LIFE INSURANCE BULLETIN

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CONTENTS

Note from the Editor

TPD. Seriously, does it need to be this hard?

The microscopic examination of the minutiae of the insurer's interpretation of the medical evidence in both the original case and now by the majority of the NSWCA in *Sandstrom* is arguably of little guidance going forward given the strong dissenting judgment by Macfarlan JA in this case. As our author wryly points out, the reasonable minds on the NSWCA obviously differed in their views of this case. On a wider level, remembering that we are dealing with opinion based clauses in most of the TPD controversies coming before the courts, one can't help but wonder if the fundamental and well settled principle that should guide judicial decisions on such clauses, namely, that reasonable minds may take different positions on such complex matters (especially when doctors will often disagree with each other and future events are obviously uncertain) has been lost. As always, you can decide but we hope our analysis of this case helps you on your way.

Plenty of other good reading in this quarter's edition including interesting pieces on an AFCA decision on war exclusions and a FCA decision on the time an insurer should have to make a complex TPD decision in circumstances where they are receiving little cooperation from the claimant. IDII reform is also bubbling away and we have the latest on that.

Finally I would like to remind all our eligible readers that the **2021 ALUCA Turks Scholarship** has launched for its 15th season. Click here for entry details and your path to life insurance stardom!

Enjoy the read and please reach out to your favourite Turks life expert if you have any queries.

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LIFE AND SUPERANNUATION CASES

NSWCA confirms close judicial scrutiny of insurers' reasons

MetLife Insurance Limited v Sandstrom (NSWCA 2021)

Key Takeaways

The NSWCA has reiterated the Courts' willingness to intensely scrutinise life insurer's TPD decision letters.

Brief Facts

- The plaintiff was a former NSW police officer who sought payment of a TPD benefit due to suffering PTSD and related psychological conditions.
- The plaintiff was 28 at the date for assessment and had prior education, training or experience as an office assistant and cinema attendant and had completed 18 months of an Arts degree before joining the police force.
- The relevant definition was concerned with whether the plaintiff was unlikely ever to engage in relevant work, as to which she was to provide proof to the insurer's satisfaction.
- The insurer declined the claim on the basis that the plaintiff was '*likely to be able to return to work at some point in the future, external to the NSW Police Force*' in identified administrative and sales roles.

The trial judge found that the insurer failed to fulfil its contractual duties in dealing with the plaintiff's claim and its determination was therefore void, and that she satisfied the TPD definition at the relevant date, and made orders against the insurer for payment. We discussed his Honour's decision in our article in the April 2020 edition of the Bulletin.

The insurer appealed the decision to the NSWCA. The issue on appeal was whether the trial judge erred in concluding that the insurer breached its contractual obligation to assess the claim in good faith and to act fairly and reasonably in making that assessment. It did not separately challenge the trial judge's assessment of total and permanent disablement.

Judgment

By a majority of two to one, the NSWCA upheld the decision of the NSWSC. It was central to the majority's decision that the plaintiff's cover was held through her superannuation fund. The Court quoted Commissioner Hayne's observation in the Final Report of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry that the majority of life insurance policies on issue in Australia are held through superannuation funds. It was held that:

> The fact that beneficiaries who rely on such cover through the intermediary of a superannuation fund have no entitlement to challenge the merit of decisions of the insurer in court suggests that, if not strict scrutiny, at least careful scrutiny of the evidence as to whether the insurer has properly understood and fairly complied with its contractual obligations should be applied.

It is unclear what the Court intended by the statement that beneficiaries under group cover have no entitlement to challenge the merit of decisions of the insurer in court.

Specifically, the majority held that it was unfair to rely on certain opinions of particular doctors suggesting at one point in time (without reference to the words of the TPD definition) that the plaintiff would potentially be able to work in a job outside the police force, when they provided later opinions couched in terms of the TPD definition to the opposite effect.

Similarly, statements that the plaintiff had a permanent impairment but '*may be able to return to some form of work*

with a different employer' were held by the majority to be ambivalent (in that it was unclear whether *'may'* meant there was or wasn't any real chance that the plaintiff would do so). The majority upheld the decision of the trial judge that it was unfair to rely upon this ambivalent answer as adverse to the plaintiff.

The majority also cautioned that '*The importance given to the most nearly contemporaneous opinions was permissible, but should have been accompanied by an acknowledgment that many medical conditions take time to stabilise*'. Similarly, in his dissenting judgment, Macfarlan JA stated '*The date the opinion was expressed might not have been of crucial significance but it was at least a matter the appellant was entitled to take into account*'.

