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'Insurance Law Case Update 2025'

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Introduction

This presentation examines a selection from the panoply of insurance law and market issues that have either arisen or piqued interest over the past year. The content has been derived from a number of published articles and cases. I am indebted to those authors.

The topics to be covered are:

- AI and Insurance: new and emerging risks
- Directors risk update
- *Aged Care Act* 2024: new insurance implications
- Construction claims
- Pre-existing conditions exclusions: unfair contract terms
- Institutional historical abuse claims – prior notification
- Natural disasters: uninsurable, unaffordable, or both?

AI and Insurance: new and emerging risks¹

One of the most talked about topics in insurance and legal risk this year has undoubtedly been the emergence, and increasing sophistication, of AI technology.

On 29 October 2024, ASIC released a report entitled “Beware the gap: Governance arrangements in the face of AI innovation” urging financial services and credit licensees to ensure their governance practices keep pace with their accelerating adoption of AI.

AI risk is therefore likely to be a key focus area for regulators over the short to medium term. Currently, there is no AI-specific legislation or regulation in place in Australia. However, there are voluntary frameworks and principles to assist organisations with self-regulation, and proposals for more specific regulation including mandatory guardrails that would apply to the use of AI in high-risk settings.

Risks

What then are some of the risks associated with the use of AI?

So far, we know that AI can be both unreliable and even potentially harmful if it is not properly supervised. For example, AI is well known to be susceptible to several limitations and issues including:

- Model drift: when an AI model's performance degrades over time due to changes in data distribution, the operating environment, or even the model's goals or objectives, requiring monitoring and updating or retraining the model;
- Hallucinations: AI models can generate false or inaccurate information in response to human prompts. For example, Air Canada was recently ordered to pay damages after its chatbot gave incorrect information about bereavement fares, leading to a customer's financial loss. ChatGPT was also involved in a legal case where a lawyer submitted fabricated court cases to support a legal brief;

¹ Herbert Smith Freehills Policyholder Insurance Highlights 10th edition 07

- Discrimination: when an AI model makes connections between data based on algorithms, this may result in bias/ discrimination against individuals or groups;
- Garbage in/garbage out: when an AI system is trained on poor quality input data, the output will inevitably be of equivalently poor quality. It is inherently susceptible to human error at the data input stage and in all aspects of its subsequent use; and
- Cybercrime: AI is also susceptible to exploitation by malicious actors. It has been used to increase the sophistication of phishing attacks making phishing emails more believable by improving their wording and grammar. AI has also been used to generate 'deepfakes', audio or video content that mimics a genuine actor in order to extract personal and financial details.

Claims

From those risks, the main types of claims by third parties from the use of AI include:

- IP Infringement: central to almost any AI system is a large mass of data on which the system is trained. Although referred to as “data”, the training materials are frequently themselves original works, in which copyright can subsist. The use of GenAI systems therefore has the potential to result in copyright infringement by users. There is a complex statutory regime governing copyright in Australia including defences of “fair dealing” for certain limited purposes, against which use of GenAI needs to be considered to understand infringement risk. Misuse of confidential information through use of GenAI is also a relevant issue. Steps to reduce risk include ensuring contractual arrangements with AI service providers are negotiated with protections in place in case things go wrong, implementing policies and training directed to minimising key risks and using ‘closed’ system AI products (to protect confidential information).
- Customer claims: the use of AI in the provision of services (whether directly or even potentially in the background) has the potential to result in liabilities to customers or other third parties if they suffer loss or damage as a result. This could result in liability for negligence or contractual breaches if services are not provided with reasonable care or products that use AI technology do not comply with capabilities represented.

- **Discrimination:** the use of AI has the potential to result in unintended and unpredictable bias or profiling. Therefore, care needs to be taken when AI is used in facial recognition technology, the employment space or in determining eligibility for financial products such as mortgages.
- **Regulatory action:** regulators such as ASIC and the ACCC are increasingly focused on taking action to avoid harm resulting from AI. Whilst new codes and AI-specific legislation are under consideration, there are a number of existing laws relating to misleading and deceptive conduct and directors' duties that could be used by regulators to seek civil penalties for AI misconduct in appropriate cases. For example, 'AI washing' (ie where a company claims to possess a level of service relating to its use of AI which it does not in fact have) may be one of the new frontiers of regulatory action (like recent cases of greenwashing in climate disclosure cases).
- **Class Actions:** the Australian class action regime continues to be an avenue for plaintiff law firms and funders to bring proceedings against both listed and unlisted companies involving allegations of loss to shareholders and consumers. To the extent a company is facing a regulatory investigation or suffers a substantial share price decline following the disclosure of adverse information to the market arising from an AI event, the possibility of a class action continues to loom large.

First party losses

Whilst third party liability risk presents some of the most obvious and significant potential liabilities facing companies that use AI, there are also a number of 'first party' issues that can potentially occur causing loss to companies directly. For example:

- **System damage:** as AI becomes increasingly embedded in IT systems, it is possible that IT malfunctions or programming errors could result in system outages that cause system damage and business interruption loss. The recent CrowdStrike outage that caused global system failures is an example of the type of issue that can arise and also highlights the risks in relying on critical third party service providers. A logistics company which relies on AI to optimise its delivery routes and storage capacities could also suffer first party loss if the system does not perform.

- Crime: as noted above, threat actors are increasingly using AI to improve the sophistication of phishing scams and enhancing their ability to breach data security protections. The rise of AI arguably increases the risk of theft of company assets (both financial and data).
- Physical damage: given the extent of automation powered by AI already being used today, it is increasingly more likely that AI may cause physical damage. For example, by way of autonomous vehicles colliding with other property or even by way of an AI-powered thermostat malfunctioning and causing a fire in a factory.

