Reforming Insurance Contract Law

SUMMARY OF RESPONSES TO SECOND CONSULTATION PAPER

Post Contract Duties and other Issues

Chapter 1: Damages for Late Payment

This document summarises the responses to chapter 1 of the Law Commissions' second consultation paper in the joint insurance law project

December 2012

THE LAW COMMISSION
THE SCOTTISH LAW COMMISSION

Joint Review of Insurance Contract Law

SUMMARY OF RESPONSES TO SECOND CONSULTATION PAPER: POST CONTRACT DUTIES AND OTHER ISSUES

Chapter 1: Damages for Late Payment

Contents

	Page
Approach taken in this paper	ii
Part 1: Introduction	1
Part 2: Should damages be available?	3
Part 3: The definition of a reasonable time	8
Part 4: Business insurance: exclusion clauses	13
Part 5: Consumer insurance	18
Part 6: Limitation	22
Appendix: List of consultees	26

Approach taken in this paper

Describing responses

This paper describes the responses we have received to the proposals on damages for late payment set out in our joint Consultation Paper: Post Contract Duties and other Issues. This document aims to report the arguments raised by the consultees. It does not give the views of the Law Commission or the Scottish Law Commission.

Comments and Freedom of Information

We are not inviting comments. However, if having read the paper you do wish to put additional points to the Commissions, we would be pleased to receive them.

Please contact us:

By email at commercialandcommon@lawcommission.gsi.gov.uk

By post, addressed to Laura Burgoyne, Law Commission, Steel House, 11 Tothill Street, London SW1H 9 HL

We will treat all responses as public documents. We may attribute comments and publish a list of respondents' names.

Information provided, including personal information, may be subject to publication or disclosure in accordance with the access to information regimes (such as the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002 and the Data Protection Act 1998). If you wish your information to be confidential please explain to us why and whilst we will take a full account of your explanation, we cannot give assurance that your confidentiality will be maintained in all circumstances.

PART 1
INTRODUCTION

1.1 The Law Commission and Scottish Law Commission are carrying out a major review of insurance contract law. As part of that review, in December 2011, we published a joint Consultation Paper on "Post Contract Duties and other Issues".[1]

1.2 The first chapter considered the remedies available to a policyholder where an insurer has unreasonably refused a claim or paid only after unreasonable delay. The current position in English law is that an insured is not entitled to damages for any loss suffered as a result of the insurer's unreasonable actions.

1.3 The case of *Sprung v Royal Insurance (UK) Ltd* illustrates the problems.[2] When Mr Sprung suffered damage to his factory, the insurers failed to pay his claim for four years, by which time he had been forced out of business. The judge at first instance found that, as a result of the insurer's delayed payment, he had suffered further losses of £75,000. The Court of Appeal held, with "undisguised reluctance", that the insurers were not liable for losses of this type.

1.4 This differs from the law in Scotland and most other common law jurisdictions, where such damages are available.[3] We argued that the English position was anomalous and out of step with general contractual principles.

1.5 We first considered damages for late payment in Issues Paper 6, published in March 2010,[4] and responses to that paper showed strong support for reform. As the Association of British Insurers (ABI) put it:

> The ABI accepts that there is a need for reform in this area …. If the insurer has declined a valid claim and has acted unreasonably, we accept that the law should be brought into line with general commercial contractual principles.

[1] Insurance Contract Law: Post Contract Duties and other Issues, the Law Commission and the Scottish Law Commission, LCCP 201 / SLCDP 152 (December 2011) (hereinafter referred to as the "Consultation Paper").

[2] *Sprung v Royal Insurance (UK) Ltd* [1999] 1 Lloyd's Rep IR 111.

[3] *Alonvale Ltd v J M Ing* [1993] GWD 36-2345, discussed in the Consultation Paper at para 2.67. See also paras 2.62 to 2.66 of the Consultation Paper and Insurance Contract Law Issues Paper 6: Damages for Late Payment and the Insurer's Duty of Good Faith (March 2010), Part 3.

[4] Insurance Contract Law Issues Paper 6: Damages for Late Payment and the Insurer's Duty of Good Faith (March 2010).

1.6 The Consultation Paper therefore proposed that an insurer who unreasonably delays or wrongfully repudiates a claim should be liable to pay damages according to normal contract law principles – that is for proven and foreseeable losses. We proposed that the definition of a "reasonable time" should be flexible, taking into account market practice, the type of the insurance, and the size, location and complexity of the claim.

1.7 For consumer insurance we proposed that insurers should not be entitled to exclude liability for failing to pay valid claims within a reasonable time. The FOS already recognises such a duty, and this appears to be accepted by the industry.

1.8 By contrast, for business insurance, we wished to preserve freedom of contract. We thought that there may be good commercial reasons to limit damages, for example to enable insurers to reserve claims and put the necessary reinsurance provisions in place. We therefore proposed that in business insurance, an insurer would be entitled to use a contract term to limit or exclude its liability to pay damages for late payment, provided that the insurer has made an honest error in good faith.

1.9 We commented that our proposals had implications for the time available to a policyholder to commence litigation against an insurer for failing to pay an insurance claim. We asked for views on the appropriate limitation period in England and Wales.

RESPONSES

1.10 We received 39 responses to our proposals on damages for late payment in the Consultation Paper, as shown in the table below:

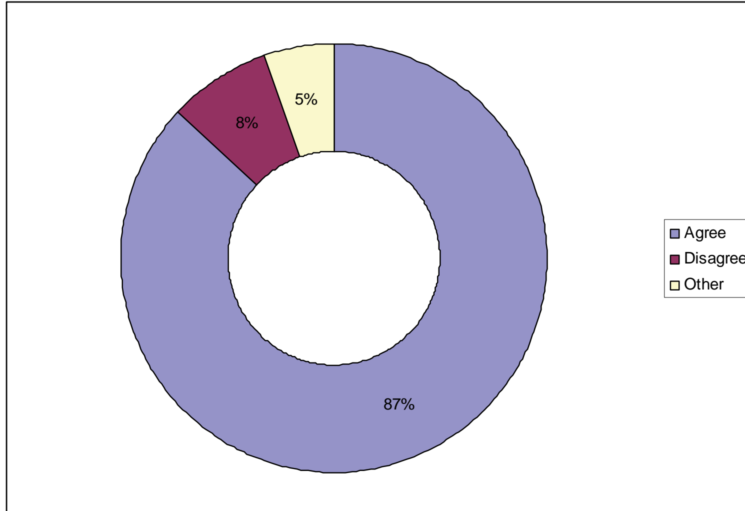
Type of respondent	Number
Insurers and insurance trade associations	14
Lawyers, legal associations and the judiciary	15
Brokers and brokers' associations	2
Academics	3
Policyholders and policyholder/consumer groups	2
Other	3
Total	39

THANKS

1.11 We would like to thank all the consultees who responded to our Consultation Paper, or who met with us or contacted us to express their views. Whilst we are unable to directly quote all consultees' submissions in this brief summary, those views are important to us as we put together our recommendations for the final report. A list of all the consultees is contained in the Appendix.

