Summary: Intervention & Options

Department /Agency:	Title:	
Law Commission and Scottish Law Commission	**Impact Assessment of Reforming Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation**	
Stage: Final report	**Version: Final**	**Date:** 1 December 2009

Related Publications: Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation: Final Report

Available to view or download at:

http://www.lawcom.gov.uk/insurance_contract.htm and http://www.scotlawcom.gov.uk

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What is the problem under consideration? Why is government intervention necessary?

The law relating to what a consumer must tell an insurer before taking out insurance is out-of-date and unfair. Since 1977 it has been overlain by a variety of self-regulatory codes, Financial Services Authority rules and ombudsman guidance. These are complex and often inconsistent, leading to unacceptable confusion for both insurers and consumers. Consumers with claims under £100,000 can obtain justice from the Financial Ombudsman Service, but those with larger claims must go to court, where they face unfair law.

The existing law has been codified in statute. Therefore another Act is needed.

What are the policy objectives and the intended effects?

The aim is to deliver coherent, clear and understandable law so that insurance providers and consumers know what their rights and obligations are. Consumers should understand their duty to take reasonable care in completing an application, and insurers should understand which claims to pay.

The intended effect is to increase consumers' trust and confidence in the insurance industry, leading to increased sales.

What policy options have been considered? Please justify any preferred option.

1. Do nothing. This would leave the current confusion of out-dated law, inconsistent codes and FSA regulation.

2. Improve consumer protection by preventing insurers from refusing life claims for careless misrepresentations after a policy has been in force for five years.

3. Reform the law based on accepted practice. This is the preferred option, as it will embed good standards and increase confidence within the industry.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

Recommended 3-5 years from the date of implementation.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

..... Date:

Summary: Analysis & Evidence

Policy Option: 2 REJECTED	Description: **Insurers may not reject life claim for careless misrepresentations after policy in force for five years**

COSTS

ANNUAL COSTS	
One-off (Transition)	**Yrs**
£ minimal	1
Average Annual Cost (excluding one-off)	
£ 30 to 95 million	

Description and scale of **key monetised costs** by 'main affected groups':

Cost to life insurers of paying more claims (£30 million). Risk that consumers will take less care to complete forms accurately, leading to insurers receiving less information to underwrite risks (which may involve additional costs of up to £65 million).

Total Cost (PV) **£ 30 to 95 million**

Other **key non-monetised costs** by 'main affected groups':

Honest, careful consumers may pay higher premiums to subsidise the dishonest and careless.

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£ 0	
Average Annual Benefit (excluding one-off)	
£ 30 million	

Description and scale of **key monetised benefits** by 'main affected groups':

Consumers who have acted honestly are more likely have their claims paid.

Total Benefit (PV) **£ 30 million**

Other **key non-monetised benefits** by 'main affected groups':

Consumers would have greater confidence that life insurance claims will be paid.

Key Assumptions/Sensitivities/Risks

Main risk is changes in the law will lead to changes in consumer behaviour, with some consumers taking a "conscious gamble" to supress information. We have therefore decided against this option.

Price Base Year 2005	Time Period Years 60	**Net Benefit Range** (NPV) £	**NET BENEFIT** (NPV Best estimate) £

What is the geographic coverage of the policy/option?				Great Britain	
On what date will the policy be implemented?					
Which organisation(s) will enforce the policy?				Courts; FOS	
What is the total annual cost of enforcement for these organisations?				£ Minimal	
Does enforcement comply with Hampton principles?				Yes	
Will implementation go beyond minimum EU requirements?				Yes	
What is the value of the proposed offsetting measure per year?				£ N/A	
What is the value of changes in greenhouse gas emissions?				£ Minimal	
Will the proposal have a significant impact on competition?				No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large	
Are any of these organisations exempt?	No	No	N/A	N/A	

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase £ Decrease £ **Net** £

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Summary: Analysis & Evidence

Policy Option: 3	Description: **Embedding existing good practice in law**

COSTS

ANNUAL COSTS	
One-off (Transition)	**Yrs**
£ Minimal	1
Average Annual Cost (excluding one-off)	
£ 10 to 25 million	

Description and scale of **key monetised costs** by 'main affected groups': Protection insurers who currently breach the ABI Code will be required to pay more claims (£4.4 million a year). General insurers who do not follow FOS guidelines will ask better questions, and will need to process the additional information they receive (£5 to £20 million a year).

Total Cost (PV) **£ 10 to 25 million**

Other **key non-monetised costs** by 'main affected groups': None

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£ 0	
Average Annual Benefit (excluding one-off)	
£ 10 to 25 million	

Description and scale of **key monetised benefits** by 'main affected groups':

The costs to insurers in paying claims represents a benefit to consumers, who are less likely to have claims rejected in breach of the ABI Code and Financial Ombudsman Service guidelines.

Total Benefit (PV) **£ 10 to 25 million**

Other **key non-monetised benefits** by 'main affected groups':

Improved questions, and fewer disputes. Consumers have greater peace of mind. Increased confidence in the insurance industry (leading to a greater willingness to buy insurance).

Key Assumptions/Sensitivities/Risks

The impact depends on the extent to which insurers are currently failing to comply with industry guidance and consumers are failing to challenge unfair decisions. This is difficult to assess accurately.

Price Base Year 2005	Time Period Years 60	**Net Benefit Range** (NPV) £	**NET BENEFIT** (NPV Best estimate) £

What is the geographic coverage of the policy/option?				Great Britain	
On what date will the policy be implemented?					
Which organisation(s) will enforce the policy?				Courts; FOS	
What is the total annual cost of enforcement for these organisations?				£ Minimal	
Does enforcement comply with Hampton principles?				Yes	
Will implementation go beyond minimum EU requirements?				Yes	
What is the value of the proposed offsetting measure per year?				£ N/A	
What is the value of changes in greenhouse gas emissions?				£ Minimal	
Will the proposal have a significant impact on competition?				No	
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase £ Decrease £ **Net** £

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Evidence Base (for summary sheets)

BACKGROUND

1. The process of buying insurance is a common one. Each year, 76% of households take out or renew contents insurance, and 74% take out or renew vehicle insurance. Just over a third of households have life insurance (36%) (ONS Spending 2008, pp 87-88). It is therefore important that consumers understand what they must tell an insurance company before buying insurance.