Role of insurance

Insurance has a key role to play in helping companies mitigate the financial impacts of the rising risk by spreading losses across the global insurance market. There are a number of policies, both traditional and emerging, that may respond to AI-related losses such as affirmative AI cover and AI endorsements in cyber insurance policies.

Even where AI risks are not affirmatively covered, they may be 'silently' covered under traditional policy lines that do not exclude them such as:

- Professional indemnity ("PI") insurance will be relevant in the event of customer claims for services-related liabilities. Exposures may arise from AI related services or the use of AI in the provision of services or in the event of a regulatory action. Liabilities, defence costs, regulatory investigation costs and possible fines might be covered under PI policies.
- D&O insurance may protect directors or officers facing regulatory action for a failure to manage AI risks appropriately. Separately, Side C (if purchased) may be relevant in the event of the company facing a securities' class action arising from the use (or alleged misuse) of AI.
- Product liability insurance may cover compensation and costs if a consumer suffers damage from a product powered by AI, such as a smart home device.
- Cyber policies may respond to security breaches or system failures and other privacy breaches relating to AI. They may also potentially respond to certain first party losses, including ransoms paid to malicious threat actors (a Crime Policy may also be relevant in the event of a ransom or conduct involving financial theft).

- Employment Practices Liability insurance may cover an employer for compensation claims for discrimination or unfair treatment resulting from AI systems.
- Property Damage and Business Interruption insurance will be relevant in the event that AI causes property damage and consequential business interruption.

Whether these policies may be engaged in the event of AI-related losses will of course depend on a number of factors such as:

- Blurred lines: liability policies typically require a causal link between any claim against the company (or insured person) and the perils insured by the policy (e.g. acts/omissions in the performance of professional services in PI policies or wrongful acts by persons in their capacity as directors/officers in a D&O context). In this new frontier of autonomous AI decision-making, it is possible that real questions may emerge as to which party has committed an act/error and whose conduct has given rise to the claim, and therefore which policy is the responsive one: are the acts attributable to humans or the AI itself? This may sound like science fiction, but policyholders should think carefully about how they are using AI and how any liabilities associated with AI translate to their policies.
- AI exclusions: as these new risks develop, insurers will likely take a view on whether to price in or exclude AI risk. As with cyber exclusions, policyholders should keep a close eye on AI exclusions being adopted in the market (either as standalone clauses or within existing cyber exclusions).

Directors risk update

*D&O insurance demand spikes amid rise in upheld claims*²

The Global Insurance Law Connect (GILC) D&O Global Trends 2025 report on the directors' and officers' (D&O) insurance market has highlighted increased regulatory scrutiny, growing litigation risks, and shifting market dynamics as key themes for 2025.

² From an article by Rod Bolivar, published on 11 February 2025 in <https://www.insurancebusinessmag.com/au/news/professional-liability/dando-insurance-demand-spikes-amid-rise-in-upheld-claims-524178.aspx>

From a survey of 24 markets, the GILC identified legislation, environmental, social, and governance (ESG) issues, and macroeconomic uncertainty as the primary concerns influencing underwriting decisions and pricing structures.

The findings suggest that claims against directors are increasingly being upheld, while demand for D&O insurance is rising across both mature and developing markets.

Among surveyed professionals, 74% pointed to legislative and regulatory changes as the most influential factor affecting the market. ESG considerations ranked second at 57%, while 52% cited macroeconomic conditions. Cyber risk also remains a prominent issue, with 48% highlighting its impact on market sentiment.

The report indicates a shift from the concerns outlined in 2021, when the market was still responding to the aftermath of the COVID-19 pandemic. ESG, which was a secondary issue at the time, now plays a central role in underwriting and liability discussions. Regulatory pressures have intensified, and courts are increasingly upholding claims against directors, adding new complexities to corporate governance. This trend spans both developed and developing markets, signalling heightened legal exposure for directors worldwide.

In Australia, there has been an uptick in regulatory focus on misconduct relating to reporting on environmental sustainability (and ESG generally) and a continued emphasis on technological and operational resilience (including cyber resilience) for market operators and market participants, including in relation to the use of Artificial Intelligence (AI).³

Despite pricing variations, demand for D&O insurance is rising globally. Premium trends vary significantly based on market maturity. While 62% of respondents reported a general increase in premiums, mature markets such as the UK, Australia, Finland, and the Netherlands have seen prices decline. In contrast, developing markets - where political and economic uncertainty increases litigation risks - continue to experience rising costs.

³ Herbert Smith Freehills, Policyholder Insurance Highlights 10th Edition, 5 February 2025.

Aged Care Act 2024: new insurance implications ⁴

On 25 November 2024, the Australian Government passed the new *Aged Care Act* 2024. The Act, which is set to take effect on 1 July 2025, marks a sweeping transformation of aged care laws, introducing stricter governance requirements, heightened oversight, and increased liability exposures.

Key insurance considerations include:

- **Directors & Officers/Management Liability** - The Act imposes stricter governance requirements on registered providers and responsible persons in governance roles. The introduction of the concept of associated providers also has the potential to extend these enhanced governance requirements beyond their own operations to include the activities of associated providers, thereby increasing the complexity and scope of responsibilities and heightening the risk of governance breaches. The Act emphasises the duty of responsible persons to exercise due diligence, which means that directors and officers must continually assess and improve their governance processes to prevent breaches. This ongoing requirement for continuous improvement necessitates regular reviews and updates to compliance systems, which can be resource-intensive and challenging to sustain. The increased governance risks may require a review and potential expansion of Directors & Officers (D&O) insurance policies to cover new liabilities.
- **Statutory Liability** - The Act introduces several statutory liability risks, primarily due to the increased likelihood of regulatory investigations by bodies such as the Aged Care Quality and Safety Commission (ACQSC). These investigations can lead to significant legal fees for registered providers, including costs for legal representation, documentation preparation, and participation in hearings or inquiries. While severe criminal penalties have been removed, civil penalties remain a significant risk, with substantial fines and potential compensation claims from affected parties further increasing potential financial liabilities. The new

⁴ From an article by Lyle Steffensen in Lockton Re: "Preparing for the New Aged Care Act: Risk and insurance implications for aged care service providers", 24 February 2025: <https://global.lockton.com/au/en/news-insights/preparing-for-the-new-aged-care-act-risk-and-insurance-implications>

regulations also introduce enhanced oversight and compliance requirements, raising the risk of non-compliance.

