Regulatory duties in handling commercial insurance claims

- the next area for FSA scrutiny?

| by Nathan Willmott & Kelly Jones

Once the banking sector is back on its feet, will the FSA's next area of focus in the insurance sector be improving standards in commercial insurance claims-handling?

In the five years since general insurance became fully regulated by the FSA, a range of different aspects of commercial insurance have come under close scrutiny by the regulator. The FSA has conducted reviews of London market issues such as contingent commissions, financial reinsurance, broker conflicts of interests, contract certainty, client money, anti-fraud controls, anti-bribery procedures and commission disclosure, in an attempt to raise standards within the market.

Perhaps strangely, one important area that the FSA has not yet addressed is commercial insurance claims-handling, and in particular whether firms are meeting their regulatory duties. This is despite specific problems with commercial claims-handling being identified in consultation documents prior to the introduction of full FSA regulation. In early 2006 the FSA conducted a relatively limited thematic review of claims-handling in personal lines business, but no equivalent review has been undertaken in the commercial sector. Similarly, no disciplinary cases have yet been brought against an insurer for failing to meet its duties in respect of handling commercial insurance claims.

The FSA now has in place two individuals with extensive insurance industry experience - Ken Hogg (formerly of MGM Assurance and AIG Life) as Insurance Sector Leader, and Tony Brooke-Taylor (formerly of Aviva) as Head of Department, Wholesale Insurance Firms. It would therefore not be at all surprising to see commercial claims-handling coming under the regulator's microscope for the first time during 2010.

This article identifies the core regulatory duties that insurers are required to abide by when handling commercial insurance claims, and considers what these mean in practice for the London market.

Core regulatory duties relating to handling commercial insurance claims

The FSA Handbook imposes a range of high-level regulatory duties on insurers which govern the manner in which commercial insurance claims must be handled. In parallel, one or more members of senior management are subject to personal regulatory duties to ensure that the commercial claims are handled in accordance with the firm's

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obligations. In each case, if the firm fails to meet the regulatory duties then the firm and individual approved persons can be investigated and fined an unlimited amount by the FSA. Individuals may also be prohibited from working in the industry.

The rules specifically governing claims-handling are to be found at paragraph 8.1 of the Insurance Conduct of Business Rules ("ICOBS"). In addition a number of the high-level Principles for Businesses, which impose binding obligations on all FSA-authorised firms, are directly relevant to the manner in which firms handle their commercial insurance claims. Although very high-level in nature, the Principles for Businesses are the binding duties normally relied upon by the FSA when it pursues disciplinary cases against firms.

ICOBS 8.1 imposes specific duties on an insurer when it is handling a policyholder's claim. These duties apply to commercial policyholders as well as consumers. ICOBS 8.1 provides as follows:

"An insurer must:

- handle claims promptly and fairly;
- provide reasonable guidance to help a policyholder make a claim and appropriate information on its progress;
- not unreasonably reject a claim (including by terminating or avoiding a policy); and
- settle claims promptly once settlement terms are agreed."

Also of direct application to claims-handling activities will be the following seven of the 11 Principles for Businesses:

Principle 1
A firm must conduct its business with integrity.

Principle 2
A firm must conduct its business with due skill care and diligence.

Principle 3
A firm must take reasonable care to organise and control its affairs responsibly and effectively, with adequate risk management systems.

Principle 5
A firm must observe proper standards of market conduct.

Principle 6
A firm must pay due regard to the interests of its customers, and treat them fairly.

Principle 7
A firm must pay due regard to the information needs of its clients, and communicate information to them in a way which is clear, fair and not misleading.

Principle 8
A firm must manage conflicts of interest fairly, both between itself and its customers and between a customer and another client.

So how do these various high-level duties translate into concrete requirements for those who are handling commercial insurance claims in the London market? The six core duties when handling claims are each assessed below.

Claims-handling duty 1: An insurer must handle claims "promptly"

ICOBS 8.1(1) imposes a clear regulatory duty on insurers to handle insurance claims promptly. No definition or guidance is included on what "promptly" means in these circumstances, although it seems likely that the FSA would construe this as meaning "without any undue delay".

