Archaic, unclear & unfair?

Part one: Consumer insurance law reform is long overdue, says Peter J Tyldesley

IN BRIEF
- Consumer insurance law is archaic, unclear and unfair.
- Measures including industry codes, FSA rules and the existence of an Ombudsman do not provide a full solution.
- The Law Commissions are expected shortly to recommend reform of the law to bring it into line with current best practice.

Later this year the English and Scottish Law Commissions will publish a joint final report on consumer insurance law. This is the culmination of a four-year project to review an area of law which is widely regarded as archaic, unclear and unfair. It is anticipated that the report will recommend reform of the rules on non-disclosure, misrepresentation and breach of warranty.

The critical flaw in insurance law is that it provides insurers with remedies which in many circumstances will be disproportionate. Much of the current law was established in commercial cases in the 18th and 19th centuries. At that time there was no mass market for insurance. Types of cover commonly bought by consumers today, such as household and motor insurance, simply did not exist. Insurance was typically arranged face-to-face rather than by telephone or over the internet. It is perhaps not surprising that unjust results are produced when old commercial rules are applied to modern consumer insurance contracts.

Take, for example, the rules on non-disclosure in general insurance cases. Insurance policies are contracts of the utmost good faith. A consumer seeking cover is obliged to disclose to the prospective insurer all material facts, that is facts which would have an effect, not necessarily decisive, on the mind of a prudent insurer in assessing the risk. If the insurer is induced to offer cover on particular terms by a non-disclosure it may, on becoming aware of the true position, avoid the policy. Avoidance means the policy is set aside from outset and any claims can be rejected. There are five main criticisms of these rules:

- The test of materiality requires the consumer to look into the mind of a prudent underwriter—few will have the expertise to do so.
- There is no obligation on the insurer to ask any questions.
- No allowance is made for the state of mind or conduct of the consumer—avoidance is permitted regardless of whether the policyholder acted fraudulently, negligently or entirely innocently.
- Once a policy has been avoided, any claim can be rejected, even if there is no connection between the non-disclosure and the loss.
- The law encourages inadequate underwriting. An insurer can limit the questions it asks when a policy is sold, knowing that if a claim is made it can search for non-disclosures to escape liability.

The potential impact of the law is demonstrated by the case of Lambert v Co-operative Insurance [1975] 2 Lloyd’s Rep 485. Brenda Lambert suffered a loss of jewellery. On investigating her claim, the insurer discovered that her husband had been convicted of a criminal offence prior to the policy last being renewed. At no point had the insurer indicated that it wished to be informed of such convictions. Nevertheless, it avoided the policy for non-disclosure and rejected the claim. The court was obliged to find in the insurer’s favour but Mr Justice MacKenna, as he then was, made clear his distaste: “The present case shows the unsatisfactory state of the law. Mrs Lambert is unlikely to have thought that it was necessary to disclose the distressing fact of her husband’s recent conviction when she was renewing the policy on her little store of jewellery. She is not an underwriter and has presumably no experience in these matters. The defendant company would act decently if, having established the point of principle, they were to pay her. It might be thought a heartless thing if they did not, but that is their business, not mine.”

Those who oppose reform seldom argue that the current law is sound. Instead they point to measures which may mitigate the harshness of the law—industry codes of practice, rules issued by the Financial Services Authority (FSA) and the existence of the Financial Ombudsman Service (FOS) to deal with complaints. Are these measures really a satisfactory alternative to law reform?

Industry codes
In 1977 the British Insurance Association, predecessor to the Association of British Insurers (ABI) published the Statement of General Insurance Practice. It did so as the price of an exemption from the Unfair Contract Terms Act 1977. This statement, amended in 1986, remained in force until statutory conduct of business regulation was introduced for general insurance on 14 January 2005. In respect of non-disclosure, the statement required insurers to ask questions about matters commonly found to be material. It also included the following provision: “Except where fraud, deception or negligence is involved, an insurer will not unreasonably repudiate liability to indemnify a policyholder: (i) on the grounds of non-disclosure...of a material fact when knowledge of the facts would...
not materially have influenced the insurer’s judgement in the acceptance or assessment of the insurance.’

This wording appeared to restrict the rights of insurers only in cases of innocent non-disclosure. Even then it seemed to contemplate that there might be some circumstances in which it would be reasonable to repudiate liability. The decision in *Pan Atlantic v Pine Top* [1995] 1 AC 501, [1994] 3 All ER 581 established that as a matter of law insurers had to show inducement before non-disclosure gave rise to a right to avoid. From that point onwards it must be doubted whether the statement offered the consumer any additional protection over the law. In any event the statement was not legally binding nor was there initially an ombudsman who could enforce it.

