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E D I T O R I A L

US Healthcare reform

This issue of the BILA journal starts with a full discussion of the US healthcare reforms. This is a difficult topic little understood by British lawyers. The article is by Alice Kane and Stephen Levitsky of Dewey & LeBoeuf LLP. It describes the reforms, how they affect healthcare insurance in the USA and the legal and constitutional issues raised.

Leaders, followers and layers

The next article discusses :

- the relationship between leading and following underwriters generally,
- the operation of the new Lloyd's claims scheme, and
- the relations between the insurers on different layers in a vertical programme or "tower".

The authors are Julian Burling, Barrister, practising at Serle Court chambers, Helen Ashenden, Senior Claims Manager, Lloyd's Market Performance, and Jacquetta Castle, Fishburns LLP. Their article follows a BILA presentation by them on the same subject on 20 January 2012.

Investment rules and practice in the Lloyd's and UK insurance markets

Steven McEwan, of Hogan Lovells International LLP, presented on this difficult but important topic for BILA on 17 February 2012. His article follows this up and covers the topic under the current Solvency I prudential regime as well as under Solvency II, now expected to come into force in 2014.

Microinsurance: the challenge for law and regulation

Jonathan Teacher of Norton Rose LLP covers the subject of microinsurance and the legal and regulatory issues which it gives rise to. These include the issue of what amounts to an insurance contract, distribution arrangements for microinsurance, offer and acceptance and the requirement in some jurisdictions for "wet signatures".

European class actions

Dr. Thomas Heitzer describes the use of class actions in European jurisdictions following the judgment of the US Supreme Court in *Morrison v. NAB*. That judgment decided that "f-cubed" claims cannot be filed in the United States. F-cubed claims are those filed by foreign, non US investors, against a non US company in relation to shares bought on a foreign exchange.

Test-Achats and gender discrimination in insurance

Chris Finney, Mark Everiss and Stephen Ixer of Edwards Wildman Palmer LLP provide an update on developments following the European Court's judgment in *Test-Achats*. These developments include the UK government's proposals for transposition of the impact of the judgment and the European Commission's guidelines on how the judgment should be applied.

Insurance Coverage Issues affecting the Financial Services Industry

Graham Denny of Holman Fenwick Willan discusses coverage issues affecting financial services involving different types of cover. These include bankers blanket bond/crime, errors and omissions, professional indemnity, and directors and officers.

"Principles of European Insurance Contract Law: A Model Optional Instrument"

Jacquetta Castle reviews this work, which is a commentary on the Principles of European Insurance Contract Law (PEICL).

Association Internationale de Droit des Assurances (AIDA) conference: London 13/14 September 2012 "Testing times, uncertain outcomes: how are insurers and reinsurers expected to measure up?"

Finally Tim Hardy provides a brief foretaste of the proposed agenda at this conference.

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U.S. Healthcare Reform 2010-2011

By
Alice Kane[1] and Steven Levitsky[2]

1. Introduction

In 1932, the number one song on the U.S. hit parade was "Brother, Can You Spare a Dime?"[3] It expressed the bafflement of millions of American workers who had built the great infrastructures of the 1920s, only to find themselves standing on bread lines in the 1930s.

That song could be a perfect anthem for the healthcare crisis in the United States today. Once perceived as the greatest healthcare delivery system in the world, U.S. health care proceeded to, as Milton put it, "stumble on and deeper fall," with between 50 to 85 million uninsured people straining the system and causing ever-increasing losses.[4] A recent analysis of the U.S. healthcare system reported that the U.S. spent twice as much as other industrial countries on healthcare but ranked *last* out of 16 industrialized countries in medical care mortality.[5]

The "Affordable Care Act"[6] is the Obama administration's comprehensive attempt to reform the private healthcare industry, improve medical care and halt catastrophic financial losses. The Act is highly controversial. Its opponents believe it not only violates the Constitution but also imposes intolerable costs on the U.S. economy. Its proponents argue that the cost is already being borne by the U.S. economy, but in an economically unplanned and uncontrolled way.

The Act raises literally dozens of legal issues. In this paper, we provide a summary of the key elements.

2. Background to Reform

A few quick historical facts about U.S. health coverage. Almost 100 years ago, in his 1912 presidential campaign, Theodore Roosevelt first raised universal healthcare as a national goal. But nothing more happened until 1945, when Harry Truman made a very committed effort to pass healthcare legislation. He failed in the face of exactly the same type of ideological opposition that the 2010 legislation faced: charges that the legislation was "socialist."[7] In 1965, Lyndon Johnson succeeded in introducing his "Great Society" programs that included Medicare and Medicaid (programs for medical care based on age or low-income levels). At the signing ceremony, Johnson issued the very first Medicare card to Harry Truman, who attended.[8]

But Medicare and Medicaid are limited coverage programs. The next attempt to pass universal health legislation took place in 1992-1994 with Bill Clinton. But that effort backfired amid charges that Hillary Clinton, who was unelected and unaccountable to

anyone except her husband, tried to develop a comprehensive health reform plan in secret sessions.[9] Public fury, generated by what was characterized as "Star Chamber" action on a topic of tremendous public interest, essentially killed healthcare reform for almost 20 years.

Today, employer-provided, private group health coverage is the backbone of the U.S. healthcare delivery system. Nearly 55% of the population is enrolled in these plans.[10] Medicare and Medicaid, with coverage for the very poor and the elderly, adds coverage for about 30%.[11] But there still remains a 16% gap in coverage among the jobless, self-employed, part-time employed, and employees of small business, who make up the 50 to 85 million uninsureds.[12] Obviously, many uninsureds *do* get minimum essential medical treatment because virtually all hospitals are required to provide emergency services without regard to ability to pay.[13] The real question is how to pay for this treatment.

By the time of President Obama's election in 2008, the healthcare had already become a heavy burden on the U.S. economy. In 2008, uninsured Americans consumed $116 billion of healthcare services. Those massive losses were transferred to insured Americans. Ongoing job layoffs throughout the economy ended employer-provided group coverage for millions of people. This inflated the already large ranks of uninsureds. Some companies dropped health coverage for employees.[14] Finally, the lack of jobs for newly-graduated students meant that they had no access to employer-sponsored group coverage. They too were added to the uninsured population.

The unemployed, self-employed, and small business employees remain the groups that do not qualify for large group health plans and are most likely to be uninsured or inadequately insured. The only alternative for them — private health plans for individuals or small businesses — remains vastly more expensive than large group coverage, has higher deductibles, excludes pre-existing conditions, and offers lower benefits, leaving millions without comprehensive insurance. The result is that hospital emergency rooms are increasingly packed with uninsureds seeking subsidized health care, subverting the real purpose of emergency care facilities, and driving up medical costs for everyone else.

Today, U.S. health care accounts for 17% of the GDP, estimated to become 20% by 2020. From 2001 to 2007, healthcare costs reportedly rose four times faster than wages.[15] In the 10 years from 2001 to 2011, healthcare costs for a family more than doubled, from $7,061 to $15,073,[16] and is projected to reach $32,175 by 2021.[17] In 2011, an economically stagnant year, the cost of health insurance still rose 9%.[18] More employers are shifting a greater proportion of the costs to their employees.[19] And, in the last year alone, 9% of employers dropped medical coverage for their employees.[20]

3. The Affordable Care Act

These are the facts used to justify healthcare reform. Opponents of reform claim the country cannot afford the cost. Proponents of reform claim the country is already paying through *de facto* cost-shifting.

In March 2010, the Obama administration succeeded in enacting the 975-page "Affordable Care Act." Its short-term purpose is to extend health coverage to those not covered by private health plans, Medicare, or Medicaid. This essentially means the self-employed, part-time employed, small business employees, and the unemployed. Its long-term goal is to impose premium-containment measures and quality standards on all U.S. health care by 2018.

Congressional voting on the Act was fiercely partisan. Not a single Republican supported it in either the Senate or the House. House Republicans are publicly committed to its repeal. Some Republicans charged that the legislation would lead to "death panels" that would deny medical funding for the sick and elderly. "Obamacare" became a pejorative term.[21] On November 9, 2011, 61% of Ohio voters repudiated mandatory healthcare.[22] There are at least 28 private or government lawsuits that challenge the law. Republican governments of 26 states have jointly challenged the Act's constitutionality, and the Supreme Court of the United States will probably decide that case by June 2012 (see section 8).

4. U.S. Health Care: A Patchwork Blend of Private and Government Responsibilities

Unlike the British or Canadian single-payor systems, U.S. healthcare responsibilities have always been inefficiently and ineffectively divided among the private sector, federal, and state governments.

Today, the federal government funds Medicare (the older-age medical program). Federal and state governments, and in some cases, counties, fund Medicaid (the low-income medical program). States administer Medicaid. And, for those who are not familiar with U.S. practice, insurance is separately regulated in 51 independent jurisdictions (50 states plus the District of Columbia). Most states traditionally exerted little power over rates.

Healthcare reform increases the already great complexity of these overlapping responsibilities. The private sector will continue to deliver almost all healthcare coverage (since the proposed, government-run "public option" was killed by the Senate Finance Committee). Starting in 2014, virtually every uninsured person will be required by federal law to buy private health insurance. The overwhelming proportion of them will buy insurance on exchanges run by the states, according to federal standards, initially funded by federal money, subject to rigorous federal and state rate-regulation, and with the right of federal preemption if the state does not carry out its responsibilities. In this context, federal preemption means that the federal government will displace the state, establish the state exchange itself, and then run it according to federal standards. Even states that oppose the Act and have sued to stop it do not want the federal government operating their exchanges.

The Act is designed to work within this patchwork through four major reform initiatives:

First, the Act expands Medicaid coverage for low-income insureds, and provides sliding scale subsidies for moderate income individuals and families .To enhance the affordability of coverage, the Act requires states to set up state or regional "exchanges" or information/marketplaces, and directs the federal government to run exchanges if a state does not organize one. Individuals and small businesses can use the exchanges to compare and buy comprehensive and "approved" private health plans from "certified" vendors. (Those with large group coverage cannot buy from the exchanges until 2017.)

Second, the Act requires every uninsured person (including individuals, small business employees, and the jobless) to buy private medical coverage — or risk a fine if they don't. This controversial part of the Act has led to major Constitutional challenges (please see section 8).

Third, the Act imposes minimum standards on all health plans, including traditional employer-paid health plans. Some of these changes, like exclusion of pre-existing conditions or elimination of lifetime limits, take effect right away.

Fourth, the Act and related legislation has extensive and radical premium-containment provisions. One change with immediate effect is the imposition of "medical loss ratios" (discussed in section 7). One writer likened these to utility regulation.

Let's look at each of these in turn.

5. The "Insurance Exchange": a New Information Center and Marketplace

The new "Affordable Insurance Exchanges," to be phased in by 2014, are a key feature of the legislation. Private plans for individuals and small groups will be marketed through state-controllled exchanges, all subject to federal and state quality and premium-containment review. In government terms, the exchanges will replace the current "dysfunctional" market for individual and small business coverage with one that is efficient and "transparent."[23]

The goal of the electronic "marketplaces" is to increase head-to-head competition in the sale of private health plans to individuals and small businesses. This is meant to lower prices and enhance quality. To enhance competition, insurers who want to sell on the exchanges must describe their plans in plain English and must use a standard template and fixed terms (like "deductibles" and "co-payments") so that people can see how health plans differ on an "apples-to-apples" basis.[24] To compete on an exchange, all health plans must meet minimum federal standards, and all insurers must be certified.

The exchanges will also let consumers see if they qualify for Medicare, Medicaid, or government subsidies, and then let them buy coverage through the exchanges if they need it.[25]

The idea of exchanges is not new in the U.S. California tried a health exchange in 1992, followed by Texas, Florida and North Carolina.[26] All of them failed. Allegedly, private

insurers had "cherry picked" the small businesses with healthy employees and left a pool of expensive insureds in the public exchange.

On the other hand, Massachusetts started its exchange in 2006, when it also introduced an individual mandate and prohibited insurers from excluding applicants. As a result of these reforms and related measures, the state achieved a 98.1% coverage rate. The Massachusetts exchange is the general model for the federal program. Under the new federal law, insurers are not allowed to refuse to cover pre-existing medical conditions. This in theory will put each private insurer in the same competitive position, with the identical risk pool.

There is no one model for exchanges. Individual states (or groups of states) must establish and run the exchanges according to minimum federal standards. But they can be flexible in how they set up their exchanges.

The federal government has already committed close to $300 million to the states to develop exchanges, including the complex IT systems they require. So far, it has granted close to $220 million.[27] If a state exchange does not meet federal standards by 2014, the federal government will step in, take it over, and run it.

The Act also offers "Early Innovator" awards to induce states to develop systems that can be adopted by other exchanges. The federal government has already awarded $155 million under this program.[28] But politics intervened in the exchange rollout. Kansas, for example, received a special $31.5 million grant to develop an IT infrastructure that was to have been shared with other exchanges. But then, in a controversial move, Kansas abandoned the project and returned the money, allegedly at the behest of state Republicans.[29] Oklahoma returned a $54.6 million grant for the same reason.[30] Both states are plaintiffs in a lawsuit challenging the constitutionality of the Affordable Care Act. This is a graphic reminder of how U.S. healthcare reform treads heavily on sensitive ideological feet.

6. The "Individual Mandate" Requirement

The "individual mandate," or mandatory purchase requirement, requires almost everyone without health insurance to sign up for a private health plan. (For those who can't afford it, there will be graduated subsidies available for up to 400% of the federal poverty level). 26 states are challenging this provision as an unconstitutional extension of the Commerce Clause (please see section 8).

The "individual mandate" was driven by underwriting economics. The key to lower rates is the ability to spread risk and include as many low-risk members as possible in the insurable pool. This overcomes the "adverse selection" phenomenon: as one witness observed during the Congressional hearings on the Act, the "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital."[31] In fact, about 30% of those aged 20-29 go without health insurance, even when it is available through their employers, because it is too expensive. But they are the group whose premiums, good health, and low incidence claims are needed to support the

system. The new Act tries to prevent this "free rider" approach. To prompt the young and healthy to buy insurance (and expand the risk pool), the Act uses penalties, assessed by the IRS as part of the tax process. For constitutional reasons, to invoke the "taxing power" of the federal government, these penalties are called "taxes."

But whatever the name, this structure raises two strategic questions. *First*, if people are near the poverty level with only limited resources, will they really spend their money on a private health plan instead of food? These, of course, are the people who don't file tax returns and therefore won't be "taxed" by the IRS for their failure to buy insurance. In fact, the Senate Finance Committee recently announced that 51% of U.S. households pay no federal income taxes.[32]

Second, even when the uninsureds can afford to buy insurance (for example, young people starting to work), are the fines set high enough to pressure them to buy? The only penalty is a fine (there are no criminal sanctions or liens). But the penalty that starts in 2014 is only the greater of $95 or 1% of income, and rises in 2016 to $695 or 2.5% of income. For some, the health plans cost *more* than the fines. Will this work?

And there always remains the ultimate question: will people who stubbornly refuse to buy insurance ever actually be denied medical care if they really need it? Most people bet not, especially since laws require most hospitals to provide at least emergency treatment without regard to ability to pay. If they're right, that undermines the entire economic theory of the Act.

On this issue, some point to the success of the Massachusetts health care model. In 2006, long before federal healthcare reform, Massachusetts independently set up a system that incorporated most of what became federal features. There is an exchange model where seven different health carriers offer coverage for individuals and small business. There is a mandatory purchase requirement, together with low-income subsidies for those who need a financial assist, and penalties for those who do not enroll. The state now boasts that 98.1% of its residents are insured.[33] On the other hand, health insurance costs in Massachusetts are growing at a faster rate than anywhere else in the country, and a rate that is largely seen as far higher than anticipated when Massachusetts enacted its reform law in 2006.[34]

7. Mandatory Changes to Health Plans

The new Act requires states to expand their Medicaid coverage for those with low-incomes. It also requires that every health plan issued after September 23, 2010 provide coverage in 10 defined categories of care. ("Grandfathered" plans are excluded). However, in December 2011, the federal Department of Health and Human Services announced that they intended to allow the individual states to select the types of minimum benefits for each category of care.[35] This surprised many observers, who had believed that there was going to be a national standard for healthcare.

Generally, the most important features of medical reform are:

- Elimination of lifetime or annual limits on health care.
- Mandatory coverage programs for those with pre-existing conditions.
- Children up to 26 years can already stay on their parents' health plans.
- Elimination of an insurer's right to cancel a policy except in the case of *relevant* fraud.
- 100% coverage of preventive services.
- The Act also imposes general infrastructure changes to help reduce long-term healthcare costs. For example, it imposes electronic health information standards to eliminate paperwork. The government estimates this change alone would save as much as $12 billion.
- These enhanced health benefits will be funded by a variety of tax increases, including upper income payroll taxes, taxes on brand-name drugs, and taxes on seemingly random taxable targets (including tanning salons, and a 3.8% real estate transfer tax regardless of whether there was a profit or not). Finally, the Act will also impose a 40% tax on high-cost health insurance policies (above $10,200 for individual coverage and $27,500 for family coverage). These are typically high-benefit, low-deductible plans offered to senior executives of large corporations, and are widely known as "Cadillac" plans, named after the American luxury automobile. These types of taxes have provoked charges that "Obamacare" is creating class hatred.

There is major debate over the economic impact of the legislation. The Congressional Budget Office claimed that the Act would *reduce* the federal deficit by $143 billion over ten years.[36] The Republican House Budget Committee claimed it would *increase* the deficit by $700 billion over the same time, and also kill 1.6 million jobs.[37]

8. The Premium-Containment Provisions

The new federal law contains premium-containment provisions that apply to health plans. At the same time, the federal Department of Health and Human Services also encourages states to amend their insurance laws to give insurance regulators more control over *all* healthcare plans, including the large group plans that were not the real target of this legislation.

These provisions are often described as "cost containment." In fact they do not change many of the problems that have driven up healthcare costs. For example, they do not deal with tort reform or put any cap on pain and suffering, both factors that have driven up the cost of malpractice insurance and have prompted what some people think are really "defensive" rather than necessary medical tests.

Here are some of the key features:

First, the federal law imposes new medical loss-ratio reviews. The federal Department of Health and Human Services has set minimum "medical loss ratios" (meaning the part of the premium that must be spent on health services and not on administrative costs or profits). For individuals and small group plans, the rate is 80%; for larger groups, 85%.

Historically, medical loss ratios for individual and small business markets have ranged from 55% to 80% in recent years.[38] Insurers that don't meet these new standards will be forced to rebate part of the premiums they collected.

One commentator observed:

> "this law involves substantial regulation of the health insurance industry that rises to the level of systematic coercion. The control that the United States Legislature exerts over the insurance industry through PPACA is tantamount to that of a public utility."[39]

The reference to public utilities is exactly right. Insurers will now need to justify their annual rate increases above 10% through very extensive rate-making examinations and public hearings, both typically subject to political pressure, as has the property and casualty segment of the insurance industry.

The National Association of Insurance Commissioners developed this formula for calculating medical loss ratios:

MEDICAL LOSS RATIO =
(claims + activities to improve health care quality)/
(premiums – total federal income taxes – state premium taxes and assessments + federal income tax on investment income).[40]

Even the secretary of the National Association of Insurance Commissioners has admitted that "loss ratios in the health field are especially complicated . . . . Companies use so many tools to manage care, and classification is not easy."[41] This is a potential area for litigation.

Some critics see this combination of "competitive" exchanges and rate regulation as an economic anomaly. The general theory of service-industry regulation is that the government grants a monopoly in exchange for the right to restrict prices to a "reasonable return." Here, the exchanges are supposed to be competitive markets and there is no contemplation of any monopoly. But the "competitors" are still subject to rate control.

Second, the law imposes a requirement for insurers to publish and justify healthcare rates. From September 1, 2011, insurers asking for 10% or larger increases (on non-grandfathered plans) must disclose the reason for them. (In 2012, the 10% will change to state-specific limits.) States that have the ability to perform effective rate reviews will conduct them. For states that don't, the federal Department of Health and Human Services will conduct the rate reviews. These rate justification provisions allow states to compare an insurer's rate increases on an exchange with its rate increases elsewhere. From 2014, states can exclude high-increase insurers from their exchanges unless the rates can be defended. Although 10% may sound like a large increase, healthcare costs have been rising at about

8% annually. As a result, this provision will put many insurers in the position of seeming to justify high rates when their own margins may be small.

Third, the law eliminates most traditional healthcare underwriting criteria (such as existing medical conditions). It will allow health insurers to consider only four factors: (1) the type of plan being offered (family or individual plan), (2) the geographical area, (3) age, and (4) tobacco use. Insurers will be forbidden to consider traditional underwriting elements such as "health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury . . . or any other health status-related factor determined by the Secretary [of Health and Human Services]."[42]

Fourth, the federal Department of Health and Human Services encourages individual states to amend their insurance laws and exert greater control over all healthcare rate increases, not just the plans to be sold on the exchanges. The federal government has allocated $250 million to help states increase their ability to review rate increases. Many states have already increased their power to review rates and some states have used federal funding to enlarge their staff and hire more specialized actuaries. Since the provisions became effective, there have been several cases where insurers backed down from dramatic rate increases in the face of state challenges.[43]

Fifth, while insurers will have to justify increases greater than 10% on the exchanges, even smaller increases can be and have been challenged under existing state insurance law.[44] As we mentioned, each of the states has its own insurance laws, some of which differ substantially. Some states already empower their insurance departments to review and approve healthcare rate increases *before* they become effective.

One carefully-watched proceeding of this sort is unfolding in Maine, a prior approval state. There, the regulator must decide that proposed rates are "adequate" but not "excessive." Based on this power, the regulator cut back a proposed rate increase from 18.5% (with a profit margin of 3%) to 10.9% (with a 0% profit margin) for one year and allowed small increases for later years. The regulator considered the insurer's historic profits in the state as well as its company-wide reserves. The regulator also concluded that its economic analysis did *not* need to be restricted to the product line being approved. The insurer sued, claiming that the decision violated the Due Process and Taking clauses of the Constitution.[45] The case is on appeal to the state's highest court and has received national attention because of its precedential value.

One aspect in this case is of particular interest because it will doubtless feature in the many rate-making cases to come. Maine allows the public, as well as consumer advocates, to appear and "testify" at rate-approval hearings, even though their "testimony" may be unsworn. (The expenses of the consumer advocates are, by regulation, paid by the insurer.) Consumer "testimony" in rate-making proceedings has been a traditional American populist practice over the years. Some highly-controversial utility hearings of the 1970s

took on the characteristic of revival meetings, with public prayers for low rates literally offered as the hearings began. The public appears to believe that if members can "testify," their testimony must have some effect. In the Maine proceeding, the hearing officer claims not to have considered the unsworn statements. Whether they should have been taken at all is an issue to be dealt with by the next level of appeals court.

9. Other Major Medical Industry Changes

Aside from rate-making issues, other containment changes in the Affordable Care Act include:

- For federally-funded programs, physicians and hospitals will now be paid on *value-based* standards, not on individual tests and procedures. The federal government will have the power to change "misvalued" fees and to impose fines for waste such as hospital-acquired infections and unnecessary readmissions.
- New "accountable care organizations" will allow physicians and hospitals to coordinate care and reward them with a share of any savings if the actual cost is less than projected.
- New pilot programs will be developed to encourage all healthcare professionals to achieve savings through *result-oriented* care, as opposed to less inefficient, "fee-for-separate-service" care.
- There will be increased funding for fraud control.
- More money will be earmarked for preventive medicine.
- An Independent Medicare Advisory Board will set treatment standards and costs not only for Medicare spending but also private medical coverage. This suggests that there will be a single medical-practice standard for all treatment regardless of the payor or the patient. This Board's recommendations will become law unless overridden by new legislation.
- New "CO-OPs" (Consumer Operated and Oriented Plans) that are designed to establish non-profit, consumer-managed insurers in each state. The federal government will spend close to $4 billion on start-up or operating loans to establish these CO-OPs.

