



British
Insurance
Law
Association

Journal
October 2012
No. 125

THE BRITISH CHAPTER OF AIDA,
THE INTERNATIONAL ASSOCIATION
FOR INSURANCE LAW



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16 November, 2012

7 December, 2012

19 October, 2012

“The wording of meaning and the meaning of wording”
by Chris Henley, Head of SL Wordings and Business Development at Beazley

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16 November, 2012

to cover reform of the Insurance Mediation Directive

7 December, 2012

“What is a contract of insurance?” by Robert Purves,
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BILA JOURNAL EDITION 125

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EDITORIAL

Professor Bob Carter

Professor Rob Merkin reports:

“Readers will be deeply saddened to hear of the passing of Professor Bob Carter on 18 September 2012. Bob was for many years professor of insurance at Nottingham University, and is probably best known to the membership of BILA as author of the classic text “Reinsurance”, a new edition of which was close to completion at the time of his death. Those of us who knew him will remember a brilliant, gentle and humble man, whose advice and expertise was sought constantly in the insurance market. He leaves an impressive legacy of published work. After retirement from the University, Bob and Rita spent much of their time in Sidmouth, where we passed many hours discussing the intricacies of the London market, for which his enthusiasm never waned. Latterly he returned to Nottingham. Bob was a towering figure who will be greatly missed.”

2012 BILA article prize

I am pleased to be able to announce that Alice Kane and Steven Levitsky of Duane Morris LLP have been awarded the 2012 BILA article prize for their outstanding article “US healthcare reform 2010-2011” in issue 124 of the BILA Journal. As noted below it is being followed up by a further article in this issue.

Insurance fraud

The first contribution in this issue is a study of the subject of insurance fraud by Aysegul Bugra and Rob Merkin of Southampton University. They argue that the Law Commissions’ recommendations on this subject demonstrate insufficient flexibility.

Damages for late payment of insurance claims

Kees van der Klugt of the Lloyd’s Market Association and member of the BILA Committee, on the other hand, discusses the Law Commission’s proposals for damages for late payment. He questions whether, if enacted, they would lead to greater litigation costs, reserving problems, higher claims handling costs and claims ratios, higher premiums, and some disproportionate awards of damages.

Evolving role of insurance brokers

The contribution of Sir John Thomas, president of the Queen’s Bench Division, is a transcript of his Derrick Cole memorial lecture for BILA on 23 February 2012.

European Commission proposals for a revised Insurance Mediation Directive

Julian Burling, barrister of Serle Court Chambers, and member of the BILA Committee, has provided a full analysis of and commentary on the European Commission's proposal, in the summer of 2012, for a revised Insurance Mediation Directive (IMD2).

The employers' liability trigger litigation

Natasha Gunney, senior associate at Hogan Lovells LLP, has written an article on this subject, which was discussed at a BILA lunchtime event earlier this year. She provides an analysis of the historical and medical background to asbestos related litigation. She discusses the judgment of the Supreme Court earlier this year which considered when liability in such claims is triggered in employers' liability litigation.

Consumer insurance: the risks of contracting on unfair terms

Alice Carse and Alison Padfield, barristers of Devereux Chambers, consider the current state of the law in relation to terms in contracts between consumers and insurers or brokers or other intermediaries which are found to be unfair.

US Supreme Court judgment on the Affordable Healthcare Act

Steven Levitsky, attorney in the New York Office of Duane Morris LLP, has followed up the article he and Alice Kane wrote for issue 124 of the BILA Journal. This second article considers the judgment of the US Supreme Court which upheld the constitutionality of the Affordable Healthcare Act.

Book reviews

There are 3 book reviews in this issue:

- Nathan Hull, associate, Edwards Wildman Palmer UK LLP, provides an extended review of "The Bermuda Form, interpretation and dispute resolution of excess liability insurance" by David Scorey, Richard Geddes and Chris Harris. He compares the approach in this work with the other textbook on this subject by Richard Jacobs QC, Lorelie S. Masters and Paul Stanley QC,
- Peter Fidler, also of Edwards Wildman Palmer UK LLP, reviews the "Research handbook on international insurance law and regulation" edited by Julian Burling and Kevin Lazarus,
- I have written a review of the third edition of "Insurance Claims" by Alison Padfield (who has also contributed an article to this issue (see above)).

Jonathan Goodliffe

Editor

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“Fraud” and fraudulent claims

Aysegul Bugra*

Rob Merkin**

Abstract

In this paper we examine the meaning of the word “fraud” as it is applied in the context of fraudulent claims.¹ We consider whether the definition and the legal treatment of fraudulent claims are appropriate. We seek to argue that the law is too rigid and that some judicial discretion would be a worthwhile modification. We also suggest that the approach of the English and Scottish Law Commissions, in their December 2011 Joint Consultation Paper² demonstrates insufficient flexibility. The paper includes some reference to the position in Australia under s 56 of the Insurance Contracts Act 1984 (Cth), under which the law is, in certain circumstances, able to allow the punishment to fit the crime, a principle which in our view could be extended. We have no sympathy with fraudsters, and we do not underestimate the costs of fraud for the insurance industry and for honest claimants³ but, for the reasons indicated in our paper, we are wary of absolute rules and we suggest that fears that a more generous approach might amount to a fraudster’s charter are somewhat overstated.”

The legal basis for the insurers’ rights and remedies

As a prelude to our analysis, it is necessary initially to identify the underlying common law principle which allows insurers to refuse to pay fraudulent claims. Early statements, including the oft-quoted view of Mr. Justice Willes in *Britton v Royal Insurance Co*⁴ that a fraudulent claims clause which states that the assured is to forfeit all benefit under the policy is “in accordance with legal principle and sound policy” entirely begs the question as to what “forfeit all benefit” actually means.⁵ The traditional view is that the duty not to make a fraudulent claim is an element of the general duty of utmost good faith set out in s 17 of the Marine Insurance Act 1906. If that is right, then any breach of duty has the consequence of allowing the insurers to avoid the policy *ab initio*, i.e. from the beginning.⁶

The notion that there can be a pre-contractual remedy for a post-contractual infringement⁷ has fallen out of favour,⁸ and the balance of authority now supports the proposition that the duty not to make fraudulent claims is a contractual one which is independent of notions of utmost good faith and which accordingly attracts contractual remedies.⁹ Those remedies allow the insurers to refuse to pay the fraudulent claim itself, and it is generally assumed that they also have the right to terminate the contract as from the date of the fraud.

This issue was discussed but not resolved in *Axa General Insurance v Gottlieb*¹⁰ as the policy year in which the fraud occurred had naturally come to an end and the point did not arise for decision. There is, however, some support for the right to terminate in *Orakpo v*

*Barclays Bank Insurance Services Co Ltd*¹¹ on the basis that any fraud in making the claim amounts to a repudiation of the entire policy. It thereby confers an option on the insurers to accept the repudiation and bring the relationship to an end. If such a right exists and is exercised, it would mean that valid claims made prior to the fraud¹² remain payable and any payments actually made for previous claims in the policy year cannot be recouped.¹³ There is no suggestion in the authorities that fraud has an automatic terminating effect.

Accordingly, if any part of a claim is fraudulent, the entire claim is lost. Quite why this should be so is, at least as a matter of legal doctrine, to some extent uncertain.¹⁴ What is undoubted, however, is that severance of genuine from fraudulent loss is rarely possible.

It is of course open to insurers to specify their own contractual solutions where a fraudulent claim has been made, and these may¹⁵ have more drastic consequences than the common law.¹⁶ However, we will proceed on the assumption that the duty not to make a fraudulent claim derives from contract and gives rise to contractual rather than special remedies.

Dishonesty and fraud

The classic definition of fraud was provided by Lord Herschell in *Derry v Peek*:¹⁷ “Fraud is proved when it is shown that a false representation has been made (i) knowingly (ii) without belief in its truth or (iii) recklessly, careless of whether it be true or false.” *Derry v Peek* was a case involving fraudulent misrepresentation outside the context of insurance, although that definition has been applied in insurance decisions.¹⁸ More recent cases introduced the concept of utmost good faith under s 17 of the Marine Insurance Act 1906 into the discussion of fraudulent claims – *The Litsion Pride*¹⁹ and *The Captain Panagos*²⁰. They gave rise to the argument that the insurers could avoid the policy by proving something less than fraud in the *Derry v Peek* sense.²¹ However, with the demise of those cases it now appears that *Derry v Peek* remains the governing decision. That said, the application of *Derry v Peek* to insurance cases is not straightforward.

Insurance cases decided before *Derry v Peek* referred to fraud in terms of a statement which was “wilfully false in any substantial respect”²² and to a fraudster as one who “knowingly preferred a claim he knew to be false or unjust”²³. The statutory definition of fraud in the Fraud Act 2006 refers to a false representation which occurs where a person dishonestly makes a false representation and intends by making the representation to make a gain for himself or another, or to cause a loss to another or to expose another to a risk of loss.²⁴ *Twinsectra Ltd v Yardley*,²⁵ now the leading authority on knowing assistance for breach of fiduciary duty, sought to clarify the meaning of dishonesty. Lord Hutton stated in that case that “before there can be a finding of dishonesty it must be established that the defendant’s conduct was dishonest by the ordinary standards of reasonable and honest people and that he himself realised that by those standards his conduct was dishonest”. The modern gloss on the law accordingly recognises an objective and a subjective test. That definition was applied by Mr. Justice Eder in *Aviva Insurance Ltd v Brown*²⁶ to support the

view that for a misrepresentation to be fraudulent, the assured himself had to realise that his conduct was dishonest. Certainly there is authority for the proposition that even a grossly exaggerated claim is not necessarily fraudulent.²⁷

Recklessness and fraud

Where does recklessness fit into this? It was noted above that, according to Lord Herschell, an assured who makes a statement recklessly can have no real belief in the truth of what he has said, and in this sense recklessness is an instance of type (ii) fraud. That is an extreme possibility. In other cases, recklessness could amount to nothing more than indifference by the assured as to the truth or falsity of his statement, perhaps in the belief that it does not much matter in the context of the claim, and that is not necessarily tantamount to dishonesty. One of the essential elements in deciding whether a claim is fraudulent is the intention to defraud and mislead the insurers and it is uncertain whether recklessness in any form, whether culpable or innocent recklessness, evidences such an intention. It is not obvious therefore, that recklessness satisfies the dishonesty test suggested in *Twinsectra*.

Nevertheless, the modern tendency is to treat recklessness as an aspect of fraud. The courts may, if not satisfied that the conduct is deliberate, refer to it as “at the least, reckless”.²⁸ Lord Justice Mance (as he then was) explained in *Agapitos v Agnew* that “A fraudulent claim exists where the insured claims, knowing that he has suffered no loss, or only a lesser loss than that which he claims (or is reckless as to whether this is the case)”. Lord Hobhouse in *The Star Sea*²⁹ referred to recklessness as a decision by the assured not to enquire into the true facts, fearing that the outcome would be unfavourable for him. He added, however, that that the position might be different if the assured did not enquire because he was too lazy or believed that there was nothing potentially amiss.³⁰ There may, therefore, be degrees of recklessness falling on either side of the dividing line between negligence³¹ and fraud.

Materiality and inducement

For an insurer to refuse payment of a fraudulent claim, the relevant fraud needs to be material. The concept of materiality in the context of fraudulent claims is not the same as its equivalent in the pre-contract utmost good faith context.³² It can rather be considered as a “substantiality” requirement. English law is clear that there is a quantitative element to fraud,³³ but it is less certain whether substantiality relates to the quality of the assured’s conduct. That may be a live issue where the alleged fraud does not constitute overvaluation, but rather some act or statement designed to induce payment by the insurers. Lord Justice Millett suggested in *Galloway v Guardian Royal Exchange (UK) Ltd*³⁴ that fraud is substantial if, “taken in isolation, the making of that claim by the insured is sufficiently serious to justify stigmatising it as a breach of his duty of good faith so as to avoid the policy”³⁵. This can presumably be dismissed, given that fraudulent claims and good faith are now recognised as separate concepts.

That aside, what is apparent from the cases is that fraud may be substantial even though it has no financial value and does not cause loss to the insurers, and it was said in *Agapitos v Agnew*³⁶ that a lie would be substantial if it would objectively yield a not insignificant improvement in the assured's prospects of obtaining settlement or winning a trial. It is irrelevant that the lie cannot as a matter of fact be relevant to the claim.³⁷ Two examples suffice. In *Aviva Insurance v Brown*³⁸ the assured's property had suffered damage flowing from an insured peril and he had to look for alternative accommodation. In a letter that he sent to the insurers, he informed them of accommodation that he thought suitable, but he did not disclose that he was its owner. In the event he chose not to occupy it. The representations were held to amount to substantial fraud³⁹ even though they did not affect, and could not have affected, the handling of the claim. Similarly in *Sharon's Bakery (Europe) Ltd v Axa Insurance plc*⁴⁰ the assured, needing to prove title to damaged machinery but unable to do so, presented a fraudulent invoice to the insurers in order to substantiate an otherwise valid claim. The lie of the assured was held to be substantial and the claim was forfeit although again there was no real significance in use of that fraudulent device.

As far as inducement is concerned, in contradistinction to the pre-contractual position, a statement which is fraudulent retains that quality even though it actually had no inducing effect upon the insurers in deciding whether or not to pay a claim.⁴¹ If the assured rightly or wrongly believed that his statement could not have an inducing effect then he has not been fraudulent in the first place, but if he believed that it could have such effect then his conduct would be classified as fraudulent even if he was wrong and the insurers actually knew the truth or regarded the misstated fact as irrelevant to their decision. That in turn means that *Danepoint Ltd v Underwriting Insurance Ltd*⁴² is³² incorrectly decided. In that case, following a fire at the assured's block of flats, exaggerated claims for repair costs were submitted. The claim was held not to be fraudulent because the insurers, through adjusters, had themselves examined the premises and made their own assessment of the costs and had thereby rejected that of the assured.

The principle that no inducement is required leads to the further proposition that fraud cannot be retracted. That was specifically stated to be the case by Mance LJ in *Agapitos v Agnew*,⁴³ a point confirmed by him speaking for the Privy Council in *Stemson v AMP General (NZ) Ltd*,⁴⁴ a case in which the assured sought to withdraw a fraudulently exaggerated claim after the insurers had discovered the fraud.

Classes of fraud

One of the central themes of our argument is that the all or nothing rule does not adequately distinguish between the various classes of fraud conveniently classified by Mance LJ in *Agapitos v Agnew*.⁴⁵ Our argument is that each merits discrete treatment.

The first class arises where the assured has not suffered a fortuity giving rise to loss: either there is no loss at all, or the loss is the result of the deliberate act of the assured.⁴⁶ Plainly the assured should recover nothing in either situation because there is no loss.

The second class consists of exaggerated claims, where the assured has suffered some loss but not as much as the amount he is seeking to recover. That may involve the overvaluation of lost property, or the embellishment of what has been lost by the addition of other property. This is the paradigm situation in which the all or nothing rule hits home. But not every overvaluation is fraudulent. The *Twinsetta* test requires that the assured appreciates his own dishonesty, and many assureds are rightly or wrongly of the view that they will not be offered the full amount of their loss and so some creative claiming is necessary. The courts have recognised this possibility and there is now a body of authority accepting that some degree of overvaluation is not fraud.⁴⁷ The greater the exaggeration, the greater the prospect there is of a finding of fraud.⁴⁸ Ultimately the judicial approach has become to “consider the fraudulent claim as if it were the only claim and then to consider whether, taken in isolation, the making of that claim by the insured is sufficiently serious to justify stigmatising it as fraud.”⁴⁹ *De minimis* (i.e. insignificant) fraud is thus to be disregarded.⁵⁰

The bar on severance applies even where the losses are different in nature. It was held in *Danepoint v Allied Underwriting*⁵¹ that there was a single claim following a fire, and it was irrelevant that there were two heads of damage, repair costs and lost rent: fraud in relation to the former tainted the claim in respect of the latter. Similarly in *Direct Line v Khan*⁵² the assured under a home and contents insurance policy made a fraudulent claim for lost rent following a fire, and that was held to taint his claim for reinstatement of the buildings and replacement of the contents arising from the same event. In *Yeganeh v Zurich Plc*⁵³ a combined property and contents insurance was at issue, and it was assumed that a claim under this insurance was a single claim. The assured made a genuine claim for fire damage to his house, costing £270,000 to reinstate, but lost the entire sum because a small part of a contents claim worth in total £12,465 was fraudulent. It is uncertain just how far this goes: if fraud can travel across different sections of the same policy, can it also travel across different policies with the same or indeed a number of insurers?

Mance LJ’s third class arises where the assured, having apparently sustained a loss, subsequently discovers that there is no loss at all, or a loss of a smaller amount, but continues to press his claim. This class may, for present purposes, be regarded as indistinguishable from the second class.

The fourth class encompasses that of an assured who makes a claim against his insurers knowing that they have a defence to the claim under the policy. This overlaps with the fifth class, discussed in the next paragraph, but it may be thought not to be an absolute principle. Plainly if the assured has carried out welding operations in breach of policy provisions, and that welding has given rise to the loss, suppression of the welding ought to give the insurers a defence.⁵⁴ But is it really the case that an assured has to draw to the insurers’ attention a defence which they could easily have discovered for themselves based upon the facts known to them?

The fifth class, which in our view raises the most difficult questions, is the use of fraudulent means or devices by the assured in presenting his claim. What is contemplated here is a loss which is perfectly genuine and which the insurers are liable to pay, but the

assured – through impatience with non-settlement, or perhaps through embarrassment of the circumstances in which the loss has occurred⁵⁵ – has misstated⁵⁶ facts about his own conduct before or after the loss. The decisions in *Sharon's Bakery* and *Aviva v Brown*, discussed above, demonstrate that policyholders who have done no more than attempt to secure payment which was undoubtedly due to them and in a manner which cannot affect the insurers' interests may lose their claim by virtue of deliberate misstatement.

The consequences of fraud

Few would argue with the need to deter fraud through the removal of all possible incentives for an assured to put forward a fraudulent claim. However, the loss of the entire claim is not necessarily the only means to achieve that end, as is demonstrated by a comparison with the treatment of other forms of fraud in the insurance context. What is apparent is that discretions – even in the case of fraud – are far from unknown in the law.

Where a tort claim is in part valid and in part fraudulent – as where the degree of personal injuries suffered by a person, or indeed the number of victims of a motor vehicle collision – are exaggerated, the law required only the valid part of the claim to be paid. The principle that the entire claim is lost is one unique to insurance frauds. That does not of course mean that a fraudulent claimant will actually walk away from the court with pockets bulging. In *Fairclough Homes Ltd v Summers*,⁵⁷ the Supreme Court denied the possibility of the court giving judgment striking out the claim as a whole, other than in exceptional circumstances. It noted, however, that costs could be awarded against the claimant on an indemnity basis and interest could be refused. Any attempt to prove the amount of the valid part of the claim would be looked upon with scepticism, and permission to launch contempt proceedings could be granted by the judge. These devices, coupled with the ability of the judge to refer the matter to the criminal prosecution authorities, mean that a claimant is likely to be substantially worse off as the result of any attempted fraud.

It is also clear that fraud following the commencement of legal proceedings is not to be regarded as any part of the claim but rather is a matter for the court to resolve by the application of its own contempt rules. So if the assured submits false or exaggerated invoices, or misstates the circumstances of the loss, in court proceedings,⁵⁸ the insurers cannot deny liability or indeed exercise any other contractual right but are in the hands of the court. Quite what a court would do is uncertain, but it is obvious that it would reach a proportionate decision utilising some or all of the remedies detailed in *Fairclough Homes*. Again, the fraudulent claims rules cannot be relied upon before the assured has made a claim against the insurers, as where circumstances which may give rise to a claim against the assured are notified to the insurers under a professional indemnity policy and there are fraudulent misrepresentations in the notification,⁵⁹ or where there is fraud (eg, the submission of forged invoices for payment of the agreed sum) after the claim has been

settled.⁶⁰ Each of these possibilities may give rise to the very problems caused by fraudulent claims but the remedies are quite different. In the former case the insurers may well incur substantial expenditure ascertaining the true position and preparing a defence on behalf of the assured which is entirely unnecessary, and their remedy is damages for their loss. In the latter case there is presumably no sanction at all other than that the assured has failed to establish that he has incurred the relevant expenditure and so cannot claim reimbursement.

Some reference may also be made to the law of illegality. An assured who has committed a criminal offence as a result of which he has suffered an insurance loss does not automatically lose his claim. The principle that illegality bars a claim necessarily applies where the assured is seeking an indemnity against a fine or other punishment, but the rule is less rigid where the criminality is simply the backdrop against which the assured has suffered loss, eg, speeding or transporting drugs: he will lose his claim only if his criminality has a close causal connection to the loss and the criminality is of a type which would cause a court to refuse to lend its assistance to the claim.⁶¹ An extreme illustration of the same principle is found in the Forfeiture Act 1982, which removes the right of a beneficiary to derive any benefit from homicide but nevertheless confers upon the court a discretion to allow the claim in full or in part other than in cases of murder.⁶²

So it could be argued that loss of the entirety of an insurance claim where part of it is fraudulent is simply one means to achieve the aim of deterrence, and one which is not available in a number of important situations. Proportional remedies are plainly inappropriate where the assured has deliberately caused his own loss. There is room for debate as to whether proportionality should be applied to exaggerated claims, a position which can in any event be reached by treating fraud as *de minimis* and thus to be ignored. However, our point is that the “all or nothing” treatment extends not just to the paradigm cases of manufactured or exaggerated loss, but also affects the rather less heinous use of fraudulent means or devices where it may be thought that a different and less rigid approach is appropriate.

Third party fraud

Where two or more policyholders are insured under the same policy and only one of them acts fraudulently, it is important to have clear rules as to whether and how the innocent policyholders are affected. The law adopts a distinction founded on the nature of the parties' interests rather than on the description of the policy.⁶³ Where the policyholders have a joint single and indivisible interest over the same subject-matter there can only be one claim and accordingly the fraud of one policyholder is fatal to them all. Where, however, the co-assureds have different and severable interests over the subject-matter insured but are insured by a single document, the policy is composite and each policyholder has a separate claim against the insurers.⁶⁴ That said, an innocent composite

assured might lose the claim if the fraudster is regarded as having acted as agent, which was the somewhat inexplicable assumption of the Court of Appeal in *Direct Line Insurance v Khan*⁶⁵. In that case the husband made a fraudulent claim in respect of lost rent and his fraud was held to bar any claim by his wife, not because the policy was joint (which was almost certainly the case) but because the husband was acting as agent for his wife.

Classifying spouses as joint assureds, or one spouse as agent for the other, is scarcely an enlightened approach to relationships, and the balance of recent authority from other common law jurisdictions has rejected it. In *Maulder v National Insurance Company of New Zealand Ltd*⁶⁶ the High Court of New Zealand expressed the view that categorising property as “joint” was meaningless and that if an insurer wished to prevent an innocent party from recovering due to fraud by a co-assured, the policy had to state it clearly and unambiguously.⁶⁷ That does not of course mean that the innocent co-assured will actually benefit: in cases of deliberate destruction by one co-assured the insurers will, having indemnified the innocent co-assured, possess subrogation rights against the fraudster which, if exercised, will strip the couple of any recovery. But that does not affect fraud of different types, where no subrogation rights will exist.

The innocent may suffer independently of co-insurance principles. If the controller of a company deliberately sets fire to the company’s property, the doctrine of attribution⁶⁸ will treat the acts of the controller as if they were the acts of the company, thereby depriving other shareholders of the benefits of the policy.⁶⁹

The position in Australia:⁷⁰ the remedy for fraud

The Insurance Contracts Act 1984 (Cth), s 56, based upon the recommendations of the Australian Law Reform Commission in its seminal Report No 20, 1982,⁷¹ (“ALRC 20”) partially addresses some of the problems identified above. The requirement of the assured to observe utmost good faith is maintained by s 13, but the full consequences of breach of that duty at common law are removed. Section 56(1) accordingly states that if the assured makes a fraudulent claim the insurers may not avoid the policy *ab initio* although they may refuse payment of the claim.⁷² This more or less represents the position reached by the common law since the passing of the 1984 Act and also the codification proposals of the English and Scottish Law Commissions. There is no definition of “fraud” in the legislation, and the authorities have accepted the forms of fraud recognised by the common law fall within s 56(1).