More recently, the ABI has conducted some worthwhile work in connection with the FSA’s Treating Customers Fairly initiative. Arguably the greatest advance is guidance on non-disclosure drawn up in initiative. Arguably the greatest advance is some worthwhile work in connection with the FOS and published in January 2008. From 19 January 2009 this guidance was upgraded to a code, so that insurers are required to follow it as a condition of membership of the ABI. The code largely adopts the approach taken by the FOS but incorporates some useful additional guidance and examples. Unfortunately at present it applies only to life and health-related insurances and is not legally binding.

**Financial Service Authority rules**

When the FSA took responsibility for conduct of business regulation of general insurance it issued rules effective from 14 January 2005. The current version of those rules is to be found the Insurance Conduct of Business Sourcebook (ICOBS). Under ICOBS 8.1 an insurer must handle claims fairly and not unreasonably reject a claim by avoiding a policy. In particular: “A rejection of a consumer policyholder’s claim is unreasonable, except where there is evidence of fraud, if it is for: (1) non-disclosure of a fact material to the risk which the policyholder could not reasonably be expected to have disclosed.”

Again the effects of this provision seem to be only to limit the rights of insurers in cases of innocent misrepresentation. If the non-disclosure was negligent then the policyholder could reasonably have been expected to disclose the fact concerned. There is a further difficulty in that the rules are not directly enforceable by a consumer. Instead the consumer has two options: (i) to complain to the FOS; or (ii) to pursue a case against the insurer for breach of statutory duty under s 150 of the Financial Services and Markets Act 2000.

**Financial Ombudsman Service**

The most effective protection for the consumer is undoubtedly the service provided by the FOS. Under s 218 of the Financial Services and Markets Act the FOS is obliged in respect of its compulsory jurisdiction to make decisions that are fair and reasonable in all the circumstances. Consequently whilst the FOS takes account of the law it is not obliged to follow it. In fact the FOS takes a robust line—it does not enforce the duty of disclosure. In Ombudsman News 46, the FOS indicated that if an insurer requires information it should instead ask a clear question.

**What’s new?**

This is not a novel approach. In December 1980 the Guardian Royal Exchange voluntarily declared that it would no longer rely on the duty of disclosure in consumer non-life insurances. The move was announced by Mike Harris, Assistant General Manager, who shortly afterwards established the insurance ombudsman bureau. His justification still rings true: “You cannot import into the way we handle bulk insurance products now the close contractual relationship derived from the time a ship or cargo owner dealt directly with an underwriter in a coffee house 300 years ago and bargained over a single voyage.”

“Defence of the traditional duty implies that although for many years we have handled hundreds of millions of transactions we still do not know all the right questions to ask. If this be so, then surely many of us should be seeking a living in some less demanding walk of life?”

**Unsatisfactory**

However the FOS is not a complete solution. There is a high attrition rate with complaints—it takes persistence to pass through an insurer’s internal complaints procedure and the possible stages at the FOS. And it is plainly unsatisfactory that anyone should have to complain to obtain fair treatment.

A consumer may in any event find it necessary to pursue all or part of their claim in the courts where the full harshness of the law applies. The FOS has a limit on awards of £100,000. Also, under the FSA rules there are various grounds on which the FOS can decline to deal with a complaint. For instance, after a final decision from an insurer the consumer has just six months to refer the matter to the FOS. And if there are evidential issues—for example evidence is needed from an uncooperative third party the FOS may decide a matter should be dealt with by the courts.

In November 2005 Nick Kirwan, then protection market director at Scottish Widows, recognised that these problems should be addressed by law reform: “Over the years, a gulf has opened up between what the law says and what is actually happening in the insurance industry. There are some important reasons to close the gap as not everybody is enjoying the jurisdiction of the Ombudsman. Their only recourse is through the court. By closing the gap, these individuals could receive the same protection as those covered by the Ombudsman.”

**The need for reform**

Reform holds little fear for the better insurers. They do not rely on their strict legal rights. Instead, in accordance with best practice, they follow guidance from the FOS. Indeed for such insurers reform may hold two attractions: removing the economic advantage their competitors gain by relying on bad law and preventing the damage that such reliance does to the reputation of the insurance industry as a whole.

**Consumer interests**

It is, though, the interests of the consumer which render law reform essential. Insurance is intended to bring peace of mind through the transfer of risk. If fair treatment is at the discretion of the insurer, that peace of mind may prove to be illusory. Consumers deserve enforceable rights under modern, clear and fair law.

Peter J Tyldesley is a PhD student and part-time lecturer at the University of Manchester who formerly worked at the English Law Commission. E-mail: peter.tyldesley@manchester.ac.uk. In Part 2, he will explore the Law Commissions’s anticipated proposals.