EDWARDS ANGELL PALMER & DODGE

Insurance and Reinsurance Review

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Bad Faith: Choice of Law Matters

Choice of law issues cannot be overlooked in insurance bad faith litigation, and often play a critical role in the outcome of such claims. In *Schwartz v. Twin City Fire Insurance Co., et al.*, 492 F.Supp.2d 308 (S.D.N.Y.2007), *aff'd. sub nom Schwartz v. Liberty Mutual Ins. Co.*, 539 F.3d 135 (2nd Cir.2008), the district court was faced with the issue of whether California law or New York law applied to the defendant Excess Insurers' cross-claims against the co-defendant Primary Insurer for bad faith failure to settle an underlying securities class action lawsuit.

At trial, the district court instructed the jury on the elements of bad faith that are common to California law and New York law, and then instructed the jury to decide (separately) whether the Excess Insurers proved that the Primary Insurer acted with "gross disregard" of the interests of the Excess Insurers, a showing that is required for recovery under New York law but not under the law of California. The jury returned an awarded totaling $5 million in favor of the Excess Insurers on their bad faith cross-claims, but found that the Primary Insurer did not act with "gross disregard." After post-trial briefing, the Primary Insurer snatched victory from the jaws of defeat, when the district court decided that the law of New York applied to the Excess Insurers' bad faith cross-claims and amended the judgment in a significant way by dismissing the bad faith cross-claims.

Background: The Securities Class Action

In 2003, Loral Space & Communications Ltd., a public company, filed for Chapter 11 protection as a result of its failed investment in a satellite telephone business known as Globalstar. The chief executive officer of Loral ("Schwartz") also served as chief executive of the Globalstar companies.

Schwartz became the sole defendant in a certified federal securities class action (the Securities Class Action) arising out of his service with Globalstar. In his capacity as an officer, he was insured under a primary layer of insurance with limits of $10 million, together with excess layers providing an additional $40 million in coverage.

At several points in pre-trial settlement discussions, class counsel expressed a willingness to resolve the case for $15 million. After evaluating the case, the Primary Insurer did not tender its limits of $10 million during the course of the action. With the primary layer unexhausted, the excess insurers were unwilling to contribute to a settlement.

"In bad faith litigation, the choice of law issues cannot be overlooked."

With settlement not having been achieved, the second excess insurer, with limits of $5 million excess of $15 million, asserted that the Primary Insurer was acting in bad faith by not tendering its limits. The third excess insurer, with limits of $5 million excess of $20 million, took a similar position, but did not use the words "bad faith."

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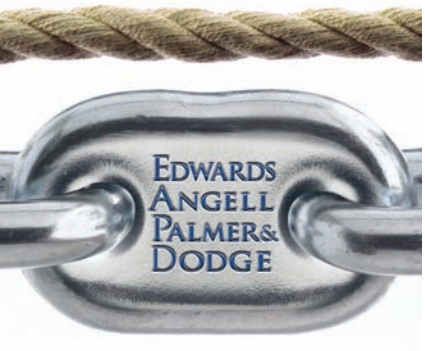
By Marc S. Voses
New York

"Taking the time to draft jury instructions carefully and proposing the use of special interrogatories to highlight the differences in the bad faith standards between states' laws could mean the difference between judgment or dismissal."



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Over a weekend break in the trial, Schwartz concluded that the most prudent course of action was to settle the case. Class counsel, however, was no longer willing to accept $15 million in settlement, but stated that the case could be settled for $20 million. When the trial resumed, the parties announced that a $20 million settlement-in-principle had been reached. With no consent from any insurer having been received, Schwartz agreed to fund the settlement personally.

The Coverage Action

Within days of paying the $20 million settlement, Schwartz commenced a coverage action in the United States District Court for the Southern District of New York against the Primary and first three excess insurers to recover the $20 million settlement payment. The second and third excess insurers (the "Excess Insurers") asserted cross-claims against the Primary Insurer for bad faith failure to settle the Securities Class Action.

Prior to trial, the Primary and first excess insurer settled with Schwartz by paying their limits. Schwartz's claims against the Excess Insurers, and the Excess Insurers' cross-claims for bad faith against the Primary Insurer, proceeded to trial.

Following the presentation of evidence to the jury, the district court and the parties engaged in lengthy discussions concerning the jury charge and the special interrogatories to be included on the verdict sheet.[1] A question arose as to whether California law or New York law applied to the Excess Insurers' bad faith claim.