The majority acknowledged that the insurer was entitled to be sceptical as to whether the plaintiff was unlikely ever to return to work. '*Her youth, together with the long period over which that assessment needed to be made, warranted a level of scrutiny of the available evidence which might not otherwise have been justified.*' However, the majority emphasised the importance of insurers applying that scrutiny consistently, and that objections should not be raised to reports supportive of a claim when the same objections would apply to reports which did suggest a reasonable possibility of future employment. For example, if the insurer was to reject some opinions on the basis that they were not expressed in the terms of the policy definition, it was held to be unfair to rely upon other evidence which was not so framed.

In his dissenting judgment, Macfarlan JA held that having regard to the relevant medical opinions, the insurer was entitled not to be satisfied of the plaintiff's permanent disability.

Macfarlan JA noted the underlying principle that '*a decision may be set aside if the process of consideration underlying it was not undertaken reasonably and fairly, even if the outcome itself is not also shown to have been unreasonable on the material before the insurer*'. The plaintiff's challenge to the insurer's decision on appeal was directed at the process by which it was arrived at, rather than the outcome as such.

> ***However, the majority emphasised the importance of insurers applying that scrutiny consistently, and that objections should not be raised to reports supportive of a claim when the same objections would apply to reports which did suggest a reasonable possibility of future employment.***

His Honour held that where (as here) there were a series of medical reports referred to in an insurer's decision correspondence that went to the failure to form a view that the claimant was TPD, the fact that part of one of those reports read in isolation was potentially capable of being described as equivocal or ambiguous was not sufficient to invalidate the insurer's reasoning. His Honour stated:

> *The medical opinions then referred to, including that of Dr George, were followed by the conclusion expressed in respect of each policy that the appellant had 'not formed' the required opinion as to permanent incapacity. None of the opinions referred to needed on its own to establish the basis for the appellant's non-formation of that opinion. Rather, reading the letter logically and reasonably, the descriptions of the opinions were given to provide some, but not necessarily conclusive, support for that conclusion.*
>
> *As the issue to be addressed by the appellant was whether it was, acting reasonably and fairly, positively satisfied of the respondent's permanent disability, the opinion of Dr George, who had assessed the respondent at about the date for assessment, that the respondent 'at some time in the future… may be able to return to some form of work with a different employer' was supportive of the appellant's non-satisfaction. Particularly is that so when Dr George expressed his opinion in response to a question that specifically asked him about the policy issue of permanent incapacity. Because Dr George was apparently not satisfied of the relevant matter, the appellant, if attention is at this stage confined only to Dr George's opinion, was similarly entitled not to be so satisfied.*
>
> *In these circumstances, I respectfully disagree with the primary judge's view that the appellant 'should not have relied on this sentence, as it did, but should have gone back to Dr George and asked him what he really meant'.*

It was important, in his Honour's view, for the Court not to read part of a single report in isolation and seize upon it to invalidate an insurer's decision where the words in question might be regarded as equivocal, but there is other evidence to similar effect (including other evidence authored by the same expert) which lends weight to a body of evidence which, read as a whole, makes it reasonable for the insurer not to be satisfied that a claimant is TPD.

His Honour also reiterated the principle that an opinion as to unlikelihood of a return to work expressed to relate to the 'foreseeable future' was not 'evidence directly supporting' the view that the plaintiff satisfied the TPD definition, which is concerned with whether a claimant is unlikely ever to do so.

Implications

Clearly, insurers' decisions on TPD claims will continue to be closely scrutinised. It will be important for insurers not to dismiss material supportive of a claim on the basis that they are not framed in the precise terms of the TPD definition, if the insurer relies upon other opinions that also do not do so.

Insurers should also consider whether it is necessary to clarify any actual ambiguity in medical opinions, for example, where opinions are expressed to the effect of a somewhat noncommittal '*may*' formulation.

It is also clear from the majority judgment that where doctors have provided different opinions at different points in time, an insurer acting fairly and reasonably should engage with all of those opinions rather than only those that support a particular proposition.

The case continues a recent theme that evidence contemporaneous to the date for assessment is not necessarily the best evidence of a claimant's future unlikelihood ever to return to work, at least in the case of chronic conditions, but nor is it necessary to disregard it.

Finally, in a plain manifestation of '*reasonable minds reasonably differing*', it is evident that even the judges of the NSWCA differ in their interpretation of the decisions of life insurers, and the probative value of the material that underlies those decisions.

PRODUCT / REGULATORY

AFCA says fairness requires the cancellation procedure in s210(5) to apply to all life insurance policies

Following consultation, AFCA has finally and definitely outlined its view on the cancellation of life policies for non-payment of premiums. That is, its position paper entitled '*The AFCA Approach to cancellation of insurance policies for non-payment of premiums*' indicates that s210(5) of the *Life Insurance Act* 1995 provides the correct cancellation procedure for life policies as opposed to s59 of the *Insurance Contract Act* 1984.