2. The law on this issue is outdated. It is based on 18th and 19th century principles, and was codified in the Marine Insurance Act 1906. The law imposes a duty on consumers to tell insurers anything which would "influence the judgment of a prudent insurer" in fixing the premium or deciding whether to take the risk. The problem is that most consumers have little idea of what might influence a prudent insurer. Yet the penalties for failure are harsh. If a consumer fails to disclose material information, the insurer may treat the policy as if it does not exist and refuse all claims under it.

3. It is now accepted that a duty to volunteer information is unsuited to a modern mass-consumer market. Since 1986, industry statements of practice have required insurers to ask questions about matters generally found to be material. The Financial Ombudsman Service (FOS) goes further and requires insurers to ask questions about all the information they wish to know. Meanwhile a variety of self-regulatory codes, Financial Services Authority (FSA) rules and ombudsman guidance provide consumers with protection where they have acted honestly but nevertheless made mistakes, often because they have failed to understand the question. In 2008, the Association of British Insurers (ABI) issued guidance on non-disclosure in protection insurance, which was upgraded to a Code of Practice in 2009 (ABI Guidance 2008; ABI Code of Practice 2009).

4. Unfortunately, these various codes, rules and guidance leave gaps and inconsistencies. For example, the ABI's 2009 Code of Practice does not address general insurance. Here, where a consumer has been careless, the FSA rules permit the insurer to refuse the whole claim. However, the FOS requires insurers to make proportionate payments, based on what the insurer would have done had it known the information.

5. The purpose of the draft Bill is to reform the law to bring it into line with accepted practice as currently applied by the FOS. The duty to volunteer information will be replaced with a duty to take reasonable care to answer the insurer's questions accurately and completely. Equally, if consumers provide the insurer with information which was not asked for, they must do so honestly and reasonably.

6. Under the reforms, a consumer who acts reasonably is protected. However, where a consumer acts deliberately or recklessly in misrepresenting the facts, the insurer may avoid the policy and refuse all claims. Where the consumer acts carelessly, the insurer will be granted a remedy based on what it would have done had it known the true facts. Where the insurer would have charged a higher premium, it is required to pay a proportion of the claim.

PROBLEM UNDER CONSIDERATION

7. The rights of insurer and insured currently depend on confusing layers of law, self-regulatory codes, FSA rules and ombudsman discretion. This leads to six problems:

   - *The rules applying to non-disclosure and misrepresentation are unacceptably confusing*. Many of the "warnings" given by insurers on this subject are misleading rather than helpful. Claims handlers sometimes fail to understand what the FOS requires, leading to claims being rejected unfairly. Given that the FOS does not publish its decisions, smaller firms which have only a handful of complaints brought against them each year find it particularly difficult to understand the FOS approach. In addition, consumers whose claims are rejected may not realise that they have a right to complain to the FOS.

   - *This penalises some vulnerable groups*, including those who are recently bereaved or suffering from cancer or multiple sclerosis. In our 2007 survey of final ombudsman decisions, 25% suffered from cancer, 12% from multiple sclerosis and 6% from severe back, neck or joint pain.

   - *This confusion leads to a loss of confidence in the insurance industry*. As the Insurance Industry Working Party report points out, a strong insurance industry provides much needed protections, but "these benefits are dependent on consumer trust and confidence in the industry" (IIWP 2009, p 10). Negative publicity over unfair claims rejection can lead to a sudden and dramatic reduction in sales.

   - *Consumers are only able to obtain justice from the Financial Ombudsman Service, not from the courts*. Although the FOS decides cases according to what is fair and reasonable, it cannot help all those with disputes. Its compulsory jurisdiction is limited to awards of £100,000, and the FOS declines cases which require witnesses to be cross-examined. If a consumer takes a claim to court, the courts are required to apply unfair law.

   - *The present system imposes inappropriate roles on the FOS and the FSA*. The FOS is forced to act as a policy-maker rather than an adjudicator. Meanwhile the FSA cannot change the law. Instead, its rules allow it to impose sanctions on an insurer that exercises its legal rights. In theory, an insurer could win in court but then be fined for taking the action, though this has not happened in practice.

   - *The current state of the law cannot be justified.* At a time when differences in commercial law between the UK and its European partners need to be justified, it is difficult to justify the UK law in this area to an international audience.

RATIONALE FOR GOVERNMENT INTERVENTION

8. The law on non-disclosure was codified by Parliament in 1906. This means that the courts are bound by the clear and unambiguous words of the statute. Only Parliament can change this.

9. Consultation with stakeholders has indicated strong support for reform. Law reform would lead to simpler, more transparent rules. Consumers would have a greater understanding of their duty to take reasonable care in completing insurance application forms. The small minority of insurers who do not follow accepted good practice would be less likely to attempt to rely on strict but unfair legal rights. This will increase trust and confidence in the insurance industry.

10. A loss of confidence can have tangible effects on sales. An example is the fall in sales of stand-alone critical illness protection in 2007-08. It has also been suggested that the pension mis-selling scandal led to a fall in pension sales (Observer 2009; Hansard 2002).

11. A healthy UK insurance industry is important for UK economic performance. The industry is the largest in Europe and the second largest in the world, accounting for 11% of total worldwide premium income. In 2007, the insurance industry accounted for almost a third of all financial sector jobs and contributed £9.7 billion in tax income (ABI Key Facts 2008, pp 3-4).