Thus the subsection applies to deliberate destruction, as in *Preseed Pty Ltd v Colonial Mutual General Insurance Co Ltd*,⁷³ exaggerated claims, as in *Entwells Pty Ltd v National and General Insurance Co Ltd*⁷⁴ (falsified stock sheets) and also to the use of fraudulent means or devices as in *Tiep Thi To v Australian Associated Motor Insurers Ltd*⁷⁵ (misstatement as to the circumstances of the loss). The section also maintains the principle that the fraud need not be material, but it does not enlarge that definition but merely removes the harsh

consequences of the avoidance remedy.⁷⁶ Consistently with the common law, a claim is not fraudulent within s 56(1) if made in the course of judicial proceedings on the policy.⁷⁷ Section 56(1) does not affect the rules on joint and composite assureds, so an innocent composite assured is able to recover irrespective of the fraud of the other in the absence of agency⁷⁸ and one joint assured is barred by the fraud of another.⁷⁹ The section leaves untouched the doctrine of imputation, which may preclude a company from recovering where the fraud is that of its controlling mind and will.⁸⁰

As to the continuing relationship between the assured and the insurers, ALRC 20 favoured the position that the insurers should be entitled to cancel both the policy under which a fraudulent claim was made and also any other existing policies to which the assured is party, on the basis that the insurers could not be expected to continue to be in a contractual relationship with a fraudster.⁸¹ These proposals were implemented by s 60(1)(e). This allows the insurers to cancel any existing policy where the assured has made a fraudulent claim,⁸² including a claim against some other insurer. The subsection goes much further than the common law, which has yet to recognise a right to terminate any other policy.

There is one further variation, but in favour of the assured. Under s 50(2A)(a)(i) termination takes effect fourteen days after notice of cancellation is tendered, whereas the common law does not impose any notification requirement and termination becomes effective from the date of the fraud. That leaves open the questions whether a genuine claim made between the fraudulent claim and termination becoming effective has to be paid, and whether cancellation removes claims for independent genuine losses occurring prior to the making of fraudulent claim.⁸³ What is clear is that if the right to cancel is not exercised, the policy remains valid and enforceable, and later claims have to be paid.⁸⁴

The position in Australia: proportional recovery

Section 56(2) states as follows:

In any proceedings in relation to such a claim, the court may, if only a minimal or insignificant part of the claim is made fraudulently and non-payment of the remainder of the claim would be harsh and unfair, order the insurer to pay, in relation to the claim, such amount (if any) as is just and equitable in the circumstances.

The court may, therefore, apply a proportional remedy.⁸⁵ In doing so the court must, under s 56(3) “have regard to the need to deter the fraudulent conduct and to any other relevant matter.” In assessing the impact of these provisions, two questions must be posed: to what classes of fraud do they apply; and do they lay down principles which would not otherwise be reached by the English courts?

Turning to the first of these matters, it is apparent from both ALRC 20 and from the wording of s 56(2) that the targeted fraud is exaggerated claims. The use of fraudulent means and devices was not under consideration, and there was indeed authority for the proposition that if the assured had a valid claim then later fraud could not affect it.⁸⁶ Although ALRC 20 was expressed in the general terms that the courts should have discretion to order the insurer to pay a just and equitable amount “in cases where the total loss of the insured’s claim would be seriously disproportionate to the harm which the insured’s conduct has or might have caused”,⁸⁷ the section is not drafted in those terms. ALRC 20 gave an example of when its proposals might bite, namely, a claim for contents worth A\$3000 coupled with a claim for a non-existent computer allegedly worth A\$200.

The Explanatory Memorandum to the 1984 Act gave a further illustration of a claim for lost contents worth A\$100,000 along with a claim of A\$50 for a non-existent watch. The implementing words of s 56(2), “non-payment of the remainder would be harsh and unfair” presume that the claim is divisible into a fraudulent part, which is minor, and the remainder, which is substantial. It follows that if the fraud taints the entirety of a claim and not just a divisible component of it, the subsection cannot apply. That is the case with the use of a fraudulent mean or device, consisting of a misstatement in the claims process⁸⁸ or with a quantum claim which is expressed not in financial terms but by way of comparison with the value of other equivalent property.⁸⁹ On the same basis it is unlikely that s 56(2) could be prayed in aid to benefit an innocent joint assured.

However, the divisibility requirement has not always been adhered to in practice, and indivisible fraud which is minor has been regarded as capable of being disregarded. In *Rego v Fai General Insurance Company Ltd*⁹⁰ the assured when completing an insurance proposal form, in response to a question about prior losses, suppressed a prior burglary claim he had made against another insurer in respect of the same premises. The assured suffered a further loss and, when he completed the claim form, he falsely answered the same question because he did not want to delay the handling of the claim. It was held that the only part of the claim which was fraudulent was the answer to the question about previous claims, and that this was minimal and could be disregarded under s 56(2) because denial of the claim would be harsh and unfair. It is difficult to see how this can fall within s 56(2) if the indivisibility principle is applied, because the fraud affected the entire claim and there was no issue as the payment of any “remainder”. In the same way, the Insurance Ombudsman Service, the forerunner of the present Financial Ombudsman Service, has ruled that a fraudulent statement of the circumstances of the loss is to be disregarded if it is retracted before fraud has been alleged or the claim denied.

Turning to the second of these matters, the Australian courts have been reluctant to exercise their power under s 56(2) to apportion a claim based upon the degree of fraud, and it might be thought that there is little difference in practice between the s 56(2) power of apportionment and the common law *de minimis* principle.⁹¹ Gerald Swaby⁹² has

helpfully collated the English and Australian case law, and has noted that the test of substantiality is both relative and absolute, assessed by way of percentage and the figure sought. He also notes that the outcomes in each of the jurisdictions are more or less comparable, although the limited evidence shows that the Australian cases are marginally more generous. In his words, and based on the English cases: “although 2% in itself can appear to be a relatively small *quantitative* amount, anything greater than 2% is capable of being substantial, with 0.3% or below considered to be *de minimis*”.⁹³ As far as Australia is concerned, in *Allianz Australia Insurance Ltd v Douralis*⁹⁴ the Supreme Court of Victoria was of the view that a false statement by the assured in the course of the litigation, alleging that anxiety and stress had been suffered would have justified invoking s 56(2), because the amount claimed was minimal and insignificant⁹⁵. In *Entwells Pty Ltd v National & General Insurance Co Ltd*⁹⁶ the court’s view was that, had the claimant not been a party to the fraudulent setting of the fire, a claim totalling A\$520,000, including a genuine stock claim of A\$100,000 and a fraudulent stock claim of A\$27,000, would have been dealt with under s 56(2) by depriving the assured of the entirety of the A\$100,000 stock claim but allowing the remainder. This indicates that fraud of between 5%-12% could trigger the section. By contrast, a claim exaggerated by at least 33% (the fraud being worth at least A\$15,000) has been held to be incapable of condonation under s 56(2).⁹⁷

Reforming English law

We have in this paper highlighted the problems which are inherent in the common law all or nothing approach. We have also analysed the Australian reforms and we have concluded that, despite the best of intentions, they achieve relatively little, not the least because some of the issues which have recently come to the fore – and in particular the strict application of the law to fraudulent means and devices – were not in contemplation when they were drafted.

Where, then, should the law go from here? The English and Scottish Law Commissions, in their December 2011 Joint Consultation Paper, felt that only minor tweaking of the common law was necessary and that there was no place for the Australian modifications. The Law Commissions confirmed the current principles that fraud should be an all or nothing defence, that insurers should be permitted to terminate but without prejudice to pre-fraud valid claims and that there should be no right of avoidance *ab initio*. The Law Commissions also recommended that policies should not be allowed to confer greater rights against consumers although express clauses should be enforceable in business policies. The Law Commissions were unconvinced that a case had been made out to reform the law on joint and composite insurance. In our view, however, pulling together the various strands discussed above, the law is unsatisfactory. Our case is based upon the uncertainties of the law and upon the fine distinctions that presently have to be drawn. We would point to the following specific issues and we suggest possible reforms.

First, the definition of fraud is of itself uncertain. There is some protection for an assured who has made a false statement, in that the court may undertake a close examination of the assured's motives for making an uncorroborated statement and conclude that the conduct should be classified as merely lazy or negligent. Dishonesty may also be negated by the assured's belief as to the effects of his statement. In *Aviva Insurance Ltd v Brown*⁹⁸ Mr. Justice Eder held a deliberate false statement by the assured in making a claim for renting alternative accommodation when the premises in question were under his indirect control was dishonest by objective standards. It did not amount to fraud, on the other hand, because of his subjective but incorrect belief that the insurers knew the true position. In other words an assured who believes that the insurers will not be fooled by his falsity is to be regarded as not dishonest. However, given the absence of any need for proof of inducement, the position of the insurers in law may well be better if they have not been fooled than it is when they have, because the focus is on the assured and not on the insurers.

This leads to the second point, which is that the insurers' own conduct is to be left out of account. *Aviva v Brown* is an extreme example of the point. The assured's house suffered subsidence damage in 1989. The insurers did not admit liability, and maintained their stance despite an award in the assured's favour by the Financial Ombudsman Service. It was not until 2008 that repair works were commenced. Eder J held that none of this delay in any way mitigated the assured's intended (but not implemented) fraud to claim rental costs for premises he actually owned. Less extreme scenarios can be imagined, as where an insurer offers to settle for an amount less than the sum insured but without apparent justification or where the insurers unreasonably insist upon proofs of loss.⁹⁹ We have already noted that "bargaining claims" which either anticipate or respond to that possibility are not fraud if the additional sum sought is *de minimis*. Reforming the law on payment of claims, requiring payment to be within a reasonable time,¹⁰⁰ may remove some frauds of the *Brown* type, but it may be said that poor claims-handling may well provide a trigger for the very fraud which justifies complete refusal of the claim. Even as the law stands such poor claims-handling will generally be a breach of the insurer's duty to "handle claims promptly and fairly" under Rule 8.1.1R of the Financial Services Authority's Insurance Conduct of Business Sourcebook.

Thirdly, it is not obvious why the all or nothing approach should extend beyond the precise fraudulent claims and to other claims which arise from the same event but falling under different policy sections. Can it be said that that principle gives a proportional remedy, particularly where – as in *Yeganeh* – the innocent element dwarfs the fraudulent element? The fraud entitles the insurers to terminate their relationship with the assured as from its date, so they are under no further risk of fraudulent claims. Does that not suffice? The English and Scottish Law Commissions felt that this matter should be left to the courts. The Australian approach in *Entwells Pty Ltd v National & General Insurance Co Ltd*¹⁰¹ evidences a proportional approach to this situation.

Fourthly, insufficient attention has been given to the distinctions between the different types of fraud. If the claim is exaggerated, then the loss of the entire claim is a settled – although, as we have argued, not a necessary – principle of English law. But we would suggest that the situation in which a perfectly genuine claim becomes tainted by the use of fraudulent means and devices is quite different. It is one thing for an assured to manufacture documents to boost the value of the lost subject matter,¹⁰² but it is quite another for the assured to resort to such conduct in order to establish to the satisfaction of insurers title to property which he already owns.¹⁰³ It is here of interest to compare the generous approach of the Western Australian District Court to the interpretation of s 56(2) of the Insurance Contracts Act 1984 (Cth) in *Rego v Fai General Insurance Company Ltd*¹⁰⁴ with the hard common law line of the English courts in both *Aviva v Brown* and *Sharon's Bakery*.

The attitude of the Financial Ombudsman Service in the UK is also instructive. FOS has drawn a distinction between false or exaggerated claims and the use of fraudulent means or devices, so that “fraud which does not prejudice the insurer’s liability to pay the claim should, in effect, be disregarded ... where the fraudulent act or omission makes no difference to the insurer’s ultimate liability under the terms of the policy, it should not entitle the insurer to ‘forfeit’ the policy or reject the claim. In the example ... of the forged receipt, the claim should be paid. Indeed, it was the insurer’s unreasonable insistence on strict proof that caused the policyholder to act dishonestly in the first place.”¹⁰⁵ FOS has indeed ordered an insurer to pay a self-employed plumber who suffered a genuine loss of tools by theft but forged purchase receipts in order to establish his undoubted title to them.

Fifthly, the rules which deny a co-assured any recovery if the fraudster has deliberately destroyed the subject matter or submitted a claim which is exaggerated or tainted by fraudulent means or devices are outmoded. The English and Scottish Law Commissions chose not to make any recommendation on the point, as they did not regard it as of sufficient significance to justify law reform and could find no way of ensuring that the guilty party did not benefit.¹⁰⁶ The notions that a wife should be denied recovery either because she is a joint assured or because her husband acted as her agent are outmoded, subrogation will ensure that the guilty husband receives no benefit in the case of deliberate destruction. Similarly the corporate attribution rules reinforce artificiality and it is surely possible to find a mechanism, which could be subrogation in destruction cases, for confining payments to the innocent. Alternative approaches might be either to reduce the claim to the extent to which the fraudster himself would benefit¹⁰⁷ or alternatively to allow the claim in full but with insurers having a right of subrogation against the wrongdoer.

Finally, as regards the rule that a fraudulent claim cannot be retracted, a case can be made out for a different outcome where the assured voluntarily retracts his fraud before it has

been discovered and before the insurers have acted to their prejudice as a result of it. It is a well established principle in the general law of contract that a party who repents of illegality performance is entitled to restitution of sums paid by him under the contract, but a repenting fraudster has no rights whatsoever.

Endnotes

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- ¹ See: Anthony Tarr, “Dishonest Insurance Claims” (1998) 1 Ins LJ 42; Julie-Anne Tarr, “Fraudulent Insurance Claims: Recent Legal Developments” [2008] JBL 139.
- ² *Post Contract Duties and Other Issues*, LCCP 201/SLCDP 152, Chapter 2, building on *The Insured’s Post-Contract Duty of Good Faith*, Issues Paper No 7, July 2010.
- ³ The sum is estimated to exceed £2 billion per annum, although that encompasses not just claims *by* assureds, but also claims *against* assureds by those feigning or exaggerating injury or loss. The latter is a growing phenomenon. The reader is referred to the website of the Insurance Fraud Bureau for full details.
- ⁴ (1866) 4 F & F 905, 909.
- ⁵ Noted by the Court of Session in *Fagnoli v GA Bonus plc* [1997] Re LR 374.
- ⁶ That would not be the sole remedy: insofar as fraud takes the form of misrepresentation, the insurers are perfectly free to claim damages in deceit as an alternative, or in addition, to avoiding the policy. For this reason the suggested rule (see *London Assurance v Clare* (1937) 57 Ll LR 254) that insurers cannot claim damages for the costs of investigating a claim is almost certainly incorrect, and it may be noted that in *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm) it was common ground that the insurers’ non-fixed costs incurred in investigating the claim were held to be recoverable as damages.
- ⁷ First suggested in *Black King Shipping Corp v Massie, The Litsion Pride* [1985] 1 Lloyd’s Rep 437 and followed in *Continental Illinois National Bank & Trust Co of Chicago v Alliance Assurance Co Ltd, The Captain Panagos DP* [1986] 2 Lloyd’s Rep 470.
- ⁸ As well as Canada (*Gore Mutual Insurance Co v Bifford* 45 DLR (4th) 763 (1987), Scotland (*Fagnoli v GA Bonus plc* [1997] Re LR 374) and Australia (Insurance Contracts Act 1984 (Cth), s 56(1)). However, the duty is still classified as one based on good faith in New Zealand: *Blanshard v National Mutual Life Association of Australasia Ltd* (2004) 13 ANZ Insurance Cases 61-621; *Vero Insurance NZ Ltd v Posa* (2009) 15 ANZ Insurance Cases 61-791; *Fussell & McNamara v Broadbase Christchurch Ltd* (2011) 16 ANZ Insurance Cases 61-913.
- ⁹ The story begins with the judgment of Lord Hobhouse in *Manifest Shipping Co Ltd v Uni-Polaris Shipping Co Ltd, The Star Sea* [2001] Lloyd’s Rep IR 247, and the process was perfected by Longmore LJ in *K/S Merc-Skandia XXXXII v Lloyd’s Underwriters* [2001] Lloyd’s Rep IR 802 and Lord Mance in *Agapitos v Agnew, The Aegeon* [2002] Lloyd’s Rep IR 573 and *Axa General Insurance v Gottlieb* [2005] Lloyd’s Rep IR 369. For confirmation, see *Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV* [2005] Lloyd’s Rep IR 396. The matter is analysed at length by the Law Commissions, *Post Contract Duties and Other Issues*, Chapter 2, Part 6.

- ¹⁰ [2005] EWCA Civ 112, para 21.
- ¹¹ [1995] LRLR 443, 451 per Hoffman LJ, referring to the direction to the jury by Willes J in *Britton v Royal Insurance Co* (1866) 4 F & F 905.
- ¹² That almost certainly means that if claim A occurs, followed by claim B, and then the assured commits fraud in respect of claim A, claim B has accrued and remains unaffected.
- ¹³ The Law Commission Consultation Paper No 201 and the Scottish Law Commission Discussion Paper No 152, para 6.53.
- ¹⁴ See the vacillation of the Court of Appeal in *Orakpo v Barclays Insurance Services* [1995] LRLR 433 on this point.
- ¹⁵ In consumer cases validity has to be tested against the reasonableness requirements laid down in the Unfair Terms in Consumer Contracts Regulations 1999. The Regulations were prayed in aid in *Direct Line Insurance plc v Fox* [2009] EWHC 386 (QB), but the clause was held to replicate the common law and thus not unreasonable.
- ¹⁶ See, eg: the Institute Hull Clauses 2003, which create a condition precedent to recovery that the assured does not mislead or attempt to mislead the insurers; *Joseph Fielding Properties (Blackpool) Ltd v Aviva Insurance Ltd* [2010] EWHC 2192 (QB), where the clause operated with retroactive effect.
- ¹⁷ [1889] 14 App CAS 337, 376.
- ¹⁸ In *Lek v Mathews* (1927-28) 29 LI LR 141, 145 Viscount Sumner stated that a claim is false not only because it is deliberately invented, but also if it is made recklessly not caring whether it is true or false, with the sole intention to succeed in the claim.
- ¹⁹ [1985] 1 Lloyd's Rep 437
- ²⁰ [1986] 2 Lloyd's Rep 470
- ²¹ *Hussain v Brown (No 2)* 1996, unreported; *Parker & Heard Ltd v Assicurazioni Generali SpA* 1998, unreported; *Bucks Printing Press Ltd v Prudential Assurance Co* [2000] CLY 880.
- ²² *Goulstone v The Royal Insurance Company* (1858) 1 F & F 276, at 278.
- ²³ *Chapman v Pole* (1870) 22 LT 306, at 307.
- ²⁴ Fraud Act 2006 s 2(1).
- ²⁵ [2002] 2 AC 164.
- ²⁶ [2011] EWHC 362 (QB). See also: *Dawson v Monarch Insurance Co of NZ Ltd* [1977] 1 NZLR 372; *Insurance Manufacturers of Australia Pty Ltd v Heron* [2005] VSC 482.
- ²⁷ [1937] 2 A11 ER 193.
- ²⁸ As in *Tyndall Life Insurance Co Ltd v Chimsol* [1999] SASC 445.
- ²⁹ [2003] 1 AC 469.
- ³⁰ In *Vero Insurance NZ Limited v Posa* (2009) 15 ANZ Insurance Cases 61-791, the High Court of New Zealand confirmed the finding of the primary judge that a failure by the assured to enquire into the truth was a consequence of his belief that the issue was not important, so that he could not be said to be fraudulent. Cf *Australian Casualty and Life Ltd v Hall* (1999) 151 FLR

360 (a disclosure case in which the same distinction was drawn).

³¹ *Tonkin v UK Insurance Ltd* [2007] Lloyd's Rep IR 283; *US Trading Ltd v Axa Insurance Co Ltd* [2010] Lloyd's Rep IR 505; *Ricciardi v Suncorp Metway Insurance Ltd* [2001] QCA 190.

³² Where the misstatement needs to affect objectively the decision of an insurer to take on the risk.

³³ The relevant cases are discussed below.

³⁴ [1999] LRLR 209.

³⁵ *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] LRLR 209, 214.

³⁶ *Agapitos v Agnew (No 1) (The Aegeon)* [2002] EWCA Civ 247.

³⁷ Materiality in the wider sense has similarly been rejected by the New Zealand courts. Materiality was originally held to be an element of fraud (*Vermeulen v SIMU Mutual Insurance Association* (1987) 4 ANZ Ins Cas 60-812, *Kinred v State Insurance General Manager* (1990) 5 ANZ Ins Cas 60-923) but that view no longer holds sway (*State Insurance Office v Bern* (1991) 6 ANZ Ins Cas 61-085).

³⁸ [2011] EWHC 362 (QB).

³⁹ At para 96.

⁴⁰ *Sharon's Bakery (Europe) Ltd v Axa Insurance plc* [2011] EWHC 210 (Comm).

⁴¹ *Interpart Comercio e Gestao SA v Lexington Insurance Co* [2004] Lloyd's Rep IR 690; *Stemson v AMP General Insurance (NZ) Ltd* [2006] Lloyd's Rep IR 852.

⁴² *Danepoint Ltd v Underwriting Insurance Ltd* [2006] Lloyd's Rep IR 429.

⁴³ [2002] Lloyd's Rep. I.R. 173.

⁴⁴ [2006] Lloyd's Rep. I.R. 852. See also *Direct Line Insurance Plc v Fox* [2010] Lloyd's Rep IR 324.

⁴⁵ *Agapitos v Agnew* [2002] Lloyd's Rep IR 573.

⁴⁶ For burden of proof issues, see Johanna Hjalmarsson, "The standard of proof in civil cases; an insurance fraud perspective" [2013] JBL (forthcoming); *Moustakos v Federation Insurance Ltd* (1984) 3 ANZ Insurance Cases 60-587; *West End Aeronautical plc v QBE Insurance (Aust) Ltd* [2009] NSWDC 18; *AMI Insurance Ltd v Devich* (2011) 16 ANZ Insurance Cases 61-895.

⁴⁷ *Norton v Royal life Assurance Co* (1885) 1 TLR 460; *Ewer v National Employers Mutual General Insurance Association* [1937] 2 All ER 193; *London Assurance v Clare* (1937) 57 Ll LR 254; *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682.

⁴⁸ Of the many authorities, it is necessary to cite only the most recent, which include *Orakpo v Barclays Insurance Services Ltd* [1995] LRLR 443 and *Danepoint Ltd v Underwriting Insurance Ltd* [2005] EWHC 2318 (TCC).

⁴⁹ *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] LRLR 209; *Engel v South British Insurance Co Ltd* (1983) 2 ANZ Insurance Cases 77-938.

⁵⁰ As in *Tonkin v UK Insurance Ltd* [2007] Lloyd's Rep IR 283, where fraud in the sum of £2000 amounted to only 0.3 per cent of the total loss.

⁵¹ [2005] EWHC 2318 (TCC)

⁵² [2002] Lloyd's Rep IR 364

⁵³ [2010] EWHC 1185 (QB)

⁵⁴ *Agapitos v Agnew* [2002] Lloyd's Rep IR 573.

⁵⁵ *Thompson v Hopper* (1856) 6 E & E 172; *Shoot v Hill* (1936) 55 Ll LR 29; *Bucks Printing Press Ltd v Prudential Assurance Co* [2000] CLY 880.

⁵⁶ The law does not recognise a duty of disclosure, only a duty not to misstate: *Aviva Insurance Ltd v Brown* [2011] EWHC 362 (QB), dismissing the doubts expressed in *Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV* [2005] Lloyd's Rep IR 396. But contrast the New Zealand decision in *Blanshard v National Mutual Life Association of Australasia Ltd* (2004) 13 ANZ Insurance Cases 61-621, based on the classification of a fraudulent claim as part of the continuing duty of utmost good faith.

⁵⁷ [2012] UKSC 26.

⁵⁸ *The Star Sea* [2001] Lloyd's Rep IR 247 laid down this principle for the continuing duty of utmost good faith, and it was extended to fraudulent claims by *Agapitos v Agnew* [2002] Lloyd's Rep IR 573.

⁵⁹ *K/S Merc Skandia XXXXII v Certain Lloyd's Underwriters* [2001] 1 Lloyd's Rep 802.

⁶⁰ *Direct Line Insurance Plc v Fox* [2010] Lloyd's Rep IR 324. But contrast *PT Buana Samudra Pratama v Maritime Mutual Insurance Association* [2011] EWHC 2413 (Comm), where it was held to be arguable that post-settlement fraud amounted to a fraudulent claim, although *Fox* was not cited.