The release of this paper effectively ends any glimmer of hope that AFCA remained open to sensible s59 arguments noting that some Determinations seem to indicate this was the case.

Background

The law governing the cancellation of life insurance policies for non-payment of premiums is unresolved, with both s210(5) of the *Life Insurance Act* and s59 of the *Insurance Contract Act* seemingly providing competing insurer cancellation procedures.

Briefly stated, the more complicated cancellation procedure under s210(5) requires written notice to be given setting out the premium amount outstanding, the due date for payment and that the policy will be cancelled 28 days after the notice is given (if the premium is not paid) or 28 days after the premium due date, whichever is later.

On the other hand, the cancellation procedure in s59 simply requires written notice to be given of the proposed cancellation with the cancellation to take effect on the relevant prescribed day (usually 20 business days later).

It is generally accepted that the superior legal argument is that s210(5) applies only to cancellation for non-payment of premiums of certain life insurance policies with a surrender value and that s59 governs the cancellation of all other life insurance policies (including risk only policies) for non-payment of premiums.

The AFCA Approach

AFCA acknowledges the competing legal arguments and the lack of definitive case law, but adopts s210(5) as the standard for cancellation of *all* life insurance policies for non-payment of premiums on the basis it is '*fair in all the circumstances*':

- It says s210(5) is '*better suited*' to life insurance which is usually '*a medium to long term product*', noting it is harder for a person to obtain a new policy as they get older and their medical history is likely to become more extensive.
- It asserts s210(5) provides '*greater flexibility for insurers to keep customers*' as it '*provides the insured with a final opportunity to pay the premium*' before the policy is cancelled. Dismissing industry submissions that s59 affords the same opportunity, it proceeds primarily on the assumption '*a notice given under s59 states that the policy will be cancelled and does not give the insured an opportunity to prevent the cancellation*'.
- It considers its approach provides consistency in decision-making as FOS applied a similar interpretation to the application of s210(5).

It is AFCA's expectation, compliance with s210(5) '*should not be difficult*' to achieve.

Despite adopting its position, AFCA reiterates fairness may require a different outcome in some circumstances. Seemingly, strict compliance with s210(5) will not always

be enough with AFCA specifying it is '*unlikely*' to find the cancellation is fair where '*a consumer has made all reasonable efforts to pay the premium, but has not done so*'. AFCA anticipates this may arise in the following situations:

- where '*an insured makes a mistake about which amount in an insurer's notice needs to be paid and then does not pay the amount needed to avoid the cancellation*'; or
- where '*the insured had funds in an account, the account could be debited, but for some reason the insurer has been unable to debit the account*'; or
- '*If a customer has told the insurer that they are experiencing financial hardship, but the insurer chose to cancel the policy without attempting to explore other arrangements*'.

AFCA further specifies that by contrast, it may decide to uphold a cancellation in the absence of a strict compliance with s210(5). AFCA provides the example of an '*insurer's notice [which] is clear and unambiguous but contains a small error (e.g. the date of cancellation is wrong)*' and the insured has not taken any steps to pay the required premiums.

> *The release of this paper effectively ends any glimmer of hope that AFCA remained open to sensible s59 arguments noting that some Determinations seem to indicate this was the case.*

When is the notice 'given' for the purpose of s210(5)?

Section 210(5) is silent as to how written notice is to be '*given*' to the policy owner. To that end, a key aspect of AFCA's approach is that '*notice*' is not '*given*' on the date it is issued. AFCA has clarified that it will deem a notice sent by:

- email - to have been given '*on the **date** the email is sent*', in accordance with the requirements under the *Electronic Transactions Act* 1999 (Cth);
- post - to have been given or received '***on the seventh working day after** it was posted*', in line with the current iteration of s160 of the *Evidence Act* 1995 (Cth). Whilst arguments may be advanced that the *Evidence Act* has no intended application in disputes before AFCA, AFCA's approach is clear and unequivocal that s160 applies '*unless the insurer can show the notice was delivered earlier*'. This carve out otherwise appears to be consistent with the wording in s160 which contains a rebuttable presumption.

AFCA otherwise considers it is best practice for insurers to inform a customer about the impending cancellation using multiple communication methods, for example, text and email.

What happens to the outstanding premiums?

AFCA concludes that if it '*finds the policy was not correctly cancelled, then the customer must pay any outstanding premiums*'. It expects that where an insured is unable to pay the outstanding premium amount in full, '*a reasonable repayment plan should be put in place. This should not stop the insurer for assessing any claim in the meantime*'.