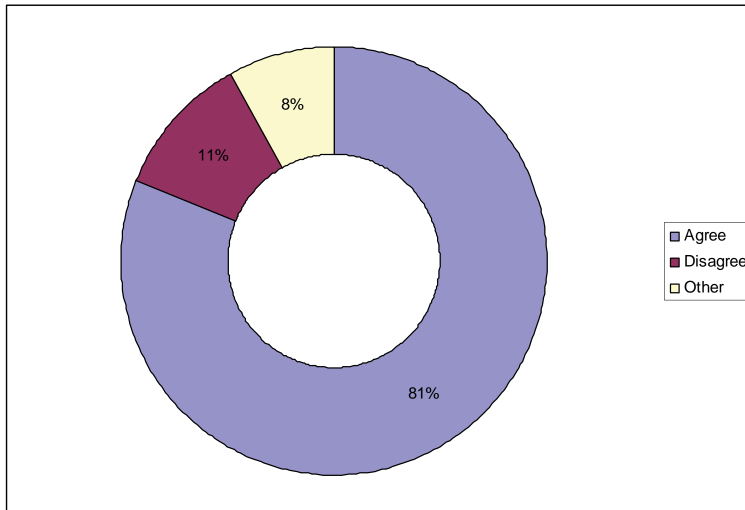
PART 2
SHOULD DAMAGES BE AVAILABLE?

2.1 We asked whether insurers should be under a contractual obligation to pay claims within a reasonable time. Of 38 respondents to this question, 33 (87%) agreed with our proposal.



Should insurers be under a contractual obligation to pay claims within a reasonable time?

2.2 Furthermore, 30 out of 37 (81%) agreed that a failure to meet this obligation should result in liability to pay damages for any foreseeable loss which results.



Should an insurer who fails to meet this obligation be liable to pay damages for any foreseeable losses which result?

Agreement

2.3 The Law Reform Committee of the Bar Council of England and Wales (the Bar Council) agreed "strongly" with the proposal. The City of London Law Society thought that a fundamental reappraisal of the insurer's "essential obligation" was necessary, and that the current interpretation "makes the law look silly". Covington & Burling LLP commented:

> The current position of English insurance law is out of step with general English contractual law. This anomaly is not defensible either on grounds of logic or on grounds of policy. Furthermore, it acts as a disincentive to international policyholders from seeking cover under English-law-governed contracts and is therefore damaging to the UK insurance industry.

2.4 K&L Gates LLP added:

> Many insurance buyers (even sophisticated ones) are surprised that damages are not already available in circumstances where insurers have unreasonably denied and/or delayed payment of a claim and where the policyholder has suffered loss in consequence of this delay. Payment of the claim by insurers many months or even years after the incident which caused the policyholder loss is not uncommon and can cause severe hardship beyond that caused by the original insured loss. This is a particular problem for smaller companies as graphically demonstrated in the *Sprung* case.

2.5 The Financial Ombudsman Service (FOS) supported reform:

> We have already been applying a remedy of damages for late payment for some time and there is also broad acceptance within the industry about the approach we take. However, this approach is inconsistent with the current legal position in the case of *Sprung.*[5]

2.6 There was also majority support for reform among insurance companies and insurance trade bodies. Out of the 14 insurers and insurance organisations who responded, 11 agreed that insurers should be under a contractual obligation to pay claims within a reasonable time:

> Zurich agrees that the decision of the English court in the case of *Sprung-v-Royal Insurance* is no longer tenable and that the correct interpretation of an insurance contract is of "one to pay defined sums of money if particular losses occur". [Zurich]

[5] [1999] 1 Lloyd's Rep IR 111.

> We agree that insurers should be obliged to pay a valid claim for foreseeable losses where the insurer has failed to pay a valid claim within a reasonable period. [RSA]

> Insurers should be obliged to pay claims within a reasonable time, provided that this is adequately defined and allows for investigation of the claim. [Hannover Life Re]

> We agree that insurers should pay valid claims within a reasonable time, a requirement that, it could be argued, is already set out in ICOBS 8.1.1 [ABI]

2.7 Furthermore, eight insurers agreed that an insurer who fails to pay a valid claim within a reasonable time should be liable to pay damages for foreseeable losses. For example, Zurich agreed that where there has been an unjustifiable delay or a claim is wrongfully repudiated, the insurer may be liable under the contractual rules set out in the case of *Hadley v Baxendale*, but they added that "the test for foreseeable loss must be interpreted restrictively".

2.8 On behalf of commercial buyers, the risk managers' association Airmic agreed in principle that damages for late payment should be available to an insured, but thought our proposal was the wrong way to achieve a fair result:

> The phrase "pay valid claims within a reasonable time" is a vague obligation and does not give the insured sufficient claims certainty.

2.9 Airmic referred us to the speed of settlement agreement they had reached with several large insurance companies in the London market in 2009 to provide a set of principles that would govern the speed of settlement of large claims.

2.10 Finally, although our proposals were aimed at reforming English law rather than Scots law, the Judges of the Court of Session argued that the new statute should apply to both sides of the border:

> Any legislation should apply to both England and Scotland, both to embed what is thought to be the Scottish position and to avoid the possible implication that the law as enacted for England and Wales may be subtly different from that in Scotland. There is also the need to deal with other matters, such as exclusion clauses and the inability to rely on them in consumer contracts or, in business contracts, unless the insurer can show he has acted in good faith.

Disagreement

2.11 By contrast, the Lloyd's Market Association (LMA) said it had "grave misgivings about framing the contractual obligation as proposed". They pointed to the danger of opening the floodgates to speculative claims, leading to higher premiums. They thought that the concept of "reasonable time" would be difficult to define, and claims managers might be discouraged from investigating doubtful claims. The LMA also considered that the issue was better dealt with through Financial Services Authority (FSA) regulations, with compensation for the insured limited to interest and costs.

2.12 ACE also thought that the issue should be dealt with through regulation.

2.13 The International Underwriting Association (IUA) agreed with idea of a contractual duty, but thought that an insured's remedy should be limited to a statutory rate of interest. Broader remedies would "drive up legal costs and the costs of insurance":

> The propensity for a damages award that vastly exceeds the value of the contract, policy limits and premium received will require the insurer, as a matter of good practice, to reassess their coverage and pricing structures.