⁶¹ *Gray v Thames Trains Ltd* [2009] UKHL 33, applied in *Safeway Stores Ltd v Twigger* [2010] EWCA Civ 1472. For a recent example of an assured committing a crime but not being denied a claim as a matter of common law, see *Delaney v Pickett* [2011] EWCA Civ 1532 (although the victim lost on other grounds).

⁶² Forfeiture Act 1982, s 2, applied in *Re S (Deceased)* [1996] 1 WLR 235.

⁶³ *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm), where a policy on property described the fraudster as a "joint policyholder", but the policy was nevertheless held to be composite.

⁶⁴ *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm). Although the parties were here married, that had occurred after the policy was taken out and it was not clear that the fraudster had any interest in the property at all; at best the policy was composite.

⁶⁵ [2002] Lloyd's Rep. I.R. 364.

⁶⁶ [1993] 2 NZLR 351, and cf *Gate v Sun Alliance Insurance* [1995] LRLR 385, although contrast the opposite view taken shortly beforehand in *Royal Insurance Fire & General (NZ) Ltd v Renata* 1990, unreported, Whangerei High Court and *McQuade v Sun Alliance Insurance Co* (1992) 7 ANZ Ins Cas 61-136. See also *Holmes v GRE Insurance Ltd* (1988) Tas R 147.

⁶⁷ See generally, Lisa Cunningham, "The Right of An Innocent Co-Assured Spouse to Recover under "Joint" Insurance Policy" (1994) 8 *Otago Law Review* 170.

- ⁶⁸ For the principle, see *Meridian Global Funds Management Asia Ltd v Securities Commission* [1995] 3 NZLR 7.
- ⁶⁹ *Americano's Ltd v State Insurance Ltd* (1999) 10 ANZ Insurance Cases 61-455.
- ⁷⁰ Mann, *Annotated Insurance Contracts Act*, 5th ed 2012, para 56.10; Greg Pynt, *Australian Insurance Law, A First Reference*, 2nd ed 2011, chapter 21; Kenneth Sutton, *Insurance Law in Australia* 3rd ed 1999, paras 15.70 to 15.97.
- ⁷¹ Para 243.
- ⁷² It has been held that, where the duty is enshrined not to act fraudulently is contained in the policy itself, the position is governed by s 56(1) and not by the causation rules for breach of contract set out in s 54 of the 1984 Act: *Entwells Pty Ltd v National and General Insurance Co Ltd* (1991) 6 WAR 68; *Gugliotti v Commercial Union Assurance Co of Australia* (1992) 7 ANZ Ins Cas 61-104; *Tiep Thi To v AAMI Ltd* (2001) 161 FLR 61; *Walton v The Colonial Mutual Life Assurance Society Ltd* [2004] NSWSC 616.
- ⁷³ 1992, unreported (NSWSC).
- ⁷⁴ (1991) 6 ANZ Insurance Cases 61-059. See also *Moxia Pty Ltd v AMP General Insurance Ltd* 1992, unreported (VSC).
- ⁷⁵ [2001] VSCA 48. See also *Gugliotti v Commercial Union Assurance Co of Australia* (1992) 7 ANZ Ins Cas 61-104 (misstating a breath test reading).
- ⁷⁶ *Tiep Thi To v Australian Associated Motor Insurers Ltd* [2001] VSCA 48, per Callaway JA at para 7
- ⁷⁷ *Brescia Furniture Pty Ltd v QBE Insurance (Australia) Ltd* (2007) 14 ANZ Ins Cas 61-740; *Allianz Australia Insurance Ltd v Douralis* (2008) 15 ANZ Ins Cas 61-763.
- ⁷⁸ *VL Credits Pty Ltd v Switzerland Insurance Co* [1990] VR 938; *MMI (Workers Compensation) Ltd v AMEV Finance Ltd* (1988) 5 ANZ Ins Cas 60-855.
- ⁷⁹ *MMI General Insurance Ltd v Baktoo* (2000) 11 ANZ Ins Cas 61-446.
- ⁸⁰ *Entwells Pty Ltd v National and General Insurance Co Ltd* (1991) 6 ANZ Insurance Cases 61-059.
- ⁸¹ Para 251.
- ⁸² There is no right to avoid the policy as of the date of the fraud: *Walton v The Colonial Mutual Life Assurance Society Ltd* [2004] NSWSC 616.
- ⁸³ See *CIC Insurance Ltd v Bankstown Football Club Limited* (1997) 187 CLR 384, although there the issue was whether the policy had terminated before the second loss.
- ⁸⁴ *Barroora Pty Ltd v Provincial Insurance (Australia) Ltd* (1992) 7 ANZ Ins Cas 61-103; *C E Heath Casualty and General Insurance Ltd v Grey* (1993) 32 NSWLR 25.
- ⁸⁵ See Michael Kirby, "Australian Insurance Contracts Law: Local Reform with a Global Relevance" [2011] JBL 300, the Hugh Rowell Memorial Lecture 2010.
- ⁸⁶ *GRE v Ormsby* (1982) ANZ Ins Cas 60-472, although this is plainly unsupportable in the light of later authority. See, in addition to the English authorities and the post-1986 Australian authorities: *New Zealand Insurance Co Ltd v Forbes* (1988) 5 ANZ Insurance Cases 60-871; *Vermeulen v SIMU Mutual Insurance Association* (1987) 4 ANZ Insurance Cases 60-812; *Back v National Insurance Co of New Zealand Ltd* [1996] 3 NZLR 363.

⁸⁷ Para 243.

⁸⁸ *Gugliotti v Commercial Union Assurance Co of Australia* (1992) 7 ANZ Ins Cas 61-104; *Marriott v Australian Associated Motor Insurers Ltd* [2010] NTMC 53. Section 56(2) has not featured in fraudulent means or devices claims; *Naomi Marble & Granite Pty Ltd v FAI General Insurance Co Ltd* [1999] 1 Qd R 507; *Rego v FAI General Insurance Co Ltd* [2001] WADC 98; *Denes v NRMA Insurance Ltd (General)* [2002] NSWCTTT 327; *Ceper v NRMA Insurance Ltd (General)* [2003] NSWCTTT 474; *Mourad v NRMA Insurance Ltd* (2003) 12 ANZ Ins Cas 61-560; *Nasser v AAMI Insurance P/L (General)* [2005] NSWCTTT 478; *Insurance Manufacturers of Australia Pty Ltd v Heron* [2005] VSC 482; *Marshall v AAMI Insurance Ltd (General)* [2008] NSWCTTT 1243; *Younan v GIO General Ltd* [2012] NSWDC 67. The contrary view was assumed in *Titely v Tower Life Australia Ltd* [1997] SADC 3646, but the matter did not proceed to trial.

⁸⁹ *Ricciardi v Suncorp Metway Insurance Ltd* [2001] QCA 190.

⁹⁰ [2001] WADC 98.

⁹¹ Indeed, the common law may be more beneficial to the assured, because a *de minimis* finding means no fraud at all, whereas the Australian approach is condonation of a proven fraud. That means that, for future applications, the latter approach may require disclosure whereas the former approach does not.

⁹² “The Price of a Lie: Discretionary Flexibility in Insurance Fraud” [2013] JBL (forthcoming).

⁹³ *Insurance Corporation of the Channel Islands v Royal Hotel* [1997] LRLR 94 (frauds ranging between 32% and 84%); *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] Lloyds IR 209 (11%); *Direct Line v Khan* [2002] Lloyd’s Rep IR 364 (10.5%); *Axa Insurance v Gottlieb* [2005] Lloyd’s Rep IR 369 (33%); *Micro Design Group Ltd v Norwich Union Insurance Ltd* [2006] Lloyd’s Rep IR 235 (2%). But contrast *Tonkin v UK Insurance* [2007] Lloyd’s Rep IR 283 (0.3%).

⁹⁴ [2008] VSCA 72.

⁹⁵ This was “*obiter*”, i.e. an incidental remark and not part of the decision itself.

⁹⁶ (1991) 6 WAR 68. Contrast *Tsorotes v RACV Insurance Pty Ltd* 1993, unreported, Supreme Court of Victoria.

⁹⁷ *Ricciardi v Suncorp Metway Insurance Ltd* [2001] QCA 190.

⁹⁸ [2011] EWHC 362 (QB).

⁹⁹ Albeit that they are under a common law duty not to do so: *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm).

¹⁰⁰ As recommended by the Law Commissions’ December 2011 Consultation Document.

¹⁰¹ (1991) 6 WAR 68.

¹⁰² *Eagle Star Insurance Co Ltd v Games Video Co (GVC) SA (The Game Boy)* [2004] Lloyd’s Rep IR 867.

¹⁰³ *Sharon’s Bakery Ltd v Axa Insurance* [2011] EWHC 210.

¹⁰⁴ [2001] WADC 98.

¹⁰⁵ *Ombudsman News*, November 2004.

¹⁰⁶ Paras 9.10 to 9.12.

¹⁰⁷ See, for such a suggestion in the context of illegality, *Moore Stephens v Stone & Rolls Ltd* [2009] UKHL 39.

Law reform and the damages for late payment of claims proposals: is this a good idea?

By Kees van der Klugt,
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Background

In March 2012, the Lloyd's Market Association (LMA) submitted a response to the joint consultation paper of the Law Commissions of England and Wales and of Scotland [LCCP 201], published in December 2011, containing proposals on damages for late payment of claims, insurable interest, remedies for fraudulent claims, broker liability for marine premium and other matters. Many of these proposals we believe are sensible or uncontroversial; others raise some difficult issues. A particular matter of concern for the LMA is the first mentioned - damages for late payment of claims.

The LMA's membership is comprised of all the managing agents, which manage the syndicates trading in the Lloyd's market, and also the members' agents which advise third party capital. Our views are distilled within the LMA Law Reform Committee and in consultation with members. We are very appreciative of the way in which the Law Commission of England and Wales itself consults with interested parties and engages with market practitioners.

The international nature of the business written in the Lloyd's market, much of it with English law as the applicable law, means that law reform in England is not purely a domestic matter. We must be wary of unexpected consequences.

The premium capacity of the Lloyd's market for the 2012 year of account is over £24 billion. The geographical split of the insurance business underwritten is approximately as follows:

UK	18%
EU/EEA	16%
USA	41%
Other	25%.

The percentage of premium capacity in Lloyd's, where the supporting capital originates from overseas, is approximately 50%.

The current law and the proposals

The initial thinking of the Law Commission in relation to damages for late payment, as set out in their Issues Paper 6 (published in March 2010), was to balance the mutual duty of good faith between the parties to an insurance contract: a fraudulent claim would lead to forfeiture (as proposed in Issues Paper 7 and Consultation Paper LCCP 201); bad faith by an insurer in resisting the payment of a valid claim would give rise to a statutory remedy of damages.

The reasoning behind the damages proposal is that the existing remedy of avoidance of the policy by the claiming insured, because of the insurer's breach of its duty of good faith, would not be satisfactory; and the courts in England and Wales do not award damages on damages. Since the payment of a claim under a general insurance policy (as opposed to a life policy) is in law a payment of damages, this precludes a further award of damages for late payment. [See Issues Paper 6 and Consultation Paper LCCP 201 for an exposition of the law.]

The intention was laudable and this reform would bring English law somewhat more into line with some other jurisdictions. However, the Law Commission received a heavy weight of opinion that introducing a bad faith claim for damages in this way would import into English law some of the less attractive aspects of some USA State law. Other views included that the common law in general insurance had developed as it had for sound policy reasons: the floodgates would open if consequential loss claims could be brought for losses which were not within the insurance cover purchased.

In the Consultation Paper of December 2011 [LCCP 201], to remove the bad faith litigation ogre, the proposals were re-formulated so that an insurer would be liable to pay damages for foreseeable consequential losses if in breach of a statutory obligation to pay a claim in a reasonable time. The reasonable time would include time for assessing and investigating a claim. In commercial contracts, it is proposed that the parties would be able to limit or contract out of this liability, but this would be subject to a good faith test (so "bad faith" litigation could be imported here). In consumer contracts, there would be no contracting out of the new statutory provisions.

These proposals present a significant change in the law for general insurance.

Possible problems

On the face of it, the concept of being held liable for damages for failing to pay a claim in a reasonable amount of time seems uncontroversial. Good claims' handling is after all seen as a selling point by Lloyd's managing agents and insurers in a competitive market. Bad practice is quite rightly something which would bring down the force of the Financial Services Authority (FSA) on the firm concerned. The new UK conduct of business regulator will no doubt have claims handling at the centre of its conduct of business regime, both for consumer and commercial business, when (and if) the FSA splits into two in the Spring of 2013 and the Financial Conduct Authority (FCA) and Prudential Regulatory Authority (PRA) are formed.

However, if one delves deeper into the possible consequences of this reform, things begin to take on a different hue. The reasonable time for payment of a claim will introduce uncertainty and scope for litigation. If an insurer suspects fraud, how long will it have to investigate before the reasonable time runs out? How should a claims manager react when he or she is aware that a necessary investigation may nonetheless put the insured under

financial strain, if payment is delayed. The trained claims manager would have in his or her mind the question as to whether the consequences of delay would have been reasonably foreseeable by his or her colleague, the underwriter, at the time of contracting. Will this pressure cause claims departments to take fewer steps in investigating fraud? This would not please the FSA, which looks to regulated firms to combat financial crime, so it can meet its own statutory objective in this respect. It would not please the general pool of policyholders if claims levels rise and premium levels follow.

In another case, a coverage dispute may arise. The claims department will have the same question in its collective mind - how long have we got before we are in breach of the contractual obligation to pay this claim in a reasonable time? Is this before we can even get the litigation to resolve the dispute under way, acting with the utmost diligence? The claimant's solicitor, doing his or her job, may put the insurer on notice of certain losses being run up by his or her client, whilst the coverage litigation is in progress. If this is a speculative device, to force a settlement, the court may take a view under the Law Commission's new statute that the claim was made in bad faith and the whole claim should be forfeit. The Commission's current proposals on the policyholder's post contractual duty of good faith would be relevant here [LCCP 201].

Proving the loss, foreseeability and mitigation

It could be that some of the losses faced by the insured during the coverage litigation would have been foreseeable by the underwriter at the time of contracting as not unlikely if a claim payment was to be delayed. The claimant would have to prove the loss was incurred and that reasonable steps had been taken to mitigate it. However, if the dispute, brought in good faith, goes against the insurer in court, then the reasonable time for payment may be found to have been before the litigation was even commenced. The Law Commission's proposals allow for investigation and assessment, in a reasonable time, but not for a reasonable time for coverage disputes.

Payment of interest would be an appropriate remedy for a late payment of a monetary claim and this could in any case be awarded by a court. If the insurer takes on the responsibility itself to repair the insured property, then damages could be claimed by the policyholder if the contract to reinstate the property is breached. The proposed law reform is not needed here.

The Law Commission's view is that its proposals, if they become statute, would not be followed by such a high level of claims for damages for consequential losses, genuine or speculative, as to affect the working of the market (claims handling load and costs, for example) and the general levels of claims and premiums. Even if there was to be an initial rise in litigation, this would drop back when the courts bring the leading case of *Hadley v Baxendale* [1854] EWHC J70 to bear. Therefore, justice would be done in hard cases (something we would all like to see), but a plethora of litigation or reduced anti-financial crime measures would not result.

Many market practitioners are not so sure this would be the case and worry about the proposals.

Drafting the policy

Another concern has been raised: how would a reasonably competent wordings specialist go about drafting a policy document, when a limitation on one aspect of cover may be seen by a court as a limitation clause on the payment of consequential losses following late payment of a claim. Clauses excluding or limiting liability to pay damages for late payment of a claim would be banned in consumer contracts and subject to a good faith test in commercial contracts under the Law Commission's proposals.

For example, take a clause in a household policy, which limits a claim for alternative accommodation, in the event of the house becoming uninhabitable, to 4% of the sum insured of the bricks and mortar (such a clause in this form or in the form of a monetary limit is common in household policies). Would this clause be banned by the new statute?

The Law Commission's view is that it would not - if there is no dispute on a claim, then the clause would operate as a policy limit in the usual way. If a policy dispute arose, the house took a long time to rebuild and the alternative accommodation limit was far exceeded, then the policyholder could bring a claim for damages for late payment, and the policy limit would not operate if the damages claim was successful.

Nonetheless, the wordings specialist may well puzzle as to whether he or she is drafting a policy in clear words with clearly defined limits (thereby offering choice, because the policy and price could be compared to other products) or drafting something through which a red line would be scratched in the event of a claims dispute. What exactly is the underwriter scratching if the policy limits are at risk of being struck out?

Practitioners are concerned that the proposals could result in disproportionate claims for damages, in the event of a late payment, compared to cover purchased. In the commercial context, will the proposals have an effect on business continuity cover?

Limitation period and reserving

There is a further concern which the Law Commission accepts is a drawback to their proposals. There would be uncertainty in the limitation period, if this runs from the date of breach of contract. Under the new statute, this would be at the reasonable time for payment of the claim. At present the limitation period runs from the date of loss (the breach of contract under common law). Whereas the date of loss is usually certain, the point of time when it is reasonable to pay the claim, after investigation and assessment, is not. This may not matter in many cases but in large or complex claims it may be a difficult question.

Added uncertainty in the limitation period would in turn affect the reserving of claims by insurers. This feeds into capital modelling, whether under the present system or under

Solvency II. Greater uncertainty leads to a greater capital requirement. Yet, if the new statute were to build in a special limitation period for insurance claims, for instance, that this runs from the date of loss (as at present), then one of the purposes of the law reform, which is to bring insurance law into line with general law, is fouled. The proposals do therefore lead to a problem in this area, which would have to be measured against the perceived benefits.

Other controls and remedies

Consumers and small businesses already have the possibility of redress through the Financial Ombudsman Service (FOS). In a case like that of Mr Sprung (see the Law Commission's papers, the facts of Sprung being at the root of the proposals), the FOS would have jurisdiction if the business falls within the small-business limit or the complainant is a consumer. Then justice could be done without a change in general insurance law, given the appropriate award is within the FOS's limit.

Further, under the Unfair Terms in Consumer Contracts Regulation 1999, the FSA and Office of Fair Trading (OFT) are able to obtain undertakings from insurers not to use particular policy terms (for example limitations or exclusions) which are perceived as unfair. Compliance Departments monitor such undertakings on the OFT website and policy wordings are amended accordingly. For example, it was thought that the use of the words "consequential loss" in general consumer insurance contracts, to exclude consequential loss, was not plain and intelligible "as it refers to an expression that has a legal meaning" [see http://www.fsa.gov.uk/pubs/other/consequential_loss.pdf]. The OFT and FSA did not think that the average consumer would understand the phrase and therefore the cover. As a result, firms have tried to find other, clearer ways of describing what is covered and what is not. It is ironic that under the Law Commission's proposals a red line could be struck through the new phrases, because these may limit of exclude liability for damages for late payment.

Importantly, the ICOBS rules of the FSA (8.1.1R) cover both commercial and retail business: these provide that an insurer must handle claims promptly and fairly; provide reasonable guidance to the policyholder in making a claim and as to its progress; not unreasonably reject a claim; and settle claims promptly once terms are agreed. Whilst ICOBS provides a remedy for the insured in person only in limited circumstances [see LCCP 201 at page 37, paragraph 3.22], it does provide a standard and a basis for supervision. Jonathan Goodliffe, in the BILA Journal of November 2011 (No 123), explores regulation and regulatory reform as an alternative to the Law Commission's proposals for law reform, including the availability of redress.

In the London market, dealing with thousands of risks from all over the world under English law, there is a danger that the Law Commission's proposals for damages for late payment, if enacted, would lead to greater litigation costs, some reserving problems,

higher claims handling costs, higher claims ratios and higher premiums, with potentially some disproportionate awards of damages. The reason that the common law has developed as it has, may hold good. It may be preferable to rely on competition in the market, supervision by the FSA Conduct of Business Unit (due to become the FCA), the FOS and the OFT to minimise the occasions when an insurer handles a claim badly or in breach of good faith.

Kees van der Klugt is a solicitor and a member of the BILA committee and also of the sub-committee which has considered the Law Commission's proposals.

Insurance brokers – their evolving role

Sir John Thomas, president of the Queen's Bench Division

Derrick Cole memorial lecture, 23 February 2012

It is a very great honour to have been asked to give the Derrick Cole Memorial Lecture. Alison Green has outlined the career of a remarkable man in the insurance market. It was my privilege to have known him not only for his great experience of the industry but also for his many kindnesses to me over the years when I have worked with BILA.

I have chosen to speak of insurance brokers and their evolving role mainly as Derrick was a great insurance broker with a real commitment to bringing the market and lawyers together, but also because it is an interesting study of a profession that has had to evolve continually with the way the market has developed.

Perhaps more than ever today we appreciate the dynamic effects of markets and the need for any profession to identify the characteristics of that profession that will enable it to survive and prosper in dealing with the changes that will inevitably occur. The lawyers amongst you might reflect on how much of what I will say could, with a little adaptation, be said of the legal profession. That profession is itself in the process of undergoing very profound changes as a result of market forces, the removal of restrictions on the ownership of law firms and the new business models that lawyers can adopt.

Brokers have always played a central role in the insurance market. Why? It is, I think, because of the characteristics that have moulded and, in the longer term will continue to mould, the profession of the insurance broker.

History and analysis show that there are a number of identifiable characteristics which have been essential to the evolution and will continue to be essential to the evolution of the profession. These are first, skill and competence second, integrity and loyalty to the assured, third, reasonable remuneration, properly disclosed, fourth, a clear understanding of the relationship with the underwriter and fifth, the need for adaptability in the vicissitudes of the market. Let me therefore turn to look at those characteristics first by considering episodes in the development of broking over the past few centuries.

The early days

How ancient the profession is is not clear to me, but in a statute of 10 Richard II they were referred to as Broggars or in Latin *Abrocarii* or *Brocarii*. Certainly by Elizabethan times there were about 30 brokers who were engaged in the writing of insurance policies of marine insurance near the Royal Exchange. We know that because in 1574 an associate of Sir Thomas Gresham, the great financier, a Mr Richard Candler, tried to obtain a monopoly over the making and registering of policies of insurance through an Office. The Company of Brokers considered they were "likeliy utterly to be undone" by the monopoly

and petitioned against it. They made the point that might well be made today that it would be an infringement of the liberty of every good citizen if such a monopoly were imposed because any person might make his own insurance and write his own policy. It appears that the protests of the brokers, who were joined by notaries in this protest, did not prevent the establishment of the Office for which a patent was granted to Richard Candler. However some sort of compromise was arrived at under which the profession continued to be able to make and write policies of marine insurance, for it was in marine insurance that the profession developed.

The emergence of a specialist and well paid profession

By the beginning of the 18th Century the business of insurance broker had become more specialised. That appears to have been the case because no specialist underwriters had yet developed. The services of a broker were needed by merchants in London who wished to place insurance and by merchants abroad who wished to take advantage of the London market. They then earned 5% on the original premium and 10% discount on the final balance of the account. Balances were not in practice settled until some 6 to 12 months after they were due but this could at the time possibly be justified by the fact that, as underwriters did not have to make a deposit, the delay in settling balances provided some measure of security to the assured.

They are described by Hatton in his “A New View of London” published in 1708 as follows:

“Offices that Insure Ships or their Cargo are many about the Royal Exchange, as Mr. Hall’s, Mr. Bevis’s, etc., who for a Premium paid down procure those that will subscribe Policies for Insuring ships (with their Cargo) bound to or from any part of the world, the Premium being proportioned to the Distance, Danger of Seas, enemies, etc. But in these Offices ‘tis customary upon paying the Money on a Loss to discount 16 per Cent.”

It seems to modern ears extraordinary that a loss was paid at a 16% discount to brokers but it is perhaps evidence of the vital service they then performed.

It may be that these very high fees that were earned can be seen as giving rise to the attack made by Mr John Weskett in 1781. As Wright and Fayle comment in their “A History of Lloyd’s”, the main objects of his attack were the “folly of underwriters, the chicanery of brokers and the dishonesty of the assured” as well as the “daily attendance of no less than four or five attorneys at Lloyd’s coffee house” and the failure to use arbitration. It is a reminder of how little in fact changes, as such sentiments were often expressed exactly 200 years later in the many turmoils that engulfed the market in the 1980s.