- **Professional Indemnity/Medical Malpractice** - The introduction of associated providers significantly increases the risk of vicarious liability for registered providers, meaning they can be held responsible for the actions or omissions of their associated providers, including any professional negligence or malpractice that occurs within the scope of their services.
- **Public Liability** - The new regulations introduce the concept of Associated Providers, significantly impacting Public Liability. Registered providers are now responsible for ensuring their associated providers comply with the Act, making them directly liable for any breaches or incidents involving these providers. This change means that Public Liability insurance may need to be broadened to cover direct liability for the actions of associated providers and their staff, including incidents like injuries to clients or property damage. Breaches of the new regulations can lead to investigations, fines, or restrictions on operations, directly affecting the registered provider's registration and service delivery.
- **Workers Compensation Recovery Actions** - The new regulations create uncertainty regarding the responsibility for injuries to employees of associated providers. If registered providers are ultimately responsible for the actions of associated providers, this may strengthen workers compensation recovery actions against registered providers' public liability policies.

When considering Public Liability and Professional Indemnity/Medical Malpractice policies, naming associated providers as insureds can introduce several risks for the registered provider, including:

- **Policy Access:** By naming associated providers as insureds, they gain full access to the registered provider's insurance policy. This means they can utilise the policy as if it were their own, potentially leading to increased claims and usage that the registered provider might not have anticipated.
- **Subrogation Rights:** The insurer's rights of subrogation are removed when associated providers are named as insureds. Subrogation allows an insurer to pursue a third party that caused an insurance loss to the insured. Without this

right, the insurer cannot seek recovery from the associated provider if they are at fault, which could lead to higher costs for the registered provider.

- **Increased Premiums and Excesses:** Adding associated providers, especially those whose risk management practices may not meet the standards of the registered provider, can lead to increased premiums and potentially higher excesses imposed by the insurer. This is because the overall risk profile of the policy increases, making it more expensive to insure.
- **Policy Ambiguity:** Without clear legal guidance, it can be unclear how the policy will respond to the associated providers' activities outside of their contract with the registered provider. This ambiguity can impact the loss ratio on the policy, complicate efficient claims handling, and create challenges in policy administration. It is essential to clarify these aspects to avoid potential disputes and ensure smooth operation of the policy.

Construction Claims

Zurich Australian Insurance Limited v CIMIC Group Limited & Ors [2024] NSWCA 229

This decision illustrates how an insured must closely consider its disclosure obligations, including (as far as possible) from the perspective of a reasonable person in its circumstances, and having regard to particular types of operational risks which are sufficiently unusual or serious to warrant specific disclosure (including circumstances which suggest impropriety or unlawfulness).

The principal issue was whether CIMIC ought to have disclosed to insurers information contained in a file note prepared by a senior officer of Leighton prior to inception of the policy. The file note suggested the company had won a tender in Iraq by way of an unlawful payment and that there was an opportunity to win another tender by a similar unlawful payment.

The Court of Appeal held that:

- (contrary to the primary judge) that there was sufficient evidence that the representations in the file note were true;
- Leighton knew the payments may have been unlawful;

- a reasonable person in the insured's circumstances would have known, and not merely 'strongly suspected or believed', that the serious allegations set out in the file note regarding the alleged payment of bribes would be relevant to the insurers' decision to accept the risk;
- the facts should have been disclosed to insurers;
- had the relevant matters been adequately disclosed prior to inception of the policy, the insurers would have inserted a bribery exclusion or similar; and
- as a result, the insurers were entitled to reduce their liability to nil.

AAI Ltd v The Owners - Strata Plan No 91806 [2025] FCAFC 6

Fairview manufactured and supplied aluminium composite panels (**ACP**) which were affixed using a top hat subframe to the exterior of two high-rise residential buildings at Warwick Farm. AAI was Fairview's insurer during the relevant period.

In March 2019 (subsequent to the expiry of AAI's policies) and following fires in residential towers in London and Melbourne, the Owners Corporation was directed by the Liverpool City Council to remove the ACP.

In June 2019, the Owners Corporation commenced representative proceedings against Fairview on its own behalf and on behalf of the class of persons who owned or had a leasehold interest in either building which had been fitted with the ACP panels.

In July 2020, Fairview went into voluntary administration. The Owners Corporation was granted leave to proceed pursuant to section 444E of the *Corporations Act* 2001 (Cth).

In July 2023, Wigney J ordered that AAI be joined to the proceeding and granted the Owners Corporation leave to bring and continue the proceeding against AAI.

AAI sought leave to appeal broadly on the grounds that the decision was attended by sufficient doubt and, if allowed to stand, the orders would cause AAI substantial injustice.

AAI argued that the primary judge ought to have decided on a final basis, rather than interlocutory, that it was entitled to disclaim liability within the meaning of s 5(4) of the *Civil Liability (Third Party Claims Against Insurers) Act* 2017 (NSW) (**Third Party**

Claims Act). The Full Court considered that such a determination was an exercise of discretion, requiring AAI to demonstrate that the primary judge had erred in a manner akin to that of *House v the King*.

However, the Court considered that the approach taken by primary judge approach was "*consistent with a strong line of authority*" and that the decision demonstrated a detailed and careful analysis, including findings that the Owners Corporation had an arguable case against Fairview; there was an arguable case that the policies responded to the claim; AAI had not established an entitlement to disclaim liability under the policies; AAI was not entitled to disclaim liability on the basis of any exclusion clauses; and there was no reason not to exercise the discretion in favour of the Owners Corporation.

