Fair Play in Claims Handling: the US and UK experience

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This paper considers the duties of insurers to deal fairly or in good faith in settling claims. A comparison is drawn between the North American and UK approaches. The UK position is considered as it currently stands and as it will be from 15 January 2005, when a new system of regulation is due to come into force.

A Typical Bad Faith Claim

The judgment of the Canadian Supreme Court in *Whiten v Pilot Insurance Co* ([2002] 1 SCR 595) illustrates the approach to this issue adopted in most North American common law jurisdictions.

The Whitens discovered a fire at their home at night in the Canadian winter when the temperature was minus 18° Celsius. The fire totally destroyed the home and contents, including three cats. Mr. Whiten suffered serious frostbite.

Initially the Whitens' household insurer made a payment to allow the Whitens to move into temporary accommodation. It changed its mind shortly thereafter and hotly defended the claim through the trial, claiming that the Whitens had torched their home. The defence was not, however, supported by the local fire chief or the expert initially instructed by the insurer. It was discredited at trial. The insurer's own counsel conceded that there was an air of unreality to the allegation of arson.

The jury awarded compensatory damages and $1 million in punitive damages for the insurer's bad faith. This was aggravated by misconduct, which the jury appears to have considered to be "high-handed, malicious, arbitrary or highly reprehensible".

The punitive damages were reduced to $100,000 by the Court of Appeal of Ontario, but a majority of the Supreme Court restored the jury's award. It considered that although $1m was more than it would have awarded it was *"still within the high end of the range where juries are free to make their assessment"*.

The North American Experience

In the USA and Canada, the tort of bad faith has grown in an effort by the courts, various interest groups and state legislatures to deter perceived unfair claims practices under insurance policies. The courts in the USA and various state legislatures have used tort and contract law to expand the rights of insureds under insurance policies

while attempting to deter what is regarded as misconduct by insurance carriers. In California, for example, since the case of *Gray v. Zurich Insurance Co.* (65 Cal 2d 263, 10 Cal. Rptr 781(1961)), the law of bad faith has continued to expand. *Gray* involved an insurer's failure to defend a third party action.

The justification for the development of the doctrine includes the following: the insurer, normally with a superior bargaining position, and relied on by the consumer, should be held to a higher standard than other types of commercial enterprises. The consumer, it is argued, is in a weaker bargaining position and has an inherent inability to negotiate, for example, specific clauses of insurance contracts.

Thus the concept of a duty of good faith and fair dealing owed by insurers to insureds in most US jurisdictions has expanded exponentially, as has the potential for a jury award if it can be established in court that the duty was breached.

Along with the concept of good faith and fair dealing the courts and legislatures of many states have imposed a fiduciary duty on insurance companies. A California case, *Egan v. Mutual of Omaha Insurance Co.,* (24 Cal.3d 809, 157 Cal Rptr. 482 (1979)) concerned delays in the payment of claims to the disabled plaintiff. The court approved the imposition of punitive damages in bad faith suits based on a breach of fiduciary duty. The punitive damages award of $5 million in that case, however, was reversed on the grounds that it was motivated by *"passion and prejudice"*.

Bad faith case law in most US states has now expanded the duty of good faith and fair dealing in settling claims to all types of insurance, including life, disability, title, fire, property, health and motor.

US Statutory Provisions

It may be instructive for British readers to see an extended extract from one of the US statutes. Section 790.03(h) of the California Insurance Code prohibits the following, among others, as *"unfair methods of competition"* and *"deceptive acts or practices in the business of insurance"*:

> *"Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:*
>
> *(1) misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue;*
>
> *(2) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;*

(3) *failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies;*

(4) *failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured;*

(5) *not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;*

(6) *compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;*

(7) *attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application;*

....

(10) *making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;*

...

(13) *failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement;*

(14) *directly advising a claimant not to obtain the services of an attorney;*

(15) *misleading a claimant as to the applicable statute of limitations;*

(16) *delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome ...* "

...

Other practices that have been treated as in breach of the insurer's duty of good faith and fair dealing include unreasonably refusing to settle within policy limits, thus exposing the insured to a higher risk of a judgment outside those limits.

Tactics

In the USA claims against insurers are often joined with claims alleging bad faith or breach of the insurance code, or equivalent statutory provisions in other US states. C. Lee Cusenbary commented that the impact of the leading judgment in the Texas Supreme Court, *Arnold v National County Mutual Fire Insurance Co* (725 S.W.2d 165 (Tex. 1987)) had:

> *"created an atmosphere of defensive insurance claim adjusting, legal seminars to educate insurers' employees in how to properly handle claims in preparation for potential litigation, and a range of defences that attempt to grapple with this relatively new breed of tort."*

These defences include acting in good faith on legal advice (*Fuentes v Texas Employers Insurance Association* 757 S.W.2d 31(Tex. 1988)).