1810: the skill required of a broker

But whatever criticism might be made of the market, there is no doubt that the professional skill required of a broker was recognised. In the Parliamentary debates in 1810 when there was an attempt to establish by a number of merchants a new company which Lloyd's saw as a threat to its business, Mr Marryat MP, who led the Parliamentary opposition to the attempt, spelt out the skills required of brokers and underwriters.

"I am aware," he said, "that the occupations of an insurance broker and underwriter are generally considered as demanding but very superficial attainments; but a candid investigation of the subject will prove this idea to be erroneous. An insurance broker can only qualify himself for his business by considerable study and application. He must learn how to fill up policies of every description, with all the various clauses adapted to every possible circumstance. He must be able to make accurate declarations of interest, so as to cover the parties in case of loss, and yet not expose them to the payment of any unnecessary premium in case of arrival. He must know how to make up complex statements of average and partial losses on every species of merchandise, and on the various principles applicable to every different case. He must be informed of the current rates of premium on every voyage, in order that he may be enabled to transact the business intrusted to him to the best advantage; and he must be well acquainted with the character of the different underwriters, to guide him in the selection of names he takes upon his policies."

If this were adapted from its marine insurance context, it would not be an inapposite description of the skills required of the modern broker.

It was perhaps these skills which justified the brokerage that brokers were then earning. By this time the broker received 5% on the original premium and 12% discount on the payment of balances. During the course of the Parliamentary hearing it was admitted that this represented nearly a quarter of the underwriter's gross profits. But this did not mean that brokers were wealthy men. Some thought that what they were paid was not too much for "labour, the agitation of mind, the perpetual vexation" of a broker's business. A partner of John Julius Angerstein, the underwriter and Chairman of Lloyd's whose art collection formed the cornerstone of the National Gallery, said that few brokers retired with great fortunes:

"The utmost that I recollect do not live beyond this establishment; two maids and a manservant."

When he was told this did not apply to Mr Angerstein's fortune, he retorted that that was made more as an underwriter than as a broker.

The nineteenth century: innovation and expansion

During the 19th Century brokers were generally small firms of two or three partners who generally handled marine insurance with a circle of connections in London and provincial sea ports and correspondents abroad for whom they placed risks in the London market.

Illustrative of the importance the position that brokers by then held is the fact that the 8th edition of Sir James Alan Park's seminal work on Marine Insurance published in 1846 required a chapter on brokers. There had been none in previous editions. The editor described brokers as those who undertook to perform their duties with integrity, diligence and skill and as "persons of great respectability and honour and to whom the merchant is able to look with confidence for the proper performance of his duty ...".

Although fire and life insurance companies had placed business through agents, they had until this time made little use of brokers. However the use of brokers increased for, as the London insurance market, and in particular Lloyd's, expanded its non-marine business, brokers took on the business and flourished. Towards the end of the 19th Century, the great broking houses emerged. One example of this can be seen in their entry into re-insurance business as that developed during the latter part of the 19th Century, as can be seen by the fact that the Swiss Re, established in 1863, first entered into a treaty with an English company in 1864. By the end of the century and the early part of the 20th Century there had emerged firms whose names were familiar until very recently. The emergence saw in 1906 the formation of an Association of Insurance Brokers and Agents.

The involvement in underwriting

As part of the innovation of the latter part of the 19th Century and much more in the 20th Century brokers began to take a much greater interest in actual underwriting, although, as I have said, Angerstein was both broker and underwriter. It is clear, at least from the end of the 19th Century with the expansion of brokers overseas and the bringing back of business to London, that brokers not only formed their own underwriting operations but participated as members of syndicates at Lloyd's. In his evidence to the Committee on the Lloyd's Bill in 1982 Mr Robert Hiscox demonstrated how when Price Forbes & Co (one of the origins of Sedgwicks) was formed, Mr Price became an underwriter with risks passed to him by other parts of the firm. The same can be seen in Derrick's firm of Willis Faber where when Mr Spence, the chairman at the turn of the century, retired he was recognised not only as a good broker, but also as an able and successful underwriter. But it was not only brokers who entered the underwriting business, but Lloyd's underwriters formed broking businesses to bring them business – the most well known being Cuthbert Heath who formed a brokerage in 1890.

By the 1930s and 1940s it appears that the incidence of taxation had the consequence that underwriters sought to capitalise the goodwill of their agencies and brokers became a ready source of that capital.

The reasons for steady growth of the ownership of underwriting agencies at Lloyd's and the benefits were summarised in the Cromer Report which had been commissioned by the then Chairman of Lloyd's, Sir Henry Mance, in 1969 to consider the future of Lloyd's:

“249. A broker is anxious to secure as much business as possible and his weight will, therefore, normally be thrown against any effort to restrict the volume of Lloyd's business on too narrow a view of profitability. Many brokers are also men of great force and energy and infuse useful qualities into any organisation they control. A broker through an agency company can provide capital for any expensive equipment required by the syndicate.

For his part, the broker secures a substantial return from the agency especially if underwriting becomes profitable again. He controls the use of substantial syndicate funds. He can use clerical and computer resources to best advantage, as between the broker's business and the underwriting business.”

The report went on to conclude that there was a substantial body of Lloyd's that believed that broker control was undesirable and should be discouraged, if not brought to an end. The report concluded that there was a conflict of interest which could not be ignored.

“253. That the Lloyd's market developed on the scale that it has and enjoys the world wide reputation that it unquestionably does enjoy is due in very large part to the energy and ingenuity of Lloyd's brokers and to a not inconsiderable degree the foreign brokers that Lloyd's brokers have cultivated through the years. There can be little question that the Lloyd's underwriting syndicate and the Lloyd's broker are essentially complementary to each other in forming the Lloyd's market as a whole. Although complementary, and this is a cardinal point, they are not interchangeable. The broker is the agent of the insured and in any conflict with any underwriter should put first the interest of the insured. He should not even adopt the role of an arbiter in a conflict unless this can be seen to be to the advantage of the insured. If a conflict were to arise between an insured and an underwriter who happened to be an employee (even indirectly) of the broker to the insured the problem is most difficult. But, short of conflict of this kind, we find it difficult to accept that, in exercising judgment of what business to accept and what to refuse, an underwriter who is an employee of a broker-owned agency can at all times be wholly impartial. That conscious effort is made to achieve this, we are left in no doubt, but the very fact that this is the case leaves doubt as to the degree that it is attainable under the day to day stresses and pressures in a market. In so far as any influence might be exercised it would be to encourage an

underwriter to accept risks he would, if independent, refuse, so that the names of his syndicate could be carrying more than in the free judgment of the underwriter were desirable.”

The report recommended that brokers ought to reduce their interest in underwriting in the long term interest of their broking business, but this was a matter for discussion between Lloyd’s brokers and underwriters.

That report was not published, but events in the insurance market and in particular in Lloyd’s saw a return to the issues of the relationship between brokers and underwriters in the report by Sir Henry Fisher commissioned by Sir Peter Green and published in 1980. That report, perhaps typical of a lawyer of that generation (who incidentally remains the only judge to have resigned from the High Court Bench shortly after his appointment) was over-dogmatic and over-legalistic in its approach. To a more modern eye, it displayed insufficient understanding of the operation of free market economics. Sir Henry Fisher recommended that there should be compulsory divestment of the ownership by brokers of underwriting agencies on the basis that the interests of the assured and the interests of the names were separate and distinct and were sometimes in conflict. It was, in his view, unacceptable that brokers should have power to control an agency which owed legal duties to names. The insured were at risk that the broker would not be whole-hearted in looking after the assured’s interests if he had a financial stake in an agency.

The result was the Lloyd’s Act of 1982 which brought about compulsory divestment. It was a radical though, from an economic viewpoint, somewhat simplistic solution to what is a much more complex issue. It is not the least surprising that the solution was abandoned in what, looked at in the context of the centuries of the market, was a relatively short period of time.

Failures of integrity

The nature of that more complex issue relating to the relationship of underwriter and broker can be seen as what lay behind major failures of integrity in the market, some of which attracted public notoriety. These scandals included Unigard, Sasse, Savonita, Ashby, Tonners, Oakley Vaughan, David Gale Underwriting Agencies, PCW and the Personal Accident spiral.

An analysis of each of these would show that the cause of the problem was not ownership links between underwriters and brokers nor the lack of regulation, but weak underwriters, a failure to control terms of binding authorities, a failure to understand that business was being written for commission and, at the root, a failure of integrity on the part of brokers. I cannot emphasise too much how great that failure of integrity was. Each scandal highlights the need for a real understanding of how the relationship between insurance broker, the underwriter and the client should be managed and how that relationship is dependent on the five characteristics of the profession of broker that I identified at the outset.

Let me now then turn in a little more detail to those five characteristics.

1. Skill

It is self evident, in my view, that a broker needs that level of skill and learning to which Mr Marryat alluded in 1810 as much today as ever. For the placing broker the skills include – a mastery of the law relating to insurance, an ability to draft clearly and with precision, an ability to explain to the assured their duties and then to understand the nature of the risk to be insured so that a fair presentation can be made to underwriters and a knowledge of the underwriters. Other skills are needed for the claims broker.

Today perhaps the most difficult aspect of the skill of the placing broker is to apply in practice what is required by the law of disclosure. In a piece Derrick Cole wrote for the BILA Journal in 1998 entitled, “Are the judiciary re-writing insurance policies and do they have a sufficient knowledge of what actually happens in the market place?” he observed:

“... I expect the underwriters to ask sensible questions and send the broker away if he cannot provide the answers (as I have been sent away on several occasions). I would not expect the underwriter to ask technical questions where the broker has a duty to explain, for example, the combustible nature of the goods stored, which may not be in the public knowledge ...

... I believe the law should recognise that placing a risk is a two-way discourse and not simply a matter of the broker making a presentation and the underwriter saying yes or no! ...”

The balance between making a fair presentation of the risk and an underwriter understanding sensibly what is put before him and asking questions is in any specific case fact sensitive. I think experience has shown, however, that the courts have not been insensitive to the dangers that can arise from placing too much emphasis on the passive position of the underwriter to merely receive a fair presentation. I think Derrick Cole was right to say that in essence the placing of the risk should be a dialogue as the broker in putting the risk to the particular underwriter has to put that risk not only on the basis of what a reasonable underwriter would expect, but one that takes into account the subjective position of the particular underwriter.

2. Integrity and duty of loyalty to the assured

The hallmark of any professional person, which must be seen as such, is that person's integrity. This is again the quality required of the insurance broker, just as of any other profession, mentioned by Park and the lack of which was the root cause of the numerous scandals to which I briefly referred.

The most obvious legal exemplification of the duty is his duty to act in the interests of his client to the exclusion of other interests. There have been suggestions, as for example expressed in 1981/2 by David Palmer, Chairman of Willis Faber, when he said in a

presentation to BILA, that he had never taken too literally the legal concept that the broker solely represents the interests of the client. He said that when he first came to the market the broker was 60% for the client and 40% looking after the market, the underwriter. The position might have changed by the time he was speaking so that he thought under the pressure of consumers and fair trading the pressures of competition the percentages had slipped nearer to 75/25.

Despite the eminence of the maker of those observations, there are, I think, two things to note. First the timing of the observations; they were made at the outset of the major problems of the market; I doubt whether they would be made today. Secondly, acting in the interests of one's client does not require the broker to ignore other factors. He must not drive so hard a bargain that the market in which the broker is operating ceases to be one he can use again; it is in the interests of the client that there remains a market in which business can be placed in future years. But it does emphatically mean that he must see that the interests of the client for whom he is acting are protected; for example, the broker cannot use his position to place easy business at more generous rates that disadvantage one client in the expectation that by doing so he will be able to place a difficult risk for another client.

But the more interesting question is how is such integrity maintained? Until the 1960s, it was clear that the internal structures of the market, its small size, the fact that people knew each other and the authority of persons such as the Chairman of Lloyd's acted as the mechanism through which those who failed to adhere to the integrity could more easily be identified. Some of the scandals to which I have alluded showed that that system had broken down and it was not therefore surprising that first self regulation on a formal basis and then statutory regulation became necessary. Insurance brokers, like almost every other profession, became subject to this regime. It is too early to tell whether regulation will prove an effective means of maintaining integrity and, if so, what form it should take – detailed rules or principles. Experience has shown that it is still essential to rely on a personal judgment of the individual with whom one is dealing and, if possible, the swift and sure ruin of those who transgress the basic principles of integrity.

3. Reasonable remuneration properly disclosed

Any profession, if it is to attract those of ability sufficient to carry out the work with skill and care, must provide for reasonable remuneration. One of the other obvious problems of the market in the 1970s was the poor payment for some essential task. When I used to go to the City to advise or to appear at an arbitration in the 1970s, it was indeed remarkable to see the very low rates of pay being advertised for those who wrote policy wordings when it was self evident that a number of problems that were then occurring had arisen because of the lack of skill by those employed in writing policy wordings. The only beneficiaries have been the succeeding generation of lawyers.

The question of remuneration raises the issue as to how the broker should be remunerated and whether the amount that he is remunerated by the underwriter should be disclosed to the client. The traditional view was very clear. It had been the practice of the market for many years that the broker was remunerated by the underwriter; those were the terms upon which brokers traded. Everyone understood that it was the mechanism for paying the broker.

However, the way the system of remuneration operates is contrary to modern standards of transparency. It was therefore interesting to observe that earlier this year a court in Hong Kong, looking at the question of whether the payment of commission by an insurer to a broker was prohibited by the prevention of bribery ordinance, that the duty of the broker was confined merely to disclosing the fact that he was remunerated. I do not believe this position is sustainable or that it will continue to be upheld. I would very much hope that the broking community takes the lead in ensuring full disclosure of commission earned, including any incentives.

4. A clear understanding of the relationship to the underwriter

I have already touched on aspects of the broker's relationship to the underwriter in relation to the duty of disclosure, the issue of integrity and remuneration. But the nature of the relationship with the underwriter is historically what has distinguished the insurance broker from other types of broker and that is why it is so important that both underwriter and broker understand the position.

The difficulties arise when a broker is placed in a position where he acquires two or more principals in relation to the same transaction. One instance is where the broker in seeking to place cover for the original assured cannot do so unless he does so by arranging a reinsurance package that those who subscribe will take up; provided the broker does not abuse the relationship by breaching the duty of integrity by churning or creating a spiral, this should not cause any real difficulty. More problematic, though pragmatism dictates its use, is the grant of a binding authority to a broker. The potential for conflict of interest is obvious. Its extensive use in Lloyd's was one of the principal arguments of those who opposed divestment of managing agencies who made the obvious point that the grant of binding authorities to a broker produced a greater conflict than ownership of an underwriting agency where there was a separate entity and collection of individuals that did the underwriting. However the market at Lloyd's could not conduct certain important parts of its business without the use of binding authorities and pragmatism took the place of the supposed principle.

Although the position of the insurance broker is in these respects unusual for brokers, there is no reason of actual principle why a conflict of interest cannot be managed. Any lawyer engaged in litigation has to manage his duty to the court and his duty to the client; the duties often conflict, but are managed by very clear rules such as those requiring a lawyer to draw to the attention of the court any case which is adverse to his argument for his client, even if the other side has not found that case.

There is no reason why such conflicts cannot be managed in insurance broking by (1) clear contractual arrangements, (2) disclosure and transparency and (3) active management of the contractual arrangements. My experience of the abuses that occurred in the 1970s and 1980s in relation to binding authorities arose because (1) the contracts were hopeless; (2) there was a lack of transparency and (3) often an abdication of any management by the underwriter which allowed the dishonest and unscrupulous to commit those abuses.

In any developed market where the consumer is not involved, experience has taught me to be very sceptical of those who insist on detailed regulations and do not leave the market to develop its own mechanisms to manage conflicts by adherence to basic principles.

5. The need for adaptability

It is I trust self evident that the profession of insurance broking is one that is in my view essential to the operation of the market. It has over the centuries adapted and prospered by adherence to the core characteristics I have attempted to outline.

The change in the markets and the continuous development of new products and new ways of doing business at an ever increasing rate is a fact of life. During his life, Derrick Cole saw that one of the vital links that had to be maintained was ensuring the lawyers and the judges understood the market and that the law developed to reflect those changes. Whereas a judge of the nineteenth and early part of the twentieth century could be reasonably confident that little had fundamentally changed in the market since his time in practice, today the position is very different. In respect of the financial markets, the Financial Markets Law Committee provides annual seminars for the judiciary. We are fortunate that BILA, in particular through the energy of Derrick Cole, has provided that vital updating link. That is vital, for our law of insurance still is significantly based on the application of principles decided in the 18th and 19th centuries. The development in this way, provided judges understand the market, has in particular provided a modern workable law. Clearly some of the provisions of the Marine Insurance Act 1906 need amending, but I am not over optimistic of time being found for changes outside the sphere of consumer protection.

May I reciprocate for the assistance given by the market by simply observing that whilst the products and mechanisms of the market might change, the fundamental characteristics of the insurance broker must not. It is vital that those are not lost and in particular the lessons of history, including in that the terrible times of the 1970s and 1980s, are not forgotten when those values are inculcated into the new generation. Maybe the generation in the 1970s and 1980s (which saw the scandals to which I have referred) would have done well to recall the values of earlier generations and the lessons of what goes wrong when they are not followed.

IMD2: European Commission proposals for a revised Insurance Mediation Directive

By Julian Burling¹

Introduction

On 3 July 2012 the European Commission published² a proposal for a “recast” insurance Mediation Directive (“IMD2”) together with an accompanying Explanatory Memorandum,³ and an Impact Assessment.⁴ IMD2 is part of the new “consumer retail legislative package” which includes also information requirement proposals relating to packaged retail investment products (PRIIPS) and proposals for defining the duties and tasks of depositaries of undertakings for collective investment in transferable securities (“UCITS”) and remuneration policy for UCITS fund managers (the proposed “UCITS V” directive). This article summarises and discusses the salient features of the draft IMD2.

Insurance Mediation Directive (2002/92/EC)

The Insurance Mediation Directive (2002/92/EC) (“IMD”) was designed to co-ordinate national provisions on professional requirements and the registration of persons taking up and pursuing the activity of “insurance mediation”, so as to contribute to the completion of the single market for financial services and the enhancement of consumer protection in that field.⁵ The IMD applies to the carrying on of “insurance mediation” activities by “intermediaries” and not simply to persons who can be characterized as insurance agents or brokers. Insurance mediation activities are

“the activities of introducing, proposing or carrying out other work preparatory to the conclusion of contracts of insurance, or of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim”,

except where carried out by an insurance undertaking itself.⁶ Where the premium does not exceed €500 p a, the sale of travel insurance by travel agents, and the complementary sale by providers of goods or services of certain insurances such as extended warranty insurance or mobile phone insurance, are excluded from the scope of the Directive, as are (re)insurance mediation services provided in relation to risks or commitments located outside the European Economic Area (“EEA”).

The IMD requires the registration of insurance and reinsurance intermediaries by a competent authority in their home state.⁷ Such registration is to confer entitlement to provide (re)insurance mediation services throughout the EEA on a services or an establishment basis.⁸ Where an intermediary intends to provide services in another member state (the “host member state”) on either basis it must inform the competent authorities of its home member state, which must then inform the competent authorities

of any host member state wishing to know.⁹ Host member states may impose “general good” conditions applicable to business carried on in their territories.¹⁰

Article 4 of the IMD stipulates professional requirements to be imposed by member states. (Re)insurance intermediaries are to have appropriate knowledge and ability, as determined by the home member state: this requirement need not apply to every employee but is to apply to a reasonable proportion of the management of an undertaking and all persons in it who are directly involved in insurance mediation.¹¹ They are to be of good repute. They are to have professional indemnity insurance of at least €1m each and every claim and €1.5m in aggregate.¹² Member states are also to take measures for the protection of premiums and claims moneys in transmission, being either requirements that premiums received from the assured by the intermediary are treated as received by the insurer,¹³ minimum financial capacity requirements calculated by reference to 4 per cent of annual premiums received, segregated client money account requirements, or the establishment of a guarantee fund. Member states are permitted to reinforce these requirements, or add to them, as regards intermediaries registered within their jurisdiction.¹⁴ Where a member state implements a directive by applying such “super-equivalent” requirements, it is commonly described as “gold-plating” the directive.

Chapter III of the current IMD specifies requirements as to information to be provided by intermediaries to their customers, except when the intermediary mediates in the insurance of “large risks”¹⁵ or in reinsurance. This must include disclosure as to holdings by the intermediary in any insurance undertaking or vice versa. It is also to include a statement whether the intermediary gives advice based on a fair analysis of a sufficiently large number of contracts available in the market to enable him to make a recommendation regarding which contract would be adequate to meet the customer’s needs. Alternatively the intermediary may be under a contractual obligation to conduct insurance mediation exclusively with one or more undertakings, or is not under such a contractual obligation but nevertheless does not conduct a fair analysis of a large number of contracts available on the market.¹⁶ Member states may impose stricter requirements.¹⁷ Insurance intermediaries are also to be required to provide a “demands and needs statement” to the customer, on the basis of information provided by the customer, stating the underlying reasons for advice given on a specific insurance contract.¹⁸

Member states were required to implement the IMD before 15 January 2005. In the UK the IMD was transposed principally by means of the Financial Services and Markets Act 2000 (Regulated Activities)(Amendment)(No.2) Order 2003, SI 2003/1476. It specified various activities in relation to “relevant investments” (ie insurance contracts, both life and non-life) as “regulated activities” for the purpose of the Financial Services and Markets Act 2000 (“FSMA”). This necessitated the authorisation of non-life insurance intermediaries by the Financial Services Authority under FSMA from early 2005: most life insurance salesmen were already covered by other delegated legislation under that Act¹⁹.

The FSA made the “Insurance: Conduct of Insurance Business Sourcebook” (“ICOB”), implementing the customer information provisions in IMD with much “guidance”, and subsequently the stripped-down “Insurance: New of Insurance Business Sourcebook” (“ICOBS”). ICOB and ICOBS also transposed in part the Distance Selling of Financial Services Directive (2002/65/EC) and the E-Commerce Directive (2003/31/EC). ICOB and ICOBS applied to activities in relation to “non-investment insurance contracts” (except reinsurance or large risks outside the EEA or large risks within the EEA mediated for commercial customers). Those activities include not only “insurance mediation activities” but also the carrying on by insurers of insurance business, the management of Lloyd’s syndicates and the communication or approval of financial promotions. Direct selling and claims handling by insurers were thus included in the “insurance mediation regime” so far as the UK was concerned.

In the absence of such provision in the IMD itself, the Luxembourg Protocol²⁰ provides a framework for co-operation between the competent authorities of the EEA member states in the implementation of the IMD and the carrying out of their functions under it.

Reform

The IMD was a minimum harmonisation instrument, containing high-level principles. Its implementation across the EU varied considerably between countries, with much gold-plating in some countries and minimalist, more literal “copy-out” in others. This inhibited the development of a single insurance market. Implementation checks by the European Commission between 2005 and 2008 revealed a need to review it.

Recital (139) of the Solvency II Framework Directive (2009/138/EC) (“Solvency II”) required the European Commission to put forward by the end of 2010 a proposal for the revision of the IMD, given that Solvency II “changes the risk profile of the insurance company vis-à-vis the policy holder”. Some members of the European Parliament had considered that there was a need for improved consumer protection in the wake of the financial crisis, particularly as regards investment-type life insurance. To ensure cross-sectoral consistency the European Parliament requested that any review of the IMD should take into account the ongoing revision of the Market in Financial Instruments Directive (“MiFid II”).²¹ The Commission, after obtaining initial advice from the Committee of European Insurance and Occupational Pensions Supervisors (“CEIOPS”),²² issued a consultation document²³ on 26 November 2010.

That consultation document identified the following main weaknesses in the current IMD:

- the insufficient quality of information given to consumers (varying significantly between member states);
- ineffective rules in Article 12 on conflicts of interest, and the absence of any rules at all as to transparency on remuneration;

- legal uncertainty resulting from the definition of the scope of IMD and, even more importantly, the lack of a level playing field between all concerned in selling insurance products given the exclusion of direct selling by insurance companies; and
- the burdensome notification system for cross-border establishment or services, limiting the market for cross-border retail insurance.

The consultation document sought comment on various proposals designed to address these shortcomings. It proposed in addition a higher level of professional requirements as to knowledge and ability for all sellers of insurance products. In the context of insurance PRIPS (investments packaged as life insurance products, such as unit-linked life policies) the consultation document urged the importance of consistent conduct of business rules, inducements and conflict of interest rules applicable to all persons selling packaged investment products, whether product originator or intermediary.