2.14 QBE also stated that "the remedy for breach should be limited to a claim for statutory interest". They accepted that this "does not align with general contractual principles" but thought it provided the necessary certainty.

2.15 Similarly, Munich Re thought that a statutory remedy was unnecessary, and that the courts had sufficient discretion over the period and rate of interest to deal with the problem. An alternative would be to tie any right of damages to a breach of "good faith" by the insurer. This would protect the consumer, but

> insurers would not be exposed to uncertain and potentially unlimited liabilities in circumstances where they have made a bona fide claims decision, perhaps based on uncertain evidence, but where the Court subsequently finds against the insurer.

2.16 Finally David Turner QC thought that the change would be "an unnecessary interference with the autonomy of parties to a commercial contract".

Concerns

2.17 Although a majority of insurers agreed that they should be liable to pay damages for the late payment of claims, they raised two particular concerns about our proposals.

2.18 The first concern was that the concept of a "reasonable time" should be defined clearly. The ABI said:

> "Reasonable time" and what would be considered an "unreasonable delay" needs to be clearly defined in order to ensure that it is not possible for claimant lawyers to simply put in a claim for late payment as a matter of routine.

2.19 Several other insurers echoed this point:

> Legislation must set out a definition or clear guidelines on what constitutes "a reasonable time". [Allianz]
>
> More clarity is required on what a 'reasonable time' is, and what would be considered an 'unreasonable delay'. [Direct Line Group, formerly Royal Bank of Scotland Insurance]

2.20 The second concern was that the concept of "foreseeable loss" should be defined narrowly. As NFU Mutual put it:

> What constitutes foreseeable losses needs to be clarified, to avoid insurers being exposed to claims for damages for late payment outside the reasonable contemplation of the parties at the time the insurance cover came into being.

2.21 RSA commented that “the level of losses may be uncertain, surprising, and disproportionate, where loss of business is concerned”. They referred to a recent case which took a broad definition of foreseeable loss, and hoped that “the legislation might be drafted to contain application”. Both RGA and the Investment and Life Assurance Group (ILAG) suggested that the legislation should add the word “reasonable” before damages. RSA thought it important that “insurers have the ability to limit exposure to consequential losses, provided the insurer has acted in good faith”.

2.22 The ABI was particularly concerned “to avoid a situation where insurers pay out claims without a proper investigation, simply to avoid having to pay damages if their decision not to pay a claim is repudiated”. They commented:

> Without greater legal certainty, insurers will have difficulty calculating the reserves necessary for Solvency II and the reinsurance needed to cover these additional liabilities.

2.23 The definition of reasonable time and the way that damages may be limited are considered in more detail below.

PART 3
THE DEFINITION OF A REASONABLE TIME

A THREE STAGE PROCESS

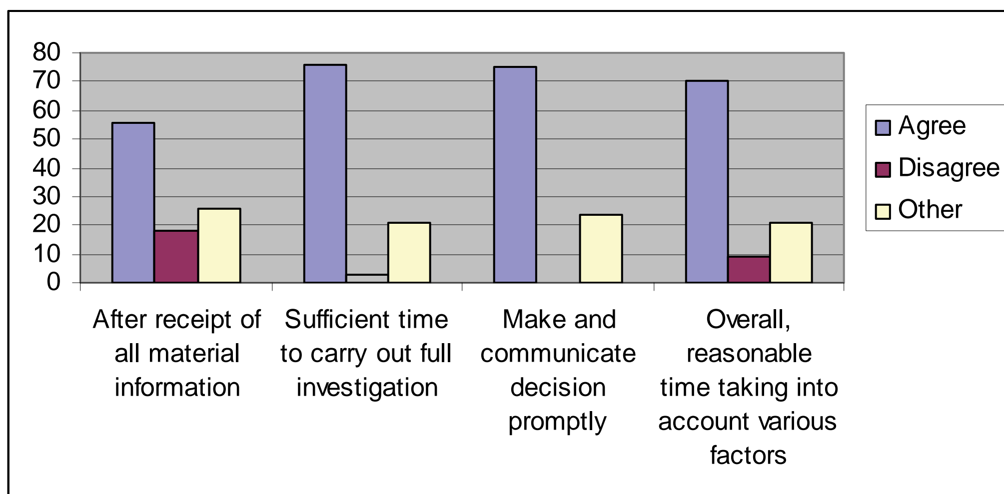
3.1 The Consultation Paper argued that, ultimately, how long was reasonable to investigate a claim was a question of fact for the courts. We did however see a need for guidance on how the period should be assessed. We therefore approached the overall time scale in three stages:

(1) We proposed that the insurer should not be held responsible for the time the insured took to make the claim. So long as the insurer acted reasonably in asking the insured for information, the time to investigate should only begin once the insured has provided all the material information. Of the 34 consultees who responded to this proposal, 19 agreed (56%), six disagreed (18%) and nine marked "other" (26%).

(2) We proposed that, on receipt of a "clean claim", the insurer should have sufficient time to carry out a full investigation, including time to seek information from third parties. Of the 33 consultees who responded to this proposal, 25 (76%) agreed, one consultee (3%) disagreed, and seven (21%) marked "other".

(3) Once it has investigated, the insurer should assess the claim and arrive at and communicate its decision promptly. Of the 33 consultees who responded to this proposal, 25 (76%) agreed and eight (24%) marked "other".

3.2 Overall, we said that the insurer should have a reasonable time to investigate and assess the claim, taking into account market practice, the type of the insurance, and the size, location and complexity of the claim. Of the 33 consultees who responded to this proposal, 23 (77%) agreed, three (9%) disagreed and seven (21%) marked "other".



3.3 These figures show that most consultees agreed with our underlying policy. It was accepted that insurers should not be held responsible for delay by policyholders; that insurers should have sufficient time to carry out a full investigation; that it may take time to seek information from third parties; and that once the information was available the insurer should make a prompt decision. RSA said it is:

> comforting to see that the Law Commission acknowledges insurers are sometimes dependent upon third parties … This must be taken into consideration in any judgement on whether the time taken was reasonable, and the legislation should be clear on this point.

3.4 On the other hand, many comments expressed concern that this three-pronged approach was overly complex. As the ABI put it, our proposal "appears to involve three periods of time". It will also vary from case to case according to the individual elements of that case. They said:

> Although a number of ABI members are in favour of this proposal, substantial concern remains regarding the definition of "reasonable" time, whether it be in statute or regulation. This option is likely to result in a great deal of speculative litigation.