Third Party Claims

Most US states do not treat any of the duties of the insurer either at common law or under statute as being owed to third party claimants (see for instance in California *Moradi-Shalal v Fireman's Fund Ins. Companies* (46 Cal. 3d 287)). This rule may, however, be circumvented by a third party who enters into a settlement with the insured and takes an assignment of the latter's rights against the insurer (*Smith v State Farm Mutual Automobile Insurance Company* (5 Cal. App. 4th 1104)).

Six states (Florida, Kentucky, Montana, New Mexico, North Dakota and West Virginia) do, however, treat the third party as having direct rights. In *Barefield v DPIC Companies*, (25 June 2004 (No 31226)), the Supreme Court of Appeals of West Virginia held that a claimant could rely on violations of the West Virginia Code sections 33-11-1 to 10. In that case it had been established that the insurer, *"through its own actions knowingly encouraged, directed, participated in, relied upon or ratified wrongful litigation conduct of a defence attorney hired by the insurer to represent the insured"*.

As a result of this, some insurers may refuse to underwrite insurance risks in states which allow third parties to sue in respect of bad faith. Where they do underwite those risks the cost of cover may discourage litigation prone professionals, such as obstetricians, from practising in the state in question. Alternatively, the terms of cover may require the professional to practice his/her profession in a defensive way. Where cover is difficult to obtain professionals may sometimes practise without it: "going bare".

The UK Approach

A number of factors have led to a radically different approach in the UK to the problem of insurers with poor claims handling practices:

- speculative high value litigation is more difficult to finance, because:
  - damages awards are generally made by judges rather than juries;
  - UK damages awards are usually made at much lower levels than in North America, and;
  - lawyers cannot be paid a share of the damages awarded as may be agreed between lawyer and client in the USA.
- In general, and with rare exceptions, the UK courts do not award punitive damages.
- The UK courts do not award damages for the wrongful defence of civil claims and court actions, or for breach of any duty to negotiate.
- Although the UK common law duty of good faith in insurance law is reciprocal it is little developed in relation to claims handling by the insurer.

Moreover, in the UK the successful party to litigation will generally recover most of its "costs" (including court fees, lawyers' and experts' fees, etc.) from the unsuccessful party. The prospect of having to pay two sets of costs may therefore discourage the raising of very weak defences. "Costs" in this wide sense are less frequently awarded in the USA.

On the other hand if the claimant's court action in the UK against the insurer is unsuccessful the insurer will generally get an order for most its costs from the claimant (which it may or may not be able to enforce). The same rule will apply where the insurer offers the claimant more than the claimant eventually recovers at the trial. In that event the claimant will pay the insurer's costs (or those costs will be deducted from the damages awarded) from the time of the offer. This again tends to discourage speculative litigation.

In 1999 major Civil Justice Reforms were introduced on the initiative of Lord Woolf, the English Lord Chief Justice. In pursuance of these reforms, the courts have published "pre-action protocols" setting out, for different types of claim, what steps should be taken by the parties before court proceedings are issued. One of these protocols is designed for personal injury claims, most of which tend to be made in road traffic accidents where the defendant is usually insured. They are aimed at

encouraging the parties to try to settle before going to court and to promote reasonable behaviour and communication towards that end, including the use of mediation where appropriate. Any party that does not adhere to the protocol may be penalised by an unfavourable costs award.

The Current UK Regulatory Position

There is currently (August 2004) very little statutory regulation in force covering how general insurers should handle insurance claims. There are some rules relating to legal expenses insurance deriving from the EU Legal Expenses Insurance Directive (the Insurance Companies (Legal Expenses Insurance) Regulations 1990) allowing the insured, among other things, to choose his own lawyer. Paragraphs 6.8.26R to 28R of the Financial Services Authority's (FSA) Conduct of Business Sourcebook require motor insurers to, among other things, respond to claims within 3 months or pay a penal rate of interest. These rules implement the EU Fourth Motor Insurance Directive.

The Association of British Insurers (ABI) published a voluntary General Insurance Claims Code setting out how its members should respond to insurance claims from private individuals. The code set out a timetable for:

- responding to the initial claim;
- dealing with subsequent communications from the claimant, and
- arranging settlement of the claim or completion of repairs within 10 days of agreement having been arrived at.

This is accompanied by a Statement of General Insurance Practice containing details of "best practice" not only on claims but also proposal forms, renewals and other matters.

Insurers who subscribed to the Code and Statement belonged to independent dispute settlement organisations which provided a free service for policyholders who were private individuals. The Code applied not only to policyholders but also to third party claimants. Such claimants, however, had no remedy where the Code was not adhered to, other than to sue on their claim against the insured and ultimately recover from the insurer.

