Insurance contract law reform Bill

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This is latest in a series of technical legislative measures with the broad remit of updating insurance statute law. Whilst the industry and, to an extent, commercial law have moved on, some of the statutory conditions date back over 100 years. Most of the Bill is derived from recommendations from the Law Commission and Scottish Law Commission and the Bill will be treated according to the accelerated procedures associated with Law Commission measures. The Bill includes provisions on disclosure; the treatment of fraudulent claims; requires insurers to act with 'good faith'; limits the use of warranties in contracts and provides for the expansion of the groups of individuals or companies which can be affected by the existing third party rights against insurers provisions.

The Bill applies to the whole of the UK, different parts applying to N. Ireland where appropriate.

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1 Introduction

Problems

In the year ending March 2014, 84% of new cases brought to the Financial Ombudsman were about insurance related matters.[1] Even ignoring the fact that the overwhelming majority of these (76% of new cases) were PPI related, insurance contracts have formed a 'healthy' 10% of the Ombudsman's caseload over a number of years.

At the heart of many complaints is a failure on the part of insurers to meet the generalised expectations of consumers. Those expectations are forged in a legal framework drawn up in the 18th and 19th centuries, 'clarified' by a shipping Act at the start of the 20th century and mostly executed with all these ease and complacency of a few clicks on 21st century technology. Perhaps the wonder is that there are so few complaints rather than that there are so many.

It has been long recognized that the interaction between insurance statute law, the body of common law interpretation of individual cases and the technological developments in society has produced an incoherent whole. The Insurance Bill's explanatory notes state that:

> Its provisions are now significantly out of line with best practice in the modern insurance market. The law has also failed to keep pace with developments in other areas of commercial contract and consumer law, and with insurance law in other jurisdictions.[2]

Legislation reviewed

This is not the first time in recent history that the Law Commission has looked at insurance law and legislation has resulted. Two recent Acts, *Third Parties (Rights against Insurers) Act 2010* and the *Consumer Insurance (Disclosure and Representations) Act 2012* looked at aspects of general applicability of the market and at one of the specific causes of significant consumer –industry argument (disclosure).[3] The third insurance – related Law Commission Report forms the basis of this new Bill.

2 Law Commission Report[4]

The Report was published in July 2014: *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late Payment.*[5] The accompanying press release from the Law Commission outlines the key elements of their recommendations (most but not all are included in the Bill, where they are not the fact is **highlighted**). [Commentary added by author]:

> **A duty of fair presentation in non-consumer insurance**

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1 Financial Ombudsman, *Annual Review 2014*, p42

2 Explanatory Notes pp7

3 More information on these Acts can be found in Library Research Papers on both bills *Third Parties (Rights against Insurers) Bill* and the *Consumer Insurance (Disclosure and Representations) Bill*

4 Law Commission includes Scottish Law Commission unless otherwise stated

5 Law Com 353 / Scot Law Com 238

The 1906 Act imposes a duty on a prospective policyholder to disclose to the insurer "every material circumstance" which would "influence the judgment of a prudent insurer" in fixing the premium or deciding whether to take the risk.

Many businesses have little idea of what might influence a prudent insurer. Yet the penalties for failure to disclose information to insurers are harsh. If a policyholder fails to disclose material information, the insurer may treat the policy as if it does not exist and refuse all claims under it.

We identified several problems with the current law, including:

The duty of disclosure is poorly understood.

Knowing how to comply with the duty is difficult, particularly for large companies.

The law encourages data dumping by businesses.

[Data dumping is where the insured company gives an insurer a large amount of undigested information for the insurer to sort through and decide what's relevant and thus comply with its obligations.]

The law encourages underwriting at claims stage.

The remedy for failure is too harsh.

We therefore recommend:

- Replacing the duty of disclosure with a duty of fair presentation based on developments in case law, covering what should be disclosed and the form of disclosure.
- Encouraging insurers to take a more active role.
- Setting out rules concerning attribution of knowledge, particularly to non-natural persons such as companies.
- Putting the common law "inducement test" on a statutory footing.
- Providing a regime of proportionate remedies in the event of breach by the policyholder based on what the insurer would have done if it had received a fair presentation.

[The identical topic was addressed by the *Consumer Insurance (Disclosure and Representations) Act 2012* (CIDRA) as it applied to individuals who were similarly often unclear about what was required of them.]

