer's interests (such as for example the fees that applied to the other accounts and how those fees were applied).

Chief Justice Allsop consequently concluded that while he agreed with the judgment at first instance that "*the caller from the licensee's Super Activation Team was following the QM framework and was not taking into account the customer's objectives, the overall context of the campaign would lead a reasonable person to think the consolidation recommendation was appropriate for each particular customer's circumstances.*"

Unfairness

The reasoning that the conduct was unfair and consequently in breach of the general licence obligation in section 912A(1)(a) that the financial services covered by the licence must be provided "efficiently, honestly and fairly" essentially turned on the same inequality of knowledge between the licensee and the customer.

Essentially, the licensee could not make the recommendation when it did not know whether it would be in the customer's best interests or not, and not taking into account matters that would enable it to assess what the customer's best interests were, did not absolve the licensees when they benefited from making the recommendation.

Implications

There are some significant takeaways for Australian financial services licensees in this judgment.

No matter how much a licensee may try to script individual customer conversations to limit the nature of the product advice, whether personal advice is being given, will always be judged by the overall context of the entire interaction.

This contextualising will affect how the representations and the recommendations made to the customer are construed and will also shape the expectations of a reasonable person about whether personal circumstances are being taken into account.

Consequently, the decision is further affirmation that the courts will be looking at the ways a customer has been influenced to make a decision about a financial product that are not necessarily reflected in an explicit statement of opinion or recommendation.

A protocol that is intended to avoid personal advice being given is unlikely to be effective in circumstances where a court feels that the proposition being put to the customer ought to have been the subject of personal advice in the first place and was not.

This suggests that the first question a licensee needs to ask before it shapes a customer conversation is whether that conversation really requires personal advice to be fair to the customer.

Not fully explained in the judgment is the possibility briefly raised by Chief Justice Allsop that the conclusion personal advice was provided may have been altered if the callers had not sought to get the customers agreement before the call ended and instead "the customers had the opportunity to consider their own positions and, having done so, later communicated an acceptance".[4]

This observation, at the very least, suggests that giving a customer time to reflect will be the way the courts prefer that licensees do business.

[1] [2015] NSWSC 1527

[2] Paragraph 38

[3] Paragraph 148

[4] Paragraph 5