Information asymmetry in insurance contracts and "the weaker party": Duty of good faith disclosures in India

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Abstract

Adverse selection for insurers which arises due to asymmetric information in the insurance market is unquestionably a barrier for efficient insurance contracts. The insurance economics literature postulates that the insurance company suffers from a lack of information which can be harmful to its financial health. In Carter v. Boehm (1766) 97 E.R. 1162 which formulated the concept of good faith, the C.J. Lord Mansfield, observed that "in insurance contracts good faith forbids either party by concealing what he privately knows, to draw the other into a bargain from his ignorance of that fact, and his believing the contrary". This article examines the contractual duty of good faith disclosures in life and health insurance during contract negotiations in the law of India. The findings underline significant problems in regard to insurability resulting from information asymmetry between the parties and inaccurate risk assessment. It is asserted that the focus should be on establishing a balanced regime which protects the interests of both the insured and insurer. In conclusion this would lead to some concrete suggestions for more deliberation.

Keywords: Adverse Selection, Information Asymmetry, Life Insurance, Health Insurance, Duty of Disclosure, Good Faith, India

1 Duty of good faith disclosures, information asymmetry and insurance market

The concept of insurance rests on the law of large numbers which expounds that a large number of people who are susceptible to similar types of risks come together and provide financial security to one another cooperatively (Mishra, 2016). They share the financial loss caused by the insured peril by way of premium contributed by them. It is also based on the principle of risk sharing in which the risk of loss of a few individuals is shifted to a large number of individuals (Mishra, 2016). The premium that is charged by the insurance companies is based on the actuarial science applying the theory of probability which works on the previous experience of losses and claims. The insurers adopt a pooling equilibrium in which high risk and low risk individuals are provided insurance coverage at special rates/terms and standard premiums respectively. Thus, high risk and low risk people are jointly the members of the insurance pool, and once high-risk individuals suffer losses, their insurance claims are subsidised by low-risk people's premium (Ronen, 2012).

The premium that is charged by the insurer is directly proportional to the risk i.e., greater the risk, higher is the premium. Customarily, the premiums include the value of the risk of loss of the insured, administrative costs incurred and the profit to the insurer. Any deficiency in assessing the risk of loss and estimating the premium accordingly, the insurer is very likely to run into financial difficulties. Therefore, the principle of utmost good faith constitutes one of the pillars of the law of contract formation in insurance which legally obligates the parties to act fairly and avoid withholding material information relating to the risk they intend to insure. The insured or the buyer of the insurance is duty bound to act in good faith and disclose all the material facts relating to the subject matter of insurance which is likely to affect the judgement of the insurer in fixing the premium or determining whether the proposal/risk should be accepted or not (LIC v. G. M. Channabasamma, 1991) (Dawson's Bank Ltd. v. Vulcan Insurance Co., 1935) . The effect of failure to observe the duty of good faith disclosure by the insured allows the insurer to repudiate the insurance contract, notwithstanding the absence of any fraudulent intent to suppress the material facts. On the other hand, there is no explicit guidance on the duty of good faith disclosures falling on the insurer but the courts require the insurer to disclose to the insured any material facts relating to the exact scope of the insurance coverage and the recoverability of a claim under the policy (Banque Financiere v. Westgate Ins. Co., 1990).

The consequence is that although the general contractual duty of disclosure applies to insurers as well as the insured, the duty is more heavily enforced for the latter as the potential policyholder often has more knowledge about the insured risk than the insurer. The rationale for this additional obligation on the insured was first laid down by Lord Mansfield in the leading case, *Carter v. Boehm* which formulated the duty of disclosure in insurance contracts. Lord Mansfield's approach to duty of utmost good faith considers the incorrect statements/honest misrepresentation by the insured as non-disclosure and the effect is therefore the same as with fraudulent suppression of material facts i.e., repudiation of the insurance contract:

> "Insurance is a contract based upon speculation. The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only; the underwriter trusts to his representation and proceeds upon the confidence that he does not keep back any circumstance in his knowledge, to

> mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risk as if it did not exist. The keeping back of such circumstances is fraud and therefore policy is void. Although the suppression should happen through mistake without any fraudulent intention, still the underwriter is deceived and the policy is void; the risk run is really different from risk understood" (Carter v. Boehm, 1905).

Further, an example can be found in another judgement, *Rozanes v. Bowen*:

> "As the underwriter knows nothing & the man who comes to him to ask him to insure knows everything. It is the duty of the assured, the man who desires to have a policy, to make a full disclosure to the underwriters without being asked of all the material circumstances, because the underwriters know nothing & the assured knows everything. This is expressed by saying that it is a contract of utmost good faith- uberrima fides." (Rozanes v. Bowen, 1928).

