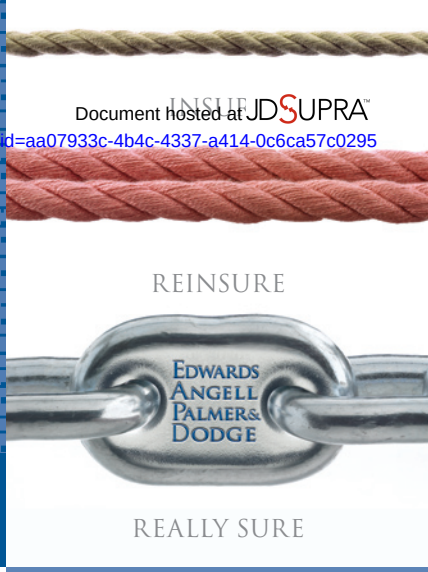
EDWARDS ANGELL PALMER & DODGE

# Insurance and Reinsurance Review

September 2009






## *Wasa v. Lexington*: House of Lords Not Back-to-back With the Court of Appeal

House of Lords considers the extent to which facultative reinsurance should be construed as being back to back with the underlying insurance.

The question of whether reinsurers whose reinsurance was for a three year period should be liable only for property damage occurring during that three year period or for the whole of its reinsured's loss, relating to over forty years worth of damage caused by the insured, has finally been resolved by the House of Lords. As we reported in the June 2008 issue of the *Insurance and Reinsurance Review*, the Court of Appeal had held that the reinsurers' liabilities were not so limited, because the reinsurance wording relating to the period of cover had to be given the same meaning as that in the insurance, as determined by the Supreme Court of Washington. The House of Lords, (which is to be reconstituted as the United Kingdom Supreme Court from 1 October 2009), has now rejected this view in *Lexington Insurance Company v AGF Insurance Limited* [2009] UKHL 40.

### Background

The Respondent insurer, Lexington Insurance Company (Lexington) insured Aluminium Company of America and its subsidiary Northwest Alloys, Inc (Alcoa). Lexington obtained reinsurance with the Appellants, AGF Insurance Limited (AGF) and Wasa International Insurance Company Limited (Wasa). Alcoa incurred losses as a result of being required by the United States Environmental Protection Agency to fund the clear up of various contaminated sites occupied by Alcoa since the 1940s.

Alcoa then sought to obtain an indemnity from its various insurers, including Lexington, for these costs. It commenced proceedings in the State of Washington against its insurers; these proceedings ultimately resulted in a settlement by Lexington of $180million of claims made by Alcoa for $103million. It was common ground between the parties that this was a business-like settlement.

Lexington in turn sought to recover its losses from Wasa and AGF. The subject of the appeal to the House of Lords was whether Lexington could recover under the terms of its reinsurance with Wasa and AGF for the whole of its loss, being in respect of Alcoa's losses arising over forty plus years, or whether the reinsurers' liabilities were limited to those occurring during the three year policy period of the reinsurance.

### The Insurance

The insurance provided by Lexington in 1977, was in respect of *"all physical loss of, or damage to, the insured property..."*. It contained a Limit of Liability of $20million for loss or damage arising from any one occurrence, defined as *"any one loss(es), disasters(s), or casualty(ies) arising out of one event or common cause"*. The policy term was three years beginning on 1 July 1977 and ending on 1 July 1980.

### The Reinsurance

Wasa and AGF had a 2.5% line on the London market slip reinsuring Lexington. The slip expressed the interest to be *"All property of every kind and*

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UPCOMING
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Workshops 2009 — London UK
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By Lisa Peatfield
London

## UPCOMING EVENTS

- **Nick Pearson** (New York) is attending the Vermont Captive Insurance Association (VCIA) Annual Conference in Vermont on 11-13 August.
- **Richard Spiller** (London) and **Alan Levin** (Hartford) are attending the National Association of Insurance Commissioners (NAIC) Meeting in Washington, DC on 21-24 September.
- **Jeanne Kohler** (New York) is attending and hosting a breakout session at the Reinsurance Association of America (RAA) ReClaims Conference in New York City on 24-25 September. EAPD is also hosting a cocktail reception and a marketing booth at this event.
- **Charles Welsh** and **Theodore Augustinos** (Hartford) are attending the American Bankers Insurance Association (ABIA) Conference in Washington, DC on 4-6 October. EAPD is also hosting a marketing booth at this event.
- **John Emmanuel** and **Theresa Feliciano** (Hartford) are attending the Association of Insurance Compliance Professionals (AICP) Conference in Phoenix on 4-7 October. EAPD is also hosting a marketing booth at this event.

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*Description and/or Business Interruption and OPP &/or as original"*. The policy period was expressed to be "*36 months at date 1.7.77 ... and/or pro rata to expiry of original"*. The sum insured was $20million each occurrence. The references in the slip to *"&/or as original"* under the headings 'Form' and 'Interest' were sufficient, the House of Lords said, to incorporate the relevant insurance provisions relating to the subject matter and risks into the reinsurance. The reinsurance was accepted to be governed, by implication, by English law due to the fact that it was on an English form and broked and issued in the London market.

### Lexington's Liability to Alcoa

In the US proceedings, the judge at first instance had to consider claims for coverage against 70 insurers, involving hundreds of policies and 58 contaminated sites. As a preliminary issue the judge found that Lexington's insurance (and Alcoa's other policies) was governed by Pennsylvania law. The Supreme Court of Washington, reversing the lower court, held that Alcoa's insurers were jointly and severally liable for all Alcoa's losses which flowed from the contaminated sites even if the property damage occurred before inception of the policies. The Washington Court decided that the insuring clause was very broad and was not limited by the time of the physical loss or damage, consequently *"any physical loss or damage manifesting itself during the time a...policy was in effect was covered by the policy, including pollution damage starting before the policy inception."*

### The House of Lords' Decision

The effect of the Washington Court's decision was that Lexington was liable for all damage manifesting itself during the three year period of insurance irrespective of whether the damage had begun prior to the inception of the policy. In essence, the question for the House of Lords was the extent to which the cover under a proportional facultative reinsurance contract is co-extensive with the cover under the insurance contract.

### The Nature of Facultative Reinsurance

The House of Lords stated that the starting point for analysing the extent of the reinsurance is that proportional facultative reinsurance is normally back to back with the underlying insurance: the scope and nature of cover provided by the reinsurance is co-extensive with that of the insurance. The reinsurer takes a proportional share of the premium and accepts the risk of the same share of the insurer's losses. The 'obvious' commercial intention of proportional facultative reinsurance, the House of Lords said, is for the insurer to reinsure part of his risk and therefore it was equally obvious that the terms of the reinsurance should be construed to be consistent with the insurance.

### Governing Law of the Insurance

The House of Lords stated that, in order to give effect to the principle in English law that the terms of the reinsurance should accord with those of the insurance, the question to be answered was what, in the reasonable contemplation of the parties at the time the contracts were entered into, was the governing law of the insurance policy. The Washington judge's decision that Pennsylvania law applied to the insurance contract was, said the House of Lords, to be viewed in light of the fact that she had to determine the issue with respect to a large number of insurers, insurance contracts and periods of insurance and light of a general consideration of the issues arising which were extraneous to the policy issued by Lexington.

*"The fact that the reinsurance was governed by English law meant, their Lordships said, that it did not have the same meaning and effect as that accorded to the insurance by the Washington Court."*

Their Lordships determined, however, that in 1977 when the insurance policy incepted there was no identifiable, and thus no predictable, system of law applicable to the insurance by which the reinsurance, in turn, could have been construed to mean something other than its London market meaning, as determined by English law (as the governing law of the reinsurance). The Court was therefore able to distinguish the instant case from the appellate decisions in *Forsikringsaktieselskapet Vesta v Butcher* [1989] AC 852 and *Groupama Navigation v Catatumbo CA Seguros* [2000] 2 Lloyd's Rep 350 where in each case at the time the insurances and reinsurances were placed, the governing foreign law of the insurance contracts could be identified, thereby allowing the relevant reinsurers to interpret the terms of the reinsurance contracts.

The fact that the reinsurance was governed by English law meant, their Lordships said, that it did not have the same meaning and effect as that accorded to the insurance by the Washington Court. As a matter of English law, the reinsurance only covered property damage which occurred during the three years of the policy; this was *"clear beyond argument"*. If, said Lord Mance, the position under the reinsurance was as found by the Washington Court then reinsurers would be liable for the whole of Lexington's losses even if the reinsurance was for a period less than that of the insurance; a result

described by Lord Collins as *"wholly uncommercial and outside any reasonable commercial expectation of either party"*.