Instead of definitively ruling on the choice of law issue, the district court elected to charge the jury on the elements common to both California and New York bad faith claims.[2] Separately, the district court instructed the jury on New York's bad faith standard, requiring that the insurer be found to have acted in "gross disregard" of the rights of the Excess Insurers' interests. Accordingly, the district court charged the jury as follows:

> In determining whether [the Primary Insurer] acted with gross disregard of [the Excess Insurers'] interests you should consider whether [the Primary Insurer] acted deliberately or recklessly in failing to place [the Excess Insurers'] interest on equal footing with its own. In determining whether [the Primary Insurer] acted with gross disregard by recklessly or deliberately failing to consider [the Excess Insurers'] interest in refusing to tender its policy or to approve a settlement at an earlier point in time, you may consider [Schwartz's] likelihood of success on the issue of liability, whether [the Primary Insurer] had investigated the circumstances of the allegations of securities fraud against [Schwartz] sufficiently to be able to evaluate the probability of a verdict against [Schwartz], the potential damages awarded to the [Securities Class Action] plaintiffs, the financial burden on each party if [the Primary Insurer] refused to settle, the information available to the insurer when the demand for settlement was made, and any other relevant proof tending to establish or negate the insurer's good faith in refusing to settle. If you conclude that [the Primary Insurer] acted negligently but did not deliberately or recklessly fail to consider the excess insurer's interests, then you must find for [the Primary Insurer]. [3]

Since New York requires a finding of "gross disregard," included among the special interrogatories submitted to the jury was one requesting the jury to state whether each Excess Insurer had proved by a preponderance of the evidence that the Primary Insurer acted with "gross disregard" of the rights of the Excess Insurers.

After the seven day trial, the jury returned a verdict in favor of Schwartz against the Excess Insurers. The jury also returned verdicts in favor of each of the Excess Insurers against the Primary Insurer on their bad faith cross-claims and awarded them $3 million and $2 million, respectively. However, in response to the special interrogatory, the jury found that the Primary Insurer had not acted with "gross disregard." The district court initially entered judgment in favor of the Excess Insurers, but then considered the choice of law issue.

If California law applied to the Excess Insurers' cross-claims, the Primary Insurer would be liable for damages to the Excess Insurers for bad faith. However, if New York law applied, because the jury found by way of the special interrogatory that the Primary Insurer did not act with "gross disregard" of the rights of the Excess Insurers, the Primary Insurer would prevail against the Excess Insurers. The district court's choice of law analysis would determine the outcome.

Post-Trial Motions and Decision

The Primary and Excess Insurers filed post-trial motions directed at the bad faith claims. The threshold issue, of course, was which state law applied, California or New York. Since a federal court sitting in diversity must apply the choice of law rules of the forum state, the district court applied New York's choice of law principles.

In conducting its analysis, the district court concluded that the substantive law of California and New York were in conflict on the issue. Next, the district court determined that under New York law, a bad faith claim for unreasonable failure to settle sounds in contract and as a result, New York courts apply the contractual "grouping of contacts" analysis to determine which state's substantive law should govern. The district court found that the "grouping of the contacts" analysis favored the application of New York law to the bad faith claim, and stated:

> New York was the place of "performance" of the contract as it is the place where the events which constitute the basis of the underlying lawsuit occurred as well as where that suit was filed and defended. Additionally, New York is where the claim was handled and where all settlement discussions occurred, including the eventual settlement. Further, New York is the site of any alleged breach of the covenant of good faith and fair dealing since any wrongful conduct, including an unreasonable refusal to settle, occurred in New York. Additionally, New York has a substantial public policy interest in application of its bad faith law. [4]

On appeal, this finding was echoed by the Second Circuit, which found:

> "the location of the subject matter" of the bad-faith cross-claims points strongly toward New York. The [Securities Class Action] was filed, tried and ultimately settled in New York. Prior to settlement, the parties participated in a mediation session and a settlement conference in New York. (The other two mediation sessions occurred in Washington, DC.) The underlying class action was tried in New York, and [the Primary Insurers'] alleged misconduct was the refusal in New York to settle that New York litigation. None of these events took place in California. [5]

The district court also found that New York's compelling interest in the application of its bad faith law to this claim, coupled with the state's contacts with the Securities Class Action, its defense, evaluation and settlement, all led to the conclusion that New York law governed the Excess Insurers' bad faith claim.

While the district court applied New York law to the Excess Insurers' bad faith claim, it also concluded that California, and not New York law, governed the interpretation and meaning of the relevant insurance policies, which were formed before any claim arose. Since the conduct of the Primary and Excess Insurers in the handling of the claim occurred in New York, the district court found it appropriate that New York govern only the aspects of the bad faith claim.