Adverse selection for insurers which arises due to asymmetric information in the insurance market is unquestionably a barrier for efficient insurance contracts (Islam, M.R., Liu, S., Biddle, R., Razzak, I., Wang, X., Tilocca, P., and Xu, G., 2021). Following Ronen Avraham (2012), the author of this paper uses the term *efficient insurance contract* explained as "those made with perfect information and low transaction cost and are those that maximise social welfare while still sustaining the company providing the contract" (Ronen, 2012). The insurance economics literature postulates that the insurance company suffers from a lack of information (Eisen, R., and Zweifel, P., 2012) which can be harmful to its financial health in the long run. In the insurance market, the information in regard to the material facts relating to the subject matter of insurance may not be uniformly exchanged between the insured and the insurance company. The potential insureds or the applicants of insurance, notably in cases of health and life insurance, are likely to have more knowledge about the risk and their prospective preventive actions. For example, one case would be where an insured seeks to take out a life or health insurance having a family health history of heart ailments or been a victim of alcoholic abuse without making such disclosures in the proposal form. The insurer, in these situations, merely relies on the information disclosed by the insured in the proposal form. A potential policyholder's risk type, hidden characteristics directly affect the cost of the insurance product in terms of premium (Einav, L. and Finkelstein, A., 2011). This informational asymmetry may result in faulty risk classification by the insurer enabling the high-risk applicants to obtain insurance coverage at a standard premium rather than special rates/ terms and therefore exposing the insurer to increased insurance claims. As a consequence, this makes the cost of premium expensive and insurance products unmarketable to low-risk individuals (Born, 2019). In such cases, the premium charged to the entire pool is too expensive which might also compel the existing insureds who are low risk individuals to discontinue their insurance coverage and leave the insurance pool (Ronen, 2012). The policy makers and the insurance companies are cognizant of the asymmetric information problem that exists in the insurance market and they have taken various measures to avoid adverse selection in insurance contracts. In the life and health insurance market, for example, the insurer uses the proposal form to gather information on the medical history, family health history, lifestyle and dietary habits of the insured. However, the buyer of the insurance can conceal these material facts and the risk factors from insurers, either to escape the rejection of the policy or to pay a lesser premium. In such circumstances there can be no confusion with the fairness of rigorous duty of disclosure requirements established for the insured. Therefore, it is imperative to have stricter regulations and practices to protect the insurers from the adverse consequences of asymmetric information.

There are also situations where the buyer of the insurance policy, unfamiliar with the nitty gritty of insurance law, may not know what particular facts are material and would, accordingly, determine the decision of a prudent insurer. Therefore, the proposal form must seek to cover all the material facts relevant to the insurer's decision.

This article examines the contractual duty of good faith disclosures in life and health insurance during contract negotiations in the law of India. The findings underline significant problems in regard to insurability resulting from information asymmetry between the parties and inaccurate risk assessment. It is asserted that the focus should be on establishing a balanced legal regime which protects the interests of both the insured and insurer. In conclusion this would lead to some concrete suggestions for more deliberation.

2 The development of the disclosure duty in insurance contracts and its statutory codification in India

2.1 Statutory good faith requirement in India

The Insurance Act, 1938 lays down disclosure duties on the insured in regard to all the material facts within his knowledge to reduce the risk of adverse selection in insurance contracts. This is based on the doctrine of Uberrimae Fidei (good faith) derived from the common law. The Supreme Court of India has acknowledged the doctrine of good faith laid down in *Carter v. Boehm* in the context of insurance contracts in its various judgements like LIC v. Asha Goel (2001) 2 SCC 160, Mithoolal Nayak v. LIC AIR 1962 SC 814 mandating the insured to disclose all material facts in regard to the subject matter of insurance. Customarily, the insurance companies draft the questions in the proposal form in a way that it is possible to elicit all material facts relating to the subject matter of the insurance from the insured. The disclosure of full information regarding the risk as well as the past and future behaviours of the buyer of insurance enables meticulous assessment of the risk, estimation of the premium and pricing of the complete insurance pool. However, the buyer of the insurance can circumvent the insurer by concealing these material facts, either to escape the rejection of the policy or to pay a lesser premium.