3.5 Covington & Burling LLP made a similar point from the perspective of lawyers acting for commercial policyholders. They thought that "a potentially protracted 3 stage process … could be used by insurers to delay claims unduly" and could lead to anomalous results, especially where an insurer requested further information from a policyholder. Insurers could use the rule to delay payment. They said:

> Covington instead favours a non-prescriptive approach, whereby insurers must inform policyholders of their decision on coverage within a timeframe that is "reasonable" overall.

3.6 QBE said that the concept of a "clean claim" was too uncertain to be defined in legislation:

> A claim is an ongoing process, combined of enquiries, information exchange and investigation. Information may arrive which creates a new line of enquiry and insurers should feel unhindered in raising legitimate additional queries.

3.7 The Judges of the Court of Session pointed out that "the proposed wording may be thought to suggest that the insurer has no obligation even to begin its investigations until all the material information has been received". As the British Insurance Brokers' Association (BIBA) put it, "investigation should not wait until all information is to hand. Investigation can start earlier".

3.8 Several consultees commented that a three stage process could lead to disputes:

> We anticipate that there will be disputes about whether or not the insured has provided all the material information and when all such information was provided. [British Insurance Law Association (BILA)]

> We should warn that there will be arguments about when it can be said that the time to investigate began. The type of points that will be taken are: Did an insurer act reasonably in asking an insured for certain information? Was such information material? [Bar Council]

3.9 DAC Beachcroft LLP commented that a three stage process provided “three flashpoints for disagreement and therefore costs and litigation”. A “simpler, single test” would provide less opportunity for debate.

3.10 The City of London Law Society also favoured a more general test:

> No matter what guidelines one seeks to provide, the court will be left with the question of whether a particular payment has been made within a reasonable time and that will depend on the facts in each case.

FACTORS TO BE TAKEN INTO ACCOUNT

3.11 We proposed that the insurer should have a reasonable time to investigate and assess the claim, taking into account the market practice, the type of the insurance, and the size, location and complexity of the claim.

3.12 Most respondents agreed with the proposal. Of the 33 consultees who responded to this proposal, 23 (70%) agreed, three disagreed and seven marked “other”. The comments raised some important issues, which we explore below.

The balance between certainty and flexibility

3.13 The ABI recognised that there was a difficult balance to be struck. On the one hand, “unreasonable delay needs to be clearly defined in order to ensure that it is not possible for claimant lawyers to simply put in a claim for late payment as a matter of routine”. On the other hand, “defining ‘reasonable time’ will be very difficult, and will differ from product to product”.

3.14 Many respondents acknowledged that the test needed to be flexible. For example, Hannover Life Re supported the criteria because they provided “flexibility in considering what a reasonable time to investigate a claim should be”.

3.15 The IUA also thought that the period must be flexible:

> Reasonableness has to be assessed from the perspective of the reasonable insurer throughout the period of the claim. This should also take into account existing market practice, value of the potential claim, class of business, complexity and location of the risk, whether a broker is used and the actions of the insured, including any mitigation of loss and submission of documentation.

3.16 Norton Rose LLP made a similar point:

> Although we would generally be in favour of clarity and certainty in the law … we do not think it would be possible for legislation to consider the many possible different scenarios which may occur as what is reasonable will vary hugely depending on the facts of the case.

Industry protocols

3.17 Several respondents, including the IUA and Norton Rose LLP, suggested that one possible answer would be for industry bodies to provide guidance on what is reasonable in relation to certain classes of business. As the IUA put it, "a non-exhaustive guide as to reasonableness, developed in consideration of market practice, would be valuable". The Faculty of Advocates also thought that there may be merit in developing benchmark standards for different types of claim and/or for different types of insured.

3.18 Airmic went further, describing a set of agreed claims protocols as "essential":

> A set of agreed claims protocols established between the insured and the insurer in advance of losses occurring as to how the claims will be handled and how the staged payment of large losses will occur is essential, so any delays in payments can be monitored in relation to this contractual agreement.

3.19 A few respondents suggested more definite periods. The Law Society of Scotland suggested a rebuttable presumption that it was reasonable to pay a claim in three months. David Turner QC favoured "hard line periods imposed by statute":

> perhaps 20 working days for claims <£500K in value; 30 working days for claims >£500K but <£1M in value and 40 working days for claims >£1M in value.

Market practice

3.20 Most insurers supported the reference to market practice. The LMA in particular commented that "a reasonableness test should be looked at from the point of view of a reasonable insurer and not an independent bystander".

3.21 On the other hand, K&L Gates LLP and Covington & Burling LLP both took issue with reliance on market practice. K&L Gates LLP said:

> We are concerned at the suggestion that a concept as nebulous as "market practice" should be included within any definition of "reasonable time" as it might be used as a basis for insurers to justify delay. There may well be divergences of opinion as to what is market practice, and just because a practice has grown up in the insurance market does not necessarily mean it is right. Certainly in our experience policyholders are often surprised and indeed horrified by the length of time which insurers and their professional advisors take to investigate and provide a coverage decision….

Fraud

3.22 Several insurers were keen that the period was sufficient to investigate potentially fraudulent claims. RSA said:

> Inevitably fraud investigation requires some discretion regarding the disclosure of information, for example where an informant has provided information. Consequently it may be difficult for insurers to persuade claimants that continued claim investigation is required and

> that a reasonable time has yet to expire where the customer may be unaware that fraud is suspected.

Was the decision to refuse a claim reasonable?

3.23 The Bar Council thought that the legislation should refer to whether any decision to decline a claim was reasonable:

> Reasonable time should be measured not only by reference to the time it takes to investigate and assess a claim but also the reasonableness of the decision to decline the claim, for example, the original decision to decline may appear reasonable but may subsequently be shown to be unjustified by relevant information emerging only during the trial.

What if the decision is dependent on that of another insurer?

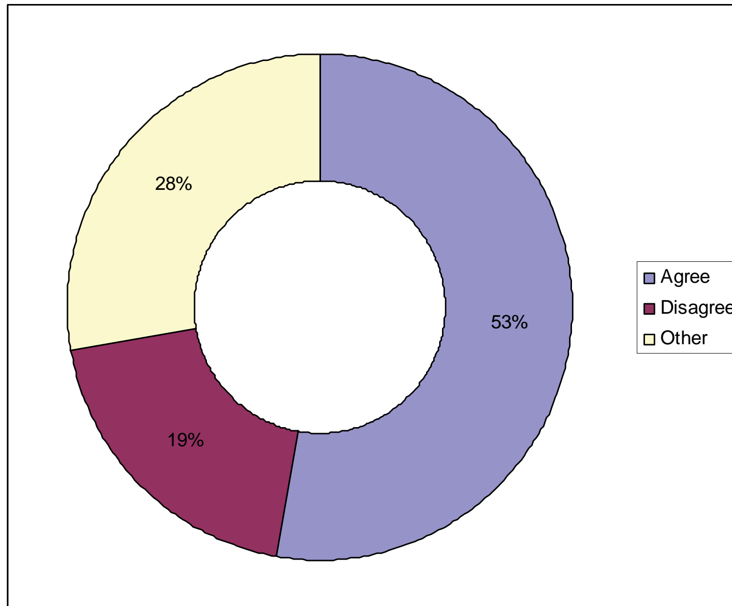
3.24 Finally, DAC Beachcroft LLP raised a question about how the test would apply where one insurer was dependent on another insurer's decision. For example:

> We are unclear how "reasonable time" would be assessed in circumstances where the property damage (PD) and business interruption (BI) cover is held by different insurers. In such a scenario, the BI insurer is going to be dependent on the actions of the PD insurer and should not be penalised for circumstances out of their control.