AAI also contended that the primary judge had misdirected himself by interpreting the statutory test as only requiring the Owners Corporation to establish that it had an arguable case, without engaging with ss 5(4) of the Third Party Claims Act, which would have required refusal of the application if AAI could establish an entitlement to disclaim liability.

However, the Court described that contention as a "*false dichotomy*", as the "*question whether an insurer is entitled to disclaim liability is not separate from, but forms part of, the inquiry as to whether there is an arguable case. If the insurer can establish such an entitlement, then there can be no arguable case*". The Court considered that, on the evidence "*currently before [him]*", the primary judge had recognised the effect of s 5 in determining that AAI had failed to demonstrate an entitlement to disclaim liability.

On the question of substantial injustice, the Court found that:

- the question of whether the policies responded was yet to be determined on a final basis, and AAI would not be deprived of the opportunity to contend the policies were not responsive at a final hearing;
- if AAI could establish that it ought not to have been joined on the basis of non-responsive policies, it would have a prima facie entitlement to its costs; and
- there was no evidence that AAI was unable to bear its costs or that incurring the costs would cause it any difficulty.¹²

Accordingly, AAI's application for leave to appeal was dismissed.

Although the decision provides a useful indication of the position the court will likely take in determining questions of leave concerning whether proceedings may be brought or continued directly against insurers pursuant to the Third Party Claims Act, insurers and building practitioners will need to wait for any final hearing of the proceeding for certainty as to whether a long line of authority on the meaning of "property damage" will be overturned, and whether that term extends to the removal of defective ACP cladding thereby triggering third party liability policies in place at the time the cladding was installed.

Chubb Insurance Australia Limited v WSP Structures Pty Ltd [2024] FCAFC 123

In 2015, Icon Co (NSW) Pty Ltd (**Icon**) was contracted to design and construct the Opal Tower, a high-rise development in Sydney Olympic Park. Icon engaged WSP, consulting engineers, to provide the engineering design.

In December 2018, serious structural damage to Opal Tower resulted in three proceedings in the NSW Supreme Court, all of which settled in 2022. In one of the settlements, WSP accepted liability to pay an amount to Icon, which was paid by its holding company WSP Australia Pty Ltd, and a proportion of the class action settlement costs was paid by WSP's professional indemnity insurers.

Icon held a third-party liability insurance policy with Liberty Mutual Insurance Company and excess layers on relevantly the same terms with Chubb and Tokio. Within the policy, 'Insured' was defined as:

- the Insured named in the Schedule and/or;
- joint ventures (incorporated or not) in which the Insured is a co-venturer and is responsible for arranging insurance; and/or
- principals and/or owners; and/or
- subcontractors engaged by any of the above; and/or
- lender and/or financiers for their respective rights and interests; and/or
- directors, officers and employees of any of the above but only in respect of the Business and/or Activities of the Insured; and/or

- manufacturers and suppliers, but only in relation to their manual on-site activities; and/or
- architects, engineers and other professional consultants, but only in relation to their manual on-site activities and/or
- any other company for which the Insured assumes management together with all other parties for whom the Insured is required under contract or any other legally binding agreement to provide insurance protection are also included as an Insured."

Relevantly, "*contractors and subcontractors*" were also referenced in the defined term 'Insured' contained in the Schedule to the Policy.

In 2023, WSP brought proceedings against Liberty, Chubb and Tokio, seeking a declaration that it was covered by the Policy (including the Chubb and Tokio excess layers) and that the insurers were liable to indemnify WSP in respect of its payment on the settlement and its defence costs.

At first instance, Colvin J held:⁵

- the words "*and/or*" appearing at the end of each item in the Definition, meant that an insured may fall within multiple descriptions and thus WSP could be both an engineer and a subcontractor;
- the term 'subcontractors' broad enough to encompass suppliers and consultants, irrespective of whether they were undertaking manual on-site activities, making those provisions redundant;
- however, engineers who were not subcontracted by an Icon entity, but who conducted manual on-site work, constituted consultants but not subcontractors;
- the term 'Insured's Business' in the Schedule to the Policy extended the scope of the policy beyond only those who were named as insureds who were construction contractors;
- therefore, the policy was plainly intended to cover engineering activities undertaken by subcontractors of the named insured;

⁵ *WSP Structures Pty Ltd v Liberty Mutual Insurance Company t/as Liberty Specialty Markets* [2023] FCA 1157.

- further, that the ability of the policy to provide effective coverage would be substantially compromised if it did not cover WSP.

The insurers also contended that when two insurers cover the same risk and the loss has been met by one (in this case, WSP's professional indemnity insurer), then the other insurer may plead the indemnity as a valid defence to liability pursuant to ss 76(1) of the *Insurance Contracts Act*. Colvin J rejected that argument and found that the agreement between WSP and its insurers was not "*an enforceable agreement*" that required payment to WSP from its insurers, and that "*[i]t is the actual receipt of full reparation that gives rise to the discharge of the second insurer from any claim by the insured*", which, in this case, had not occurred.

Finally, his Honour held that WSP Australia was the incorrect applicant because the payments it made "*were not made by way of indemnity*" and that "*...it should be inferred that WSP Australia made the payments on the basis that WSP Structures would pursue any and all rights that it may have to recoup or recover the costs and account for those monies to WSP Australia.*"

In the result, his Honour granted the declarations and orders sought by WSP for indemnity from Liberty, Chubb and Tokio.

The insurers appealed only in respect of the primary judge's construction of the policy definition of "insured".