Having determined that New York law applied to the Excess Insurers' bad faith claims, the focus turned to the special interrogatories presented to the jury. The first interrogatory asked whether the Excess Insurers had demonstrated that the Primary Insurer had acted in bad faith, as defined in the district court's instructions, which encompassed the elements common to both California and New York law. The jury concluded that there was bad faith, but the jury's work did not end there. The jury was then required to determine whether the Primary Insurer acted with "gross disregard" for the Excess Insurers' interests. The Excess Insurers' interests were set forth in the district court's instructions to the jury, which were framed in accordance with New York law.

Because the jury did not find that the Primary Insurer acted with "gross disregard," and because the district court found that New York law applied to the Excess Insurers' bad faith cross-claims, the district court amended the judgment and directed the entry of judgment in favor of the Primary Insurer, dismissing the bad faith cross-claims.

Conclusion

With so few bad faith cases going to trial, let alone to verdict, the *Schwartz* case provides valuable insight into the advocacy process that can be employed during trial that could help preserve a winning argument on an unresolved choice of law issue. Taking the time to draft jury instructions carefully and proposing the use of special interrogatories to highlight the differences in the bad faith standards between states' laws could mean the difference between judgment or dismissal. In bad faith litigation, the choice of law issues cannot be overlooked.

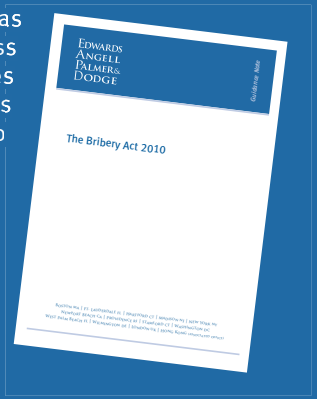
Endnotes

1. Trial Tr. 1159-209, January 18, 2007
2. Trial Tr. 1356-62, January 18, 2007; *see also Schwartz* 492 F.Supp. 2d at 326 n.9.
3. Trial Tr. 1361-62, January 18, 2007
4. *Schwartz*, 492 F.Supp. 2d at 327 (internal citations omitted).
5. *Schwartz v. Liberty Mutual Ins. Co.*, 539 F.3d 135, 152 (2nd Cir. 2008).

Bribery Act 2010

We reported on what was then the proposed Bribery Act in our March 2009 issue of the *Insurance and Reinsurance Review*. This resulted in the Bribery Act 2010 and the Government has announced that the Act will be implemented in April 2011.

The Act applies to bribery in both the private and public sectors, and to bribes paid overseas. It is intended to provide a consolidated scheme of offences. A bribe could be the payment of money, another financial advantage or a non-financial advantage, including, for example, lavish hospitality or gifts. In addition to offences relating to paying a bribe and being bribed, the Act includes offences of bribing a foreign public official. Of importance to the insurance and reinsurance industry is the offence of a commercial organisation failing to prevent bribery by someone performing services on its behalf. That includes services undertaken by employees, but also third parties such as agents and subsidiaries and even sub-contractors. This corporate offence applies both to organisations incorporated or formed in the UK, and to organisations which carry on any business in the UK. The Act undoubtedly creates an obligation to implement, maintain and enforce effective anti-bribery policies, systems and controls, as an organisation will be liable for a bribe paid on its behalf unless it can demonstrate that it had implemented adequate procedures designed to prevent bribery. It will also be an offence for directors and other senior members of a company to consent or connive to (turn a blind eye to) offences under the Act.



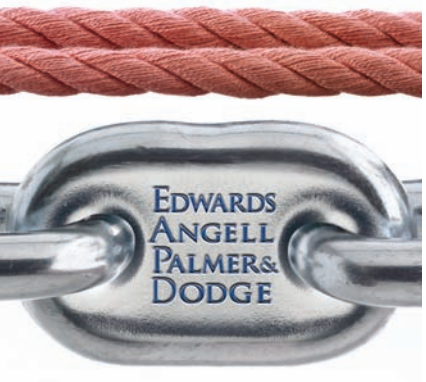
EAPD's Guidance Note on the Bribery Act 2010 can be viewed at: http://www.eapdlaw.com/newsstand/detail.aspx?news=2045. Our experts provide in-house seminars on the Act and its implications.

By Ambereen Salamat
and Chris Collins
London

Solvency II – An Update

The Solvency II project has made significant strides towards implementation over the last year. Now that there is some clarity on what the new rules will look like, we review where we are in the process and consider some of the key issues that arise with the new regime.

"The proposed capital requirements have caused concern in the EEA insurance sector... CEIOPS' more detailed proposals are far more stringent than had been envisaged from the Directive alone."



