Interest on late payment **CR379**

Dispute about calculation of payment in respect of a disability claim based on psychiatric grounds; whether interest payable.

Background

1. The complainant last worked on 21 January 2014. She lodged a disability claim in respect of depression (for a lump sum) with the insurer on 10 March 2014. At this time the cover amount was R3 675 000.The claim was repudiated in October 2014, and an ongoing dispute about this arose. At all times the complainant continued to pay premiums.

2. The insurer eventually asked a psychiatrist well-versed in insurance matters to assess the complainant. His report, dated 16 July 2016, concluded that her multiple symptoms prevented her from working, but that it was still premature to consider her condition permanent. He recommended admission to hospital for an observation period and treatment in a multidisciplinary setting. The complainant was subsequently admitted to hospital, following which her psychiatrist reported that her psychiatric and physical symptoms impaired her capacity to return to work, and recommended medical boarding.

3. The insurer admitted the claim on 6 August 2015. By this time the lump sum had increased to R3 895 500.

4. The insurer determined the date of disability to be 21 January 2014, and the lower amount of R3 675 000 was paid, together with a refund of premiums from January 2014. No interest was paid. The complainant claimed the higher amount, ie R3 895 500, on the basis that this was the amount payable at the date when the claim was admitted.

5. The insurer's position was that permanence of a depression claim could not be determined until up to two years of treatment had been undergone, but that the date of disability, as determined by the insurer, governed the cover amount payable.

6. The Chief Medical Officer's reasoning was set out as follows:

> "A medical condition is calculated as permanently disabling using the following logic:
> - The day the impairment prevented the claimant from going to work, provided that
> - The impairment has been treated adequately, according to guidelines laid down by the appropriate specialist group
> - Permanence can only be determined once treatment of the condition has failed
> - Only then can it be calculated that the date of permanence is the day that the impairment initially prevented the claimant from going to work, or when the impairment commenced
>
> The reasons for this are the following:

- Some conditions need to be treated for up to two years before 'permanence' can be established
- In this time many claimants are unable to work and have no other source of income, and their policies might lapse
- It will not be possible to pay out claims if the date of permanence is considered that date when it was determined that treatment had failed, and the policy had lapsed
- It is logical that permanence often can only be determined after a while, and should therefore be retrospectively applied to the date that the impairment actually commenced or was diagnosed".

7. Our office requested a copy of the claim acceptance letter from the insurer. The letter furnished to us, dated 13 August 2015, reads as follows:

> "Good day
>
> CONFIRMATION OF PAYMENT
>
> Thank you for all the documents submitted to date. We are happy to confirm that we have now received all the outstanding information needed for the payment of your claim.
>
> We confirm that payment has been made as follows on 12/08/2015:
>
> Payee
> [Complainant]
>
> Amount
> R3 765 000 (CLAIM AMOUNT)
> R18 637.00 (REFUND OF PREMIUMS)"

Arguments concerning interest

8. The question of interest on the capital amount from 21 January 2014 had been raised by our office, in the course of the investigation of the complaint.

9. The insurer's response was that the medical evidence in support of the claim was received on 28 July 2015, and the claim paid on 12 August 2015, so no interest was payable.

10. It was contended that this position was in line with the Life Offices Association (LOA) guideline on interest for late payment of claims, which is to the effect that interest is payable on an equitable basis (even if there is no liability in law) once a claimant has duly submitted proof of entitlement to the insurer (the claim documentation) and it is shown that the insurer, having had a reasonable time to consider the claim, did not make payment. (The LOA guideline indicates that an insurer should be able to make a decision on a disability claim within 120 days.)

11. Our office had then pointed out that the insurer had derived value from non-payment of the benefit after January 2014, as it retained the value of a benefit which the insurer decided accrued to the complainant as at

January 2014. We had expressed the view that it was not equitable for an insurer to require the insured to wait for a long period while permanence was established and then to receive a lump sum disability benefit as at the disability date many months prior to the determination of permanence, without interest being paid.

12. The insurer's senior legal adviser responded as follows:

> "The client's own specialists indicated over an extended period of time that she is in fact not permanently disabled, alternatively failed to properly substantiate the claim. As late as 16 July 2015 [the psychiatrist] still advised that her condition does not present permanent disability. From the medical evidence it appears that right up to admission of the claim on 6 August 2015, it was not all that clear whether the definition of permanent disability has been met. Further, my understanding is that the client failed to follow the optimal treatment procedure prescribed by the medical practitioner. However, [the insurer] gave the client the benefit of the doubt in admitting the claim. In doing so, I believe [the insurer] has already acted fairly and equitably towards the client".