Implications

The life industry backed by strong legal opinion and common sense has long argued that the s210(5) cancellation procedure is restricted to certain life policies and that s59 is the correct section for most cancellations for non-payment of premiums. Against this background, the release of this paper must be disappointing although not unexpected.

Legislative reform may one day clarify the true meaning of the arcane s210(5) and of course the matter could be determined in a court, however for the time being, it seems that the issue has now for most practical purposes been determined by AFCA and effective cancellation of life policies for non-payment of premiums will now have to be s210(5) compliant.

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LIFE AND SUPERANNUATION CASES

AFCA upholds '*militant activities*' exclusion

Key Takeaways

This Determination is a reminder of the importance of ensuring that contractual terms are properly defined in a policy. Where a term is not properly defined, AFCA may interpret the clause in accordance with its ordinary meaning, which may differ to the intended meaning. Where an insurer or trustee relies on publically available material in support of a decision, it should ensure the evidence is from a reliable source and will withstand scrutiny.

Brief Facts

The dispute concerned a claim for a benefit following the death of a young woman (**the Deceased**) who departed Australia in December 2013 under the guise of travelling to Denmark for humanitarian work but instead travelled to Syria. According to extensive media reports, the Deceased travelled to Aleppo Syria to actively fight (alongside her husband) in support of Al Qaeda. On 9 January 2014, the Deceased and her husband were killed in Syria and their bodies were never recovered.

The insurer and trustee declined the claim for the death benefit on the grounds that:

1. The Deceased died while working overseas in a Hazardous Destination (clause 4.10); and/or
2. The death was a result of the Deceased participating in '*Militant Activities*' (clause 8.6).

> *Absent precision, and as we have seen with the recent business interruption case on the pandemic exclusion in a general insurance policy[1], the courts will not be concerned with the intentions of the parties on such matters if the clear words of the policy do not match such intentions.*

Policy Terms

In support of its decision, the insurer relied on clause 4.10 of the Policy which stated:

4.10 COVER DURING OVERSEAS RESIDENCE

Cover may continue for an Insured Person working overseas provided that

[…]

(c) at the time of the Insured Person's departure, the country of residence is not considered a

Hazardous Destination.

In relation to the 'Militant Activities' exclusion, the Policy relevantly stated:

8.6 Exclusions

No benefit is payable under The Policy where the death or Total and Permanent Disablement is the result of the Insured Person participating in Militant Activities.

Determination

AFCA considered that cl 4.10 of the Policy had no application to the complaint as the insurer had not demonstrated that cover had ceased in the first instance under clause 8 of the Policy (covering cessation of cover).

In the circumstances, cover not having ceased in the first place, cl 4.10 which had the effect of continuing cover except for in '*Hazardous Destinations*' (which Syria in 2014 clearly was) had no application.

It was accepted that the term '*Militant Activities*' in cl 8.6 was not defined in the Policy. In the absence of a defined term, AFCA had regard to the Macquarie Dictionary meaning of '*militant*' as including '*engaged in warfare… someone engaged in warfare or strife… a militant person*'.

AFCA considered the purpose of the Militant Activities exclusion clause was clear in that it intended to exclude cover for insured members engaged in warfare or combative activities. That is, the Policy was intended to cover death arising in the normal course of life '*rather than through insured persons putting themselves in harm's way*'.

In support of the decisions to decline the claim based on the Militant Activities exclusion clause, the insurer and trustee referred to several newspaper articles relating to the Deceased, including interviews with her father regarding the circumstances of the Deceased's travel and her death. In particular, AFCA had close regard to a Daily Telegraph interview with the Australian Federal Police's (**AFP**) counter terrorism manager in which the AFP alleged the Deceased was actively fighting with her husband in Syria at the time of her death.

The Deceased was mentioned by name by the AFP as being a female fighter that had lost her life in the war zone. AFCA considered the AFP's counter terrorism manager had special knowledge of the facts surrounding the Deceased's travel and death in Syria. The complainant was unable to provide compelling evidence to demonstrate the Deceased travelled to Syria for humanitarian reasons or that she was not involved in the alleged terrorist activities.

The complainant argued the insurer and trustee were required to show the exclusion clause had been satisfied to the *Briginshaw* standard (i.e. the test applicable to fraud) due to the serious allegation that the Deceased was fighting for a terrorist organisation and participating in militant activities. AFCA declined to adopt this test and stated:

> *AFCA is not bound by the rules of evidence, however, so for the purposes of determining this complaint the panel considered whether the available evidence supported the insurer's and trustee's decisions on the balance of probabilities.*

Based on the extent of the media coverage, in particular the AFP interview, AFCA was satisfied that the decisions of the insurer and trustee to apply the Militant Activities exclusion were made fairly and reasonably in the circumstances and resolved to affirm the decisions.