Another voluntary regulatory organisation, the General Insurance Standards Council (GISC), published various insurance codes to which its members subscribed, including a Private Customer Code. This provided among other things:

"As members of GISC, we promise that we will:

- *act fairly and reasonably when we deal with you;*
- *make sure that all our general insurance services satisfy the requirements of this Private Customer Code;*
- *make sure all the information we give you is clear, fair and not misleading;*
- *avoid conflicts of interest or, if we cannot avoid this, explain the position fully to you;*
- *give you enough information and help so you can make an informed decision before you make a final commitment to buy your insurance policy;*
- *confirm your insurance arrangements;*
- *make sure that our service meets GISC's standards;*
- *handle claims fairly and promptly;*
- *make sure you receive all the documentation you need;*
- *protect any personal information, money and property that we hold or handle for you; and*
- *handle complaints fairly and promptly."*

There was a dispute resolution scheme for policyholders who wished to make a complaint in relation to a breach of the code. The Code may not, however, be invoked by third party claimants.

The Financial Ombudsman Service

When the Financial Services and Markets Act 2000 came into force at midnight on 30 November 2001, a unified Financial Ombudsman Service ("FOS") was created. This took over a number of informal dispute resolution functions from a variety of ombudsmen who, until then, had operated in different financial sectors.

One of FOS's new functions was the settlement of unresolved claims between insurers and their retail customers. It provides a low cost informal alternative to litigation. Its rulings on claims are binding on insurers and other FSA regulated firms but not on customers. If the customer does not accept the FOS ruling, he/she can still sue in the courts. Its procedure is more inquisitorial than is traditional in litigation in common law countries. Consequently, lawyers are less frequently involved.

FOS does not have jurisdiction to settle disputes between third party claimants and insurers.

FSA's Dispute Resolution (Complaints) Sourcebook (which sets out the jurisdiction of FOS) provides at para 3.8.1R:

"(1) *The Ombudsman will determine a complaint by reference to what is, in his opinion, fair and reasonable in all the circumstances of the case.*

(2) *In considering what is fair and reasonable in all the circumstances of the case, the Ombudsman will take into account the relevant law, regulations, regulators' rules and guidance and standards, relevant codes of practice and, where appropriate, what he considers to have been good industry practice at the relevant time."*

So FOS takes into account, but is not bound by, for instance, the law, FSA rules and industry codes of practice. Thus, although the ABI's Statement of General Insurance Practice (referred to above) only applies to policyholders in their private capacity, FOS has, in resolving claims, applied some of its provisions for the benefit of small businesses because it considers it fair and reasonable to do so.

Forthcoming Regulation by the FSA

From 15 January 2005, in pursuance partly of the EU Insurance Mediation Directive, the Financial Services Authority (FSA) will be taking over full responsibility for the regulation of, among other things, the conduct of general insurance business, including the handling of claims. It will also be regulating insurance intermediaries. The FSA's rules and guidance for the new regime are currently available in final or "near final" form. FSA's regime will apply many of the principles which it already applies to the conduct of business of regulated firms selling investment products, including life insurance policies with an investment element.

FSA initially consulted on the general outline of its proposed new regime in its Consultation Paper 160 published in December 2002. At that time it was not proposing that its rules on claims handling should apply for the benefit of third party claimants, although it had power so to apply the rules under section 138(7)(c) of the Financial Services and Markets Act 2000.

In its Consultation Paper 187 published in June 2003 it changed its mind and proposed rules which would put third parties in a position to rely on the claims handling rules contained in its "Insurance Conduct of Business Sourcebook" ("ICOB").

In January it published the final version of ICOB due to come into force the following year. By this time it had changed its mind again. It commented:

> *"After further consideration we have concluded that introducing provisions relating to third party claimants would not align well with the current legal position. We also concluded that rules relating to third party claimants could give rise to conflicts of interest with the insurer's duty to its customers. So, we have decided to remove the requirements relating to third party claimants and replace them with guidance reminding insurers of their obligations under the Principles for Businesses."*

FSA's Principles and Insurance Conduct of Business Rules

FSA's Principles for Business are high level rules applying to the firms which it regulates (including insurers). For example, Principle 6 provides that a regulated firm must pay due regard to the interests of its customers and treat them fairly.

The Principles are often relied upon by the FSA when taking enforcement action in respect of behaviour which is considered to be incompatible with those Principles, although not banned at a detailed level in accordance, for instance, with the approach to regulation of the California Insurance Code.

