Declining Prospects: Why Courts Keep Setting Aside Insurers' Decisions in TPD Claims

Opinion clauses

Most total and permanent disablement (**TPD**) cases that come before the courts involve the "standard" "ETE"[1] clauses found in group life policies. These clauses differ from insuring clauses in non-TPD contexts in requiring the insurer to form its own opinion as to whether the insured member satisfies the requirements of the definition (in general terms, whether the insured member has become incapacitated to such an extent as to be unlikely ever to engage in work for which they are suited by education, training or experience). In effect, the policy provides that the insured member is TPD if the insurer decides that they are TPD.

The origins of the "opinion" clause date back at least 170 years. As a Queensland appellate judge noted in a 2001 case, the use of opinion clauses in insurance policies is "*not a recent phenomenon*" and "*seems to have been the product of a well-founded belief that juries commonly found verdicts against them*".[2] If that explanation is correct, the purpose of having an opinion clause in the policy is to take control of the fact-finding process away from the courts. Although insurance cases are no longer decided by juries in England and Australia, opinion clauses have remained.

Response of the courts

For their part, the courts have resisted the attempt to remove them from the fact-finding process, imposing qualifications and restrictions on the ambit of the opinion an insurer may reach. The potential grounds for challenging an insurer's decision have proliferated in recent years.

The original ground of challenge was based on unreasonableness. The English High Court concluded in 1854 that "*proof*" to the directors' "*satisfaction*" was to be qualified by a requirement of reasonableness - that is, if the proof would satisfy a reasonable person, the claimant was entitled to the policy monies irrespective of whether the directors were actually satisfied.[3]

In 1992, the NSW Supreme Court held in a case that has been frequently quoted and applied since that the "reasonableness" requirement was one of 3 terms implied by the law in the insurance policy, the other two being terms requiring the insurer to consider and determine the correct question and act with good faith and fair dealing in having due regard for the interests of the claimant.[4] The court in that case qualified the reasonableness requirement by noting that "*reasonable persons may reasonably take different views*" - provided the insurer's decision was in the range of reasonable views, the court would not interfere with what lawyers refer to as the "merits" of the decision.

Despite some judges expressing misgivings about the courts "re-writing" the contract that had been agreed between the parties,[5] the NSW Court of Appeal held in 2016 that the principles

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[1] "Education, training or experience"
[2] *McArthur v Mercantile Mutual Life Insurance Company Ltd* [2001] 2 Qd R 197 at [15]
[3] *Moore v Woolsey* (1854) 4 El & Bl 243; 119 ER 93
[4] *Edwards v The Hunter Valley Co-Operative Dairy Co Ltd* (1992) 7 ANZ Ins Cas ¶61-113 at 77,536
[5] see *TAL Life Ltd v Shuetrim* (2016) 91 NSWLR 439; [2016] NSWCA 68 at [159]-[160]

were settled throughout Australia and beyond and observed that courts "*have rewritten parties' contracts for many decades*".[6]

In 2018, the NSW Court of Appeal added a further ground of challenge. Not only will an insurer's decision be set aside if the court considers the decision itself was flawed, it will also set it aside if it thinks there was some unfairness or unreasonableness in the underlying process that led to the decision.[7] The unreasonableness in that case was not addressing affidavits of the claimant and a friend about her involvement in a business.

In the last five or so years, a number of judges have increasingly used language derived from administrative law, stating that an insurer's decision will be liable to be "*reviewed and avoided*" if the insurer "*takes into account an irrelevant consideration or fails to take into account a relevant consideration*".[8] "Relevance" is a broad concept. If its meaning in this context is similar to the definition found in the Evidence Acts, it encompasses anything which "*could rationally affect (directly or indirectly) the assessment of the probability*" that the claimant will engage in relevant work in the future.[9] This "relevance" ground poses a particular challenge to the claims handler who has to draft a decision letter. Do they attempt to put forward a view about every fact they have been presented with, thereby running the risk that the court views one or more of those facts was irrelevant, or put forward more limited reasons, thereby running the risk that they will be held to have failed to take into account something the court considers to have been relevant? How should they deal with a recommendation from a reinsurer, which will likely be viewed as irrelevant to task of determining TPD under the policy?[10]

In a 2021 decision, NSW Court of Appeal applied a more general criterion, simply asking whether it was "*unfair*" of the insurer to rely on treating medical reports that pointed against a conclusion that the claimant was TPD.[11]

Do opinion clauses still serve their purpose?

An observer of the courts' decisions in TPD cases over the past 10 years might conclude that there is no real utility in retaining the opinion element in the TPD definition. That may be too pessimistic a view.

Firstly, it does not take into account claims where the claimant either accepted the insurer's decision or the claim settled prior to a court hearing. Data is not publicly available to assess the proportion of decisions which have "succeeded" in such cases.