Implications

The concept of excluding life cover for those engaging in war or war like activity is as old as insurance itself and through the years, various fine lines have been drawn by courts and tribunals as they seek to discern meaning from policy terms dealing with this issue. Here the insurer chose to let its clear words '*Militant Activities*' speak for themselves (rather than define them) which was definitely a bold choice. Generally speaking, as we move far away from concepts of traditionally defined military conflicts, insurers should give careful thought to the activities they wish to exclude and define such activities with precision, either with the words they use (as the insurer did here) or in the attached definitions.

Absent precision, and as we have seen with the recent business interruption case on the pandemic exclusion in a general insurance policy[1], the courts will not be concerned with the intentions of the parties on such matters if the clear words of the policy do not match such intentions.

Finally, in relation to the '*standard of proof*' required when alleging serious misconduct by an insured, while AFCA declined to apply the standard required in fraud cases, the evidence must nevertheless be from a reliable source and unequivocally support the insurer's and trustee's decision.

[1] *HDI Global Specialty SE v Wonkana No. 3 Pty Ltd* (NSWCA 2020)

LIFE AND SUPERANNUATION CASES

FCA confirms AFCA not required to comply with rules of evidence

Cummins v Petterd (FCA 2021)

Key Takeaways

The recent FCA decision in *Petterd* confirms that AFCA is not required to follow rules of evidence or the rule in *Browne v Dunn* (a long standing technical rule of evidence that requires a witness to have a chance to respond to evidence which may contradict what they say).

AFCA can determine a decision to be '*fair and reasonable*' without necessarily determining the truth of competing accounts. As such, submissions in disputes involving competing factual accounts, should focus more broadly on the ways in which the evidence supports a particular version of events and, if a party considers an interview is required to clarify discrepancies then such a submission will need to be made to AFCA (noting that AFCA generally does not interview the parties).

Brief Facts

AFCA determined to affirm a decision of the trustee of a superannuation fund that death benefits were payable to Ms Petterd, the '*claimed spouse*', of the deceased. The deceased's children appealed that decision claiming that Ms Petterd was not their father's '*partner until his death*' and that the death benefits should be payable to them.

The question of law ultimately pursued before the Court by the deceased's children was: Is AFCA required to accommodate the rule in *Browne v Dunn* before coming to a decision?

In general terms, the rule in *Browne v Dunn* is that when a witness is giving evidence and evidence is intended to be called that contradicts their evidence, then the substance of that contradictory evidence must be put to the witness during cross-examination, and they be given the opportunity to respond or comment on the adverse evidence.

Judgment

The FCA dismissed the appeal and determined that AFCA was not required to accommodate the rule in *Browne v Dunn* for the following five reasons:

1. Administrative decision-makers are not normally required to comply with the rules of evidence nor the rule in *Browne v Dunn*. There was no reason identified as to why that general proposition should not apply to AFCA.
2. The AFCA framework '*does not sit comfortably with – and is in fact inconsistent with – any application of the rule in Browne v Dunn*.' The Court identified that AFCA is directed to affirm a decision of the trustee if '*satisfied*' that the decision was '*fair and reasonable in all the circumstances.*' The Court noted that AFCA may reach such a state of '*satisfaction*' without any necessity to determine the '*truth*' of competing accounts.
3. The statutory and regulatory provisions which address how AFCA is to discharge its functions support a conclusion that the rule in *Browne v Dunn* is not a rule to be followed or applied by AFCA. For example, the requirement that AFCA is to determine complaints '*in a way that is fair, efficient, timely and independent*'.
4. There was nothing in the facts of the case which mandated that AFCA could only be satisfied that the decision of the trustee was '*fair and reasonable*' by applying the rule in *Browne v Dunn*. The Court noted that the competing accounts as to whether Ms Petterd was

the '*partner*' of the deceased until the time of his death, was a factual issue upon which the deceased's children had been afforded an adequate opportunity to advance for consideration their competing account.

5. The way in which AFCA proceeded in the present case was not procedurally unfair. The reasoning provided by AFCA demonstrated how AFCA weighed the evidence and drew a conclusion. The Court commented that a submission was never made before AFCA and that it would not be proceeding in a fair manner if it did not conduct interviews for the purpose of getting the input of those who had advanced conflicting accounts of the relationship between the deceased and Ms Petterd.

> *Administrative decision-makers are not normally required to comply with the rules of evidence nor the rule in Browne v Dunn. There was no reason identified as to why that general proposition should not apply to AFCA.*

Implications

It is not surprising that the FCA dismissed the appeal given that AFCA's rules and framework make it clear that it is not bound by the rules of evidence. The FCA decision demonstrates that challenges to AFCA's decisions on the basis that they did not follow the rules of evidence will generally fail.

