Determination

Case number	800295
Financial firm	Westpac Life Insurance Services Limited

1 Determination overview

1.1 Complaint

The complainant had surgery for ductal carcinoma-in-situ (a kind of breast cancer) in 2020, and then radiotherapy in 2021. She made a claim on her living insurance policy. The insurer rejected the claim, saying that the policy specifically excluded her type of cancer.

1.2 Issues and key findings

Should the insurer pay a benefit?

Yes. The insurer is relying on an outdated medical definition to reject the claim. It has not assessed the claim against a definition which reflects current medical practice. That is inconsistent with good industry practice.

Why is the outcome fair?

Good industry practice requires an insurer to assess claims against medical definitions which reflect current medical practice. Fairness requires an insurer to act in accordance with good industry practice, and also to meet a customer's reasonable expectations. A customer reasonably expects that an insurer will not rely on a medical definition in a policy if that definition is out of date or does not reflect current medical practice.

1.3 Determination

This determination is in favour of the complainant. The insurer must pay the full trauma benefit, plus interest calculated in accordance with section 2.1 below.

2 Reasons for determination

2.1 Should the insurer pay a benefit?

Yes. The insurer is relying on an outdated medical definition to reject the claim. It has not assessed the claim against a definition which reflects current medical practice. That is inconsistent with good industry practice.

Policy has definition of cancer which excludes some carcinomas-in-situ

The policy pays a benefit if the complainant is diagnosed with one of a number of listed and defined conditions. One of the conditions is cancer. The definition of cancer in the original policy document says:-

> The following are specifically excluded:
>
> …
>
> (b) all tumours which are histologically described as pre-malignant or showing the malignant changes of 'carcinoma in situ', including cervical dysplasia (rated as CIN 1,2 or 3)

The complainant's policy was upgraded in 2011 and the definition of cancer was changed. The 2011 definition of cancer says:-

> The following are specifically excluded:
>
> …
>
> (b) all tumours which are histologically described as microcarcinoma, pre-malignant or showing the malignant changes of 'carcinoma in situ', including cervical dysplasia rated as CIN 1, 2 or 3 ('carcinoma in situ' of the breast is covered if it results directly in the removal of the entire breast. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment);

Complainant not entitled to benefit under terms of her policy

The complainant had carcinoma-in-situ. She had surgery, but there is nothing to suggest that the surgery amounted to removal of the entire breast.

It follows that the complainant's kind of cancer is excluded under the terms of the policy. On this interpretation of the policy, the insurer does not have to pay a benefit under the terms of the policy.

Complainant entitled to the full trauma benefit under the 2019 policy

The insurer issued a new and upgraded trauma policy in 2019. The insurer did not apply the new and upgraded terms in relation to breast cancer from the 2019 policy to the complainant's policy.

In her initial submissions to AFCA, the complainant said that the insurer should pay a partial benefit, because under the terms of the insurer's 2019 policy, a partial benefit for breast cancer would be paid even if the entire breast was not removed. However, upon review, it is clear that the 2019 policy pays a full trauma benefit for carcinoma in situ of the breast if a claimant has

> • breast conserving surgery and adjuvant therapy (such as radiotherapy and/or chemotherapy). The surgery and treatment must be undertaken specifically to arrest the spread of malignancy, and be considered the appropriate and necessary treatment as confirmed by an appropriate specialist doctor acceptable to us. Chemotherapy means the use of drugs as prescribed by an appropriate specialist doctor specifically designed to kill or destroy cancer cells.

The complainant had radiotherapy to treat her tumour. I consider that the complainant would be entitled to the full trauma benefit under the terms of the 2019 policy.

Royal Commission considered a similar case

The complainant referred to the findings of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Royal Commission). She said that the Royal Commission found that insurers should pass on upgrades to all customers. I reviewed the hearings and findings of the Royal Commission, and provided the following information to the insurer, inviting them to make a submission in response:

> Because the complainant referred to the Royal Commission, I looked at the case studies about trauma insurance considered by the Royal Commission. One of them is very similar. It concerned a rejected claim under a trauma policy for carcinoma-in-situ of the breast. The policy was old. It required 'radical' breast surgery, which the insurer treated as meaning a full mastectomy. I note that [the complainant's] policy, as upgraded in 2011, also required removal of the entire breast for the benefit to be paid.
>
> Coming back to the Royal Commission case study – this evidence was given [by Ms HT, the CEO of life insurer Comminsure, during questioning by counsel assisting]:-
>
> *But CommInsure had decided, contrary to the view of those doctors, that you could only have radical breast surgery if you had had removal of your entire affected breast?---Yes.*
>
> *And the claim was denied on that basis?---Yes, it was.*
>
> *Now, CommInsure was, of course, relying on a definition of cancer at this stage that was more than 15 years old. I think we established before it was about 18 years old by this point?---Yes, that's right.*

…

One of the other medical practitioners [said]:

> … in saying that I believe that repeated surgery (lumpectomies) plus radiotherapy in combination constitutes radical surgery.

He went on to say …:

> I also believe that if the insured's condition had occurred about 20 years ago when the policy was taken out, that the resultant treatment of two excisions would, in all probability, have resulted in a left breast mastectomy. It is now current practice that the insured's condition, carcinoma in situ of the left breast, would be treated with breast-conserving surgery and radiotherapy.

So medical practice had moved on, hadn't it, Ms T?---Yes.

I now seek you submissions in these issues [sic]:

1. It seems to me that the changes to the cancer definition in the 2019 policy may reflect more up to date medical practice in the treatment of carcinomas-in-situ than your previous definition which required removal of the entire breast. Please give a detailed account of whether you agree and your reasons.