In dismissing the appeal, the Full Court held that:

- the duality of the definition of the Insured in the policy was consistent with the manner in which the primary judge construed the policy;
- there was no basis on which the Court could conclude that a commercial judgment to effectively have the engineers and consultants insured at Icon's expense was so unreasonable that it points away from the ordinary and natural meaning of the language used by the parties;
- the primary judge's construction of the Policy had not changed a public and product liability policy into an occurrence-based professional indemnity policy, in favour of those who would ordinarily have their own professional indemnity cover, and that the proper construction of a particular policy was not determined by such generalised categorisations of policies. The Liberty Policy remained relevantly a

policy for liability for Property Damage, which extended to subcontractors by the breadth of the definition of the Insured.

This decision highlights the importance of insurers exercising care and precision when defining classes of insureds and the extent of an insured's business under a policy, as they may prove critical in determining third-party coverage.

Pre-existing conditions exclusions: unfair contract terms

Australian Securities and Investments Commission v HCF Life Insurance Company Pty Limited [2024] FCA 1240

In this decision, Jackman J considered whether HCF could deny indemnity across a range of its life insurance policies if a policyholder failed to disclose a pre-existing condition prior to entering the contract and a medical practitioner subsequently formed an opinion that signs or symptoms of their condition existed prior to entering the contract.

Historically, HCF's exclusions for pre-existing conditions mirrored ss 47(2) of the *Insurance Contracts Act 1984* (Cth) which provides that an insurer may not rely on a provision limiting or excluding liability by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into, if the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability, at the time of entering the contract.

However, in August 2019, HCF amended the term in three of its life products to exclude cover where a medical practitioner forms the opinion that signs or symptoms of the relevant condition existed before policy inception.

ASIC contended that:

- the terms were partially unenforceable because of their inconsistency with ss 47(2) of the ICA;
- by publishing the relevant PDS containing the pre-existing condition terms to members of the public and entering into the life cover contracts with them, without advertizing to or explaining the existence or effect of ss 47(2), or that the Pre-

Existing Condition Terms were partially unenforceable, HCF had engaged in conduct that was liable to mislead the public in contravention of s 12DF of the ASIC Act; and

- the terms were unfair within the meaning of s 12BF of the ASIC Act.

His Honour held, in summary, that HCF had breached s 12DF of the *Australian Securities and Investments Commission Act 2001* (ASIC Act) by engaging in conduct that was liable to mislead the public as to the nature, characteristics and operation of their life insurance products. Notwithstanding, his Honour did not find that the pre-existing condition terms were unfair contract terms for the purposes of s 12BF of the ASIC Act.

His Honour reasoned that:

- the terms turned upon a medical practitioner's subjective opinion of whether signs or symptoms of a condition, illness or ailment existed before the policy was entered into, while, by distinction, s 47(2) of the ICA asks whether the insured was aware (or a reasonable person in the circumstances could be expected to have been aware) of the underlying sickness or disability;
- in giving determinative value to the subjective opinion of the medical practitioner, the terms had the effect of broadening the exclusion beyond the scope of ss 47(2), noting that '*one individual's satisfaction of an objective fact will inevitably be broader than a provision that is engaged only upon the actual existence of that same fact*';
- therefore, the triggering test required by the terms was materially different from ss 47(2), thereby rendering them partially unenforceable;
- the phrase 'liable to mislead' in s 12DF(1) requires an 'actual probability that the public will be misled by the impugned conduct';
- in applying the four-step test discussed by the High Court in *Self Care IP Holdings Pty Ltd v Allergan Australia Pty Ltd* [2023] HCA 8, his Honour considered:
 - whether the "impugned conduct" had been identified with precision;
 - whether the identified conduct was conduct "in trade or commerce";
 - what meaning the conduct conveyed; and

- whether that conduct in light of that meaning was misleading or deceptive, or, for the purposes of s 12DF, 'liable to mislead'.
- the meaning conveyed by the wording of the terms was such that an ordinary and reasonable member of the public would:
- read and understand them as being an accurate and complete statement of when benefits will not be payable because of a pre-existing condition; and
- be ignorant as to the potential effect of s 47(2), given that nothing in the PDSs adverted to the possibility that it may preclude HCF from relying upon the terms in particular circumstances;
- although s 47 does not oblige insurers to notify insureds of its effect and does not render inconsistent contractual provisions void, in the absence of any reference to that provision, the resulting absolute statement by HCF as to the insureds' rights was misleading conduct;
- even though s 12DF does not require the public to be misled 'to their detriment', ordinary and reasonable readers of the PDSs, who were unaffected by the terms would still have been misled by the impugned conduct.

The proscription against unfair contract terms in the ASIC Act was extended to insurance in 2021. In March 2024, Jackman J delivered the first decision in *Australian Securities and Investments Commission v Auto & General Insurance Company Limited (Auto & General)* [2024] FCA 272. ASIC appealed that decision. As at the date of this article, that appeal is still pending.

In the HCF case, Jackman J followed his decision in *Auto & General* and held that:

- the operation of s 47 had the practical effect of ameliorating any potential imbalance in the parties' rights and obligations;
- in relation to ss 12BG(1)(b), although HCF had a legitimate interest to protect, both the terms and the historical pre-existing condition clauses would have equally protected those interests since the practical effect of the new terms was limited to its consistency with s 47 of the ICA;

- in relation to s 12BG(1)(c), HCF application of the terms would cause detriment to the insured to the extent that the terms created uncertainty as to whether an insured could make a claim, which would be disadvantageous to an insured;
- however, as ASIC failed to establish the requisite elements of s 12BG(1)(a), namely, that the terms would cause a significant imbalance in the parties' rights and obligations arising under the contract, the terms were not unfair.

The decision provides a salient reminder of the dangers for insurers in drafting policy terms and providing policy information to customers through PDSs, particularly when such terms are in conflict with the provisions of the ICA. Further, it illustrates that even if a policy term is not found to be unfair, the making of representations involving the term as to the rights and obligations of insurers or policyholders that are inconsistent with the ICA may constitute misleading conduct.