Indeed, parties before AFCA need to ensure submissions are generally framed in a way, which does not stress the rules of evidence but rather attempts to demonstrate in other ways why particular evidence should receive more weight by AFCA, in the event of conflicting accounts.

AFCA does not generally conduct interviews. AFCA's Operational Guidelines indicate circumstances where AFCA may exercise their power to require a party to attend an interview to answer questions; an example being when material provided to AFCA is unclear or contradictory and requires clarification.

What is clear from the FCA decision, is that a party who considers that AFCA should conduct an interview (noting cross-examination is not permitted), should put forward that submission during the AFCA complaint process.

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PRODUCT / REGULATORY

Sustainability in Disability Insurance – An update…

Readers may recall that our final Life Insurance Bulletin for 2020 shone a light on a report from the Actuaries Institute Disability Insurance Taskforce which focused on the long term sustainability of disability insurance, particularly individual disability income insurance (**IDII**) product offerings in both the retail and group space, which continues to be of significant concern within the industry.

The AI Taskforce report effectively echoed APRA's previously held concerns in relation to IDII and its long term sustainability. According to APRA, the long term viability of IDII in the absence of critical reform or substantial intervention, is bleak and '*at risk of failure*'. Indeed, APRA noted in its letter to life insurers on 30 September 2020 that the '*industry cannot afford further delays in taking decisive action*.'[1] APRA's message therefore was simple: IDII is in desperate need of a reset. Things must change if life insurers are going to be in a position to offer a manageable and profitable IDII cover long into the future. It has been APRA's desire for life insurers to have '*appropriate mechanisms to keep products in step with changing external and consumer circumstances*,' with the aim of arresting unsustainable losses year on year.

> ***It will be up to life insurers to take that next step, and sooner rather than later, be in a position to demonstrate those actions taken to mitigate or roll back extended contract terms with a view to adopting the Contract Term Measure by 1 October next year.***

Central to the AI Taskforce report was the issue of '*product design*', suggesting practical improvements for the industry to adopt with respect to its product offerings going forward. Among other things, the report highlighted the long-term nature of IDII cover (whether that be group or retail) where substantial monthly benefits are often paid on the back of increasingly generous policy terms (where claimants need only satisfy '*any one income producing duty*' total disability definitions) for years on end. Put simply, claimants can easily find themselves on claim long into the future and in many cases, decades after the commencement of the claim.

To provide some context, this has been the result of somewhat of an arms race which has snowballed to the point where IDII products are now considered so complex and '*too feature heavy*' that they have gradually strayed from attending to the customers '*core*' disability insurance needs. Certainly, the sale of life insurance has become increasingly steeped in distribution targets, aimed at '*optimising the advice/sales process*' which has meant that for many life insurers, in order to compete in the market, providing various '*add-ons*' or extra features into their product design has become par for the course.

Be that as it may, the unintended consequences of this long term IDII cover is that claimants will have very little, if any, incentive to return to work. As we all know, this has long been identified as a problem, with the NSWSC noting more than a decade ago that IDII policies designed in this way, will result in a '*disincentive to work*' unless the benefits of so doing '*are that good that they outweigh the benefits which would be received whilst the insured remained idle*'.[2]

In an effort to reign in the long-term nature of IDII, the AI Taskforce referenced '*APRA's 2019 proposal to have 5-year contracts with guaranteed renewability on updated terms*', otherwise known as the '*Contract Term Measure*', which reportedly resonated with many Taskforce interviewees.[3] APRA's expectation was that life insurers '*have a framework to periodically update policy contract terms, while ensuring policyholders' insurability rights are maintained; and manage their exposure to long benefit periods and have effective controls to manage the associated risks*'.[4]

Understandably, such sweeping product design changes attracted some concerns within the industry, particularly around the renewal process in respect of the Contract Term Measure and the disclosure/underwriting challenges that naturally follow as a consequence. Indeed, APRA has observed that up to this point, '*the fear of first-mover disadvantage has proven to be an insurmountable barrier to (life insurers) making the necessary changes*.'