Their Lordships therefore determined that there was no principled basis on which to find that the three year period of reinsurance should be treated as having the same scope as the insurance, as interpreted by the Washington Court according to Pennsylvania law. The House of Lords were clear that whilst Lexington was unlikely to have bargained for the liabilities it was held by the Washington Court to have, that was no reason to pass that liability to Reinsurers who were entitled to believe no such liability could arise under the clear terms of the English law reinsurance contract. Having said that, their Lordships also made clear that insurers and reinsurers accept the risk of changes in the law and neither can complain that the scope of the insured's liability has been increased by judicial decisions.

### Concluding remarks

Lord Mance suggested that in order to avoid the same result in future, insurers should ensure that the insurance and reinsurance are subject to the same governing law or at the very least that the insurance is subject to an identifiable governing law. This would make it more likely that the insurance and reinsurance will be considered back to back. Whilst this decision will come as a relief to reinsurers, it is once more, a salutary lesson to insurers and reinsurers to ensure that all the terms they wish to contract by, including the law governing their bargain, are clearly stated rather than leaving such matters to chance.

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# Reading Between the Lines of the Financial Services Reform Proposals: What Does it Mean for the Insurance Industry?

By Geoffrey Etherington
New York

On June 17, 2009, the U.S. Treasury Department released the Obama administration's broad overhaul of the federal financial regulatory system. Entitled "Financial Regulatory Reform, A New Foundation: Rebuilding Financial Supervision and Regulation", the 88 page report outlines reforms that, if adopted by Congress, will have far-reaching impacts upon the U.S. financial system, including new regulation of hedge funds, non-banking companies, over-the-counter derivatives, rating agencies, securitizations and consumer financial products and enhanced regulation of banks, investment banks and bank holding companies.

Despite its length, Treasury's report is short on specifics. While several new agencies are proposed and new powers are to be granted to existing agencies, including the Board of Governors of the Federal Reserve System and the Securities Exchange Commission, details have been left up to Congress and the administration to work out in the legislative process. A series of hearings has begun before the House Financial Services and Senate Banking Committees that will last into the fall, and some legislation has been introduced. There is much work to be done and open issues to be addressed before a complete detailed new scheme of financial services regulation can be implemented.

Most segments of the financial services industry can expect major changes in regulation and oversight even if only portions of the administration's plans are enacted. However, the report and subsequent public statements by Treasury Secretary Geithner, President Obama and their representatives offer little of substance with respect to the insurance and reinsurance industry. As a result, p&c, life and reinsurance industry leaders and trade groups have generally not taken issue with specific aspects of the reform proposal. Those on either side of the federal charter and state regulation of insurance debate have advocated that these matters be addressed in the reform proposal. Notably, the industry to this point has convinced the Treasury Department and some members of Congress that insurance products should not be regulated by the new Consumer Financial Protection Agency described below.

Significantly, the Report takes no position on federal charters for insurance companies and

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*"If the reform proposal is adopted as proposed, the Federal Reserve Board for all intents and purposes will be the new federal regulator of the insurance industry..."*

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## Rendez-vous de Septembre Monte Carlo 2009

**Ambereen Salamat** (London) and **Nick Pearson** (New York) are attending the Rendez-vous de Septembre, taking place in Monte Carlo from 4-10 September .

does not overtly propose changes to McCarran-Ferguson or the current state-based regulation of the insurance industry in the United States. But, as discussed below, the reform proposals grant to the Federal Reserve Board unfettered authority to regulate large insurance industry firms. Unfortunately, while for the first time a federal regulator could directly regulate insurance and reinsurance holding companies, the Administration has not offered a prescription for coordination of federal and state regulation of insurers and reinsurers.

The Treasury Department's reform proposal is intended to address, through more robust supervision, a number of factors that the Administration believes were the roots of the current financial crisis:

- insufficient risk management systems;
- lack of market transparency and standards;
- compensation systems that did not reward creation of long-term value;
- gaps and weaknesses in the supervision and regulation of financial firms that did not protect the economy and financial system as a whole.

Without offering any evidence or theoretical support, the report suggests that there is little doubt that these factors caused the financial meltdown and that the fix for the ills of the financial services industry are embodied in the reform proposal. Many commentators, regulators, legislators and industry participants have expressed broad support for the President's proposal. Notable among those expressing contrary views is Richard A. Posner who, writing at www.theatlantic.com on June 17, 2009, noted:

> "throwing a raft of proposals at the banking industry while the industry is struggling to regain its footing, is sure to distract the banks' management, not to mention the Administration's economic team."

A central tenet of the reform proposal is the reordering of the federal regulatory system. A new body, the Financial Services Oversight Council, composed of the Secretary of the Treasury, Chairmen of the Federal Reserve Board, FDIC, SEC and the Commodity Futures Trading Commission, and the Directors of the new National Bank Supervisor, the new Consumer Financial Protection Agency, and the Federal Housing Finance Authority, will coordinate financial services regulation and oversight. Notably, since the proposal does not establish any separate federal insurance regulator, no representative to the Council will have a primary insurance or reinsurance regulatory focus. As discussed below, the Federal Reserve Board will regulate certain large insurance firms, but it will have many other responsibilities, including oversight of the banking industry and managing systemic risk within the financial service industry. The industry should ask itself whether there will be a federal regulator with sufficient interest in the insurance industry as a whole to effectively preserve and protect its future prospects.

A new Office of National Insurance within the Treasury Department will be established to gather information, coordinate policy and negotiate international agreements. However, this Office will have no regulatory authority over the insurance industry or policymaking authority. The Office will have no formal role within the Financial Services Oversight Council except the through the Secretary of the Treasury, who will chair the Council.

In addition to bank holding companies, the Federal Reserve Board will have authority over all financial services firms that could pose a threat to financial stability if they fail ("Tier 1 FHCs"). The Federal Reserve Board will determine what firms are Tier 1 FHCs. Thus, an insurance holding company, whose size, leverage and interconnectedness are deemed by the Federal Reserve Board to pose a sufficient threat to the financial system, will find its activities, capital and leverage subject to federal regulation, while it and its insurance subsidiaries also remain subject to state regulation. The Federal Reserve Board can require periodic reporting from all U.S. financial services firms meeting criteria to be established by the Federal Reserve Board to enable it to identify firms that may be Tier 1 FHCs. Accordingly, many insurance and reinsurance holding companies should expect to have federal reporting obligations, even if they are not classified as Tier 1 FHCs. Federal reporting requirements need not conform to or be consistent with current statutory or holding company reports to state regulators.

If the reform proposal is adopted as proposed, the Federal Reserve Board for all intents and purposes will be the new federal regulator of the insurance industry, or at least the larger participants in the industry, through its power to regulate Tier 1 FHCs.

Thus, it seems certain that if the President's proposals for broad oversight and supervision of the financial services industry are to apply to the insurance industry, the Federal Reserve Board may obtain by statute or court decisions the power to preempt state regulation of the insurance industry. Hopefully, Congress will take it upon itself to determine how overlapping state and federal authorities will be resolved with respect to large insurance and reinsurance companies, and their parent companies that are deemed to be Tier 1 FHCs, and that previously were not subject to federal regulation. If Congress does not address this conflict, inevitable tension between federal and state regulators will arise. Given past efforts by federal regulators to limit state regulation of banks, one can expect the Federal Reserve to seek clarification in court of any significant dispute with

state insurance departments. This may mean a further erosion of the reservation of the regulation of insurance by the states but also could lead to uncertainty for the industry as to what regulatory master it serves. To avoid creating unfavorable decisions in federal court, state regulators may well shy away from confrontation with the Federal Reserve Board as to Tier 1 FHCs.

A new Consumer Financial Protection Agency would be created to establish standards and disclosures in connection with the sale of consumer financial services products. While the proposed reforms do not reference insurance products as included within this new Agency's authority, elsewhere in the proposals insurance companies are clearly considered to be financial services firms. As noted above, the industry for now is winning the argument that insurance products will not be subject to regulation by the new Agency.

The full impact of the reform proposals on the insurance and reinsurance industry will likely become clearer in coming months as Congress takes up the President's overhaul recommendations after hearings and testimony and discussion of enabling legislation. However, it seems clear that the industry will be regulated to some extent at the federal level and that the decades-old question of whether to repeal McCarran-Ferguson in whole or in part may be reconsidered again.