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Progress Check

As many readers are aware, Solvency II is being developed using the Lamfalussy process under which four 'levels' of legislation are created. The current status of each level can be summarised as follows:

- Framework Directive – the text of the Level 1 Framework Directive was adopted in November 2009.
- Implementing measures – the Committee of European Insurance and Occupational Pensions Supervisors (CEIOPS) (the EEA body tasked with advising the European Commission (EC) on the detail of the Directive, particularly by preparing draft implementing measures) has provided all of its advice to the EC on Level 2 implementing measures. It is expected that this advice will be broadly adopted by the EC during 2011.
- Supervisory standards – CEIOPS will develop the Level 3 standards and guidance, to ensure consistent implementation of the regime. A limited amount of this guidance has been produced to date, with more expected over the next 12 months.
- Evaluation – following the deadline for implemen-tation by EEA Member States, the EC will monitor the transposition of the Solvency II regime across the EEA and take enforcement action where necessary.

CEIOPS will continue its work of calibrating the new requirements through the use of field-testing exercises, known as Quantitative Impact Studies (QIS). Since 2005, CEIOPS has been undertaking QISs to test the financial impact of Solvency II and the suitability of the proposed requirements. Four have been completed to date. A fifth QIS will be completed by November 2010 with results expected to be published in March 2011. Attention will then turn to completing the supervisory standards before the expected implementation date for the new regime of 1 January 2013.

Capital Requirements

The proposed capital requirements have caused concern in the EEA insurance sector. This is largely because, as a result of the recent financial crisis, CEIOPS' more detailed proposals are far more stringent than had been envisaged from the Directive alone.

The Directive sets down a minimum capital requirement (MCR) and a solvency capital requirement (SCR) that must be met by (re)insurance entities operating in the EEA. The MCR is calculated using a formula set out in the Directive and the SCR may be calculated using a standard financial risk model prescribed by the Directive. However, as each firm has its own unique business profile and operates in different markets, the Directive allows for the use of either a stand-alone unique model developed by the firm (known as an 'internal model') or an adaptation of the standard model to calculate the SCR.

The Directive's capital requirements must be met by a firm's eligible own funds. Own funds are separated into two types: basic own funds and ancillary own funds.

Basic own funds comprise the excess of assets over liabilities and subordinated liabilities (eg paid up share capital). Ancillary own funds consist of items other than basic own funds (ie that are not on the balance sheet) and which can be called upon to absorb losses. Ancillary own funds include, for example, unpaid share capital, letters of credit and guarantees or other legally binding commitments. The use of such ancillary own funds as capital is subject to prior supervisory approval.

Following the determination of whether funds are basic or ancillary own funds, the capital is then classified into three tiers depending on a number of factors. In particular, it is worth noting that ancillary own funds, such as letters of credit, cannot constitute the highest tier of capital.

CEIOPS has recommended that, as far as compliance with the SCR is concerned:

- at least 50% of the total amount of eligible own funds must consist of capital in the highest tier; and
- capital in the lowest tier can only constitute a maximum of 15% of the total amount of eligible own funds.

CEIOPS has also stated that, as far as compliance with the MCR is concerned, at least 80% of the total amount of eligible own funds must consist of capital in the highest tier.

The results of the fourth QIS, published in November 2008, showed that whilst the vast majority of undertakings (98.8%) would meet the

MCR, 11% of participants would not meet the SCR. Most affected would be captives, of which over 28% would not meet the SCR. However, for the EEA insurance industry as a whole, no additional capital would be needed.

As noted above, a fifth QIS will be completed this year. The technical specifications for QIS5 were released in July 2010. Initial comment on these specifications is favourable - many commentators believe that the capital requirements have softened from QIS4 and that the EC has listened to (re)insurers' concerns. A sixth QIS may also be run by CEIOPS, however, this has not been confirmed.

Insurance Groups

Solvency

In addition to supervision at an individual level, Solvency II regulates groups of which authorised entities are a part. A key issue for an (re)insurance group will be to determine the level at which group supervision will be applied. This will usually be at the level of the ultimate parent undertaking of an insurance group, however, Solvency II does introduce the possibility of alternative supervision at sub-group level.

For groups headquartered in the EEA, full group supervision will mean maintaining solvency at group level (ie eligible own funds must be available in the group equal at least to the SCR of the group), preparing an annual group solvency and financial condition report and a group own risk and solvency assessment (broadly equivalent to the "individual capital assessment" required under the FSA's current rules for individual entities), and reporting of risk-concentrations and intra-group transactions. For these purposes, the group may include non-EEA and non-regulated entities, as determined by the relevant group supervisor.

Where a group is headquartered outside the EEA, the extent of the group supervision which will apply will depend on whether group supervision in the jurisdiction in which the group is headquartered is assessed as equivalent to Solvency II. If the local group supervision is equivalent, that regime will apply. If it is concluded that there is no equivalence either at the level of the ultimate parent or below, group supervision may be applied at the level of the ultimate parent company (in the same manner as for groups headquartered in the EEA) or may be applied more flexibly by Member States (for example, the group supervisor could insist that an EEA insurance holding company is established and group supervision applied from this entity downwards).