Institutional historical abuse claims – prior notification

Allianz Australia Insurance Limited v Uniting Church in Australia Property Trust (NSW) [2025] FCAFC 8 ⁶

On 7 February 2025, the Full Court of the Federal Court delivered judgment in *Allianz Australia Insurance Ltd v Uniting Church in Australia Property Trust (NSW)* [2025] FCAFC 8. The decision is instructive on:

- the test for when an insured has relevant knowledge for notification purposes;
- the importance of making prior notifications as soon as reasonably practicable in accordance with ss 40(3) of the *Insurance Contracts Act* (Cth) 1984 (ICA); and
- the validity of a prior known circumstance exclusion.

The case concerned the Uniting Church's right to indemnity under various policies underwritten over time by Allianz in respect of historic sexual and physical abuse claims by former students of Knox Grammar School. While prior matters and claims regarding a specific teacher had been notified to, and paid by, Allianz, in issue was the availability of cover for claims by other students in respect of other teachers. A blanket notification in respect of those other claims was made in 2009. However,

⁶ From "Prior Known Circumstance Exclusions are no longer valid in insurance policies" by Patrick Boardman and Antonia Rose of Colin Biggers & Paisley published online: <https://cbp.com.au/insights/publications/prior-known-circumstance-exclusions-are-no-longer-valid-in-insurance-policies>

Allianz disputed the validity of that notification on the basis that in 2004 Knox had commissioned a report (termed "LKA2") which raised the potential for more expanded claims, but the contents were not disclosed to the Church or Allianz at that time.

The issue before the Court was whether the blanket notification was a valid notification pursuant to ss 40(3) of the ICA (which requires notice "as soon as reasonably practicable after the insured becomes aware of those facts") and, if it was, whether cover was available.

In determining the coverage position the Full Court determined the following relevant issues.

[1] *Whether the report disclosed facts and circumstances which may give rise to a claim beyond the previous known specified teacher* – The Court considered that the report contained "red flags", "drew the reader's attention to highly questionable conduct of other staff and warned in clear terms of the prospect of further claims relating to a pattern of alleged and some sustained behaviour from the 1980s and early 1990s". The Court clarified that the relevant test did not require the insured to be aware of the full extent of possible claimants or their identity. "It is enough if there is awareness of a problem which is of a character that is likely to give rise to claims of a kind that are covered by the policy ...". "The required awareness is of facts that expose the possibility of a claim, not an unfounded suspicion or belief of what amounts, in effect, to conjecture". The Court referred to "... the awareness of facts that point to the realistic prospect that such claimants exist and may bring forth claims would meet the statutory terms ...". Given those findings, the Full Court held that upon receiving the report, "a reasonable insured would become aware of facts that may give rise to all of the claims which subsequently emerged and in respect of which ... was the subject of the blanket notification some years later".

[2] *Whether the knowledge of the Knox headmaster was also that of the Church, such that the Church's 2009 notification pursuant to ss 40(3) was a notification "as soon as reasonably practicable after the insured became aware of those facts"* - The Court held that the Church was effectively the nominal defendant in the proceedings, with the real defendant being Knox. The Church argued that as the policy expressly provided that notification of claims was to be given by the General Secretary of the Synod, the General Secretary had to be aware of those circumstances in order to

effect proper notification, and there was no such awareness. However, the Court considered that contention would "bring about the uncommercial consequence that Allianz would not have the benefit of notification of a claim despite being liable to indemnify". The better construction of the policy was that each individual insured was responsible for notifying the Synod, who was responsible for notifying Allianz. The Court held that where the insured is covered for liability as a nominal defendant (here, the Church), it is the awareness of the substantive defendant (here, Knox) that is relevant. The Court recognised that there are important differences between the nature of s 21 (Disclosure Obligations) and ss 40(3) (Notification) of the ICA, such that a conclusion as to the proper attribution approach for one will not indicate the proper approach to the other. However, in this "special case" where the Church sought indemnification on the basis of its liability as a nominal defendant for the conduct of Knox, there was an obligation under the policy for Knox to notify. The Court explained that in the "very unusual circumstances" of the case where all notifications were required to be given by the General Secretary of the Synod and the Church had cover both as to its own liabilities and as to additional liabilities as nominal defendant, the knowledge of Knox was the knowledge of the Church for the purposes of notification of a claim. Although the Court considered the attribution of Knox's knowledge to the Church as being "rather contrived", the finding of knowledge on the part of the Church in 2004 meant that its blanket notification pursuant to ss 40(3) in 2009 was not made 'as soon as reasonably practicable after it became aware' of the facts in 2004, and was therefore invalid. In other words, notification ought to have occurred in 2004.

[3] *Did s 54 of the ICA apply to remedy the Church's failure to notify as soon as reasonably practicable* – The Church argued that its failure to notify in 2004 could be remedied by s 54 of the ICA (Insurer may not refuse to pay claims in certain circumstances). It is well established that s 54 does not apply to a failure to notify a circumstance unless there is a contractual deeming clause in the policy, which allows the insured to notify a circumstance within the policy period and that any subsequent claim arising out of that notified circumstance will be deemed to be first made at the time of the circumstance notification. The Courts have taken a different approach and disallowed the application of s 54 where there is no contractual deeming clause and the insured merely seeks to rely on ss 40(3) for a late notification. A failure to rely on ss 40(3) cannot be remedied by ss 54, because it is a failure to rely on the legislative

right provided by ss 40(3) and it does not arise as the effect of a contract of insurance. Here, the Court maintained that s 54 did not assist the Church where it sought to rely on ss 40(3) but yet had failed to notify relevant facts as soon as reasonably practicable.

