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Unfair contract terms – striking a balance

With effect from April 2021, the Insurance Contracts Act will be amended so all contracts of insurance will be subject to the Unfair Contract Terms (UCT). The purpose of these laws is to strike out contractual terms which cause a 'significant imbalance in the contracting parties' rights and obligations'.

What is the potential impact of the UCT laws on life insurance contracts? Will they result in better outcomes for customers? What challenges lie ahead for underwriters in striking a balance between the underwriting risk accepted by the insurer and not disproportionately or unreasonably putting the insured at a disadvantage? Discuss how underwriting practices could be improved or changed accordingly.

Introduction

Introduced in Australia from 1st January 2011 to provide consumers greater protection against unfair terms and conditions, the Unfair Contract Terms (UCT) law has applied to most financial products and services regulated by the *Australian Securities and Investments Commission Act 2001* (ASIC Act).

It applies to "standard form" contracts for financial products and services where the terms are typically provided by one party on a "take it or leave it" basis, with little or no scope for negotiation.[1]

From 12th November 2016 coverage was extended to include small businesses that employ less than 20 people and where the upfront price payable under the contract is within specified monetary amounts defined within the ASIC Act.[2]

Life insurance contracts were exempt from this law due to being regulated by the *Insurance Contracts Act 1984* (ICA), where section 15 of the Act states a contract of insurance is not capable of being the subject of relief under any other Act.

The ICA was introduced to allow a fair balance between the interests of insurers, insureds and other members of the public so that contract provisions and insurer practices operated fairly. The Australian Law Reform Commission's 1982 report, that led to the ICA, suggested the requirement of both parties to act with utmost good faith '*should provide sufficient inducement to insurers and their advisers to be careful in drafting their policies and to act fairly in relying on their strict terms'*

Following recommendations made in the final report of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services industry, the *Financial Sector Reform (Hayne Royal Commission Response – Protecting Consumers (2019 Measures)) Bill 2019* amends the ASIC Act, allowing UCT law to apply to life insurance contracts governed by the ICA

UCT laws will apply to all life insurance contracts except for group insurance. These are owned by a superannuation trustee who can negotiate contracts on behalf of members to a certain degree, i.e. not a standard form contract. Moreover, they will not meet the small business criteria.

UCT Law – the potential impact on life insurance contracts

The UCT regime will apply to all contracts effected, renewed or varied on or after 5th April 2021 and will grant an insured an avenue to bring action against an insurer should a contract term meet ***all*** the following:

1. It would cause significant imbalance in the parties' rights and obligations arising under the contract,
2. is not reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term, and
3. the term would cause detriment (financial or otherwise) to a party if it were to be applied or relied on.[3]

The transparency and prominence of a term within the contract will assist when considering fairness, i.e. expressed in reasonably plain language, presented clearly and not buried in

small print or a separate annexure. Transparency alone may not prevent a term from being unfair but will provide weight.

There are a few exceptions to the UCT provisions, i.e. terms that define the main subject matter of the contract; terms that set the upfront price payable under the contract; or terms that are required, or expressly permitted, by a law of the Commonwealth, a state or territory.[4]

The approach of other countries

This important milestone brings Australia into line with Europe and the UK where the UCT regime for life insurance contracts was introduced on 5th April 1993 by virtue of the European Council Directive 93/13/EEC.

The European Directive provides similar exclusions around price and subject matter but provides a broader interpretation of subject matter, excluding terms which clearly define or circumscribe the insured risk and insurer's liability as these restrictions are accounted for in calculating the premium.

The Australian regime is stricter, providing a narrower definition which states any terms setting out the risks covered be reviewable, with the onus on the insurer to justify why they are necessary to protect its legitimate interests.

Underwriting challenges

Prior to 5th April 2021, each insurer will need to prospectively analyse its full product offering and redraft any terms likely to breach UCT law. Any term that is perceived as detrimental to the insured but necessary by the insurer will require reinforcement with reliable actuarial data.

The underwriter's role in evaluating the risk posed by an application for insurance will be critical in supporting the insurer's position. Unfortunately, not all applicants are a standard risk and some may only be offered cover subject to a premium loading or an exclusion (medical, occupational or avocational). These revised terms will also fall within the UCT regime.

As stated previously, a term is considered unfair if:

1. It would cause significant imbalance in the parties' rights and obligations arising under the contract;
2. is not reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term; and
3. the term would cause detriment (financial or otherwise) to a party if it were to be applied or relied on.