10. Constitutional Challenges

At least 24 lawsuits, including 28 state governments as plaintiffs, have challenged the constitutionality of the Affordable Care Act. As we already mentioned, private insurers are separately challenging the right of state regulators to limit rate increases. There are also private actions to declare the Act unconstitutional. One case challenged the Act because it was signed by a President who was not a "natural born citizen."[46] Another case, recently dismissed, charged that the Act violated religious freedoms.[47]

The state government challenges essentially claim that the Act violates the sovereignty of the individual states, mainly on the ground that it tries to regulate purely *state* commerce,

as opposed to *interstate* commerce. One state attorney general explained that the Act is "an assault against the Constitution," and that "a legal challenge . . . appears to be the only hope of protecting the American people from this unprecedented attack on our system of government."[48]

Of all these cases, the most important is *United States Department of Health and Human Services v. State of Florida*, 648 F.3d 1235 (11th Cir. 2011), a case that pits 26 states against the federal government in a lawsuit that began literally minutes after the passage of the Act.

The main legal issue on this appeal involves the "individual mandate" provision and its relationship to the Commerce Clause of the U.S. Constitution. Under Article I, §8, Cl. 3, Congress has the power to "regulate Commerce . . . among the several States." That provision was narrowly interpreted in the late 18th and early 19th century. As industrialization increased, the Supreme Court expanded the interpretation of these powers, which now extend to the regulation of "purely local" *intra*state conduct that has a "substantial *effect* on interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 17 (2005). This was the constitutional basis on which the Obama administration justified the powers of the Affordable Care Act. The administration argues that the Act does not challenge the "sovereignty" of the states but rather regulates private conduct that *affects* interstate commerce.

In January 2011, a U.S. district court found that the "individual mandate" was an unconstitutional reach of the Commerce Clause, could not be severed from the rest of the legislation, and that therefore the entire Act was invalid.[49] On appeal, by a 2-to-1 vote in August, the U.S. Court of Appeals for the Eleventh Circuit affirmed that the Act was unconstitutional.[50] But it concluded that the unconstitutional parts (like the "individual mandate") could be severed and the rest of the Act upheld.

As we saw, the economic basis of the entire legislation is that mandatory coverage is necessary to enlarge the risk pool and offer an inducement to private insurers. The majority of the 11th Circuit (which covers Florida) rejected this argument, concluding that the "individual mandate" provision is invalid because it compels economic action from people who may not need health care for years (and who, presumably, do not yet affect interstate commerce). The dissent argued that the cost-shifting caused by uninsureds already affects interstate commerce.

As a separate matter, the majority also held that the penalty provision for those who do not buy insurance is illegal because it is not a proper exercise of Congress' taxing power under Article I of the Constitution. They held that it is a fine, not a true tax.

On November 14, 2011, the Supreme Court agreed to review the case.[51] It scheduled 5 ½ hours of oral argument for March 2012 (the longest time allotment since 1955). The decision should be published by June 2012. The three questions the Court will consider are (1) whether the "individual mandate" requirement is unconstitutional; (2) whether the provision is severable; (3) whether the federal government can force the states to expand Medicaid coverage; and (4) whether the tax penalty can be challenged at all until 2015, when it actually takes effect.

11. The Prognosis

Some dramatic change is needed to deal with the relentless rise in healthcare costs, with the overall ineffectiveness of the system measured by health outcome, and with the 50 to 85 million uninsureds. The federal government has already spent billions to implement the 2010 Affordable Care Act. But the form of the outcome is not necessarily fixed. Constitutional challenges, as well as Republican vows to repeal the Act, mean that this may not be the final salve for the country's healthcare woes.

Endnotes

[1] Alice Kane is a partner in Dewey & LeBoeuf LLP and leads the Health Insurance Practice. She was General Counsel of New York Life and Zurich Financial Services, Executive Vice President in charge of Asset Management at New York Life, and both President of the Mutual Fund business of American General as well as Executive Vice President in Asset Management.

[2] Steven Levitsky is an antitrust and regulatory lawyer at Dewey & LeBoeuf, and a member of the Health Insurance Practice. He is co-author of BNA's Antitrust Compliance Portfolio/M&A Portfolio, and has handled domestic and international antitrust clearances for some of the largest insurance transactions in history.

[3] Written by "Yip" Harburg and Jay Gorney, "Brother, Can You Spare a Dime?" was recorded by Bing Crosby and Rudy Vallee. Each version topped the charts. One verse of the song reads:

> Once I built a railroad, I made it run, made it race against time.
> Once I built a railroad; now it's done. Brother, can you spare a dime?
> Once I built a tower, up to the sun, brick, and rivet, and lime;
> Once I built a tower, now it's done. Brother, can you spare a dime?

[4] The U.S. Census reported that 46.3 million were uninsured in 2008, rising to 50.6 million in 2009. *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, p. 23 (U.S. Dept. of Commerce, September 2010). According to *Americans at Risk*, p. 2, a March 2009 report prepared by Families USA, in 2007-2008, at least 86.7 million people under 65 went without health coverage for at least some period in 2007-2008, and at least 51 million went without health insurance for more than nine months.

[5] *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011*, The Commonwealth Fund Commission on a High Performance Health System, October 2011, pp. 9, 24-25. available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Oct/1500_WNTB_Natl_Scorecard_2011_web.pdf

[6] Passed March 23, 2010, its full name is the Patient Protection and Affordable Care Act.

[7] On November 19, 1945, President Truman sent a message to Congress that began:

> In my message to the Congress of September 6, 1945, there were enumerated in a proposed Economic Bill of Rights certain rights which ought to be assured to every American citizen.
>
> One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the

> "right to adequate protection from the economic fears of . . . sickness . . . ."
>
> Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

http://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1=. The American Medical Association attacked the bill as "socialized medicine" and attacked Truman's White House staff as "followers of the Moscow party line." Monte M. Poen, "National Health Insurance," in Richard S. Kirkendall (ed.), *The Harry S. Truman Encyclopedia* (Boston: G.K. Hall & Co, 1989), p. 251.

[8] http://www.ssa.gov/history/lbjsm.html

[9] *The New York Times*, March 5, 1993, described the task force meetings as "the unusual and highly secretive decision-making process devised by the White House for what is likely to be the costliest, most ambitious initiative in domestic policy since the New Deal."

[10] *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, Table 10, p. 29 (U.S. Dept. of Commerce, September 2010).

[11] http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/table10.pdf

[12] http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/table8.pdf

[13] Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.§ 1395DD(a)-(b).

[14] "Wal-Mart Cuts Some Health Care Benefits," *The New York Times*, October 20, 2011. The article reports that Wal-Mart cut off all coverage for employees who work less than 24 hours a week, and spouse coverage for employees who work less than 24 to 33 hours a week.

[15] According to a Kaiser Family Foundation study, "premiums for family coverage have increased 78%, while wages have risen 19% and prices have risen 17%." http://www.kff.org/insurance/ehbs091107nr.cfm

[16] "Health Insurance Costs Rising Sharply This Year, Study Shows," *The New York Times*, September 27, 2011.

[17] "Health-Benefit Costs Increase The Most in Six Years, Surpassing $15,000," *Bloomberg News*, September 27, 2011. http://mobile.bloomberg.com/news/2011-09-27/health-benefit-costs-rise-most-in-six-years-surpassing-15-000-per-family

[18] *The New York Times*, September 27, 2011. http://www.nytimes.com/2011/09/28/business/health-insurance-costs-rise-sharply-this-year-study-shows.html?pagewanted=all

[19] http://insight.milliman.com/article.php?cntid=7628

[20] http://www.bloomberg.com/news/2011-09-27/health-benefit-costs-rise-most-in-six-years-surpassing-15-000-per-family.html

[21] However, President Obama appears to have embraced it, saying, "I have no problem with people saying Obama cares. I do care." Reported by CBS News at http://www.cbsnews.com/8301-503544_162-20092578-503544.html

[22] "Ohio Vote on Labor Is Parsed for Omens," *The New York Times*, November 9, 2011. http://www.nytimes.com/2011/11/10/us/politics/ohio-vote-on-collective-bargaining-is-parsed-for-2012-omens.html?_r=1&scp=2&sq=ohio%20health%20referendum&st=cse

[23] http://docs.house.gov/energycommerce/cost_containment.pdf

[24] These descriptive labels include "What is the premium?", "Are there other deductibles . . . ?", "Are there services this plan doesn't cover?" The government's template for the disclosure of standardized terms appears at http://www.healthcare.gov/news/factsheets/2011/08/labels08172011b.pdf

[25] In a June 2, 2009 letter to the dying Senator Edward Kennedy (who had made universal health care one of his primary goals in life), President Obama wrote that the purpose of the exchanges was to create "...a market where Americans can one-stop shop for a health care plan, compare benefits and prices, and choose the plan that's best for them, in the same way that Members of Congress and their families can." http://my.barackobama.com/page/community/post/obamaforamerica/gGGGpK

[26] Cappy McGarr, "A Texas-Sized Health Care Failure," *The New York Times* op ed page, October 5, 2009. McGarr was chairman of the Texas Insurance Purchasing Alliance from 1993 to 1995. For the California experiment, see Jill Mathews Yegian, Thomas C. Buchmueller, Mark D. Smith, and Ann F. Monroe, "The Health Insurance Plan of California: The First Five Years," *Health Affairs*, Vol. 19, No. 5, p. 158. The California exchange was renamed

[27] http://www.statehealthfacts.org/comparereport.jsp?rep=89&cat=17

[28] http://www.statehealthfacts.org/healthreformsource.jsp

[29] http://www.khi.org/news/2011/aug/09/kansas-rejects-315-million-insurance-exchange/

[30] http://www.ihealthbeat.org/articles/2011/4/15/oklahoma-to-return-early-innovator-grant-for-insurance-exchange.aspx

[31] Professor Mark Hall, "47 Million and Counting: Why the Health Care Marketplace Is Broken," Hearing before the Senate Committee on Finance,110th Cong., 2d Sess. 52 (2008).

[32] http://finance.senate.g.ov/newsroom/ranking/release/?id=e7723a9e-ed4a-4e10-af90-a56dfb0ccec5

[33] https://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef-6f47d7468a0c?fiShown=default

[34] http://www.kff.org/uninsured/upload/7777.pdf

[35] http://www.hhs.gov/news/press/2011pres/12/20111216c.html

[36] Cost Estimates for H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation), p 2. (available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf)

[37] "Obamacare: A Budget-Busting, Job-Killing Health Care Law," p. 2 (available on the website of

the Speaker of the House at http://www.speaker.gov/Blog/?postid=219114)

[38] http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf

[39] Rebecca J. Kopps, "Dead on Arrival: The Health Insurance Industry's Bleak Prognosis due to Unconstitutional Ratemaking in the Patient Protection and Affordable Care Act," *North Illinois University Law Review*, Volume 31, Issue 3 (Summer 2011), p. 577.

[40] http://www.naic.org/documents/ppaca_sub_draft_mlr_rebate_reg.pdf

[41] http://money.cnn.com/2010/05/25/news/companies/medical_loss_ratio/index.htm

[42] PPACA, §2705.

[43] http://www.healthcare.gov/news/factsheets/2011/05/ratereview05192011a.html

[44] This does not mean that a state must accept a 10% increase. For example, the Rhode Island insurance department recently reduced a proposed rate increase from 7.9% to 1.9%. http://www.pbn.com/BCBS-of-Rhode-Island-Direct-Pay-rate-increase-slashed-from-79-to-19,56172

[45] The Fifth Amendment, which applies to the States under the Fourteenth Amendment, provides that "No person shall . . . be deprived of . . . property, without due process of law; nor shall private property be taken for public use, without just compensation." As far as ratemaking standards, the Supreme Court has said: "The guiding principle has been that the constitution protects utilities from being limited to a charge for their property serving the public which is so 'unjust' as to be confiscatory." *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307 (1989).

[46] Section One of Article Two of the United States Constitution states that "No person except a natural born Citizen . . . shall be eligible to the Office of President;" *Purpura v. Sebelius*, (USDC, DNJ, Index # 10-4814 (GEB)) alleges, among other things, that the Affordable Care Act is unconstitutional because it was signed by a President who was not a "natural born citizen." Complaint, ¶¶53-61. The substance of this claim is that the President is a dual citizen, because his father was a British subject, and that the term "natural born citizen" (not defined in the Constitution) means someone both of whose parents were citizens.

[47] *Susan Seven-Sky v. Holder*, ___ F.3d ___ (D.C. Cir., November 8, 2011).

[48] Statement of South Carolina Attorney General Henry McMaster, March 22, 2010, quoted in *The Christian Science Monitor*. http://www.csmonitor.com/USA/Justice/2010/0322/Attorneys-general-in-11-states-poised-to-challenge-healthcare-bill

[49] A copy of the district court decision appears at http://www.politico.com/pdf/PPM153_vin.pdf

[50] A copy of the Court of Appeals decision appears at http://www.uscourts.gov/uscourts/courts/-ca11/201111021.pdf

[51] http://www.supremecourt.gov/orders/grantednotedlist.aspx?Filename=11grantednotedlist.html

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LONDON MARKET ISSUES: LEADERS, FOLLOWERS AND LAYERS

By Julian Burling, Helen Ashenden and Jacquetta Castle[1]

Introduction

In the commercial insurance markets a single large risk may be divided between different insurers, each insurer taking only a share of the total, with several liability only (the subscription market). Or the risk may be divided into several layers above a retention, with a different insurer (or insurers) on each layer. For the convenience of insured and insurers in the subscription market it is common for one or more insurers to undertake administrative functions on behalf of, or for the benefit of the others.

This article discusses the relationship between leading and following underwriters generally; next it describes the operation of the new Lloyd's claims scheme; finally, it analyses the relations between the insurers on different layers in a vertical programme or "tower".

Leaders and Followers

Where a risk is placed in the London subscription market, whether at Lloyd's or in the company market, the slip is likely to confer on the leader functions in relation to determining the precise wording of the original contract, any subsequent endorsements, and the settlement of claims. Questions arise from time to time as to the authority of the leader to bind the following market at each stage, any duties owed by the leader to the following market, and the effect on the following market of material misrepresentations or non-disclosure by brokers in their dealings with the leader.

A leading underwriter agreement may be an ad hoc clause in the slip or a standard form market agreement incorporated into it by reference. Since October 2001 the LMP (London Market Principles) General Underwriters Agreement (GUA), produced for use with the LMP slip and subsequently the standard form Market Reform Contract (MRC), has replaced the earlier LUA/ILU market agreements in the London market. It incorporates, as appropriate, schedules for use by the different markets, ie non-marine, marine cargo, marine hull etc.[2] But the GUA is not in universal use so it is necessary first to consider questions that have arisen under less comprehensively drafted arrangements.

Purpose and scope of leading underwriter clauses

A leading underwriter clause may give the lead underwriter the power to agree the original wording or terms of the policy (eg "wording tba L/U") so as to bind the followers, although this will be much less common now that, in the London market, the Contract Certainty Code of Practice (and the use of the MRC slip) requires "the complete and final agreement of all terms between the insured and insurer by the time that they enter into the contract, with contract documentation provided promptly

thereafter." O'Neill and Woloniecki, in *The Law of Reinsurance*,[3] take the view that contract certainty would still allow a leader and a follower to sign a slip with wording to be agreed by the leader alone, but the leader's agreement of the wording would have to be given before the date the contract came into force, ie the signatures of the leader and follower took effect subject to that condition subsequent.

Does the leader have power to agree wording which includes an arbitration clause not mentioned in the slip? In *Unum Life v Phoenix Israel*[4], Mr. Justice Andrew Smith held not,[5] relying on authorities involving the incorporation (or not) of arbitration clauses where general words had incorporated by reference the terms and conditions of retroceded contracts or lower layers of cover. Those cases had followed a line of authorities on the incorporation of charterparty arbitration clauses into bills of lading. In the Court of Appeal, however, Lord Justice Mance took the view[6] that the incorporation cases had little, if anything, to do with the scope of a leading underwriter's authority to bind the following market. He would have given leave to appeal on the point if the followers had not already terminated the leader's authority by avoiding the contract by the time he got round to agreeing the wording.

A leading underwriter clause normally gives the leader power to agree endorsements, extensions, changes in conditions etc. The clauses can be wide in scope. In *Barlee Marine Corp v Mountain ("The Leegas")*[7] the leading underwriter clause provided:

> "Any amendments, additions, deletions, including new and/or acquired and/or managed and/or chartered, notices of assignment, ratings and alterations of any description to be agreed by Leading Underwriter and to be binding on all others hereon".

In that case extensions of a marine war risks policy granted by the leader were attacked by the followers on the ground that they purported to convert what was intended to be a policy covering 8 voyages over 4 months to 20 voyages over 8 ½ months. Market understanding was said to be that the purpose of the leading underwriter clause was limited to minor or immaterial amendments: a wider construction would permit infinite variation by the leading underwriter, the granting of indefinite time limit extensions or even converting it into an aviation policy. Mr. Justice Hirst rejected this *reductio ad absurdum*. He held that the clause was limited by the "Type" of cover afforded by the policy, viz "Marine – Hull etc War". Followers would not be saddled with infinite extensions because they could always have recourse to the termination clause. "Underlying the whole relationship between the leading underwriters and the following underwriters is the former's manifest duty of care. In any event, the task before the Court is not to lay down a construction which will cover any possible eventuality, but rather to decide whether the extension and alterations in fact agreed to by the leading underwriter are within the scope of the leading underwriter clause."[8] He held that they were.

A clause of even wider scope was considered in *Roadworks (1952) Ltd v Charman*[9] :

> "All alterations, additions, deletions, extensions, agreements, rates and changes in conditions to be agreed by the Leading Lloyd's Underwriter and Leading Company Underwriter only. Such agreement to be binding on all Underwriters subscribing hereon."

It was held to confer authority on the leader to waive a condition requiring Salvage Association approval of beaching arrangements prior to the beaching of a barge.[10] The Salvage Association had said it could not approve the beaching in view of the many unknowns regarding the seabed. The broker and the underwriters had not used the Leading Underwriter Agreement General Marine (LUAGM) clause on the slip, which would have incorporated a code identifying the leaders and specifying their authority and limiting it to alterations "which in the judgment of those leading underwriters do not constitute a material alteration to the risk".

Leading underwriter clauses may sometimes also allow the leader to bind the followers as to the settlement of claims: see *Roar Marine v Bimeh Iran*[11] and T*he Buana Dua*[12], below.

Identification of leader

The leader will normally be appointed or identified[13] as such in the slip. If there are two slips, eg one Lloyd's and one company market, there may then be two leaders, or one of them may be identified as leading London underwriter. If there is no specific appointment, the leader will have to be identified by inference from the circumstances. Relevant indicia may be: the order in which underwriters scratch the slip (notwithstanding that he may have taken only a 5% line in contrast to a 20% line taken by one of the followers); any assumption by an underwriter of the role as leader, such as agreeing or purporting to agree an endorsement in that capacity; or a reference in the broker's cover note to a particular underwriter as leader.[14]

Agent or trigger?

Debate has arisen whether the leading underwriter clause in a slip scratched by each follower confers on the leader authority as agent to act on behalf of the following market or operates as an agreement between followers and the assured to be bound by what the leader does. On the latter analysis an endorsement agreed between assured and leader would act as a "trigger" to a change in the agreements between the assured and the followers. In *Roadworks* v *Charman* His Honour Judge Kershaw QC, sitting as a Deputy Judge of the Commercial Court, held that the leader acts as agent of the following market: by taking a line they not only contract with the assured but also make the leader their agent for the purpose shown in the leading underwriter clause.[15] That purpose included waiving a contingent condition as to the survey arrangements for the beaching of the insured barge.

In *Mander* v *Commercial Union*,[16] however, Mr. Justice Rix tentatively suggested that, at least under a facultative open cover, the leader is not constituted an agent of the

following market by the leading underwriter clause. The better view was that by subscribing to the cover the followers agree to be bound by a declaration to the cover agreed by the leader, the agreement by the leader to the declaration acting as a "trigger" rather than an act of agency. This analysis, in the judge's view, avoids imposing on the leader the unrealistic fiduciary obligations of an agent (such as the duty to avoid conflicts of interest). Moreover, since the terms of the open cover are there for all to see, there can be no reason to think the leader makes representations about the scope of the leader's authority that might give rise to actions for breach of warranty of authority on his part.

The assured itself is never expressed to be a party to any separate subscription agreement between the underwriters.

Leaders' duties of care to followers

In *Roadworks* v *Charman* (mentioned above) the judge, without expressing any concluded view on the point, envisaged the possibility that in exercising power under a leading underwriter clause the leader might owe a duty of care to the followers. Such a duty might arise from an implied term in a contract of agency or exist independently of contract.[17]

As regards the initial underwriting, there is generally a defined potential class of following underwriters who the leader knows may well rely on his expert judgment in rating the slip and deciding its terms and conditions. It is, however, not at all clear that he can be said consciously to assume functions in relation to them sufficient to create a duty of care to them. The leader might be writing or rating the contract influenced by all kinds of considerations, such as the availability of reinsurance or the desire to get other business from the broker, and the followers will realise this. By way of analogy, in *Bonner* v *Cox*[18] underwriters negligently underwrote an open cover, ceding severely loss-making business under their reinsurance, but it was held that they owed no duty of care to the reinsurers in the way risks were selected and underwritten.[19]

Once a leader has authority under a leading underwriter clause, however, he is aware that the class of followers rely on his judgment, having given him the authority (or at least, on the "trigger" view, the power) to agree endorsements which they will not have the opportunity to consider for themselves. In that context, as Mr. Justice Hirst put it in *The Leegas*:

> "Underlying the whole relationship between the leading underwriter and the following underwriters, furthermore, is the former's manifest duty of care".[20]

In the context of a claims agreement clause Mance J considered in *Roar Marine v Bimeh Iran* that the existence of such a duty of care was likely. [21]

There is, however, no mention of any duty of care in the GUA or its antecedent market agreements.

Termination of leader's authority

Can the authority of the leader (or power, depending on whether one takes the agency or trigger view) be terminated? In *Unum Life* Mr. Justice Andrew Smith declined to hold that there was an implied term that it expires by effluxion of time.[22] He was also satisfied that it was not usually the case that a leading underwriter provision would be revocable, but he accepted the force of the argument that the wider the scope of the leader's authority, the stronger the argument that it would be revocable, at least on notice.[23] This would accord with the general principle that an agency is always revocable (even if revocation constitutes a breach of the agency contract) unless coupled with an interest or in certain other special circumstances. The leader might well continue to have ostensible authority until the assured or its broker was given notice of the revocation.

In *Unum Life* the judge at first instance and Lords Justices Mance and Keene on appeal had no doubt that the agency had been terminated by the follower's avoidance of the reinsurance for non-disclosure of material facts.

Disclosure and representations by the broker to the leader

In *The Zephyr*[24] Mr. Justice Hobhouse held, at first instance, that the broker owed a duty of care in tort not only to the leading underwriters to whom "signing" indications were given, and to the members of their respective syndicates, but also to the syndicates to whose underwriter (Mr Posgate) no express signing indication had been given. This was on the footing that, knowing the particular broker as he did, it was reasonable for Mr Posgate to assume that the broker would follow his usual practice of obtaining substantial oversubscription. A sufficient proximity arose as regards the following syndicates because the broker knew, or ought to have known, that the following underwriter, Mr Posgate, would rely on the broker's judgment as well.[25] But Lord Justice Mustill held, on appeal, that the brokers owed no such duty of care to the Posgate syndicates. Unlike the judge at first instance, he would have been prepared to hold that the signing indication gave rise to a contractual relationship between the broker giving it and those underwriters to whom it was given. He was not prepared to find that failure to perform a positive undertaking could give rise to an action in the tort of negligence, as opposed to in contract.[26] That conclusion now seems questionable in the light of *Henderson* v *Merrett*,[27] applied to insurance brokers by *BP* v *Aon*[28] and *HIH* v *JLT*,[29] in which brokers were held liable in tort for failure adequately to perform functions assumed by them, independently of any contract.