On occasion certain insurers in the London market may respond to large insurance claims with a blanket reservation of rights which may delay the process of determining whether the claim will be paid. The claim may be transferred to a law firm which may result in delays in determining liability in respect of the claim. Document requests result in further delay.

Claims-handling in relation to, for example, Errors & Omissions policies and Directors' & Officers' liability insurance, can be a very slow and burdensome process until an insured obtains confirmation from the insurer that a claim is covered.

There will, of course, be circumstances in which insurers need to spend time assessing whether a claim falls within the policy terms or whether there has been material non-disclosure or misrepresentation prior to the policy being bought. No criticism can be made of such conduct. However, where an insurer unnecessarily delays the prompt determination of the claim, it risks being found in breach of ICOBS 8.1(1) and potentially also Principles for Businesses 2 (due skill care and diligence), 3 (systems and controls) and 6 (treating customers fairly).

Furthermore, if an insurer were to adopt a policy that is specifically designed to delay or obstruct the prompt payment of legitimate claims, they could well be subject to more serious sanctions as a result of breaches of Principles for Businesses 1 (integrity) and 4 (proper standards of market conduct).

Claims-handling duty 2: An insurer must handle claims "fairly"

In addition to the duty to handle claims promptly, ICOBS 8.1(1) imposes a duty on the insurer to handle each claim "fairly". This is mirrored by the duties imposed by Principle 6 (treating customers fairly).

In the context of consumers, the FSA has given a great deal of informal guidance on what it believes the concept of "fairness" requires of firms. In particular, the FSA believes that acting "fairly" requires a regulated firm to take all of the circumstances of the situation into account, and to act in a way that gives appropriate priority to the customer's interests. This may well require the firm to put the customer's interests ahead of its own interests.

In the context of consumer claims, the FSA has stated that "When a customer makes a claim, a firm should consider the burden of proof placed on the customer to ensure it does not act as a deterrent to genuine claims".

- Kelly Jones, Associate

"Where an insurer unnecessarily delays the prompt determination of the claim, it risks being found in breach"

The same will apply to commercial insurance claims. More generally, conduct by an insurer that is designed to discourage the policyholder from pursuing genuine insurance claims is likely to constitute a breach of the insurer's regulatory duties.

While directly applicable only to personal lines business, it is notable that it has become, since May 2008, a criminal offence for insurers to require a policyholder who wishes to claim on an insurance policy "to produce documents which could not reasonably be considered relevant as to whether the claim was valid, or failing systematically to respond to pertinent correspondence, in order to dissuade a consumer from exercising his contractual rights."

In the context of commercial claims, this type of behaviour would be likely to amount to failing to handle the insurance claim fairly and would therefore amount to a breach of ICOBS 8.1(1) as well as breaches of Principle 6 (treating customers fairly) and Principle 4 (proper standards of market conduct). Principles 1, 2, 3 and 7 may also be relevant.

Claims-handling duty 3: An insurer must provide reasonable guidance to help a policyholder make a claim

It is a regulatory requirement under ICOBS 8.1(2) that an insurer must provide "reasonable guidance" to help a policyholder make a claim.

What specifically this requires a firm to do in the context of a commercial claim is not entirely clear. In circumstances where the policyholder may have access to expert advice and assisted by specialist claims-handlers, there may be relatively little that an insurer could reasonably be expected to do proactively in order to help the policyholder make a claim.

As an example of good practice in the retail sector, the FSA has identified that "When a claim is made some firms send customers a guide to explain the claim process and the likely timescale they can expect their claim to be dealt with. Some name the person who will be dealing with the claim".

In relation to commercial claims-handling, ICOBS 8.1(2) may therefore require the insurer proactively to provide information to the claimant as to the information and documentation that it will need before coverage can be confirmed, the likely timescale for that assessment and the personal contact(s) at the insurer with whom the policyholder can make contact if necessary.