Perhaps of most concern to the industry is whether effective regulation and supervision of the industry is maintained at the state level or finally largely federalized. As some in the insurance industry have noted, the Office of National Insurance seems ill-suited to play the role of a federal insurance regulator, at least as currently constituted. Through its ability to regulate large insurance firms, there is a danger that through slow regulatory mission creep the Federal Reserve Board may gradually emasculate state regulators or create unequal playing fields between insurers controlled by Tier 1 FHCs and smaller firms. But since it will not have authority over all insurers it too cannot be a federal regulator of the entire industry.

The failure of the Administration's reform proposal to squarely address federal regulation of the insurance business creates significant challenges for the industry in planning for the future or seeking to influence the final form of the legislation. Reading between the lines of the proposal cannot provide much comfort to any insurance or reinsurance firm.

# Healthcare Update

## News from Washington, DC



- The annual August congressional recess is upon us, and this year's month away from Washington, DC is proving to be a crucial period in the Democrats' quest to overhaul the nation's healthcare system. The majority party is working to stay in control of President Obama's top legislative priority, and to bolster the public's opinion that their ideas will be most effective in increasing access to health insurance. Republicans, on the other hand, have been hard at work trying to reframe the debate – citing the pitfalls of government-controlled healthcare, as well as their fear that Democrats are moving much too quickly on a proposal that will affect nearly one fifth of the economy.
- With the initial goal of having legislation passed by both the House and the Senate before the August break a distant memory, Congress now looks ahead to September as the make-or-break month for healthcare reform.
- In the House, the Democrats' healthcare reform bill advanced through the committee process by the end of July, following a contentious markup in the Energy and Commerce Committee. The legislation – H.R. 3200 – is focused on expanding health insurance access via a government-run public insurance option, individual and employer mandates to obtain and provide coverage, and a tax increase on those making more than $250,000 in order to finance the expansion of coverage.
- Although the bill enjoyed relatively smooth sailing through two other House committees with jurisdiction over healthcare issues, it hit a snag in the Energy and Commerce Committee, where a powerful group of conservative Democrats (known as Blue Dogs) had a large enough presence on the committee to insist on substantial changes to the bill.
- Healthcare leaders in the House are expected to iron out differences between each committee's bill over the August break, and a vote on the House floor is expected in September. Despite the majority party's strength of 256 Members, striking a balance that gives Democrats the 218 votes they need for passage could prove tricky. Water down the moderate Energy and Commerce Committee amendment, and leaders risk losing a substantial portion of the 52 member Blue Dog caucus. Stray too far from the bill's original robust government-run public plan option, and the more liberal factions of the party may abandon ship.
- The Senate faces a similar dilemma. In July, the Health, Education, Labor and Pensions (HELP) Committee approved healthcare reform legislation similar to the House's bill without a single Republican vote. Meanwhile, the Senate Finance Committee has spent months attempting to produce legislation that will attract some Republican support, so that the bill can receive 60 votes on the Senate floor – the magic number necessary to prevent a filibuster. An agreement has proved elusive thus far, as the committee grapples with the difficult task of coming up with an estimated $1 trillion to pay for healthcare reform, as well as alternatives to the government-run public insurance option.
- Reports suggest that the Finance Committee has until September 15 to produce a bipartisan agreement. After the 15th, it is anticipated that the committee will move forward on a bill without Republican support, combine that product with the HELP Committee bill, and bring legislation to the Senate floor through the budget reconciliation process – a controversial move that only requires 51 votes for passage and would prevent a Republican filibuster.

**This article is current as of August 4, 2009. EAPD continues to follow this debate closely, and you can subscribe to our timely healthcare reform updates by emailing Les Levinson at LLevinson@eapdlaw.com.**

# Payment Protection Insurance: the Final Instalment?

By Ambereen Salamat and Chris Collins, London

Issues with the sale of Payment Protection Insurance (PPI) in the UK have been a regular feature in both the financial and consumer press for nearly half a decade. In this article, we summarise the action being taken by the main regulatory bodies overseeing this product and consider whether recently proposed legislation will increase either competition in the market or consumer confidence in the product.

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## Background

PPI generally protects insureds from the inability to make repayments on credit products (such as unsecured loans, mortgages, credit cards) if the insured suffers from, for example, accident, sickness, unemployment or death.

As credit markets became more competitive, lenders tried to increase profitability by providing PPI with the main credit product being purchased. This practice became controversial for a variety of reasons but mainly because consumers were not told they were purchasing insurance with their credit product or that the PPI was not a pre-requisite to obtaining the credit. Lenders would also front load the single premium onto the credit, leading in many cases to interest on the premium making up the majority of the cost of the main credit product.

As a result of some of these practices, the consumer body Citizens Advice made a 'super-complaint' to the Office of Fair Trading (OFT) in September 2005. The OFT agreed to undertake a market study into the supply of PPI, which was conducted in 2006. In February 2007, as a result of its finding that features of the PPI market may be anti-competitive, the OFT referred the issue to the Competition Commission (the Commission) for a full investigation. The final Commission report was published in January 2009 and draft legislation, based on the Commission's recommendations, is now under consultation.

It should be noted that the sale of PPI also falls under the remit of the Financial Services Authority (FSA). The view of the FSA throughout the various OFT and Commission investigations has been that whilst it is able to govern and control selling practices and elements of the PPI market that fall under the FSA's principles for business, it is for the Commission to determine whether the market itself is anti-competitive and, if so, to deal with this aspect.

## The Commission Review

### *The PPI Market*

The Commission reviewed the PPI market and the business models of PPI providers. It found that most PPI was sold at the point of sale of the credit product and there were very few stand-alone PPI providers. Typical commission rates on gross written premium (GWP) for PPI providers were between 40 and 80% depending on the type of risk. Claim rates were generally 11% - 28% of GWP. Providers also often had profit-sharing agreements with underwriters, generally 90% - 100% in favour of the providers. PPI was primarily sold through the same channels as credit products, namely face-to-face contact in branches, over the telephone and on the internet and was paid for either by a single premium or in monthly or annual instalments. The Commission

also found that whilst prices for PPI did vary as between different providers, a particular provider generally did not vary the price of its product.

### *Competition Between Providers*

The Commission found very little competition between PPI providers. This conclusion was based, amongst other things, on the following:

- little variation in PPI prices over time or evidence of PPI providers seeking to win sales from each other by competing on price or non-price factors such as quality, innovation or choice;
- very limited advertising of PPI itself, rather the focus of advertising being on the underlying credit product;
- despite variations in price and quality of PPI products, the low incidence of substitution between PPI policies, or combinations of PPI and credit; and
- providers tending to sell the same PPI products for a considerable period of time and the level of commission being used as a marketing tool by underwriters to attract providers to sell their PPI.

### *Features of PPI Market Preventing Competition*

The Commission found four main features of the PPI market that prevented competition, resulting in higher prices and less choice for consumers. The features were:

- providers and other intermediaries failed to seek to win customers by using the price or quality of their PPI policies as a competitive variable;
- consumers could not easily compare PPI products. This was largely due to their complexity, the way information on PPI was presented to customers, the bundling of PPI with credit and the limited number of stand-alone PPI providers and policies;
- consumers wishing to switch PPI policies were restricted from doing so as the terms of most PPI products made switching expensive (in the case of single-premium policies) or risked leaving consumers uninsured (eg due to limits on claims during the initial period of a policy or due to the exclusion of medical conditions that became apparent during the term of the current PPI policy). These barriers to switching limited consumer choice. They also, therefore, acted as barriers to expansion for other PPI providers, in particular, providers of stand-alone PPI; and
- the sale of PPI at the point of sale of the credit product further restricted the extent to which other PPI providers could compete effectively.

### *Commission's Recommendations*

In order to stimulate competition in the PPI market, the Commission made a number of recommendations, including:

- a prohibition on selling PPI at or shortly after the credit point of sale or provision of a PPI quote for a period of seven days (unless the consumer has initiated the PPI transaction and has confirmed that he has seen the personal PPI quote, in which case the prohibition period is reduced to 24 hours);

*"The approach taken by the FSA ... shows the flexibility and effectiveness of principles-based regulation."*

- all providers and other intermediaries who arrange credit for consumers must provide a personal PPI quote to the consumer and an annual statement for PPI policyholders;
- a requirement on all PPI providers to disclose prominently certain information in any marketing materials, including that PPI is optional and available from other providers;
- all PPI providers must supply comparative data to the FSA, as specified by, and in a format requested by, the FSA and a recommendation to the FSA to use the information for price comparison tables on its "money made clear" website;
- a prohibition on selling single-premium PPI policies;
- premium rebates to be paid to consumers on a pro-rata basis if the consumer terminates the policy during its term; and
- no separate charges to be levied for administration or for the setting-up or early termination of a PPI policy.