[4] *Was the prior known circumstance in Exclusion 7(c) void either by reason of ss 33 (no other remedies) or 52 (contracting out prohibited) of the ICA?* - Allianz sought to rely on a prior known circumstance exclusion clause in the policies ("7(c)") to deny cover for any liability for or arising directly or indirectly from ... any Claim, fact, circumstance or occurrence: ... of which the Insured is aware before the commencement of the Period of Insurance, which may give rise to a claim. The Court acknowledged the distinction between a prior known circumstance exclusion (which defines the extent, or parameters of, cover provided, i.e. cover does not extend to claims arising from known circumstances) and the duty of disclosure which requires the insured to disclose all relevant known information. By that distinction, the Court reasoned that the exclusion clause was not rendered void by s 33 because it did not affect the duty of disclosure. The Court opined that *"Policies of insurance provide cover for risks, not for fortuities that are known or risks that are already manifest. The exclusion of risks of that kind is consistent with delimiting the extent of cover rather than conferring a right upon the insurer in the event of a breach of the duty of non-disclosure"*.

However, the majority went on to hold that the exclusion clause was void by reason of s 52 which provides, relevantly *"Where a provision of a contract of insurance... purports to exclude, restrict or modify, or would, but for this subsection, have the effect of excluding, restricting or modifying, to the prejudice of a person other than the insurer, the operation of this act, the provision is void"*. The Court held that an "effect" of the clause was that it confined the policy coverage to an extent that is dependent upon the insured's awareness of facts before the commencement of cover. However, if that exclusion was omitted, a failure by the Church to disclose those facts prior to policy inception would be a breach of disclosure, the consequences of which are limited by s 28 which requires insurers to establish prejudice, rather than a blanket exclusion.

Therefore, to deny liability, Allianz had to demonstrate prejudice (i.e. it would not have insured the Church if proper disclosure had been made). But, Allianz did not bring a non-disclosure case. The Court held that the Act expressly requires a stipulated

disclosure process and provides for the limitation of an insurer's right to limit its cover by reference to what had not been disclosed to it, and yet Allianz's exclusion clause had the effect of excluding, restricting or modifying the operation of s 28. The Court held that the clause had the effect of transforming a matter of disclosure (i.e. the insured's knowledge that bears upon the insurer's decision whether to accept the risks to be insured) into a general exclusion from cover in all instances. As such, it substantially excluded the application of the duty of disclosure provisions to the policy, and was therefore, by operation of s 52, was void.

It is reasonable to expect an application for special leave to appeal to the High Court.

Until then, the apparent implications of the decision are that insurers may not be able to rely upon a Prior Known Circumstance Exclusion to deny or limit cover. In such circumstances, an insurer's sole remedy will be to establish a breach of the insured's duty of disclosure or misrepresentation of the risk along with the resultant prejudice to the insurer. That, in turn, places greater emphasis on the need for underwriting evidence to establish those disclosure issues, such as underwriting guidelines and compliance with them, the nature and extent of questions asked in the proposal, and the importance of those issues to the underwriter's deliberation and decision. It will also require evidence to support the hypothetical question of what the underwriter would have done if proper disclosure had been made. Otherwise, Prior Notification and Retroactive Date Exclusions should still be operative, as those confine the scope of cover, rather than affect the operation of the ICA.

Natural disasters: uninsurable, unaffordable, or both? ⁷

In Australia, the frequency and severity of natural disasters such as droughts, bushfires, cyclones and major flooding have increased over recent years. Modelling indicates that, at present, that trend is likely to continue. As well as the immediate, tragic and devastating effects of natural disasters, there are flow-on effects that reverberate for years. Impacts and implications for insurance are among those flow-on effects. As a result, the cost of extreme weather is growing across the nation.

⁷ "Spotlight on: Insurance affordability and availability", Elkington Bishop Molineaux Insurance Brokers Pty Ltd, 30 January 2025: <https://www.ebminsurace.com.au/resources/news/climate-change-vs-insurance/>

The recent California wildfires have exposed a growing insurance crisis with potentially global implications.⁸ For instance, major insurers are withdrawing from or restricting coverage in California due to increasing wildfire risks, rising construction costs, and state-imposed premium caps. The state-run FAIR Plan program which provides insurance to those who cannot get coverage from private insurers, is facing a surge in demand and potential strain from wildfire damage. Analysts estimate that the insurance losses could be more than \$20 billion. Many homeowners in fire-prone areas are left without adequate insurance coverage, struggling to rebuild after wildfires. California's Department of Insurance has issued new regulations requiring insurers to increase their wildfire coverage in high-risk areas. Insurers are passing on reinsurance costs to consumers, further driving up premiums. The increasing frequency and severity of wildfires are exacerbating the insurance crisis, making it harder for insurers to manage risk. One major insurer, State Farm, has announced it will not renew policies in certain California postcodes deemed too risky for wildfire. The upscale Pacific Palisades area, which was heavily impacted by the recent fires, has seen a significant number of insurance policies cancelled or not renewed.

According to the Insurance Council of Australia, since the 2019-20 Black Summer Bushfires, insurers have paid out \$16.8 billion in claims from 13 declared insurance catastrophes or significant events. In 2022 alone, there were more than 302,000 disaster-related claims lodged from four declared insurance events across the country, costing \$7.26 billion in insured losses. Of these losses, some \$6 billion stemmed from the northern New South Wales and south-east Queensland floods early in that year – the costliest insured event in Australian history and, according to global reinsurer Munich Re, the second costliest insured event in the world in 2022. Australia's National Insurance Brokers Association (NIBA) notes that over the past five years, insurers have incurred \$20.9 billion in claims due to natural disasters. In comparison, insurers incurred less than half that (\$9.9 billion) in the five-year period prior. According to Swiss Re, global insured losses from natural catastrophes exceeded \$100 billion for the fourth consecutive year in 2023.

⁸ “California fires put spotlight on insurance chaos” by Cat Woods, published on 17 January 2025 in the Law Society of NSW Journal.