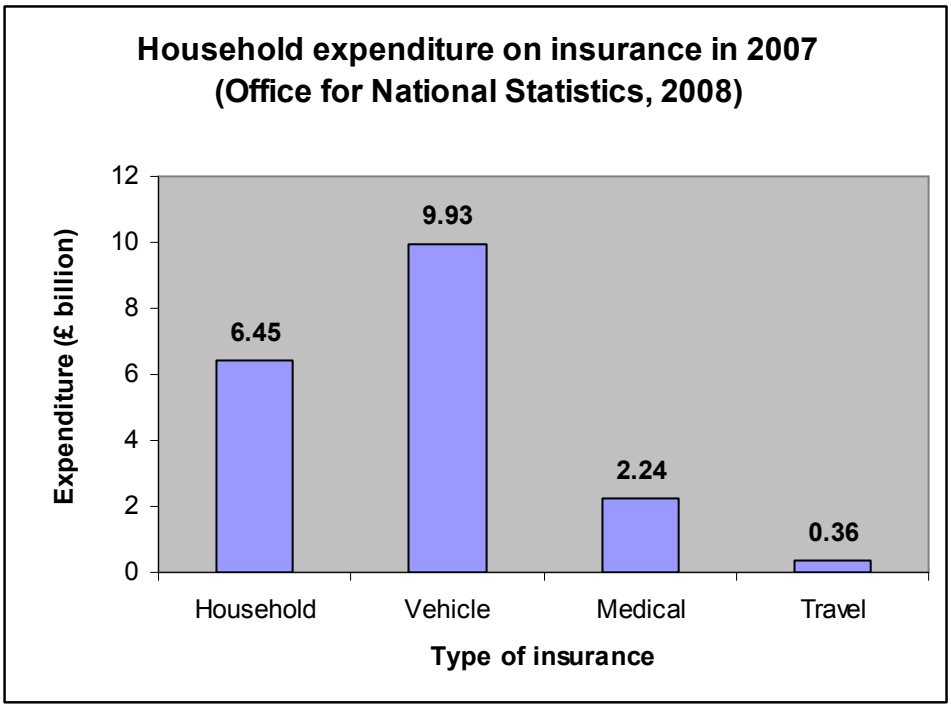
POLICY OBJECTIVES

12. The objectives are:

- to simplify the current position by bringing the law into line with accepted good practice, as set out in the ABI Code of Practice and applied by the Financial Ombudsman Service.
- to improve compliance with good practice, by encouraging both consumers and insurers to know what is expected of them.
- to increase trust and confidence in the insurance industry.

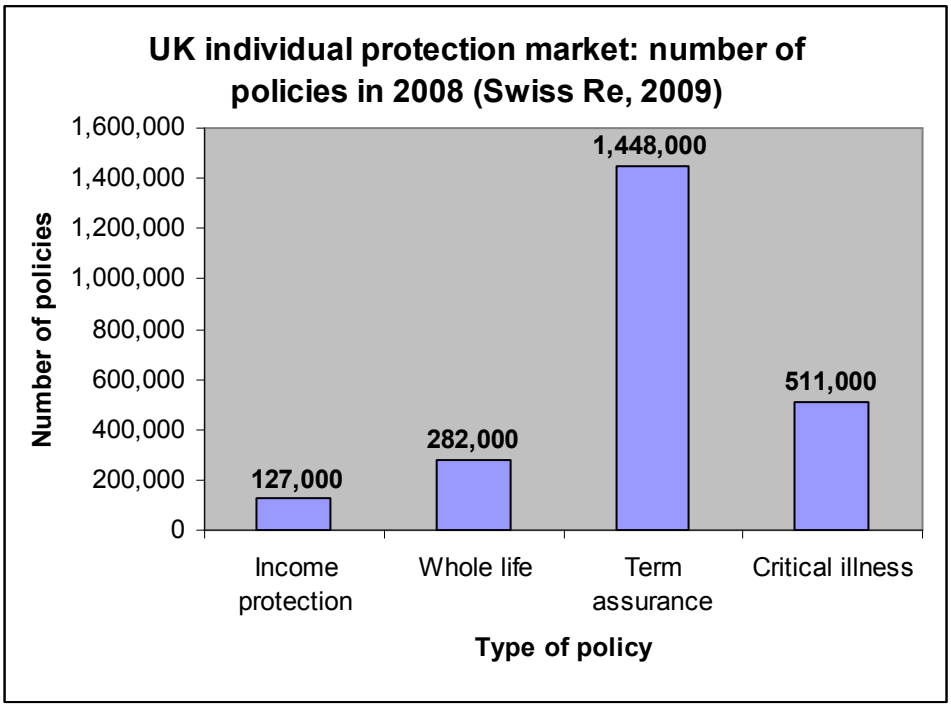
SCALE AND CONTEXT

13. Consumer insurance is a vital part of the UK economy. The Family Spending survey shows that in 2007, UK households spent £19 billion on general insurance, including £10 billion on vehicle insurance, £6.4 billion on household insurance and £2.2 billion on medical insurance (ONS Spending 2008, p 87).



14. Insurance to private individuals represented over half the premium income of the total general insurance market, which in 2007 amounted to £32.9 billion (ABI Key Facts 2008, p 6).

15. The long-term insurance business is even more significant. In 2007, the total net premiums for life and pensions business was £194 billion, of which over £50 billion was spent on life insurance and other protection products. Figures from Swiss Re show that last year, 1.4 million term life insurance policies were sold, together with 0.5 million critical illness policies (Swiss Re 2009).