Following publication of the Commission's review, Barclays Bank has appealed against certain findings of the Commission to the Competition Appeal Tribunal. Barclays' main objection is to the prohibition on selling PPI at the credit point of sale. The Commission challenged Barclays' appeal and the FSA has also intervened on the Commission's behalf. The appeal is due to be heard in September 2009.

Despite this impending appeal, the Commission consulted on draft legislation to implement its recommendations. Responses were requested by 9 August 2009 and whilst the Commission has not set a date for the implementation of the legislation, the intention is to implement it swiftly if the appeal upholds the Commission's findings.

### FSA Action

The focus of the FSA in relation to PPI has been to improve sales practices, taking enforcement action where it has deemed necessary.

The FSA has stated that the sale of PPI is one of the most extensive thematic reviews it has undertaken. As a result of this review, progress has been made in improving sales practices and customer awareness of the issues surrounding PPI. Notable actions include:

- directions (that have now largely been adhered to) to stop the sale of single premium PPI;
- a number of reviews of sales practices of providers of various types of PPI, including 'mystery shopper' exercises and an escalation in regulatory interventions since October 2008;
- prominent features and advice on PPI on the FSA's "money made clear" website, including a detailed price comparison table of various PPI policies; and
- publication of 20 enforcement cases relating to the sale of PPI, including one of the largest ever fines imposed by the FSA (£7million) on Alliance & Leicester in October 2008.

### Conclusion

As can be seen, progress has certainly been made in improving the sales practices of PPI providers and opening up the market, particularly to stand-alone PPI providers. The approach taken by the FSA, namely the implementation of the Commission's key recommendations before they are on the statute book, shows the flexibility and effectiveness of principles-based regulation.

However, problems still remain. Consumer groups claim that PPI providers routinely reject consumers' complaints, leaving the Financial Ombudsman Service to determine these cases (and routinely find in favour of the consumer). As sales practices improve and the market is opened up, these cases are likely to start to decline. However, after over five years of bad publicity, it may take some time before PPI is seen as the important protection it could be in uncertain economic times.

# Breach of Warranty in Hong Kong: In Theory and In Practice — *Leung Yuet Ping v Manulife*

By Martin Lister and Patrick Peng, Hong Kong

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Where an insured fails to provide his insurer with accurate information at the time of taking out an insurance policy, Hong Kong law provides the insurer with a number of potential remedies including: (i) the right to avoid the contract, and possibly to claim damages, for misrepresentation; (ii) the right to avoid the contract on the ground of non-disclosure, which arises out of the duty of utmost good faith; and (iii) the right to terminate the contract for breach of a warranty, which is effectively a pre-contractual promise that a fact is as stated.

Warranties are commonly used for three purposes: (i) to define the initial risk undertaken; (ii) to enable the insurer to take precautions in managing the risk; and (iii) to enable the insurer to avoid the liability under the contract should there be a change in the risk.

Under Hong Kong insurance law, any breach of a warranty will result in the contract being discharged automatically, which means that an insurer is not liable for any claims arising after the breach. Though English insurance law is in many aspects similar to Hong Kong insurance law, this draconian effect is to some extent ameliorated by the courts in England which tend to interpret warranties strictly so as to reduce any unfairness to policy holders that may result from this approach.

The High Court in Hong Kong in *Leung Yuet Ping v. Manulife (International) Limited* (HCA 2380 of 2006) recently upheld that a breach of warranty would entitle an insurer to avoid liability under a policy and reinforced the need for strict compliance with warranties (whether they be material to the risk or not) in insurance contracts.

## The Facts

The deceased applied for a life insurance policy for HK$1 million on 18 June 2004 with Manulife. He was later diagnosed with colon cancer in June 2006 from which he died on 9 November 2006. The deceased's widow, the Plaintiff, applied to Manulife for payment of the benefits under the policy to her as the beneficiary.

Manulife discovered that the deceased had made a visit to his doctor following experience of an episode of shortness of breath and palpitations on 7 June 2006, merely 11 days before applying to Manulife for the relevant life insurance cover. The deceased was then advised by his doctor to consult a cardiologist but he did not follow that advice. There was no evidence of any recurrence of the episode and he was declared "healthy" after examination by Manulife's doctor.

The medical cause of death was given as colon cancer, though the death certificate did note evidence of coronary heart disease.

Manulife refused to pay out on the policy relying on the fact that the deceased had failed to inform them in the proposal (application) form and the medical examination form of the visit on 7 June 2006 to his doctor. In the proposal form, the deceased had answered "No" to a question asking whether within the 60 days prior to the application the applicant had consulted a doctor and been advised to have a diagnostic test or surgery that had not yet been performed. The deceased also answered "No" to a question in the medical examination form about whether to his knowledge he had or had been treated for or had been told that he had any disease or disturbance of *inter alia* palpitation or shortness of breath.

The Plaintiff argued that the episode of shortness of breath and palpitations was an isolated matter and a once-only incident, which could not be reasonably required to be disclosed and reported in the proposal form, and that in any event, the deceased was examined by Manulife's own doctor who confirmed, as a matter of policy and procedure, that he was healthy.

The Court held that the information provided by the deceased in the proposal form was a condition precedent to attachment of the risk, or to the liability of Manulife under the policy, and was therefore a warranty. Under Hong Kong insurance law, Manulife would have a defence to any claim that arose after the warranty had been broken, even if there was no causal connection between the loss and the breach of warranty. In addition, where an insurance warranty is breached, the insurer was not required to consider the test of materiality. The Court found the answers given by the deceased in the proposal form and the medical form to be inaccurate and misleading. As the deceased had breached the warranties, Manulife was therefore entitled to repudiate the insurance contract.

The Court also considered that the nature of an insurance contract was based on the duty of utmost good faith and therefore the insured was under a duty to make full and frank disclosure in applying for an insurance policy and was required to give accurate information in respect of all material facts when completing the proposal form and the medical form.

## UPCOMING EVENTS

*Continued from page 2*

- **Charles Welsh** and **Alan Levin** (Hartford) are attending the American Council of Life Insurers (ACLI) Conference in Chicago on 18-20 October. EAPD is also hosting a marketing booth at this event.
- **Nick Pearson** (New York) and **Mark Everiss** (London) are attending the Association of Insurance & Reinsurance Run-off Companies (AIRROC)/ Cavell Commutation & Networking Event in New Jersey on 19-21 October. EAPD is also co-sponsoring the conference Golf Outing on 19 October.
- **Richard Hopley** (London) is speaking on asbestos issues at the Swiss Asbestos Working Party meeting in Winterthur on 13 November.

**For further details on any of these upcoming events please contact Kalai Raj at: KRaj@eapdlaw.com.**

In determining what facts would be considered material, Manulife was required to show that a prudent insurer would have taken the information regarding the visit by the deceased to his doctor on 7 June 2006 into account in coming to its decision as to whether to underwrite the risk and at what premium. In this regard, the Court held that the episode experienced by the deceased constituted material information which Manulife as a prudent insurer would have taken into account in deciding whether to issue a policy on the life of the deceased.

Once there is evidence of non-disclosure of a material fact or that a misrepresentation has been made, the insurer must show that it was induced by the non-disclosure or the misrepresentation to enter into the contract on terms that it would not have agreed if all the material facts had been known to it. The Court held that an insurer was not required to show that the non-disclosure was deliberate. The test relates to the conduct of the reasonable prudent insurer and not that of the reasonable assured. The Court held that Manulife was only required to show that the non-disclosure or misrepresentation was an effective inducement and that it need not have been the sole inducement to issue the policy.

### Comment

This decision demonstrates the Hong Kong court's insistence on strict compliance with warranties in insurance contracts. Despite the harsh effect, the Court upheld the stringent requirement that a warranty must be complied with exactly, whether it be material to the risk or not. Any inaccurate information given by an applicant in an insurance proposal form may amount to a breach of warranty which will discharge the insurer from its liability. This may work injustice to the assured as he is compelled to assume responsibility for the accuracy of all material facts and information given to the insurer, even if he does not understand or is unaware of the importance of that information to the insurer. Though this decision represents present Hong Kong insurance law, it may not reflect recent developments in the insurance industry.

