LIABILITY INSURANCE - CLAIMS MADE POLICIES

by

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Liability insurance, that is insurance under which the insured insures against its liability to others, usually arising as a result of its negligence, is traditionally effected by either an occurrence policy or a claims made policy.

Conceptually, an occurrence based policy is quite simple. The insured is entitled to indemnity in respect of any liability arising from an occurrence happening during the currency of the policy. Employers' liability insurance (including workers compensation), motor vehicle third party insurance and public liability insurance are usually effected by way of an occurrence based policy.

Professional indemnity insurance, directors' and officers' insurance and like cover is usually effected by a claims made policy. While there should be no conceptual difficulty in understanding and operating a claims made policy, many years of bad drafting and of attempts by the courts to apply section 54 of the Insurance Contracts Act 1 (which was not drawn with claims made policies in mind) have resulted in considerable confusion. The latest consideration by the High Court is in FAI General Insurance Company Limited v Australian Hospital Care Pty Limited 2, "Hospital Care".

The starting point is to understand the risk which is insured under a claims made policy. It is the risk that the insured will become liable to somebody else following a claim first made upon the insured during the policy period. As a commercial matter, insurers will not normally insure against liability for occurrences which took place while the insured did not have liability cover. Accordingly, the policy will often have a retroactive date, (for example, in the case of a first policy, the date of the commencement of the policy period), limiting the cover to liability arising from occurrences after that date. Subject to this limitation, it does not matter whether the liability
of the insured actually arose before or during the policy period, subject of course to proper
disclosure before the policy was entered into. The risk which is insured is the risk of liability in
respect of claims first made against the insured during the policy period plus, in many cases, the
cost of defending any such claim.

An obvious advantage to the insurer is that, at the end of the policy period, assuming that the
insured has reported all claims made against it, the insurer can complete a bordereaux of claims;
there is no need for a provision for IBNR (claims incurred but not reported). This is not to say
that some juggling of claims does not take place; but that is more a question of administration than
principle. Importantly, taking note of this consequence should not confuse the understanding of
the risk which is insured, namely liability arising from claims first made during the policy period.

There are also likely advantages for the insured. First, as the sum insured for each policy year
usually increases with the inflation of verdicts, the sum insured at the time of a late claim is more
likely to protect against the then likely verdict. Next, because the insurer has more understanding
of the claims history, it may be able to offer lower premiums.

It is inherent in a claims made policy that if, during the currency of the policy, the insured
becomes aware of circumstances which could give rise to a claim which could be made against it
during the currency of the policy, creating a liability which would otherwise fall within the cover,
the insured can notify those circumstances to the insurer and any subsequent claim arising from
those circumstances is treated as though it were a claim made against the insured during the
currency of the policy period, ie the insured is entitled to indemnity in respect of any liability
arising from that claim. The reason for this is twofold,

(a) if this were not the case, upon renewal of the policy (either with the same or a
different insurer) the insured would be obliged to disclose the circumstances, with
the likelihood that the insurer for the subsequent period would exclude any liability
arising from those circumstances from the cover under the new or renewed policy ³, and

(b) otherwise, to protect itself, the insured may well invite the potential claimant to make a claim so that the insured obtains cover under the policy. This is unlikely to be in the best interests of either the insured or the insurer ⁴.

This concept is consistent with section 40(3) of the Insurance Contracts Act ³, although that may be accidental ⁶. It is in attempting to put into express terms this concept in the context of this section and of section 54 that much bad drafting has emerged.

If this reasoning be correct, the classification of claims made policies into a) claims made, b) claims made and notified and c) discovery policies falls away. The following being the case:

1. Under any claims made policy, the insured may, during the policy period, notify circumstances and thus become entitled to indemnity in respect of any liability which may arise from those circumstances.

2. Any requirement to notify, during the policy period, a claim actually made has the same standing as a term requiring early notification under any policy and is only effective to the extent that late notification prejudices the insurer.

3. A liability of the insured which does not arise from a claim made against the insured during the policy period or from circumstances notified during the policy period is just not covered by the policy. It is not a question of "exclusion" or "refusing to pay"; it is just not an insured risk. Cover was not intended and no premium was paid. If the insured has chosen not to insure against claims made during some later period, that was its choice ⁷.
No one would suggest that a fire policy for the year 1990 would or should give cover for the consequences of a fire in 1995. Why should a claims made policy be different?

Which leaves outstanding whether, by reason of the operation of section 54, the insured is entitled to indemnity in respect of a liability arising from an occurrence, or circumstances, of which it became aware during the policy period but of which it did not notify the insurer, for example, until twenty years later when a claim was made. The High Court granted leave in *Hospital Care* to resolve this question; that being a case where the policy provided an express right to notify.