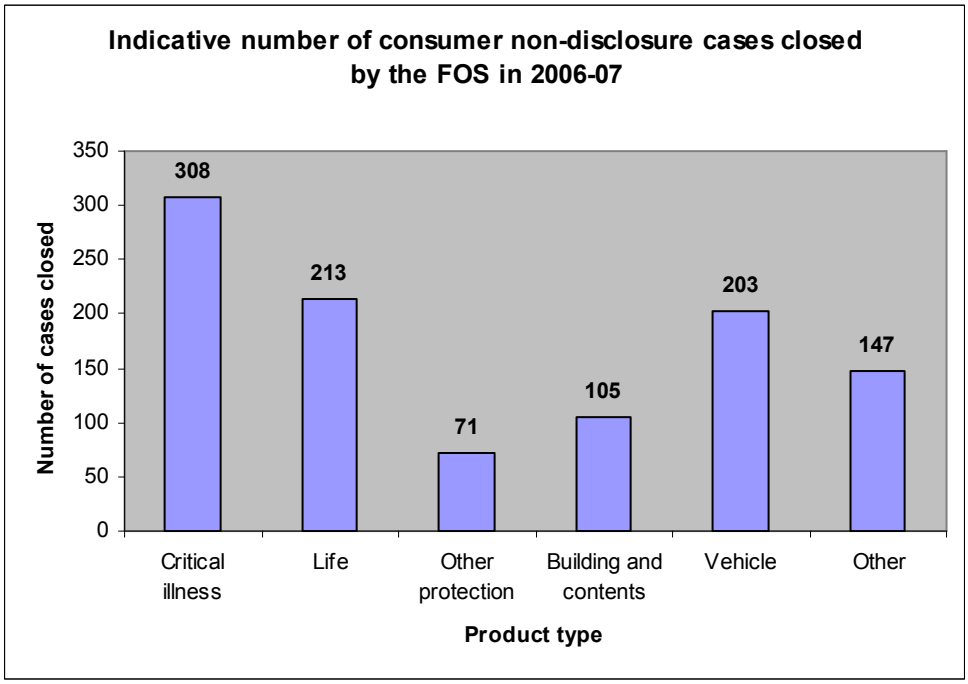
16. As the recent report of the Insurance Industry Working Group makes clear, insurance provides much needed protection for consumers from everyday risks, including the potentially devastating effects of floods and fire. It also enables consumers to manage the financial burdens of illness or bereavement (IIWP 2009, p 10).

17. In comparison with the scale of the insurance industry as a whole, the number of complaints about non-disclosure reaching the FOS is small. However, it is a difficult, ongoing issue, which appears to generate around 1,000 disputes a year.

18. In our 2007 consultation paper we reported that in the three years from 2003/04 to 2005/06, the FOS received around 1,000 such complaints a year (p 359). The latest available figures, relating to cases closed from April 2006 to March 2007, show a similar figure. In this period, the FOS closed 1,047 complaints from consumers about non-disclosure or misrepresentation by the insured.

19. It is not possible to provide precise figures for 2007-08 or 2008-2009. However, in order to provide more up-to-date figures, we recently read through a sample of ombudsman decisions closed between April 2008 and 2009. Based on this sample, we made a rough estimate that in 2008-09 the FOS closed around 1,000 complaints which involved an allegation that the consumer made a non-disclosure or misrepresentation.

20. Although much of the discussion about non-disclosure has focused on the critical illness market, the issue can occur across all types of consumer insurance as shown in the following graph.



CONSULTATION

21. Our present recommendations and draft Bill follow substantial consultation with the insurance industry and with consumer groups over several years. In 2006 we set out our initial views in a series of issues papers, which we discussed in 25 seminars and meetings.

22. In July 2007, we published a formal consultation paper, setting out detailed proposals for reform (CP 2007). We received 105 written responses and attended over 50 meetings with insurers, policyholders, brokers, lawyers and representative groups. In May 2008 we summarised the responses that commented on our consumer proposals (Summary of Responses 2008).

23. We were greatly encouraged by the strong support for reforming the law on misrepresentation and non-disclosure as it affects consumers. We received support not only from consumer groups, brokers, lawyers and the FOS, but also from insurers themselves. Of the 39 insurers and insurance organisations who responded to our paper, only four argued against reform. Many actively welcomed reform to make the law simpler and clearer. A major reinsurer put the case for reform in the following terms:

> We believe that making the law fairer and more transparent for consumers would improve consumer protection by giving consumers the legal rights they are entitled to. Reform would also enhance the reputation of the industry by reducing the scope for insurers to rely on strict legal rights that are unfairly balanced in their favour. Reform would simplify the rules for the benefit of all stakeholders… Finally, reform should also provide guidance to the FOS on what Parliament considers to be a reasonable balance between the interests of the consumer and the insurance industry. (Summary of Responses 2008, p 5)

STUDIES OF THE COSTS AND BENEFITS OF REFORM

24. Two studies have been commissioned into the costs and benefits of our proposals. Alongside the July 2007 consultation paper, we published a report from London Economics, which used the critical illness market as a case study of the impact of reform. The ABI also commissioned an independent report from PricewaterhouseCoopers (PwC) into the financial impact of our proposals. This major study was published in November 2007, as a 189 page report (PwC 2007).

25. In the discussion which follows, we draw heavily on the PwC report. This report starts by identifying those proposals in the initial issues papers and consultation paper which would have the greatest impact on the costs of insurance. It is important to note that the Law Commissions are no longer proceeding with any of those proposals identified as having a high negative impact on insurers. We have therefore recalculated the costs and benefits identified by PwC, looking only at the options currently under review.

POLICY OPTIONS

26. In the course of this review, we considered three options:

    - Option 1: Do nothing.
    - Option 2: Improve consumer protection by preventing insurers from refusing life claims for careless misrepresentations after a policy has been in force for five years.
    - Option 3: Reform the law based on accepted practice, as applied by the Financial Ombudsman Service.

27. The first option would retain the current confusion. The second option would increase consumer protection, but runs the risk of leading to changes in customer behaviour, as some take a "conscious gamble" to suppress information. After discussion, we have decided not to pursue this option.

28. Our preferred option is to reform the law to bring it into line with accepted industry standards. This will embed good practice within the industry. It will increase consumers' trust and confidence in the industry, and make consumers more aware of their responsibilities.

OPTION 2: A FIVE YEAR NON-CONTESTABILITY PERIOD

29. In the consultation paper we asked whether in consumer life assurance, the insurer should be prevented from relying on a negligent misrepresentation after the policy has been in force for five years. After consultation, we are no longer proceeding with this option.

30. Many years may elapse between filling in a proposal form and making a claim for life assurance. In the consultation paper we noted that it may be difficult for the insurer or the bereaved family to assess the reasonableness of a mistake made many years earlier by someone who has now died. Many jurisdictions (including Australia, New Zealand and several states of the USA) deal with this problem by imposing a cut-off. Insurers are prevented from relying on a careless misrepresentation at application once the insurance has been in force for a set period – typically between two and five years. We asked if the same approach should be taken in the UK.

31. The proposal received a mixed response. Of the 61 consultees who addressed this issue, 34 were in favour, 24 thought that there should not be a cut-off period, while three would have preferred a shorter period. Some insurers supported a non-contestability period on the ground that it would increase trust in the industry. However, most insurers were concerned that it would encourage fraud and increase costs (Summary of Responses, p 33).

