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Insurance Commercial Banking

Life Insurance case note
TPD - Stage 1 review

Hart v MetLife Insurance Limited (NSWSC 2022)

Link to decision

The Supreme Court of NSW (**NSWSC**) has delivered a judgment in a TPD matter (*Hart v MetLife Insurance Limited* (NSWSC 2022)) which provides guidance on several recurring issues in insurer opinion based TPD assessments.

Key Takeaways

- In terms of insurer procedural fairness and decline communications, the absence of a specific reference to documents which support an insured's argument, is not suggestive of a breach by an insurer to consider relevant evidence as long as it is evident from the reasoning that such material has obviously been noted but found to be irrelevant, inconclusive, inconsistent with other evidence or simply lacking in weight compared to other evidence which supports the counter view.
- An insurer which adopts the unchallenged reasoning of a court or tribunal on the matters before it in its own decision, will not be breaching its duties and in fact, it should not depart from following such reasoning '*without good reason to do so*'.
- The significance of an insurer's procedural fairness letter and how it is responded to continues to grow. Here the Court found:
    - In determining the full scope of an insurer's reasons for declining a claim, a court is entitled to take into account earlier reasons articulated in a procedural fairness letter even though such reasons are preliminary.
    - The absence of a response to procedural fairness challenging preliminary views, is a matter which an insurer can take into account in making its ultimate decision.
- Absent specific contractual terms, an insurer is not under an ongoing obligation to '*reconsider*' TPD decisions upon request by an insured.

Background

The insured member (**the plaintiff**), a former police officer, challenged the group insurer's decision to refuse her TPD claims in the NSWSC. The trustee was not joined to the proceedings.

Aside from the question of whether the plaintiff is TPD, the primary controversy to date in these claims (there were claims under two policies issued by the insurer) has been which life insurer is on risk given there was a change in group insurers at a material time which in turn, brought into play the application of the IFSA takeover terms and how each insurer's policy responded to the presenting facts including the possibility there were coordinate causes of TPD (an orthopaedic injury and mental illness). This controversy was the subject of both an SCT complaint and a successful application by the insurer to the Federal Court, appealing the SCT decision. These matters however are not directly relevant to the present judgment and we do not touch upon them here.

Rather the present NSWSC decision, being a separate question determination, dealt with the TPD stage 1 issue between the parties, namely, whether the decisions by the insurer to decline the claims (following the successful Federal Court appeal) should be vitiated for a breach of the well-known insurer duties in considering such opinion based TPD claims.

Judgment - Key Findings

The Decline

The plaintiff asserted that there was '*no reasonable basis*' for the key decline findings by the insurer that the plaintiff was relevantly '*not at work*' by reason only of her orthopaedic injury and the timeline for the onset of her psychological illness. The Court did not agree and found that the insurer's positions on these issues were amply supported by the evidence and that conversely, the evidence the plaintiff relied on as establishing the opposition position was '*not sufficiently material to establishing the relevant fact*'. In reaching these findings, the Court noted that the insurer was not obliged to

describe every single document it considered in making its decision (one could accept that it had taken into consideration such documents) and also that it was permitted and entitled to make qualitative judgments about the weight it would give certain pieces of evidence i.e., particularly giving less weight to evidence which lacked a contemporaneous perspective. For example at para 88:

> *In any event, I am not persuaded that it was unreasonable for **MetLife** not to give any substantial weight to that opinion. First, A/Prof Robertson did not begin to treat Ms Hart until 2014 and had no direct knowledge of her condition as at 1 January 2010; an assertion, without more, of that matter by A/Prof Robertson had no greater weight than an assertion of that matter by Ms Hart.*

The plaintiff also took issue with the insurer treating the SCT decision as determinative of its liability (on one aspect of the claim) and asserted this was unreasonable. The Court also rejected this position and found that once the plaintiff had accepted she was bound by the SCT decision, the insurer acting in accordance with the SCT position was clearly consistent with its duty of utmost good faith.

The Court also rejected a technical argument from the plaintiff that the insurer's decline reasoning should be viewed as being restricted to the decline letter only without regard to the more detailed procedural fairness letter which set out the insurer's preliminary views. The Court said:

> *Mr Coombes submits that, as a preliminary step to any examination of **MetLife's** reasons for declining Ms Hart's claim, the Court must determine whether the content of the 9 June 2021 letter forms no part, some part (in tandem with the 9 August 2021 letter) or the entirety of **MetLife's** reasons for declining Ms Hart's claim. He submits that **MetLife's** reasons are confined to the 9 August 2021 letter, for several reasons. I do not accept that submission, where the reader of the 9 August 2021 letter would understand its reasoning by reference to the more detailed articulation of that reasoning in the 9 June 2021 letter*

Additionally, the Court found that the absence of a response to a detailed procedural fairness letter was a matter the insurer could take into account in making its determination.