Supervision

The way in which (re)insurance groups are supervised under Solvency II will change. Most groups operating in the EEA will have a group supervisor. The determination of who takes on this role will depend on the structure of the group and whether the regime in the non-EEA jurisdiction in which the group supervisor is or would otherwise be located is regarded as equivalent to Solvency II. The group supervisor has responsibility for supervising the financial situation of the group and co-ordinating with the other supervisors who have an interest in the group (both within the EEA and outside). Together these supervisors make up the "college of supervisors". The organisation of the college of supervisors is very flexible and will depend on the requirements to supervise that group effectively at any given time. Any arrangement that the college of supervisors makes should be set out in a co-operation or co-ordination arrangement, CEIOPS being on hand to assist the college of supervisors, if required.

"In addition to supervision at an individual level, Solvency II regulates groups of which authorised entities are a part. A key issue for an (re)insurance group will be to determine the level at which group supervision will be applied."

Equivalence

Equivalence is a key issue in the context of Solvency II, with those groups headquartered in non-EEA jurisdictions that achieve it gaining significant regulatory advantages in the EEA.

Under various parts of the Directive, the regulation that is applied by non-EEA states can be deemed equivalent to the Solvency II regime. This will be particularly useful for groups headquartered outside the EEA because, as discussed above, the fuller supervisory and solvency regime with regard to the worldwide (re)insurance group under Solvency II will not apply. Instead, reliance will be placed on group supervision in the jurisdiction concerned.

In addition to group solvency and supervision, the EC is also expected to determine the equivalence of non-EEA jurisdictions in respect of reinsurance. If a jurisdiction is deemed equivalent, Member States:

- will be required to treat reinsurance contracts concluded with undertakings having their head office in such a non-EEA jurisdiction in the same manner as reinsurance contracts concluded with an undertaking that is authorised in the EEA;
- cannot require the pledging of assets to cover unearned premiums and outstanding claims provisions; and
- may not require the localisation of assets held within the EEA to cover technical provisions relating to risks situated in the EEA, nor assets representing reinsurance recoverables.

The EC's timetable for the implementation of Solvency II envisages that, by the time the Directive comes into force, it will have made a determination of the equivalence of the most significant non-EEA jurisdictions.

CEIOPS recently published draft advice and proposed that in its first wave of assessments, Bermuda and Switzerland should be considered for equivalence under all relevant areas of the Directive and Japan in respect of reinsurance only. CEIOPS stated that *"advice on possible countries should focus primarily on the risk based nature of the third country regime and the materiality of an equivalence finding to EU insurance and reinsurance undertakings and their policyholders"*. When considering these factors, Bermuda, Switzerland and the US scored highly and were considered of importance to the EU market. Whilst the creation of the Federal Insurance Office in the US may alleviate some of the difficulties in making an assessment of US equivalence, these difficulties (for example, day-to-day supervision of (re)insurers remaining an individual state competence), combined with the resources required to undertake multiple simultaneous assessments, led to CEIOPS proposing not to undertake an equivalence assessment of the US at this stage.

By Christopher M. Tauro
Boston

The Threat of a New Wave of Foreign Asbestos Claimants in United States Courts

In July 2009 in New Castle County in the State of Delaware, three separate plaintiffs filed civil suits against E. I. Du Pont De Nemours and Company, Inc. ("DuPont") alleging that their work at a DuPont textile plant in Mercedes, Argentina from 1961 to 2002 caused them to be exposed to and inhale asbestos fibers.[1] Specifically, these former DuPont employees (collectively "Plaintiffs") allege they developed asbestos-related diseases as a result of DuPont's negligence in creating and maintaining a dangerous work environment at DuPont's Mercedes, Argentina facility.

"With a foreseeable end of asbestos litigation in sight, the filing of new asbestos lawsuits in the United States that concern parties, premises and events from foreign countries is alarming."

This article was previously published in *Latin American Law and Business Report*, June 28, 2010 and *El Dial Suplemento de Seguros & Reaseguros*, June 2010.

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Asbestos litigation in the United States, like asbestos itself throughout the middle of the last century, is ever-present; however, the majority of asbestos claims in the United States are filed by plaintiffs that actually *live in the United States*. Plaintiffs reside in Argentina and concede in their complaints that the textile mill in Argentina is actually owned and operated by DuPont Argentina S.A. ("DuPont Argentina"), a duly organized corporation under the laws of Argentina. Nonetheless, Plaintiffs assert that DuPont is the parent company of DuPont Argentina and that the former directed and controlled the manufacture and use of asbestos by DuPont Argentina.