The insurance industry is one of the few industries in Hong Kong that enjoys a high degree of self-regulation. The Hong Kong Federation of Insurers (the HKFI), a self-regulating body of insurers, was established on 8 August 1988 to advance and promote the development of the insurance industry in Hong Kong and in May 1999, the HKFI adopted the Code of Conduct for Insurers (the Code) in order to promote good insurance practices amongst insurance companies and to strengthen public awareness of the expected standards of insurance services offered. Paragraph 24 of the Code stipulates that "an insurer should not refuse a claim by a policyholder:

- on the grounds of non-disclosure of a material fact which the policyholder could not reasonably have been expected to disclose, or if the insurance was issued without the policyholder being requested to submit a proposal;
- on the grounds of misrepresentation unless this is a deliberate or negligent misrepresentation of a material fact, provided that this does not apply to marine or aviation policies; or
- in the absence of fraud by the policyholder, on the grounds of a breach of warranty or condition if the loss is unrelated to the breach."

Though the Code does not have the force of law and does not directly contradict the judgment in *Leung Yuet Ping v. Manulife ((International) Limited*, nevertheless the Code clearly suggests a move away from termination of a policy for breach of an unrelated warranty (in the absence of fraud) and from the prudent insurer test to a test of an innocent reasonable assured. Such a move and reform of the present Hong Kong insurance law may be appropriate as there are clearly circumstances where an injustice may occur and the reasonable expectations of an insured may be defeated.

# The Continuing Evolution of the Follow-the-Settlements Doctrine in the U.S.

The follow-the-settlements doctrine addresses the effect of a claim settlement made by a ceding company with its insured on its reinsurer. The doctrine remains at the vital center of reinsurance claims handling, and its meaning and effect is implicated in many disputes. And as a living doctrine, it continues to evolve as new issues are presented and courts render new decisions.

By Vincent J. Vitkowsky
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### When Does the Doctrine Apply?

Some recent cases have focused on the threshold question of whether the doctrine applies to a given dispute at all. The inconsistent results of these cases demonstrate that if the parties expect the doctrine to apply, they should include an express follow-the-settlements provision in the reinsurance contract. If they do not, then before even reaching the merits, parties can find themselves in prolonged and expensive preliminary motion practice about whether a follow-the-settlements obligation can be constructed from other provisions in the contract, whether one can be implied into the contract as a matter of industry custom and practice, and what burdens of proof apply. This motion practice most often includes a battle of expert witnesses, opining on contract interpretation or industry custom and practice, which adds an increased level of expense and unpredictability to dispute resolution.

In *Employers Re v. Mass Mutual*, 2008 WL 3890358 (U.S.D.C., W.D. Mo.), Employers Re reinsured Connecticut Mutual Life Insurance

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*Continued on page 10*

Company, which merged into Mass Mutual Life Insurance Company, under an Excess Disability Income Treaty. Questions arose about claims handling, and the parties entered into a series of claims control agreements. Following review, Employers Re objected to 12 claims, and then filed suit for alleged breach of contract based on mishandling those claims.

Both sides sought summary judgment on the issue of whether the follow-the-settlements doctrine applied at all. There was no express follow-the-settlements provision in the treaty. But the court in Missouri, applying Connecticut law, found that the treaty contained a follow-the-settlements provision "within the four corners of the agreement." The court constructed one out of the following factors: (1) there was a provision requiring Mass Mutual to investigate, settle, pay or defend claims; (2) there was a provision requiring Employers Re to indemnify Mass Mutual for losses; (3) nowhere in the Treaty did it state that Employers Re could question claims once losses were incurred and paid; (4) Employers Re was the drafter of the Treaty, but did not expressly provide that the doctrine did not apply; (5) if there were any ambiguity, the "course of conduct" clarified it, because Employers Re paid claims for 13 years before objecting. To this court, that meant that Employers Re had "followed the settlements" in the past.

A court in California, however, came to a different result in *American Motorists v. American Re,* 2007 WL 1557848 (U.S.D.C., N.D. Cal.). Although the court noted that other cases in California had construed certain language to constitute a follow-the-settlements provision (even though the contracts in those cases did not use those precise words), none of those formulations appeared in the contract at issue in this case. Here, the court found that a follow-the-settlements obligation could not be constructed from these three provisions: (1) a provision saying the reinsurance follows the terms of the policy; (2) a provision giving the reinsured the right to settle claims; and (3) a provision requiring the reinsurer to indemnify the reinsured.

If the doctrine does not apply, what is the effect? That, too, can vary from jurisdiction to jurisdiction. But in a follow-up to *American Motorists v. American* Re, 2007 WL 4197427 (U.S.D.C., N.D. Cal.), the California court developed one rule. Both parties moved for summary judgment, and both motions were denied. The court found that even though the certificate required the reinsured to defend claims to a "final determination," that did not require litigating a case through judgment. But in the absence of a follow-the-settlements obligation, it would not be sufficient for the reinsured to show simply that the claim had been settled without bad faith. Rather, at trial, the reinsured would have the burden of proving that the claim was actually covered by its policy (as opposed to "arguably covered").

## Do the Exceptions Apply?

The general rule is that a cedent's settlement is binding on its reinsurer, but this is subject to several exceptions. The first exception requires that the settlement be made in good faith, after a reasonable and businesslike investigation. (This is sometimes referred as to the bad faith exception.) Next, the settlement must be on a claim arguably encompassed within the scope of the underlying insurance policy. Next, the claim must actually be encompassed within the terms, conditions and limits of the reinsurance contract. Finally, the payment cannot be *ex gratia*.

The *ex gratia* exception is sometimes conflated with either the bad faith exception or the exception relating to claims not arguably encompassed within the underlying policy, but it is actually distinct. *Granite State Ins. Co. v. ACE American Reinsurance Company,* 849 N.YS.2d 201 (1st Dep't 2007) illustrates this point. The AIG Group issued seven excess umbrella liability policies to Castle & Cooke, which subsequently became Dole Foods. Tens of thousands of workers in Central America and the Philippines sued Dole Foods for injuries allegedly suffered as a result of exposure to pesticides. One of the policies, written by an AIG company called Granite State, was facultatively reinsured by ACE American. AIG initially disclaimed coverage on the Granite State policy, relying on an exclusion. It entered into a future cost agreement (FCA) for defense and indemnity in connection with other policies. The FCA did not mention the Granite State policy.

AIG later realized it had paid amounts beyond the available limits on one of the policies. It charged the overpayments to the Granite State policy and amended the FCA. ACE American moved for summary judgment but was unsuccessful. The court recognized that the bad faith exception and the *ex gratia* exception were distinct. But it found questions of fact that precluded summary judgment and required further proceedings. First, there were questions about how the mistake in calculation occurred, which policy the payments should be allocated to, and the reversal of the coverage position from the initial disclaimer. All of these went to bad faith. Next, there was a question of whether by its silence, the original FCA affirmatively excluded the Granite State policy, thereby rendering any further payments *ex gratia*.

## Special Issues in Torts-for-Import Cases

The *Granite State* case is notable not only for its exposition of the follow-the-settlements doctrine, but also for its broader background, which is especially relevant to claims arising outside of the U.S. This is because recent years have seen the emergence of the Torts-for-Import business, empowered by the combination of aggressive U.S. trial lawyers and local officials and judges in other countries with weak judicial systems or cultures with a tolerance for corruption.

U.S. trial lawyers find plaintiffs in other countries to assert claims in U.S. courts. Evidence from faraway lands can be hard to gather -- and harder still to refute. At times, "evidence" is simply manufactured, with complicity from local officials. For example, the *Granite State* case arose from underlying claims of plaintiffs who alleged they became sterile after exposure to pesticides when working in Dole Foods' banana fields. They received some favorable judgments against Dole Foods in Nicaragua. But when related cases were heard in the U.S., the real evidence proved that most of the plaintiffs never even worked in Dole's fields, nor were they in fact sterile. In early 2009, a U.S. judge dismissed the cases as a "fraud on the court" and a "blatant extortion." She scolded the plaintiffs' lawyers, and having heard evidence suggesting they had conspired with corrupt Nicaraguan judges and local officials, she asked federal prosecutors to investigate.

Plaintiffs can have greater success if the claim is adjusted or litigated in countries where the rule of law is weak, and manufactured evidence is more readily accepted. As a rough guide to high-risk countries, claims handlers can look to political risk indices in common use in the insurance industry, or to rule-of-law indices prepared by human rights groups.