An insurer is unlikely to win an argument around application of revised terms on points 1 and 3 as these benefit the insurer and cause a financial burden to the insured, particularly if an exclusion is relied upon to decline a benefit.

Its main defence will be point 2 with reliance upon the underwriter's critical analysis of the risk and demonstration of an appropriate understanding of the insured's medical history to support its decision being fair and reasonable.

The *Disability Discrimination Act 1992* (DDA) protects people from being treated less favourably than others because of their disability. The DDA, however, does allow certain exemptions including reasonable differences in the provision of insurance and superannuation (s46); hence, it is a vital consideration within the underwriting assessment and complements the principles of fairness expected by UCT law.

This importance of DDA was highlighted in the case of *Ingram v QBE Insurance (Australia) Ltd (Human Rights) [2015] VCAT 1936.* Ms Ingram argued she was discriminated against when QBE issued a travel policy and relied upon a standardised mental health exclusion within the policy to refuse indemnity. Ms Ingram pursued a claim on the grounds of discrimination and subsequently VCAT held that QBE had been unable to produce evidence to prove the exclusion had been applied based upon actuarial or statistical data at the time of issue.[5]

Although this case is related to travel insurance and doesn't have much precedent value (turning on the facts and is a decision of an administrative tribunal), the underlying principle highlights for all insurers the importance of current actuarial data to support an exclusion as reasonably necessary.

How can underwriting practices respond?

It is not unusual for exclusions to be imposed to limit the cover available and prevent the insured from receiving a benefit due to a pre-existing medical condition that was considered to pose an unacceptable risk at time of application.

Where multiple exclusions must be applied, this would significantly reduce the coverage and the value of the product to the insured.

In the interest of fairness, insurers may need to contemplate a revised premium where a large portion of cover is removed by an excluded key definition, e.g. cancer definition in Trauma. This would impose a premium more reflective of the cover granted, with the insurer safe in the knowledge the overall claim incidence remains reduced.

This was touched on by a recent ASIC report regarding the activities of daily living definition (ADL) under Total and Permanent Disability (TPD) benefits where it concluded that insurers consider the removal of this definition altogether as it was deemed too restrictive and unfair.[6] The summary of findings highlighted that insureds were generally paying the same premium for an ADL definition as a more general TPD definition despite the term being so restrictive.

Pre-Existing Condition Clauses

Some contracts include standardised pre-existing condition clauses (PEC) which have not been individually underwritten. These terms will attract scrutiny under UCT law unless an insurer can provide data to justify the need, that it is not broader than necessary, and it is brought to the applicant's attention rather than being hidden in small print.

Contracts which cannot be protected by a PEC, will inherently rely on underwriters to obtain all material information to fully understand the insurer's actual risk.

With an underwriter's decision critical to demonstrating revised terms are fair and reasonable, their autonomy around waiving standardised requirements may lessen to ensure they can clearly demonstrate a full knowledge of the insured's individual circumstances.

Mental health

Mental Health Australia provided an extensive submission to the Hayne Royal Commission detailing the difficulties consumers with mental health conditions experience when purchasing insurance, including reliance on exclusions.[7]

The trajectory of mental health conditions can be difficult to predict; therefore, underwriters must take a cautious approach when evaluating the risk. As a result, exclusions related to mental health are usually wide-ranging to capture all facets of mental health, some of which may never be experienced by the insured.

From a consumer perspective, mental health awareness is increasing with many people now pro-actively managing their condition by seeking medical support at an early stage of symptom presentation. This should not be discouraged but clearly will need to be disclosed when applying for insurance cover.

Until more targeted exclusions can be considered, there may be opportunities to provide alternative solutions for certain conditions that are well managed.

A capped benefit period of 1 or 2 years is currently offered in the United States for income protection benefits. This approach would allow an insured meaningful financial protection during an acute phase of illness while appropriate medical treatment is sought. Cover of this nature would reduce the longer-term risk and pricing implications for the insurer.

Considering a reduced benefit period for applicants who may otherwise be refused coverage, also has the potential to uncover additional data which may not routinely be captured during the current product control cycle. The expectation being to enhance underwriting data and allow ongoing review of underwriting practices.