Furthermore, where a notification of circumstances or a claim is made by the policyholder, ICOBS 8.1(2) is likely to impose a regulatory duty on the insurer to inform the policyholder if the notification is incomplete in some way, so that the policyholder's right to make a claim under the policy is not inadvertently lost.

The duty to provide reasonable guidance to help the policyholder to make a claim builds upon the broader regulatory duties under Principle 7 (due regard to the information needs of clients) and Principle 6 (treating customers fairly). Given the inherent conflict of interest that an insurer faces when an insurance claim is made, it also requires this conflict to be managed fairly in accordance with Principle 8.

Claims-handling duty 4: An insurer must provide the policyholder with appropriate information on the progress of the claim

As well as providing the policyholder with reasonable guidance to help it make the insurance claim, the insurer must also provide the policyholder with appropriate information on the progress of the claim.

This places a proactive duty upon the insurer to update the policyholder at regular intervals on how the claim is progressing and the reasons for any delays. If an insurer simply reserves its rights in relation to the claim and then fails to provide details to the policyholder as to why there is a delay in confirming coverage, the insurer is likely to be acting in breach of ICOBS 8.1(3). It will therefore not be sufficient for the insurer simply to rely on its legal rights when investigating a claim and leave the policyholder in the dark; appropriate information must be provided to the policyholder on a regular basis to ensure that the policyholder understands the reasons why coverage cannot be confirmed immediately.

This duty is supported by Principle 7 (due regard to the information needs of customers).

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Claims-handling duty 5: An insurer must not unreasonably reject a claim

ICOBS 8.1(3) states that an insurer must not "unreasonably" reject an insurance claim. This covers not only claims rejected because they fall outside the scope of coverage, but also claims that are rejected by reason of the policy being avoided for material non-disclosure or misrepresentation at the pre-contract stage, claims rejected for late notification, and insurers invoking a contractual right to terminate the policy (for example by reason of the policyholder's conduct).

What amounts to rejecting a claim "unreasonably" is not clear in the context of commercial insurance claims. In the context of personal lines business, ICOBS prescribes specific circumstances in which it would be unreasonable for the insurer to reject a claim – including, for example, non-disclosure of a fact material to the risk which the policyholder "could not reasonably be expected to have disclosed" or where there has been a breach of warranty or condition unconnected with the circumstances of the insurance claim (in both cases, unless there is evidence of fraud by the policyholder). No such circumstances are specified for commercial claims.

Plainly it is the intention of the rulebook to afford consumers greater protection than commercial policyholders. However that is not to say that it will necessarily be reasonable for an insurer to reject a commercial claim where it has the legal right to do so. A wider assessment must be undertaken by the insurer into the claim being made, including the circumstances in which the insurance was written and the extent to which relevant matters were brought to the attention of the policyholder as part of the placement / renewal stage.

For example, if the policyholder omitted to notify the insurer of a material fact but in the circumstances the policyholder genuinely and reasonably did not appreciate that the information was material to the insurer, then rejection of that claim may well amount to a breach of the insurer's regulatory duties. The question of what information ought to have been disclosed at the placement or renewal stage needs to be considered from the policyholder's perspective, taking into account all of the circumstances, rather than solely from what a prudent underwriter would have taken into account when assessing the risk.

For example, would it be reasonable for an insurer to refuse a claim in circumstances where the commercial policyholder has breached a wholly unconnected warranty or condition in the insurance policy? The FSA Handbook does not answer this question, although the FSA may well take the view that it is unreasonable for an insurer to decline a claim in such circumstances. At the very least, the FSA would expect that an insurer's claims department should undertake an assessment as to what is reasonable in each case – and then to document its reasons for coming to its view.

In essence, the insurer's duty is to adopt a two-stage approach. An assessment of its legal rights will, of course, need to be undertaken by the insurer. However the insurer's regulatory duties mean that it must also follow an entirely separate process of determining whether, if there are legal grounds for refusing to pay a claim, it would be reasonable in all the circumstances for the insurer to decline the claim. It cannot be said that it is reasonable to decline the claim simply because there is a legal right to do so – a wider set of circumstances must be taken into account, including assessing the position from the policyholder's individual perspective.