PART 4
BUSINESS INSURANCE: EXCLUSION CLAUSES

SHOULD INSURERS BE ABLE TO LIMIT LIABILITY?

4.1 In the Consultation Paper we proposed that insurers should be able to contractually limit or exclude their liability to pay damages for late payment.



Do consultees agree that in business insurance insurers should be able to limit or exclude their liability to pay damages for late payment through a term of the contract?

Agreement

4.2 Insurers were unanimously in favour of this. RSA reflected the views of the whole industry in stating that:

> We need to preserve the freedom to agree and vary policy terms. In commercial insurance customers are sufficiently sophisticated to contract freely on terms, or they have access to advice.

4.3 Several insurers suggested that exclusions would be rare. For example, QBE commented that exclusion clauses would be rejected by brokers acting for insureds and "it is also likely to prove too undesirable for insurers to seek an exclusion in order to retain and not mar their reputation".

4.4 Among other respondents to this question, views were mixed. Out of the non-insurer respondents, six were in favour, seven against and nine marked "other".

4.5 DAC Beachcroft LLP agreed with the proposal as an "ability to limit liability is going to be necessary for insurers to reserve accurately and obtain adequate reinsurance cover".

Disagreement

4.6 Three arguments were put against the proposal:

(1) it is unfair to permit parties to restrict liability for their own unreasonable behaviour;

(2) in insurance, freedom of contract was more apparent than real, with many insureds offered standard terms on a take it or leave it basis;

(3) the proposal failed to protect small businesses, which were often particularly vulnerable to late payment.

4.7 BIBA, for example, described the proposal as unfair. They commented:

> In practice very few business insureds have the power to negotiate a change in insurers' normal conditions.

4.8 The Law Society of Scotland worried that "the inevitable effect of conferring on insurers the right to contract out of their liability for consequential losses is that it will become a standard term".

4.9 BILA said its members were split on the issue. The majority thought that insurers should not be able to exclude their liability, as it was "a fundamental part of the insurance bargain that insurers should pay valid claims". They said:

> The majority regard it as probable that a significant number of insurers would seek to exclude such liability, as they would not wish to be exposed to damages, which could be unpredictable and costly. It may be that major businesses and their brokers could resist such an exclusion when negotiating insurance terms. However, most small and medium size enterprises ("SME"s) would not be able to exert such influence.

4.10 By contrast, BILA reported that "the strongly held minority view is that in business insurance parties should be free to negotiate and set their own terms".

4.11 Several respondents, including the Judges of the Court of Session and the Bar Council, suggested that insurers should be entitled to restrict the quantum of damages but not exclude liability altogether. Thus the Bar Council said that insurers should be able:

> to limit the quantum of such damages so far as business insurance is concerned, provided they are not entitled to do this to a derisory level ... It may be appropriate for insurers to limit the maximum damages recoverable to the limit provided for by the section of the policy under which the claim arises.

THE EXCLUSION AND GOOD FAITH

4.12 The Consultation Paper proposed that the exclusion clause should only apply where the insurer had acted in good faith. If the court concluded that the insurer's delay or refusal was not made in good faith, the insurer should not be entitled to rely on a contract term to exclude liability.

4.13 Just under half of consultees agreed. We received 31 responses to question 5, of which 15 (48%) agreed, nine disagreed and seven marked "other".

4.14 Several respondents representing policyholders or brokers favoured an outright ban on all exclusion clauses instead. For example, the Financial Services Consumer Panel expressed concern about small firms. Covington & Burling LLP commented:

> As failure to respond to a claim within a reasonable time represents a *prima facie* failure of an insurer's duty of good faith, it is arguably illogical to permit exclusion of liability unless caused by a further breach of the duty of good faith.

4.15 Some respondents expressed concern that the concept was uncertain. Norton Rose LLP commented that "it is not clear what bad faith would involve and might mean". The Bar Council and BILA thought the principle would lead to more disputes.

Insurers' views

Agreement

4.16 Meanwhile, insurers' views were evenly split: 7 insurance companies or industry bodies supported the proposal, while 7 did not.

4.17 RSA supported the proposal:

> It seems fair and just that the exclusion should only be exercisable in circumstances where the insurer has acted in good faith.

4.18 They argued, however, that "an allegation of 'bad faith' is serious, and the party making the allegation should be required to prove this to a high standard".

4.19 Other insurers who agreed with the proposal also qualified their support. QBE agreed on the basis "that this does not give a right to an additional cause of action for breach (i.e. avoiding bad faith style claims)". Hannover Life Re agreed "on the assumption that 'good faith' has its generally accepted legal meaning".

Disagreement

4.20 Other insurers argued that an exclusion clause should apply irrespective of the insurer's contract. For example, Munich Re argued that the "ability to opt-out should be an absolute right":

> The proposals put forward by the Law Commissions are out of step with the general contract position, where parties are free to exclude liability for consequential losses without being subject to additional regulation.

4.21 The LMA said that the proposal was "a recipe for speculative claims and litigation". They believed "that note should be taken of the position in the USA in the area of "bad faith" claims and lessons taken from this".

4.22 Allianz also commented on US experience:

> One only has to look at how bad faith damages have developed in America to see the vast potential for extra cost and the increase in premiums that would result to the disadvantage of the public and business community.

4.23 It was said that the concept of good faith was too uncertain to apply in practice. Furthermore, as the IUA noted, other "mechanisms are in place to deal with bad conduct or fraudulent activity", including FSA regulations and the law of deceit.

THE PROCEDURE TO DECIDE WHETHER THE INSURER ACTED IN GOOD FAITH

Giving reasons

4.24 In the Consultation Paper we proposed that an insurer who seeks to rely on an exclusion clause should explain to the insured why the payment was delayed or rejected. 28 consultees responded to this proposal, of whom 21 (75%) agreed. Only two disagreed and five marked "other".