In *The Zephyr* Mustill LJ also doubted the supposed earlier rule that a misrepresentation made to the leader of such a character as to entitle the leader to avoid the insurance is effective to give a similar right to the followers.[30]

However, followers may have a remedy. *Aneco* v *Johnson and Higgins*[31] was a case in which brokers were sued for negligence in placing a risk on behalf of their client in such a way

that the retrocessionaires were entitled to avoid it for misrepresentations or non-disclosures to the leaders and the followers. The brokers had misrepresented to the leaders the nature of the underlying reinsurances. The arbitrators who had declared that the retrocessionaires were entitled to avoid the contracts observed that the avoidances by the followers could also have been based on an (untrue) implied representation by the brokers to each of the followers that the risk had been broked fairly to the leader(s) on the slips, which had induced the followers to subscribe to the risk.[32] Mr. Justice Cresswell, at first instance, held, explicitly on the basis of expert evidence of practice in the Lloyd's marine market in late 1998/early 1999, that the fact that in broking the retrocession contracts the broker had (negligently) misrepresented to the leader(s) the nature of the underlying reinsurance was a material circumstance which the brokers were required to disclose in order to make a fair presentation of the risk to the followers. There was a presumption in the case of those followers who had not given evidence that they had been induced by that non-disclosure to enter into the contracts.[33] This aspect of the judgment, which was not overturned on the subsequent appeal,[34] has since been followed in several cases.[35] In relatively specialised business there may be a greater degree of reliance by the followers on the leader's judgement (and therefore on broker's presentation to him) than in more general business.

In *Sirius* v *Oriental* [37], a decision to the contrary, the point does not appear to have been fully argued, and Mr. Justice Longmore found that there had in fact been no inducement.

Claims settling authority

Leading underwriter clauses do not confer claims settling authority unless they expressly so provide. In the absence of a clause giving the leader claims settlement authority, or a "follow the leader provision" in relation to claims, an arbitration award or a judgment against the leader does not bind the followers.[38] Nor are the followers entitled to see the award, even though it might be commercially persuasive in pending proceedings involving them, unless the rights of one of the parties to the arbitration can be protected or enforced only by disclosure of the award to the follower.[39]

Where leading underwriter clauses do confer claims settling authority, or there is a "follow the leader" clause, the courts construe them generously, having regard to their obvious commercial purpose of simplifying administration and claims settlement - *Roar Marine v Bimeh Iran*[40], followed in *The Buana Dua*.[41] So the courts will not imply a term into leading underwriter clauses that the settlement must have been concluded in a proper and businesslike way, by analogy with "follow the settlements clauses" in reinsurance contracts.[42] Nor will they exclude from the ambit of the clause losses alleged by the followers to be "outside the cover" because not perils insured against (eg wear and tear rather than crew negligence),[43] or because there is alleged to have been a breach of a warranty, so that the loss does not fall within the leader's authority to make "… settlements *within the terms of the policy*".[44] The followers will not be allowed to reinvestigate the factual

cause where they contest the view of the leader[45] or, in the absence of the clearest words, argue that they are bound only as to quantum and not liability.[46]

In *Roar Marine* Mr. Justice Mance, without expressing a concluded view, considered it likely that in exercising his authority to bind them as to claims settlement the leader owed a duty of care to the following market: he doubted whether the leader's duty differed from that considered by Mr. Justice Hirst in *The Leegas* as "manifest".[47]

Leaders and followers: General Underwriters Agreement

The scope for uncertainty or disputes outlined above is significantly reduced where the General Underwriters Agreement (GUA) is used in conjunction with the MRC Slip. The MRC is now compulsory for most Lloyd's business, except where the client otherwise requires.[48] Because the Contract Certainty Code of Practice require the complete agreement of all terms before the contract is entered into, the GUA assumes that the initial wording is already agreed, and so confers authority only as regards amendments, not the initial wording, and does not cover claims.

The "Subscription Agreement" section of a duly completed MRC slip identifies the Slip Leader. It specifies the basis of agreement for contract changes (eg "GUA 2001 with Non-Marine Schedule"). It identifies the "Agreement Parties" for contract changes which are to bind the whole market on the slip, and those who are to agree changes for their own proportion only.

The Subscription Agreement of a duly completed MRC slip specifies the "Basis of Claims Agreement", eg Lloyd's Claims Scheme (Combined) and IUA claims agreement practice, and identifies the "Claims Agreement Parties ", eg "Slip Leader plus insurance company and Scheme Service Provider".

The GUA provides that the terms of the slip override it where inconsistent.

Notwithstanding the possible advantages of the "trigger" theory, the GUA unequivocally constitutes the leader the agent of the followers for the purpose of agreeing post-placement alterations (but not settling claims). It says nothing about any duty of care owed by the leaders to the followers.

The Slip Leader alone and the Slip Leader together with the other Agreement Parties (if any) are given the powers to amend the contract set out in detail in Parts 1 and Parts 2 respectively of the appropriate Schedule for the class of business in question (specified in the subscription section of the slip). Part 3 of the relevant Schedule specifies in detail types of alteration to the contracts (ie the several insurance contracts with each "Underwriter") that can be agreed only by those Underwriters themselves.[49] "Underwriter" is not defined but appears, as in many other generic market documents, to include the members of a Lloyd's syndicate taken together, acting through the underwriter employed by the syndicate's managing agent. A GUA stamp is to be applied to, if it is not already incorporated in, any endorsement presented for agreement, initialled in the appropriate box so as to indicate which Agreement Parties have authority to agree the endorsement.[50]

Where there is any conflict the slip and any endorsement override the GUA, "provided that they have been shown to and agreed by each[51] subscribing Underwriter for its own proportion". This enables adaptation of the Schedules to confer agreement authority otherwise than contemplated by the schedules.[52]

An alteration agreed by Agreement Parties is to be notified to the other Underwriters if the Agreement Parties so require, or where required by the slip or by Part 1 or 2 of the relevant schedule to be notified or "listed" to other Underwriters.[53]

There are provisions for the replacement of the Slip Leader in certain circumstances such as insolvency, withdrawal of regulatory permissions, or going into run-off.[54] The delegated authority can be terminated by an Underwriter at any time with effect from the date of giving notice to the broker, but not so as to affect accrued rights of that Underwriter or the assured as regards alterations already agreed.[55] The authority will be automatically terminated where the Underwriter is subject to an insolvency or similar procedure or has regulatory permission withdrawn for the relevant class of business.[56]

The GUA is an agreement between the subscribing insurers themselves but is not expressed to be an agreement between them severally and the assured, who is, however, assumed to have rights as regards the GUA under the Contracts (Rights of Third Parties) Act 1999.[57]

Lloyd's Claims Schemes

Since 1991 Lloyd's has required managing agents and their syndicates to participate in a series of claims schemes which apply when two or more syndicates underwrite the same risk (except where managed by the same managing agent). The claims schemes have simplified the administration and settlement of claims by focusing those functions on one or more lead underwriters and a claims office.

2010 Claims Scheme

Under the 2006 Claims Scheme, notwithstanding any agreement on the slip or elsewhere scheme claims were to be determined by the leader on behalf of his own syndicate and by a "scheme service provider" (approved by the Franchise Board and authorised by a contract entered into with each relevant managing agent) on behalf of the followers, following appropriate consultation between them. A new scheme, the 2010 Claims Scheme, is being introduced in phases at specified dates for claims made under policies with specified risk codes incepting (or policies written under binding authorities incepting) on or after those dates.[58] It is intended that all risk codes should be covered after 1 July 2012. The timing of its introduction for legacy claims (ie those under policies incepting before the specified dates) is under consideration.

The 2010 scheme applies only to claims notified by electronic claims file (ECF).

The key features of the 2010 scheme, from January 2012, are as follows. Claims are categorised into "standard" and "complex" claims, the latter being (broadly) claims

potentially not less than specified amounts (£250,000 except for £500,000 for energy and property treaty risks) for given risk codes or claims that are likely to be difficult to resolve, including claims subject to dispute resolution proceedings.[59] The managing agent of the lead syndicate "triages" the claim, determining whether a claim is a standard or a complex claim.[60] The managing agent of the lead syndicate can initially assign,[61] or subsequently reassign,[62] a standard claim as a complex claim if it considers it appropriate, having regard to guidance given by Lloyd's from time to time;[63] and the managing agents of the lead and second syndicates may reassign a complex claim as a standard claim if they both think it appropriate.[64]

"Standard claims" are determined by the managing agent of the lead syndicate alone on behalf of the following syndicates;[65] "complex claims" are determined by the managing agents of the lead and second syndicates in agreement with each other,[66] on behalf of the following syndicates.

The managing agent of the lead syndicate may delegate its claims handling authority to another person provided that the delegation is properly documented and is notified to the following syndicates and any relevant Lloyd's broker. The managing agent of the second syndicate can delegate its claims settling authority only to Xchanging Claims Services (XCS) or another scheme service provider authorised by the Franchise Board (except where , as a managing agent of a leading syndicate it has already delegated claims handling to another person, in which case it can again delegate to that person).[67]

In each case the lead managing agent, and the managing agent of the second syndicate, if involved in determining a complex claim, are required to exercise the reasonable care of a reasonably competent managing agent.[68] The liability of each to the followers is limited in aggregate to £2m in respect of any one 2010 scheme claim and £10m in respect of all such claims made in any one calendar year.[69]

On receipt of a 2010 scheme claim the managing agent is to take appropriate steps (usually by ECF) to inform the managing agent of the second syndicate, and to provide the claims information it has received, if it is a complex claim;[70] and in every case to inform the followers of receipt of a 2010 scheme claim.[71]

Where a managing agent is required to act on behalf of following syndicates under the 2010 Claims Scheme it is obliged to act in the best interests of all those syndicates on whose behalf it acts. If it concludes that it cannot do so (presumably because of a conflict of interest) it must notify the managing agents of the followers and the managing agent of the next syndicate in slip order shall take its place for the purpose of the scheme.[72]

The followers have various rights to be involved. All relevant documents and comments should be on the ECF. Proposed ex gratia settlements, commutations and rescissions must be referred to the followers for agreement.[73] Professional advisers' reports are to be sent to the followers,[74] and in the case of complex claims subject to dispute resolution proceedings simultaneously to the leaders and any follower(s) so requesting. The leader(s)

are required to notify the followers as soon as practicable of recommended reserves for a claim, any revision of recommended reserves, the receipt of notice of dispute resolution proceedings, and the delegation of claims determination to another person under paragraph 10 of the 2010 Claims Scheme. A following syndicate's managing agent may request the leader(s) to provide such further information as it may reasonably require.[75]

Where the leader and the managing agent of the second syndicate disagree as to the handling of a claim they are to use best endeavours to resolve their difference and if they are unable to so, to convene a market meeting of the followers to attempt to achieve a consensus.[76]

Detailed procedures as to the leader's proactive handling and communication of claims, establishment of reserves and appointment of third party experts are set out in guidance by Lloyd's.[77]

Excess Layers

There has been little decided case law on issues relating to layers in England; nor is there any overriding or binding market practice to provide answers. One is therefore left to rely on basic principles, analogy with other legal areas, and in the last resort, a fair dose of conjecture. The following discussion approaches the subject from a practical and personal stance to reflect the issues that one of the authors (JLC) has encountered as a practitioner.

There seem to be seven main problem areas, often interconnected.

(i) *Inconsistency in wordings between layers*

The primary layer provides the first layer of coverage that attaches upon an occurrence covered by the terms of the policy. Excess insurance is written to apply to an insured's loss after the primary is exhausted (or the wording might instead refer to the underwriters of the underlying policies having paid or admitted liability or having been held liable to pay the full amount of their indemnity).

The excess layer may "follow the form" of the underlying coverage or be written on its own insuring agreement. A typical clause might be

> "[e]xcept as stated to the contrary, this policy shall be subject to the same terms, exclusions, conditions and definitions as the primary policy".

Sometimes, an excess policy may be created unintentionally, in which case one would expect no reference to other layers.

Generally, the policies will dovetail. If not, there may be issues, as in the recent *Teal v W R Berkley*[78] case where the excess policy at the top of the tower did not cover claims arising in the USA, unlike the policies lower down. That difference was unintentional but differences may also be intentional For example, with solicitors' professional indemnity, the primary will be subject to the Solicitors' Regulation Authority Minimum Terms and Conditions and the primary will have contracted out of the right to avoid for material

misrepresentation and non-disclosure. The excess layers, however, may not be so constrained and indeed any excess policies are likely to state specifically that such conditions shall not apply.

There appear to be two reported cases in which inconsistencies between layer wordings were raised. The first was the first instance preliminary issue decision of Mr. Justice Moore-Bick in *Friends Provident v Sirius;*[79] the point was not live in the Court of Appeal, but Lord Justice Mance said he entirely concurred with what the judge had said.[80] The second was *Dunlop Haywards v Barbon*.[81]

In *Friends Provident* the question was whether the cover provided in the excess layer policies included General Condition 2 of the primary layer policy although it was not specifically included in the excess layer wording. The clause required that notice be given to underwriters as soon as possible of circumstances that might give rise to a loss, but also provided for extension of cover to claims arising after the policy period from circumstances notified to underwriters during the policy period. The excess layer policies provided that they were subject to the same terms as the primary layer policy.

Expert evidence of market practice was that, in the absence of any indication to the contrary, it is generally assumed that the scope of cover provided under the excess layer is intended to be the same as that provided under the primary layer (apart from policy limits). While a material difference in the scope of the two might not render the cover wholly unworkable, an insured would bear a greater part of the risk if the scope of the cover were more limited than under the primary.[82]

The judge held that the cover extension clause supplemented rather than contradicted the insuring clause and was consistent with the express terms of the excess layer policies. Indeed, there were strong grounds for concluding that the parties intended to incorporate the extension of cover, since a failure to do so would mean that the insured would, as regards the excess layer policies, be unable to recover during any policy period where claims arose from circumstances of which it became aware during one policy period but were not made until a later policy period.[83]

He held that the usual starting point when deciding whether a clause can be effectively incorporated by reference is to construe it as if it were written out in full in the contract into which it is said to be incorporated. It will then become apparent whether it makes sense in that context (with or without an acceptable degree of verbal manipulation) and whether it is inconsistent with other clauses in the contract.[84]

The judge also had to decide whether the condition of the cover extension clause (as incorporated into the excess layer policies) that notice of circumstances be given to underwriters required that notice be given to the excess layer underwriters as well as to the primary layer. He held that the term "the underwriters" in the cover extension clause, for the purpose of the requirement to give notice of circumstances to the underwriters, meant the underwriters on the primary layer even when read in the context of the excess

policies. Further, it required little manipulation for "this policy" in that clause to refer to the excess layer policies into which that clause, as a whole, had been incorporated.[85]

In *Dunlop Haywards* (mentioned above), where cover was in two layers, a primary of £10m and an excess layer of £10m over £10m, the primary layer accepted claims (lenders' claims based on negligent or fraudulent valuations) up to the limit of indemnity but the excess layer rejected the claims, on the basis that excess cover was limited by the policy wording to the group's property management activities only. The brokers were sued and excess layer was joined.

It was held[86] that as a matter of ordinary language there was a clear distinction between "property management" and "property valuation", a distinction well recognised in professional indemnity. As a matter of construction, the excess did not cover the valuation claims. The claim for rectification failed. The common intention was to provide cover for commercial property management activities alone.

(ii) *Relationship/duties between layers*

The starting point in any discussion is that there is generally no contractual relationship between the primary layer insurer and the excess layer insurer of a common insured that would lead to contractual duties between them. Even though the contracts may cover the same subject matter, the primary and excess are strangers to each other's contracts. Insurance contracts create rights between the insured and the insurer, not between co-insurers.

It seems highly unlikely that any court would impose a direct tortious duty of care on the primary layer towards the excess layer**.** So, although there is no authority on the point, it seems unlikely that there is any liability on a primary layer who mishandles a claim in such a way that the loss is actually increased or who fails to take an opportunity to settle within its layer so that the excess layer has to pay.

From first principles it seems that a court would find it very difficult to find a duty of care. It is the responsibility of each layer to ascertain whether the loss falls within its terms and layer. In practice the excess will probably have had the opportunity to make representations, for example, in market meetings; it may have its own legal representation; and while it may be easy to be wise after the event, a court would probably take the view that it is not fair and reasonable to impose a duty and second guess how better the primary could have handled the claim. The excess layer has no legitimate expectation that the primary layer will give as much consideration to the excess layer's interests (as a stranger to the contract) as to its own or to the insured's interests.

What possible contrary arguments could there be?

a. USA position

In the USA there is much more decided law and the question arises whether any of the same logic could be applied here? Claims brought by excess layers against primary seem not uncommon in the USA, not that they always succeed.

It is often said in the UK that in the USA, or in some jurisdictions there, the primary does owe a distinct duty to the excess. This is not quite correct. So far as one of the authors (JLC, not US qualified) understands it, it is only in New York, and possibly Florida, that the courts have held that an excess insurer may maintain a direct action against the primary.[87] Generally, the courts are most conservative and the majority of states do not recognise a cause of action in tort against the primary in the absence of contractual obligations (see for example *Federal Ins. Co. v Travalers Casualty & Surety Co.*[88]). In the majority of states the courts hold that the excess layer's rights, if any, against the primary arise through the doctrine of equitable subrogation, which is derivative from the primary's duty to the insured. So if an excess pays off a tort claim by a third party in excess of the primary's limits and then takes an assignment from the insured, the excess is subrogated to the insured's right to sue the primary carrier for actions in bad faith against the insured.

This may be of limited significance. Where the insured has consented to the settlement or where the insured's assets are not put at risk (perhaps even because there is sufficient excess insurance), excess insurers may be barred from proceeding against the primary, since the excess can be in no better position than the insured. Equally if the excess layer steps in and pays the settlement to prevent it reaching an even larger loss the majority of courts have said that there is no cause of action.

Of course, in the USA duties owed by the insurer to the insured are much more developed in the sense of the availability of bad faith damages, and the insurer's duty to defend. But even given this, could this subrogation reasoning be exported over to England? We shall deliberately leave this as a question and simply mention that if our own law on insurers' duties to the insured were to become more defined, for example, with the adoption of the current Law Commission proposals, it might come be seen to be more of a realistic possibility.

b. Assumption of responsibility under existing English law?

Might an English court, on the special facts of any particular case, consider that the primary layer had voluntarily assumed a specific responsibility towards an excess layer ?

A possible example might be where an all-market steering committee has agreed that the primary will act for the rest of the market and in this case there may be an assumption of responsibility or even agency, so that failure by the primary layer claims handler to pursue a subrogated claim within the limitation period might render the primary layer liable to the excess layers.

c. Unconscionable behaviour or dishonesty?

There are judicial comments in cases dealing with other legal situations where there is clearly no contractual or other duty – and also in the USA - along the lines that

if there has been bad faith or collusion, the position might be different - see for example the suggestion in *Normid Housing Association v Ralphs*[89]. Thus, if a settlement is reached which impacts on the excess and which involves concealment, duress, fraud, mistake, unconscionable conduct, or similar irregularity, would a prejudiced excess be able to claim some sort of fiduciary relationship? It is difficult to see how the primary could find itself in the position of a fiduciary. Presumably, any settlement obtained by fraud would not bind the excess in any event - for example if a primary and insured acted collusively to allocate certain dates to claims to maximise the excess's liability.

(iii) *Excess layer insurers: "going it alone" and influencing events*

Can excess layer insurers act differently from the rest of the market and to what extent do they have an influence?

Taking policy coverage first, there is nothing to stop an excess insurer coming to a genuinely different view from the primary: an excess might just want to pay its limits and get out.

It is more difficult where a third party claim is in progress and the excess layer wants to adopt a different strategy from the primary. This is where one probably sees the most issues in practice. Not surprisingly, the stance taken by the various parties tends to depend on where their attachment point is.

Generally, there will be no agreement in place to govern whose views should prevail. In the absence of such an agreement, there appears to be no legal rule (or market practice) that a primary has to consult or have regard to the interests of the excess as regards strategy on the claim or as regards settlement, although they may do so in practice particularly if the market wants to be seen to be acting in a united way.

Equally, unless specifically agreed beforehand or there are some other special circumstances, the primary does not have authority to agree to settle a claim so as to bind the other layers.

If the excess layer wants to influence events, this is generally achieved by negotiation or commercial pressure and via the applicable claims control clauses. Where there are differences of opinion, excess layers are likely to have their own legal representation and they will certainly do everything they can to exert any commercial muscle they might have.

Any claims control clause in the primary policy is likely to mean that the insured will have to do the bidding of the primary layer in the defence of the third party claim, which will effectively give the primary control over strategic decisions – in other words, via the insured. The excess layer is likely to have seen the claims control clause in the primary, or have had the opportunity to see it, when writing the risk and so would be ill-placed to complain.

Claims control clauses in the excess wording may also be relevant. The excess wording will probably contain a clause specifying that the insured cannot agree to settle without their

consent. The excess layer insurers should be able to utilise such a clause, at least in negotiation, by trying to ensure, via the insured, that the unwanted settlement is blocked.

One excess layer wording which one of the authors (JLC) has seen, states that excess may make a full and final payment to the insured of the indemnity limit or of any lesser sum for which the claim can be settled. It goes on *"provided that if the Underlying Policy(ies) refuse to agree to any such settlement, Insurers may require the Insured to exercise all rights available to the Insured under the Underlying Policy(ies) not to be required to contest the claim"* (…). The insured is therefore under a duty to the excess insurers to be as "awkward" as it legitimately can be with the primary (and in that clause, exercising all its rights under the QC clause).

(iv) *Dropping down*

It appears, depending of course on the wording, that liability under an excess policy only attaches once the primary has been exhausted. The excess layer may, however, provide in some cases that it is to "drop down" to take the place of the primary layer once (or to the extent that) the primary layer is exhausted.

A typical drop down clause might be as follows:

> "(a) In the event of partial exhaustion, this Policy will apply in excess of the remaining balance of the Underlying Limit(s) of Liability; and
>
> (b) In the event of total exhaustion, then this Policy shall continue in force as the underlying."

There have been two recent cases in England on drop down: *Flexysys America v XL*[90] in 2009 and *Teal Insurance v W R Berkley*[91] in 2011.

In *Flexysys*, a master policy was supposed to drop down to provide coverage that would have been available under a local policy. However, the clause had no application to a claim which while it exceeded the limits of the local policy, fell outside the terms of the master policy.

In *Teal* there was an attempt to engineer the order in which claims were paid from a PI tower so that a reinsurance recovery could be made in circumstances where the top layer excess policy (and its reinsurance) excluded USA claims - unlike the policies further down. The Court of Appeal held that claims under the policies had to be allocated in the order in which losses were suffered by the insured, based on the date on which its liability was established and quantified in respect of each claim against it.

The other point that seems clear, although not from any of these cases, is that an excess does not drop down where an insurer on the layer below becomes insolvent. An excess is not a guarantor of the solvency of the primary layer. However, if one had a clause providing for liability in excess of sums "actually recoverable" from the primary that might open the way for a drop down in those circumstances.[92]

One issue that could also provide problems is where a sublimit only is exhausted (say on regulatory expenses); does the excess drop down at all, in part or what? The wording would have to be looked at very carefully.

(v) *Notification to excess layers*

The excess layer will normally provide for notification by the insured and this can often be in the form of a condition precedent.

It is clear that the primary does not owe any general duty to the excess to notify. The primary is not the notification agent to excess layer insurers – *Tioxide v CGU.*[93]

In *Sirius v Friends Provident*, however, the Court of Appeal held that notification to the primary was deemed to be notification to the excess as a result of the incorporation into the excess policy of the notification provision in the primary, irrespective of the actual state of knowledge of the excess.

An insurer may be on more than one layer (in both *Sirius* and *Dunlop Haywards*, the primary was also on a higher layer too) and have notice in one capacity but not the other. There is no case law as to the effect of this. However, it would most likely be argued that if an insurer had actual knowledge of a claim through being on another layer, it ought to be precluded from taking policy defences that would otherwise have been available. This might be thought to produce anomalous results if the other insurers on the same excess layer were held not to have notice.