32. PwC provided detailed costing on this issue. The model they used showed that the full costs would take some time to work through the system. If the proposal was introduced for policies taken out in 2012, the full costs would not be seen until 2032. At that point, assuming constant prices and no change in consumer behaviour, the costs of the proposal would amount to just over £30 million a year. Most of the costs would arise in the stand alone term assurance market (£24 million), though some costs would also arise in products which combined term insurance with accelerated critical illness cover (£6 million). There would be relatively little effect in the whole of life or group life markets (PwC 2007, p 123).

33. These costs are not excessive. There is an argument that the costs would be justified for the additional peace of mind which would be generated. The problem, however, is that consumers may change their behaviour to take less care with application forms. Consumers may even take a "conscious gamble" to give false information on the ground that they expected to live for at least five years, after which it would be difficult to prove that they acted deliberately or recklessly.

34. Working on the assumption that a quarter of consumers have something to disclose, PwC calculated the impact of behavioural changes, assuming that 10%, 25%, 50%, 75% or 100% of consumers failed to give full information on the application form. We think that some of these assumptions are far fetched. We doubt that more than half of consumers would lie on application forms. Many are honest, and many are risk averse. They would not wish to run the risk of leaving their families penniless should they die within five years, or should the fraud be discovered. However, PwC calculated that if half of those with something to disclose changed their behaviour, the total costs of the proposal would amount to £95 million a year. We accept that there is some risk of changed behaviour and that the costs may exceed the benefits in terms of peace of mind. Honest consumers would not wish to cross-subsidise those who took a conscious gamble in this way (PwC 2007, p 59).

Conclusion

35. The costs would be between £30 and £95 million, depending on how far consumers changed their behaviour. The benefits are difficult to quantify in monetary terms. We have therefore decided not to proceed with this option.

OPTION 3: LAW REFORM BASED ON ACCEPTED PRACTICE, AS APPLIED BY THE FOS

36. This option reforms the law in line with the guidance currently applied by the FOS, and generally accepted as treating customers fairly. The current duty to volunteer information is replaced with a duty to take reasonable care to answer the insurer's questions accurately and completely. Equally if consumers provide the insurer with information which was not asked for, they must do so honestly and reasonably. A consumer who acts reasonably is protected. However, if a consumer acts deliberately or recklessly in misrepresenting the facts, the insurer may avoid the policy and refuse all claims. Where the consumer acts carelessly, the insurer will be granted a remedy based on what it would have done had it known the true facts.

37. The aim is to clarify ombudsman guidance and improve compliance with it. Insurers will be less likely to reject claims if to do so would contravene the law, and if they do, consumers will be more likely to seek redress.

38. Understanding the effect of this change is far from straightforward, as most insurers already comply with FOS guidance. Insurers are already expected to treat their customers fairly, and the FOS will already overturn insurers' decisions which breach their guidance. However, there are some areas of confusion, where some insurers do not always understand what the FOS requires. Here we think that enshrining FOS guidance in law will result in a positive change in practice.

39. The main effects of this option will differ between protection insurance and general insurance. Below we consider each in turn.

Life and protection insurance

40. Both the PwC and London Economics reports identified the main effect of this option as leading to more proportionate settlements and fewer outright rejections (PwC 2007 p 52; London Economics, p 36).

41. For many years, the FOS has divided misrepresentations into three categories: "innocent", "inadvertent" and "deliberate or reckless". Where the misrepresentation was "innocent", the FOS would require the insurer to pay the claim. Where it was inadvertent, the FOS asked what the insurer would have done had it known the information. If the insurer would have charged a higher premium, it required the insurer to pay a proportion of the claim. However, if the misrepresentation was deliberate or reckless, the insurer was entitled to avoid the whole policy and refuse all claims under it.

42. In 2007 we said that the main problem with this system was a lack of clarity in the dividing line between "reckless" and "inadvertent". Many insurers assumed that "inadvertence" connoted only mild negligence. Thus moderate or serious negligence was considered reckless. We said that this was a misunderstanding. "Reckless" conduct was a form of dishonesty. Where the consumer was negligent, we said that the remedy should reflect what the insurer would have done had it known the information. If the insurer would simply have added an exclusion or charged a higher premium, the insurer should not be entitled to refuse to pay the whole claim (CP 2007).

43. Thus the reforms would lead to an increase in proportionate settlements, and a reduction in outright refusals where the consumer had behaved carelessly rather than dishonestly.

The effect on claims payments

44. London Economics took critical illness as a case study, and calculated the cost of increased proportionate settlements at £10 million across critical illness claims as a whole (London Economics 2007, p 47). Interestingly, PwC came to a similar conclusion using a different methodology. It calculated the effect of an increase in proportionate settlements as £11 million for policies covering both term insurance and accelerated critical illness cover, plus another £0.5 million for stand-alone critical illness claims (PwC 2007, pp 53-54).

45. Across the whole protection market, PwC calculated that clarifying the definition of deliberate or reckless, and increasing the number of proportionate payouts would increase the amount of claims paid by up to £22 million. The breakdown was as follows:

Term assurance	£ 5.5 million
Term and accelerated critical illness assurance	£11.0 million
Stand alone critical illness insurance	£ 0.5 million
Rest of market (estimate: up to)	£ 5.0 million
Total	**£22.0 million**

(PwC 2007, pp 52-54, 124).

46. The effect on premiums would be greatest in the critical illness market, where PwC estimated that it would add around 0.4% to premiums (PwC 2007, p 55).

47. We think these costs and benefits represented a reasonable estimate of the cost of implementing our proposals at the time of calculation in 2007. At the time, critical illness insurers declined around 12% of claims for reasons of non-disclosure – though insurers differed in their approach. Some declined only 2% to 3%, while others declined around 17% (London Economics 2007, p 43; PwC 2007, p 44). The 2007 report from London Economics calculated that the rate of complaints received for critical illness policies was more than a hundred times greater for critical illness insurance than for contents, buildings or vehicle insurance (London Economics 2007, p 25).