4.25 Most insurers accepted that giving reasons was in accordance with good practice. As Zurich put it, "best practice would involve a formal explanation of the application of the exclusion".

4.26 The Faculty of Advocates went further and agued that there "should be a requirement that such explanation must be contemporaneous with the decision". The City of London Law Society also thought that an explanation should be provided for all rejected claims.

4.27 By contrast, the ABI did not agree that insurers should have to provide reasons. Instead, "insurers should be free under the principle of freedom of contract to limit their liability without having a specific additional requirement/restriction".

A matter of fact for the court

4.28 We did not suggest providing any further definition of good faith. Instead, we proposed that the court should evaluate whether the insurer was acting in good faith in relation to the exclusion clause given the circumstances and information available at the time.

4.29 Two thirds of respondents to this proposal (19 out of 28) agreed. As the IUA stated, claims handling guidelines were "best left to regulatory supervision through ICOBS and industry guidance".

4.30 Nevertheless, several respondents expressed concern about how the test would work. Insurers argued that the threshold must be a high one. As Zurich said:

> The test for bad faith should be set at a similar level that constitutes misfeasance in public office, the arbitrary and oppressive abuse of power in the knowledge that it is detrimental to the policyholder.

4.31 By contrast, K&L Gates LLP thought that the test was too high. Policyholders would have to challenge the conduct of the insurer in circumstances where they would not have access to the insurer's internal and/or privileged documents. K&L Gates LLP questioned "whether, on the test currently proposed, insurers would ever be ordered to pay damages for late payment".

4.32 DAC Beachcroft LLP asked:

> Where does the burden of proof lie? Is it anticipated that both sides obtain expert evidence on what would commonly have happened in the market or is the court to second guess what would have happened?

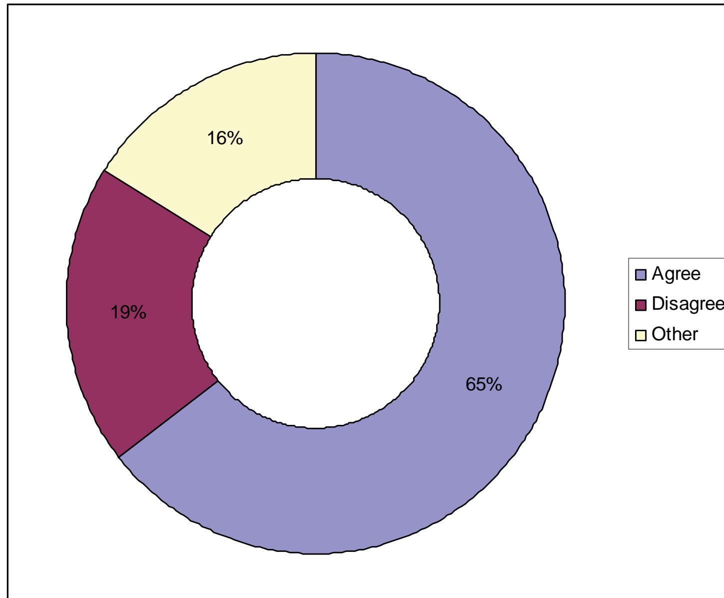
4.33 RSA also had specific "concerns in relation to fraud investigation, and the ability of an insurer to disclose information to a claimant":

> As part of a fraud investigation insurers may not be able to be open and honest regarding the reasons for delay in settlement. For example an informant may be in danger, or insurers may not wish to 'tip off' the claimant by disclosing the nature of inquiries. We must ensure that such secretive inquiries, where honesty and transparency are not the right approach, are not deemed to fall outside of 'good faith' where the underlying intention is to get to the truth.

PART 5
CONSUMER INSURANCE

SHOULD THE DUTY BE NON-EXCLUDABLE?

5.1 The Consultation Paper proposed that, in consumer insurance, insurers should not be able to limit or exclude their liability to pay damages for late payment. Of the 31 responses to this proposal, 20 (65%) agreed, six disagreed and five marked "other". This included 11 responses from insurers or insurers' trade bodies, of whom five agreed, four disagreed and two marked "other".



Do consultees agree that in consumer insurance, insurers should not be able to limit or exclude their liability to pay damages for late payment?

Agreement

5.2 The Financial Services Consumer Panel felt strongly that exclusion clauses should not be permitted in consumer contracts:

> The Panel strongly agrees that insurers should not be allowed to exclude liability for failing to pay valid claims on a personal lines insurance policy within a reasonable time period. Any such clause would be difficult for consumers to understand and would most likely be included in the lengthy terms and conditions which most consumers struggle to understand.

5.3 The City of London Law Society said: "the consumer is defenceless if such duties can be written out in policies. We do not think it sufficient that the insured may be able to call on [the Unfair Contract Terms Act 1977]".

5.4 Norton Rose LLP described our proposal as "consistent with the approach adopted in other consumer legislation". They commented that an exclusion clause may not survive "the scrutiny of the Financial Ombudsman or FSA's [Treating Customers Fairly] principles".

5.5 Several insurers also recognised that the proposal was in line with FSA provisions, the operation of the FOS and unfair contract terms legislation. The IUA agreed with the exclusion on this basis, but questioned whether "in light of the existing mechanisms in place", a statutory provision was actually needed.

Disagreement

5.6 The LMA thought that no duty should exist unless specifically granted by contract:

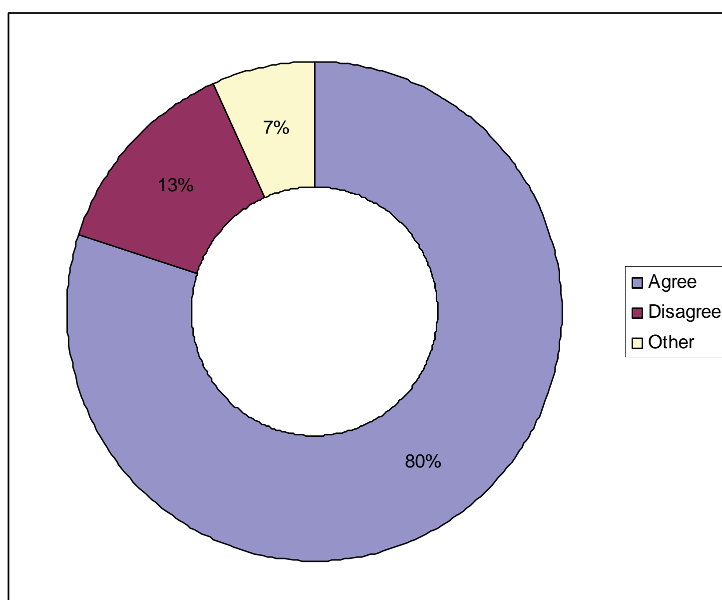
> If protection is desired against a particular type of loss, then this should be purchased. Ultimately, this is a fairer system (given effective competition in, and supervision of, the insurance market) than the general insurance pool financing secondary damages claims.