Finally, like its views on the SCT decision, the Court found that the insurer did not breach its duties in circumstances where its reasoning concurred with the reasoning of the Federal Court decision, particularly absent any challenge to this reasoning.

The failure to reconsider

The second separate question the Court determined was whether subsequent to the insurer's decline of the claim, the insurer was obliged to '*reconsider*' the plaintiff's claim when the plaintiff asked it to do so, some three months after the decline noting such request was supported by further evidence. The insurer did not do so.

The Court rejected that such an obligation to '*reconsider*' existed noting at para 114:

> *I am not persuaded that any duty in respect of reopening applicable to superannuation trustees should be extended to insurers generally, or TPD insurers specifically* (our emphasis). *First, there are extensive statutory regimes for the regulation of insurers and superannuation; the legislature has had ample opportunity to introduce such a duty, if it considered it should exist; and the Court extending that duty to insurers, or TPD insurers, will necessarily impact on the balancing of policy and economic issues in that legislative structure. It is not self-evident that such a duty would promote public policy, where there is a countervailing public benefit in finality in determination of claims. Second, the recognition of such a duty, unbounded by any identified limitation as to the number of times that matters should be reconsidered (which Mr Coombes suggests should be left to future cases), would have significant economic implications in imposing the additional costs of such reconsiderations on insurers (and superannuation trustees or policyholders who pay their premiums), limited only by the appetite of policyholders whose claims were denied to agitate issues by submitting additional materials and requesting reconsideration. That duty would have wider impacts, because additional decisions made by an insurer in a "reconsideration" of a claim could then potentially be referred to the Australian Financial Complaints Authority or challenged in the Courts as involving a breach of a duty of utmost good faith or to act fairly and reasonably. An insurer could not bring that process to an end by deciding, even reasonably, that enough was enough, because that decision could itself be challenged as a breach of those duties. The question whether the benefit of that duty outweighs its costs cannot be assessed by a Court, which has no empirical basis for an assessment of whether reconsideration applications would be largely meritorious or largely unmeritorious. A Court also has no ability to address transitional issues, where the recognition of such a duty now would potentially require reconsideration of decisions previously made, where a Court's decision does not only have a prospective effect.*

Later at para 118, the Court stated:

> *Second, I address the question of a recognition of such a duty in the insurance cases to which Mr Coombes refers, Heitman v Guardian Assurance Co Ltd (1992) 7 ANZ Insurance Cases 61-107 at 77,491–2 ('**Heitman**') and Nile v Club Plus Superannuation Pty Ltd (NSWSC 2005) ('**Nile'**). Mr Lloyd submits that neither Heitman nor Nile established the existence of a 'duty' on an insurer to reconsider, and points to Robb J's reference to an insurer's agreement to reconsider in Hellessey without any suggestion that the insurer was there obliged to do so. It seems to me that neither Heitman nor Nile*

provides any reasoned basis for the recognition of such a duty, or identifies any previous English or Australian authority in respect of insurers that has recognised such a duty. I do not consider that I should now recognise such a duty, as an aspect of the duty of utmost good faith, for the same reasons that I have held above that I should not extend any such duty applicable to superannuation trustees to insurers generally or TPD insurers specifically (our emphasis).

Implications

The fact that an insurer is permitted to give different weight to pieces of evidence, does not have to mention every piece of evidence it considers in its decline letter, can reference its procedural fairness reasoning in its decline letter on a shorthand basis and can safely rely on and adopt relevant unchallenged reasoning of a court or tribunal, are all matters that have been considered in earlier TPD judgments. Nonetheless, the restatement of such common sense concepts is welcome and confirms that (at least for now) nit-picking of otherwise sound insurer TPD decisions supported by evidence, will not win the day in stage 1 decisions.

What does seem to be novel however is the unambiguous rejection by the Court that TPD insurers are under an obligation to '*reconsider*' decline decisions on the same basis as superannuation trustees under *Gilberg v Maritime Super Pty Ltd* (NSWCA 2009). It is possible that many TPD insurers do see their obligations in this regard as analogous to that of superannuation trustees (who are obliged to reconsider when further information is supplied which indicates '*a reasonable possibility of a different result*').

This judgment may cause insurers who take such a view to review such practices but noting that many insurers may wish to continue to '*reconsider*' decline decisions (at least for unlitigated matters) when provided with new evidence for a multitude of reasons including:

- such *'reconsideration'* requests may in any event be fresh claims under any particular policy;
- clause 8.19 of current LICOP and clause 5.48 of LICOP 2.0 (which is yet to commence) arguably contain promises to review decline decisions upon request (at least for unlitigated matters);
- ignoring such review requests may simply funnel insureds into litigation/EDR.

Additionally it should be remembered that the comments of the Court should not be considered as impacting on an insurer's statutory IDR obligations.

For more information, please contact

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