For over three decades, corporations and their insurances carriers have defended claims in the asbestos arena throughout the United States. Initially, plaintiffs with asbestos-related diseases – mesothelioma, asbestosis, lung cancer and pleural plaques – targeted corporations that mined and distributed raw asbestos fibers or manufactured products in the insulation trade. Indeed, literature and studies in the 1950s and 1960s focused primarily on the hazards of working with asbestos insulation products.

In the 1970s and early 1980s, studies and government regulations warned about asbestos-containing products such as cement pipe, joint compound, brakes, gaskets and roofing products and, consequently, asbestos litigation evolved so as to include this group of manufacturers in newly filed lawsuits. Today, insurance companies and their insureds still expend millions of dollars defending asbestos claims all over the United States; however, given government regulations concerning permissible exposure limits that were enacted as early as 1972, it is expected that fewer individuals will develop asbestos-related conditions in the future.[2] Notably, many experts expect that the number of asbestos claims in the United States will steadily decrease beginning in 2025.

With a foreseeable end of asbestos litigation in sight, the filing of new asbestos lawsuits in the United States that concern parties, premises and events from foreign countries is alarming. The costs inherent in defending asbestos claims in the United States can be exorbitant as attorneys and experts are retained to conduct discovery, disprove plaintiffs' allegations, provide medical, industrial and "state of the art" defenses, and ultimately settle or try asbestos cases. These costs could double if not triple if asbestos lawsuits concerning a plaintiff's exposure to an asbestos-containing product in a foreign country were permitted to be litigated in the United States simply because a defendant corporation has ties to the United States.

In response to Plaintiffs' complaint, DuPont filed a motion to dismiss on the grounds that Plaintiffs improperly sued DuPont instead of DuPont Argentina and that the doctrine of forum *non conveniens* requires that these cases proceed in Argentina where the facility, all of the witnesses and documents are located. In support of its argument,

EAPD Articles

EAPD's article-writing is not limited to the IRD Review. The following list is a selection of recently published articles by our professionals:

- **Mary-Pat Cormier** (Boston) Issues In Public Company Directors And Officers Insurance Coverage: Canada – What's New And Why You Should Care, to be published by *WorldTrade Executive/Thomson Reuters in Insurance Finance & Investment.*
- **Antony Woodhouse** and **Rhys Davis** (London) "Follow the settlements" – *IRB v CX Re*, to be published by *The Review Worldwide Reinsurance Guide to the Reinsurance Law Firms 2010*.
- **Antony Woodhouse** and **Rhys Davies** (London) "Loyaltrend and Business Interruption Losses in UK," *Law360*, June 1, 2010.
- **Richard Spiller** and **Theo Godfrey** (London) "Once More Unto the Breach: The UK Data Protection Regime and Action in the Event of a Data Breach," *JD Supra*, June 1, 2010.

For further details on any of the above contact Jennifer Topper at: JTopper@eapdlaw.com.

DuPont referenced a May 1, 2009 ruling issued by the Seventh Circuit Court of Appeals affirming the dismissal of two cases based on the doctrine of forum *non conveniens* brought by Argentines against United States corporations.[3] In the two cases before the Seventh Circuit, the plaintiffs referenced the Treaty of Friendship, Commerce and Navigation Between Argentina and the United States – signed into law by President Franklin Pierce on July 27, 1853 – for the proposition that they were entitled to sue the defendants in the United States. Judge Posner, writing for the Court, did not disagree but rather concluded that the lower courts reached the correct opinion that these cases should be litigated in Argentina because that was where the plaintiffs resided and were injured, but expressly left the door open to foreign plaintiffs to bring lawsuits in the U.S.

The prospect of a new wave of asbestos claimants from foreign countries being permitted to bring suit in the United States has significant ramifications for defendant corporations already involved in asbestos litigation, their insurance and reinsurance carriers, and many Courts in the United States. Significantly, as Plaintiffs' counsel warned in its June 24, 2009 press release, more suits based on foreign subsidiaries' use of asbestos in countries in Latin America, Africa and Asia are "soon to follow." True to his word, Plaintiff's counsel filed 19 additional cases on behalf of an additional 19 former employees of DuPont's foreign subsidiary, Dupont Argentina S.A. ("DASA") also filed four cases alleging household exposure and environmental claims related to DASA's manufacturing operations in Argentina. Should the Court in New Castle County deem Delaware a proper forum for Plaintiffs to file their asbestos lawsuits, aggressive plaintiffs' counsel and their injured claimants will certainly turn to United States courts for adjudication of their claims for years to come.