Warranties and other terms

An insurance warranty is a promise made by the policyholder to the insurer which, if broken, has harsh consequences for the policyholder. The general principles of insurance warranty law are founded on the rulings of Lord Mansfield in the eighteenth century, and codified in the 1906 Act.

A warranty "must be exactly complied with, whether material to the risk or not". If not, then "the insurer is discharged from liability from the date of the breach of warranty". Once a warranty is breached, the policyholder "cannot avail himself of the defence that the breach has been remedied, and the warranty complied with, before loss".

We identified several problems with the current law:

An insurer may refuse a claim for a trivial mistake which has no bearing on the risk.

The insured cannot use the defence that the breach was remedied before any loss occurred.

Breach of warranty discharges the insurer from all liability, not just liability for the type of loss in question. For example, a failure to install the right sort of burglar alarm would discharge the insurer from liability for a flood claim.

A statement may be converted into a warranty using obscure words that few policyholders understand. For example, if a policyholder signs a statement on a proposal form that their answers form the "basis of the contract", this can have draconian consequences.

We make three recommendations in this area:

- Abolish "basis of the contract" clauses in business insurance, having already done so for consumer insurance in CIDRA.
- Where a warranty has been breached, the insurer's liability should be suspended, rather than discharged. Where a breach has been remedied before loss, the insurer should be brought back on risk.
- Where a term relating to a particular type of loss, or loss at a particular time or in a particular location, is breached, the insurer's liability should only be suspended in relation to that type of loss or loss at that time or place.

The final of these recommendations was not included in the Insurance Bill introduced into Parliament by the Government in July 2014.

Insurer's remedies for fraudulent claims

The law should provide clear remedies for the insurer where a policyholder makes a fraudulent claim, yet the current law appears confused and contradictory.

Under the common law, the fraudster forfeits the fraudulent claim. However, section 17 of the 1906 Act gives the insurer a statutory remedy of avoidance of the whole contract in the event of a breach of good faith. In theory, this allows the insurer not only to refuse to pay any part of the fraudulent claim, but also to avoid the entire policy from the outset, with the parties being returned to their pre-contract position. This means the insurer could recover from the policyholder any sums previously paid out on genuine claims. Although, in practice, the courts have been reluctant to apply the remedy of avoidance, its status is still uncertain.

As a result, it is not clear whether the insurer is liable to pay other genuine claims, whether they arise before or after the fraud.

[This has been a contentious issue. The insurers argue when there is proof that a claim is fraudulent or exaggerated unless the courts invalidate the claim entirely there is no deterrence to the making of them. The issue was raised by way of government new clauses to the *Criminal Justice and Courts Bill* currently before the House. Commentary on the issue can be found in the Library's standard note on the committee stages.[6]]

We recommend:

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6 HCL SN/HA/6882, p29

Where an insured makes a fraudulent claim, the insurer should not be liable to pay the claim and should be able to recover any sums already paid in respect of it.

In addition, the insurer should have the option to treat the contract as having been terminated at the time of the fraudulent act.

The insurer should remain liable for genuine losses before the fraudulent act.

Damages for late payment

Where an insurer has unreasonably refused to pay a claim or paid it only after unreasonable delay, the current law in England and Wales does not provide a remedy for the insured. Notably, the insured is not entitled to damages for any loss suffered as a result of the insurer's unreasonable actions.

This differs from the law in Scotland and most major common law jurisdictions, where such damages are available. The legal position in England and Wales is anomalous and out of step with general contractual principles.

We consider that a policyholder should have a remedy where an insurer has acted unreasonably in delaying or refusing payment. However, we recognise that insurers need a reasonable time to investigate claims, and that the length of time required will depend on factors such as the type of insurance and the complexity of the claim. We also understand that the speed with which a claim can be paid may depend on the insured themselves, and other factors outside the insurer's control. Furthermore, insurers have an obligation to ensure that only valid claims are paid.

We recommend:

- An implied term in every insurance contract that the insurer will pay sums due within a reasonable time. Breach of that term should give rise to contractual remedies, including damages. In Scotland, a statutory provision would serve to confirm and clarify the position already established at common law.
- Guidance as to factors to be taken into account when considering what constitutes a "reasonable time".
- Insurers should not be liable for delays caused by genuine disputes.

The recommendations relating to late payment are not included in the Insurance Bill.