Section 45 of the Insurance Act, 1938, amended by the Insurance Amendment Act, 2015 lays down that a policy of life insurance may be repudiated by the insurer on the ground of fraud and innocent misrepresentation within the period of three years from the date of issuance of policy or commencement of risk whichever is later. Therefore, any repudiation of life insurance contracts by the insurer beyond the period of three years of the commencement of the policy is not allowed. However, before the Insurance Amendment Act, 2015, the insurer was allowed to repudiate the policy even after the expiry of two years from the date of policy on the ground of fraudulent suppression of material facts.

> Section 45: No policy of life insurance, after the expiry of two years from the date on which it was effected be called in question by an insurer on the ground that statement made in the proposal or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy-holder and that the policy-holder knew at the

time of making it that the statement was false or that it suppressed facts which it was material to disclose.

The position that existed before the Insurance Amendment Act, 2015 which allowed the insurer to repudiate the policy after the expiry of two years from the date of policy created difficulties for the legal heirs/nominees of the deceased policyholder. In particular, the insurance companies repudiated the claim upon the death of the policyholder after several years of the date of issue of policy for the fraudulent misstatement made by the policyholder at the time of buying of policy thus leaving the dependents of the deceased policyholder with no means/records to prove the contrary (Law Commission of India, 2004). Therefore, in the interest of the policyholders, the Law Commission's Report No. 190 on the Revision of Insurance Act, 1938 had recommended that the time limit of five years as sufficient period to scrutinise the authenticity of the details provided by the insured in the proposal form and that beyond this time limit no repudiation on any ground by the insurer to be permitted (Law Commission of India, 2004). However, in contrast to Law Commission of India recommendation of the outer time limit of five years, the new section 45 (1) of the Insurance Act, 1938 amended by the Insurance Amendment Act, 2015 provides that a life insurance policy cannot be called in question on any ground after the expiry of three years from the date of issue of policy/ commencement of risk. As a result of this new amendment, any life policy repudiated within three years on the ground of fraud, no amount is payable under the policy. However, according to the proviso to Section 45(4), Insurance Act, 1938, in case of repudiation of the life policy on the ground of misstatement or suppression of a material fact without any intention to deceive the insurer, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees. The consequence that results upon the insurer avoiding the contract on the ground of fraud is that the entire amount of premium paid till the date of repudiation of contract stands forfeited. The duty of disclosure is not a continuing duty and exists only up to the time the contract is concluded unless the contract specifically provides otherwise. Any alteration in the material facts disclosed in the proposal form during the negotiation stage must be notified to the insurer (Looker v. Law Union and Rock Ins. Co, 1928). As laid down in Section 45(3), Insurance Act, 1938, the insured's duty of disclosure is restricted to the material facts within his or her knowledge at the time of buying of the policy and the insurer cannot repudiate the contract on the ground of fraud if the insured can prove that the mis-statement or suppression of material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact.

2.2 Criticisms of the duty of disclosure: Who is the weaker party?

The development of the law relating to duty of disclosures in India subsequent to *Carter v. Boehm* in which the notion of good faith was developed in fact curtailed the inequities that result when insurers avoid the insurance contract after several years for non-disclosure of material facts. This amendment of establishing a time limit for the repudiation of life insurance policies that was suggested in the Law Commission Report was evidently in support of the policyholders, contemplating the reality of the insurance markets in India where policies are sold by the agent of an insurance company and not voluntarily purchased by the policy holders. Although the legislators undertook the steps to settle the legal position relating to the insured's duty of disclosure in the 2015 amendments, it did not revert to the concern connected to the purported inequities of the insurer's limited right to avoid the contract on non-disclosure of material facts within a time frame of three years of the date of issue of the policy. On many occasions, the insurer is able to easily discover information and check whether the insured

breached duty of disclosure only after the occurrence of the contingency (Ronen, 2012). Then, the inevitable question that arises is, whether the period of three years is sufficient for the insurer to check the accuracy and authenticity of all the details disclosed by the insured in the proposal form. At this juncture, the author relies upon a simple illustration used by Ronen (2012) which relates the question of whether an insured who died of lung cancer was a smoker. "Instead of investigating the condition of the lungs of all insured persons who stated they were not smoking at the time of buying of the policy, the insurer, upon the death of the policyholder, can only investigate those who died from lung cancer, thus saving resources across the entire pool" (Ronen, 2012). In these circumstances, the insurer may discover the non-disclosure of material facts by the insured only after the death of the latter which may occur after three years of the commencement of the policy. Thus, establishing a time limit for repudiation of life policies can be detrimental to insurers and likely to put them in a weaker bargaining position. While the life insurance and health insurers in India may require the medical examination report of the potential policyholders before buying insurance coverage to avoid adverse selection, it is not a mandatory prerequisite for all age groups. Some of the insurance companies may not require the applicant to undergo the medical tests and require them only to submit a declaration of good faith along with the filled proposal form which shall be the basis of the contract. In such cases, truth shall be made a condition for carrying out the contractual obligations by the insurer. The insurance market practices and the statutory provisions suggest that the duty of utmost good faith as it applies to insurers, does not require them to have a very proactive approach in the disclosure process/contract negotiation and may rely solely upon the insured's disclosures made in the proposal form to conclude the insurance contract.