48. However, the practice of insurers has now changed. In January 2008, the ABI responded to public concern by issuing formal written guidance on non-disclosure in protection insurance (ABI Guidance 2008). This Guidance embodied the FOS approach by dividing misrepresentations into three categories: "innocent", "negligent" or "deliberate or without any care". It also adopted the definition of deliberate or reckless that we proposed in our consultation paper. In January 2009 the ABI upgraded the status of the Guidance to that of a Code of Practice (ABI Code of Practice 2009). This means that compliance with the Code is now a condition of ABI membership.

49. As a result, the number of critical illness and income protection disputes reaching the FOS has fallen. In 2006-07, the FOS closed 376 complaints about critical illness or income protection in which non-disclosure was the dominant issue. In 2008-09 it closed 130 such cases. Our recent survey of FOS cases suggested that insurers are now more inclined to offer proportionate payments (Final Report 2009, Appendix C).

50. Thus many of the costs (and benefits) of the proposal have already been actuated. Law reform would now consolidate existing trends, embedding accepted good practice with the minority of claims handlers who are not applying the ABI Code. However, it would not have a dramatic effect on claims payment.

51. We think that at least 80% of the costs predicted by PwC have already become part of insurer practice. This suggests that the effect of the reform in increasing the claims paid by insurers to consumers will be in the region of **£4.4 million**.

52. In terms of costs and benefits, this represents a direct cost of £4.4 million to insurers who will pay additional claims. At the same time, it represents a direct benefit of £4.4 million to those consumers who will receive a proportionate payment of their claim rather than an outright refusal. In the long term, however, any additional cost of claims is likely to translate as an increase in premiums, in the order of 0.08%.

The effect on sales

53. PwC considered how far a 1% increase in premium would affect sales. It concluded that even such a large premium increase (12.5 times larger than the increase produced by our final recommendations) would have no noticeable effect on sales or demand. In its report PwC commented that:

> The more general economic and commercial concerns are likely to dominate fluctuation in sales and demand and that, in the current environment among the top 10 providers it is not uncommon to have premium rates differing by up to 25% for the same risk. We do not, therefore, expect any noticeable effect on sales or demand from the changes arising from the Law Commission's proposals. (PwC 2007, p 140-141)

54. The report stressed that "it is important to note, however, that demand will not only change due to changing price but also due to benefits that individual consumers may perceive from the Law Commission's proposals" (PwC 2007, p 140). Thus as consumers become more confident of being treated fairly, sales are likely to increase.

55. Confidence that insurers will treat claims fairly is crucial to the market for protection insurance. A collapse in confidence may therefore lead to a sudden collapse in sales. In 2007, the Chartered Insurance Institute commented in its response to us that the high refusal rates for critical illness insurance had led to poor public confidence in this market. The FSA data show that sales of stand-alone critical illness policies fell by 49% from 86,000 in 2006-07 to 44,000 in 2007-08 (FSA 2008, p 2). Swiss Re suggested that "concerns around the viability of the product, premium increases and generally negative comment around entitlement to, and payment of claims, were all seen as contributing factors to this decline" (Swiss Re 2008).

56. Furthermore, the practice of a minority of insurers may undermine confidence in the products offered by the majority. As we saw, in 2007, declinature rates for reasons of non-disclosure for critical illness claims varied between 3% and 17%, depending on company policy. Yet this information may not be readily accessible to buyers, which means that the reputation of the majority of insurers is undermined by a limited number of firms. We think that underpinning good practice with clear law will address this problem.

57. By increasing consumers' confidence that insurers will behave fairly, our reforms are likely to increase sales. Swiss Re has identified a "protection gap", calculated as the difference between the resources needed and the resources which would be available to maintain a family's living standard after the death of the primary earner. Following the reforms, we think that this gap is more likely to reduce than increase.

General insurance

58. The effect on general insurance is more difficult to calculate. PwC identified the main effect of the changes as encouraging insurers to ask better questions, especially at renewal:

> At the renewal stage it is likely that the insurers would need to implement a more robust process in terms of the information sent to the insured, which would include developing systems to generate more detailed statements to be sent and agreed by the insured. (PwC 2007, p 82)

59. At present, it is common for insurers to ask very general questions on renewal, along the lines of "please inform us of any material change in your circumstances". Consumers often do not know what type of reply is required. Thus the FOS will not allow the insurer to refuse a claim for a failure to answer a general question where most reasonable consumers would not have provided the information. Under the reformed scheme, this will be built into law.

60. PwC pointed out that insurers might respond in one of two ways. They may improve the questions asked, or they might increase the number of claims paid. PwC costed only the first strategy, estimating that the process of gathering better information might add up to two or three minutes to the underwriting process. This time was costed at £15 to £30 an hour (PwC 2007, pp 83-84). Based on these assumptions, PwC calculated that the reforms might add between £20 million and £80 million to the cost of general personal lines insurance, which would represent an increase in premiums in the order of 0.1% to 0.3% (PwC 2007, p 128).

61. In theory, asking only general questions on renewal could save the insurer money. As general questions rarely receive a reply, the insurer does not have to incur the costs of reading or processing the information. And, on a literal interpretation of the Marine Insurance Act 1906, an insurer could argue that it is entitled to refuse a claim because a consumer failed to answer such a general question. However, if the consumer complains, the Financial Ombudsman Service requires the claim to be paid where it is clear that most consumers in the market would have failed to respond to the question.

62. Although there are some examples of harsh decisions, we do not think that general insurers routinely refuse claims on this basis. The proportion of general insurance claims rejected for non-disclosure is much lower than for critical illness and other protection insurance claims. As PwC acknowledge:

> In the current process only a small number of claims are repudiated for non-disclosure, therefore it is likely that these costs are lower than the costs associated with increasing the processing time. (PwC 2007, p 83)

63. Under the reforms, insurers may continue to ask very few questions. However, the draft Bill clarifies that if an insurer decides on this strategy, it is not entitled to refuse claims because consumers have not provided information which no reasonable consumer would have thought was required.