Large-scale cases are fiercely defended, but there is also cause for caution in other, less notorious international claims. Most basically, there can be questions about the *bona fides* of the settlements. Claims adjusters or company executives can be placed under enormous pressure to approve losses of questionable causation, or to exaggerate the damages from legitimate claims. Or they can be duped, if local building, medical or other records are forged. It is even worse where judges are compliant or corrupt. These circumstances can have implications under the follow-the-settlements doctrine with respect to both the bad faith exception and the *ex gratia* exception. At a minimum, cedents should take special care to investigate and document their settlements in high-risk countries.

# Insurer Can Sue Retained Defense Counsel for Failure to Accept Settlement Demand, Says U.S. District Court in Florida

By Craig E. Stewart
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John David Dickenson
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In a case of first impression, *Hartford Ins. Co. of the Midwest v. Steven G. Koeppel, et al*, 2009 WL 1229250 (M.D. Fla. May 5th, 2009),[1] a Federal District Court Judge denied the defendants' motion to dismiss and permitted Hartford Insurance Company of the Midwest ("Hartford") to proceed with legal malpractice claims against its insureds' defense counsel. Hartford's claims stemmed from defense counsel's work on a catastrophic personal injury claim asserted against Hartford's insureds.

Prior to suit being brought, Hartford retained defense counsel to 1) represent its insureds and *also* 2) specifically to accept a time-limited policy limits settlement demand issued by the underlying claimant's attorney. In attempting to accept the time-limited demand, defense counsel failed to precisely comply with the terms of the demand. As a consequence, the tender of policy limits was rejected and suit was filed against Hartford's insureds resulting in considerable excess exposure to Hartford's insureds and to Hartford itself.

Following Hartford's subsequent settlement of the underlying matter for an amount substantially in excess of the policy limits, Hartford brought a legal malpractice and breach of contract action against defense counsel on the basis of the failure to accept the time-limited settlement demand. The underlying defense counsel, now the defendant, moved to dismiss on the ground that Hartford lacked standing. Defense counsel contended that he was hired to represent only the insureds and that under Florida law he could not represent both the insureds and Hartford. The United States District Court for the Middle District of Florida, disagreed and held that, based upon the face of the Complaint, Hartford had standing as a matter of fact because it appeared that Hartford was in privity of contract with defense counsel.

In so ruling, the Court noted that shortly after receiving the claim, Hartford had successfully encouraged its insureds to secure personal counsel because it was clear that the available policy limits were unlikely to cover the plaintiff's very serious injury claims. The Court further noted that, a few months later, the claimant tendered a time-limited settlement demand to Hartford. Hartford then in turn hired defense counsel to accept the demand and, thus, at least in part, to represent Hartford. Based on the factual allegations of the Complaint, the Court found privity of contract between Hartford and defense counsel, and therefore held that Hartford had standing to pursue legal malpractice and breach of contract claims.

The Court went on, however, to consider whether Hartford would also have had standing to bring the action *even if* defense counsel had specifically been retained *only* to represent the insureds. The Court noted that the majority of jurisdictions recognize an insurer's right to pursue a legal malpractice action against counsel that it retained to represent its insured. Because no Florida court had rendered an opinion on the subject, the Court's assessment in this regard required an analysis of how the Florida Supreme Court would decide this issue. The Court pointed out that those jurisdictions that represent the majority rule have confirmed an insurer's standing in such a case in at least two ways: 1) a finding of privity of contract between the insurer and defense counsel, or 2) a finding that the insurer was an intended third-party beneficiary of the relationship between defense counsel and the insured.

Although the Court found no Florida appellate court decision directly on point, the District Court noted persuasive state court authority in three specific areas. First, the Rules Regulating the Florida Bar, as interpreted by Florida's Second District Court of Appeals, provide that an attorney may ethically represent both an insured and an insurer absent conflicting interests. Second, Florida courts have recognized exceptions to the strict privity requirement for legal malpractice claims in other areas of law, such as will drafting. Finally, the Court found that the Florida Supreme Court implicitly approved an insurer's standing to sue defense counsel for malpractice via a question certified from the Eleventh Circuit regarding the statute of limitations for an insurer's malpractice case against its insured's defense counsel. The Florida Supreme Court issued its ruling without raising any objections to the insurer's standing to sue insured's defense counsel for malpractice.

Based upon these decisions, the District Court concluded that the Florida Supreme Court would likely follow the majority rule and find either that the insureds' defense counsel had an attorney-client relationship with Hartford or that Hartford was an intended third-party beneficiary of the attorney-client relationship between the insureds and defense counsel.

## Footnote

1 Edwards Angell Palmer & Dodge LLP, by Craig E. Stewart and John David Dickenson, represents Hartford in the action.

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By Simon Williams and Richard Spiller, London

# Acquiring Producers: The Legal Basics

A Producer is the colloquial name given to an insurance intermediary who generates business for insurers. A Producer can be any type of insurance intermediary; for example it might be an insurance broker acting as agent of the insured, placing business with insurers selected by the broker. It might also be an underwriting agent writing business under a binding authority as agent of the insurer. The key feature is the insurance intermediary's book of business.

Producer acquisitions have become increasingly common as insurance carriers and other intermediaries, such as wholesale (or placing) brokers, seek to secure sources of business. This article examines some of the common legal issues that can arise on a Producer acquisition.

## What are the Acquisition Options?

There are three main options:

- ***Share Acquisition:*** the Acquirer acquires the shares of the Producer company.
- ***Business/Assets Acquisition:*** the Acquirer acquires the underlying business, staff and assets of the Producer company.
- ***Team Move:*** the Acquirer recruits a team of key production personnel from the Producer company.

## Some of the Issues

Each acquisition option has pros and cons. These will obviously be very fact specific depending on the nature of the Producer itself and its book of business. We look at some of the key advantages and disadvantages below.

### *Skeletons in the Closet*

On a share acquisition, the Acquirer buys the company with all of its business, assets and liabilities, whether the Acquirer (or the seller) knows about them or not. The Acquirer should seek to protect itself by extensive due diligence, coupled with effective post-completion protections (for example warranties, indemnities and possibly insurance).

In contrast, a business/asset acquisition gives the Acquirer the option of cherry picking assets and liabilities. The Acquirer will only assume liabilities which it consciously takes on; this is a major advantage over share acquisitions. There are certain exceptions, a key one being in relation to employee liabilities. If there is a transfer of an "undertaking" – for example, the transfer of a business unit – the undertaking's employees (and the liabilities in relation to them) transfer by operation of law to the Acquirer (under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE)). It is important to remember that under TUPE employees transfer on their existing employment terms and with continuity of service. The employment terms cannot be changed in connection with the transfer. This is a significant issue on a business transfer. In practice, under TUPE employees are unlikely to object if they are offered improved terms as part of any acquisition, but imposing new terms such as restrictive covenants is legally difficult to achieve.

A team move also has the advantage that it is 'clean', except again possibly the employee liabilities. Whether employees and their liabilities transfer by TUPE to the Acquirer on a team move will depend on whether, and to what extent, the business of the team (which for TUPE purposes means the transfer of an economic entity that retains its identity) moves as well. As team moves are generally aggressive in relation to the existing employer, great care needs to be taken to ensure that team members do not breach their duties to the existing employer, for example, by encouraging other employees to move, copying confidential customer information or approaching customers to move their business. Such actions can give rise not only to legal (and regulatory) action instigated by the existing employer against the employees for breach of contract but also against the Acquirer for inducing that breach.

### *People*

It is trite to say that insurance is a people industry, based on relationships. Personnel will be at the heart of any Producer acquisition. Whichever route is chosen, the Acquirer will need to ensure that its new staff are suitably incentivised to produce and to remain with the business in the long-term, are not prevented from bringing with them their business relationships, and that (should key staff decide to leave) there are adequate protections in place. With a Producer, the simple fact is that if key people leave, the business effectively walks out the door with them.

On a share acquisition the Acquirer should seek to include robust (or more robust) restrictive covenants in key staff's employment contracts. Most likely the Acquirer will be able to negotiate this because key staff will receive part of the purchase price or because they are getting a significantly improved remuneration package. This is not possible

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The US Re/Insurance Recession Survival Guide 2009

EAPD New York partner **Paul Kanefsky** co-edited a supplement to the *The Review magazine* with the editor of *The Review*, Greg Dobie – "The US Re/Insurance Recession Survival Guide 2009". It aims to, through a series of EAPD-authored articles, offer pragmatic advice and recommendations for re/insurers to do business cost-effectively in a recession. The EAPD authors featured in this supplement are as follows: **Vincent Vitkowsky**, **Nick Pearson**, **Geoffrey Etherington**, **Gayle Levy**, **Mohana Terry** and **Marc Voses**, **Richard Spiller** and **Craig Stewart**.