In the event revised terms are unavoidable, the insured should have a legal right to have these reviewed after a period to determine if more favourable terms can be offered. A proactive approach from the insurer by instigating this process will determine whether the revised term remains necessary to protect its legitimate interest and potentially avoid conflict at claim stage should the insured argue the exclusion is no longer relevant.

Customers – will better outcomes be achieved?

The goal of the UCT regime alongside the current utmost good faith principles is to enhance consumer protections, and should be considered a positive step towards re-building consumer trust and strengthening fairness principles.

With Australia adopting a narrow definition of the main subject matter, many terms that are fundamental to allowing a benefit payment will be open for challenge. This includes eligibility criteria, waiting periods, definitions of disability/insured event, benefit limitations, pre-existing/standard policy exclusions and benefit periods.

If a dispute cannot be resolved between both parties, the insured has the option to involve an external dispute resolution body, e.g. the Courts, Australian Financial Complaints Authority (AFCA) or depending on the situation, ASIC.

With each body adjudicating through a different lens, outcomes may differ depending on the platform chosen.

Should a term be deemed unfair it may be declared void.[8] If the contract can operate without the unfair term, then it will remain in force with both parties bound by the remaining terms.[9] However, if the contract cannot fulfil its purpose it could result in the insured being left without cover. This is not a favourable outcome considering any disagreement in terms is likely to arise at the time of claim when the insured is at their most vulnerable and in need of financial support.

Courts are expensive for both parties, take time, and focus on who is right and who is wrong rather than fairness, whereas, AFCA decisions are strongly underpinned by fairness while having regard to legal principles, industry codes of practice and previous determinations.

The latter adjudication will likely result in more favourable outcomes for an insured, considering their principle of fairness. This has been evidenced by some recent AFCA's determinations relating to Trauma benefits.[10] The outcome being direction to pay a benefit outside the insurer's intent of the policy.

Although this is a positive outcome for the individual complainant, the consequences of paying claims on the grounds of what is considered fair may have a cost which will inevitably fall on other consumers.

The long-term nature of life insurance contracts will challenge insurers when managing risk exposure across all customers. With specified events insured until retirement age and beyond, an insured's personal circumstances (health and financial needs) are likely to change. What may have been deemed fair at inception of the policy may not be considered fair 10 years later.

This contrasts with general insurance policies which are usually short term and renewed on a regular basis - typically yearly, thus allowing the opportunity for insurers to review terms and premiums routinely. Conversely, the insured also has an opportunity to reconsider alternative cover with another insurer.

With uncertainty around whether terms can be relied upon, product wording and pricing will be difficult to predict with confidence.

There is an expectation that premiums will increase for new policies post 5th July 2021 until insurers have more meaningful data around their exposure. Subsequently, the choice and scope of products that an insurer can offer may also alter.

UCT – how do we measure its success?

Statistics reveal the number of claims paid in 2019 as:

- 90% Total and Permanent Disability
- 95% Income Protection
- 86% Trauma[11]

An increase in these percentages is not necessarily a sign of success. Meaningful cover at an affordable cost is a common goal but can only occur if invalid claims are declined.

In this developing climate of fairness, a focus on complaint causation and outcomes will determine whether contract wordings are meeting expectations. If so, this will provide confidence in product wording, processes and pricing capability.

Conclusion

The impending UCT laws will prompt changes to life insurance contracts that improve transparency and provide better outcomes for customers, but with the majority of UCT challenges anticipated to arise at time of claim, it will take time before the results can be measured.

Underwriters will need to adapt to these new obligations and ensure the principles of risk assessment do not disadvantage insured's disproportionately.

The UCT regime is one of several compliance obligations being implemented to strengthen consumer protection.

A clearer picture of whether an equilibrium is achieved will develop once these regimes are embedded.

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[1] ASIC Act s12BF; ASIC Act s12BK

[2] ASIC Act s12BF

[3] ASIC Act s12BG

[4] ASIC Act s12BI

[5] Victorian Civil and Administrative Tribunal

[6] Report 633: Holes in the Safety Net: A review of TPD insurance claims

[7] Royal Commission into Misconduct in the Banking, Superannuation and Financial services Industry, Submission by Mental Health Australia (October 2018)

[8] ASIC Act s12BF

[9] ASIC Act s12BF

[10] AFCA Determination(s) 607118, 658132, 674917 & 674068

[11] Sourced from the FSC-KPMG life insurance data project and APRA Life insurance claims and disputes statistics