Since the release of the AI Taskforce report and the '*Final individual disability income insurance sustainability measures*' on 30 September 2020[5], APRA has acknowledged '*the challenges associated with implementing the Contract Term Measure, as well as the industry's efforts to date in working to formulate viable solutions*'[6]. APRA notes that '*life companies have considered various options, but to date have not settled on solutions that satisfy both the legal and operational constraints and without unintended adverse consequences for consumers.' Regardless, 'APRA views this measure as an important mechanism to manage the risks associated with long contract terms. Without the policy contract term measure, it is unlikely there will be a change to the current practice that effectively locks in terms and conditions for extended periods of time, leaving premium changes as the primary (or only) lever to deal with the impact of external changes on IDII sustainability.*'

However, APRA has recently decided to provide life insurers with more time to implement the Contract Term Measure, thereby postponing the implementation of the measure, among other things, to **1 October 2022**. Readers may be aware that APRA wrote to all life insurers and friendly societies on 12 May 2021 to advise of its decision in this regard and otherwise confirmed its expectation that in the interim, life companies are expected '*to intensify their efforts to explore and develop workable solutions to meet the intention of the Contract Term Measure and to proactively keep APRA informed of progress.*' In this regard, APRA has highlighted a few ongoing '*areas of focus*' as follows:

- Life insurers are to have appropriate mitigants to manage the risks associated with extended contract terms.
- Life insurers are encouraged to challenge the status quo in formulating viable solutions to operationalise the Contract Term Measure in a timely manner, with due consideration to legislative requirements and consumers' needs.
- Life insurers must show '*demonstrated actions taken*' to mitigate the risks associated with extended policy contract terms.

Implications

As noted in our final bulletin of 2020, the issues associated with IDII cover will not be new to life insurers. APRA, together with ASIC continue to actively engage with the FSC and other industry stakeholders on the implementation of the Contract Term Measure, among other things, to improve the overall operating environment going forward.

Whilst APRA will be buoyed by the third quarter figures reported by the industry in relation to overall profitability, '*APRA will continue to engage and work with industry stakeholders and ASIC to support the implementation of the Contract Term Measure and sustainable practices more broadly.*' Clearly, APRA will continue its oversight of life insurers in this regard but ultimately, '*it is the responsibility of life companies to proactively manage the risks associated with the design of their IDII products to ensure ongoing sustainability.*' It will be up to life insurers to take that next step, and sooner rather than later, be in a position to demonstrate those actions taken to mitigate or roll back extended contract terms with a view to adopting the Contract Term Measure by 1 October next year.

We fully expect APRA to monitor the steps taken by life insurers in this regard over the course of this calendar year and into 2022. As noted in APRA's letter of 30 September 2020, '*APRA's focus will shift towards monitoring the progress of life companies in meeting APRA's expectations. The onus is now on individual life companies, and the industry collectively, to move IDII to a sustainable state and thereby deliver better outcomes for policyholders.*'

Watch this space.

[1] https://www.apra.gov.au/final-individual-disability-income-insurance-sustainability-measures
[2] *Bottrell v National Mutual Life* (NSWSC 2007)
[3] Actuaries Institute Disability Insurance Taskforce Report – Provisional Findings and recommended Actions for Individual Disability Income Insurance (September 2020) pg 21
[4] https://www.apra.gov.au/sustainability-measures-for-individual-disability-income-insurance
[5] https://www.apra.gov.au/final-individual-disability-income-insurance-sustainability-measures
[6] https://www.apra.gov.au/individual-disability-income-insurance-deferral-of-implementation-of-policy-contract-term-measure

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LIFE AND SUPERANNUATION CASES

FCA considers '*constructive rejection*' of claim

MetLife Insurance v Marie Hart and Aware Super Pty Ltd and the Superannuation Complaints Tribunal (FCA 2021)

Key Takeaways

Life insurers are not uncommonly faced with allegations of '*constructive decline*' or '*rejection*' of a claim. That is, the assessment of the claim has not been completed in a timely manner or in such a way that the insurer has discharged its duty of good faith and fair dealing to an insured.

In this decision, the FCA upheld the life insurer's appeal in relation to a Superannuation Complaints Tribunal (**SCT**) determination on a number of grounds, including that it '*constructively rejected*' the claim. The determination was set aside and remitted back to the Tribunal, or other appropriate body (being AFCA) to be determined according to law.

The judgment provides useful guidance for life insurers as to whether a refusal to assess a claim constitutes a '*constructive decline*' and the manner in which they should go about investigating and assessing whether they are '*on risk*'.

Brief Facts

The life insured was a former member of the NSW Police Force (**NSWPF**) from 29 August 2003 until her discharge on 3 July 2016. By way of her employment, the life insured became a member of the First State Superannuation Scheme which relevantly provided a TPD benefit pursuant to the '*Blue Ribbon*' Group Life Insurance policy (**the PBR Policy**).

In 2011, the PBR Policy ceased, with cover transferring from the life insurer (**the out-going insurer**) to the in-coming insurer. The in-coming life insurer assumed liability for any new claims arising under the PBR Policy from the date of cessation, except for certain claims in respect of which the out-going insurer remained '*on risk*' pursuant to IFSA terms.