64. Nor do we think that the cost of processing additional information will apply to every claim. It will only apply to the minority of claims in which the consumer has information which the insurer would want to know about. General characteristics, which apply to large segments of the population, can simply be built into the general risk pool. For protection insurance, PwC estimated that only a quarter of the population had something to disclose (PwC 2007, p 58). Applying the same assumption to general insurance would reduce the estimated cost range by 75%. The new figures would be **£5 million to £20 million a year**, representing an increase in premiums of **0.025% to 0.1%**

65. In conclusion, we think that PwC has overestimated the extent to which firms currently ignore FOS guidelines. It has therefore overestimated the effect of reforming the 1906 Act in accordance with FOS guidelines. In our view the costs will not exceed £20 million a year, representing an increase in premiums of 0.1%.

The wider benefits

66. PwC noted that there were "significant non-financial benefits for the consumer and the industry". These included:

- improved peace of mind that a claim would be paid even if the consumer makes an innocent mistake;
- potentially improved regard for and confidence in the insurance industry; and
- continued encouragement to improve clarity of questions in the underwriting process (PwC 2007, p 4).

67. We also think that there is likely to be a reduction in the costs of resolving disputes if both parties know where they stand.

Conclusion

68. The main impact of the reforms lies in improving compliance with FOS guidelines. The extent of non-compliance cannot be estimated with precision, though we have been greatly assisted by the work commissioned by the Association of British Insurers from PricewaterhouseCoopers LLP.

69. We estimate that the reforms will result in additional claims payment of £4.4 million in the life and protection market, and between £5 million and £20 million in the general insurance market. This may be seen as a cost to insurers and a benefit to those consumer policyholders who receive a full or partial payment of their claims. However, we would anticipate that the cost of additional claims would be passed on to consumers. This would add around 0.08% to the cost of life and critical illness insurance and 0.025% to 0.1% to the cost of general insurance.

70. This means that consumers as a group would both bear the costs and receive the benefits of the reforms. Consumers would be required to pay between 2.5p and 10p for every £100 of premium currently paid. We think that consumers would be happy to pay these small additional premiums for the increased peace of mind that they will be treated fairly, and that valid claims will be paid. When claims are rejected unfairly, this often occurs at a particularly vulnerable time, for example when consumers have been bereaved, diagnosed with a serious illness or rendered homeless through fire or flood. If fully informed, we think that consumers would be willing to pay a small additional premium to prevent the unfair rejection of claims.

71. The benefits lie in improved questions, fewer disputes and increased peace of mind. It will also improve consumers' trust and confidence in the insurance industry, which will improve sales.

SPECIFIC IMPACT TESTS

Competition assessment

72. Firms have varied rates of rejecting claims for non-disclosure. As PwC point out, in the critical illness market, rates vary from around 2% to around 17% (PwC 2007, p 44). This suggests that there is only limited competitive pressure to keep rejection rates low.

73. At present, consumers cannot obtain information about a firm's claims record. Such information is rarely published, and even if it were, consumers would struggle to understand the information, at a time when they are already given too much to absorb. FSA research published in 2006 shows that only a minority of consumers conducted an active search for the best buy: over four million people bought their most complex financial product without considering any other options (FSA 2006, p 18).

74. Furthermore, evidence from the past may be inaccurate for the future, especially in long-term insurance, where many years may elapse between sales and claims. Once an insurer has closed its book of business or is in run-off, there is no market incentive for it to act fairly. The insurer's primary duty is to its creditors and shareholders, which may require it to reject all claims for which it is not legally liable.

75. The result is that firms which abide by industry codes and ombudsman guidance may be undermined by a minority of firms which apply the letter of the law. Furthermore, the activities of that minority may destroy confidence in the whole industry.

76. We think that, given these pressures on insurers, there needs to be a clear floor of acceptable practice.

Impact on small firms

77. The insurance industry is characterised by a few very large firms, and many much smaller firms. Out of 808 firms authorised to carry out general insurance business in the UK, the top 10 firms account for 71% of business written (ABI Key Facts 2008, p 6). This means that the remaining 29% of business is spilt between 798 firms.

78. Long-term business is similarly concentrated. The top 10 firms account for 80% of business written, while the remaining 20% is split between 242 firms (ABI Key Facts 2008, p 6).

79. These differences in size can be seen in the considerable disparity in the number of complaints each company receives. In September 2009, the FOS released data showing how many complaints were received in the first six months of the year, broken down by financial provider. The data revealed that some companies received large numbers of complaints. On the general side, 43 firms received over 100 complaints about general insurance. Three very large firms received over 1,000. However, some firms received only a handful of complaints: there were 22 firms which received between 1 and 10 complaints over same period (FOS Complaints 2009).

80. A similar pattern can be seen on the life insurance side: 17 companies received more than 100 complaints while 18 companies received between 1 and 10 (FOS Complaints 2009).

81. Large firms are able to build up a database of FOS decisions. They are not only aware of FSA rules and ABI codes, but they understand how these have been applied and interpreted by the FOS. This information is not available to the smaller firms. FOS decisions are not publicly available, and there is little detailed public discussion about what the FOS expects.

82. Our proposals to embed FOS guidance into clear law will make this information available to all firms. It will be discussed and explained in a variety of text books and practitioner guides. It will not be confined to those who receive a sufficient number of FOS decisions to know what is required of them. Thus the proposals will benefit smaller firms.

Gender equality

83. In long-term protection insurance, questions focus on medical disclosures. Typically questions ask consumers how often they have been to the doctor in the past three or five years. In the event of a claim, the answers may be checked against the consumer's medical notes. The more often the consumer has consulted a GP, the more difficult this memory test becomes. It is especially difficult for consumers to provide full and accurate answers where they have made a large number of visits about routine matters which do not relate to specific illness, especially if the consumer has used these visits to raise what seemed like minor niggles.

84. There are substantial differences between men and women in the way that they use doctors. According to the General Household Survey 2007, on average men aged between 16 and 44 consult a GP twice a year. Women in the same age group consult a GP five times a year (ONS Household 2007, table 7.18). Women are more likely to visit the doctor in a routine way, over (for example) contraception or pregnancy, or while accompanying children.