(vi) *Sharing/obtaining information*

This, particularly the provision of legal and other expert reports, is quite a common, and contentious, issue in practice.

The important point is that no duty is owed by the primary to provide information to the excess.

The excess layer contract may impose a specific duty on the insured to provide information to the excess or the excess might try to rely on a term incorporated from the primary. However, the excess insurer is likely to be able to obtain information and cooperation from the insured only insofar as it specifically relates to that insurer's layer (for example to investigate the claim, determine his liability and to exercise his rights under the policy to defend the claim): so the excess layer probably cannot expect that the insured should provide it with exactly the same information as he (the insured) provides to the primary, which would be needed for the purposes of defending the third party claim.

The excess has no automatic right to see legal reports. If the excess is contributing to the lawyers' costs on an ongoing basis, that would be a matter for agreement.

One issue that seems to be quite common at the moment is the primary who obtains a draft report and will only let excess see a final or edited version. Subject to the precise arrangements agreed beforehand and subject to how fees are being paid for, the primary

layer is probably within its rights to refuse to hand over drafts or the original version. The excess could equally well obtain a lawyer's opinion of its own.

Insurers should consider the question of maintaining common interest privilege before releasing any advice. They also need to be alive to data protection and other confidentiality issues. If an insurer on one layer is given confidential information, and he is on another layer too, he cannot release information to others on that layer and indeed he may have difficulties using that information himself in any other capacity from that in which he is given it.

(vii) *Sharing costs and recoveries*

Sharing of costs and recoveries may be dealt with in the excess wordings or by subsequent agreement. Alternatives include:

a. The primary pays the costs of defending the claim (with perhaps an accounting process at the end of the day)

b. The costs will be shared pro rata between all layers that are ultimately impacted by the claim according to their shares or respective ultimate liabilities

c. The costs are shared equally or according to other fixed percentages.

Generally there will be a condition in the excess that no costs are payable without consent.

In the absence of agreement, there is no market practice or quantum meruit type of rule to govern the situation. Costs apportionment is generally dealt with on a commercial basis as to what seems workable in the circumstances. Often costs issues are left over until the end of a matter with a final reckoning to come. This can be the only solution where, for example, it is not known how many claims there will ultimately be. But it does cause issues.

In *John Wyeth v Cigna*[94] a primary insurer exercised its right under a buy-out clause, capping its liability by making payment of the maximum amount for which it might be liable under the (product liability) policy. Not until four years later was it ascertained how many claims there were and into which years they fell. The underlying product liability litigation ultimately failed but significant defence costs were incurred. The Court of Appeal held that the primary layer had been exhausted and the excess layer triggered by the exercise of the buy-out clause: in those circumstances payment by the primary of actual claims was not necessary for the excess layer to become liable for the defence costs incurred after the buy-out in relation to claims which fell within the terms and conditions of the excess. There was to be no apportionment to reflect periods when they were not on risk. There was a "maintenance clause" in the excess layer policies under which the insured warranted that the primary cover would be maintained in force, except for reduction in aggregate limits "caused solely by payment of claims". It was held that this had not

been breached by the exhaustion of the primary layer by the exercise of the buy-out rather than payment of actual claimants.

Recovery is usually applied top-down so that insurers at the top benefit first. The usual justification for this it that primary insurers usually receive more premium. Clauses in excess contracts normally provide that recovery shall be applied "as if recovered or received prior to such settlement".

Endnotes

[1] This article is based on a BILA lunchtime talk given on 20 January 2012 by the authors, Julian Burling, a barrister practising at Serle Court chambers ("Leaders and Followers"), Helen Ashenden, Senior Claims Manager, Lloyd's Market Performance ("Lloyd's Claims Scheme"), and Jacquetta Castle, Fishburns LLP ("Excess Layers").

[2] http://www.marketreform.co.uk/Documents/RD_Doc_Archive/GUA211206.pdf.

[3] 3rd ed,, London, Sweet and Maxwell, 2010, para 3-059, n 182.

[4] [2002] Lloyd's Rep IR 374.

[5] At 377-8.

[6] At 380, [6].

[7] [1987] 1 Lloyd's Rep 471.

[8] Ibid, at 475.

[9] [1994] 2 Lloyd's Rep 99.

[10] ibid, at 106.

[11] [1998] 1 Lloyd's Rep 423.

[12] [2011] EWHC 2413 (Comm), [2012] Lloyd's Rep IR 52.

[13] Eg The Buana Dua: "follow AXA".

[14] *Unum* v *Israel Phoenix* [2002] 1 Lloyd's Rep IR 374, at 377 (Andrew Smith J).

[15] *Roadworks (1995) Ltd* v *Charma*n, at 105. See also *Youell v Bland Welch* [1990] 2 Lloyd's Rep 423, at 429, per Phillips J, *obiter*.

[16] [1998] Lloyd's Rep IR 93, at 143-144.

[17] [1994] 2 Lloyd's Rep 99, at 106.

[18] [2005] EWCA Civ 1512.

[19] [2005] EWCA Civ 1512, [2006] 2 Lloyd's Rep 152.

[20] *The Leegas* [1987] 1 Lloyd's Rep 471, at 475.

[21] [1998] 1 Lloyd's Rep 423 ,at 430, *obiter.*

[22] *Unum Life, at 378.*

[23] Ibid. cf the view expressed in Colinvaux 1-040.

[24] .[1984] 1 Lloyd's Rep 58, at 85-86.

[25] .ibid, at 597.

[26] [1985] 2 Lloyd's Rep 529, 538.

[27] [1995] 2 AC 145.

[28] [2006] EWHC 424 (Comm), [2006] 1 Lloyd's Rep 549.

[29] [2006] EWHC485 (Comm), [2006] Lloyd's Rep IR 493; affirmed [2007] EWCA (Civ) 710, [2007] 2 Lloyd's Rep 278.

[30] The Zephyr[1985] 2 Lloyd's Rep 529, at 539.

[31] [1998] 1 Lloyd's Rep 565.

[32] Ibid, at 596, col 1.

[33] ibid, at 597.

[34] [2000] Lloyd's Rep IR 12 (CA).

[35] *International Lottery Management* v *Dumas* [2002] Lloyd's Rep IR 237, 258 at [78]; *International Management Group* v *Simmonds* [2003] EWHC 177 (Comm), [2004] Lloyd's Rep IR 247, at [150]-[152]; *Brotherton* v *Aseguradora Colseguros (No.3)* [2003] EWHC 1741(Comm), [2003] Lloyd's Rep IR 762, 779 at [44]. For reservations about the trend of this line of authorities see Merkin, *Colinvaux's Law of Insurance*, 9th ed, London, Sweet and Maxwell, 2010, p307.

[36] eg. *Brotherton*, at [44].

[37] [1999] Lloyd's Rep IR 343.

[38] *Insurance Company v Lloyd's Syndicate* [1995] Lloyd's Rep IR 37, at 39, col 2.

[39] Ibid, at 40, col 2.

[40] [1998] 1 Lloyd's Rep 423, at 430 per Mance J.

[41] [2011] EWHC 2413 (Comm), [2012] Lloyd's Rep IR 52.

[42] *Roar Marine*, at 430.

[43] Ibid, at 427.

[44] *Buana Dua*, at [17]-[29], emphasis added.

[45] *Roar Marine*, at 427, col 1, 430, col 1.

[46] *Buana Dua, at [26]*.

[47] *Roar Marine*, at 430.

[48] Underwriting Requirements, para 3A, except where the slip relates to motor, personal lines or term life business and is not to be processed by LPSO.

[49] GUA, clause 3.

[50] Ibid, clause 4.

[51] It is not quite clear whether this is to be construed, literally, as meaning that the agreement of all is necessary for any of them to be bound, or, as seems more likely from the context and the reference to the Underwriter's own proportion, that none is to be bound as regards its own several contract unless it has agreed the slip provision or amendment .

[52] GUA, clause 10.

[53] GUA clause 6.1, 6.2.

[54] Ibid, clause 7.

[55] Ibid, clause 8.1.

[56] Ibid, clause 8.2.

[57] Ibid, clause 9. The former market agreements expressly provided that they did not form part of any contract with the assured.

[58] Lloyd's Market Bulletin Y4522, 30 September 2011, *Lloyd's Claims Scheme (Combined) and Expansion of Scope of 2010 claims Scheme under Claims Transformation Programme.*

[59] 2010 Claims Scheme, para 2(d), sch 5. Dispute resolution proceedings are litigation, arbitration, regulatory or other contested proceedings.

[60] Ibid, para 2(d).

[61] Ibid, para 2(d).

[62] Ibid, para 3.

[63] See Market bulletin Y4531, 10 November 2011, *Claims Transformation Programme: Revised 2010 Claims Scheme Process Guidelines.*

[64] 2010 Claims Scheme, para 4.

[65] Ibid, para 5.

[66] Ibid, para 7.

[67] Ibid, para 10.

[68] Ibid, paras 5 and 7.

[69] Ibid, paras 27-31.

[70] Ibid, para 2(e).

[71] Ibid, para 2(f).

[72] Ibid, para 9.

[73] Ibid, para 17.

[74] Ibid, paras 14, 15.

[75] Ibid, paras 18, 19.

[76] Ibid, paras 20-22.

[77] Market bulletin Y4531, above.

[78] [2011] EWCA Civ 1572.

[79] [2004] EWHC 1799 (Comm), [2005] Lloyd's Rep IR 135.

[80] [2005] EWCA Civ 601, at [14], [2006] Lloyd's Rep IR 45.

[81] [2009] EWHC 2900 (Comm), [2010] Lloyd's Rep IR 149, at [203], Hamblen J.

[82] [2004] EWHC1799 (Comm), at [14].

[83] Ibid, at [17].

[84] Ibid, at [19].

[85] Ibid, at [29].

[86] [2009] EWHC 2900 (Comm), [2010] Lloyd's Rep IR 149.

[87] See helpful summary by Linda S Woolf,Goodall DeVries Leech & Dann FDCC Journal July 2005.

[88] 843 So.2d140 (Ala.2002).

[89] [1989] 1 Lloyd's Rep 265.

[90] [2009] EWHC 1115 (Comm), [2010] Lloyd's Rep IR 132.

[91] [2011] EWCA Civ 1572.

[92] See, for example, *Hudson Ins Co v. Gelman Sciences Inc* 706 F Supp 25.

[93] [2005] EWCA Civ 928, [2006] Lloyd's Rep IR 31.

[94] [2001] EWCA Civ 175, [2001] Lloyd's Rep IR 420.

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INVESTMENT RULES AND PRACTICE IN THE LLOYD'S AND UK INSURANCE MARKETS

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Summary

This article discusses the investment rules that affect the assets in which UK insurers and participants in the Lloyd's insurance markets may invest. This includes both the applicable investment restrictions and the capital consequences that follow where an insurer invests in assets that are not admissible assets or invests in admissible assets to an extent exceeding applicable limits.

It also discusses the impact that Solvency II will have on these matters when it is implemented, focusing on the capital consequences of investment in particular types of assets. The relationship between asset portfolios and applicable capital requirements is one of the most controversial issues in the ongoing development of the Solvency II rules.

Introduction

In general, there are no restrictions on the types of assets in which UK insurers may invest. The main exception relates to the assets which cover linked business carried on by long-term insurers. In relation to that business, the policyholder benefits are linked to the value of particular assets held by the insurer. Such assets must be limited to "permitted links" (as defined in the FSA Handbook).

Nevertheless, investment in certain types of assets may have negative consequences for an insurer, affecting its position under the three regulatory pillars (Pillar 1: minimum capital requirements; Pillar 2: additional individually-determined capital requirements; Pillar 3: public disclosure). First, insurers (other than pure reinsurers) who invest in assets which are not "admissible assets", or who invest in admissible assets beyond certain asset and counterparty limits, are required to make deductions when calculating the amount of regulatory capital that they hold to meet their Pillar 1 and Pillar 2 capital requirements, and this will be reflected in their Pillar 3 disclosures. Second, inadmissible assets, and admissible assets in excess of the limits, are not eligible to cover insurance liabilities of an insurer (other than a pure reinsurer). Third, the assets held by an insurer will have a direct impact on its Pillar 2 capital requirement.

The rules that apply to participants in the Lloyd's insurance market depend on the context in which the investment is being made. UK-based assets held on behalf of a syndicate must comply with the requirements applicable to the relevant premiums trust funds (the funds into which premium income of Lloyd's syndicates is required to be paid), which are now broadly aligned with the list of admissible assets under FSA rules. Where these assets are transferred overseas to fund a regulatory deposit (for example, in respect of US surplus lines or reinsurance business), then local law investment requirements will apply.

A different set of rules applies to "funds at Lloyd's" - the assets which members of Lloyd's deposit with Lloyd's as a condition of being permitted to become or remain members of Lloyd's syndicates. These rules are in some respects narrower, and in other respects wider, than the list of admissible assets.

The Solvency II Directive[2] is due to create a new prudential regime for insurers in Europe from January 2014. When it is implemented, Solvency II will emphasise that member states may not impose specific investment restrictions on insurers, other than in certain circumstances in relation to linked business. This is subject to a specific investment restriction relating to investment in securitisations involving repackaged loans. Instead, a set of "prudent person" principles will apply to the investments that insurers may make. These principles are similar to those that already apply to pure reinsurers.

However, under Solvency II the capital requirement applicable to an insurer will be determined in part according to the assets held by that insurer, so that in theory the more risky the assets, the higher the capital requirement will be. This is similar to the manner in which the Pillar 2 capital requirement is currently determined. The exact calculation by which the relevant part of the capital requirement is determined is one of the most controversial issues in the ongoing development of the Solvency II rules.

For members of Lloyd's there is a further implication of Solvency II: because funds at Lloyd's are treated as capital, the limits that apply to "eligible own funds" will also apply to assets held as funds at Lloyd's. In particular, because letters of credit will be treated as tier two capital, they will not be permitted to constitute more than 50 per cent of the total capital of Lloyd's.

Lloyd's managing agents, Lloyd's members' agents and Lloyd's brokers are subject to rules which apply to them as individual legal entities (treated distinctly from their syndicates). These rules are not considered in this article.[3] This article also does not consider group-level implications arising from investments.[4]

Part I: UK insurers

Admissible assets and exposure limits

UK insurers, other than pure reinsurers[5], are subject to FSA rules which contain a list of "admissible assets" (contained in the FSA's General Prudential Sourcebook "GENPRU", chapter 2 Annex 7) and a list of asset and counterparty exposure limits (in the FSA's Prudential Sourcebook for Insurers "INSPRU" rule 2.1.22). With certain exceptions, there is no obligation to invest only in admissible assets or to keep exposures within applicable limits. However, where an insurer holds assets which are not admissible assets or holds admissible assets which give rise to an exposure exceeding the applicable limits, two consequences arise:

> First, the value of any inadmissible assets, or the part of the value of admissible assets in excess of the applicable limits, must be disregarded when assessing whether the

insurer has sufficient assets to cover its technical provisions[6] (INSPRU 1.1.20 and INSPRU 2.1.22(2)).

Second, the insurer must make a deduction when determining its capital resources (INSPRU 2.1.22(1)).

In extreme cases, these deductions could cause an insurer to breach the rule requiring it to ensure that its technical provisions are covered (INSPRU 1.1.20) or the rules requiring it to maintain adequate capital resources (GENPRU 1.2.26 and GENPRU 2.1.13). In any event they will reduce the buffer available to the insurer to protect it against breaches of these rules.

Admissible assets

The list of admissible assets includes bonds (referred to in the rules as "debt securities"), loans, shares, land and buildings. There is no requirement for bonds or shares to be confined to those that are dealt in on a regulated market (that is, to be listed). Certain other assets are included as admissible assets only where they meet certain conditions:

Collective investment schemes: Investments in collective investment schemes are included, but where the scheme is unregulated the insurer's investment must be sufficiently small to be consistent with a prudent overall investment strategy.[7]

Derivatives and quasi-derivatives[8]: Derivatives are included subject to conditions relating to their purpose (which must be reduction of investment risk or efficient portfolio management), the cover the insurer holds in respect of them (against future adverse variations which may affect the amount that the insurer may have to pay under them) and the ability of the insurer to value them and to close them out (see INSPRU 3.2.5).

Securities lending transactions[9]: Securities lending transactions are also included subject to conditions relating to the assets being lent (which must be admissible assets), the counterparty (which must normally be a regulated entity) and the collateral which is provided by the counterparty (see INSPRU 3.2.36).

It is possible for certain types of investment to fall within more than one category of admissible asset. For example, a credit linked note may be in the form of a bond, but it will normally also be a quasi-derivative. To address this scenario, the FSA rules require that assets be treated as falling within the three categories above even where they may also fall within another category, which means that the applicable conditions will apply.[10] It is therefore important to consider whether investments may fall within these three categories even if they are not intended to do so.

Examples of assets that are not admissible assets include works of art and commodities such as oil or gold, or derivatives based on them.

Exposure limits

Exposure limits set a limit on the degree of "exposure" arising from particular assets or particular counterparties by reason of the admissible assets that the insurer holds.

The "counterparty exposure" arising from an asset is the amount that the insurer would lose if a counterparty were to default (INSPRU 2.1.9(1)). The "asset exposure" arising from an asset is the amount that the insurer would lose if an asset were to become worthless (INSPRU 2.1.9(2)).

Often the exposure will be equal to the value of the asset or the claim against the counterparty, but this will not always be the case. For example, where the insurer holds collateral or benefits from a guarantee given by a third party, it may not suffer any loss unless the value of the collateral or the availability of the guarantee is also affected. In these circumstances, the insurer could therefore regard itself as having an exposure to the collateral or the guarantor rather than to the original asset or counterparty (see INSPRU 2.1.9(5), 2.1.35 and 2.1.36).

The key exposure limits are defined by reference to the insurer's "business amount", which is the amount of the insurer's technical provisions, other liabilities and capital resources. The limits vary according to the identity of the counterparty, the relationship of the firm to the counterparty and the nature of the asset.[11]

Certain assets are not subject to any limits. These include UCITS collective investment schemes and approved securities (see INSPRU 2.1.33). Approved securities are securities of Zone A countries[12] (such as UK gilts) or certain specified central banks.

One potential pitfall for insurers is the definition of "collective investment scheme" which excludes schemes in which the operator (the manager) is in the same corporate group as all of the participants.[13] This provision often results in schemes being structured with some element of third party investment to ensure that they will be treated as collective investment schemes.

Currency and localisation

With certain exceptions:

(a) INSPRU 3.1.53 requires that an insurer (other than a pure reinsurer) must hold assets in each currency of an amount equal to at least 80 per cent of the amount of its liabilities in that currency; and

(b) INSPRU 1.1.30 requires that the currency-matching assets required by INSPRU 3.1.53 must be held in any EEA State or in the country of the relevant currency (this is referred to as a "localisation" requirement).

Qualitative requirements

In addition to the specific requirements described above, UK insurers (other than pure reinsurers) are subject to certain qualitative requirements relating to their investments. In

particular, INSPRU 1.1.34 imposes requirements relating to safety, yield, marketability, diversity and spread, sufficiency, currency, and term.

With-profits funds

Insurers who carry on with-profits business (that is, insurance business in which policyholders are eligible to participate in the profits of the insurer as part of their policy benefits, normally in the form of discretionary bonuses) are required by the FSA's Conduct of Business Sourcebook ("COBS") to produce a document referred to as the Principles and Practices of Financial Management (referred to as a "PPFM").[14] The PPFM sets out how the insurer will manage its with-profits funds. Insurers are required to report annually to with-profits policyholders on the extent to which they have complied with the PPFM[15], and are subject to limitations when making amendments to the PPFM.[16]

The PPFM must include details of the investment management strategy that the insurer intends to apply to each with-profits fund.[17] Although this does not create a binding obligation to follow this investment management strategy, an insurer who deviates significantly from it without good reason may be considered to have treated its customers unfairly, in breach of Principle 6 of the FSA's Principles for Business.

With-profits insurers who have more than £500 million of with-profits liabilities (known as "realistic basis life firms") are required to calculate an additional component of their Pillar 1 capital requirement.[18] This component is known as the "with-profits insurance capital component" or "WPICC". The calculation of the WPICC involves a number of factors, including the "risk capital margin" which is determined based on how the value of the insurer's assets and liabilities would change in a number of future scenarios. These scenarios include specific scenarios affecting the market risk arising from UK and non-UK equities, real estate and fixed interest securities, and the credit risk arising from bonds, debts and derivatives.[19]

Life insurers with less than £500 million of with-profits liabilities

Life insurers which do not carry on with-profits business or which have less than £500 million of with-profits liabilities are known as "regulatory basis only life firms". They are required to calculate an additional component of their Pillar 1 capital requirement. This component is known as the "resilience capital requirement". Like the risk capital margin that forms part of the WPICC calculation for realistic basis life firms, it is calculated on the basis of how the value of the insurer's assets and liabilities would change in a number of future scenarios.[20] These scenarios are similar to, but not as complex as, the scenarios that apply for purposes of the risk capital margin.

Discounting liabilities

When calculating the present value of their insurance liabilities, long-term insurers are permitted to use a discount rate calculated by reference to the risk-adjusted yield that is expected to be achieved on their assets.[21] By holding assets with a higher risk-adjusted

yield, a higher discount rate can be used, meaning that the present value of the insurance liabilities will be lower. The risk-adjusted yield is therefore an important factor relevant to the selection of assets by long-term insurers.[22]

Pure reinsurers

It was noted above that the rules relating to admissible assets, exposure limits and currency matching and localisation, and the qualitative requirements of INSPRU 1.1.34, do not apply to pure reinsurers (that is, insurers who carry on only reinsurance business, and are not permitted to write any direct business).

Pure reinsurers are subject to a set of requirements relating to the way in which they invest their assets (see INSPRU 3.1.61A). These requirements do not include a list of assets or any quantitative limits, but instead impose qualitative requirements relating to sufficiency, liquidity, security, quality, profitability, matching, diversity and spread, and prudence, and the avoidance of excessive reliance on particular assets and counterparties.

Permitted links[23]

Under certain types of insurance policies, referred to as "linked" policies, the value of the benefits is linked to the value of assets identified in the policy. The assets may be specifically identified, but often they are the assets held by an insurer from time to time in one of its own internal funds (referred to as a "linked fund").

The assets to which the policy benefits are linked are required to be limited to the list of "permitted links" set out in COBS 21.3. This means that the insurer must ensure that the assets in a linked fund are limited to the permitted links, and there will be an automatic breach of an FSA rule if the insurer holds an asset that is not a permitted link in a linked fund.[24]

The main differences between the list of permitted links and the list of admissible assets is that the conditions that investments must satisfy in order to be included as permitted links are generally stricter. In particular:

(a) unlisted bonds and unlisted shares must be "realisable in the short term";

(b) land and property must be located in a territory with a properly functioning market, and are subject to a limit on borrowing;

(c) investments in unregulated collective investment schemes must be limited to collective investment schemes which invest only in assets that are permitted links[25], and are subject to a limit of 20 per cent of the gross assets of the linked fund in which they are held; and

(d) stock lending transactions must relate to assets that are permitted links.

The conditions applicable to derivatives are also different, though in certain respects they are more liberal than the conditions that must be satisfied for a derivative to be an admissible asset.[26]

Pillar 2 capital requirement

In addition to the ordinary capital resources requirement (the "CRR", also known as the "Pillar 1 capital requirement"), UK insurers are required by GENPRU 1.2.26 to satisfy a Pillar 2 capital requirement. To determine its Pillar 2 capital requirement, the insurer must produce an individual capital assessment (an "ICA") showing its assessment of the amount of capital that it would need to hold in order to remain solvent over a one year period with a probability of 99.5 per cent.[27] The FSA will then review the ICA and, if it thinks appropriate, give individual capital guidance ("ICG") to indicate any additional amount of capital that should be held.