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on a business acquisition (or a team move where there is a TUPE transfer) because the transferred employees' terms and conditions cannot change. On a TUPE transfer the Acquirer will need to check adequate restrictive covenants already exist. In our experience there is often room for marked improvements in the terms of existing restrictive covenants.

Another advantage of a company or business acquisition is that since the acquisition is friendly, the Seller will not be seeking to restrict the activities of departing staff (and indeed will probably itself be entering into non-compete restrictions). This is a major potential disadvantage of a team move. The Acquirer may be seeking to extract a key team from one of its competitors; which of course means that the competitor is likely to resist this move – whether by way of seeking to encourage all or some of the team to stay (say with a counter-offer) or by enforcing their contractual obligations (discussed above). Team moves can become messy and expensive. That said, although of course the incoming team will have to be remunerated, the Acquirer will not have to pay a purchase price for the team.

### *Regulation*

A Producer acquisition will involve consideration of regulatory issues. The Acquirer will need to establish the Producer's current regulatory status, determine how it will be regulated post-completion and allow sufficient time for obtaining regulatory consents or applications.

Producers are very likely to be carrying on activities regulated under the Financial Services and Markets Act (FSMA). To comply with the law, a Producer can either hold its own permission from the Financial Services Authority (FSA) or another EEA regulator or be exempt as the appointed representative (AR) of an authorised person (the Principal).

An authorised Producer is directly regulated by the FSA or another EEA regulator. In contrast an AR is indirectly regulated. The AR is appointed by the Principal, which is responsible for supervising the AR and ensuring its regulatory compliance. If the AR does not comply with the rules the FSA will hold the Principal responsible.

On a share acquisition of an authorised Producer the Acquirer will require change of control consent from the FSA. Under FSMA this can take up to 60 working days (with possible extensions if further information is required) but a straightforward case is likely to take closer to 20 working days.

A FSA authorisation will not transfer as part of a business/asset acquisition or a team move. If the Acquirer does not already have authorisation or the necessary mediation permissions, it will need to obtain them before the acquisition or team move is completed. Under FSMA such an application must be determined within six months of being received by the FSA, although in practice three months will probably be adequate if a fully developed business plan and information are provided at the time of application.

A Producer's AR status will not transfer on a business acquisition or a team move. There is also likely to be a term in the AR's appointment preventing it transferring automatically on a share acquisition. The Acquirer has a number of options. On a business acquisition or team move the Acquirer's permissions may already cover the new business, alternatively the Acquirer could apply for an authorisation or for top-up permissions for the new business.

On a share acquisition, if the Producer is not authorised, the Acquirer might itself appoint the Producer as its AR (if the Acquirer has the requisite permissions) or seek authorisation for the Producer. Alternatively the Acquirer could seek to retain the AR Producer's existing appointments (although clearly this will not be possible if the Acquirer is a competitor of the Producer's Principal). The position will be further complicated if the AR Producer is the appointed representative of a number of Principals. Renewal of the AR status would need to be agreed with all Principals.

### *Contracts*

Along with personnel, contracts are likely to be a key factor in any Producer acquisition.

Although one of the potential advantages of a company acquisition is that there is no need to transfer or assign the business contracts (the contracting party – the Producer – remains unchanged), it is fairly common that certain insurance-related contracts (such as binding authorities and terms of business agreements) contain change of control clauses. In other words, the other parties to these contracts may need to consent to the acquisition of the Producer.

For business acquisitions and team moves, the counterparties to contracts must consent to their assignment or novation.

Transfer/assignment of insurance-related contracts is important for a number of reasons, for example:

- The Producer holds binding authorities which are key to the Acquirer's acquisition decision; if the Acquirer wants the binders to remain in place following completion, the Producer/Acquirer will need to obtain the carrier's approval. Obtaining approval should be a condition precedent to completion.
- The Producer holds binding authorities; however on closing the Acquirer wants to terminate the binders and write the business on its own paper. The Producer/Acquirer will need to consider the contracts carefully. Is termination permitted? If so, what (if anything) does the contract provide as to 'ownership' of the business or of the records? Does the Producer have to return, or give access to, the underwriting records to the original carrier – enabling the original carrier to compete with the Acquirer? Would the Producer have ongoing obligations after termination (for example, run-off responsibilities)?
- In the case of a team move, does the team have a close enough relationship with the carrier to negotiate a new binding authority? Can the team's former employer continue to carry on the team's business without the team (and prevent the team using customer information)?

In our experience these issues are common, and some of the issues have resulted in reported case law.

### *Tax*

Tax is often a crucial driver of acquisition structures; the parties will naturally seek legally to minimise their tax exposures. The key taxes are capital gains tax (CGT) and income tax.

Sellers are liable to CGT at 18% on any capital gain on a sale of a company or business. In the past certain sellers could reduce their CGT tax bills to 10% with taper relief. Today Entrepreneur's Relief can still potentially reduce CGT to 10%, however it is a much more limited tax relief. These rates need to be compared with income tax rates of up to 40% (50% from April 2010).

Since CGT rates are lower than income tax rates, there are obvious tax savings if payments to key staff can be structured as capital rather than income. The consideration payable on a company or business disposal is likely to be capital and not income. It might be possible to structure some of the on-going incentives for the Buyer's new staff as capital rather than income.

### Conclusion

Producer acquisitions make sound commercial sense in the current economy as carriers and intermediaries seek to secure their sources of business. We expect the number of Producer deals to continue to rise. Structuring is key to any acquisition to ensure a balance between commercial risk and legal protections.

By M. Machua Millett
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# Brazil: Latin America's Largest Insurance Market Slows with Global Economic Downturn, But Continues to Grow with Positive Signs for the Future

Brazil is by far the largest insurance market in Latin America, representing more than 40% of the gross written premiums in the region. Brazil also has the largest population in South America, the 10th largest economy in the world by GDP and a low insurance penetration rate. These factors indicate that, despite the relatively impressive size of the Brazilian insurance market, it still has tremendous growth potential, estimated by some to be the third best in the world behind China and India. Not surprisingly, therefore, although the growth of the insurance market has slowed in 2009 with the global economic crisis, industry growth is widely expected to break double digits in both 2008 and 2009.

Note: This article was originally published in *World Insurance Report*.

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## Market Trends and Characteristics

Like the rest of Latin America, the Brazilian economy has struggled in the face of the global economic downturn. This overall stagnation has negatively impacted the Brazilian insurance market, reducing the predicted industry growth rate to 4.9% for 2009, from the average 13% growth experienced annually between 2003 and 2008. Nonetheless, the insurance industry has outperformed and is expected to continue to outperform GDP. The anticipated economic recovery, coupled with low insurance penetration and the development of the nation's reinsurance market, has sustained optimism about future growth.

In May 2009, Brazilian insurance regulator Susep released a report finding that total insurance premiums were 7.9% higher in the first quarter 2009 than the first quarter 2008. The report further maintained Susep's projection of 4.9% insurance premium growth in 2009, despite revising downward from 1.5% to -.5% its assumption about GDP growth for the year. Such growth in 2009 would result in total premiums in Brazil of approximately US$35.5 billion. The report's projections for premium growth in 2010 and 2011 were down only slightly, with Susep predicting 10.6% growth in 2010 and 10.4% in 2011. Such growth would result in total premiums of approximately US$39 billion in 2010 and US$43B in 2011.

In July 2009, Fitch released a report on the Brazilian insurance market that balanced bad news about the Brazilian economy with continued optimism as to the country's insurance industry. The report found that, despite an expectation of continued negative pressure from the struggling economy in the near-term, continued low insurance penetration rates (3.3% of GDP in 2008 and 3.5% for the first four months of 2009) combined with relative economic stability, a growing consumer class and the opening of the reinsurance market indicate that the insurance market has substantial potential for growth in the coming years.

## The First 16 Months Since the Reinsurance Market Opening

One of the reasons that industry observers remain positive about the future of the Brazilian insurance market is the recent opening of the country's reinsurance market to private and foreign competition. After many years of debate and an "impending" opening that had lasted some ten years, on April 19, 2008, Brazil's government-sponsored monopoly over the reinsurance market was brought to an end.