13. The insurer's product actuary commented as follows:

> "[The insurer's] stance has been strict application of the contract and ASISA guidelines and I don't think this can be disputed. The contract states when the benefit is calculated (date of event) and the guidelines refer to receipt of all relevant information, which only happened shortly before the payment. But given that it was a marginal call on admitting the claim (there's a strong argument for no claim), [the insurer's] view is that it has gone beyond fairness already and further compensation (interest) is unfair. Overall, it's hard to see a strong case for inclusion of interest on the grounds of fairness given the overwhelming sense of fairness in paying the claim. While the claim was admitted, there's a significant 'ex-gratia' element to the decision and the amount, which implicitly includes additional compensation beyond the letter of the contract. Even without this, the contract, agreed to by the customer, clearly states the benefit amount and the industry guidelines recommend no interest be paid".

Discussion

14. The case was referred to an adjudicators' meeting for discussion.

15. The policy provided that:

> "The Cover Amount is determined as at the date on which the Life Covered became Occupationally Disabled. This date must be confirmed by [the insurer's] Chief Medical Officer".

16. The meeting was satisfied that the Chief Medical Officer's decision to confirm 21 January 2014 as the date on which the Life Covered became Occupationally Disabled (as defined in the policy) had been a rational and reasonable exercise of his discretion to determine the date of disability. The insurer admitted the claim on 6 August 2015, a confirmation that by that date it considered the complainant to have met the requirements of the definition. These included the requirement for permanence, as treatment of the condition was shown to have failed over a long period, establishing that the disability was of a permanent nature. 21 January 2014 was the last date that the complainant had

worked, and this must retrospectively be considered the date the disability commenced. This date determines the applicable cover amount, which in January 2014 was R3 675 000. Premiums paid after the date of disability were correctly refunded.

17. The meeting then considered the question of interest.

18. Our rules enjoin us to accord due weight to considerations of equity (Rule 1.2.4). Specifically, Rule 3.2.6 provides that we may "*order a subscribing member, in addition to any other recommendation or determination made, to pay interest to a complainant on the pertinent sum at a rate and from a date that is considered to be fair and equitable in the circumstances*".

19. We are not restricted by the LOA guidelines on the payment of interest, although we will obviously take these into consideration.

20. The meeting was of the view that the insurer had not taken account of the prejudice to the complainant inherent in being obliged to wait until permanence could be established (in itself a reasonable requirement), but then having her benefit backdated to the date on which her permanent condition was retrospectively determined to have begun. There had been no consideration of the fact that she had been without the benefit from this date of disability, and that the insurer had had the use of the money over that period.

21. The comments of the senior legal adviser appeared to blame the complainant for the fact that it was not proved from the outset that she was permanently disabled. This was at odds with the more compelling view of the Chief Medical Officer that it was logical that permanence could only be determined after a while.

22. It was also ironic that insurers have sometimes used the reverse argument to defend a claim apparently lodged late (outside policy time limits for lodging claims). For example, if a claimant waits out a period of unsuccessful treatment and then lodges a claim, the argument is made by some insurers that the claim should have been lodged soon after the diagnosis or first day unable to work, regarded as the "date of disability". Some insurers then use this "late lodging" as a contractual defence against paying a claim.

23. The comments of the product actuary made out a case that the insurer had "gone beyond fairness already" in admitting a claim on which there was a "strong argument for no claim", and therefore a "significant 'ex-gratia' element to the decision".

24. The problem with this was that at no stage did the insurer indicate to the complainant that it had made an *ex gratia* decision, or that it was making a decision to admit the claim based on fairness even though it considered that there was a strong argument for no claim. Payment was

not couched or offered as a settlement in view of any stated arguments for no claim. The claim was simply admitted and paid. The rationalisations were only made after the fact.

25. It was so that the insurer only received the final medical information which it accepted as confirming permanence in July 2015. Strict compliance with the LOA guidelines for paying interest on late payment would support payment of interest "*once the claimant has submitted proof … that would satisfy a reasonable insurer that he has a valid claim in terms of the policy; and the insurer has had a reasonable time to consider the claim*".

26. However the meeting was of the view that the strict application of the provisions of the contract in conjunction with the industry guidelines produced a result which was unfair.

27. It was noted that it is not an uncommon situation for a date of disability to be determined retrospectively, for example where permanence can only be established after a period of unsuccessful treatment, and in our experience it is the usual practice that insurers pay interest on a lump sum as from date of disability, or pay arrear monthly disability payments as from date of disability.

28. The meeting was of the view that this particular case cried out for some accommodation of the complainant's position, on grounds of equity. It viewed the insurer's attitude as one of "trying to have its cake and eat it", in that it was not prepared to pay the higher lump sum value as at the date of admission of the claim, but also was not prepared to pay interest from the retrospectively determined date of disability.

Result

29. A provisional ruling was made against the insurer in the following terms:

    31.1 The complainant was not entitled to the higher benefit value of R3 895 500. Payment of the benefit value of R3 675 000, being the value applicable as at 21 January 2014, was correct.

    31.2 The insurer must pay interest to the complainant on the claim value as at the date of disability, calculated from 8 July 2014 (being 120 days after the complaint was received) to date of payment, at the rate offered by Standard Bank on deposits for a period of 12 months.

30. The insurer accepted the provisional ruling, and interest in the amount of R242 952 was paid to the complainant.

SM
October 2017