2. Did [the insurer] consider passing the 2019 definition on to customers with policies of the kind held by [the complainant]? If not, why not? If so, why was the 2019 definition not passed on?

3. If the 2019 definition reflects current medical practice, is it unfair for that definition not to be applied to the complainant's claim?

Insurer refused to make submissions on these points

Regrettably, the insurer did not fully answer these questions. AFCA pointed that out, and again sought submissions, but again the insurer refused to give complete answers. Instead, the insurer made these submissions:

- the Royal Commission reviewed outdated medical conditions in insurance policies, but did not make a finding that all policy upgrades should be passed onto all customers if the policy terms do not require it
- the complainant's policy does not have an automatic upgrade provision
- as a consequence, the insurer is not required to pass on upgrades
- it is therefore irrelevant whether the medical definition is outdated or not.

Good industry practice requires insurers to not rely on outdated medical definitions

I am satisfied that good industry practice requires insurers to assess claims against medical definitions which reflect current medical practice, rather than relying on outdated medical definitions. In making that finding, I have found these things to be important:

1. The Royal Commission also examined a case concerning a heart attack definition in a trauma policy. The insurer had a policy which covered only severe heart attacks, but that limitation was not obvious. The definition of heart attack in the policy was not consistent with the universal medical definition of heart attack.

   The insurer eventually updated its definition to match the universal definition, but did not backdate the change to 2012, when the universal definition was published.

   The Royal Commission said:

   > [The insurer] rightly acknowledged that, by failing to update its 'heart attack' definition in 2012 and in 2014 to accord with the medical definition that was accepted at that time, [the insurer] engaged in conduct that fell below community standards and expectations.

2. The Final Report of the Royal Commission said:

   > The witness statements tendered in the sixth round of hearings indicated that the Life Insurance Code of Practice has played an important role in addressing previously problematic behaviours within that industry. The two clearest examples related to reducing the use of surveillance of claimants and reducing the use of outdated medical definitions. I consider it important that industry continue to identify opportunities for improvement. It is equally important for industry to commit, in its codes, to making those improvements.

3. Clause 3.2 of the Life Insurance Code of Practice says:

   > The medical definitions in our on-sale policies for benefits that are payable after a defined medical event will be reviewed at least every three years and updated where necessary to ensure the definitions remain current. This will be done in consultation with relevant medical specialists

4. Many life insurers have upgraded not only their on-sale products but their 'legacy', or off-sale products to remove outdated medical definitions. Counsel assisting the Royal Commission said in hearings on 13 September:

   > Although the code introduced requirements for the review of medical definitions in on-sale products, it says nothing about the review of medical definitions in off-sale products. We asked the 10 life insurers to tell us about their process for reviewing and updating medical 45 definitions in their off-sale products. Many of the life insurers said that they have a similar process for updating medical definitions in off-sale products as for on-sale products.
   >
   > …
   >
   > [The insurer in this case] adopts the same process, except that it only conducts such reviews at least every three years for off-sale products rather than annually.

Distinction to be drawn with upgrades which give broader scope of cover

The insurer says that it is not required to pass on all upgrades from later policies to holders of earlier and different policies. I agree.

There is a difference between an upgrade which provides greater benefits (or broader cover), and an upgrade which replaces an outdated medical definition. An insurer may choose to pass on an upgrade which provides greater benefits (or broader cover), but unless the terms of the policy require it, it does not have to. However, an upgrade to replace an outdated medical definition is different. Such an upgrade is intended to *maintain* the existing cover. For example, where a definition requires treatment of a particular kind, but that kind of treatment is no longer provided or becomes much less common in current medical practice, the cover provided by the policy will be reduced unless the outdated medical definition is replaced.

That distinction explain why good industry practice requires an insurer to assess trauma claims under a definition which reflects current medical practice.

Insurer must pay the full benefit

I am satisfied that the definition relied on by the insurer in this case – which required removal of the entire breast – was outdated. I make that finding based on the evidence given and the findings in the hearings in the Royal Commission and the inclusion of the additional test – for adjuvant therapy – in the insurer's own 2019 policy.

I am also satisfied, for the reasons set out above, that it is inconsistent with good industry practice for an insurer to assess a claim against an outdated medical definition.

The complainant meets the requirements of the up-to-date medical definition in the 2019 policy. It follows that she should be paid the full trauma benefit.

If the complainant accepts this determination, the insurer must pay her the full trauma benefit within seven days, plus interest from 13 April 2021 to the date payment is made. Interest must be calculated in accordance with s57 of the *Insurance Contracts Act* and the insurer must provide a copy of its calculations to the complainant.

2.2 Why is the outcome fair?

Unfair for insurer to refuse to pay benefit based on outdated medical definitions

In section 2.1 above I have set out why I have found that good industry practice requires an insurer to assess claims against medical definitions which reflect current medical practice. Fairness requires an insurer to act in accordance with good industry practice, and also to meet a customer's reasonable expectations. A customer reasonably expects that an insurer will not rely on a medical definition in a policy if that definition is out of date or does not reflect current medical practice.

3 Supporting information

3.1 The AFCA process

AFCA's approach is based on fairness

AFCA has determined this complaint based on what is fair in all the circumstances, having regard to:

- the legal principles
- applicable industry codes or guidance
- good industry practice
- previous decisions of AFCA or its predecessor schemes (which are not binding).

The respective parties have completed a full exchange of the relevant information, and each party has had the opportunity to address any issues raised. I have reviewed and considered all of the information the parties have provided.

While the parties have raised a number of issues in their submissions, I have restricted this determination to the issues that are relevant to the outcome.