The consultation period for the November 2010 document closed on 31 January 2011. 125 responses were received to the public consultation, generally in favour of a revision of the IMD.²⁴

IMD2

Eighteen months after the end of the consultation period, and following various public meetings, and four studies commissioned as part of an impact assessment,²⁵ the European Commission has now published a draft revised IMD, a revision in some respects considerably more ambitious than its November 2010 consultation document might have suggested. The Explanatory Memorandum states that the proposal is to be seen in the light of draft G20 high level guidelines on financial consumer protection: G20 had in November 2010 requested the OECD, FSB and other international organisations to develop common principles in the financial field to strengthen consumer protection.

The Explanatory Memorandum states that IMD2 will replace (“recast”) the current IMD as a new directive (although it takes the form of amendments grafted onto the existing legislation). Like the current IMD, IMD2 will be a “level 1” framework directive. Although IMD2 will continue to have the features of a “minimum harmonization” legal instrument, some parts of it will be reinforced by more detailed rules to be adopted under delegated powers at “level 2”. These measures should align the rules with MiFID. The European Insurance and Occupational Pensions authority (“EIOPA”), which has replaced CEIOPS, is to play a role in implementing the framework, with specific competences to be given to it. The Commission envisages such a role for itself as well.²⁶

Scope: undertakings and activities

The scope of the Directive is to be extended to include all sales of insurance products, so that it will apply to insurance undertakings selling insurance directly (and to their sales,

after-sales and claims processes).²⁷ To ensure the same level of consumer protection regardless of the distribution channel, it will include other market participants who sell insurance products on an ancillary basis, such as travel agents and car rental companies, and also suppliers of goods who do not meet the conditions for one of the exemptions²⁸ (the annual premium limit for the exemption being raised to €600).²⁹ IMD2 will also extend, as regards the activity of assisting in the performance of contracts, to professional claims managers and loss adjusters.³⁰

“Insurance mediation” is redefined as including also largely the same activities as within the current IMD definition even when carried on by an insurance undertaking without the intervention of an intermediary.³¹ It no longer includes “introducing” but now includes advising³² on the conclusion of insurance contracts,³³ otherwise than on an incidental basis.³⁴ It now includes, somewhat elliptically,³⁵ operating an aggregator website or similar facility when the customer is able to conclude an insurance contract at the end of the process, notwithstanding that the aggregator operator is not normally an agent to conclude contracts. “Customer”, however, is not defined and the question of intermediary chains is not addressed anywhere in IMD2.

Registration

The registration procedure under Article 3 for intermediaries is substantially unchanged.³⁶ Member states will now be required by Art 3(2) to establish online registration systems. EIOPA is to establish on its website a single register containing records of all intermediaries that have notified their intention to carry on cross-border business. This will act as a portal linking back to the home state registers. Member states are to ensure that competent authorities monitor continuing compliance with registration requirements.³⁷ They are to require, as a condition of registration, information about shareholders in intermediaries having holdings in excess of 10 per cent or persons having close links with them.³⁸

A new Article 4 provides a simple “declaration” procedure for intermediaries conducting insurance mediation only on an ancillary basis as regards certain classes of business, or conducting full time claims management or loss adjustment or assessment. Such intermediaries will simply inform the home state competent authority and comply on a continuing basis with specified requirements of the Directive.

Freedom of Services and Establishment

Articles 5 and 6 reflect the provisions in Articles 6 and 7 of the current IMD as regards freedom to provide services and freedom of establishment. The home state competent authority is now to obtain and provide to the proposed host state competent authority specified information about the intermediary. This should include, in the case of proposed exercise of a right of establishment, a programme of operations and the identities of any

agents to be used. The new Article 7 provides for the division of competence between the competent authorities of home and host member states. If the intermediary's primary place of business is in a different member state from that of its home state the competent authorities will be able to agree that the competent authority of the host state is to be able to act as if it were the home state competent authority with regard to the obligations in IMD2 Chapter VI (information requirements and conduct of business rules) and the new Chapters VII (PRIPS) and VIII (sanctions and measures).

A new Article 9 requires the publication by each member state of any "general good" rules applying to (re)insurance mediation. Any administrative burden on those carrying out (re)insurance mediation activities that stems from requirements beyond those in the Directive is to be restricted to what is proportionate for consumer protection. Details of "general good" rules are to be provided by the competent authorities in each member state to EIOPA, which is to publish them on its website in English, French and German. EIOPA is to examine, and inform the Commission about, the effect of "general good" rules in the context of the proper functioning of IMD2 and the Internal Market within three years after IMD2 comes into force. These provisions are designed to meet the problems resulting from fragmentary implementation and gold-plating of the current IMD.

Professional and organisational requirements

The new Article 8, in place of IMD Article 4, provides for professional and organisational requirements which are largely unchanged (including those as regards protection of insurance moneys in transmission). There is a new focus on development of staff knowledge and ability. EIOPA is to review professional indemnity insurance and financial capacity levels every five years, and to develop draft regulatory technical standards for the purpose.³⁹ The European Commission is to be empowered to adopt "delegated acts" specifying the requisite content and level of knowledge and ability of intermediaries, appropriate criteria for determining the level of professional qualifications, and continuing professional development.⁴⁰

Information requirements and conduct of business rules

IMD2 Article 15, commendably, lays down some general principles. Member states are to require that insurance intermediaries or undertakings carrying out insurance mediation "with or for customers" are to act "honestly, fairly and professionally in accordance with the best interests of their customers".⁴¹ As between principals who are simply counterparties to a contract of insurance, rather than as between principal and agent, this "best interests" requirement seems unduly demanding: where there is no fiduciary relationship such as that between principal and agent, contracting parties might each normally be expected to have primary regard to their own interests. All information addressed by intermediaries or insurers to customers or potential customers is, familiarly, to be fair, clear and not misleading.⁴²

Member states are to require that before entering into an insurance contract an intermediary is to disclose to its customer, inter alia, whether it provides advice about the products sold, whether it is representing the customer or acting on behalf of the insurer.⁴³ Similarly, an insurer is to state whether it provides any type of advice about products sold,⁴⁴ but it has already been noted that “advice” merely means providing a recommendation. As before, intermediaries are to provide customers with information about shareholding links with insurers,⁴⁵ and whether it gives advice on the basis of a fair analysis.⁴⁶

The Commission has now in IMD2, Article 17, grasped the nettle of mandatory disclosure of brokers’ remuneration, about which the FSA has to date been more reticent.⁴⁷ For some lines of business, particularly consumer business, the remuneration received by the intermediary can exceed the net premium received by the insurer. Prior to the conclusion of the insurance contract the intermediary is to disclose to the customer the nature of the remuneration received in relation to the contract. The disclosure is to state whether remuneration in relation to the contract is on the basis of a fee paid by the customer, or on the basis of a commission of any kind “that is the remuneration included in the insurance premium”, or on the basis of a combination of both. If a commission or fee is being received the full amount concerning the insurance products being offered or considered is to be disclosed, or, if the precise amount is not capable of being given, the basis of calculation is to be disclosed. If the amount of commission is to be based on targets or thresholds agreed with the insurer, ie contingent commission, the intermediary is to disclose the targets or thresholds as well as the amounts payable.⁴⁸ The new requirements do not, however, address “work transfer” payments frequently made by insurers to brokers (ie agents of the insured) for specific policy administration activities that become the responsibility of the broker. These can be substantial amounts for what is sometimes an automated activity.

For an initial period of five years disclosure of intermediaries’ remuneration in relation to non-life business will be on request only, but the customer must be informed of his right to request it.⁴⁹ The distinction is justified in the Explanatory Memorandum to the Commission’s IMD2 proposal⁵⁰ on the basis that commissions on non-life products tend to be much lower and that it is easier to change to another non-life product. In feedback to the November 2010 consultation there had been some opposition to the remuneration disclosure proposals on the ground that the consequent lowering of commissions “could result in lower quality of advice, could encourage mis-buying, could provoke diversion from the issues of coverage, conditions and price and a shift to cheaper internet non-advised sales”.

The Directive is to be reviewed five years after entry into force.⁵¹ Member states can adopt stricter provisions but must notify EIOPA and the commission if they do so.⁵²

With a view to ensuring a level playing field, the insurance undertaking or intermediary is also to be required to inform the customer about the nature and basis of calculation of any variable remuneration received by any employee for distributing and managing the insurance product.⁵³

The Commission is to be empowered to specify criteria for determining (a) how intermediary remuneration, including contingent commission, is to be disclosed, (b) appropriate criteria for determining the basis of calculation of fees and commissions (an exercise likely to be strenuously resisted by market participants), and (c) the steps that intermediaries and insurers might reasonably be expected to take to disclose their remuneration.⁵⁴

The new disclosure obligations discussed above and the current requirement for a statement of demands and needs and reasons for advice are not to apply where the mediation is of a large risk or reinsurance or where the customer is a “professional customer”, as specified in the Annex: ie one who possesses the experience, knowledge and expertise to make his own decisions and properly assess his risks. Under English common law professional customers would nevertheless be entitled to disclosure on request.

Cross-selling

IMD2 Article 21 contains succinct new rules permitting member states to allow bundling practices but not tying practices. The former permit the insurance product to be purchased separately from the ancillary service or product but the latter do not.⁵⁵ The customer is to be informed of his right to purchase the bundled products separately and of the costs and charges of each component. EIOPA is to develop guidelines for the assessment and supervision of cross-selling practices.⁵⁶ Maybe not entirely coincidentally, following the implementation of its Banking Conduct Regime, the FSA has recently published proposals for regulating the selling of packaged bank accounts, including insurance products.⁵⁷

Insurance investment products

Chapter VII of IMD2 contains additional requirements to be imposed on insurance intermediaries or undertakings selling “insurance investment products”, which are to be defined by reference to the proposed PRIIPS Regulation.⁵⁸ The Commission will be given power by “delegated act” to define steps that may be required to identify and prevent or manage conflicts of interest and to establish criteria for specifying types of conflicts that might damage the interests of customers. Article 24, based on MiFID II, stipulates that member states require insurance intermediaries and undertakings to act honestly and professionally in the best interests of customers and provide information that is fair clear and not misleading, and to provide specified types of information.

Sanctions

Sanctions have not been harmonised in EU financial services legislation. The current IMD required that member states provide for appropriate sanctions but did not specify what they should be.⁵⁹ The Impact Assessment accompanying the draft IMD2, although not the

November 2010 Commission consultation document, discerned that the enforcement system was not working. Some national authorities lacked powers; others did not enforce the rules. Surveys indicated that a majority of consumers felt powerless in relation to insurance providers.⁶⁰ A new Chapter VIII in IMD2 requires member states to provide effective, proportionate and dissuasive administrative sanctions and measures. These are to include “administrative pecuniary sanctions” for breaches of registration requirements, professional and organisational requirements and conduct of business rules. Member states are to ensure that the competent authorities have all necessary investigatory powers and to co-operate on cross-border cases.

Conclusion

The European Commission press release “frequently asked questions” assume that adoption of IMD2 by the European Parliament and Council is likely to happen during 2013, with work on the technical measures shortly thereafter and entry into force likely in 2015. Although a full “Lamfalussy structure”⁶¹ has not been adopted, the draft IMD2 would confer significant delegated authority on the Commission, which may meet some resistance. Whatever may be the internal EU politics, IMD2 will in many respects give significant enhancement of protection for potential policyholders.

Endnotes

- ¹ A barrister practising at Serle Court chambers.
- ² See http://ec.europa.eu/internal_market/insurance/consumer/mediation/index_en.htm
- ³ http://ec.europa.eu/internal_market/insurance/docs/consumers/mediation/20120703-directive_en.pdf, . Draft Directive and Explanatory Memorandum.
- ⁴ http://ec.europa.eu/internal_market/insurance/docs/consumers/mediation/20120703-impact-assessment_en.pdf
- ⁵ IMD, recital (8)
- ⁶ IMD, Art. 2(3)
- ⁷ IMD, Art. 3(1)
- ⁸ IMD, Art. 3(5)
- ⁹ IMD, Art. 6(1)
- ³ IMD, Art 6(3)
- ¹¹ IMD, Art 4(1)
- ¹² IMD, Art 4(3)
- ¹³ Called “risk transfer” in the UK.
- ¹⁴ IMD, Art 4(6)

- ¹⁵ As defined in Article 5(d) of Directive 73/239/EEC: broadly, MAT, credit and surety, and other large commercial risks.
- ¹⁶ IMD, Art 12(1)
- ¹⁷ IMD, Art 12(5)
- ¹⁸ IMD, Art 12(3)
- ¹⁹ COB and latterly COBS, implementing MiFID (2004/39/EC)
- ²⁰ https://eiopa.europa.eu/fileadmin/tx_dam/files/publications/protocols/Luxembourg_Protocol%20without%20annexes_Rev1_Oct2008.pdf
- ²¹ See Explanatory Memorandum, p2.
- ²² http://ec.europa.eu/internal_market/insurance/docs/mediation/advice-ceiops-imd2_en.pdf; https://eiopa.europa.eu/fileadmin/tx_dam/files/publications/submissionstotheec/20101111-CEIOPS-Advice-on-IMD-Revision.pdf
- ²³ http://ec.europa.eu/internal_market/consultations/docs/2010/insurance-mediation/consultation-document_en.pdf
- ²⁴ For a summary of responses, see http://ec.europa.eu/internal_market/consultations/docs/2010/insurance-mediation/summary_of_responses_en.pdf
- ²⁵ See Explanatory Memorandum, p4.
- ²⁶ *Ibid*, p6.
- ²⁷ IMD2, recital (5).
- ²⁸ IMD2, recital (6).
- ²⁹ IMD, Art 1(2)(f)
- ³⁰ IMD2, recital (7), Art (1).
- ³¹ IMD2, Art 2(3).
- ³² “Advice” is now to be defined in Art 2(9) as the provision of a recommendation to a customer whether at their request or on the initiative of the insurance undertaking or intermediary.
- ³³ *Ibid*.
- ³⁴ IMD2, Art 2(3)(a)
- ³⁵ IMD2, recital (12)
- ³⁶ Insurance undertakings registered as such under the Insurance Directives will not be required to register under IMD2.
- ³⁷ IMD2, Art 3(6)
- ³⁸ IMD2, Art 3(7)
- ³⁹ There seems to be some confusion in the draft as to whether these are to be regulatory technical standards or implementing technical standards: presumably they are to be the former.

For the distinction see “The path to Solvency II implementation – rocks and hard places”, BILA Journal 123 (November 2011) page 13, by Chris Finney

⁴⁰ IMD2, Art 8(8).

⁴¹ IMD2, Art 15(1)

⁴² IMD2, Art 15(2)

⁴³ IMD2, Art 16(1)(a)

⁴⁴ IMD2, Art 16(1)(b)

⁴⁵ IMD2, Art 17(1)(a), (b)

⁴⁶ IMD2, Art 17(1)(c)

⁴⁷ As regards consumers, the FSA has made no requirements for mandatory disclosure of commissions paid by insurers, concluding from surveys that they are not generally influenced by such matters but rather by absolute price : FSA “ICOB Review Interim Report” 2007, section 5.1, http://www.fsa.gov.uk/pubs/other/icob_review.pdf. As regards commercial customers there is a requirement to disclose, on request only, remuneration paid by insurers. Trade bodies have been left to develop guidance for their members: FSA FS08/7

⁴⁸ IMD2, Art 17(1)(e)-(g)

⁴⁹ IMD2, Art 17(2)

⁵⁰ at p10.

⁵¹ IMD2, Art 35

⁵² IMD2, Art 19(1)

⁵³ IMD2, Art 17(3)

⁵⁴ IMD2, Art 17(5)

⁵⁵ IMD2, Art 2(19), (20)

⁵⁶ IMD2, Art 21(3)

⁵⁷ CP11/20, CP12/17

⁵⁸ IMD2, Art 2(4)

⁵⁹ IMD, Art 7.

⁶⁰ Impact Assessment, pp18-19.

⁶¹ See http://ec.europa.eu/internal_market/securities/lamfalussy/index_en.htm

The employers' liability trigger litigation

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Introduction

When asked to name the main causes of disease related death in the UK we are quick to point the finger at alcohol and tobacco. Current estimates indicate that 114,000 people die from tobacco related disease in the UK each year whilst between 5,000 and 40,000 die from alcohol or alcohol related causes.² But we are less likely to mention asbestos which the NHS estimates accounts for approximately 4,000 deaths in the UK every year³ and which the World Health Organisation calculates accounts for 107,000 deaths per annum worldwide.⁴ To put this into context the number of asbestos related deaths in the UK each year is more than double the number of people killed on our roads.⁵

This lack of general public interest in asbestos related disease may be driven by a perception that the risk is limited to occupational exposure to asbestos during the 1920s to 1970s. As a result the issue commonly only generates substantial media attention when issues concerning who should meet the increasing social and economic costs arise in the courts. An example of this is the recent Supreme Court decision of *Durham v BAI (Run off) Limited (in scheme of arrangement); Fleming and another v Independent Insurance Company Limited (in provisional liquidation)* – the so-called “EL Trigger Litigation”.⁶ That such litigation exists should, perhaps, not be surprising in view of the cost to the NHS of treating mesothelioma victims. It has been placed at £16,014,640 per annum.⁷ Meanwhile, the overall future cost to UK industry of asbestos related claims is placed at between £4 billion and £10 billion.⁸

Background

Asbestos is a naturally occurring silicate which appears in six different forms. The three most common are chrysotile (white), amosite (brown) and crocidolite (blue). Their fibres have different bio-persistence. 20 years after exposure about half of inhaled amosite fibres remain in the body. A smaller proportion of crocidolite and an even smaller proportion of chrysotile remain.

Asbestos has been mined for over 4,000 years but became increasingly popular in the UK in the late 19th century for its resistance to fire and heat. This, combined with the fact that its abundant supply meant that it was available at low cost, made it the insulator of choice. It was extensively used on the railways and in the shipyards throughout the latter part of the 19th century and early part of the 20th century. However, the main use of asbestos was in manufacturing and construction during the 1940s to 1970s. During this period asbestos was commonly found in insulating materials used in factories, chemical plants, power plants, refineries, commercial buildings and even homes and schools.

The sequence of developing knowledge about asbestos and disease has generated historical controversy. The first medical paper on the subject appeared in the *British Medical Journal* in 1924 and dealt with the death from fibrosis of the lungs of Nellie Kershaw, who had worked in the spinning room of a Rochdale asbestos factory⁹. This paper led to a review by the UK factory inspectorate which resulted in the introduction of the Asbestos Industry Regulations 1931¹⁰. In the 1950s and 1960s the first clear epidemiological evidence revealed the strong link between asbestos exposure and cancer (specifically mesothelioma, a cancer of the mesothelial cells which form part of the protective lining covering the lungs, which is always fatal and usually within 15 to 18 months of diagnosis). This led to a reassessment of the hazards caused by asbestos exposure. It resulted in the introduction of the stricter Asbestos Regulations 1969¹¹ which provided the first quantitative control levels for exposure to asbestos in the workplace. The Asbestos (Prohibition) Regulations 1985¹² banned the import of the most dangerous types of asbestos. The Asbestos (Prohibitions) (Amendment) Regulations 1999¹³ finally banned the import of all types of asbestos into the U.K.

In the latter half of the 20th century employees exposed to asbestos in the workplace started pursuing actions against their employers for both breach of the 1931 and 1969 regulations and for breach of duty (negligence). The introduction of compulsory employers' liability insurance following the Employers' Liability (Compulsory Insurance) Act 1969¹⁴ meant that these claims were commonly dealt with by employers' liability ("EL") insurers. EL insurers "on risk" during the period of exposure commonly apportioned claims between them based on the proportion of the exposure period for which they were on risk.

Towards the end of the 20th century a number of things started to become clear. The latency period between the date of exposure to asbestos and the development of mesothelioma was far longer than previously suspected. Up to 40 to 50 years pass between exposure to asbestos and the manifestation of the disease. This, in turn, gave rise to an increasing awareness that the total number and cost of asbestos claims was going to be far greater than ever previously anticipated. Indeed asbestos claims are the longest and most expensive mass tort in English legal history resulting in the insolvency of manufacturers and insurers alike. This, coupled with an increasing understanding of the aetiology of mesothelioma, has led insurers to question the extent to which the traditional approach of apportioning claims based on time on risk remains appropriate. In addition, insurers have questioned, in some instances, whether the words of the insurance cover provided can be said to place insurers on risk for latent disease claims at all.

We should not, therefore, be surprised at the amount of court time devoted to the issue of who should meet the financial cost of asbestos related diseases, or that insurers continue to look to challenge how liability for claims is allocated and apportioned. This is especially true where those insurers are insolvent or in run off and owe fiduciary duties to their creditors concerning the administration of their remaining assets.

Fairchild

There have been a number of cases considering the apportionment and allocation of asbestos liabilities over the decades. The last 15 years, however, have seen a significant increase in the number of challenges which have been mounted to the traditional approach outlined above. The first of the recent cases is *Fairchild v Glenhaven Funeral Services Ltd and others*¹⁵, decided in 2002. By this time mesothelioma was generally understood to be an indivisible disease triggered by a single, unidentifiable exposure to one or more fibres rather than being a result of cumulative exposure. This gave rise to uncertainty as to which period of exposure had actually *caused* the eventual development of mesothelioma. The *Fairchild* case considered the position where a mesothelioma sufferer had been exposed to asbestos, as a result of breach of duty, by more than one employer, but was unable to show which period of exposure had *caused* him to develop the disease.

The Court of Appeal in *Fairchild*¹⁶ ruled that, applying the strict rules of causation, the claimant was unable to establish, on the balance of probabilities, which period of exposure had caused the disease. The court accordingly held that the claimant had failed to establish causation against any of the defendants.

On appeal to the House of Lords¹⁷ the court overturned the decision of the Court of Appeal. The House of Lords determined that, where an employee had been exposed to asbestos during a number of different periods of employment, but where current medical knowledge did not enable the onset of the disease to be attributed to a particular employer, then a modified approach to causation was justified. In such circumstances the House of Lords ruled that it was sufficient for the claimant to show that each employer had “materially contributed” to the risk that he would contract mesothelioma in order for liability to be established. Whilst each of the Law Lords gave slightly different reasons for allowing the appeal, it was generally considered that there was “a strong policy argument in favour of compensating those who have suffered grave harm at the expense of their employers who owed them a duty to protect them against that very harm and failed to do so”.¹⁸ The House of Lords ruled that any injustice, involved in imposing liability on a duty breaking employer where it cannot be shown which period of employment gave rise to the mesothelioma, “is heavily outweighed by the injustice of denying redress to the victim”.¹⁹

Barker

The issue next arose in the 2006 case of *Barker v Corus UK Ltd*²⁰. This case again considered the position where a mesothelioma sufferer had been exposed to asbestos by more than one employer acting in breach of duty. This time the House of Lords considered whether liability on the part of the employers was joint and several or should be attributed according to each employer’s relative degree of contribution to the risk.

A majority of the House of Lords considered that where liability was imposed on an employer on the basis that that employer had *materially increased* the risk that the employee would contract mesothelioma, then liability should be attributed in accordance with each defendant's relative contribution to the risk. Lord Rodger of Earlsferry dissented. Lord Hoffmann said:

“[c]onsistency of approach would suggest that if the basis of liability is the wrongful creation of a risk or chance of causing the disease, the damage which the defendant should be regarded as having caused is the creation of such a risk or chance. If that is the right way to characterise the damage, then it does not matter that the disease as such would be indivisible damage”²¹

Barker created a gap in compensation in circumstances where one or more of a claimant's employers, or their insurers, was insolvent or could not be identified. This situation was addressed by The Compensation Act 2006.²² Section 3 of the Act reversed the common law position under *Barker*. It made each employer, found to have acted in breach of duty, jointly and severally liable for the damage. This enabled a mesothelioma claimant to recover the totality of his damages from an individual employer without the need to identify each and every employer and/or their insurers. This left employers and/or their insurers to recover a contribution from any other employers/insurers involved. So the position following *Fairchild*, *Barker*, and *The Compensation Act* was, to all intents and purposes, the same as the pre-2002 position. However *Fairchild*, *Barker* and *The Compensation Act* did develop the legal basis by which liability was established in a manner which kept pace with changing medical evidence as to the contraction and development of the disease.