Likewise, the insurance companies in India have adopted various measures through underwriting practices like no claim bonus, premium rebates, waiting period, group-based insurance etc to avoid the problem of adverse selection. The health insurance companies in India generally do not cover the pre-existing diseases i.e., the diseases already contracted by the insured at the time of entering into contract. They are generally termed as excluded categories of illness. In this regard, deliberate suppression of pre-existing illness which was within the knowledge of insured is a ground for repudiation of health policy. The burden is on the insurer to prove that the pre-existing disease has a connection to the disease revealed during the term of the health insurance policy for which the claim is sought (New India Assurance Co. Ltd v. Arunaben Jayantibhai Shah , 2009). The clauses on waiting periods are generally incorporated in the health insurance contracts to serve as a countermeasure to adverse selection. During this period, the insured cannot make any claims. Generally, the waiting period can be for all illnesses or pre-existing diseases during which the risk is not covered (IRDAI Circular, 2009). It is pertinent to note that the outer time limit of three years imposed on the insurers in case of repudiation of life insurance policies under Section 45 of the Insurance Act, 1938 is not applicable to health insurance policies as they are largely annual contracts subject to renewal every year. The minimum capital requirement, maintenance of solvency margin mandated by the Insurance Regulatory Development Authority of India (IRDAI) and reinsurance ensure the safety and financial health of the insurance companies in cases of adverse selection resulting in financial loss to insurance companies due to payment of increased claims.

To cope up with the problem of information asymmetry and adverse selection in the life and health insurance market, the sharing of genetic test information with the insurance company is deliberated at the national and the global level as a countermeasure to all these problems (Clayton, E.W., Evans, B.J., Hazel, J.W., and Rothstein, M.A., 2019) . Accessibility to genetic information enables the insurance company to anticipate the future risk of diseases in regard to the potential applicants and thus estimate the premium accurately. However, apart

from privacy concerns, the use of genetic tests in insurance has its own limitation as the insurers seek a heterogeneous pool comprising both the high-risk and low-risk individuals. These tests may deter the healthy or low risk individuals from taking out the life /health policies and thus creating an insurance pool consisting of high-risk individuals only. This will have repercussions on the charging of premium by the insurance companies thus increasing the cost of insurance and making it unmarketable.

3 Conclusion and Suggestions

It is imperative to have stricter regulations and practices to protect the insurers from the adverse consequences of asymmetric information. The legislative framework and the insurance trade practice in India contain different measures like the mandatory disclosure requirements, waiting period, exclusion of coverage of pre-existing diseases, maintenance of solvency margin, reinsurance etc to mitigate the problem of adverse selection in life and health insurance contracting. In regard to life insurance policies, the Insurance Amendment Act, 2015 which stipulates a time limit of three years beyond which no repudiation of life policy is allowed on any ground whatsoever, can be detrimental to the insurance companies as they may obtain adequate means to prove non-observance of the duty of disclosure by the insured only after the happening of the contingency. In such cases, where the insurer is able to defend that they did not have sufficient means to discover the fraudulent suppression of material facts within the outer time limit of three years, paying reduced insurance claims to the insured by deducting the premium accordingly (the premium which the insurer could have charged if he had known the risk at the inception of contract) can be considered as an alternative instead of totally incapacitating the insurer from challenging a policy. It is possible that the buyer of the insurance can conceal the material facts relating to the subject matter of insurance and the risk factors from insurers, either to escape the rejection of the policy or to pay a lesser premium. The insurer, in many situations, merely relies on the information disclosed by the insured in the proposal form. Therefore, the primary focus should be on establishing a balanced regime which protects the interests of both the insured and insurer. Many industrialised countries are also adopting compulsory insurance as a solution to the problem of asymmetric information and adverse selection (Eisen, R., and Zweifel, P., 2012). This is due to the fact that compulsory coverage does not need any risk classification by the insurer and uniform terms and conditions apply to all the insured (Eisen, R., and Zweifel, P., 2012). However, in developing economies like India, excepting the employer sponsored insurance schemes, the ability to pay the premium remains an impediment for compulsory insurance.

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