In summary, if there is a legal basis for refusing the commercial customer's claim, but in all the circumstances it would be unreasonable for the claim to be refused, then the insurer's regulatory duty would be to pay the claim.

Also relevant to the requirement that an insurer must not unreasonably reject a policyholder's claim are Principle 6 (treating customers fairly) and Principle 4 (proper standards of market conduct).

Claims-handling duty 6: An insurer must settle claims "promptly" once settlement terms are agreed

A more clear-cut regulatory duty in the context of commercial claims-handling is the requirement to pay claims promptly once settlement terms are agreed.

The ICOBS rules do not specify the time period envisaged by the word "promptly". In the context of personal lines business, the original version of the ICOB rules prescribed a maximum of five business days for the payment to be made. However this provision was deleted when ICOB was rewritten as part of the FSA's move towards a more principles-based rulebook. In practice it would be difficult for an insurer to argue that a period longer than 14 days for payment of a commercial claim (once settlement terms are agreed) is reasonable, save in exceptional circumstances.

Personal duties of senior management responsible for claims-handling

Any breach of the commercial insurer's claims-handling duties, whether specifically under ICOBS 8.1 or more generally under the Principles for Businesses, may result in an enforcement action being pursued against the insurer.

However where the FSA suspects a breach by the firm, its standard practice now is to conduct a parallel investigation to assess whether the member(s) of senior management who had responsibility for the relevant area of the business complied with their personal regulatory duties. In the last two years the FSA has significantly stepped up its actions against approved persons. Breach of these personal duties can result in an unlimited fine and/or prohibition proceedings against the specific approved person.

The individual approved person with responsibility for the claims-handling function within the insurer will therefore need to take steps to satisfy himself or herself that the firm's regulatory duties are being met in the area of the business for which he/she is responsible. The three Principles for Approved Persons (known as APER Principles) of most direct application to these duties of oversight are APER Principles 5, 6 and 7.
These provide as follows:

An approved person performing a significant influence function must:

- take reasonable steps to ensure that the business of the firm for which he is responsible in his controlled function is organised so that it can be controlled effectively (APER Principle 5);
- exercise due skill, care and diligence in managing the business of the firm for which he is responsible in his controlled function (APER Principle 6);
- take reasonable steps to ensure that the business of the firm for which he is responsible in his controlled function complies with the relevant requirements and standards of the regulatory system (APER Principle 7). (emphasis added)

These personal duties are expanded upon in the Code of Practice for Approved Persons, which makes clear that approved persons conducting these activities must take steps to ensure that proper procedures are implemented (either personally or in conjunction with the firm's Compliance department) and that effective monitoring is undertaken to ensure that regulatory requirements are being met.

As a result, an approved person with responsibility for the commercial claims-handling function within an insurer conducting business in the UK will need to take proactive steps to ensure that the commercial claims-handling function:

> "Claims-handling requirements impose fairly onerous and far-reaching duties on insurers dealing with commercial claims"

a. is organised so that it can be controlled effectively;
b. is managed with due skill care and diligence; and
c. complies with the relevant requirements of the regulatory system.

It will not be sufficient for an approved person simply to sit back and rely on the fact that the insurer has in place an effective Compliance department. Rather, the approved person should engage with the Compliance department and actively challenge it (as well as members of the claims-handling team itself) on whether they properly understand the regulatory requirements in relation to commercial claims handling, have implemented effective procedures for ensuring that those requirements are met, and are conducting regular monitoring and other controls to identify instances where the procedures are not being followed. Similar considerations will apply where the insurer has outsourced its claims-handling function to a third-party.

To conclude, the claims-handling requirements impose fairly onerous and far-reaching duties on insurers dealing with commercial claims. There is a risk that if a formal thematic review is undertaken by the regulator, perhaps during 2010, the FSA could assess claims-handling conduct over a long period, which could then result in serious enforcement action against an insurer and members of senior management with responsibility for claims-handling found to be in breach.

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