Research by the McKell Institute in 2022 found the direct costs from extreme weather events in Australia are estimated to grow by 5.13% each year (before inflation) and reach \$35.24 billion (in 2022 dollars) by 2050.

Insurance prices risk and, as risk from extreme weather worsens, so do pressures on insurance affordability in risk-exposed areas of Australia. According to the Actuaries Institute, in 2023, more than one million Australian households experienced some form of insurance affordability stress (defined as paying more than four weeks of household gross income towards annual home insurance premiums). According to the Climate Council, climate change is creating an insurability crisis in Australia due to worsening extreme weather and sky-rocketing insurance premiums.

The Australian Bureau of Statistics Insurance recorded that premiums rose 16.2% in the year to the December 2023 quarter (in the previous 12 months, to December 2022, prices rose 6.3%). This marked the fastest rate of any consumer spending category and the largest increase since 2001. In some cases, insurance premiums in disaster-prone regions have increased by up to 400%. The ABS attributes this overall increase to higher reinsurance and natural disaster costs, which have driven up premiums for house, home contents, and motor vehicle insurance.

The Law Council notes that households and small businesses in affected regional and rural areas are plagued by chronic underinsurance and significant insurance affordability stress.

The Australian Small Business and Family Enterprise Ombudsman's *Small Business Natural Disaster Preparedness and Resilience Inquiry Report* found that many businesses cannot secure appropriate insurance at an affordable price, and some businesses are operating uninsured, or significantly underinsured, with excesses that would preclude any claim being made.

NIBA notes that insurance products may be unavailable due to a lack of available cover within a region or class, or the insurance premiums are so high as to be unaffordable to the average policyholder, making insurance effectively unavailable. "This phenomenon is already occurring in parts of Northern Australia where on average, home insurance premiums are almost double that of the rest of Australia."

The World Economic Forum *Global Risk Report 2024* estimates that nearly 521,000 Australian homes are predicted to be uninsurable by 2030 due to the risks of extreme weather.

Modelling from Climate Valuation shows 380,000 properties in Australia – equating to about one in every 20 homes – are either uninsurable or unaffordable to insure, and within the decade this figure will rise to one in 10 properties.

Without insurance, those affected by natural disasters will find it harder, if not impossible, to recover from a catastrophic event.

Recognising the growing problem, the Australian Government established the Hazards Insurance Partnership in the October 22-23 budget, and the Insurance Affordability and Natural Hazards Risk Reduction Taskforce in May 2024 to develop strategies for mitigating disaster impacts and address affordability issues across the insurance sector.

On 16 May 2024, the Senate established the Select Committee on the Impact of Climate Risk on Insurance Premiums and Availability. The Committee was charged with investigating and reporting on the unaffordability and unavailability of insurance in some regions due to climate-driven disasters, and how this can be addressed.

On 26 November 2024, after conducting six public hearings and receiving 56 submissions from agencies, industry and the public, the Committee released its report. It contained eight recommendations designed to help drive down premiums, improve community resilience, improve insurance industry transparency, boost disaster preparedness, and better protect Australians in the face of worsening extreme weather. The recommendations centre around governments, communities and insurers working together to improve resilience to extreme weather risk.

In summary, the Committee recommended:

- [1] Establish and maintain a publicly accessible national disaster risk map in collaboration with all levels of government and the insurance industry.
- [2] Require insurers to provide policyholders with detailed explanations of premium costs, including how disaster resilience efforts affect pricing.
- [3] Require the Australian Competition and Consumer Commission (ACCC) to monitor and publish premium prices across Australia.

- [4] Phase out general insurance taxes through intergovernmental cooperation.
- [5] Expand the Cyclone Reinsurance Pool to include all natural disasters.
- [6] Increase federal investment in resilience measures.
- [7] Review land use and planning policies to reduce future exposure to high-risk areas.
- [8] Introduce a levy on coal and gas extraction companies to fund disaster mitigation and offset rising insurance premiums.

The committee's findings are likely to significantly influence future government policies and the insurance industry. Key industry representatives (including the ICA, NIBA and Australian Consumers Insurance Lobby) welcomed the findings and support a number of the recommendations. It remains to be seen which recommendations will be adopted and successfully actioned, and how these might influence cover going forward.

Another facet of addressing the problem going forward is the need to rebuild with sustainability and safety as priorities. California Governor Gavin Newsom has said he is overriding the environmental regulations that would have delayed rebuilding to ensure very fast rebuilding. However, as Kirsty Evans, the Director of Cheney Suthers Lawyers and The Law Society of NSW's 2024 President's Medal winner, points out, without comprehensive environmental risk management protocols taking place, nor the requirement to meet certain standards of sustainability and disaster-aversion, "there is a very real risk" that insurance companies will avoid this market.⁹

Ms Evans also noted that "... in the context of Australian law, the committee for the Parliamentary Inquiry into insurers' responses to the 2022 major flood claims recommended that building codes and planning rules be strengthened to future proof and improve the resilience of communities and households. This is in stark contrast to the position of Governor Newsom. Without environmental risk management and adherence to disaster-aversion protocols, insurers may model significantly higher risks associated with properties rebuilt in catastrophe prone areas. Homes that are reconstructed without incorporating sustainability or mitigation measures, such as fire-resistant materials, proper zoning, or defensible space, are inherently more vulnerable

⁹ From the Cat Woods article, *ibid* at fn 8.

to future disasters. This heightened vulnerability could result in substantially higher claims costs for insurers. Ultimately, a considered, careful rebuilding strategy is good for insurers and good for residents. Insurers base their premiums and coverage decisions on catastrophe-modelled calculations of risk. If the rebuilding process neglects appropriate standards, leading to increased risks of property damage or loss, insurers may find themselves facing unsustainable financial exposure. As a result, they may respond by raising premiums, limiting coverage options, or even withdrawing entirely from high-risk markets where the risk outweighs the potential returns.”