Bolton

The position changed again following the 2006 Court of Appeal decision in *Bolton Metropolitan Borough Council v Municipal Mutual Insurance Limited*²³. By the time of *Bolton* there had been further developments in the understanding of the aetiology of mesothelioma. By 2006 it was known that mesothelioma was caused by a mutation in one of the cells in the pleural lining of the lung. This might be repaired by the body's own repair mechanism. Or the body might fail to repair itself, thus allowing the mutation to continue until the point at which it became a malignant tumour. Only if the mutated cell developed into a malignant tumour would mesothelioma result and death become inevitable²⁴. This was considered to take place around 10 years before diagnosis.

Bolton concerned an individual who was employed to work on a building site occupied by the local authority in the early 1960s. He went on to develop mesothelioma in the 1990s. The local authority concerned brought a claim under its public liability insurance. The question arose whether the relevant policy was the policy in place at the time of exposure to asbestos in the 1960s (which was with one insurer) or the policy in place from 1980 onwards (which was with another insurer). The medical evidence suggested the

malignant tumour was formed and the victim went on to develop symptoms during the latter period.

The argument proceeded on the basis that public liability policies commonly provide cover for “injuries occurring during the period of insurance”. No injury was sustained in this instance at the time of exposure and was not sustained until 1980 at the earliest, when the tumour became irreversible and there was no longer the possibility that any cell mutation would simply be repaired by the body’s own defence mechanism.

The Court of Appeal accepted this argument and ruled that the public liability policy in place in 1980 was the relevant policy for coverage purposes. Lord Justice Longmore stated that:

“[t]hese cases have established a pattern at first instance to the effect that an actionable injury does not occur on exposure or on initial bodily changes happening at that time but only at a much later date; whether that is when a malignant tumour is first created or when identifiable symptoms first occur does not matter for the purposes of this case”.²⁵

EL Trigger

Following *Bolton* four EL insurers in run-off started to decline liability under EL policies. They argued that it was the date at which mesothelioma became irreversible which determined which policy year should respond and not the date of exposure. This formed the basis of the EL Trigger litigation. By the time of the EL Trigger litigation the medical evidence had moved on still further. The point at which mesothelioma was considered to become irreversible was now considered to be the point at which a malignant tumour developed its own blood supply (known as the date of “angiogenesis”)²⁶. By this point the medical evidence suggested that angiogenesis took place around 5 years before diagnosis.

The policies contested in the EL Trigger litigation contained historical wording not used in EL policies underwritten today. The wording provided cover for “injuries sustained” and/or “disease contracted” during the relevant policy period. The insurers contended that the aetiology of mesothelioma (as now understood) meant that no injury could be said to have been sustained, and no disease contracted, at the time of the exposure itself. Instead, the disease could not be said to have been contracted (or injury sustained) until the moment of angiogenesis decades later.

Mr. Justice Burton²⁷ agreed with the decision in *Bolton* that the injury of mesothelioma was not sustained at the date of exposure, but was sustained at the point that the sufferer went on to develop mesothelioma. Despite this, he was prepared to construe the “injury sustained” and “disease contracted” wordings as meaning “injury/disease *caused*”. This meant that, in keeping with market practice to date, it was the EL policy/policies in place at the time of exposure which were the relevant policies.

The Court of Appeal²⁸, in turn, did *not* agree with the decision in *Bolton*. It considered itself bound, however, by precedent to follow it, such that injury was again said to have occurred at the date of angiogenesis. But, as with Burton J, the Court of Appeal was prepared to interpret “disease contracted” as meaning “disease caused”. So the policies in place during the period of exposure remained the relevant policies for compensatory purposes. However, the Court of Appeal was only prepared to interpret “injury sustained” as meaning “injury caused” in those EL policies which post-dated the Employers’ Liability (Compulsory Insurance) Act 1969. Where an EL policy pre-dated the Act, and contained “injury sustained” wording, then that policy did not respond and the relevant policy became the policy in place at the date of angiogenesis.

The Court of Appeal ruling created uncertainty. The question whether insurance cover was available often turned on the precise wording of policies purchased 40 or 50 years ago when mesothelioma was not fully understood. These uncertainties led to an appeal to the Supreme Court.

The Supreme Court considered both (a) the construction of the various EL policies in issue; and (b) the reduced test of causation developed by *Fairchild*, *Barker* and *The Compensation Act* (namely, to enable employees suffering from mesothelioma to recover from those employers who increased the risk of them contracting the disease by exposing them to asbestos). Should this be extended to enable employers to also recover from their EL insurers using the same test of causation? This second issue was not considered by Burton J or the Court of Appeal, nor did it form part of the parties’ agreed statement of fact or list of issues before the Supreme Court.

As regards the issue of construction, the Supreme Court took a different view to that expressed by the Court of Appeal in *Bolton*. It was unanimous in construing the words “injury sustained” and “disease contracted” in the policy period as meaning injury and/or disease *caused* during the policy period. The Supreme Court did not overturn *Bolton* (or express a view as to whether it considered the decision in *Bolton* to be correct). It simply distinguished the decision from that in *Bolton*, on the basis that *Bolton* was concerned with public liability insurance, whilst the EL Trigger litigation was concerned with EL insurance²⁹.

Lord Mance’s judgment

In the leading judgment Lord Mance indicated that the court had taken into account a number of considerations:-

1. The Supreme Court referred to the previous House of Lords decision of *Charter Reinsurance Company Limited v Fagan*³⁰, which is one of the key cases on construction of contracts. In particular, Lord Mance referred to the judgment of Lord Mustill in that case, who said that single words or phrases in a contract

should not be viewed in isolation. They “must be set in the landscape of the instrument as a whole”³¹ and any “instinctive response” to their meaning “must be verified by studying the other terms of the contract, placed in the context of the factual and commercial background of the transaction”.³² Applying this to the present case, Lord Mance considered that it was important that the EL policies in question should be viewed more broadly than the interpretation argued for by the insurers allowed. In particular, Lord Mance held that it was important to bear in mind that the policies involved a close link between the actual employment undertaken during each policy period and the premium agreed for the risks undertaken by the insurers. Premium was clearly linked to actual wages paid to employees during the policy period. In Lord Mance’s view this made it improbable that the policies in issue were intended to pick up liabilities which could be attributed to activities undertaken in employment decades before³³.

2. The second factor considered by the Supreme Court was the potential gap in cover which would exist if the construction argued for by EL insurers was correct. Employers’ breaches of duty towards employees in one period might lead to injury or disease in a later (uninsured) period.³⁴ Similarly, employers would be vulnerable to any decision by EL insurers not to renew; and such decision might arise from disclosure by employers of past negligence on renewal.³⁵ Lord Mance dismissed the argument advanced by insurers that this issue would not arise in the overwhelming majority of EL cases, since most cases involve short-tail claims: typically an accident involving injury. Referring to the earlier Supreme Court decision of *Rainy Sky SA v Kookmin Bank*³⁶, Lord Mance stated that the position contended for by insurers “gives too little weight to the implications of the rival interpretations” and that whilst the insurance could “operate entirely successfully in some 99% of cases”, the “1% of cases in which there might be no cover could not be regarded as insignificant”.³⁷
3. The way in which the EL policies in issue dealt with other matters, in particular extra-territorial matters, suggested that the wording of the policies had not been carefully considered at the relevant time. As a result the Supreme Court felt that there was no requirement for the court to stick literally to what might be perceived as the natural meaning of the words contained in the policy³⁸.
4. Evidence as to the previous application of the policies did not demonstrate a binding usage, and evidence as to the general purpose of EL cover was largely inadmissible. Lord Mance considered, however, that there were still some useful conclusions which could be drawn about the commercial purpose of EL insurance as part of the background. He felt that relevant conclusions could be drawn about the general nature and purpose of the individual policies³⁹. Lord

Mance felt that, given the protective purpose of the Employers' Liability (Compulsory Insurance) Act 1969, insurance on a causation basis was required to give proper effect to the legislation.⁴⁰ This suggested that the correct interpretation of the "sustained" and "contracted" wording was "caused" as contended for by the claimants.

The test of causation

The Supreme Court considered what constitutes the correct test of causation, when determining the liability of EL insurers to indemnify employers for their liabilities to mesothelioma sufferers exposed to asbestos whilst in their employ. It was divided, with Lords Kerr, Clarke and Dyson agreeing with the judgment of Lord Mance and Lord Phillips dissenting.

Lord Phillips considered the reduced test for causation developed in *Fairchild, Barker and The Compensation Act*, in order to establish a causal link between the negligent exposure to asbestos by an employer and the subsequent development of mesothelioma by an employee in his employ. He expressed the view that it should not be extended to encompass the relationship between that employer and its employer's liability insurers. Put simply, Lord Phillips considered that the looser test for causation developed by *Fairchild* was one of liability for the *risk* of mesothelioma created by the exposure and that this test was required "to ensure that those who had breached the duties that they owed to their employees did not escape liability because of scientific uncertainty".⁴¹ But Lord Phillips did not believe that it was the position of the judiciary to extend this test to make EL insurers liable in respect of policy years where it could not otherwise be shown that mesothelioma had been initiated during that policy period.

Lord Mance, by contrast, considered that the test for causation developed in *Fairchild, Barker and The Compensation Act* was one of *deemed causation*. An employer was deemed to have *caused* an employee's mesothelioma (assuming that he went on to develop mesothelioma) by virtue of having exposed him to asbestos. Having determined that the EL insurance policies should be construed as operating on a causation basis, then the policies must therefore respond to liabilities caused (or deemed to be caused) during the relevant policy period.⁴² In adopting this approach, and in holding the EL insurers liable, Lord Mance stated that "if the common law during or even after the currency of an insurance develops in a manner which increases employers' liability ... that is a risk which the insurers must accept".⁴³ To do otherwise would be to create an inconsistency in approach which would result in a gap in coverage.

Asbestos litigation and employers' liability trigger litigation – a lesson for the future?

The result of the Supreme Court's ruling is that negligent exposure of an employee to asbestos during a policy period is sufficient to trigger the EL insurer's obligation to indemnify the employer. This was the practice universally adopted prior to the EL Trigger Litigation and so the Supreme Court's judgment effectively confirms the historical practices of the insurance industry.

So what lessons can be drawn? There are perhaps three main observations.

1. Some sectors of the insurance market maintain that the costs of asbestos liabilities have taken too great a toll on both insurance and industry. They contend that what is now needed is a publicly funded no-fault compensation scheme which compensates victims of asbestos related diseases. The introduction of such a scheme is unlikely to have political support. The overwhelming likelihood is that the government will continue to look to the private sector to meet the costs of asbestos related claims. In April 2012 an Employers Liability Tracing Office was launched to upload and manage a central database containing EL policies. In February 2011, the Financial Services Authority (FSA) published new rules requiring policies entered into, renewed or for which claims are made from April 2011 to be entered onto a register⁴⁴. Then, in July 2012, the FSA issued a consultation paper in relation to the tracing of historical EL policies⁴⁵. This coincided with the announcement by the Department of Work and Pensions, on 25th July 2012, of a new scheme (similar to the Motor Insurers Bureau). Under the scheme the EL insurance industry will meet the cost of mesothelioma claims where the relevant EL insurer cannot be traced. The intention is to extend the scheme to other asbestos related diseases in due course. The scheme is estimated to cost the insurance industry a further £30m a year in the first ten years on top of the £200 million a year already paid out. These initiatives make it clear that the private sector will be asked to pick up the costs of asbestos claims for the foreseeable future.⁴⁶
2. *Bolton* remains good law in relation to public liability claims. So the relevant policy will be the one in place at the time of manifestation of the disease and not the one in place at the time of exposure. It seems inevitable that this will be subject to judicial challenge. What will be the impact on public liability premiums in the meantime and to what extent will public liability insurers be able to force the removal of asbestos from properties that they insure? The Department of Education estimates that asbestos is present in more than three quarters of UK schools, from hard plastics used in toilet cisterns and floor tiles to walls and ceilings made of asbestos insulating board⁴⁷. Whilst generally seen

as safe unless undisturbed, to what extent might we see claims from maintenance contractors, supply staff and pupils in the next 30 to 40 years, if this asbestos remains where it is?

3. Finally, innovation in manufacturing is necessarily a balancing act between product development and risk. Are we applying the lessons of the past to the products of the future? Nanofibres used in the nanotechnology industry are amongst the strongest and stiffest materials known to man with impressive electrical and thermal properties. They are used in manufacturing in a wide range of goods from aeroplane wings to tennis rackets, from self-cleaning windows to computer parts and from medicines to cosmetics. However, they are similar in shape and size to asbestos fibres. They have been shown to cause tumours in mice although the long term impact to those who work in manufacturing and to the general public is not yet clear. Could and should we be doing more to investigate the possible long term impact (if any) of new technologies or, as with asbestos, will we only really become fully aware of the risks once the damage has been done. Will today's innovations become tomorrow's headlines for very different reasons?

Endnotes

- ¹ Natasha Gunney is a senior associate in the commercial litigation, product liability and insurance team at Hogan Lovells. She has 15 years experience of litigation and arbitration dealing with complex commercial disputes.
- ² www.drugscope.org.uk/resources/faqs/faqpages/how-many-people-die-from-drugs
- ³ www.nhs.uk/Livewell/lungcancer/pages/asbestosandlungcancer.aspx
- ⁴ www.who.int/mediacentre/factsheets/fs343/en/index.html
- ⁵ Statistics published by the Department of Transport show 1,901 casualties of road accidents in the UK in 2011 – www.dft.gov.uk/statistics/releases/reported-road-casualties-gb-main-results-2011
- ⁶ [2012] UKSC14; [2012] 1 WLR 867
- ⁷ The Economic Costs of Health Service Treatments for Asbestos Related Mesothelioma Deaths, Occupational and Environmental Health Research Group, University of Stirling, Watterson A, Gorman T, Malcolm C, Robinson M, Beck M, Ann NY Acad Sci 2006 Sept 1076:871-881
- ⁸ UK Asbestos – The Definitive Guide – www.actuaries.org.uk/system/files/documents/pdf/Lowe_0.pdf
- ⁹ <http://pmj.bmj.com/content/80/940/72.full>
- ¹⁰ SI1931/1140
- ¹¹ SI1969/690
- ¹² SI1985/910

¹³ SI1999/2373

¹⁴ 1969 c.57

¹⁵ [2002] UKHL 22; [2003] 1 AC 32

¹⁶ [2002] 1 WLR 1052

¹⁷ [2002] UKHL 22; [2003] 1 AC 32

¹⁸ [2003] 1 AC 32, 67

¹⁹ [2003] 1 AC 32, 67

²⁰ [2006] UKHL 20; [2006] 2 AC 572

²¹ [2006] 2 AC 572, 588

²² 2006 c.29

²³ [2006] EWCA Civ 50; [2006] 1 WLR 1492

²⁴ [2006] 1 WLR 1492, 1499-1500

²⁵ [2006] 1 WLR 1492, 1502

²⁶ [2012] 1 WLR 867, 873-874

²⁷ [2008] EWHC 2692 (QB); [2009] 2 All ER 26

²⁸ [2010] EWCA Civ 1096; [2011] 1 All ER 605

²⁹ [2012] 1 WLR 867, 889

³⁰ [1977] AC 313

³¹ *ibid*, 384

³² *ibid*, 381

³³ [2012] 1 WLR 867, 878-879

³⁴ *ibid*, 879

³⁵ *ibid*, 880

³⁶ [2011] 1 WLR 2900

³⁷ [2012] 1 WLR, 867, 880

³⁸ *ibid*, 881

³⁹ *ibid*, 885-886

⁴⁰ *ibid*, 889

⁴¹ *ibid*, 918

⁴² *ibid*, 899

⁴³ *ibid*, 898

⁴⁴ PS11/4 Tracing Employers' Liability Insurers – February 2011.

www.fsa.gov.uk/pubs/policy/PS11_04.pdf

⁴⁵ CP12/14 – Tracing Employers' Liability Insurers – Historical Policies – July 2012.

www.fsa.gov.uk/static/pubs/cp/cp12-14.pdf

⁴⁶ www.dwp.gov.uk/newsroom/press-releases/2012/jul-2012/dwp085-12.shtml

⁴⁷ www.education.gov.uk/schools/adminandfinance/schoolscapital/buildingsanddesign/a00203143/managingasbestos

Consumer insurance: the risks of contracting on unfair terms

by Alice Carse and Alison Padfield

Introduction

The Unfair Terms in Consumer Contracts Regulations were first enacted in 1994, in order to implement Council Directive 93/13/EEC on unfair terms in consumer contracts (“the Directive”). After five years, the Regulations were replaced by the Unfair Terms in Consumer Contracts Regulations 1999 (“the Regulations”). Although the Regulations have given rise to little in the way of reported cases in the insurance context, the Financial Services Authority has used its enforcement powers under the Regulations to secure undertakings in relation to unfair terms from a number of UK firms in the insurance sector. These include AXA Insurance UK plc, National House-Building Council, Legal & General Insurance and RBS Insurance.

This article considers the current state of the law in relation to terms in contracts between consumers and insurers or brokers or other intermediaries which are found to be unfair. It discusses the impact on *Bankers Insurance Co Ltd v South*¹ of the recent decision of the European Court of Justice (“ECJ”) in Case C-618/10 *Banco Español de Crédito SA v Camino*² and the approach of the Financial Services Authority (“FSA”) to enforcement of the Regulations in relation to the insurance market.

The Directive and the Regulations

The Directive is a consumer protection measure which applies to unfair terms in contracts concluded between sellers or suppliers and consumers where those terms are standard (or, in the words of the Directive and the Regulations, “have not been individually negotiated”).³ The earlier domestic legislation on unfair contract terms – the Unfair Contract Terms Act 1977 – excludes contracts of insurance from its scope, thereby increasing the importance in the consumer context of the 1999 Regulations. The Directive and Regulations require that contract terms be in “plain intelligible language”. Where there is doubt about the meaning of a term, the interpretation most favourable to the consumer must prevail.⁴

This reflects the English principle of interpretation of contracts against the party putting forward, or benefitting from, the wording (commonly denoted by the Latin phrase “contra proferentem”), and is therefore not of great significance. Of potentially greater significance is Article 6(1) of the Directive, which sets out the consequences of a term being found to be unfair, as follows:

“Member States shall lay down that unfair terms used in a contract concluded with a consumer by a seller or supplier shall, as provided for under their national law, not be binding on the consumer and that the contract shall continue to bind the parties upon those terms if it is capable of continuing in existence without the unfair term.”

This is implemented in the United Kingdom by Regulation 8, “Effect of unfair term”, which provides as follows:

- “(1) An unfair term in a contract concluded with a consumer by a seller or supplier shall not be binding on the consumer.
- (2) The contract shall continue to bind the parties if it is capable of continuing in existence without the unfair term.”

A term is unfair if, contrary to the requirement of good faith (which is not defined), it causes a significant imbalance in the parties’ rights and obligations arising under the contract, to the detriment of the consumer.⁵

Bankers Insurance Co Ltd v South

Neither Article 6(1) nor Regulation 8 gives any hint that a national court is expected or even permitted to modify an unfair term in a contract between a consumer and a seller or supplier. However, that was the approach taken by Mr. Justice Buckley in 2003 in *Bankers Insurance Co Ltd v South*⁶, a decision in relation to the 1994 Regulations the reasoning of which is equally applicable to the 1999 Regulations. The insured’s travel insurance policy stated that the payment of claims was dependent on him observing certain conditions. These included requirements to report in writing to the insurers, as soon as reasonably possible, full details of any incidents which might result in a claim under the policy and to forward to the insurers immediately upon receipt every writ, summons, legal process or other communication in connection with the claim.

The judge construed these requirements, with which the insured had failed to comply, as conditions precedent. This meant that the consequence of the insured having failed to comply with them was that insurers were not obliged to pay his claim even if his failure had caused them no prejudice.

Having reached the conclusion that the requirements were conditions precedent, the judge decided that the fact that they entitled the insurers not to pay the claim even if they had suffered no prejudice meant that they caused a significant imbalance in the parties’ obligations to the insured’s detriment. They were accordingly unfair contract terms within the meaning of the Regulations. He then considered the consequences of this finding, and decided to hold that it was “only that part of the clause denying recovery whatever the consequences of the breach, which is not binding on the insured”. In so doing, the judge recognised, at least implicitly, that this was inconsistent with the strict wording of the Regulations, saying: “I regard this as consistent with the spirit, at least” of the Regulations. The judge went on to hold that the breaches of the conditions precedent by the insured were “manifestly serious” and had caused the insurer significant prejudice. On this basis the insurers were entitled to rely on the insured’s breach of the conditions precedent in order to deny liability under the policy.

Case C-618/10 *Banco Español de Crédito SA v Camino*

Banco Español de Crédito SA v Camino concerned a loan agreement entered into by a borrower with a bank. The rate of interest on late payments was 29% and the term of the loan was seven years. Early into the second year of the term, the borrower had failed to make seven of the monthly repayments. The bank made an application to the relevant Spanish court for repayment of the outstanding sum, contractual interest (including interest for late payment) and costs. The court held that the term was unfair and void, but amended it so that interest on late payments was fixed at 19%.

One of the questions put to the ECJ was whether Article 6(1) of the Directive precluded legislation of a member state which allowed a national court to revise the content of a term which it found to be unfair term.

The ECJ answered this question in the affirmative. In reaching its conclusion, the ECJ relied on the wording of Article 6(1), which expressly required member states to provide that unfair contract terms “shall not be binding on the consumer”, and on the objective and overall scheme of the Directive. In relation to the latter, the long term objective of the Directive is to prevent the use of unfair terms in contracts concluded between consumers and sellers or suppliers. The ECJ was concerned to preserve the “dissuasive effect” of the Directive. It agreed with Advocate General Verica Trstenjak, who had described Article 6(1) as having a “deterrent effect” on sellers or suppliers, and effectively raising the stakes for sellers or suppliers who gambled on including unfair terms in their contracts.⁷

Advocate General Trstenjak had said that if national courts were able to modify, rather than declaring void, unfair terms, the risks to a seller or supplier from the use of unfair terms in commercial practices would be reduced considerably. In this way, if national courts were permitted to revise the content of unfair contractual terms, sellers and suppliers would be tempted to continue to use those terms. Even if they were declared to be invalid, the national court could revise the unfair terms in such a way as to safeguard the interests of sellers and suppliers. Not only would this compromise the attainment of the long-term objective of preventing the use of unfair terms in consumer contracts by sellers or suppliers, it would not ensure such efficient protection of consumers as the refusal to apply, in their entirety, terms found to be unfair.

The implications of the *Camino* ruling for English law are clear: terms found to be unfair cannot be modified by the courts and must be disregarded in their entirety. The approach taken in *Bankers Insurance Co Ltd v South* to the construction of the Regulations is, in the light of the interpretation of the Directive by the ECJ, incorrect as a matter of law and will not be followed.

The impact of the ruling in practice is less certain. It is uncommon for the Regulations to be relied on in litigation involving insurance policies, and reference is rarely, if ever, made to *Bankers Insurance Co Ltd v South*. However, the ECJ also considered an aspect of

Spanish procedural law, and held that the Directive precluded procedural arrangements in national courts which did not allow the court to assess of its own motion at the outset or at any time the fairness of a term. The ECJ also referred to its own earlier judgment in Case C-473/00 *Cofidis*⁸ in which it decided that, in order for the Directive to provide effective protection for consumers:⁹

“The protection which the Directive confers on consumers ... extends to cases in which a consumer who has concluded with a seller or supplier a contract containing an unfair term fails to raise the unfair nature of the term, whether because he is unaware of his rights or because he is deterred from enforcing them on account of the costs which judicial proceedings would involve.”

It seems, therefore, that national courts may be obliged in some circumstances to assess of their own motion the fairness of a contractual term falling within the scope of the Directive. The answer to the question posed in the *Camino* case was put in negative terms – the Directive precludes legislation which does not allow a national court to assess of its own motion whether a term in a consumer contract is unfair. However, the judgments in *Camino* and *Cofidis* together at least arguably give rise to the intriguing prospect of courts raising, of their own motion, the question of whether a term in a consumer insurance contract is unfair within the meaning of the Regulations. They do this at present in cases which appear to involve illegality.

Wider implications for insurers and intermediaries

Since 2001, the Financial Services Authority (“FSA”) has had power in certain circumstances to take action against the firms that it regulates to enforce the Regulations. The firms concerned include insurers and intermediaries and the FSA’s powers extend to general insurance and life assurance. In 2007, the FSA published guidance in the form of the Unfair Contract Terms Regulatory Guide (“UNFCOG”). This guide sets out the FSA’s policy on how it will use its powers under the Regulations. It was updated in August 2012.