In *Hospital Care* the policy referred to the insured becoming "aware of any occurrence which may subsequently give rise to a claim against him or them". On the facts in that case, the insured, upon investigation, deliberately decided, knowing of the occurrence and that the potential claimant had sought legal advice, that the occurrence would not give rise to a claim, both for the purpose of notification under that policy and for disclosure in a proposal for subsequent insurance. The High Court majority found this to be an occurrence within the meaning of that word in the policy. Thus the awareness of the insured is limited to the occurrence, not to any possible legal consequence of it. For example, any pathologist reporting in 1990 on a specimen is aware of that "occurrence". Presumably, although that occurrence (which was not then thought may give rise to a claim) was not reported within the policy period the pathologist is still entitled to indemnity from the 1990 insurer in respect of a claim made many years later. Even assuming that this extreme view is wound back in some way, the basic problem remains: Can or should an insured under a claims made policy who does not notify, during the policy period, a circumstance of which he is aware, but which is not the subject of a claim during this policy period, be entitled to indemnity under that policy. Where there is an express term, the majority in *Hospital Care* say "yes" (Gleeson CJ dissenting), which turns the policy into something close to an occurrence policy, but without the structure of such a policy.
So what has been the response in the marketplace? Those insurers who still write professional indemnity business in Australia, by way of claims made policies, have removed from the policy the express right of the insured to notify a circumstance upon which the section 54 extension relies. Two issues, at least, remain: namely whether this removal is effective, bearing in mind the inherent qualities of a claims made policy posited earlier, and what will be the position of an insured who purports, relying upon section 40(3) or otherwise, within the policy period, to notify an occurrence. These issues will no doubt be fought out over the years.

All of this because the Australian Law Reform Commission did not consider claims made policies when is recommended section 54; or, conceptually, probably at all. The next step should be informed legislative intervention. It is not really satisfactory to rely on the extension introduced by section 40(3) to give some hybrid entitlement to the insured, even if this is ultimately upheld. This also raises reinsurance problems.

It is interesting to consider some of the language used in this area. First, the use of the word "claim" to mean liability, which it clearly does not. Unfortunately lawyers seem wedded to this use, although it is hard to find a legal dictionary which supports the practice (as an example of the misuse, see the speeches of all members of the House of Lords in BCCI v Ali).

Next, "omission", which has been discussed in the cases dealing with this subject. In Hospital Care the majority held that a deliberate decision not to notify was an omission. Kirby J appears to hold the view that the fact that someone did not claim in a particular year, or presumably on a particular day, there being no reason for the claimant to do so, is an "omission" to claim, although this was not relevant to the operation of section 54 in the present case. In both cases a wider meaning than most would give.
Then there is "may not refuse to pay". Even by today's drafting standards this is an odd phrase to use to negate a contractual exclusion under a contract which expressly excludes that entitlement and even odder to use to confer a statutory entitlement which was never intended under the contract 15.

Whilst it may not matter, there is confusion about "long tail liability insurance". This phrase merely means categories of insurance in which claims may remain outstanding for a long time, as opposed to short tail business, such as fire insurance, where this is unusual. Long tail business may be written by either occurrence or claims made policies.

Finally the use of the word "deemed" in the policy in question in Hospital Care. While this is not usually regarded as a safe way to create a contractual entitlement, the draftsman may well have sought to emphasise the claims made concept and hide the element of notice. Certainly it has been so used for a long time 16

1 Section 54 reads, relevantly:

"(1) Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into ... the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

...

(6) A reference in this section to an act includes a reference to:

(a) an omission..."


3 By way of illustration, if a lawyer disclosed on a proposal for professional indemnity insurance that he had allowed a good claim for damages by a seriously injured client to be statute barred and that the client had retained other lawyers, it can be expected that any policy which issued would exclude liability to that client. Which, of course, is why, in 1980, the compulsory insurance of NSW solicitors was of the profession and did not require a proposal by an individual solicitor.


5 Section 40(3) reads:
"40 (3) Where the insured gave notice in writing to the insurer of facts that might give rise to a claim against the insured as soon as was reasonably practicable after the insured became aware of those facts but before the insurance cover provided by the contract expired, the insurer is not relieved of liability under the contract in respect of the claim, when made, by reason only that it was made after the expiration of the period of the insurance cover provided by the contract."

6 While paragraph 265 of the ALRC No 20 (1982) refers to policies of a claims made nature it does not express any conceptual understanding of such policies. On the contrary, it refers to a "severe complexity ... difficult to unravel". That paragraph purports to deal with what is described as "an insurer's right to refuse to renew a contract of general insurance" (a "right" which would have the late W. N. Hohfeld turning in his grave). The position is put better in the note to the proposed clause 41 of the bill (now sec 40). For what it is worth, that note does not suggest any intention that a notification after the policy period should give a right of indemnity.

7 In Hospital Care the insured had insured during the subsequent period and obtained cover under that policy for the liability in question.

8 Per Kirby J, para 54.

9 The present position is excellently recited by Robert Beaton, "Claims Made" Policies in Australia - At the Crossroads, ANZ Institute of Insurance and Finance Journal Vol 25 No 1 p30.

10 Where the notification/claim by the insured under the policy is outside the policy period, indemnity has been refused (at first instance, at least) McInally.

11 Perhaps simply by excluding the entitlement to indemnity upon notification in claims made policies (as defined) from the operation of section 54. See also Beaton, op cit.

12 HL (E) [2001] 2 WLR 735.

13 Para 45.

14 Para 73ff

15 Or, put the other way, ".....the insurer is entitled to refuse to pay a claim if it falls outside the scope of its promised obligations." Kirby J, para 77.

16 See Madge, op cit.