Endnotes

1. The plaintiffs, Cristian Dematei (C.A. No. 09C-06-247), Juan Carlos Laborda (C.A. No. 09C-06-248) and Ceferino Ramirez (C.A. No. 09C-06-249). Plaintiffs time at the textile facility varied but, as a whole, the dates of their employment ranged from 1961 to 2002.
2. The development of an asbestos-related condition follows a latency period of many years that is determined by the dose of the exposure to asbestos. Accordingly, an individual exposed to asbestos may not develop an asbestos-related condition until 10 to 50 years from the date of the initial and subsequent exposures.
3. *See Abad v. Bayer Corp.*, 563 F.3d 663 (7th Cir. 2009)(concluding that Argentine courts would apply Argentine law in tort case because Argentina was where plaintiffs resided and were injured).

Lehman Brothers: Client Money Appeal

Just as this issue of the *Insurance and Reinsurance Review* was going to press, the Court of Appeal handed down its decision in the appeal in *CRC Credit Fund Ltd & Ors v GLG Investments Plc (Sub-Fund: European Equity Fund) & Ors* (reported at [2010] EWCA Civ 917) against the decision of Mr Justice Briggs, reported in our March 2010 issue.

The Court of Appeal agreed with Briggs J that the CASS rules created a trust over client money from the date it was received, rather than from the date it was segregated from the firm's own money. It also agreed that Lehman Brothers International (Europe) (LBIE) did not hold client money for the purposes of the CASS rules simply because LBIE owed a certain sum to its client under an agreement, for example an obligation to pay a manufactured dividend under a stock lending agreement.

However, the Court of Appeal disagreed with the first instance judgment on two key issues. First, it was held that the trust imposed by the CASS rules applied to money which was identifiably client money whether or not it had actually been segregated by LBIE. It would be unfair for the trust to apply only to those clients whose money happened to have been be placed in segregated accounts. Second, the Court of Appeal held that the effect of the CASS rules was that clients would share in the client money pool according to the amount which ought to have been segregated on their behalf, rather than (as held by Briggs J) on the basis of the sum which had in fact been segregated.

This judgment is highly important, as it will significantly increase the number of creditors who may be entitled to make claims for client money held by LBIE and possibly the amount of their claims. Creditors whose client money was not segregated by LBIE, but ought to have been, may now have a claim to the pool of client money held by LBIE. It is unlikely, however, that the decision will increase the size of the pool because it does not turn the money in LBIE's house accounts into trust money (and therefore client money) except to the extent that tracing rights can be established over such funds. This would *prima facie* seem unlikely. Except to that extent, the decision will diminish the share of the client money pool of those creditors whose client money was in fact segregated.

The decision depends heavily on the meaning and interpretation of the CASS rules as they now stand (the FSA has consulted on possible changes to the regime) and should not be taken to apply to trust rights in a non-CASS context. Given the significant effects this decision could have on the distribution of funds by the administrators of LBIE it seems likely that there will be an appeal to the Supreme Court.

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By Antony Woodhouse
and Rhys Davies
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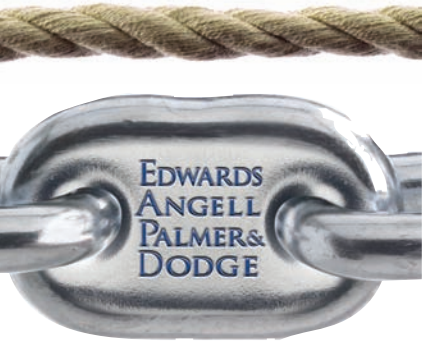
"But for" and Business Interruption

In a recent appeal from an arbitration award in a case concerning business interruption losses, the Commercial Court has held that the arbitration tribunal had correctly applied the "but for" test as the appropriate test of causation. On a further point, the Court held that the tribunal had reached the correct conclusion regarding the construction of a business trend clause.



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Hurricanes Katrina and Rita in Autumn 2005 caused significant damage to the Gulf of Mexico, and in particular to New Orleans, Louisiana. In *Orient-Express Hotels Limited v Assicurazioni General S.p.A. (UK Branch) t/a Generali Global Risk* [2010] EWHC 1186 (Comm), the court considered an appeal under section 69 of the Arbitration Act 1996 against an arbitration award.

Background

Orient-Express Hotels (OEH), a luxury-hotelier and holiday operator, was the owner of a hotel situated in the Central Business District of New Orleans. Generali Global Risk was its insurer under a combined property damage and business interruption (BI) policy.

The hotel suffered significant physical damage from wind and water as a result of the hurricanes. The hotel was closed throughout September and October 2005 re-opening on 1 November 2005. OEH sustained significant business interruption losses. A state of emergency was declared and a curfew imposed on 27 August. On 28 August a mandatory evacuation of New Orleans was ordered (with limited exceptions) and again (without most of the prior exceptions) on 6 September 2005. New Orleans was re-opened and the curfew lifted by the beginning of October 2005.