Paragraph 1.3.6 of UNFCOG states that where a court finds a term to be unfair in litigation between a seller or supplier and a consumer, the seller or supplier will “have to stop relying on the unfair term in existing contracts governed by the Regulations”. Not only is this entirely consistent with the decision in *Camino*, but it means that a finding in litigation brought by one party will be applied by the FSA to all current contracts which include that term. The finding will seemingly not be limited to contracts entered into after the term has been found to be unfair. There is no scope for consideration of the unfairness of the term in a different contract involving a different consumer and her particular circumstances. To put it shortly, a finding of unfairness is a knockout blow to a contractual term in all of the consumer contracts in which a particular seller or supplier (including an insurer or intermediary) deploys it.

UNFCOG also focuses on the language used in the terms of contracts concluded between a consumer and a seller or supplier. Under Regulation 6(2), terms written in plain, intelligible language cannot be reviewed for fairness within the meaning of the Regulations if the terms relate to either the definition of the main subject matter of the contract or the adequacy of the price or remuneration, as against the goods or services supplied in exchange. A recital to the Directive makes plain that, in insurance contracts, these include terms which clearly define or circumscribe the insured risk and the insurer's liability, as those restrictions are taken into account in calculating the premium paid by the consumer. Terms which are not written in plain, intelligible language do not fall within the exemption. Under Regulation 13, the FSA has the power to challenge sellers or suppliers using terms which it regards as unfair. It is clear from the FSA's approach, which can be seen from its website publications including its "Library" in relation to unfair contract terms, that there is a particular focus on the use of language which is neither plain nor intelligible.

Examples of terms which the FSA has challenged as being unfair and which have subsequently been amended are on the FSA website. For example, a home insurance policy contained the following term:

"The buildings are insured against loss or damage caused by ... subsidence or heave of the site on which the buildings stand or landslip

We will not pay for loss or damage ...[c]aused by settlement, shrinkage or expansion"

The terms "subsidence", "heave", "landslip", and "settlement" were not defined in the policy. The FSA considered that this term was not drafted in plain and intelligible language because "settlement, shrinkage or expansion" was not defined in the policy. It believed that the possible definition of these words was very broad and that the average consumer would have difficulties in determining whether she was insured under the policy. Nor did this term clearly define the insurer's liability. As a result of the FSA's challenge, the original term was deleted from all contracts of insurance in which it appeared. It was replaced with a term which provided definitions of the terms used and set out clearly the extent of the insurer's liability.

Similarly, the FSA challenged a term in a 2011 home insurance policy which was similar to one of the terms at issue in *Bankers Insurance Ltd v South*. This particular term stated, under the heading "What you must do when making your claim", that the insured was required to give the insurer, at the insured's reasonable expense, all the information, reports, certified plans, specification information and assistance that it may need in progressing the claim. A similar clause in a 2009 policy relation to what the insured must do after making a claim required the provision of the same information, but was to be provided at the insured's expense, without the qualification that the expense must be "reasonable".

The FSA considered that these terms had the potential to cause significant imbalance to the detriment of the consumer by being an unreasonable and excessive requirement for consumers to comply with. They were therefore unfair. The insertion of "reasonable" into

the 2011 policy wording did not in its view redress any potential imbalance, because what was reasonable might not be clear to the average consumer. Following the FSA's challenge the term was revised to clarify what the insured might be asked to provide. It also stated that the insurer would only ask for information relevant to the insured's claim and would pay for any reasonable expenses of providing the insurer with the information.

Nowadays consumers increasingly purchase their insurance policy with the assistance of price comparison websites. Significantly the Regulations apply not only to the insurer from whom the consumer purchases her insurance, but also to the providers of such websites. These providers are precluded from limiting their liability for potentially unfair circumstances. These might include a failure to highlight unusual or onerous terms in a contract of insurance, a failure to accurately reflect a quotation for insurance or a failure to provide a true comparison of available insurance policies. Providers should also ensure that consumers can properly understand their liability.

Final thoughts

The decision in *Camino* puts beyond doubt that the powers of courts under the Regulations are limited: unfair terms in consumer contracts, including policies of insurance and agreements with insurance brokers, cannot be revised or modified, but only declared unenforceable against the consumer. Insurers and intermediaries, and those advising them, should continue to examine policies for any potential unfairness and pay close attention to the FSA's guidance. *Camino* underlines the fact that the stakes are high, and getting it wrong could be costly.

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Endnotes

¹ [2003] EWHC 380 (QB), [2004] Lloyd's Rep IR 1.

² Judgment of the European Court of Justice of 14 June 2012.

³ Article 3(1) and Regulation 5(1).

⁴ Article 5 and Regulation 7.

⁵ Article 3(1) and Regulation 5(1).

⁶ See note 1 above.

⁷ See the judgment, paragraphs 66-70, and Advocate General Trstenjak's Opinion of 14 February 2012, paragraphs 86 to 89.

⁸ [2002] ECR I-10875.

⁹ Paragraph 34.

Broccoli and U.S. Healthcare Insurance Legislation: The Constitutional Conundrum

Steven Levitsky¹

Would anyone have believed that health insurance legislation in the United States would, in 2012, become a constitutional and moral battleground? Yet, that is exactly what the Affordable Care Act has achieved.

The ACA, or mandatory health insurance law for the uninsured, has divided the country in a way unseen since the Vietnam War. Supporters and opponents of the law battle each other with the virulence of crusaders. On one side, some see national health insurance as an economic and moral necessity; on the other, it is a constitutional and civil rights violation. And, even though the Supreme Court of the United States recently upheld the constitutionality of the health insurance law, most Americans oppose it and Republicans have vowed to repeal it if they get into office in November 2012.

1. The Background

To quickly review, in 2010, the United States was the only advanced country in the world without comprehensive health care.

Nearly 55% of the population was enrolled in private or group health plans. About 29% more of the elderly or poor had Medicare and Medicaid coverage. But there still remained a 16% gap in uninsured coverage, mainly the self-employed, part-time employed, and employees of small business, and jobless. This amounted to between 50 million and 80 million Americans (depending on the length of time you measure their uninsured status).

Obviously, many uninsureds *do* get essential medical treatment, because virtually all hospitals have to provide *emergency* services without regard to ability to pay. Uninsureds may also receive non-emergency or even preventive medical care through charitable organizations, get discounted medical services at a clinic, or just use services and never pay for them.

But, obviously, the cost of their medical and hospital care is always passed on to paying users of health services as much higher insurance premiums or taxes. In 2008, the uninsured collectively used \$116 billion worth of medical services. They imposed a cost of over \$1000 *per family* on those who *did* pay for health insurance. Plus, it is especially ironic that those who can't pay are actually billed far *more* for medical services than insureds (because insureds' insurance carriers have negotiated medical and hospital discounts up to 66% off the "rack rate").

The Affordable Care Act of 2010 was designed to cover about 50 million uninsureds and expand Medicaid coverage for low income people. But, as we explained in an earlier article,² the partisan politics involved in health coverage, together with the peculiarities of the American constitutional system, led to a major legal battle over health insurance reform.

2. The “Tangled Web”

Most Americans do not want to leave their fellow Americans unprotected from health disasters. But many disagree with the convoluted technical legal acrobatics that were used to devise or justify the new health insurance legislation.

The Federal government could simply have provided socialized or national health coverage similar to that in Britain, Canada, and other countries. But it didn't. Instead, in a political deal to avoid confrontation with private health insurers, it agreed to rely exclusively on private carriers to provide health insurance to uninsureds. However, to get acceptable rates, those private insurers needed a huge risk pool. That meant that almost every uninsured American had to be *compelled* to buy private health insurance. But the government did not have the power to actually force people to buy a product. Instead, the government decided to *urge* the purchases with a penalty (called a “tax,” to be paid with your annual Federal tax return). The legislation calls this the “individual mandate.” Its critics call it “coercion.” But whatever its name, the convoluted and compromised scheme raised serious practical and legal problems.

To make the whole program work, uninsureds need to sign on to state or regional exchanges, available on the internet, to review and buy private health plans. Depending on their financial status, they may be entitled to Federal subsidies to help them buy insurance.

The first problem is that lower income uninsureds may not have computers or internet access. And even if they did, they may choose to buy food for their families instead of paying for health insurance that they don't need right away. Of course, they face a hypothetical “tax” (a penalty) for not buying health insurance. But since about 46% of Americans (or about 76 million people) paid no Federal income tax in 2011, this is hardly a convincing threat.

The second problem is that the “tax” is capped so low that even young, healthy people entering the work force — the very people who *can* afford health insurance — may simply decide that it is cheaper to pay the “tax” than buy the insurance. As the Supreme Court decision pointed out, “for most Americans the amount due will be far less than the price of insurance.”³

These are two *practical* problems with the healthcare law that have been identified. So far, the administration has not provided a reassuring answer to either.

The *legal* problem starts with the “individual mandate” — the requirement that uninsured people buy health insurance. A Federal law that regulates local (state) behaviour raises serious Constitutional issues because of the division of power between the Federal and state governments. The Federal government has jurisdiction *over* interstate commerce⁴ and matters that *affect* interstate commerce.⁵ But the question now was whether the spiralling cost of national health care actually “affects” interstate commerce to the extent that the

Federal government has jurisdiction to regulate it and pressure people to buy health insurance. (Again, the Federal government could have *created* a national health plan without a Constitutional problem. Instead, it chose to pressure people to buy a product, sold on a local level, that they may not want. That choice generated the Constitutional problem, because the states are sovereign entities of their own within their own jurisdiction.)

Finally, the Obama administration expanded Medicaid coverage for lower income Americans, triggering vastly increased costs. Medicaid is now a combined federal/state program, with the states having already agreed to fund a specific package of coverage. By expanding Medicaid, the Federal government also expanded the states' costs of funding Medicaid. The Federal government then threatened to cut off *all* Medicaid subsidies to states that did not buy into the expanded coverage requirements and agree to make their own matching expanded cash contributions. In other words, the Obama administration changed the existing Federal/state Medicaid pact by saying, in effect, "you get no money at all if you don't agree to my new terms." This change in the existing Federal/state pact raised Constitutional issues.

These issues became the basis for judicial review of the health insurance legislation.

3. The American Doctrine of Judicial Review

Under the American system of government, Federal courts can review Federal and state laws, decide if they are constitutional, and void any laws that are not.

Curiously, that power does not appear in the Constitution. Instead, it was established by the US Supreme Court in *Marbury v. Madison*, 5 U.S. 137 (1803). In that case the Chief Justice, John Marshall, looked at the intention of the drafters of the Constitution as well as different provisions in the Constitution, and concluded that the Constitution was supreme and overrode any contrary statutes:

"the particular phraseology of the Constitution of the United States confirms and strengthens the principle, supposed to be essential to all written Constitutions, that a law repugnant to the Constitution is void, and that courts, as well as other departments, are bound by that instrument."⁶

The United States thus gained the doctrine of judicial review. Judicial review became the critical issue in health insurance reform.

4. Oral Argument at the Supreme Court

The Affordable Care Act was fiercely partisan legislation. It passed in Congress without a single Republican party vote in the house or senate. Literally minutes after passage, 26 states — more than half the states in the country — filed a lawsuit to declare the Act unconstitutional. It took two years for that case to reach the Supreme Court.

When it did, in March 2012, the Court scheduled almost six hours of oral argument over three days — the longest allotment in recent memory. People waited on line for over 48 hours for the chance to get inside to watch the arguments.

The three days of Supreme Court arguments covered three issues.

1. The Anti-Injunction Act

The first question was whether the appeal could even be heard.

Under the 1867 “Anti-Injunction Act,” a court cannot enjoin the payment of a tax. Someone who challenges a tax needs to pay first, then sue.

Because the Act “forced” people to buy insurance by imposing a “tax,” some argued that the issue was not even “ripe” until the first taxes were paid in April 2013. The Obama administration had made this argument in the early stages of this case, then dropped it when they lost.

In the Supreme Court, neither the states nor the Federal government raised this issue. The Court *itself* appointed an “amicus” to make the argument. He put in a valiant effort, even though he himself did not seem too convinced by his own argument that the law imposed a tax penalty for non-compliance:

So I — so I do think, although it’s — I certainly wouldn’t argue it’s clear — that that’s the best way to understand the statute as a whole.⁷

In response, the Solicitor-General, Donald B. Verrilli, argued that the administration wanted an immediate decision, that the Court should not apply the Anti-Injunction Act, and that it should *not* consider the penalty to be a tax. This caused some consternation, as when Justice Alito remarked,

“today you are arguing that the penalty is not a tax. Tomorrow you are going to be back and you will be arguing that the penalty is a tax.”⁸

In any event, the Justices were visibly unconvinced by this threshold issue and everyone understood that the real test was on the merits over the next two days. However, the argument focused attention on the administration’s shifting technical arguments.

2. Interstate Commerce

The second day of hearings revealed a Court dramatically split on the critical issue of Interstate Commerce.

In the past, Congress used its Interstate Commerce power to regulate *existing* commerce. But now, this power was used to force individuals to buy a product they might not want, on the grounds that *failing* to buy it affected interstate commerce. In effect, the law created a new market that was then regulated.

The Solicitor General argued that the Act was a legitimate response to an economic crisis that affected the national market for health insurance. The requirement to buy health insurance, he said, simply regulated how people would pay for services they were certain to use at some point. But he spoke for only a minute before interruptions began. Justice Kennedy demanded, “[c]an you create commerce in order to regulate it?” Justice Scalia followed with:

“Could you define the market — everybody has to buy food sooner or later, so you define the market as food, therefore, everybody is in the market; therefore, you can make people buy broccoli?”⁹

“Broccoli” was mentioned eight times as an example of compelled purchases. The “broccoli” debate soon became a national pastime, with commentators either analyzing whether the need for food or healthcare were really the same — or simply offering broccoli recipes!

A few minutes later, Justice Alito, obviously not a broccoli fan, tried a different tack:

“All right, suppose that you and I walked around downtown Washington at lunch hour and we found a couple of healthy young people and we stopped them and we said, ‘You know what you’re doing? You are financing your burial services right now because eventually you’re going to die, and somebody is going to have to pay for it, and if you don’t have burial insurance and you haven’t saved money for it, you’re going to shift the cost to somebody else.’

“Isn’t that a very artificial way of talking about what somebody is doing?”

For some, the government’s highly technical position was grating. Justice Kennedy remarked,

“it can be argued that this is what the government is doing; it ought to be honest about the power that it’s using and use the correct power.”¹⁰

3. Severability and Medicaid Expansion

The third day of argument dealt with two questions. *First*, if the mandate were unconstitutional, would the whole statute fail completely, or could the Court try to salvage (or “sever”) the redeemable parts, even though the remaining scheme might be different. And *second*, could the Federal government really threaten to cut off *all* state Medicaid aid, if the states did not agreed to Medicaid *expansion* and pay their expanded share?

5. The President’s Attack on “Unelected Officials” and Judicial Review

On April 2, 2012, soon after the Supreme Court argument but before the decision, Obama issued a public statement. He said that the Supreme Court’s overturning of

his legislation would be an “unprecedented, extraordinary step.” He added:

“I’d just remind conservative commentators that for years what we’ve heard is, the biggest problem on the bench was judicial activism or a lack of judicial restraint, that an unelected group of people would somehow overturn a duly constituted and passed law. Well this is a good example and I’m pretty confident that this court will recognize that and not take that step.”

It did not take long for a reaction. The *Washington Post* reported that “legal analysts and historians said it was difficult to find a historical parallel to match Obama’s willingness to directly confront the court.”

The day after Obama’s statement, in an unrelated case before the Federal Court of Appeals for the Fifth Circuit, the presiding judge ordered the Department of Justice to submit a

“letter . . . at least three pages single spaced, no less . . . stating specifically and in detail in reference to those statements what the authority is of the federal courts in this regard in terms of judicial review.”¹¹

The government backed down, and meekly agreed that judicial review was the law of the land.¹²

6. The Decision

On June 28, 2012, the “unelected” Supreme Court issued its divided 5-4 decision.¹³

It upheld the “individual mandate,” but *not* on Interstate Commerce jurisdiction. The Court decided that would be a major intrusion on individual rights:

“Accepting the Government’s theory would give Congress the same license to regulate what we do not do, fundamentally changing the relation between the citizen and the Federal Government.”¹⁴

“The proposition that Congress may dictate the conduct of an individual today because of prophesied future activity finds no support in our precedent.”¹⁵

In fact, the Court pointed out that the government’s theory “would justify a mandatory purchase to solve almost any problem.”¹⁶ Putting it a different way, that theory would allow the government to force people to do whatever the government wanted. The Court rejected that notion, saying, “[t]hat is not the country the Framers of our Constitution envisioned.”¹⁷

Instead, the Court decided that, while Congress could not force people to buy health insurance, it could at least tax them if they didn’t.¹⁸ As a result, the Court upheld the constitutionality of the “individual mandate” on this technical ground. But, as we pointed out before, the only “mandate” is a very minor tax. It may not achieve the desired result of universal health insurance purchases at all.

The Court also ruled that Congress *could* expand Medicaid. But it could *not* strip the states of their *existing* Medicaid reimbursement funds if they refused to go along with the Federally-imposed *expansion* of benefits:

“Permitting the Federal Government to force the States to implement a federal program would threaten the political accountability key to our federal system.”¹⁹

Finally, the Court concluded that “Congress would have wanted to preserve the rest of the Act,” so the Court decided that the unconstitutional parts of the Act did not taint the entire legislation.²⁰ However, by snipping and trimming as they did, the Supreme Court restructured the law in ways Congress never intended. The dissent argued that, “[t]he Court today decides to save a statute Congress did not write.”²¹

Chief Justice Roberts, a conservative who seemingly opposed the Act during the oral arguments, switched sides at the last moment, and voted with his liberal colleagues to uphold the law. In 2005, Obama had voted against Roberts’ confirmation.

7. The Aftermath

President Obama naturally hailed this “victory for people all over the country.” His opponent, Romney, declared that “Obamacare puts the federal government between you and your doctor.” The Republican party is committed to repeal the Act if they win the election in November.

Finally, it seems that the country as a whole is suspicious of creeping federal power over personal freedom. *The New York Times* concluded that, regardless of the judicial outcome,

“most evidence suggests the health care law has lost miserably in the court of public opinion. National polls have consistently found the law has far more enemies than friends, including a June 2012 New York Times/CBS News poll that found more than two-thirds of Americans hope the court will overturn some or all of it.”

Another critical issue is the long-term view for civil rights. The Supreme Court’s dissent observed,

“The values that should have determined our course today are caution, minimalism, and the understanding that the Federal Government is one of limited powers. But the Court’s ruling undermines those values at every turn.”²²

Proponents of health care may rejoice today at the Court’s upholding of federal jurisdiction. But would they feel the same way tomorrow if, for example, a conservative Republican administration wielded exactly the *same* jurisdictional power to impose other obligations on the country that they didn’t like? Suppose, for example, that the Federal government imposed a tax if people failed to buy and eat broccoli — an acknowledged anti-oxidant that could suppress diseases and reduce national health costs. Or suppose the

government taxed people who did not buy an American flag — a law that could arguably save the U.S.'s failing domestic textile industry?

The next year may bring some answers to these very open questions.

Endnotes

- ¹ Steven Levitsky has a Ph.D. in medieval literature and philosophy from Johns Hopkins and a law degree from McGill. He practises antitrust and constitutional law in the New York office of Duane Morris LLP. Steve has handled domestic and international antitrust clearances for some of the largest insurance transactions in history.
- ² "U.S. Healthcare Reform 2010-2011," *Journal of the British Insurance Law Association* (No 124, March 2012), p. 3.
- ³ 567 U.S. ____ (2012), p. 35. Available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>
- ⁴ U.S. Constitution, Article I, Section 8, Clause 3. Available at http://www.archives.gov/exhibits/charters/constitution_transcript.html
- ⁵ *United States v. Lopez*, 514 U.S. 549 (1995) and *United States v. Morrison*, 529 U.S. 598 (2000).
- ⁶ 5 U.S. at 180.
- ⁷ Official Transcript, Supreme Court argument, March 26, 2012, p. 28. Available at <http://s3.documentcloud.org/documents/328234/supreme-court-health-care-argument-monday.pdf>
- ⁸ Official Transcript, p. 31.
- ⁹ Official Transcript, p. 13.
- ¹⁰ Official Transcript, p. 24.
- ¹¹ *The Wall Street Journal*, "Law Blog," April 3, 2012. <http://blogs.wsj.com/law/2012/04/03/dojs-homework-assignment-tell-fifth-circuit-whether-it-supports-judicial-review/>
- ¹² <http://foxnewsinsider.com/2012/04/05/text-read-eric-holders-doj-response-to-5th-circuit-on-authority-of-the-supreme-court/>
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- ¹⁴ Decision, p. 23.
- ¹⁵ Decision, p. 26.
- ¹⁶ Decision, p. 22.
- ¹⁷ Decision, p. 23.
- ¹⁸ Decision, pp. 42-44.
- ¹⁹ Decision, p. 48; also see p. 55.
- ²⁰ Decision, p. 58.
- ²¹ Decision, p. 64.
- ²² Decision, p. 65.

The Bermuda Form – a fresh perspective?

by Nathan Hull¹

A review of David Scorey, Richard Geddes and Chris Harris, *The Bermuda Form, interpretation and dispute resolution of excess liability insurance*²

Introduction

This is an extended review of a new book on the Bermuda Form (details are given above – “Scorey et al.”). In my review I also compare the analysis in this new work with another textbook on the same subject, *Liability Insurance in International Arbitration, the Bermuda Form*. The authors of this earlier work, now in its second edition³, are Richard Jacobs QC, Lorelie S. Masters and Paul Stanley QC (“Jacobs et al.”)⁴.

Background

The Bermuda Form is a type of excess liability insurance purchased by large corporate policyholders requiring high limits of cover, particularly those exposed to liabilities in the U.S.A. The Form is an “occurrence first reported” policy – fixing coverage to the policy period to which notice of an occurrence or an “integrated occurrence” is first given. It is governed by a modified form of New York law and is subject to English arbitration.

In part due to the Form’s origins in the 1980s when the US casualty market collapsed under long tail pollution and asbestos liabilities, it has some unique features (two of which are referred to above) that even now may not be familiar to many in the industry. This is mainly due to the lack of reported decisions on the operation of the Form – a consequence of subjecting the Form to English arbitration, which is generally confidential. As a result, it is only a relatively small pool of participants that have the knowledge and experience of the operation of the Form’s unique and often complex provisions and how issues concerning those provisions have been decided by arbitration tribunals.

Given that, Bermuda Form Market participants should welcome attempts to explain the operation of the Form and the nature of arbitrations concerning it. Until recently, the only attempt at a comprehensive explanation was by Jacobs et al. However, although Jacobs et al. say that they have attempted to be evenhanded, they also concede that: “it has sometimes been gently hinted (by those who represent insurers) that our conclusions may be unduly generous to the insured”⁵.

It is against this background that Scorey et al. have published their book. The authors say that their effort is to expand the body of knowledge available regarding the Form and the arbitral process to a broader universe of interested parties⁶. In reviewing certain aspects of their book⁷, this article will comment on the extent to which the authors diverge from the views expressed by Jacobs et al.

Overview

Scorey et al's *The Bermuda Form* is split into three sections. The first and by far the shortest introduces the Bermuda Market and the Bermuda Form. There is no attempt to set out in detail the origins of the modern Bermuda Market or the Bermuda Form. The authors acknowledge that this story was told at length in the book by Jacobs et al. The second addresses the Form itself, in particular the construction of the Form and the applicable New York and English law. Certain aspects of this section (including the proper law clause, the "Expected or Intended" definition and the attachment point of the Form) are discussed below. The third focuses on dispute resolution under the Bermuda Form. It includes practical advice on the conduct of the arbitration itself, which will be of use to parties new to Bermuda Form disputes. The parts of this section dealing with disclosure will be discussed below.

The proper law clause

It would be a rare Bermuda Form dispute that did not involve any issues over the meaning of certain provisions of the Form. Therefore, the law governing the construction and interpretation of the provisions of the Bermuda Form (Article VI.O of the XL004 Form (referred to in this article as the "proper law clause")) is critical in setting the parameters within which arguments on construction must be made.