Guidance given by the FSA in Paragraph 7.2.2G in ICOB states:

> *"...the insurer should have regard to Principle 1 (Integrity), Principle 2 (Skill, care and diligence) and Principle 5 (Market Conduct) in its dealings with the third party and should not deal with the claim in any way less favourably than it would have done had the claim been proceeded against its customer."*

Again this duty is not enforceable at the suit of third parties since it arises from FSA guidance rather than any rule. Paragraph numbers in the FSA rulebook (or "Handbook" as it is commonly called) consisting of guidance have the suffix "G", whereas rules have the suffix "R".

Like the ABI and GISC codes, Chapter 7 of ICOB contains provisions on claims handling. Policyholders who are private persons (as opposed to corporations) who consider that the rules in the Chapter have not been observed, may sue for damages under section 150 of the Financial Services and Markets Act 2000. They may also make a complaint to the Financial Ombudsman Service (FOS), which in appropriate cases will award compensation.

In this respect the position in relation to rules in ICOB is different from that under FSA's Principles, its guidance (such as 7.2.2.G) and the ABI and GISC codes. FSA's

Principles are rules, but the FSA has, under section 150(2) of the Financial Services and Markets Act 2000, removed the right of private individuals to sue for damages in respect of any breach of them.

In many respects Chapter 7 contains similar content to the GISC Code, but there are some departures.

For instance ICOB 7.3.6 R (a rule rather than guidance) provides:

> *"An insurer must not:*
>
> *1 unreasonably reject a claim made by a customer;*
>
> *2 except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds:*
>
> *a of non-disclosure of a fact material to the risk that the retail customer could not reasonably be expected to have disclosed;*
>
> *b of misrepresentation of a fact material to the risk, unless the misrepresentation is negligent;*
>
> *c in the case of a general insurance contract, of breach of warranty or condition, unless the circumstances of the claim are connected with the breach ..."*

ICOB 7.3.6(2) is expressly confined in its application to "retail customers". Nevertheless it substantially reproduces provisions in the ABI Statement of General Insurance Practice. Just as FOS applied the Statement for the benefit of some business policyholders, it can be expected to do the same in relation to this rule. Doubtless there will be other provisions in ICOB containing principles which FOS considers should be applied more widely than the rules and guidance contemplate.

The enforceable requirement in ICOB 7.3.6(1) not unreasonably to reject a claim made by a customer is new in the UK regulation of general insurance claims handling. In a sense it requires insurers not only to observe the procedural fairness required by the ABI and GISC codes and the pre-action protocols, but also to be substantively fair or reasonable in how they deal with claims and what defences they put forward.

In particular, an insurer who put forward a defence for which there is an inadequate foundation in fact or in law might well be regarded as unreasonably rejecting the claim.

So policyholders who suffer similar experiences to those of the Whitens (see "A Typical Bad Faith Claim" above, page 20) may, after January 2005, choose either

to sue on their policy in the civil courts or make a claim on FOS. In addition they may bring a civil action for damages in the courts or a claim before FOS in respect of a breach of ICOB 7.3.6R. Based on typical damages awards in the UK courts, however, they may not recover more than a very small fraction of what was awarded to the Whitens.

It remains to be seen to what extent the prospect of such compensation awards by FOS or in the civil courts motivate insurers to improve claims practices.

Discussion

The ABI claims on its web site to have conducted two benchmarking surveys of motor insurer compliance with the ABI Claims Code, the most recent of which was carried out in early 2002. The survey of just over 6,000 motor claimants showed that insurers continued to achieve a high level of customer satisfaction. Overall, 85% of claimants were satisfied with how their insurer handled their claim, with 89% saying that their claim had been handled efficiently. Presumably this survey only covered policyholders as opposed to third party claimants.

The consumer lobby would argue that FSA's claims handling rules could go further than they do in imposing an enforceable general duty on the insurer to act reasonably in handling claims. Alternatively further examples might have been given (without, of course, following the prolixity of the California Insurance Code) of "substantive" unreasonable claims handling.

Where an insurer makes an unreasonably low or "nuisance value" offer in response to a valid claim it is not immediately obvious that this amounts to a breach of ICOB 7.3.6R, since in a sense the claim is not "rejected". It could perhaps be argued that it amounts to a breach of ICOB 7.3.1R *"an insurer must carry out claims handling promptly and fairly"* although that rule seems to be targeted at procedural rather than substantive fairness. Much will depend on whether FOS adopts a narrow or a wide interpretation of these rules.

The FSA's decision not to apply its claims handling regime for the benefit of third party claimants seems right at least in terms of timing. With the benefit of hindsight the proposal in CP187 to extend the protection of Chapter 7 of ICOB to third parties was not supported by adequate evidence that third party claimants really needed that protection or indeed what protection they needed.

More research into the general standard of third party claims handling and as to the existence of a real problem, if any, would seem to be necessary before such a measure is taken.