REVIEW OF THE INSURANCE CONTRACTS ACT 1984

Submission of the Australian Life Underwriting and Claims Association (ALUCA) in relation to section 54

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SECTION 54 - CLAIMS

ALUCA acknowledges the work already done on section 54 in relation to "claims made" policies, but wishes to make a further submission in relation to life insurance policies.

Section 54 is a prime example of how the *Insurance Contracts Act* fails to take into account the particular characteristics of life insurance contracts. Section 54 creates unique problems in respect of life insurance contracts.

Three examples of such problems follow. The concept of prejudice as found in section 54 and the problems of its application in a life insurance context is then discussed.

"Mitigation of loss"

The first of these problems relates to continuous disability contracts. These typically involve monthly claims payments over a period of time, which may extend to the date the insured life reaches the age of 65.

In disability insurance, insurers often face the problem of insureds who refuse to undergo reasonable medical or rehabilitation treatment. This is usually a breach of the contract.

A life insurer faced with an intractable claimant who appears to be manipulating the system so as to stay on claim as long as possible, may be prevented by the operation of section 54 from suspending payments, since that may be a "refusal to pay".

The provisions of subsections 54(2) – (4) may or may not apply. Does a refusal to undergo medical or rehabilitation treatment "contribute" to a loss? In many cases it may be arguable that it does. In other cases it will be difficult to argue this, because the results of medical or rehabilitation treatment are a future possibility.

Unless the insurer is able to refuse or suspend payment under subsection 54(2), the insurer is faced with two very difficult options:

- Seek damages for breach of utmost good faith
- Prove the prejudice to the insurer and reduce the claim payment pursuant to section 54

Both enquiries are theoretically likely to arrive at a similar result. Practically speaking, however, it is highly unlikely that either enquiry would be conclusive, since the results of medical or rehabilitation treatment are a future possibility. The effectiveness of such treatment, and the time at which such treatment may bring positive results, may reasonably be disputed by medical experts.

Yet common-sense and common morality says that a claimant should do his or her best to become better and go off claim and that, unless the claimant is taking reasonable steps to improve his or her health, the insurer should be entitled to suspend payments.

Life insurance claims managers often speak about “mitigation of loss”. Although the doctrine of mitigation of loss applies as between opposing parties in torts or contract litigation, it does not apply where no breach of contract or no tort is alleged. Thus, the contractual relationship between an insurer and an insured is not influenced by the doctrine.

In Canada, a line of cases has applied the doctrine of mitigation of loss to disability insurance contracts. The courts there have set parameters for what is and is not a reasonable requirement for the insured. For example, the courts will rarely force the insured to undergo surgery. They will however, find that the insured has failed to mitigate his or her loss by refusing rehabilitation treatment or non-invasive medical treatment.

This leads to a more even balance of the rights of the insured and the insurer, since we are usually taking about insureds who are exhibiting a lack of utmost good faith.

Late notification

Unlike general insurance policies which usually have a life of one year (rare multi-year policies can have a term of up to five years) life policies usually continuous until age 65 or until cancelled.

In the life insurance industry, claims for lump sum benefits for total and permanent disablement are often made extremely late. It is not unusual to have claims made 10 or more years after the alleged date of injury. Often, the insurers find that claimants' solicitors deliberately delay the making of a life insurance claim while a workers compensation claim is being made.

Section 54, has the effect of removing an insurer's defences against such late notification.

As a result of section 54, the life insurance industry has generally omitted clauses requiring notification of claims within any specified time, because such clauses have little or no effect. Needless to say, the life insurance industry regards this as a serious problem and would like to have an effective legal tool to deal with it. Such a tool is available in the form of contractual clauses, provided they are not rendered ineffective by the *Insurance Contracts Act*.

Non-payment of premium in group life insurance

Section 54 creates a serious problem for group life insurers. A group life policy is typically is a contract between an insurer and a trustee for the benefit of persons unnamed in the policy. Where a life insured, or an employer on behalf of the life insured, fails to pay the premium for a period of time, the group life policy typically cancels cover automatically for that life insured.

Section 59 does not apply, because the insurance policy is not cancelled, but is varied by deletion of a life insured.

The automatic cancellation of cover for the life insured is essential because of the vast number of lives insured, and the practical difficulty of identifying at the appropriate time those lives that are or are not currently paid and issuing cancellation notices to the individuals in respect of whom premium has not paid for the requisite time. Individual cancellations at the appropriate time would create an administrative nightmare.

At the moment, section 54 would regard the cancellation of cover clause as an effect of the policy entitling the insurer to refuse to pay a claim and trigger an enquiry as to prejudice. The prejudice will generally be taken to be the unpaid premium to the date of the disablement, plus possibly its investment value. Usually, this will not amount to much.

However, the problem is a serious one for the group life insurer. A retail life insurer can cancel an entire policy under section 59 or lapse the policy under the procedure in section 210 of the *Life Insurance Act 1995* (for policies that have the requisite surrender value). A group life insurer may not.