Since the opening of the Brazilian reinsurance market, more than 60 foreign reinsurers have obtained authorization to sell reinsurance for Brazilian risks as either local reinsurers *(resseguradores locales)* (reinsurers organized under Brazilian law as Brazilian corporations); admitted reinsurers *(resseguradores admitidos)* (reinsurers incorporated under the law of foreign jurisdictions that maintain a representative office in Brazil); and (3) occasional reinsurers *(resseguradores eventuais)* (reinsurers incorporated in foreign jurisdictions that do not have a representative office in Brazil, but are registered with Susep).

In the midst of the rush to gain a share of the Brazilian reinsurance market, however, a number of issues have emerged, among them: (1) what role will the former monopoly-holder, IRB-Brasil Re, take in the new market? (2) Will the Brazilian regulators continue to liberalize the reinsurance market or will barriers to truly open competition be maintained, erected and/or strengthened? (3) Is the Brazilian (re)insurance market sufficiently developed to support true competition among in excess of 60 reinsurers?

## The Role of IRB-Brasil Re

Any possible misconception that IRB-Brasil Re, the partially-government owned, former monopoly holder over the Brazilian reinsurance industry, would simply cede its dominant market position to foreign reinsurers was dispelled in May 2009 when an IRB-Brasil Re spokesman proudly announced in a BN Americas interview that the regulatory change had caused less impact than expected and the company had retained 90% of its business since the market opening in April 2008. Indeed, the spokesman reportedly further stated that IRB-Brasil Re intended to maintain its position by leveraging its significant market advantage based upon its history and experience in the market and actively competing with recent foreign entrants to the market by improving customer service and developing new and tailored solutions.

IRB-Brasil Re has followed through on these promises, seeking to maintain its historical business and competing for new business in the country, largely successfully. The company has released several new products in the health area and indicated plans for other new products in the near future, including in growing commercial areas such as D&O, energy, mortgage lending and agriculture. Through its efforts, IRB-Re Brasil has been able to retain more than 80% of the nation's local reinsurance business, which totaled earned premiums of R$1.3 billion (approximately US$661 million) for the period January 2009 to April 2009. By comparison, foreign reinsurers with local affiliates made up less than 15% of the local reinsurance market (Munich Re (8.8%), XL Re (4.1%) and Mapfre Re (.3%)).

It should be noted that IRB-Re Brasil's ability to maintain its dominant market share to date may have been aided in no small part by an advantage included in the liberalizing regulations, which now no longer exists. That is, although the market was technically opened in April 2008, IRB-Re Brasil was permitted to retrocede to any foreign reinsurer up through December 2008, while other market participants could only cede/retrocede to reinsurers authorized by the Brazilian regulator. Whether the elimination of this advantage has played a role in the 10% decrease in IRB-Re Brasil's market share between 2008 and the first four months of 2009 and will continue to play such a role remains to be seen.

## Regulatory Liberalization/Regression

Although significantly liberalized by the new reinsurance statute and regulations, Brazil's reinsurance market is not yet entirely unfettered, instead having opted for an "orderly opening of the market" reflected in several significant limitations on the role of foreign reinsurers.

- ***"Right of First Refusal":*** Ceding companies must offer local reinsurers the right of first refusal on at least 60% of the premiums ceded until January 16, 2010 (and 40% for at least three years thereafter). This vetting requirement permits a ceding company to first obtain quotes from foreign reinsurers and then present a quote to local reinsurers, who will have either five days (facultative reinsurance) or ten days (treaty reinsurance) to match such quote. The vetting requirement will be fulfilled when local reinsurers either accept 60% of the risk or when all local reinsurers have refused or partially refused to match the foreign reinsurer's quote.

  It is the sole responsibility of the local insurer, not the reinsurer, to comply with this vetting requirement. How this requirement can and will be enforced has been the source of considerable debate among commentators and market participants.

- ***Cession Limits:*** Cessions to occasional reinsurers by a Brazilian insurer may not exceed 10% of the insurer's total annual premiums ceded to reinsurers. Furthermore, no Brazilian insurer or local reinsurer may cede more than 50% of the risk it underwrites annually to admitted or occasional reinsurers. Compliance with this requirement is also the sole responsibility of the local insurer or reinsurer and has likewise caused significant debate as to its manageability and enforceability.

  On April 27, 2009, Susep made an interesting selective departure from this limitation, raising the cession limit to occasional foreign reinsurers to 25% for surety and petroleum risk business. Although the relevant resolution did not indicate the reason for the special treatment of the surety and petroleum risk lines or indicate whether or not any similar relaxation of the cession limit can be expected in any other lines, it was widely seen as an acknowledgement that the local market lacked sufficient reinsurance capacity in the areas of petroleum risk and surety.

- ***"Tax Haven" Restriction for Occasional Reinsurers:*** No foreign reinsurer may register as an occasional reinsurer if it is incorporated in a "tax haven," a term defined to mean any jurisdiction in which income tax is levied at less than 20% and/or where reinsurance companies are subject to excessively strict rules of confidentiality regarding their constitution and composition. This limitation clearly applies to companies domiciled in Bermuda and poses some concern for companies located in other jurisdictions that might be found to satisfy the definition of "tax haven," such as Delaware. Nevertheless, international companies may use companies organized in acceptable jurisdictions, so long as they meet the other requirements for registration as an occasional reinsurer, and then retrocede to companies based in Bermuda or other "tax havens."

  Although significant concerns have existed, and remain, that these and other regulatory impediments might be used to erect roadblocks to foreign participation in the otherwise opened Brazilian reinsurance market, little has occurred (other than perhaps the extension of IRB-Re Brasil's retrocession advantage through December 2008) to substantiate these concerns. Particularly in a troubled economy, however, this remains an appropriate area of attention for companies that have expended the resources necessary to enter the market.

## Cooperative Arrangements Between Local and Foreign Companies

An interesting result of the limitations maintained by Susep over the liberalization of the Brazilian reinsurance market has been the establishment

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of cooperative agreements between local and foreign players in an attempt to work around such issues. For example, local Brazilian reinsurer JMalucelli Re and foreign admitted reinsurer Hannover Life Re announced in early 2009 that they had entered into a cooperation agreement to offer life and health reinsurance in the Brazilian market. The move had reciprocal benefits for the two companies: (1) Hannover Life Re can now, through the relationship, overcome certain of the market share limitations imposed by Brazilian regulations in the form of cession limits for foreign reinsurers and a "right of first refusal" in favor of local reinsurers; and (2) JMalucelli Re, which previously operated only in the area of guarantee reinsurance, will receive substantial know-how and technical support from Hannover Life Re in developing its life and health reinsurance business.

Likewise, Maritima, Brazil's tenth largest insurer and one of the few remaining large independent Brazilian insurers active in multiple lines, reportedly recently entered into an agreement with Japanese insurer Yasuda under which Yasuda would take a $200 million stake in Maritima. Maritima, which brought in R$1.1 billion (approximately US$480 million) in premiums in 2008 (an 18% increase over 2007), reportedly sought a partner in order to meet heightened minimum capital requirements imposed by Susep to fund desired expansion that the company hopes will make it the fifth largest Brazilian reinsurer within the next five years and to benefit from the experience of a foreign company.

### Remaining Questions

Foreign reinsurers continue to struggle with indefinite tax regulations in Brazil, with little regulatory guidance and conflicting advice from local lawyers on appropriate payment of taxes on reinsurance premiums under municipal and federal Brazilian law. Furthermore, although business prospects for foreign reinsurers willing to negotiate the discussed regulatory hurdles appear bright, it remains to be seen whether: (1) the Brazilian reinsurance market, even if it grows as predicted, is of a size sufficient to support the recent influx of foreign reinsurers; and (2) can enough qualified personnel be found in Brazil and/or brought in from abroad to properly staff branch and representative offices of foreign reinsurers? So long as these issues can be appropriately managed, however, Brazil appears to be an attractive (re)insurance market for years to come.

## Reactions Magazine Legal Survey 2009

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- **Litigation (Europe)** - Highly Commended (2nd)
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- **ILS (Europe)** - Winner (1st)
- **Reinsurance (US)** - Winner (1st)
- **Overall (US)** - Highly Commended (2nd)
- **Overall (Europe)** - Highly Commended (2nd)

Reactions Magazine is an established publication for the global insurance and reinsurance market. Its annual Legal Survey is the result of independent research of key industry executives as to who they think deserves recognition in the market.

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