5.7 ILAG, the ABI and the RGA disagreed, but on a more restricted basis. They thought that there may be a case for an insurer to limit damages, if not exclude them altogether.

DAMAGES FOR DISTRESS AND INCONVENIENCE

5.8 The Consultation Paper described (at paragraphs 2.72 to 2.80) how in appropriate cases, the FOS will provide restrained and modest compensation for distress and inconvenience suffered by the consumer.

5.9 We asked if damages should also be available through the courts. Of the 30 consultees who answered this question, 24 agreed (80%), four consultees disagreed and two marked "other".



Do consultees agree that damages for distress and inconvenience should be available for consumer insurance?

Agreement

5.10 The Financial Ombudsman Service set out the arguments for bringing the law into line with FOS practice:

> The proposals set out within the consultation would bring the law more in line with our own approach to such cases and would eliminate current inconsistencies. This in turn would provide a greater level of certainty both for consumers and businesses in terms of the approach we were likely to take.

5.11 The Faculty of Advocates also agreed:

> Peoples' lives can be materially disrupted by unreasonable or illogical decisions made by insurance companies. In appropriate cases, in our view, compensation should be available.

5.12 Several insurers agreed in principle but argued that damages should be curtailed. For example Direct Line Group thought that the current FOS guidance on when to award compensation was too broad. Similarly, the ABI said that these damages should be available but only for consumer insurance policies, and they should be proportionate:

> If this principle were to be formalised in law, we would welcome clarity on what inconvenience a claimant should realistically expect, as opposed to what level of inconvenience is enough to obtain compensation.

Disagreement

5.13 Browne Jacobson LLP expressed concern about opening the floodgates to a new class of claim: "to extend those damages to include inconvenience and discomfort is to go beyond the purpose for which consumers purchase insurance and is unjustified".

5.14 ACE thought that the proposal "could encourage speculative secondary claims where the original claim may have been paid promptly".

5.15 The LMA also feared speculative claims:

> Consumers have the benefit of the FOS's discretion to award a sum in respect of inconvenience and discomfort. Such awards should remain exclusively within this jurisdiction. To bring such heads of damages within the general law of insurance contracts may encourage claims farmers and claimant lawyers to pursue claims for inconvenience and discomfort even where related valid "underlying" claims (e.g. for damaged or lost property) have been paid promptly.

5.16 Marsh also feared possible "intrusion by, and profits for, claims management companies as well as additional opportunities for fraud".

IS STATUTORY REFORM NEEDED?

5.17 We asked consultees whether this reform was best achieved through statutory reform or whether it could be left to the common law. Of the 29 consultees responding to this question, 14 (48%) argued in favour of statutory reform, nine against and six marked "other".

5.18 The ABI thought further guidance on the issue would be “helpful in order to manage expectations between the insured and the insurer”.

5.19 Direct Line Group were in favour of statutory reform. They pointed out that there was little case law on the issue, with many claims falling within the small claims jurisdiction. They also saw a need to limit expectations:

> RBSI [now Direct Line Group] considers that there is a significant risk of mismanagement of expectations between consumers and insurers both around what is and is not a reasonable delay, and where there is an unreasonable delay the amount of compensation that should be awarded. We strongly believe that this could lead to unnecessary disputes and dissatisfaction.

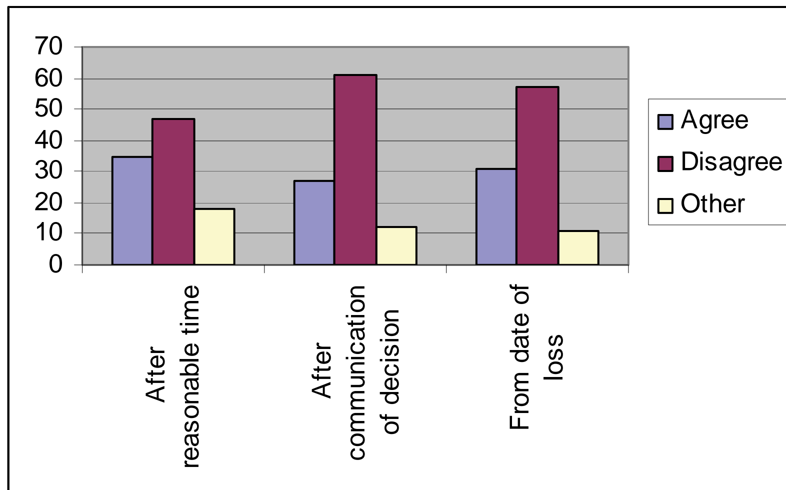
5.20 The Judges of the Court of Session agreed but thought that “only the principle need be established by legislation. Thereafter, application of the principle can sensibly be left to be worked out by the courts”. The Bar Council also thought that quantum should be left to the courts to deal with on a case by case basis.

5.21 Some consultees went further and thought that the entire issue was best left to the courts. The IUA said that it did not see “the need for statutory reform in this area and would support continuing judicial development and operation of the FOS”. Mark Wibberley commented that “circumstances will differ greatly in every case, statute is too rigid a remedy”. Finally, the Law Society of Scotland commented:

> For Scotland, it might be questioned whether legislation is necessary, given that such damages are already available at common law.

PART 6
LIMITATION

6.1 In English law, the victim of a breach of contract usually has six years from the date of breach to bring a claim.[1] In the insurance contract, since the insurer's primary duty is to "hold the insured harmless", the breach of contract is said to happen at the time of loss, meaning that an insured will usually have six years from the date of loss to bring a claim against the insurer. In the Consultation Paper we asked consultees for their views on three proposals: limitation should start to run after an insurer has had a reasonable time to investigate; that limitation should start to run from the date that an insurer communicates its decision on the claim; or, that limitation should run from the date of loss..



REASONABLE TIME TO INVESTIGATE

6.2 35% of consultees responding to these proposals (12 out of 34) thought that limitation should begin after the insurer has had a reasonable time to investigate the claim. Sixteen disagreed and six marked "other".

6.3 A number of consultees thought that the insurer's failure to pay the claim after a reasonable time should be regarded as the breach of contract, in which case limitation should begin at that point. BILA said:

> Time should run from the date of breach, namely the date of the failure to pay the claim. This is consistent with the position under other contracts.

[1] Limitation Act 1980, s. 5. For the position in Scots law, in terms of the Prescription and Limitation (Scotland) Act 1973, s 6, see the Consultation Paper, paras 2.84 to 2.85.