For the most part, the ICA must be determined by use of a computer model, in accordance with guidance set out in INSPRU 7. However, as a benchmark for the ICA, UK insurers carrying on general insurance business must calculate an enhanced capital requirement (the "ECR"), one of the components of which is an "asset-related capital requirement".[28] Under INSPRU 2.2.11, the asset-related capital requirement is determined by applying capital charge factors to each of the insurer's admissible assets (though not to any part of the value exceeding the applicable counterparty and asset exposure limits).

The capital charge factors differ according to the perceived riskiness of each asset. For example, cash deposits with banks have a 0 per cent charge factor, bonds have a 3.5 per cent charge factor, land and buildings have a 7.5 per cent charge factor, and shares and investments in collective investment schemes have a charge factor of 16 per cent.[29] Where higher charge factors apply, the ECR will be higher and it is likely (though not certain) that the Pillar 2 Capital Requirement will therefore also be higher.

Part II: Lloyd's participants

Syndicate assets held in premiums trust funds

In the Lloyd's insurance market, managing agents are required to maintain premiums trust funds on behalf of the syndicates that they manage. These are the funds into which premiums are paid and out of which claims are paid. While assets are held in premiums trust funds, they are subject to investment in accordance with the applicable premiums trust deeds.

The premiums trust deed permits investment in any asset with the exception of five categories of "Excepted Investment" (contracts of insurance, rights under a stakeholder pension scheme, Lloyd's syndicate capacity, funeral plan contracts and regulated mortgage contracts). However, under INSPRU 2.1.42, the requirements of INSPRU 1.1.20 and INSPRU 2.1.22, discussed above in relation to UK insurers, also apply to Lloyd's syndicates. Two results follow:

> *Covering technical provisions*: Managing agents must ensure that the technical provisions of each year of account[30] of the syndicate are covered by admissible

assets which do not exceed the counterparty and asset exposure limits, with the limits applied as percentages of the syndicate admissible assets (rather than the business amount).[31]

Capital deduction applicable to syndicate: In determining the capital resources of a syndicate, managing agents must make a deduction of the value of inadmissible assets of the syndicate and of the part of the value of admissible assets that are held in excess of counterparty and asset exposure limits, with the limits applied as percentages of the admissible assets of the syndicate.[32]

Managing agents must produce an annual syndicate ICA in order to determine the amount of capital that is required in order for the syndicate to be able to meet all of its liabilities over a one year period with a probability of 99.5 per cent. Among other risks, this will reflect the market risk and counterparty risk arising from the assets of the syndicate. The syndicate ICA is produced by running a computer model, but Lloyd's has specified some example stress tests intended to support the conclusions of the ICA, which include the following[33]:

Test for shares: 50% fall in the value of shares

Test for bonds: 3% increase in interest rates (which would reduce the value of bonds)

Test for currency risk: 40% adverse major settlement currency move

Syndicate assets transferred to fund overseas business regulatory deposits

In relation to certain business written by a Lloyd's syndicate, it will be necessary for syndicate assets to be transferred to an overseas trust fund as an "overseas business regulatory deposit". The best known examples of such trust funds are those established in New York in respect of US reinsurance business (the "credit for reinsurance trust fund" or "CRTF") and US excess or surplus lines business (the "surplus lines trust fund" or "SLTF"). Assets transferred to these trust funds are held subject to trust deeds which require that the assets only be invested in assets which are "of a kind permitted under the insurance laws of the State of New York, or of other United States jurisdictions with substantially similar laws, in effect from time to time"[34], so it is necessary to consider New York law requirements.[35] Recent legislative reform in New York and Florida now permits Lloyd's syndicates to satisfy credit for reinsurance requirements in those states by deposits in separate trust funds which only need to be funded as to 20 per cent of gross liabilities, rather than 100 per cent.[36]

Similar trust deeds exist for assets held in respect of Australian, Canadian and South African business. In each case it is necessary to comply with the local legal and regulatory requirements regarding the permitted investments.

Funds at Lloyd's

As a condition of becoming or continuing as a member of a Lloyd's syndicate, a member is required to deposit assets with Lloyd's, known as funds at Lloyd's.[37] Funds at Lloyd's

may only be invested in a list of "acceptable assets" which is set out in Appendix 3 to the Lloyd's Membership and Underwriting Conditions and Requirements (Funds at Lloyd's).

The list of acceptable assets includes listed shares and listed bonds (but not unlisted shares or unlisted bonds) and certain other types of money and capital market instruments (subject to currency and rating conditions). Investments in collective investment schemes are permitted subject to the same conditions that apply to UK insurers, described above. The only type of derivatives that are permitted are forward currency contracts.

A key difference between the list of acceptable assets for funds at Lloyd's and the list of admissible assets for UK insurers is the inclusion of letters of credit and guarantees. A member of Lloyd's may arrange for a bank[38] to issue a letter of credit or guarantee in favour of Lloyd's, and thereby keep its own assets outside Lloyd's for investment free of the acceptable assets restrictions. Members of Lloyd's make significant use of this facility.[39]

Assets held as part of a member's funds at Lloyd's are not permitted to exceed the counterparty and asset exposure limits that apply to UK insurers, as described above, with the limits applied as percentages of the funds at Lloyd's of the member. The same exclusions from the limits apply to funds at Lloyd's as apply to UK insurers.[40] Letters of credit and guarantees are excluded from the limits at individual level, but Lloyd's is required to ensure that the total amount of letters of credit and guarantees issued by any one bank as funds at Lloyd's of all members do not exceed 20 per cent of the total funds at Lloyd's.[41]

Where a member is a member of a single syndicate and is the sole member of that syndicate, and is in the same corporate group as the managing agent of the syndicate, it is permitted to hold its funds at Lloyd's in its premiums trust funds rather than as a separate deposit with Lloyd's.[42] This arrangement is known at Lloyd's as "funds in syndicates". This arrangement has the advantage that the assets can then be invested according to the requirements applicable to premiums trust funds rather than the acceptable asset requirements. A disadvantage of this approach is that letters of credit and guarantees cannot be held in premiums trust funds.

Part III: Solvency II

Removal of investment requirements

When it is implemented[43], Solvency II will prohibit member states from requiring insurers to limit their investment to particular types of assets.[44] It appears that this will also prevent them from imposing specific investment limits or consequences for investment in particular types of assets, although the European Commission will have power to lay down quantitative limits and asset eligibility criteria other than in

relation to linked business.[45] In addition, member states will not be permitted to impose localisation requirements requiring insurers to hold investments in the EU to cover insurance risks in the EU.[46]

An exception applies in relation to linked long-term business where natural persons bear the investment risk. In this case, member states will retain the discretion to impose restrictions on the types of assets to which policy benefits may be linked.[47] The FSA has indicated that it intends to use this discretion.[48] In addition, the Solvency II Directive imposes restrictions on investment in securities or instruments issued after 1 January 2011 which arise from the "repackaging" of loans.[49]

Instead of imposing specific investment requirements, member states will have to require their insurers to invest in accordance with the "prudent person" principles set out in article 132 of the Solvency II Directive. These principles include:

Risk assessment: The insurer must be able to identify, measure, monitor, control, report on and take into account the risks arising from the investments.

Quality: The investments must ensure the security, quality, liquidity and profitability of the portfolio as a whole, and be localised so as to ensure that they are available.

Matching: Assets which cover technical provisions must be invested in a manner appropriate to the nature and duration of the corresponding liabilities.

Best interest of policyholders: Assets which cover technical provisions must be invested in the best interest of policyholders and beneficiaries. This principle is potentially ambiguous and may be the cause of future dispute where an insurer wishes to increase the riskiness of its investment profile.

Derivatives: Derivatives must be used only for reduction of risks[50] or efficient portfolio management.

Unlisted assets: Investment in unlisted assets must be kept to prudent levels.

Diversification: Assets will have to be properly diversified to avoid excessive reliance on particular assets, issues, groups or geographical areas, or excessive risk concentration. Therefore, although the hard localisation requirements for assets covering EU risks will be abolished, the location in which assets are held will nevertheless remain relevant.

Capital consequences

Much like the approach that applies in the UK for purposes of determining the Pillar 2 capital requirement, Solvency II will impose a capital requirement (referred to as the "solvency capital requirement" or "SCR") which will depend on a determination of the amount of capital that an insurer would need to hold in order to remain solvent over a one year period with a probability of 99.5 per cent.[51] This will be calculated by a computer, either by applying a standard formula prescribed by an EU regulation to be made in accordance with Solvency II or by applying an internal model approved by the insurer's regulator.

Whether the SCR is calculated by the standard formula or by an internal model, it is intended to be risk sensitive, so that it will be higher if the insurer's investment portfolio exposes it to a greater amount of market or counterparty risk. The calibration of the standard formula and internal models are still being developed. The calibration of the capital charges that will apply to different types of assets in the standard formula is one of the most controversial issues arising from Solvency II.

Possible calibrations under consideration include charges of 39 per cent for listed equities, 49 per cent for unlisted equities and 25 per cent for property. For bonds, a charge based on rating and duration which would, for example, assign a charge of 14 per cent to an A-rated bond with a duration of 10 years and a charge of 45% to a B-rated bond with a duration of 6 years.[52] Holdings in collective investment schemes would be treated on a "look-through" basis, meaning that the capital requirements resulting from investment in a scheme would be determined by reference to the assets held in the scheme, as though held directly by the insurer to the extent of its investment in the scheme. Although a direct comparison is somewhat misleading, it is notable how much higher these charge factors are than those used by the FSA as described above.[53]

Impact on Lloyd's

The changes made by Solvency II will apply equally to Lloyd's participants. As a result, investment requirements will generally be removed and capital consequences will be imposed based on the market and counterparty risk arising from assets held by syndicates and as funds at Lloyd's. Capital requirements at Lloyd's are expected to be determined using a Lloyd's internal model which will incorporate information provided by syndicate models operated by managing agents.

Solvency II will have the effect of imposing a new limit in relation to funds at Lloyd's. Funds at Lloyd's are treated as capital of members of Lloyd's and so will constitute "own funds" for purposes of Solvency II. Currently, no limit applies to the aggregate amount of letters of credit that members of Lloyd's may include in their funds at Lloyd's. However, under Solvency II, letters of credit and guarantees will be treated as "tier 2" capital, which means that they, taken together with Lloyd's other tier 2 capital, will not be permitted to constitute more than 50 per cent of the total capital of Lloyd's. This may mean that Lloyd's is required to introduce a limit on the amount of funds at Lloyd's which may be provided by way of letter of credit.[54]

Endnotes

[1] Steven specialises in financial regulation, with a particular focus on insurance and the Lloyd's insurance market. In addition to advisory and transactional work, he speaks regularly at conferences and has written published articles on a number of topics, including Solvency II. He is a contributing author to A Practitioner's Guide to the Regulation of Insurance (ed. John Young, 4th edition, Sweet and Maxwell, 2011). This article covers much of the same material as

a BILA lunchtime lecture given by the author on 17 February 2012. The slides presented at the lecture are available on the members section of the BILA website http://www.bila.org.uk/closed/cug/lecture_scripts.asp (log in and password required).

[2] EU Directive 2009/138/EC (the "Solvency II Directive").

[3] The financial resource requirements of Lloyd's managing agents and members' agents are set out in Lloyd's Capital and Solvency Requirements 2003 (attached to Lloyd's Market Bulletin Y3086, 30 June 2003). These contain requirements to make deductions from net assets in respect of certain types of investments. For example, 50 per cent of the amount of any unlisted investment is required to be deducted. Lloyd's brokers are required to comply with the FSA's Prudential Sourcebook for Mortgage and Home Finance Firms, and Insurance Intermediaries ("MIPRU").

[4] Special rules apply to the valuation of shares in and debts due from "regulated related undertakings": GENPRU 1.3.43. In addition, insurers are required to calculate their group capital position both in respect of the Pillar 1 and the Pillar 2 capital position: INSPRU 6 and GENPRU 1.2.45.

[5] A "pure reinsurer" is an insurer whose only business consists of reinsurance business. It is not permitted to write any direct insurance business.

[6] Broadly, "technical provisions" are the insurer's liabilities arising from its insurance contracts, such as outstanding claims provisions.

[7] See endnote 10 below.

[8] A quasi-derivative is an investment which has the effect of a derivative, such as a credit-linked note.

[9] A securities lending transaction is a transaction in which the insurer transfers shares or bonds to a counterparty subject to a requirement of the counterparty to return equivalent shares or bonds on a future date or, in some cases, on demand.

[10] GENPRU 2 Annex 7, paragraphs (2) and (3).

[11] The limits include the following:

Counterparty exposures to an individual or group of closely related individuals:

0.25 per cent of the business amount for the part of the exposure arising from unsecured debt, and 1 per cent for the whole exposure.

Counterparty exposures to "approved counterparties" or groups of closely related approved counterparties:

5 per cent for the part of the exposure not arising from covered bonds or short-term deposits, and 20 per cent for the whole exposure other than from covered bonds. 40 per cent for the part of the exposure arising from covered bonds.

(An approved counterparty is, broadly, an insurer, bank or investment firm regulated in the EEA. A covered bond is a special type of bond issued by a bank which, under applicable law, confers priority rights to certain assets of the bank. The 5 per cent can be increased to 10 per cent where the total of the exposures exceeding 5 per cent (to different approved counterparties and groups) is less than 40 per cent.)

Counterparty exposures to other persons (mainly companies) or groups of closely related persons: 1 per cent for the part of the exposure arising from unsecured debt. 1 per cent for shares and bonds that are not dealt in on a regulated market (i.e. they are not listed). 5 per cent for the whole exposure (including listed shares and bonds).

Asset exposure to unsecured debt of persons other than individuals and approved counterparties:

5 per cent: this applies on an aggregate basis, irrespective of whether the persons are closely related.

Asset exposure to unlisted shares and unlisted bonds:

10 per cent: this applies on an aggregate basis, irrespective of whether the persons are closely related.

Asset exposure to a piece of land or building:

10 per cent, but where two or more pieces of land or buildings are close enough to be considered effectively one investment then they will be subject to an aggregate 10 per cent limit.

Asset exposure to collective investment schemes:

UCITS: no limit. Non-UCITS retail scheme: 5 per cent. Other collective investment schemes: 1 per cent. (See also the admissibility requirement that the investment must be sufficiently small to be consistent with a prudent overall investment strategy (GENPRU 2 Annex 7, para (1)(A)(d)(iv)). In practice, it is likely that this requirement would be treated as an additional asset limit, so that the excess above the limit would be deducted from capital and ineligible to cover technical provisions, though a strict interpretation of the rules would result in the whole investment being deducted and ineligible.)

[12] A "Zone A country" is a country which is a member of the EEA or which is a full member of the OECD.

[13] Financial Services and Markets Act 2000 (Collective Investment Schemes) Order 2001, Schedule, paragraph 10.

[14] COBS 20.3.1.

[15] COBS 20.4.7.

[16] COBS 20.3.1(4) and (5).

[17] COBS 20.3.6(2).

[18] GENPRU 2.1.18 and GENPRU 2.1.19.

[19] INSPRU 1.3.44 et seq.

[20] INSPRU 3.1.9 et seq.

[21] INSPRU 3.1.28.

[22] In certain circumstances, general insurers are also permitted to apply discount rates in determining the present value of their liabilities. However, with certain exceptions, such as where a claim is required to be paid in the form of an annuity, any benefit of discounting is nullified by a requirement to make a deduction from capital resources of the difference between the discounted and undiscounted liabilities: GENPRU 2.2.107.

[23] This article only considers linked business where the link is to assets. Linked business can also consist in benefits which are linked to an index, in which case the index must be an "approved index" (as defined in the FSA Handbook).

[24] In this respect it differs from the rules relating to admissible assets and exposure limits, where holding assets which are inadmissible or exceed the limits may not necessarily result in the breach of any FSA rule.

[25] This requirement can be problematic where the investment fund is not established specifically for investment by insurers and is therefore not operated by reference to insurance requirements.

[26] For example, in relation to whether they are held for purposes of "efficient portfolio management" (see INSPRU 3.2.6).

[27] INSPRU 7.1.42.

[28] INSPRU 1.1.72B and INSPRU 1.1.72C.

[29] INSPRU 2.2.16.

[30] INSPRU 8.1.5.

[31] INSPRU 2.1.47.

[32] INSPRU 2.1.47.

[33] See Lloyd's Market Bulletin Y4256, dated 24 March 2009, attaching the 2010 ICA Minimum Standards and Guidance, which remain in force (see Lloyd's Market Bulletin Y4467, dated 2 February 2011).

[34] See paragraph 2.6 of each of the standard form US Credit for Reinsurance Trust Deed and the standard form US Excess of Surplus Lines Trust Deed.

[35] See 11 NYCRR 125 (Official Compilation of Codes, Rules and Regulation of the State of New York, Title 11, Part 125).

[36] See Lloyd's Market Bulletins Y4511, dated 19 August 2011 (New York), and Y4524, dated 7 October 2011 (Florida).

[37] Lloyd's Membership Byelaw (No. 5 of 2005), paragraph 16, and Lloyd's Membership and Underwriting Conditions and Requirements (Funds at Lloyd's), paragraph 4.

[38] Normally the letter of credit or guarantee is issued by a bank, but it can also be issued by a building society or (in theory) a life insurance company. The bank must be approved by Lloyd's for the purposes of issuing letters of credit as funds at Lloyd's.

[39] See Lloyd's Interim Report 2011, which indicates that, as at 30 June 2011, £7,127m out of a total of £14,470m of funds at Lloyd's (just under half of the total amount) was provided by way of letters of credit and bank guarantees.

[40] See above. The exclusions include UCITS collective investment schemes and approved securities.

[41] INSPRU 2.1.46(2).

[42] See Lloyd's Market Bulletin Y3946, 11 January 2007.

[43] It is currently expected that insurers will become required to comply with the requirements of Solvency II with effect from 1 January 2014.

[44] Solvency II Directive, article 133.

[45] Solvency II Directive, article 111(2).

[46] Solvency II Directive, article 134(1).

[47] Solvency II Directive, article 133(3).

[48] FSA Consultation Paper 11/23, November 2011.

[49] Solvency II Directive, article 135(2). For example, insurers will not be permitted to invest in the securities if the originator has not retained a net economic interest of at least 5 per cent.

[50] Note that the "reduction of risks" is wider than the corresponding current requirement which refers to "reduction of investment risks" (see Directive 92/49/EEC, article 21 and INSPRU 3.2.5).

[51] Solvency II Directive, article 101(3).

[52] See the technical specifications of Quantitative Impact Study 5 published by the European Commission, dated 5 July 2010.

[53] See endnote 28 above.

[54] See Lloyd's Interim Report 2011, which indicates that, as at 30 June 2011, Lloyd's capital included £7,127m of funds at Lloyd's and £932m of subordinated debt, all of which would be treated as tier 2 capital under Solvency II. Lloyd's had £9,298m of other capital. Assuming all of this other capital will be treated as tier 1 capital under Solvency II, the current ratio of tier 2 capital for Solvency II purposes would be approximately 46 per cent, which is close to the 50 per cent limit for tier 2 capital that will apply under Solvency II.

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"Microinsurance - the challenge for law and regulation"

by Jonathan Teacher[1]

The potential market for insurance in developing economies is an estimated 1.5 to 3 billion policies with between 3 and 4 billion insureds.[2] Many insurers view opportunities for growth in their core mature markets as constrained. So it is no surprise that an increasing number of key industry participants are moving into the microinsurance sector as part of their investment in developing economies to drive their future growth.

Incentives to enter the microinsurance market are both philanthropic and commercial. They include its potential size; the significant prospects for growth; and early mover advantages in establishing brand trust and loyalty with a view to future upselling as policyholders become more financially literate and incomes rise. Impetus is also provided by regulators in jurisdictions such as China and India. They are making the grant to international insurers of some new insurance licences, or extensions to existing ones, conditional on a commitment to allocating a percentage (typically, 30%) of the new capacity to a microinsurance offering or specific microinsurance projects.

This article examines some of the key legal and regulatory issues and tensions which commonly arise for insurers engaging in the microinsurance market.

What is microinsurance?

Microinsurance is a term of art. It is used to refer to several different types of arrangement. These encompass assistance programmes sponsored by government and non-governmental organisations, mutual and self-help organisations and insurance products provided by commercial insurers. The unifying characteristic of microinsurance products is that they are simple insurance or alternative protection mechanisms designed for low income markets. Microinsurance products are characterised by low premiums and low coverage values.

It is generally accepted that a key strategy for enhancing economic development is to make financial systems more inclusive. In countries where state funded social protection is absent and individual access to cover from commercial insurers is limited, many informal "insurance" schemes have emerged which operate in the legal gaps escaping regulation. Examples of informal schemes include:

- microfinance institutions which routinely provide insurance to their customers on a "self-insurance" basis;
- community self-help groups which establish informal mutual arrangements (which may be discretionary and not provide a legally enforceable right of indemnity); and
- healthcare facilities which allow free or discounted access to medical care or medicine in exchange for regular payments (which are treated as a pre-payment for services).

English law and microinsurance: what is an insurance contract?

In the context of microinsurance, the issue of what constitutes a contract of insurance as a matter of law is often important. It can determine whether the provider of the protection needs to be a licensed insurer. The issue is also relevant to determining the legal rights of the policyholder or protection buyer. This applies particularly in jurisdictions where the rights, obligations and duties of the insurer and the insured in respect of a contract of insurance are different from their respective positions under general contract law. Whether a particular product is to be regarded as one of insurance will be a matter of applicable law and regulation (according to the purpose for which the characterisation of the contract is required).

There is no absolute definition of a contract of insurance as a matter of English law. It is, however, widely accepted that the description provided by Mr. Justice Channell in *Prudential Insurance v Inland Revenue Commissioners*,[3] together with a number of subsequent cases, forms the basis of a reasonable description of the principal fundamental characteristics of a contract of insurance. In summary, those characteristics require a transfer of risk in relation to which:

1. in return for some consideration to the provider;
2. the assured obtains a right to a benefit (which may be the payment of money or money's worth, for example a corresponding benefit such as a service);
3. upon the occurrence of an event;
4. where the event involves some uncertainty as to whether it will occur and/or when it will occur; and
5. the occurrence of the event would be adverse to the interests of the assured.

Lord Justice Buckley in the later case of *Gould v. Curtis*[4] added an important qualification. For contracts of contingency insurance, as distinct from indemnity insurance, there is no requirement for the assured to sustain a loss on the occurrence of the insured event. A further qualification to the indemnity principle underlying contracts of insurance exists in the form of so-called "valued policies". Their statutory basis arises under the Marine Insurance Act 1906[5] although they are also supported by the common law. In a valued policy, the parties to the contract of insurance determine the value of loss to be paid on the occurrence of the uncertain event when entering the contract. The assured is entitled to receive the agreed value if the insured event occurs irrespective of his actual loss. This is provided that the agreed value was a genuine pre-estimate of the potential loss and there was no misrepresentation as to the amount the assured stood to lose if the insured peril occurred.

The criterion that a contract of insurance requires consideration can present difficulties in the context of microinsurance. Insurers and distributors seeking to find innovative channels to penetrate their target markets are developing partnerships with suppliers of goods and services to provide bundled benefits, for example:

- mobile network airtime contracts which incorporate life assurance; or
- agricultural seed and fertilizer sales which incorporate crop failure insurance,

without any additional cost or premium being charged to the purchaser for the cover. In one notable instance where life assurance is provided ancillary to the purchase of airtime (described further below under the heading "Distribution"), the sum assured varies with the quantity of airtime used in the previous month.

Consideration is generally a requirement of any contract in English law, including a contract of insurance. In a case where no separate premium is added or charged to the mobile airtime purchaser, there is an open question whether the courts will find consideration for the insurance element of the transaction by apportioning the payment for the airtime. Alternatively a court may determine that an airtime contract which includes an ancillary right to receive a sum on the airtime purchaser's death is not one of insurance. Where a third party insurer provides the cover, consideration will almost certainly be provided by the seller of the goods or services. In either case, the regulatory position needs careful consideration. Additionally, from an English law perspective the recent decisions of the Court of Appeal in *Sibthorpe and another v London Borough of Southwark*[6] and *Digital Satellite Warranty Cover Limited v Financial Services Authority*[7] are relevant to the determination of whether the presence of some element of insurance in a contract for goods or services requires the entire contract to be characterised as one of insurance. A critique of those decisions and the arguments made is beyond the scope of this article. For present purposes, it is relevant that the Court of Appeal in *Sibthorpe*[8] upheld the decision of Mr. Justice MacDuff which applied the "principal object" test proposed by *MacGillivray on Insurance Law*[9] that:

> "The inclusion of indemnity provisions within a contract for the supply of services neither makes the indemnifier an insurer nor justifies describing the contract as wholly or partly one of insurance. Where a contract of sale or for services contains elements of insurance it will be regarded as a contract of insurance only if, taking the contract as a whole, it can be said to have as its principal object the provision of insurance."