A group life insurer may suffer financial harm if a large number of premiums are not paid for a period of time. Cancelling the individual covers would be an administrative nightmare. The group life insurer would effectively be forced to wait until expiry of the entire policy to deal with the problem. In the meantime, any claims by the defaulting parties would be subject only to prejudice caused by the individual default, not by prejudice suffered by the insurer as a result of a group default.

What happens when a group life insurer has a 20% default rate spread across the entire group, with no single entity able to be carved out? The group life insurer suffers a loss on the policy, but may be unable to cancel the policy because the trustee has not breached the policy. The insurer must then wait for individuals to make claims and, if they have not been paying their premium, simply deduct the outstanding premium.

This is not fair on the group life insurer. Group life insurance is very cheap compared with retail insurance. It is submitted that the consumer protection controls on group life insurance should take into account the nature of the product.

This problem can be dealt with either as a exception to section 54 or as an exception to section 59.

Prejudice

The High Court in *QBE v Moltoni*[1] held that:

> "the amount of which s 54(1) speaks, as fairly representing the extent to which the insured's interests were prejudiced, will be the actual financial damage that has been or will be sustained as a result of the relevant act or omission."

In *Ferrcom*[2] the High Court held:

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[1] *Moltoni Corporation Pty Ltd v QBE Insurance Ltd* [2001] HCA 73 at para 16 per Gleeson CJ, Gaudron, Mchugh, Kirby and Hayne JJ

> "The prejudice [to which s 54(1) refers] will consist in the existence of a liability which, in whole or in part, would not have been borne by the insurer if the act had not been done or the omission had not been made or in the non-receipt of an additional premium to which the insurer would have been entitled by reason of the doing of the act or the making of the omission."

In the *Moltoni* case, the High Court further held:

> "By contrast, if the insurer would not have gone off risk (as was the case in the present matter) the relevant prejudice suffered is to be measured by reference to what *would* have happened (as distinct from what *could* or *might* have happened) if the act or omission had not occurred."[3]

The fact is that life insurers can rarely in a respect of a claim notified years after the date of injury, say precisely what would have happened in the sense of what investigations they have been precluded from undertaking, or the effect of any treatment that they have been precluded from making available to the claimant. Making out the case that the insurer has been prejudiced to the standard of the test in *Moltoni* is often extremely difficult.

The inquiry into prejudice is also fraught with practical problems.

In a large number of cases it is not economically viable for an insurer to undertake the inquiry necessary to quantify its prejudice so as to comply with section 54. It is highly unlikely that a life insurer would undertake such an inquiry without seeking legal advice. This automatically raises a costs bar. The insurer may also need medical, actuarial and forensic accounting expertise to properly quantify its prejudice. Such expert assistance will not come cheaply.

In many cases, the cost of the "prejudice" inquiry will exceed the maximum amount of any prejudice that could be said to have been suffered by a life insurer in respect of a particular claim. For example, in a continuous disability claim with monthly payments of $4,000, where the insured's act or omission causes the insurer to pay a few extra months' benefits, it is easy to see how the cost of an inquiry may exceed the prejudice. As each case is different, it is not possible for a life insurer to standardise the inquiry. The same costs will repeatedly undermine the prospects of any inquiry as to prejudice.

In cases of failure to undergo reasonable treatment, the fact that the insurer is alleging potential or future prejudice militates against success.

In the case of late notifications, the insurer's only practical remedy may be to put the claimant to strict proof. In some cases, this may place the insurer in breach of its duty to act in the utmost good faith by providing the insured with some guidance as to making

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[2] *Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd* (1993) 176 CLR 332 at 342 per Brennan, Deane, Dawson, Gaudron and McHugh JJ.

[3] Op cit, para 18

his or her claim (cases such as *Beverley v Tyndall* and *Szuster v Hest* [4] have held that where the definition of disablement includes as an element of the definition that the insurer must be satisfied that the insured is disabled, the insurer's duty of utmost good faith obliges the insurer to provide limited guidance to the insured in making his or her claim).

Conclusions

The difficulties noted in this submission are real difficulties faced by insurers every day. The inability of life insurers to effectively deal with these difficulties because of the operation of section 54 is ultimately paid for by the consumers, whose policies become more expensive because insurers cannot deal effectively and economically with these problems.

The three examples of problems described above cannot be taken to be definitive. As has been seen in the cases relating to general insurance, section 54 has many unforeseen consequences.

What is clear is that section 54 does not adequately take into account the way in which life insurance actually works.

Whether the problems can be resolved by exceptions to section 54, or by other means, we must leave to the expertise of Parliamentary Counsel.

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[4] *Beverley v Tyndall Life Insurance Co Ltd* (1999) 21 WAR 327; *Szuster v Hest Aust Ltd & Anor* No. DCCIV-98-1071 [2000] SADC 2 (6 March 2000)