6.4 Direct Line Group agreed subject to the provision of a more detailed definition of reasonable time.

6.5 Geoffrey Lloyd agreed with this proposal, but thought that insurers should only have a reasonable time to "investigate and not procrastinate". He supported the adoption of the Financial Ombudsman Service approach:

> There, when the ombudsman decides that there is no room for negotiation he is required to issue a "Final Letter" … This should be the point when the limitation period starts. It could be laid down either by the new Act or possibly by regulation.

FROM THE TIME AN INSURER MAKES A DECISION

6.6 27% of consultees (nine out of 33) responding to these proposals thought that limitation should start running at the time the insurer's decision about the claim was communicated to the insured. 61% (20) disagreed, while 12% (four) marked "other".

Agreement

6.7 The Financial Services Consumer Panel believed:

> consumers should have the maximum opportunity to make a claim. We therefore strongly support option (3) – to provide that the time runs from when the insurer makes its decision. It is only at this point that a consumer may realise that they have reason to make a claim. We believe it would be unfair if the time, under which a claim should be made, has elapsed before the consumer was armed with the full information to enable them to bring a claim.

6.8 Zurich were in favour of this approach:

> It recognises that the investigation itself can be a complex process with each side advancing a statement of case that may take many months to crystallise to a point at which a decision can be made.

K&L Gates LLP referred to this alternative as the "logical trigger" which "is currently assumed (wrongly) by some policyholders to represent the point from which the limitation period should be calculated". They argued that it would provide greater certainty.

Disagreement

6.9 The LMA thought there "would not be a logical basis" for this approach, since it did not begin limitation at the time of breach.

6.10 Norton Rose LLP were concerned about the practical difficulties. They asked:

> Would the notice begin to run from a comment made in a telephone conversation with the insured or their broker, or would a formal written notice only signify that the limitation period had commenced?

6.11 Covington & Burling LLP proposed "that limitation should run from the earlier of when the insurer communicates its decision to the policyholder or when it has had reasonable time to assess the claim".

Common concerns

6.12 Some concerns were common to the reasonable time approach and the communication of decision proposal.

6.13 One major concern was the need for certainty in limitation periods. RSA said:

> The "reasonable time" proposal sits comfortably with the proposals of the Law Commission, however this point is likely to be uncertain for insurers, legal advisers, and for claimants. On balance we consider that the loss date is the better approach.

6.14 If the reasonable time proposal was adopted, RSA suggested a "long stop", on claims not submitted to an insurer within six years of the date of loss.

6.15 Similarly QBE preferred a date of loss approach "in the interest of maintaining clarity".

6.16 The ABI emphasised the particular need of the insurance industry for certainty in this context:

> The current law … is at least certain, both as to when the six-year period starts and when insurers may reduce their reserve against a claim to zero … This is essential in order for insurers to be able to calculate the reserves and capital to set aside for the requirements of Solvency II.

6.17 RSA noted the effect of uncertainty on pricing:

> Insurers reserve and price to include "Incurred But Not Reported" (IBNR) claims. IBNR is a projection built into reserves and into price. After 6 years there is closure on unreported claims, however this closure will never be final if limitation runs from the date of notification, or reasonable time, or from the date where a decision is communicated.

6.18 A number of consultees also raised the possibility of encouraging litigation with an uncertain limitation period. The City of London Law Society said "any provision which opened up another opportunity to litigate whether a time limit had expired would be unwelcome". Richard Buttle thought that the uncertainty would often lead to "speculative litigation" with "the potential for indefinite prolongation".

6.19 The LMA suggested that a starting point for limitation that depended on insureds bringing a claim would result in more insurers contractually stipulating a period for notification of a claim. They thought that use of such provisions would be a positive move, and encourage certainty.

6.20 The Right Honourable Lord Justice Longmore wondered "if a little more thought can be given to limitation as it affects liability for interest". He thought that if the insurer's obligation were to be re-characterised as one to pay claims within a reasonable time, "a special provision about interest" would be required to maintain the present position that interest accumulates from the date of loss. This, he felt, was expected by "most insureds".

6.21 The Faculty of Advocates observed that this was a problem of English law only, and that "any legislative provision should be confined to England and Wales".

FROM THE DATE OF LOSS

6.22 31% of consultees responding to this proposal (11 out of 35) thought limitation should commence at the time of loss. 58% (20) disagreed and 11% (four) marked "other".

Agreement

6.23 RSA preferred:

> … the date of loss to be retained as the date time starts to run for limitation purposes. This avoids potential open-ended obligations, and the difficulties associated with investigating claims made years later.

6.24 Norton Rose LLP preferred the date of loss approach "for clarity". Browne Jacobson LLP thought it provided "all parties with certainty as to the date of expiry of the limitation period".

6.25 Airmic noted that their speed of settlement principles already apply from the time of loss. They thought that "to allow an insurer discretion in terms of asking for further information places too much control with the insurer".

Disagreement

6.26 Covington & Burling LLP were "not persuaded that the 'simplicity' of this approach counterbalances its lack of logical basis".

APPENDIX
LIST OF CONSULTEES

Association of British Insurers (ABI)
ACE
Airmic
Allianz
Ms Adebowale Awofeso
British Insurance Brokers' Association (BIBA)
British Insurance Law Association (BILA)
Professor John Birds
British Vehicle Rental & Leasing Association
Browne Jacobson LLP
BTO Solicitors
Richard Buttle
CIFAS
City of London Law Society Insurance Law Committee
Professor Malcolm Clarke
Covington & Burling LLP
DAC Beachcroft LLP
Direct Line Group (formerly RBS)
Faculty of Advocates
Financial Ombudsman Service (FOS)
Financial Services Authority (FSA)
Financial Services Consumer Panel
Four New Square
Mrs Justice Gloster DBE, Mr Justice Burton, et al
GRiD
Hannover Life Reassurance (UK) Limited (Hannover Life Re)
Investment and Life Assurance Group (ILAG)
International Underwriting Association (IUA)
Judges of the Court of Session
Keoghs LLP
K&L Gates LLP
The Law Reform Committee of the Bar Council of England and Wales (Bar Council)
The Law Society of Scotland
Geoffrey Lloyd
Lloyd's Market Association (LMA)
London & International Insurance Brokers Association
Marsh Ltd (Marsh)
Miller Insurance Services Limited
Munich Re United Kingdom Life Branch (Munich Re)
NFU Mutual Insurance Society Ltd (NFU Mutual)
NMB Insurance
Norton Rose LLP
QBE
RGA UK
The Right Honourable Lord Justice Longmore
RSA
Dr Caroline Sijbrandij
Naomi Talisman
Willis
Zurich Financial Services (Zurich)