Good faith

The law currently provides for avoidance of the insurance contract where either party breaches the duty of good faith. We recommend removing this remedy. Good faith should be retained as an interpretative principle.[7]

[In plain language: insurers should act in good faith towards their customers and should not be able to avoid this by way of contractual terms].

3 The Bill

This Bill is being introduced as a Law Commission bill to which specific procedures apply, i.e. an accelerated debate format commencing In the House of Lords.[8]

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7 Law Commission press release 17 July 2014

The Bill as first printed can be found here. The explanatory notes can be found here. The relevant Law Commission Report can be found here: *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late Payment*. The Law Commission's webpage, including many other documents about the Bill can be found here.

As the section above highlighted, not all the recommendations of the Law Commission have been taken forward, in particular the late payment penalty regime has not been incorporated.

Clause 1 provides definitions of the insurer and the insured but, like the 1906 Act it updates, it does not define 'insurance'. The main point of the measure is to distinguish between insurance for individuals and insurance for companies – "consumer" and "non-consumer insurance contracts. This is important for the next clause.

Clauses 2 and **clause 3** extend the reforms to the principles for disclosure (called here the "duty of fair presentation") established by the *Consumer Insurance (Disclosure and Representations) Act 2012* (the 2012 Act or CIDRA) to non-consumer contracts.

A substantial element in the pricing of insurance is the degree of risk, or likelihood, of the insured event happening. Some elements of the risk are public knowledge, for example how likely it is that an area will flood, and the insurance company can make its own assessment of this. Other elements are known only to the insured, for example their health. The insurers try to discover these by asking questions in the proposal. Some questions – age, gender etc – are specific, however, insurers also rely on customers disclosing all relevant facts.

Since the overwhelming majority of people who take out insurance are neither underwriters nor insurance lawyers their grasp of what information is relevant and what is not is less than perfect. This can lead to disputes if insurance companies refuse a claim on the grounds of non-disclosure.

The legal principle of utmost good faith was established by the *Marine Insurance Act 1906* but it has been subsequently applied to all (non-marine) contracts of insurance. Since 1906 the practice of the industry, its regulators and those involved with dispute resolution has evolved. New rules and best practice guides have added further 'layers' of regulation and complexity to the original statute law. When the Law Commission first examined the workings of the non-disclosure rules they found them wanting as against modern business practice, standards and consumer expectations. This resulted in the 2012 Act which replaced the duty of the consumer to volunteer relevant material information to the company with a duty on them to take reasonable care not to make a misrepresentation during the pre-contractual stage. Clause 3(3) – (4) defines the principle

(3) A fair presentation of the risk is one —

> (a) which makes the disclosure required by subsection (4),
>
> (b) which makes that disclosure in a manner which would be reasonably clear and accessible to a prudent insurer, and
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> (c) in which every material representation as to a matter of fact is substantially correct, and every material representation as to a matter of expectation or belief is made in good faith.

(4) The disclosure required is as follows, except as provided in subsection (5) —

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[8] For details see First Report of the Procedure Committee 2007/8

(a) disclosure of every material circumstance which the insured knows or ought to know, or

(b) failing that, disclosure which gives the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances.

Clause 3(5) provides exceptions to the disclosure rule that replicate provisions in the 1906 Act:

(5) In the absence of enquiry, subsection (4) does not require the insured to disclose a circumstance if—

(a) it diminishes the risk,

(b) the insurer knows it,

(c) the insurer ought to know it,

(d) the insurer is presumed to know it, or

(e) it is something as to which the insurer waives information.

Clause 8 provides the insurer with remedies if there is a breach of the duty of fair representation. The standard of fault for non-consumers is set differently from consumer contracts under the 2012 Act, the explanatory notes explain:

> 79. An insured will have acted deliberately if it knew that it did not make a fair presentation. An insured will have acted recklessly if it "did not care" whether or not it was in breach of the duty, but this is intended to indicate a greater degree of culpability than acting "carelessly". "Deliberate or reckless" is particularly intended to include fraudulent behaviour.
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> 80. The deliberate or reckless definition echoes that in [the 2012 Act]. However, in [the 2012 Act] a "qualifying breach" must be either deliberate/reckless or careless, since the consumer's duty is to take reasonable care not to make a misrepresentation to the insurer. In non-consumer insurance, breaches do not have to be careless or deliberate/reckless in order to be actionable. "Innocent" breaches of the duty will also give an insurer a remedy if the insurer can show inducement. This reflects the current law for non-consumer insurance.[9]

The bill widens the remedies available to an insurer if there is a breach, currently the insurer can only 'avoid' the contract which is akin to an all or nothing 'devil take all' option. **Schedule 1** sets out a range of remedies that apply in cases of deliberate or reckless breaches (the same option as now) and a range of alternative and proportionate remedies in other cases.