By contrast, the first instance decision of Mr. Justice Warren in *Digital Satellite*[10] is more equivocal. Warren J suggested that the test for determining whether a contract which contains both insurance and non-insurance elements should be characterised as one of insurance is potentially different from the test for determining the class or classes of insurance into which the contract falls. The classification of insurance contracts in the United Kingdom is based on the list of classes set out in Schedule 1 of the Financial Services and Markets Act 2000 (Regulated Activities) Order 2001. Some contracts may provide cover which falls within more than one of those classes of insurance. In relation to the first issue, Warren J held that:

> "The "principal object" test may or may not be the appropriate test when it comes to deciding whether elements of insurance bring a contract containing both insurance and non-insurance elements within the concept of a contract of insurance. But even assuming that it is, it may not, in reality, differ much from the approach of the FSA. The "principal object" test cannot require, in every case, that a single principal object be identified. A contract may have two important elements, albeit that one is more significant than the other but it would not be right to categorise the nature of the contract by reference only to the more important element. What the "principal object" test is surely getting at is that there is to be found a principal object where the other elements are either "ancillary" or "minor" … to a main objective of providing cover in the case of breakdown or malfunction or, to use other words, where those elements are "integral with" or "subsidiary to" a main object."

For the second issue, Warren J considered the "identifiable and distinct obligation" test advanced by the Financial Services Authority (FSA) is appropriate. That test is set out in the FSA's Perimeter Guidance Manual[11]. This requires the identification of each different discrete element of a contract of insurance. However, Warren J also held that:

> "When it comes to determining whether a contract which contains both insurance and non-insurance elements is a contract of insurance requiring the insurer to be authorised, a strict application of [the identifiable and distinct obligation test] could result, as is pointed out in MacGillivray, in contracts of insurance being found where the insurance element is insubstantial. It may or may not be right to go that far. I rather doubt that it is, especially given the acceptance by the FSA that an ordinary manufacturer's warranty provided as part of a sale agreement does not give rise to a contract of insurance. Further Part C of the Annex to the [European] First [Non-Life Insurance] Directive makes express provision for certain ancillary risks. So, it seems to me at least, the FSA's statement in the Perimeter Guidance has to be tempered to some extent."

The Court of Appeal in *Digital Satellite*[12] noted the position taken by Warren J at first instance. It did not, however, find it necessary to give any further clarity on the applicable test since it was able to determine the appeal on a different basis.[13]

The principal object test may prove helpful to the development of microinsurance where cover is provided as an integrated ancillary element in the sale of goods and services, if such a contract is not one of insurance or, at least, will not be regulated as one. There is a risk that less scrupulous providers may seek to take advantage of such arrangements. As recent issues with mis-selling of bundled insurance in the United Kingdom demonstrate, providers should be concerned to ensure the suitability of any such bundled insurance product, especially where the price of the service or goods is higher because insurance is included.

Two further elements required of a contract of insurance and relevant to the development of microinsurance arise from the decision in *Medical Defence Union Ltd v Department of Trade.*[14] The judgment of Sir Robert Megarry, the Vice-Chancellor, found that to be insurance, the insurer must be under an obligation to provide the contracted benefit if an insured peril occurs. The benefit must be money, money's worth or the provision of services to be paid for by the insurer (the last element arising from the judgment of Mr. Justice Templeman in *Department of Trade and Industry v St Christopher Motorists' Association Ltd*).[15] Where the provision of the benefit under a contract is entirely at the provider's discretion, the contract will generally not be one of insurance.

In his judgment, Megarry V-C distinguished a legitimate expectation of receiving discretionary benefits and of that discretion being exercised in a proper way from a contractual right to receive those benefits. Many of the mutuals and community self-help groups active in the informal microinsurance sector operate on a discretionary basis. An example of this type of organisation is presented by the informal burial societies which operate in South Africa (amongst other places). They can be of significant size whilst operating outside of insurance regulation. It is estimated that these burial societies provide unregulated plans to some 8 million members contributing in excess of US$1 billion per annum in member contributions.

Partly in response to concerns about appropriate consumer protection and the promotion of financial inclusion policy objectives, the South African National Treasury has produced a policy document entitled "The South African Microinsurance Regulatory Framework". If the policy proposals are enacted, a friendly society (i.e. a species of mutual) would be required to register under the South African Co-operatives Act as either a financial service co-operative or a co-operative burial society. Interestingly, co-operatives which do not guarantee member benefits (i.e. operate a discretionary model) will not be considered insurance providers. They will not be required to obtain a microinsurance licence to continue their activities, although if they wish to provide insurance they would have the option to register under South Africa's proposed Microinsurance Act.

Law and regulation

The above analysis is concerned with what constitutes a contract of insurance as a matter of English law. There is commonly some tension between what the law regards as a contract of insurance and the contracts of insurance whose underwriting, sale and performance are regulated (that is, are within the scope of the regulatory perimeter). By way of example, a contract for breakdown and recovery services with a motoring organisation in the United Kingdom may be characterised as a contract of insurance as a matter of English law. It is, however, exempted[16] from regulation where it satisfies certain criteria. These include the requirements that the service provider carries on no other insurance business; that cover must be limited to the United Kingdom and Ireland (absent

the payment of additional premium); and the contract must be limited to the provision of benefits in kind in the event of a vehicle breakdown or an accident.

The ambit of insurance regulation naturally varies between jurisdictions. In some countries, as noted above, quite significant schemes operate outside the ambit of regulation. Advantages of operating outside the regulated arena include lower entry barriers and a lower cost of business. Typically there is no minimum capital requirement, no requirement to hold a solvency buffer, and no minimum standards of governance or systems and controls. There are also no (or lower) requirements for compliance with regulatory, information and sales standards (although there may be applicable general consumer and data protection legislation in the jurisdiction). Consequently, providers of unregulated microinsurance are generally subject to lower supervisory, capital, sales, administrative and training costs. These factors enable them to offer cheaper and more innovative products which may not be permitted under regulatory controls.

Unregulated schemes present some serious drawbacks too. Principally, consumers are not protected from the risk of mis-selling and insolvency and, in reality, have little recourse if a provider fails to adhere to its promises. Such schemes do not have direct access to reinsurance because they are not technically insurance. They can, therefore be more vulnerable to the occurrence of catastrophic events against which it is difficult for them to acquire protection. Concerns with the unregulated sector are growing. Some unregulated microfinance institutions have required customers to purchase unnecessary microinsurance products at inflated premium. All of these factors detrimentally affect the reputation of the market and increase the difficulty for insurers to justify the allocation of resources for significant development of their microinsurance offering.

Consequently, the regulation of nascent microinsurance markets is critical to ensuring stable and sustainable growth and developing confidence in the industry for both customers and incoming insurers.

Regulating microinsurance

In many developing economies, insurance regulations were developed with the higher value commercial and retail insurance market in mind. Local regulators have understandably focussed their constrained resources on larger regulated (re)insurers which generally pose more significant risks to the local financial system. Such regulatory systems are generally not appropriate for microinsurance. Several key factors are changing this landscape. Critically, governments and regulators are gradually recognising that a "one size fits all" approach does not allow microinsurance providers to enter the regulated market. The barriers and ongoing costs (which may include substantial capital requirements, significant demands for key management and complex reporting obligations) can generally not be surmounted by local unregulated microinsurance providers. At the same time the regulatory burden can make investment by international insurers economically unattractive or unviable (given their other expenses of developing a local microinsurance offering).

It has also been recognised that regulatory barriers could prevent the utilisation of some of the more innovative distribution channels. These include mobile telecommunication companies, airtime vendors, supermarkets and churches, which may be necessary to penetrate deeper into low income markets such as newly urbanised migrant workers and remote rural communities. The Ghanaian commissioner for insurance, speaking at the West African Insurance Companies Association education conference in Lagos in January 2009, captured this sentiment. The commissioner stressed the need to strike a balance between regulation of the industry and innovation in relation to the sale of microinsurance products.

Distribution

Innovation in developing alternative distribution channels and applying technological advances continue to be key features of the emerging microinsurance sector. As noted above, the difficulties encountered and solutions deployed by microinsurance providers and the pace of innovation present a challenge for insurance regulators. Efficiency is paramount in the often challenging socio-economic and geographical environments in which potential microinsurance markets exist.

The sale of microinsurance, largely credit life (a form of term life assurance where, typically, the sum assured equals the outstanding balance of a loan), by regulated insurers has grown significantly. It utilises the existing distribution infrastructure provided by microfinance institutions with whom insurers partnered. The range of microinsurance products available has since expanded with the development of non-traditional distribution channels and continues to do so at an increasing pace.

A fundamental challenge for insurers in the microinsurance market today is designing effective distribution channels to ensure that economies of scale will protect investment and pave the path for a profitable future. Hurdles to overcome include educating potential policyholders in "insurance literacy", implementing efficient and sustainable sales processes and managing the systems for the collection of premium as well as the handling and payment of claims. Above all, insurers are faced with the challenge of developing the trust of consumers for whom the concept of insurance is often completely unknown. They do this through effective sales and claims processes while operating a commercially viable business model. The channels through which the policies are distributed play a critical role in this process.

From the perspective of the insurers, the most significant stage in the distribution process is the sale of the product, as increased volumes of take up allow for greater operating efficiencies. Microinsurance providers are recognising that the priorities of the policyholders, who value an ability to claim successfully and expeditiously along with simplicity in all elements of the process (from the products themselves to the steps for making a valid claim), are essentially different. This is leading to microinsurance providers

across the world experimenting with new and innovative distribution channels, including cash retailers (such as supermarkets) and telecommunication networks (such as mobile phone companies). The aim is to design balanced distribution initiatives which meet the objectives of both parties.

Technology and, in particular, the advent of mobile e-wallets such as M-PESA and the MTN Mobile Wallet, for the transfer of money and payments, is proving critical to much of this innovation. For example, a Ghanaian mobile phone operator has partnered with MicroEnsure and Vanguard Life to offer "Family Care Insurance" to its customers based on how much airtime is used. Customers sign up for the service and nominate one family member to be included on their policy. The amount of cover that they are entitled to ranges from GHC 200 – 1,000 (US$ 130 – 650) and is based on the value of airtime that was purchased during the previous calendar month. If a customer buys less airtime the next month, the cover will be reduced. Claims are notified via a text message and the policies are "renewed" on a monthly basis, again via a text message.

Signature issues

One of the significant challenges facing the innovators in microinsurance distribution concerns the formalities required for the acceptance of microinsurance contracts and, in particular, the extent of the requirement for "wet" signatures. Under English law, the formation of a contract of insurance typically takes place by an insurer issuing an invitation to treat in response to which a prospective assured submits a proposal form (constituting an offer) which the insurer may accept. The rules of contract formation require that the offer and acceptance contain sufficient clarity as to the terms of the contract (essentially, it must not be incomplete or ambiguous in any material respect). There must be a demonstrable intention by the parties to be bound and acceptance must be unqualified. The issue of a policy by the insurer constitutes its acceptance. Acceptance may also arise from the application of premium received to underwriting operations where there are no pre-conditions to fulfil or remaining unsatisfied. As a general proposition, silence will not constitute acceptance under English law, a point demonstrated in the cases, amongst others, of *Felthouse v Bindley*[17] and more recently *Rust v Abbey Life insurance Co Ltd*.[18]

There is an increasing trend to sell microinsurance policies off the shelf through retailers such as supermarkets. The usual analysis of offer and acceptance is often reversed for such sales. Typically the insurer makes the offer which the assured accepts by purchasing the policy at the till and having the policy validated (for example, by scratching off a cover to reveal the policy number and/or sending a text message with the policy number to the insurer). A similar form of distribution is increasingly being applied to the sale of travel insurance by retailers at United Kingdom airports.

English law does not require a contract of insurance (other than a contract of marine insurance) to be in writing or for an assured to have read the terms of a policy. Having

the means to access the insurer's standard policy terms is sufficient. Regulation, however, superimposes a requirement to record insurance contracts in writing with a view to achieving so-called "contract certainty" and in pursuit of consumer protection. Additionally, regulatory obligations control the sale of insurance to consumers and require certain information and policy documentation to be sent to them. These obligations are contained, in the UK, in the FSA Handbook of Rules and Guidance and under the Financial Services and Markets Act 2000 (Financial Promotions) Order 2005.

However, the position in a number of other jurisdictions requires the parties' original signatures to constitute a valid and binding contract of insurance for legal and/or regulatory purposes. The requirement for such "wet" signatures represents a significant barrier to the development of innovative distribution channels for microinsurance, particularly in emerging markets where geography and infrastructure are challenging. It is sometimes permitted to use digital signatures or alternative methods of recording offers and acceptances (for example, recorded telephone calls in conjunction with the provision of policyholder documentation and policyholder payment may suffice). However, this is dependant on local law and regulation. In many instances local law and regulation has yet to accommodate the possibilities that recent technological advances permit.

Conclusions

A solution to many of the regulatory issues facing microinsurance in its emerging markets is the development of a tiered regulatory system. This would allow microinsurance products satisfying criteria as to premium, cover, class of business, terms and, potentially, distribution to be subject to lower capital and ongoing compliance and reporting requirements. As the business grows and reaches better economies of scale, the regulatory requirements can step up commensurately with the resulting greater risk to a larger number of consumers. The Philippines has adopted a two-tier regulatory system which permits mutual benefit associations to operate with a lower capital base than first tier commercial insurers. The proposed South African Microinsurance Act adopts a similar approach.

An alternative approach is to apply principles-based regulation incorporating a proportionality principle that enables the regulatory regime to be applied appropriately to the nature and scale of an insurance business. However, in a principles-based regulatory system, insurers (and international insurers in particular) will require a high degree of confidence in the relevant jurisdiction's rule of law to provide the necessary comfort that the principles will be applied in a transparent and fair way.

Scale is critical to the long-term sustainability of microinsurance. As the microinsurance market grows, the laws applicable to it and its regulation are becoming increasingly important. Flexibility is necessary to embrace microinsurance business and related distribution models appropriate to local market dynamics. These should support greater

financial inclusion in a controlled environment which protects policyholder interests. Greater co-ordination between legislators and regulators would be welcome. It would enable the regulators to share limited resources in considering new developments. It is also to be hoped that it would lead to a more uniform approach across jurisdictions which can encourage financial inclusion by creating opportunities for providers to develop distribution channels that are scalable on a multi-national level.

Endnotes

[1] Jonathan Teacher is a senior associate at Norton Rose LLP. Jonathan specialises in corporate, mergers & acquisitions and regulatory matters for the insurance industry. He also has significant experience in structured insurance products, insurance linked securities, Lloyd's and microinsurance.

[2] Swiss Re's Sigma report "Microinsurance - Risk protection for 4 billion people" (No 6/2010)

[3] *Prudential Insurance v Inland Revenue Commissioners [1904] 2 KB 658*

[4] *Gould v. Curtis [1913] 3 KB 84*

[5] Marine Insurance Act 1906, section 27

[6] *Sibthorpe and another v London Borough of Southwark [2011] EWCA Civ 25*

[7] *Digital Satellite Warranty Cover Limited v Financial Services Authority [2011] EWCA Civ 1413*

[8] *Sibthorpe and another v London Borough of Southwark [2011] EWCA Civ 25*

[9] MacGillivray on Insurance Law, Eleventh Edition, 1-008 Problems in classification

[10] *Re Digital Satellite Warranty Cover Ltd and others [2011] EWHC 122 (Ch), paragraphs 81 - 87*

[11] Chapter 6, Guidance on the Identification of Contracts of Insurance

[12] *Digital Satellite Warranty Cover Limited v Financial Services Authority [2011] EWCA Civ 1413*

[13] At the time of writing, it is understood that the appellants in *Digital Satellite Warranty Cover Limited v Financial Services Authority [2011] EWCA Civ 1413* have made an application to the Supreme Court for permission to appeal the Court of Appeal's decision. The application is awaiting determination by a panel of justices.

[14] *Medical Defence Union Ltd v Department of Trade [1980] Ch 82*

[15] *Department of Trade and Industry v St Christopher Motorists' Association Ltd [1974] 1 WLR. 99*

[16] Financial Services and Markets Act 2000 (Regulated Activities) Order 2001, article 12

[17] *Felthouse v Bindley (1862) 142 ER 1037*

[18] *Rust v Abbey Life insurance Co Ltd [1978] 2 Lloyd's Rep 386*

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Insurance Coverage Issues affecting the Financial Services Industry

by Graham Denny[1]

The last few years have seen a considerable amount of upheaval in the financial services sector: the collapse of Lehman Brothers in September 2008; the discovery of the Bernard Madoff fraud in December 2008; rogue trading at Société Générale and UBS; the liabilities arising from the sale of Payment Protection Insurance, not to mention the effect of the worldwide economic downturn and its impact on the financial services sector. Whilst these (and there are many more not mentioned) are high profile events, there are far more lower profile events that regularly lead to insurance claims and insurance coverage disputes.

It is only once coverage disputes arise in insurance claims that policy wordings are truly tested and a significant amount can be learnt both by buyers and sellers of insurance from a review of such disputes and the arguments taken by both sides. Certain clauses which may appear innocuous on the purchase of an insurance policy can prove, later on down the line, to cause substantial hurdles when an insured attempts to secure an indemnity; whilst for insurers, clauses in the policy wording may not have the effect that they were intended to have.

The various scandals and events, some of which are mentioned above, have led over the years to an influx of insurance notifications and claims, primarily on bankers blanket bond (BBB) / crime; directors' and officers' (D&O); errors and omissions (E&O) and professional indemnity (PI) policies. This article focuses on a number of coverage issues and considerations that arise or have arisen in the last few years on these policies.

BBB / Crime Policies

These are first party policies in that they are taken out by the insured (the employer) to protect it, primarily against a dishonest employee's fraud. However the scope of the cover available does vary depending upon the insured's requirements. In addition to employee dishonesty it is possible to extend cover to include loss suffered from forged instruments, computer and telephonic misuse, physical loss of property (for example currency; bank notes; bullion and precious metals), and extortion. Despite the initial intent to protect an insured against acts of dishonest employees, a number of these other covers are not restricted to acts of employees but extend to acts of third parties.

There are a number of considerations that should be borne in mind when either purchasing this product or in a claim situation:

1. Direct loss. Cover is usually provided for direct loss which is normally defined in the policies. It will usually include: direct financial loss of the insured; claims preparation costs; legal fees and verification and reconstitution of expenses costs.

The latter relates to expenses incurred in the reconstitution or removal of electronic data that has been affected. As a result it is not necessarily a given that all the losses suffered fall within the definition and scope of cover.

2. The criteria required by the insuring clause. In terms of employee dishonesty insurance claims, there are often three main criteria, usually set out in the insuring clause, which must be met for a loss to be covered:

- the act must be carried out by an employee as defined within the policy;
- the loss must be caused by a dishonest, fraudulent or malicious act;
- the act must be committed with the intent to either make an improper financial gain or cause loss to the employer. Usually salary, fees, commissions, bonuses, salary increases are expressly excluded from the definition of improper financial gain. This can often be a coverage concern arising on insurance claims for loss suffered from rogue trading events. It is not unusual for traders not to have the intent to make an improper financial gain or to cause loss to the employer. The act often begins with a trader taking certain loss making unauthorised trading positions and so the trader borrows money from other accounts in order to take further trading positions in the hope of making a profit to cover up that loss. The intent is then to return the money to the account it was borrowed from. As a result, there is often no intention to cause a loss to the employer and there is no improper financial gain to the broker.

3. Proof of Loss. A further area of potential difficulty in BBB / Crime policies is the Proof of Loss:

- Policies usually require an insured to provide insurers with a Proof of Loss setting out all the facts about the loss, the amount of loss and the supporting documentation in order to prove the loss suffered. The Proof of Loss will normally be required as a condition precedent to be provided within six months of the discovery of the fraudulent act or when the facts were such that the insured should have been alerted to the circumstances of the fraud. Confusion can often occur as to when exactly time starts to run and the exact date on which the Proof of Loss is due. To dispense with such uncertainty and the risk of breaching a condition precedent in the policy, it is always worth agreeing the date that the Proof of Loss is due with insurers. As the provision of a Proof of Loss is usually a condition precedent, it is essential to monitor its progress. If more time is required, a request should be made to insurers well before the deadline to ensure that the condition is not breached.
- The nature and complexity of the fraud can also make the formulation of a Proof of Loss a complex issue. Particularly where covered and excluded losses are involved.

E&O / PI Policies

These policies have taken the lion's share of the notifications and insurance claims, particularly following the collapse of Lehman Brothers and claims arising from the Madoff fraud. Issues that have arisen in the last few years which are worth noting include:

1. Civil Liability. Insuring clauses in these policies usually require there to be a civil liability in order for the policy to respond. What constitutes a civil liability is often set out or defined. There are a number of areas where this can cause difficulties:

   - An issue arising from the Payment Protection Insurance mis-selling was that some insureds made "*commercial*" payments to those customers who raised complaints. These payments followed an internal strategy to provide a compensatory payment to such customers to deal with the complaint at an early stage. Such strategies were not necessarily based upon whether the insured had a legal or civil liability but rather the fact that it was more cost effective to deal with such complaints at an early stage before further management time and potential legal costs were incurred. Issues therefore arose on the insurance claims as to whether for each payment made there was an actual civil or legal liability owed.

   - Civil liability does not include contractual liability. In policies there is often a specific exclusion of contractual liability in respect of: "*[l]oss resulting from any Claim for legal liability assumed by the Assured under the specific terms, conditions or warranties of any contract, unless such liability would nevertheless have attached by law in the absence of such term, condition or warranty.*" This exclusion is one that causes a considerable amount of concern given the tendency for claimants to bring a claim for breach of contract. Often many claims allege concurrent duties in tort and so the policy will usually respond to such claims; however, where disputes relate to a breach of transactional and contractual obligations only, there is a high risk of such disputes being caught by this exclusion.

2. Notification. Since the *HLB Kidsons v Lloyds Underwriters & Others [2008] EWCA Civ 1206* Court of Appeal decision and the notification cases that have followed, such as *Kajima UK Engineering Limited v The Underwriter Insurance Company Limited [2008] EWHC 83 (TCC)*, there has been a heightened awareness and concern in notifying circumstances and claims to insurers promptly and as fully as possible.

   - Timing of the notification. The practical effect of late notification has been well-publicised in case law and has heightened the awareness of insureds and insurance brokers who try to ensure notifications are made as early as possible once there is an awareness of a circumstance or claim. This concern has been driven by the fact that most notification clauses are drafted to ensure that the notification provisions are construed as condition precedents. In practice, a breach of a notification clause which is a condition precedent entitles insurers

to deny liability for the claim irrespective of whether the breach has caused loss or prejudiced insurers.

- Scope of the notification. This is another important issue which certainly caused a significant amount of tension in the insurance notifications that followed the media reporting of the Madoff fraud in December 2008. Many financial institutions' E&O policies renew their insurance on a calendar year basis and so once the fraud had been reported there was a concern by both financial institutions and their insurance brokers that notifications should be made to the expiring policy and disclosure should be made to the renewing policy prior to the expiry and inception of the respective policies. However, in many instances the true scale of the fraud and exposure faced was unknown by some insureds. Issues therefore arose, after renewal on 1 January 2009, in relation to the scope of some notifications made to the expiring policy, which were not drafted broadly enough providing a limited indemnity. In addition, there were instances of renewing insurers relying upon the prior awareness of circumstances and exclusions for circumstances notified to prior policy years to exclude notifications and limit cover to those insureds who either had not made notifications or had made limited notifications into their expiring policy. These issues highlight the need to give a considerable amount of thought to the construction and drafting of a notification in order to ensure the notification is broad enough to encompass all potential exposure that an insured considers it faces from a circumstance.