The proper law clause provides that any dispute, controversy or claim arising out of or relating to the Policy shall be governed by and construed in accordance with New York law. However, there are certain important exceptions to that (ie when New York law is not applied), including where such laws are "inconsistent" with any provision in the Policy⁸.

The proper law clause also provides that the provisions of the Policy are to be construed in an "evenhanded fashion" as between the insured and insurer. In the view of Scorey et al. the principle of evenhanded construction is intended to be a "real departure" from the approach in the US when dealing with insurance contracts⁹. Instead, the principle is akin to that adopted by English law, although it would be too simplistic to label this as a "black letter law" approach, to the extent that the relevant commercial background is ignored¹⁰.

The relevance of the English law approach and move away from the "protectionist approach of unmodified and unrestricted New York law"¹¹, the authors say, is underscored by the final sentence of the proper law clause. That provides that: "To the extent that New York law is inapplicable by virtue of any exception or proviso enumerated above or otherwise... the internal laws of England and Wales shall apply". Scorey et al. explain that:

"... this merely makes express that which is otherwise implied, namely that the modifications to New York law effected by the [proper law clause] result in a system of law that has much more in common with the approach of the

Commercial Court in London applying rules of construction under English law than undiluted New York law. This transatlantic shift possibly explains why the parties frequently engage English lawyers and advocates to argue points of New York law in Bermuda Form disputes: in effect, they are often merely applying English law under a different guise.”¹².

Although there is not the same emphasis on the English law approach as in Scorey et al’s book (if any emphasis), Jacobs et al in their book seem to have the same basic approach to construction under the proper law clause, namely that it includes the relevant commercial background to the policy. They say that the approach is to give effect to the parties’ mutual intentions as expressed in the words used, when read in the context of the policy as a whole, the purposes sought to be accomplished, and the relevant surrounding circumstances¹³.

The question, however, in many Bermuda Form disputes is what are the “surrounding circumstances” that can be taken into account? Jacobs et al set out a non-exhaustive list, which includes the legal background against which the Bermuda Form was originally drafted, and the legal system within which tort claims against which policyholders seek coverage are made against manufacturers in the US¹⁴. Scorey et al are less prescriptive, explaining that the debate is whether the “admissible ‘surrounding circumstances’ that can be considered include, for example, records of negotiations, preliminary drafts of contracts, prior agreements, the knowledge of both parties at the time of contracting and the relation of the parties at the time of contracting”¹⁵.

The Expected or Intended definition

Under the Bermuda Form, the loss must be “encompassed” by an occurrence¹⁶. There are two types of occurrence provided for in the Form: (1) an event or conditions which cause actual or alleged personal injury, property damage or advertising liability; and (2) actual or alleged personal injury or property damage arising from the insured’s products¹⁷. An occurrence can be included in an “integrated occurrence” where there is an occurrence encompassing personal injury, property damage or advertising liability to two or more persons or properties commencing over a period longer than 30 consecutive days attributable to the same event, condition, cause, defect, hazard and/or failure to warn of such¹⁸.

However, any actual or alleged personal injury, property damage or advertising liability which is “Expected or Intended” by an insured at the times provided for in the Form (including at the time of sale of any insured’s products and at the “inception date”) shall not be included in an occurrence (or integrated occurrence)¹⁹. Scorey et al comment that this requires an examination of “*perhaps the most complex and difficult area of the policy*”²⁰, namely that of the definition of Expected or Intended set out in Article III.L of the XL004 Form.

The Expected or Intended definition provides, among other things, that personal injury and property damage shall be “Expected or Intended” where the Insured experiences or

expects a level or rate of personal injury or property damage. Scorey et al comment that the relevant enquiry, being in respect of a “level or rate” of personal injury etc, may be an instance where the “evenhanded approach” called for by the proper law clause may be relevant, rather than applying New York law, which has not considered an expectation of a “level or rate” of personal injury or property damage²¹.

Expected or Intended under New York law

Insofar as New York law does apply, Scorey et al do address the well rehearsed debate of whether the insured’s expectation is to be assessed on an objective or subjective basis and on which party the burden of proof rests.

As regards the objective or subjective standard, it may be more difficult to prove that a company (or the relevant individuals within that company) *actually* expected a particular result, than to prove that they *ought* to have expected that result. Scorey et al conclude that there is support for both the objective and subjective view in the body of New York law without commenting on which is the correct or preferred view²². In contrast, Jacobs et al suggest that “as a matter of construction and logic”, “intention” and “expectation” are subjective, not objective concepts. They also say that the subjective standard is the predominant view from the New York law cases²³.

The authors of the two works also do not agree in relation to where the burden of proof lies. This debate concerns whether the wording “neither expected or intended by the insured” operates as part of the coverage afforded to the insured (in which case, under New York law, the burden would be on the insured) or as an exclusion (in which case, the burden would be on the insurer)²⁴.

Scorey et al, relying on the New York Court of Appeals decision in *Consolidated Edison Co v. Certain Underwriters at Lloyd’s (Con Ed)*²⁵, say that the burden lies on the *insured* to show that it did not expect or intend personal injury or property damage. In support of that the authors note that the insured will always be far more able to address questions of its own actions, expectations and intent, than would be the insurer²⁶. In contrast, Jacobs et al suggest that the burden is on the *insurer* to show that the insured expected or intended personal injury or property damage. They distinguish *Con Ed* on the basis that the wording at issue in that case did not contain the exclusionary wording in the occurrence “neither expected or intend by the Insured” and that the insured had to argue (unsuccessfully) that the requirement of an “accident” or an “occurrence” on its own operated as an exclusion, so that the burden to establish that would be on the insurer²⁷.

Commercial Risk

The Expected or Intended definition also provides, under the sub-heading “Commercial Risk”, that actual or alleged personal injury arising out of sales of the insured’s products after the date of the notice of integrated occurrence shall be deemed Expected or

Intended. The Commercial Risk provision is relevant where, for example, the personal injury caused by a product does not cause the insured to stop selling its products after it has given notice of integrated occurrence. Under this provision, personal injury included in the integrated occurrence arising out of post-notice sales would not be covered.

Scorey et al note that commentators have described this provision as “somewhat harsh” (referring to Jacobs et al’s book) or as essentially requiring an insured to cease sale of its product (referring to Dolin and Posner “Understanding the Bermuda Excess Form”²⁸).

However, in Scorey et al’s view neither criticism is justified: The provision appears to say only that, if the Insured does continue sale of its product, it will, in most circumstances be self-insured for the liability consequences of the injuries and damage arising from its decision to continue those sales. The authors say that:

“This is not a directive to withdraw a product from the market. To the contrary, it provides an additional source of business sense direction to the insured: if a product may only be sold profitably because the liabilities resulting from the injuries it causes are insured, it probably should not be sold; alternatively, if the insured decides to sell in those circumstances, it should bear that commercial risk rather than seek to impose it upon the insurer”²⁹.

Attachment point

The attachment point (the point in the insured’s tower of excess insurance where the cover begins) of the Bermuda Form policy is determined by Article II.A. In short, it is the greater of: (1) the minimum per occurrence retention amount set out in the Declarations; and (2) the cover provided by underlying insurances (ie responding below and therefore before the Bermuda Form) listed or which should have been listed on the present or any prior “Schedule B” annexed to the policy.

The point of Article II.A is that the Bermuda Form will attach at a minimum of the per occurrence retention amount listed on the Declarations, but may increase depending on the extent of the underlying insurance.

Scorey et al explain that the principle of excess insurance in the Bermuda Form is applied quite differently compared with other excess policies. This difference, the authors say, arises from two features of the Bermuda Form: (1) the policy is typically extended by an annual renewal, rather than replaced by a subsequent policy; and (2) by giving notice of an integrated occurrence, under defined circumstances, injuries and property damages that take place over an extended period of time are treated together as arising from a single occurrence fixed to a single policy year.

Therefore, the individual injuries or instances of property damage included in an integrated occurrence to which the Bermuda Form responds, may well have taken place over many years, thereby implicating multiple years of underlying policies. That is critical

in light of the wording of Article II.A of the Form which provides that the Form responds in excess of *all* such applicable underlying policies, not only those whose policy period coincides with that of the relevant policy period of the Form³⁰.

The importance of this difference, Scorey et al explain, is that, it is often the case that some or all of the policies underlying the Bermuda Form have been written on a different basis – usually an occurrence basis³¹. Occurrence based policies respond on a different basis than the Bermuda Form policy. First, the policy is triggered based on the date of injury or the date of damage. Second, aggregation is typically not as broad as in the Bermuda Form³². Consequently, although an integrated occurrence reported to a Bermuda Form insurer including injuries or property damages over a number of years will impact only one year of coverage of the Bermuda Form policy, it will trigger each of the years of occurrence based underlying insurances when injury took place³³. As the authors say:

“The import of this section of Article II then is to specify that underlying coverage, in the meaning of Article II, is not limited to the policies whose annual periods coincide with the annual period of the Bermuda Form policy when the notice of occurrence was received. To the contrary, ‘underlying insurance’ in this sense means any responding insurance, of whatever form and in respect of whichever period, attaching at a layer lower than the attachment point of the Bermuda Form insurer.”³⁴.

The authors explain that this does not mean that the Bermuda Form responds in excess of the *limits* of all applicable underlying insurances. Rather, only in excess of the loss which is *covered* by the underlying insurances³⁵. Therefore, where a loss is covered by the Bermuda Form policy but is not covered by an underlying insurance, the presence of that policy (for example, on Schedule B) will be irrelevant to determining the attachment point of the Bermuda Form policy. However, where it is covered by the underlying insurance, the Bermuda Form will respond in excess of that covered amount³⁶.

Jacobs et al think it would be an unlikely situation where, because of the underlying insurance limits, the attachment point of the Bermuda Form was greater than the minimum attachment point, i.e. the minimum per occurrence retention amount set out in the Declarations. Jacobs et al do, however, accept that this may happen. They make the point that Article II.A may have particular relevance where the policyholder’s programme of insurance includes a primary policy covering defence costs in addition to the limits (which are only exhausted by payments of indemnity). They say that in that circumstance, it is possible that the per occurrence retention would be exceeded, and therefore the attachment point increased³⁷.

Disclosure

The nature and scope of disclosure is often a hotly contested issue in Bermuda Form arbitrations. Insureds may argue for the adoption of the International Bar Association

(IBA) Rules on the Taking of Evidence in International Arbitration³⁸. These Rules provide for requests of documents (or a narrow and specific category of documents) relevant to the dispute. The issue often for insurers, however, is that it is difficult and often impossible to know which documents or categories of documents in the insured's possession are relevant to the dispute. This makes it hard to formulate requests to capture all relevant documents – particularly those adverse to the insured's case, which may be essential where there is an extensive factual dispute. Insurers therefore may instead seek to adopt English "standard disclosure", which requires the production by both parties of all relevant documents, including those adverse to their case.

It is of note that Scorey et al in their book say that standard disclosure is, in their experience, frequently adopted, and that it is often perceived to be the usual starting point for determining the parameters for document disclosure in an arbitration with its seat in England, unless there are factors that indicate the practice should be varied³⁹. That is in contrast, somewhat, to Jacobs et al, who say that it is now increasingly common for tribunals in international arbitrations to adopt the IBA Rules⁴⁰.

Scorey et al say that the particular justification for standard disclosure arises where there is a perceived information imbalance between the policyholder and insurer in any case involving an extensive factual dispute⁴¹. As they explain:

“... a Bermuda Form dispute will concern a contract of insurance or reinsurance relating to liabilities to third parties, which will very probably mean that there is an inequality of information between the parties to the arbitration. At least at the start of proceedings, the policyholder will presumptively have an informational advantage over the insurer with regard to facts concerning the third party liabilities and the relevant knowledge held by the policyholder.”⁴².

For that reason, the authors say, it is a fundamental purpose of document disclosure in arbitration to facilitate the aim of giving the parties equality of arms⁴³.

Comment

In light of the limited information available to those utilising the Bermuda Form, Scorey et al's *The Bermuda Form* is a welcome addition to the existing literature. The book of course only sets out the authors' own views and experiences in relation to the Bermuda Form and Bermuda Form arbitrations, and they may differ from those of others concerned with the Form, including those of Jacobs et al, as is evident at least in some respects from the discussion above.

Whilst it may be said that these differences of opinion are a reflection of the different perspectives of the authors of each of the books, the reality may be that they can be explained by the difficulty of the issues concerning the Bermuda Form and the conduct of the arbitrations in which the authors were involved.

In any case, like its rival, Scorey et al's *The Bermuda Form* will be essential reading for any participant and practitioner in the Bermuda Form market, and is likely to be the subject of extensive debate in Bermuda Form arbitrations to come.

Endnotes

- ¹ Associate, Edwards Wildman Palmer UK LLP, Dashwood, 69 Old Broad Street, London, EC2M 1QS Tel +44 (0)20 7556 4666
nhull@edwardswildman.com
- ² 2011. Oxford University Press. 512 pages. £130. ISBN-10: 0199583617 ISBN-13: 978-0199583614
- ³ 2011.
- ⁴ A further description, by Richard Jacobs, of the Form and discussion of how it is used, appeared in issue 120 of the BILA Journal, page 3.
- ⁵ Page viii of the Preface.
- ⁶ Page ix of the Preface.
- ⁷ A full analysis is not possible given the various subjects covered by the book.
- ⁸ Article VI.O(3) of the XL004 Form.
- ⁹ Paragraph 4.34, page 65.
- ¹⁰ Paragraph 4.36, page 65.
- ¹¹ Paragraph 4.37, page 66.
- ¹² Paragraph 4.38, page 66.
- ¹³ Paragraphs 4.12 – 4.18, pages 49 – 52.
- ¹⁴ Paragraph 4.26, page 55.
- ¹⁵ Paragraph 4.65, page 77.
- ¹⁶ Article I of the XL004 Form.
- ¹⁷ Article III.V(1) of the XL004 Form. Note that there is also a temporal requirement for the event or conditions for the first type of Occurrence and for the actual or alleged Personal Injury for the second type.
- ¹⁸ Article III.R of the XL004 Form.
- ¹⁹ Article III.V(2) of the XL004 Form.
- ²⁰ Paragraph 7.32, page 118.
- ²¹ Paragraphs 7.48-50, pages 122-123, and paragraph 7.82, page 134.
- ²² Paragraph 7.72, page 129.
- ²³ Paragraph 7.19-7.20, pages 105-106.
- ²⁴ Paragraphs 11.10 – 11.11, pages 190 – 191, of Scorey et al's book.

²⁵ 98 NY2d 208 (2002).

²⁶ Paragraph 7.73-74, pages 129 – 130.

²⁷ Paragraphs 7.15-17, pages 104-105.

²⁸ 1(4) Journal of Insurance Coverage 68 at 75-6.

²⁹ Paragraph 7.61, page 125.

³⁰ Paragraph 10.05, page 178.

³¹ Paragraph 10.08, page 179.

³² Paragraph 10.09, page 179.

³³ Paragraph 10.09, page 179.

³⁴ Paragraph 10.10, page 180.

³⁵ Paragraph 10.10, page 180. As the authors point out, that may of course be the same if the underlying insurance is exhausted.

³⁶ Paragraph 10.10, page 180.

³⁷ Paragraph 9.08 – 9, page 138.

³⁸ 2010.

³⁹ Paragraph 19.63, page 353.

⁴⁰ Paragraph 16.06, page 311.

⁴¹ Paragraphs 19.62-63, pages 352-353.

⁴² Paragraph 19.70, page 354.

⁴³ Paragraph 19.70, page 354. Although the authors say that disclosure should not be an unfair burden on either party.

Research handbook on international insurance law and regulation

Editors: Julian Burling and Kevin Lazarus

Edition: 2011, 1st Edition

ISBN: 978-1-84980-788-3 lxvi + 815 pages

Publisher: Edward Elgar Publishing Limited

Price: £195

Book review by Peter Fidler, Edwards Wildman Palmer UK LLP

This new book, entitled “Research Handbook on International Insurance Law and Regulation”, is one of a series of Research Handbooks on Financial law. As its title suggests, it covers, in its four parts, insurance contract law, insurance regulation, developing areas of insurance law and regulation and finally some regional studies in insurance law and regulation.

Including the two editors, there are 47 contributors, practitioners in leading firms in England and the other jurisdictions covered by the book, as well as leading academics and regulators. One of the editors was, until last year, Counsel to Lloyd’s; the other is a Solicitor at Lloyd’s.

This ambitious book consists of well over 800 pages of text and over 60 additional pages at the start containing the introduction and tables of cases and legislation. The scope of the book can be gathered from the fact that the table of legislation has sections for 28 different countries in addition to the UK and the US, and the US section comprises legislation in 21 different states.

The need for such a book is encapsulated in the Editors’ remark that practitioners no longer regard detailed law and regulation as a burden in the field of insurance but recognise the importance of adequate and appropriate law and regulation for the proper functioning of markets and for enabling consumers to have confidence in those markets. The book is not intended as a textbook across the field; it assumes that readers will be expert in their own local insurance law and regulation. Instead it focuses more on international angles and is intended to supplement practitioners’ and academics’ courses on insurance law and regulation. The regional studies at the end are intended to serve as an introduction to several other jurisdictions.

It is not possible in a review of this length to refer to all 30 chapters and instead this review can only pick out certain highlights.

The book emphasises that there is often no clear distinction between insurance law and regulation, but whereas insurance law has tended to develop nationally, there is an increasing focus on international regulation.

In the first part, the chapter on pre-contract disclosure focuses largely on the law in the UK, and contrasts the UK with Australia and Germany, with brief references to the US, and then

considers proposals for reform in the UK, Australia and Germany. The chapter on interpretation of contracts contrasts throughout the UK position with those in European countries and the US, and ends with an extensive bibliography. There is a chapter on the US tort of bad faith. The chapter on reinsurance and the balance of the interests between reinsurers and reinsureds is based mainly on the US and the UK because very few other jurisdictions have any reported cases in this area, and those that do are mostly common law jurisdictions. A significant reason for this is the prevalence of arbitration provisions in reinsurance contracts.

The chapter on closing books of business, by two UK lawyers, looks at portfolio transfers, mostly from the UK perspective, with a brief look at the EU, the US and some commonwealth states; the section on schemes of arrangement, for obvious reasons, focuses almost entirely on the UK, with brief references to Rhode Island and, even more briefly, to Australia, Bermuda and Hong Kong. The chapter on choice of law specifically contrasts the position in New York and the UK.

Conduct of business rules, the subject of Chapter 15, generally regulate the relationship between the insurer and the customer and deal with such matters as how products are advertised, what information must be given to the consumer, how claims and complaints should be dealt with, rules regarding conflicts of interest and record keeping requirements. In the common law jurisdictions, much of the relationship between insurer and customer derives from insurance contract law, which pre-dates conduct of business rules becoming part of the regulatory framework. In France and Germany the distinction between conduct of business rules and insurance contract law is less clear. The chapter surveys the origin of conduct of business rules in these jurisdictions, and their territorial application; it looks in some detail at the FSA's Principles for Businesses, such as treating customers fairly, managing conflicts of interest, ensuring suitability of advice etc.

A look at those high level rules is followed by an examination of some examples of how those principles are applied in the conduct of business rules in the UK and how they are applied, or in some cases not applied, in the other jurisdictions. This includes matters such as product information, information about the firm, advice and suitability of products and cooling off periods. Finally the chapter looks at how such rules are enforced in the UK, Hong Kong, the US and Germany. This leads into a chapter surveying different approaches to insurance regulatory enforcement in the UK, the US and Sweden. The second part of the book ends with two chapters on Lloyd's, one from each of the Editors; the first deals with its authorisation in the UK and overseas, and the other deals with the development of performance management.

The third part consists of chapters on micro-insurance, Takaful, alternative risk transfer and e-commerce. The first of these is oriented towards certain countries in Latin America and the Far East. The legal and regulatory framework regarding Takaful is still in its infancy. The most developed systems of Islamic finance and Takaful are found in Malaysia, although

Takaful products may also be found in a number of Middle Eastern and Asian countries, and in some European countries. The chapter on Takaful explains the origin and current nature of Takaful, looks at some financial reporting and general regulatory issues, and at Takaful regulations in the UAE.

The chapter on ART examines the transfer of risks to government and to financial markets, and the use of captives. Transfers to governments have been made where insurance companies were not willing to insure the risks concerned; obvious examples of this are terrorism and natural catastrophes. Transfers to financial markets deal with risks, mainly from earthquakes, windstorms, floods, droughts and other cataclysmic events, considered too large scale for insurance companies to absorb. This has included catastrophe bonds, industry loss warranties and derivatives and credit default swaps; it also covers letters of credit and the timing risk or finite reinsurance.

The chapter on e-commerce looks at the conduct of business generally by electronic means and the UNCITRAL Model Law on Electronic Commerce and then turns to legal principles underlying the exercise of jurisdiction in an online insurance context and also some potential areas of liability that could give rise to cross-border jurisdiction issues. It looks at regulatory compliance both in insurance and in terms of data protection and information security, tort liability for the content of a website, at the Brussels I Regulation and some choice of law issues.

The fourth part consists of regional studies in insurance law and regulation. Here separate chapters deal with Europe, one looking forward to a harmonised European insurance contract law and another the architecture and content of EU insurance regulation. There is a regulatory overview of insurance in the US, and further chapters are devoted to Singapore, Brazil, China, Japan and South Africa.

Insurance Claims

Third edition

Author: Alison Padfield

Bloomsbury Professional, 1992, ISBN 978 1 84766 891 Lvii + 382 pages

Price £130, discounted to £123 on amazon.co.uk

Book review by Jonathan Goodliffe

Alison Padfield is a barrister practising at Devereux Chambers. This is the third edition of her book covering the legal issues arising on claims against insurers and insurance brokers. It focuses on the most important points that arise in modern insurance claims practice.

In his forward to the first edition Lord Justice Waller said:

“The propositions of law are supported [in the book] by detailed but easy to follow references. She has deliberately not overloaded those references with citation of more ancient authority where modern authority will suffice”.

This fully accords with my own impression. The latest edition was aptly timed to enable the author to cover, among other things, the Consumer Insurance (Disclosure and Representations) Act 2012, which received royal assent in March 2012 and is likely to come into force in 2013.

Apart from insurance law issues the book contains a full analysis of the most significant regulatory issues arising, for instance, under the Financial Services Authority's Conduct of Business (COBS) and Insurance Conduct of Business (ICOBS) rulebooks. There is also discussion of the cause of action for breach of the FSA's rules under section 150 of the Financial Services and Markets Act (FSMA).

A wide perspective on the topic is adopted covering, among other things, litigation procedure, alternatives to litigation, double insurance and contribution, reinsurance and claims against insurance brokers.

There is no systematic discussion in the book of the Financial Ombudsman Service's approach to specific legal issues arising in the context of claims by an insured against insurers or brokers. If there were, the book would perhaps be 25% longer than it is. The focus is on the law as applied in the courts. So at page 90 the author expresses the view that damages for hardship, inconvenience or mental stress “will rarely be awarded” in insurance claims. Such compensation, however, is regularly awarded by FOS¹.

The general approach in the book is not merely descriptive but includes comment and, where appropriate, criticism. For instance at page 52 the author discusses the judgment of Mr. Justice Buckley in *Bankers Insurance Co Ltd v South* [2004] 1 Lloyd's Rep IR 1. In that case a clause in an insurance policy was held to be unfair, but the judge, instead of striking

out the clause, effectively added a proviso to it to avoid the unfairness. The author argues that this goes further than the Unfair Terms in Consumer Contracts Regulations 1999 allow and that “this issue will need to be considered by the Court of Appeal in due course”. In fact the author’s analysis was effectively upheld by the European Court in *Banco Español v Camino* case C 618/10. The author, in conjunction with Alice Carse, barrister, has provided a commentary on that case (and the *Bankers’ case* - see page 63). The *Camino* case was decided too late to be included in the book.

In general, therefore, this is one of the most useful textbooks on insurance law and probably the first one I will be referring to in its subject area.

Endnote

¹ See Goodliffe “The price of unfair treatment” BILA Journal 120 page 6



BRITISH INSURANCE LAW ASSOCIATION CHARITABLE TRUST

The Trustees of the British Insurance Law Association Charitable Trust have established a prize known as the “British Insurance Law Association Prize”. The Prize of £1,000 is available to be awarded annually to the author (or joint authors) of a published work constituting in the opinion of the Trustees the most notable contribution to literature in the field of law as it affects insurance.

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British Insurance Law Association Journal

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