Clause 9 again extends a reform under the 2012 Act to non-consumer insurance contracts namely to abolish the general effect of inserting warranties in contracts.

Clause 11 remedies for fraudulent claims

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[9] Explanatory notes pp79-80

The issue of inflated insurance claims is hardly and it is not always deliberate. For example, individuals seldom have a good idea of what their property is worth – it is possible that underinsurance is as common as false claims.

Recently, the insurance industry has taken a rather tougher stance on cases where it believes there is deliberate and substantial inflation of claims. Arguing that in such cases the whole of the claim should be thrown out not just the fraudulent part. Zurich Insurance took action against a policy holder to the Supreme Court in 2102. The claim for £838,000 damages had been reduced by a County Court to just £88,716 covering the genuine part of the claim. The insurer/respondent took the case to the Supreme Court and argued that the whole claim should be dismissed. The Supreme Court dismissed their claim saying:

> We have reached the conclusion that, notwithstanding the decision and clear reasoning of the Court of Appeal in *Ul-Haq*, the court does have jurisdiction to strike out a statement of case under CPR 3.4(2) for abuse of process even after the trial of an action in circumstances where the court has been able to make a proper assessment of both liability and quantum. However, we further conclude, for many of the reasons given by the Court of Appeal, that, as a matter of principle, it should only do so in very exceptional circumstances.[10]

The industry argued that without the expectation that the complete claim would be rejected if the fraud is discovered, there is no deterrent to making inflated claims in the first place. The judgement commented on this view:

> 50. It was submitted on behalf of the defendant that it is necessary to use the power to strike out the claim in circumstances of this kind in order to deter fraudulent claims of the type made by the claimant in the instant case because they are all too prevalent. We accept that all reasonable steps should be taken to deter them. However, there is a balance to be struck. To date the balance has been struck by assessing both liability and quantum and, provided that those assessments can be carried out fairly, to give judgment in the ordinary way. The reasons for that approach are explained by the Court of Appeal in both *Masood v Zahoor* and *Ul- Haq v Shah.*
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> 51. We accept that such an approach will be correct in the vast majority of cases. Moreover, we do not accept the submission that, unless such claims are struck out, dishonest claimants will not be deterred. There are many ways in which deterrence can be achieved. They include ensuring that the dishonesty does not increase the award of damages, making orders for costs, reducing interest, proceedings for contempt and criminal proceedings.

Clause 11 puts the common law rule of forfeiture on a statutory footing. It exempts the insurer from having to pay a claim and starts this from the time of the fraudulent act – rather than from the time of the fraudulent claim. **Clause 12** gives the insurer remedies where there is fraud by one member of a group scheme.

Clause 17: *Third Party (Rights Against Insurers) Act 2010*

The *Third Party (Rights Against Insurers) Act 2010* is the second recent piece of legislation aimed at reforming the insurance industry. The core purpose of the Bill was outlined by the then Government Minister, Lord Bach, during his opening remarks in the Second Reading in Grand Committee in the Lords:

> Put simply, its core purpose is to create a more straightforward and cheaper route to compensation for people who find themselves caught up in a dispute with someone

[10] Supreme Court; *Fairclough Homes Limited (Appellant) v Summers (Respondent);* 27 June 2012

> who is insolvent. To achieve this objective the Bill simplifies and modernises the procedure to be followed, not the substantive law underlying it.[11]

The Act provided a more certain and simplified procedure for the benefits accruing under an insurance policy to reach their intended recipient when the insured person become insolvent – either as a company or as an individual. The Act was though, anything but simple and emerged from a prior Law Commission paper on its own. The current Bill provides for changes to be made to the definition of the insolvent 'relevant person' which can be a person or company in the new procedures. In effect it allows for the possibility (and therefore presumably intends) to widen the definition of who can be a 'relevant person'. The changes would be made by regulation subject to the affirmative resolution procedure.

This part of the Bill is not derived from the current Law Commission Report but a 2001 one.

[11] HL Deb 7 December 2009, GC41