85. This leads to a difference of approach. To take a typical example, a woman might ask about a mole while visiting a GP during pregnancy and - when reassured that it is not cancerous - forget all about it. A man is more likely to avoid going to the doctor unless he has serious worries. And once he has taken the major step of consulting a GP he is less likely to forget that he has done so.

86. Problems occur when claims staff apply their own interpretations of the importance of a visit to the doctor to consumers with different life experiences. It is therefore important that these decisions are subject to outside scrutiny, rather than dealt with purely as a matter of internal guidance by the insurance industry. We think it is helpful to open up these questions to public debate, by making the rules publicly available through reformed law.

Disability Equality

87. The high rate of complaints over protection insurance means that many of those refused claims are vulnerable through illness or disability. In our 2007 survey of ombudsman decisions, two-thirds of complainants suffered from some form of illness or disability: 25% suffered from cancer, 12% from multiple sclerosis and 6% from severe back, neck or joint pain. The Multiple Sclerosis (MS) Society thought the current law caused particular problems for those diagnosed with multiple sclerosis. The MS Society commented:

> The unpredictability and complexity of MS, with its wide ranging symptoms, means that insurers are often able to refuse a critical [illness] payout on the grounds of non-disclosure of incidents which occurred many years before the consumer was aware of the condition. (MS Society Response to CP 2007)

88. Questions about the early symptoms of MS continue to cause problems. In our survey of recent ombudsman decisions, four out of the 17 decisions over critical illness involved an MS diagnosis (Final Report, p 31). Not everyone will pursue a complaint to the FOS. The MS Society commented that the cases they dealt with "illustrate the vulnerability many people feel after the diagnosis of MS which can make them less willing to challenge a decision".

89. In July 2009, the Insurance Industry Working Group set out a vision for the insurance industry in 2020. It proposed a greater role for private insurance in coping with the financial consequences of long-term sickness and disability (IIWP 2009, p 43). This will make clear, fair law on non-disclosure even more important to those who experience sickness and disability.

Legal aid

90. Although the reforms provide consumers with a choice between using the FOS or using the courts, we anticipate that most consumers will continue to use the FOS. In the consultation paper, we identified ten advantages that the FOS had over the courts, including that it was free, relatively rapid, and used informal, inquisitorial processes (CP 2007, para 3.56). Legal aid is not available where there are suitable alternatives to litigation, such as an ombudsman scheme (LSC Funding Code 5.4.2; LSC Guidance 7.3.9). In the great majority of cases, the FOS will continue to be a suitable alternative to litigation, meaning that a consumer who wishes to pursue a claim will not normally be entitled to legal aid.

91. The cases most likely to be pursued to court are those which exceed the £100,000 FOS limit. In Part 3 we discussed an example where a consumer brought a claim to the FOS for £119,000. Although the ombudsman recommended that the insurer should pay the full sum, she was only able to award £100,000. The consumer took the risk that the insurer would decline to pay the rest of the claim. At present, the law before the courts is so uncertain and unfair that consumers may calculate that it is better to use the FOS even at the risk of losing £19,000. Under our reforms, the calculations may change. It could be argued that the FOS is not a suitable alternative to the courts for claims substantially over £100,000.

92. We have therefore considered how many consumers with claims over £100,000 will fall within the legal aid means test. The means test consists of two parts: income and capital. Although the income test is highly restricted (covering only 29% of the population), it is possible that a recently bereaved or seriously ill claimant would fall within it, if their misfortune meant they were unable to work. (For further details of legal aid eligibility, see Griffith 2008).

93. The problem is the capital test. The current legal aid capital test takes into account the value of the claimant's house, subject to:

- a 3% deduction to cover the cost of selling the property;
- a disregard of any mortgage, up to a total of £100,000;
- a disregard of any equity in the house, up to a total of £100,000;
- a disregard of the first £8,000 of any outstanding capital.

94. The result of these various rules is that legal aid is not available to anyone who owns a home worth more than £214,000. This is the case even if the property is subject to a large mortgage. For example, a consumer with a house worth £300,000 and a mortgage of £250,000 would not be entitled to legal aid (Ling and Pugh 2009, p 18).

95. The reason why people have large insurance claims tends to be related to the value of their home, either because they took out life or critical illness insurance to protect a large mortgage, or because their home has suffered serious damage. Thus it would be very unusual for someone to have a home worth less than £214,000, while simultaneously having an insurance claim of over £100,000. We think that, in practice, most insurance claims brought to court will be brought by those above the legal aid means test. They will be privately funded, possibly through conditional fee agreements.

96. A further reason to think that the impact of our proposals on legal aid would be minimal is that a claim would only be a burden on legal aid funds if it were lost. If a claim is won, the costs would either be covered by the insurer, or would be recouped as a statutory charge on the sum recovered in the proceedings. The aim of our reforms is to clarify the law sufficiently to enable lawyers to predict with some certainty whether a case will be won or lost. Legal aid will only be granted where the chance of success is greater than 50%.

97. Under the current law, it may be possible to bring a claim which is "borderline". This category includes cases where it is not possible to say whether prospects are better than 50% because of difficult questions of law. Legal aid will occasionally cover such cases if they are of significant wider public interest or are of overwhelming interest to the client (for example, because it is the only way of keeping a roof over his or her head). We think that under the current law it would be possible for a non-disclosure case to meet such a test. It could be argued that testing the limits of the Marine Insurance Act 1906 is of wider public interest. Moreover, where life insurance is used to protect a mortgage, it might be the only way of preserving the consumer's home. Our reforms would remove this possible argument. They would clarify the law and therefore reduce the likelihood of test case litigation in this area.

98. For all the reasons given above, we have concluded that the impact of our reforms on legal aid is likely to be minimal.

Other specific impacts

99. We have considered the effect of reforming consumer insurance law on carbon emissions, sustainable development, other environmental issues, health, human rights, race equality and rural living. We do not think that the proposals will have a significant impact on any of these issues.

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Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	*Results in Evidence Base?*	*Results annexed?*
Competition Assessment	Yes	No
Small Firms Impact Test	Yes	No
Legal Aid	Yes	No
Sustainable Development	Yes	No
Carbon Assessment	Yes	No
Other Environment	Yes	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	Yes	No