3. Restitution claims. The intent of E&O and PI insurance policies is to cover compensatory liabilities to a third party. Claims for restitution are not usually considered to be claims for compensation but rather claims for a return of monies to which the defendant was not entitled in the first place - in other words unjust enrichment.

- Restitution claims therefore are normally excluded under E&O and PI policies or do not fall within the insuring clauses of such policies. An example of the difficulty this has caused is in respect of the litigation arising from the Madoff fraud where claims have been brought by the trustee of Bernard L. Madoff Investments Securities LLC against the "feeder funds", the funds that invested in Bernard L. Madoff Investment Securities LLC. In addition, feeder funds have also claimed against their investors, in restitution, in order to claw back redemption payments made to those investors. For those entities defending such claims for restitution, substantial legal costs have often been incurred which are potentially not covered as the defence costs cover is usually restricted to covered claims.
- Some insureds, however, who have been defending restitution claims on behalf of their client investors have mitigation costs cover included in their insurance

policies and therefore have had their defence costs incurred in defending such restitution claims paid on the basis that their defence of the restitution claims mitigates potential claims brought against them by their investor clients.

4. Breaches of the Securities Act 1933 and Securities Exchange Act of 1934. For those entities which are based in or have a business exposure in the United States, there are usually exclusions found in their E&O or PI policies excluding claims arising out of breaches of the Securities Act 1933 and Securities Exchange Act of 1934 or any similar State or Federal or Provincial law. It is not uncommon for such exclusions to be drafted broadly excluding claims "*arising from, attributable to or connected with*" such breaches. Where the breach of such legislation which has ultimately led to the loss was not that of the insured, an issue arises as to whether the exclusion is ambiguous and, if so, whether the exclusion was intended to relate to breaches by the insured or breaches by a third party which is connected with the claim brought against the insured.

D&O insurance

Whilst there have not been as many claims against directors in England & Wales as compared to the amount predicted following the financial services crisis, this type of policy is still an important asset to those companies and directors that operate in England & Wales, particularly to indemnify companies or pay directors' legal costs incurred by regulatory and other investigations. D&O insurance is of added importance where companies operate in those jurisdictions where the laws are such that claims against directors are more common place. Such jurisdictions include the United States, Italy, Germany and Austria. There are however issues to consider and be aware of:

1. Insuring clause. There is a requirement for a claim to arise from a wrongful act by the director or officer. What constitutes a wrongful act will be defined in the policy. The policies do not have a single consistent definition in use and this definition can have a significant effect on the scope of cover.

2. Outside directorship liability extension (ODL Extension). This extension is regularly purchased by companies as part of their D&O cover where company directors or officers are likely to hold outside directorships. There are industry sectors where this is a common business practice, for example, the private equity sector where a director or officer of a private equity firm may be appointed to the board or supervisory board of a portfolio company. In the context of the claim against the director (in their capacity as a director of the outside entity) there is always a risk of double insurance as the outside entity will usually have its own D&O insurance. To resolve the issue, the ODL Extension is normally drafted in such a way to ensure that it sits in excess of the outside entity's insurance, so long as that local insurance is valid and collectable. In situations where the outside entity's insurance is not valid and collectable, the ODL Extension will apply as the

primary insurance. However, issues have arisen where both policies are valid and collectable and are governed by different laws and jurisdictions. Complications can occur due to the different interpretations in those jurisdictions to the policies, particularly where the outside entity's policy contains a clause indicating that it will sit in excess of any other applicable insurance.

3. Professional Services exclusion. Such exclusions are usually drafted broadly in D&O policies incorporating language to ensure that the cover on offer excludes claims "*arising from or attributable to or in connection with*" the performance or failure to perform professional services "*by or on behalf of*" any director or officer. This is an exclusion that frequently causes difficulties for insureds whose business is to provide professional services. The rationale for the exclusion is that such claims should be covered by the insured's E&O or PI policy.

4. Presumption of Indemnity. Side B cover of D&O policies provides an indemnity from insurers to companies where those companies have indemnified a director for a legal liability or paid the legal defence costs of the director. Normally such cover requires a deductible to be paid by the company. There are legal limitations on companies as to what they can indemnify a director for. Where a company cannot legally indemnify a director, that director can usually seek an indemnity under side A of the policy, which responds where the claim is a "*non-indemnifiable loss*" i.e. a liability that cannot be legally indemnified by the company. Side A insurance cover does not require a deductible to be paid. However, difficulties arise where a company refuses to indemnify a director even though it is able to legally. In such situations a director may be unable to claim under side A for a "*non-indemnifiable loss*" as the company should have indemnified the director but has simply chosen not to do so. Arguments arise as to whether the director has cover at all, although usually insurers permit cover so long as the Side B deductible is paid by the director. Some policies contain clauses (Presumption of Indemnification clauses) specifying that in such circumstances the Side B deductible, which can be substantial, is payable by a director to ensure there is no doubt over the position. A solution is to ensure a clause is inserted into the policy confirming that in such situations the insurers will indemnify the director in full and the company will pay the retention. This then allows the insurers to pursue the company for their retention after indemnifying the director.

5. Erosion of policy limit. All D&O policies are written with annual aggregate limits. A concern directors frequently have is the erosion of the aggregate limit by claims made by the company for indemnification where it has indemnified a director (a Side B claim). Some policies contain Order of Payments clauses which provide a degree of protection for directors, but such clauses will not stop the erosion of the policy aggregate limit. Often the solution lies in the way the insurance programme is structured. An excess Side A layer of insurance, for example, can provide a layer

of cover which is ring-fenced specifically for directors' Side A claims to allay their concern of Side B claims eroding the policy cover.

A substantial amount can be learnt from considering the issues that have arisen from insurance coverage disputes. These not only provide an insight into which clauses regularly are an issue, but are also useful for risk managers and insurers to ensure that the insurance cover reflects their requirements and operates as they expect it to do.

Endnote

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Developing European class actions and keeping them out of the US courts

By Thomas Heitzer[1]

I. INTRODUCTION

In 2011 the US Supreme Court ruled that European claimants must take their claims back to their home jurisdictions in Europe. A number of European investors had been filing claims against European companies for many years under the US class actions regime. The plaintiffs generally accused the defendants of misleading shareholders. They typically sued the company, its directors and accountants for compensation. In *Morrison et al. v. National Australia Bank Ltd. et al.* ("*Morrison v. NAB*") the US Supreme Court decided that so called "f-cubed" claims cannot be filed in the United States[2]. F-cubed claims are those filed by foreign, non-US-investors, against a non-US-company in relation to shares bought on a foreign exchange.

In the past two years there have been many claims in the US courts against European companies and their directors relating to allegations of misconduct in connection with securities traded on foreign exchanges. These have been dismissed for lack of subject-matter jurisdiction under the US Federal Rules of Civil Procedure Law. Meanwhile in Europe, further collective action type claims are gaining momentum, at a seemingly increased speed. Following the decision by the US Supreme Court in *Morrison v. NAB*, forum shopping activity is taking place. More detailed EU-wide regulations and collective action type procedures in several European jurisdictions are now available.

Such developments and dynamics raise the question whether insurers' exposure to their global business will remain unaffected or if the claims climate will become tighter in the future. In particular, liability lines such as product liability and professional indemnity, errors & omissions and directors & officers could be in the focus of future development.

This article provides an overview of the current developments in class actions and forum shopping in Europe. It also examines whether the litigation exposure faced by European companies (and consequently their insurers) from US securities class action litigation has been minimized or just shifted to single European jurisdictions. Will the recent developments lead to a "European class action" or other collective action type regimes in the EU?

II. MORRISON V. NAB

On June 24, 2010 the US Supreme Court decided in *Morrison v. NAB* that Sec. 10(b) of the Securities Exchange Act of 1934 ("Exchange Act") does not provide a cause of action to foreign plaintiffs to recover their losses related to f-cubed claims. The case received considerable attention. Briefs (i.e. written arguments) were submitted by the governments of Australia, France and the United Kingdom.

In 1998 NAB, whose shares are not traded in the US, purchased a Florida headquartered

company, HomeSide Lending. HomeSide Lending was in the business of servicing mortgages. In 2001, NAB had to write down the value of HomeSide's assets, which resulted in a decrease of NAB's share price. The Australian claimants had purchased NAB's shares before the write-downs. They sued NAB, HomeSide and both companies' directors for violation of Sec. 10(b) and 20(a) of the Exchange Act. They alleged that HomeSide and its officers had manipulated financial models to make the company's mortgage-servicing rights appear more valuable than they really were.

The Federal District Court for the Southern District of New York dismissed the foreign plaintiff's claims for lack of federal subject matter jurisdiction[3]. The foreign plaintiffs appealed but the Court of Appeals for the Second Circuit affirmed the dismissal. The court focused on the place of the "heart" of the conduct which was in its view Australia and not Florida where the manipulation of the numbers occurred[4]. The US Supreme Court affirmed the Second Circuit's ruling and dismissed the claims. The opinion of the Court, delivered by Justice Scalia, stated that:

> *"Section 10(b) reaches the use of a manipulative deceptive device or contrivance only in connection with the purchase or sale of a security listed on an American stock exchange, and the purchase or sale of any other security in the United States.*[5]*"*

The Court further quoted the general principle that unless a contrary intent is apparent, the legislation of Congress is meant to apply only within the territorial jurisdiction of the United States. As Section 10(b) Exchange Act is silent as to its exterritorial application, it concluded that Section 10(b) Exchange Act should not be applied extraterritorially[6].

However, the US Supreme Court did not bar all f-cubed claims from US litigation. It made it clear that such decisions need to be reached on a case-by-case basis.

III. DEVELOPMENTS / ACTIVITY IN EUROPE FOLLOWING *MORRISON V. NAB*

The US Supreme Court's decision has had a far-reaching impact on global claims and liability and is therefore of remarkable importance for the insurance industry. This is not only true for liability lines of business but for the claims and litigation culture in Europe in general.

Following the decision in *Morrison v. NAB*, claims in the US against Vivendi S.A. and BP Group were dismissed. Whereas the claims against Vivendi were made as a securities class action, the decision in favour of BP was related to the Gulf of Mexico oil spill and was based on the relevant liability law in the US. Further, the AGEAS N.V. case (see below) shows that US plaintiffs are active in the process of Forum Shopping in Europe.

The filing of class actions in Europe and a corresponding framework for such claims is gaining further momentum, at an increased speed.

1. Class Actions / Collective Redress in Europe

The European Union (EU) and some of its individual Member States are preparing to embrace the concepts of collective redress regimes for consumer claims. In 2008 the European Commission ordered a study to examine the collective redress regimes which are already in place across Europe[7]. In about half of the EU Member States judicial collective redress mechanisms exist, primarily group actions, representative actions and test cases. In other jurisdictions the mechanisms for collective redress are not widely used. Collective redress procedures are often very complex and time consuming. Another key obstacle is funding, as in many states of the EU neither US type contingency fees, nor UK type conditional fees, are allowed.

On November 2008 the European Commission published its Green Paper in which it supported the implementation of collective redress instruments across Europe[8]. After public consultations from November 2010 until April 2011 the EU focused on the following six key principles to guide any future EU initiative on collective redress:

- need for effectiveness and efficiency of redress;
- importance of role of representative bodies;
- means of alternative dispute resolution;
- need for strong safeguards to avoid abusive litigation;
- availability of appropriate financing mechanisms; and
- importance of effective enforcement across the EU.

New Class Action in Italy

On 27 December 2010, the Civil Court in Milan admitted a class action against Voden Medical Instruments SpA. The claimants were an activist consumer association, Codacons, and a number of individual claimants. Voden is a provider of medical devices in the life science and pharmaceutical sectors. The claim was based on alleged defects of Voden's "Ego-rest FLU", a product designed to detect influenza infection. The Court allowed the claim to go forward in respect of an alleged misleading label.

The order by the Court of Milan in *Codacons v. Voden* is the first decision in Italy to declare a class action admissible and the first decision issued in connection with a class claim relating to a product. By the order of 20-27 December 2010, the Court of Milan ordered inter alia the publication of its ruling on admissibility so as to allow class members to opt-in and join the class by 30 April 2011.

New Class Action in the Netherlands

On 11 January 2011, a representative action[9] was filed with the Civil Court of

Utrecht by a class of claimants which consists of 140 institutional investors and a significant number of private investors. The claimants formed a special foundation named "Stichting Investor Claims against Fortis"[10]. Among the group of institutional investors are US investors seeking compensation before the Dutch Court.

The defendants are AGEAS N.V., the insurance arm of FORTIS, some of its directors and officers and the offering underwriter Merrill Lynch. The claims allege a misrepresentation of the economic value of Fortis between May 2007 and October 2008, when Fortis acquired ABN Amro. The claimants further allege that Fortis misrepresented the value of its collateralized debt obligations, the extent to which its assets were held as subprime-related mortgage backed securities, and the extent to which its decision to acquire ABN Amro Holding NV had compromised the Company's solvency. The claimants are seeking EUR 2 billion in compensation.

This case has led to the Netherlands becoming the preferred "portal" for class actions in Europe with important consequences for the insurance industry[11]. In particular, liability lines like PI, E&O and D&O are in the focus of such developments in Europe with a significantly increased risk for insured entities to be sued in the Netherlands.

2. Forum Shopping

Cases

The ruling of the US Supreme Court on 24 June 2010 in *Morrison v. NAB* has had an ongoing impact on European litigation. Some of the major cases where European companies were sued by investors in the US have been dismissed following *Morrison v. NAB*. These cases include:

BP's successful application to a Texas judge to dismiss claims by some institutional investors on the grounds that their claims that company mismanagement caused the Gulf of Mexico oil spill should be tried in British Courts[12].

In *Elliott Associates et al. v. Porsche Automobile Holding SE et al.*[13] the plaintiffs made allegations, and set forth causes of action, based upon violations of the U.S. Federal Securities laws, inter alia Section 10(b) and 10(b)-5 of the Exchange Act. The District Court dismissed the plaintiff's federal securities law claims following Morrison v. NAB.

In the **AGEAS** N.V. case[14] two U.S. Securities claimants filed an action as shareholders of that company in the Utrecht Civil Court. They were members of a specially formed Foundation[15]. The claims and the participation of the U.S. claimants were filed after US litigation was stopped by the US District Court, Southern District of New York. The Foundation in question encourages institutional investors or investors with more than 100,000 shares purchased during the relevant period and nominee shareholders/custodians from any jurisdiction around the world to participate in the Foundation. This is on condition that they have (1) purchased shares in Fortis on the open market between May 29, 2007 and October 14, 2008; (2) participated in the September

2007 Rights Issue; or (3) participated in the June 2008 Accelerated Book-Building offer.

The founders of the "Stichting Investor Claims against Fortis" announced on their website:

> "*As a previously pending U.S. Securities class action representing all interests of all Fortis investors was dismissed in February 2010, the best, and maybe only, alternative for Fortis investors to obtain a funding or liability and potentially a settlement for compensation is to become active in the Netherlands by joining the Foundation in order to provide it with the necessary regional diversity and size to proceed on behalf of all Fortis investors, globally, in a representative fashion*[16] [17].

"Brussels I" and other EU Regulations on Jurisdiction and applicable law

The jurisdiction and recognition and enforcement of judgements in civil and commercial matters is governed by the Council Regulation (EC) 44/2001 of 22 December 2000 (Brussels I). Brussels I is part of the "Brussels regime", a set of rules regulating which Courts have jurisdiction in legal disputes of a civil or commercial nature between individuals residing in different Member States of the European Union

The Brussels Regime consists of the:

(1) Brussels Convention of 27 September 1968 on Jurisdiction and the Enforcement of Judgements in Civil and Commercial matters;

(2) Lugano Convention of 16 September 1988 on Jurisdiction and the Enforcement of Judgements in Civil and Commercial Matters; and the

(3) Council Regulation (EC) No 44/2011 of 22 December 2000 (Brussels I).[18] [19]

Apart from the Brussels regime the Rome I (2008) and Rome II (2007) Regulations are aimed at the unification of International Private Law and International Civil Procedure Law. In cross-border-cases under the Rome II Regulation applicable substantive law in tort cases arising from 2008 onwards is the law of the place where the damage occurred[20] The injured party, therefore, no longer has a choice of law between the law of the place of the wrong doing and the law of the place of the occurrence of the damage. Rome II limits this kind of forum shopping and is particularly relevant in product liability cases.

In December 2010 the European Commission published a proposal regarding the reform of the Brussels I Regulation[21].; the final outcome of that proposal is expected to be published in 2012. The key amendments of Brussels I relate to the following[22]:

(1) abolition of "exequatur" procedure (allowance of automatic recognition and enforcement of judgements between EU-Member States);

(2) disputes involving non-EU-countries / International Legal Order;

(3) choice of court agreements; and

(4) arbitration.

(2) above is most relevant so far as class actions are concerned. In cases where the defendant is domiciled outside the EU, Article 4 of the regulation stipulates that each Member State's national law determines its courts' jurisdiction. As national law rules vary between the Member States the parties have unequal access to justice within the EU. The European Commission's proposals are aimed at remedying this lack of uniformity in the EU, preventing a distortion of competition for companies across the EU, and avoiding unequal business conditions.

IV. CONCLUSION

The US Supreme Court's judgement in *Morrison v. NBA* has had a direct impact on litigation in Europe. Subsequent developments should be particularly noted by the insurance industry – especially for liability lines of business like PI, E&O and D&O but also Product Liability.

At present, it seems that the Netherlands offers the most attractive environment to file collective actions, without the negative aspects of the US-class-action-claims regime. There will therefore be less exposure for companies and insurers in connection with SEC-related risks. In addition, the amendment of the Brussels I regulation may lead to a uniform procedure for cross-border related litigation within the EU.

Finally the developments discussed above are likely to lead to a more dynamic approach towards a collective redress regime to address the current challenges imposed by a globalized economy.

Endnotes

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2 Morrison v. NAB, 130 S. Ct. 2869 (U.S. 2010).

3 In re National Australia Bank Ltd. Securities Litigation, 2006 WL 3844465 (SDNY Oct. 25, 2006).

4 Morrison v. NAB, 547 F.3d at 176 (2nd Cir. N.Y. 2008).

5 Morrison v. NAB, 130 S. Ct. 2869, 2886 (U.S. 2010).

6 Morrison v. NAB, 130 S. Ct. 2869, 2877 (U.S. 2010).

7 "Study on the Evaluation of the Effectiveness and Efficiency of collective Redress mechanisms in the European Union"; Civic Consulting and Oxford Economics, Final Report (Aug. 2008).

8 Greenbook of collective redress for consumers, circulation EG 2417/2008.

9 The Netherlands currently has two collective redress mechanisms: the representative collective action in Article 3:305a of the Dutch Civil Code and the 2005 Dutch Act on Collective Settlements Mass Damages.

[10] AGEAS N.V.; "Stichting Investor Claims Against Fortis" has been established as an open foundation under Article 3:305a of the Dutch Civil Code (DCC") upon the initiative of various large institutional investors with substantial losses from their investments in Fortis. For details see http://www.investorclaimsagainstfortis.com.

[11] The Netherlands is an attractive place for group actions also from the perspective of legal costs: In the Netherlands, punitive damages are not allowed, nor are contingency fees possible yet. Lawyers are not allowed to work on a "no cure no pay"-principle. Claims management companies are allowed to work on such basis. The loser pays principle applies, but the compensation will not cover the total lawyers' fees incurred. The amount awarded is based on fixed figures by the courts and based in the amount in dispute and the number of court-related activities.

[12] Derivative action against BP was brought before Houston U.S. District Court, Southern District of Texas, 22 March 2011, Docket No. 4.10-CV-03447.

[13] No. 10 Civ. 00532 (S.D.N.Y. 2010)

[14] See above, under II.1

[15] See http://www.investorclaimsagainstfortis.com, already cited

[16] See http://www.investorclaimsagainstfortis.com, already cited

[17] Against this background it does not surprise that knowledge of the Netherlands as one favourite collective redress portal for US-claimants in Europe is widespread among US lawyers.

[18] Further, the Rome I and the Rome II Regulations aim at the unification of International Private Law and International Civil Procedure Law.

[19] Council Regulation (EC) No 864/2007 of 11 July 2007, European International Private Law on non-contractual obligations (tort law).

[20] Art. 4 para. 1 Rome II

[21] For more details and in particular the proposal's impact from an insurance perspective see: Jonathan Goodliffe, "Jurisdiction in insurance disputes: possible changes", BILA, Journal of the British Insurance Lawyers Association, issue 121, 35.

[22] See: European Commission, Directorate General Law Justice, "Proposal for a Regulation of the European Parliament and of the Council on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters", issued 17 December 2010. For the details and underlying reasons for the proposals by the European Commission see the country by country analysis by the Centre for Strategy & Evaluation Services "CSES", on behalf of the European Commission, Directorate General Law Justice, "Data Collection and Impact Analysis – Certain Aspects of a possible Revision of Council Regulation No. 44/2001 on Jurisdiction and the Recognition and Enforcement of Judgements in Civil and Commercial Matters – Brussels I", issued 17 December 2010.

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Guidance on sex in insurance: the UK and the European Commission issue their views on *Test-Achats*

by Chris Finney, Mark Everiss and Stephen Ixer[1]

The decision of the European Court of Justice (**ECJ**) in the test case of *Association Belge des Consommateurs Test-Achats ASBL and Others v Conseil des Ministres* C-236/09 (*Test-Achats*) was one of the most noteworthy of 2011[2]. It threatened to cause upheaval in the insurance industry because it seemed to prohibit the use of sex as an actuarial factor when calculating premiums and benefits for insurance contracts effected on or after 21 December 2012. Amid consternation and uproar from the industry since its publication last March, the ruling has been the subject of numerous articles and studies attempting to predict its impact on the insurance industry.

Two recent developments have now helped clarify the situation for insurers in the UK. These are the publication of the European Commission's guidelines on the application of the *Test-Achats* decision and the launch of the UK government's consultation on the UK's response to the decision. Both are described in this article, together with an overview of the ruling itself.

EU law and the *Test-Achats* decision

Equal treatment for men and women is a fundamental right under European Law (Article 6 of the EU Treaty). Expanding on that principle, in December 2004, the Gender Directive (2004/113/EC) was adopted requiring EU member states to legislate for equal treatment in access to and supply of goods and services. Article 5 of the Directive provides that, for all new contracts concluded after 21 December 2007, the use of sex as a factor in the calculation of premiums and benefits for insurance and related financial services must not result in differences in individuals' premiums or benefits (the **Unisex Rule**).

However, as the Directive recognised, the use of actuarial factors related to gender was widespread in insurance when the Directive was adopted in 2004, so a transitional period was incorporated that gave until 21 December 2007 for the differences to be abolished. Further, an exemption under Article 5(2) allowed proportionate premium and benefit differences where gender is a determining factor in the assessment of risk, based on relevant and accurate actuarial and statistical data. In practice, this is most commonly applied to motor, life and health insurance, and annuities. However, the Directive included no long stop date for an end to this exemption.

Article 5(2) was challenged by Belgian consumer group Association Belge des Consommateurs Test-Achats on the grounds that it was incompatible with equality of treatment enshrined in EU law. In September 2010, Advocate-General Juliane Kokott (**AG**) issued her opinion that Article 5(2) was invalid because the exemption focussed on gender-based statistical differentials and did not take proper account of other factors influencing risk. As expected, the ECJ decision handed down in March agreed with the AG's conclusion that Article 5(2) was incompatible

with EU law. It ruled that Article 5(2) will be invalid from 21 December 2012.

The ECJ's concise reasoning was that the indefinite application of Article 5(2) contravened the intention of the Gender Directive. The Gender Directive, the ECJ said, was based on the premise that, "*for the purposes of applying the principle of equal treatment for men and women, the respective situations of men and women with regard to insurance premiums and benefits contracted by them are comparable*". On this basis, an indefinite exemption could not be justified.