The life insured suffered a back injury on 19 February 2007 and thereafter was placed on permanent restricted duties. In August 2014, she was diagnosed with PTSD and she ceased work with the NSWPF that month.

A claim for TPD was lodged with the in-coming life insurer in March 2016, which was rejected on the basis that it did not consider itself '*on risk*' in relation to the TPD Claim.

Subsequently, the life insured lodged a TPD claim with the out-going insurer on 18 February 2018. On 27 April 2018, the out-going insurer advised that it believed it was not '*on risk*' in relation to the TPD Claim, although it indicated that it remained prepared to consider further information if made available and to reassess the claim. This was on the basis that it considered its liability for the life insured's TPD only arose in respect of her back condition which rendered her to be '*not at work*' on the working day immediately prior to the '*takeover date*', or any injury or illness directly or indirectly related thereto.

It was not until 16 April 2019 that the out-going insurer received the life insured's personnel file from NSWPF which contained further medical evidence as at the takeover date. The out-going insurer subsequently requested further medical information from the life insured and that she attend an IME. The life insured refused to authorise the provision of information or attend the IME until a final determination had been made as to which insurer was '*on risk*' in relation to her claim. A complaint with the SCT was lodged shortly thereafter.

> *It follows that despite the overarching obligation to assess insurance claims as speedily as possible consistent with good faith duties, insurers faced with such claims are entitled to a reasonable opportunity to get to the bottom of who is on risk even if this takes a little longer than might otherwise be the case in more straightforward claims.*

The SCT found that the out-going insurer '*constructively rejected*' the life insured's TPD claim. The out-going insurer appealed this decision to the FCA on the basis that a) the SCT misunderstood and misapplied the concept of a constructive rejection and b) the SCT erred by failing to consider and determine whether the out-going insurer was '*on risk*' in relation to the life insured's TPD claim and c) the SCT misconstrued the terms of the PBR Policy.

Judgment

His Honour Justice Derrington accepted all grounds of the out-going life insurer's appeal and found that the SCT determination should be set aside, relevantly finding that:

Constructive Rejection

- The out-going insurer did not constructively reject the TPD claim. His Honour noted that in assessing whether there had been a constructive decline '*such a decision is quite different to a mere refusal and involves questions of the insurer's compliance with the duty of good faith and fair dealing*'. His Honour considered that the SCT did not approach the question on the basis that the out-going insurer had not made a decision, but that it had constructively rejected the claim and in those circumstances the SCT '*failed to, ask itself or answer the question of whether, in the manner in which it dealt with the claim, the insurer breached its duties of good faith and fair dealing*'.
- His Honour was satisfied that the SCT conflated the two insurers' separate assessments of the claim (for example, the SCT did not take into account the fact that the out-going insurer did not receive the claim at the same time as the in-coming insurer) and noted that the life insured did not co-operate with all of the out-going insurer's attempts to obtain information or have her medically examined (which again the SCT did not consider).

On risk

- The SCT failed to deal with the out-going insurer's claim that it was not '*on risk*'. His Honour noted that '*there is nothing in the Tribunal's reasons which suggests that it directed itself to the submissions raised by the insurer relevant to it not being on risk in respect of the TPD claim. It did not, in terms, ask itself or address the question of, what was the medical condition which caused (the life insured) to be "not at work" on 30 September 2011, or, whether the conditions in respect of which she claimed TPD were directly or indirectly related to that injury*'.

The terms of the PBR Policy

- The out-going insurer submitted to the SCT that the life insured did not satisfy the waiting period of the TPD definition as she was not absent from her occupation for six consecutive months due to her back injury or whilst it was '*on risk*'. His Honour noted that the SCT's approach to this issue was somewhat confused as a result of its failure to appreciate the importance and effect of the IFSA Guidance note on the out-going insurer's liability.

Implications

This judgment makes it clear that complex claim scenarios straddling risk periods of multiple insurers and involving multiple medical conditions will patently require careful consideration and detailed factual/medical enquiry. This is particularly so when the insurers involved have gone to considered lengths to document the rules as to how the risk will be allocated to ensure no straddle claimant falls through the cracks.

It follows that despite the overarching obligation to assess insurance claims as speedily as possible consistent with good faith duties, insurers faced with such claims are entitled to a reasonable opportunity to get to the bottom of who is on risk even if this takes a little longer than might otherwise be the case in more straightforward claims.

Moreover, life insureds if they wish to seek relief in respect of such claims are obliged to cooperate with such reasonable insurer investigations even though such investigations may fundamentally speak to which insurer will pay the claim rather than if it will be paid.

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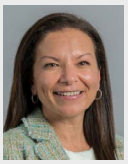

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