Secondly, there have been cases where courts have upheld the insurer's decision, although they are a minority. To give a "rough and ready" indication, taking a sample of 23 cases decided in NSW since December 2011 which involved TPD opinion clauses, the insurer's decision was upheld in 7 cases, the insurer's decision was set aside but the insurer went on to win the case (because the court independently held that the claimant was not TPD) in 2 cases, and the insurer lost in 14 cases. This (admittedly unscientific) sample set suggests a success ratio of

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[6] *TAL Life Ltd v Shuetrim* (2016) 91 NSWLR 439; [2016] NSWCA 68 at [175]
[7] *MetLife Insurance Limited v Hellessey* [2018] NSWCA 307 at [8] & [81]
[8] *Jones v United Super Pty Limited* [2016] NSWSC 1551 at [55]
[9] *Evidence Act* 1995 (NSW), s 55
[10] cf *MetLife Insurance Limited v MX* [2019] NSWCA 228 at [61] (the challenge on this ground failed on the facts)
[11] *MetLife Insurance Limited v Sandstrom* [2021] NSWCA 123 at [29], [35], [41], [71], [72] & [77]

approximately 30%. There are many reasons why this figure should be treated with caution, not least because the outcome in each case turned on its facts, however it suggests the odds are weighted against insurers' decisions.

There is, however, a cost involved in the decision-making process required to be weighed against the advantages it brings. The cost includes the cost of preparing "procedural fairness" material, evaluating any response from the claimant, drafting the reasons for the decision and engaging in one or more reconsiderations thereafter, if requested. It would also include the legal costs of defending the decisions in court. Typically a "Stage 1" hearing on the correctness of an insurer's decision[12] involves 1 to 2 days of court time, plus preparation.

What can be done to improve insurers' chances?

As an advocate who has been involved in 10 of the 23 cases used in the "rough and ready" sample set above, I have doubts as to whether it is possible to draft a decision letter that will withstand the degree of scrutiny that has been applied by judges in some of the cases I have appeared in. Judges are, of course, human and have different views and approaches, and much often depends on which judge hears the case. However, there are some common issues which courts often seize on.

Not addressing evidence the court considers to be significant is usually fatal.[13]

Decision letters often struggle to explain why one doctor's opinion has been preferred over another. Admittedly, reasons can often be difficult to articulate persuasively. The difficulty is often more acute in cases involving diagnoses which are dependent on the claimant's self-reported symptoms, such as psychiatric and chronic pain conditions.

Courts have been critical of insurers giving greater weight to medical opinions on the ground they were expressed closer in time to the date of assessment (usually the end of the "waiting period" of 3 or 6 consecutive months absence from work).[14]

There is often a suspicion that the claim has been declined because the insurer suspects the claimant has exaggerated their symptoms, particularly where the medical evidence is dependent on the claimant's self-report. If exaggeration is suspected, it should be put to the claimant. Consideration could be given to using the interview process under cl 11 of the *Life Insurance Code of Practice* to commit the claimant to a version which can then be checked for consistency with the claimant's accounts recorded elsewhere and with the objective evidence.

A related issue is whether an insurer is required to, and should, reconsider its decision if requested to do so, particularly where cover is no longer in force or the policy provides for an alternate review process to a claims review committee. Claimant lawyers invariably ask for a reconsideration because they think it will help their case and have often amassed further evidence supporting the claim by the time the request for reconsideration is made. The claimant has by then been out of work for a longer period. There may be circumstances in which utmost good faith requires an insurer to review its decision, however TPD policies generally do not provide for the original decision-maker to review their decision, once made, and the case law as

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[12] "Stage 2" being a hearing as to whether the claimant is TPD on the evidence
[13] eg *MetLife Insurance Ltd v Hellessey* [2018] NSWCA 307
[14] *TAL Life Ltd v Shuetrim* (2016) 91 NSWLR 439; [2016] NSWCA 68 at [153]-[154]; *Wheeler v FSS Trustee Corporation* [2016] NSWSC 534 at [249]

to whether there is a duty to reconsider is inconsistent.[15] While an insurer must have a review process as part of its complaints processes required under Part 7 of the Corporations Act, that is a separate process (and generally should be kept separate).

Ultimately, there are no easy fixes available at the claims assessment stage. There may be underwriting options that could be considered such as claims conditions requiring claimants to put forward information at an earlier stage[16] or to limit the opportunity for, and scope of, reconsideration requests. In many cases, though, the decision to defend a claim may be driven more by the strength of the evidence that the claimant is not TPD than by whether the decision letter will meet the high bar imposed by the courts.

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[15] *Heitman v Guardian Assurance Co Ltd* (1992) 7 ANZ Ins Cas ¶61-107; *Nile v Club Superannuation Pty Ltd* [2005] NSWSC 55 at [36]; *Ziogos v FSS Trustee Corporation* [2015] NSWSC 1385 at [89]
[16] Some policies already contain such provisions but they are often ineffective