Commission Guidelines on implementation

After spending nine months mulling over the ECJ decision and consulting with insurers and other interested groups on how it could best be implemented, the European Commission issued Guidelines on the application of the Gender Directive in light of the *Test-Achats* decision (the **Guidelines**) on 13 January 2012. The Guidelines attempt to answer many of the doubts that had been raised but, ultimately only reflect the Commission's view on how to interpret the legislation.

New contracts

With the Article 5(2) exemption eliminated, Article 5(1) of the Gender Directive prohibits "*the use of sex as an actuarial factor in the calculation of premiums and benefits*". The Guidelines confirm that this applies only to "*new contracts*", which (for these purposes) means "*whenever a contractual agreement requiring the expression of consent by all parties is made, including an amendment to an existing contract* [where] *the latest expression of such consent by a party that is necessary for the conclusion of that agreement*" occurs on or after 21 December 2012. Examples of new contracts include contracts where the offer was made before 21 December but accepted on or after that date, as well as agreements made after 21 December to extend contracts concluded before that date that would otherwise have expired.

Contracts that are not "new" (for these purposes) and which need not comply with the Unisex Rule include the automatic extension of a pre-existing contract, certain adjustments made to a pre-existing contract that do not require the consent of the policyholder, the policyholder's decision to take out top-up or follow-on policies whose terms were pre-agreed in a contract concluded before 21 December 2012, and contracts in a "straightforward" portfolio transfer from one insurer to another.

As well as describing some of the circumstances where a new contract may be created, the Guidelines also describe a number of insurance practices that are gender related but still lawful. The Unisex Rule prohibition is on differences in premiums and benefits for individuals that arise as a result of using gender as a calculating factor. It is not prohibited to use gender as a risk-rating factor in general, and gender can be used in calculating premiums and benefits at the aggregate level, as long as it does not lead to differentiation at the individual level. Further, the collection, storage and use of gender information for reserving and internal pricing, for reinsurance pricing, and for marketing and advertising is still permissible (at least to the extent that these practices are consistent with European law in

general). In life and health underwriting, the Unisex Rule means premiums and benefits cannot be different for two individuals simply because their gender is different, but other risk factors such as health status or family history which may involve gender issues, such as a family history of breast cancer, can be taken into account.

Indirect discrimination

The Guidelines also comment on indirect discrimination, and factors such as age and disability, which were identified as potential difficulties after the *Test-Achats* decision was handed down. Indirect discrimination is where an apparently neutral risk factor puts one sex at a disadvantage, the frequently cited example being motor premiums being decided on the size of car engine, as statistically men tend to drive cars with bigger engines. Under the Gender Directive, indirect discrimination is lawful only if the aim is legitimate and the means of achieving it are appropriate and necessary; the Guidelines further clarify that in motor insurance, price differentiation based on the size of a car engine "*should remain possible*" as that is a true risk factor, but differentiating on the basis of a person's size or weight would not be allowed as these matters are not.

Age and disability as risk-rating factors are not affected by the *Test-Achats* decision, and they are not currently regulated at EU level. There is a proposal for a directive on equal treatment irrespective of religion, belief, disability, age or sexual orientation, but this does not contain a general principle akin to the Unisex Rule. Therefore the proposed directive would recognise that two people of different ages are not in comparable positions with regard to life insurance and so proportionate differences of treatment based on a sound risk assessment would not constitute discrimination.

Annuities

Finally, the Guidelines consider annuities. The Gender Directive applies only to private, voluntary insurance and pensions which are separate from the employment relationship, so annuities provided for under occupational pension schemes will still be covered by Directive 2006/54/EC on equal opportunities and equal treatment in employment, and not the Gender Directive. In contrast, if an individual employee concludes an insurance contract directly with the insurer and without the employer's involvement, such as converting a lump sum into an annuity, then this will come under the Gender Directive. The Guidelines state that the Commission considers that the *Test-Achats* ruling does not affect the setting of different levels of benefits between men and women in the "*different and clearly separable*" context of occupational pensions. Such differences are allowed under Article 9(1)(h) of Directive 2006/54/EC, where different benefits are not considered discriminatory when justified by actuarial data.

As noted above, the Guidelines reflect the Commission's views and, while they may be persuasive and therefore create a degree of comfort for insurers, they are not binding. A firm that follows them slavishly could still find itself in hot water if the Guidelines are flawed, if they are misinterpreted and/or misapplied. Further, while the Guidelines do help clarify some

doubts over the effects of *Test-Achats*, they also appear to create their own problems. For example, they explain that insurers can use marketing and advertising to influence the mix of their portfolio, but any attempt to do so must still be consistent with the balance of the Gender Directive, and EU and UK law in general, which is something of a minefield. The Guidelines also seek to draw distinctions that may be difficult to use in practice, such as the lines between existing and "new" contracts, between what is and is not discrimination, and between direct and indirect discrimination. Insurers should be particularly wary of these areas when amending their practices to comply with *Test-Achats*. Insurers should also consider whether any portfolio transfers that will become effective on or after 21 December 2012 are "straightforward". In view of the Commission's Guidelines, there is at least a risk that a non-straightforward portfolio transfer that becomes effective after that date will create new contracts of insurance that are subject to the Unisex Rule. Similar issues could also arise in reattribution and other contexts.

The UK position

In December 2011, shortly before the Guidelines were published, HM Treasury opened a consultation on the UK's response to the *Test-Achats* ruling. The government had already expressed its disappointment with the judgment through a formal statement by Mark Hoban, Financial Secretary to the Treasury, in June 2011. While recognising the government's obligation to implement the judgment, Mr Hoban said that financial services providers should be allowed to make sensible decisions based on sound analysis of relevant risk factors. The consultation was opened to seek views on the likely impact of the judgment on consumers and industry as well as the government's proposed approach for implementation in December 2012.

Impact assessment

The government believes that the judgment will result in a marked net increase in the cost of premiums, with the most significant increases for those in lower-risk categories. For example, in the field of motor insurance, it is suggested that cross-subsidisation of premiums between genders will result in (generally more careful) female drivers paying the same price for insurance as (generally less careful) male drivers and thus the female subsidises the cost of the male's insurance. The government has estimated a "benefit" of approximately £600m for males due to the reduction of their premiums and a "cost" to females of approximately £900m, creating a net cost to motor insurance consumers of approximately £300m. There could also be a detrimental effect on road safety since gender-neutral pricing might encourage (or at least allow) male drivers with lower premiums to purchase higher-powered cars or increase the riskiness of their driving.

In life assurance, the government considers that adverse selection may increase the cost of insurance generally since life assurance will become a good value product for men (who have a lower average life expectancy) but a poor value product for women. As lower-risk female customers are disincentivised from purchasing such insurance by higher premiums

and/or lower benefits, the general level of risk of the insurer's portfolio increases, and thus the cost of insurance will rise to compensate. However, as mentioned above, the Guidelines provide that health status or family history, which may involve gender issues, can still be taken into account when setting life assurance premiums. Although competition in the market may eventually push prices back down, the government anticipates that the market will even out at a higher level than before.

Further problems are predicted on an industry level. The government suggests that lower-risk categories of consumers may leave the market or purchase cheaper products, thus affecting revenues. Transitional costs are also expected to be incurred in implementing changes to underwriting policies, marketing and sales approaches, although the government has requested responses from insurers to confirm the expected level of such costs.

Limiting the scope of the judgment

The government's interpretation of *Test-Achats* highlights the limits of the decision, which may be of some comfort to insurers. Firstly, it stresses that the Gender Directive only prohibits the use of gender in the pricing of premiums and benefits, and that sex may still be used as an actuarial factor. This point is also emphasised in the Guidelines, and it allows insurers to continue to collect data on gender and use it in order to assess the overall risk of a particular pool of risks.

Secondly, the government confirmed that in its view, the judgment must be limited to those insurance contracts entered into on or after 21 December 2012, the effective date of the judgment. This would mean that insurers could continue to operate any contracts entered into before that date in which gender impacts the pricing of premiums or benefits. Again, this view has subsequently been supported by the Guidelines which also give further clarification on what constitutes a new contract.

Incorporation into UK legislation

To effect the legal mechanics of implementation, the government proposes to amend the Equality Act 2010 in spring 2012 by removing paragraph 22 of Schedule 3, which implemented the Article 5(2) exemption to the Gender Directive into English, Welsh and Scottish law (the judgment will be implemented separately in Northern Ireland). Without this exemption, there is a danger that risk factors that impact one sex more than the other, ie they constitute indirect discrimination, would be affected as the Equality Act 2010 prohibits both direct and indirect discrimination. However, indirect discrimination will not be unlawful if the insurer has a legitimate aim and the means of achieving it are appropriate and necessary. Furthermore, paragraph 27 of Schedule 3 will still be available to insurers who wish to provide single-sex insurance services to cover such risks as prostate or ovarian cancer.

What next?

The *Test-Achats* decision is final and cannot be appealed. The UK government's consultation ends on 1 March 2012, after which the Treasury will publish the results on its website and

implement the amendments to the Equality Act 2010 so that they come into force from 21 December 2012. It will be interesting to see whether opposition to the decision softens in light of the publication of the Guidelines, which generally provide for pragmatic implementation. However, they are unlikely to dispel a general sentiment that removal of gender as a pricing factor will result in some overall premium increases (and benefit reductions) as insurers must reassess data, alter their income structures, and change policy terms and marketing materials. Further, as noted above, the Guidelines also create their own problems of interpretation. In particular, despite reassurances that indirect discrimination will be lawful where the aim is legitimate and the means are appropriate and necessary, this test is subjective and may encourage consumer challenges to pricing structures. For example, although car engine size is specified as one factor that "should remain possible", there are countless other factors that may also be tested. If the policyholder's occupation is used (which is likely to be complicated and problematic of itself), how difficult will it be to show that the insurer's aim is "*legitimate*" and the means it has used are "*appropriate and necessary*" if the result favours concentrations of women doing care jobs or is prejudicial to men in construction? Clearly the extent of what is acceptable indirect discrimination remains unclear.

The European Commission plans to monitor implementation by individual states (currently only Belgium, Cyprus and the Netherlands restrict gender as a rating factor in many non-life insurance lines) and it has also pledged to remain vigilant in following the evolution of the market in order to seek to identify any unjustified rise in prices attributed to *Test-Achats*. In fact, the country whose consumers brought the *Test-Achats* case is also the best-placed to allay concerns about its practical consequences: Belgium has had unisex motor insurance since 2007 but has not seen the market problems feared by insurers. Premium growth has been restrained by strong competition and safer drivers of both sexes who build up no-claims bonuses have benefited.

For now, the rest of Europe's insurance industry has a couple of years to adapt to the new rule. In 2014, the Commission will report on the implementation of *Test-Achats* in national law and in insurance practice as part of a general report on implementation of the Gender Directive.

Endnotes

[1] The authors are lawyers in Edwards Wildman Palmer LLP. Chris Finney, Partner, Insurance and Reinsurance Department, specialises in the regulation of life and general insurers, reinsurers and captive insurers, with particular expertise in Solvency II. Mark Everiss, Partner, Insurance and Reinsurance Department, is the co-chair of the Reinsurance Practice Group focusing on reinsurance litigation and has handled very many significant disputes both in the High Court and in arbitration. Stephen Ixer, Associate, Insurance and Reinsurance Department, works on complex (re)insurance disputes and is also active in the firm's Latin American practice.

[2] This decision was previously discussed by Glen James in BILA Journal 122 (see www.bila.org.uk/closed/cug/articles/archive/BILA p5-17.pdf)

Principles of European Insurance Contract Law: A Model Optional Instrument

With a Postscript in Honour of Fritz Reichert-Facilides

Edited by Helmut Heiss, MandeepLakhan, Project Group Restatement of European Insurance Contract Law

May 2011: viii, 152 pages

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Book review by Jacquetta Castle, Fishburns LLP

The title to this book is something of a misnomer, suggesting that it reproduces the Principles of European Insurance Contract Law (PEICL) or is otherwise a comprehensive commentary on them. In fact, the PEICL have been produced in a separate, larger volume published in 2009 (ISBN 978-3-86653-069-0). Notwithstanding this, the current 152 page volume under discussion is an invaluable background work for anyone interested in the PEICL or indeed in insurance contract law reform more generally.

The greater part of the book reproduces the papers presented by the eminent speakers who took part in the Vienna conference on PEICL in 2010 which was hosted by the Austrian Ministry of Justice. The speakers included MEP Diana Wallis, Vice President of the European Parliament, Professor Jurgen Basedow of the Max Planck Institute, Professor Heiss of Zurich University and Peter Hinchliffe, who was then the Lead Financial Ombudsman at the Financial Ombudsman Service in England.

What makes this work particularly interesting is the range of different views of the speakers who come from a variety of political, industry and academic backgrounds across Europe. Apart from the speakers, the editors have included a selection of comments from the floor of the conference. The criticisms of the PEICL (both from the speakers and from the floor) are generally constructive and should be useful for the Project Group if this initiative is to progress. For example, the PEICL differentiate between "large risks" and "mass risks" (as opposed to consumers vs. non-consumers): "large risks" derogations from the PEICL are allowed to the benefit of either party, insurer or insured. Professor Fontaine (University of Louvain), considers that derogation should only be allowed for a limited list of provisions and that PEICL should not allow what he refers to as "sweeping exemptions". At the other end of the scale, Peter Hinchliffe, looking at the PEICL from a consumer standpoint, raises the point that the PEICL do not appear to apply to intermediaries but even so, he feels that the assumptions in PEICL about the role and responsibilities of intermediaries should perhaps be reviewed. He also raises various drafting concerns.

One point that impressed me was that the editors have done a good job in ensuring that the various papers reproduced are in fluent, clear and readable English. However eminent the speakers and however excellent their spoken English (the conference was in fact conducted in English, rather than with simultaneous translation as some of the other PEICL conferences), I believe that English is the first language of only two of them.

The only issue I might mention is that in the 15 or 16 months between the conference and the publication, Europe is now a different environment and it would be interesting to hear current views on how realistic the PEICL are in the new political environment.

Bringing things up to date, it is understood that the PEICL project Group has completed work on its Rules on Liability Insurance and Group Insurance. The Rules on Life Assurance will be completed by the end of 2012. In 2013 the Project Group will write Comments and publish the second volume (either together with a slightly revised edition of the first volume or with both parts in one new book). This will represent the conclusion of the work of the Project. Further Principles (Rules) on other areas will only be provided if the EU Commission wants them for a legislative proposal.

The EESC's 2010 own-initiative opinion on the "The 28th regime – an alternative allowing less lawmaking at Community level" called for an optional European private law following the model of the PEICL ("2nd regime model"). This model was taken up in the EU Commission's Green Paper on policy options for progress towards a European Contract Law for consumers and businesses of 2010 as an "option 4". On 8 June 2011, the European Parliament delivered its Resolution on policy options for progress towards a European Contract Law for consumers and businesses, which advocates the adoption of an Optional Instrument including Insurance Contract Law based on the PEICL. EC Justice Commissioner Reding started a dialogue with the insurance sector about an optional European Insurance Contract Law on 21st September 2011 (Press Release 11/624). The Draft Optional Instrument on Sales Law of October 2011 also follows the "2nd Regime Model" as applied by the PEICL (it is, however, limited to cross border transactions).

It is also understood that the Commission wants to set up an expert group drafting an Optional European Insurance Contract Regulation (parallel to the Sales Regulation) by the end of this year.

The book ends with an English translation of the text of the Late Professor Emeritus Dr Fritz Reichert-Facilides , the original Chairman of the Project Group on the Restatement of European Insurance Contract Law setting out the original concept behind the project. It is a fitting tribute to this visionary academic.

13/14 SEPTEMBER 2012 – IVth AIDA EUROPE CONFERENCE PREVIEW

Testing times, uncertain outcomes: how are insurers and reinsurers expected to measure up?

Tim Hardy[1]

As London recovers this September from the Queen's Diamond Jubilee celebrations, the Olympic Games, then the Paralympics, BILA will be welcoming around 300 insurance and legal professionals, academics, regulators and others from across Europe and beyond, on the occasion of the IVth AIDA Europe[2] Conference to be held at the Grange Tower Bridge Hotel.

Held over two days (13 and 14 September 2012), the Conference will follow the pattern of similar successful events staged in Hamburg (2007), Zurich (2009) and Amsterdam (2011). The programme is already taking shape and is to be found, together with early bird registration details, on the AIDA[3] and BILA websites.

The first day will see a series of AIDA Working Party meetings. These are sessions open to all delegates, including presentations from many overseas speakers and discussions on an array of topical issues and studies across the spectrum of insurance concerns.

Working Party meetings addressing Marine Insurance, Reinsurance, Consumer Protection and the Accumulation of Claims and Subrogation will be followed by further meetings in the afternoon concerning Civil Liability, Climate Change and also State Supervision. The closing session will consider Credit Insurance, the Distribution of Insurance Products and New Technologies.

At the end of the first day delegates may participate in a number of short tours to be announced and enjoy a reception to be held at Two Temple Place on the Embankment.

Adopting the theme, "*Testing Times, Uncertain Outcomes: How Are Insurers and Reinsurers Expected to Measure Up?*" the second day will commence with a keynote speech from Karel van Hulle, Head of the Unit for Insurance and Pensions at the DG Internal Market and Services of the European Commission in Brussels, where his main responsibility has been the preparation of the new solvency regime for insurance and reinsurance companies (Solvency II).

The first of four principal sessions will concentrate upon how best to respond to regulation in so many forms in such a presently fast-changing financial and political world. Beyond Solvency II provisions, 2012 will see several regulatory and compliance challenges, proposed insurance contract law reform and further encouragement of cross-border harmonisation of laws. As the political map is being redrawn or challenged in many places it will also be timely to review how successfully companies are complying with various Sanctions and Anti-Money Laundering and Counter-Terrorism obligations imposed across different jurisdictions.

The second session will showcase five important areas being addressed by AIDA over the coming two years ahead of its quadrennial World Congress in Italy in October 2014. A collaborative study is being embarked upon by BILA, and up to fifty other AIDA National Chapters, of legal and regulatory measures to ensure transparency (and fairness) of insurance contracts in terms of the fulfilment of pre-inception obligations of disclosure by *insurers and intermediaries*. That is, disclosure about their own product and practices, not disclosure by policyholders about their risk[4]. This will consider laws, sanctions and remedies around the world in all life and non-life classes.

Other areas to be considered are: i) Reinsurance and international insurance arbitrations, including Bermuda Form; ii) Preventive Measures provided for in insurance contracts; iii) Discrimination and Insurance, including a review of the *Test Achats* litigation[5] ; and iv) Online insurance issues.

The afternoon of the Conference will repeat two very popular and practical topics of past Conferences. First, the latest claims developments and identifying the next big claims, with insights from the claims frontline. In the wake of recent major climate/natural catastrophes losses and economic and political disturbances, business interruption, supply chain and political risk claims, fraud and financial institution exposures, there is much to discuss. Also, claims emerging from new products and technologies, cyber risks, renewable energy exposures and medical and other products. The impact, too, on dispute resolution of third party funding, class actions, claims management companies and contingency fees and changes in regimes for consumer redress.

The final session, to be chaired by BILA's President, Professor Rob Merkin will allow quickfire updates to be provided of the hottest topics currently raising important legal issues around Europe and reviewing trends in liability, legislation and reform.

As BILA approaches its 50th Anniversary in 2014 it is interesting to reflect that in 1964 the earliest editions of the BILA Journal[6] discussed the merits of forming an international insurance law association (AIDA had been formed in 1960) and why it would be a mistake for the UK not to be represented within one (as it then was four years later).

In 2012 there is barely a single insurance-related legal or regulatory issue which does not require, or benefit from, an understanding and appreciation of its treatment in other jurisdictions. BILA has further since established itself as one of the largest and most active of the AIDA National Chapters.

Having hosted a number of its own international colloquia in London over the years and the Vth AIDA World Congress in 1982, BILA is therefore delighted to be associated with the staging of the first AIDA Europe Conference on English soil this year. With so many eyes already on events in Europe this coming year it is perhaps a particularly auspicious time to be doing so.

The reduced delegate rates for the event are only made possible by the generous support of a number of sponsoring firms, companies and organisations. Anyone interested in remaining opportunities to sponsor the event should make contact with AIDA Europe Chairman, Colin Croly on aidaeurope@btinternet.com .

Endnotes

[1] BILA Representative on the AIDA Europe and BILA Organising Committee for the London AIDA Europe Conference; BILA Vice President and Charitable Trustee; AIDA Assistant Secretary-General-Administrative Affairs; Chairman, AIDA Climate Change Working Party; currently non-practising solicitor and CEDR accredited mediator.

[2] AIDA Europe was established in Rome in 2007. Its aim is to bring together the National Associations of AIDA (the Association Internationale de Droit des Assurances – The International Insurance Law Association) in Europe, as a regional grouping, to further the aims of AIDA on a regional basis and to generate enthusiasm and industry involvement in the work of AIDA.

[3] http://www.aida.org.uk/AIDAEurop/Forthcoming-events.asp

[4] A copy of the Questionnaire prepared by the Italian Chapter on the subject of Transparency for completion by BILA and all other National Chapters ahead of the 2014 World Congress will be published in due course.

[5] see article at page 78 by Chris Finney, Mark Everiss and Stephen Ixer

[6] With the kind assistance of the Chartered Insurance Institute, the BILA Charitable Trustees have succeeded in recent months in completing the set of BILA Bulletins and BILA Journals held from inception. They have been scanned and included in a revised BILA Journal Archive on the BILA web site. The archive will be upgraded in due course within a new BILA website in the course of 2012.

BRITISH INSURANCE LAW ASSOCIATION CHARITABLE TRUST

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

To qualify for the prize the work must first have been published in the English Language in the calendar year immediately preceding the year in which the prize is to be awarded.

Authors wishing to have their work considered for the Prize should apply in writing to Ms Alison Green of the Trustees, before 30th June in the year following publication, submitting one copy of their work.

Address:
BILA Charitable Trust
c/o 2 Temple Gardens
London EC4Y 8AY

The Trustees in their absolute discretion may decide that the prize shall not be awarded in any year and the decision of the Trustees on any matter relating to the Prize shall be final.

BILA Journal article prize

BILA offers an annual article prize. This is aimed at motivating newcomers to BILA.

The rules for the prize are as follows:

- To be awarded by the BILA Committee at the same time as the BILA book prize (in the Autumn),
- All articles published in BILA Journal since the award of the last prize to be considered.
- To qualify, an article must have been written by an author:
    - who is not a member of the BILA Committee, or any BILA sub-committee, and
    - who has not previously written for the Journal or been a speaker at a BILA event.
- No application is necessary: all qualifying articles will be considered. The proposed successful author will be contacted in advance to check whether he or she accepts the prize.
- The prize will consist of a set of BILA glasses (normally awarded to speakers at BILA events) and a certificate evidencing the award of the prize.
- The Committee in its absolute discretion may decide that the prize shall not be awarded in any year. The decision of the Committee on any matter relating to the prize shall be final.

British Insurance Law Association Journal

GUIDELINES FOR AUTHORS

1. The aim of the BILA Journal is to add informed discussion about subjects affecting the insurance industry.

2. Reading the BILA Journal is a voluntary activity. It is therefore important that articles are written in a readable style. Short sentences help to achieve this.

3. Whilst a substantial proportion of the readership of the BILA Journal has legal training, a substantial proportion does not.Articles should be written with this in mind.

4. The guideline length for articles is 3,000 words. If your article seems likely to be less than 2,000 words or more than 4,000 words, please have a word with the Editor.

5. References to cases cited should be provided. Notes to the text should be endnotes, not footnotes.

6. If an article has been commissioned from you, the Editor will have asked you to provide copy by a specific date. Please aim to meet it as this affects the publication timeline.

7. When submitting copy, please send it preferably by email (or on a USB/disc) to the address below.

Address for copy:

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