The Tribunal's Decision

According to the arbitration tribunal, *"[T]he Insuring Clause defined "Damage" as (in effect) "direct physical loss destruction or damage" to the Hotel. Cover for Business Interruption is for "loss due to interruption or interference with the business directly arising from Damage" … The condition for cover is that there has been Damage and that "the Business be in consequence thereof interrupted or interfered with"."*

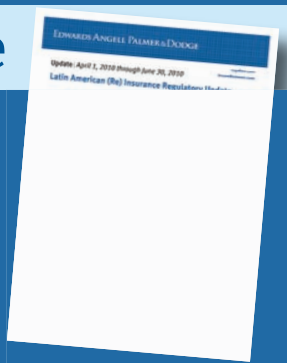
OEH claimed that it was entitled to an indemnity under the primary indemnity provisions of the Policy for all BI loss resulting from an interruption or interference caused by insured damage to the hotel, even if such BI loss was also concurrently caused by damage to the vicinity (or the consequences of such broader damage to the vicinity) resulting from the same hurricanes.

Generali submitted, and the tribunal accepted, that OEH could only recover in respect of loss which could be shown would not have arisen had the damage to the hotel not occurred - the "but for" test of causation. To assess the correct level of loss would mean putting OEH in the position of an owner of an 'undamaged hotel' in an otherwise damaged city. The tribunal held that, because an undamaged hotel would have suffered the same loss as a damaged hotel in September 2005 due to the damage to New Orleans, there was no indemnity under the primary insuring clauses of the Policy in respect of such loss.

The Appeal

The question was how the policy responded where both the hotel and the wider area (what the judge referred to as *'the vicinity'*) were damaged and where, as OEH contended, its BI loss was caused

EAPD's Latin American Practice Regulatory Update



EAPD's Latin American Practice has released the second issue of the Regulatory Update containing valuable information about the business and legal environment for insurance and reinsurance entities operating in the region.

The group has recently expanded across practices to include: **Jack Dearie** (New York), **Louis Mercedes** (Boston), **Amber Mills** (New York), and **Stephen Ixer** (UK).

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both by the damage to the Hotel and by damage to the vicinity (and the consequence of such damage to the vicinity, such as broader loss of attraction), both of which had been caused by the same hurricanes.

OEH appealed on two questions of law. Mr Justice Hamblen was asked to consider:

- Whether on its true construction, the Policy provided cover in respect of loss which was concurrently caused by: (i) physical damage to the property; and (ii) damage to or consequent loss of attraction of the surrounding area
- Whether on the true construction of the Policy, the same event(s) which caused the damage to the insured property which gave rise to the business interruption loss were also capable of being or giving rise to 'special circumstances' for the purposes of allowing an adjustment of the same business interruption loss within the scope of the "Trends Clause".

Causation Issues

It was accepted that the normal rule when looking at issues of causation was the application of the "but for" test. OEH submitted that there were exceptions when it was appropriate to depart from this established test.

OEH referred the judge to exceptions where the "but for" test should not apply, namely *"[t]he typical situation where an extension of liability may prove necessary in the interest of fairness and reasonableness, with a consequent departure from the "but for" test, is where two of more acts or events or agencies are involved and the wronged claimant is unable to prove which act, event or agency has caused the harm."*

OEH also referred to the opinion of Lord Nicholls in *Kuwait Airways Corpn v Iraqi Airways Co (Nos 4 and 5)* [2002] 2 AC 883 where his lordship stated that *"the "but for" test can be over-exclusionary. This may occur where more than one wrongdoer is involved. The classic example is where two persons independently search for the source of a gas leak with the aid of lighted candles. According to the simple "but for" test, neither would be liable for damage caused by the resultant explosion."*

OEH, whilst accepting that the cases in which it had been held inappropriate to apply the "but for" test had been cases in tort, submitted that the same approach should be applied in appropriate cases in contract. OEH submitted that this was a case of two concurrent independent causes and the application of the "but for" test would lead to *"the untenable conclusion that neither of the causes caused the business interruption loss."* Applying the "but for" test to the case, OEH submitted that they would *"recover neither under the main Insuring Clause (because "but for" the Damage the loss would still have occurred due to the vicinity damage or its consequences) nor under the POA* [Prevention of Access] *or LOA* [Loss of Attraction] *(because "but for" the prevention of access and/or loss of attraction the loss would still have occurred due to the Damage to the Hotel)."*

"The judge held that as a general rule the "but for" test was a necessary condition for establishing causation..."

This submission by OEH relied on there being two concurrent independent causes. However OEH was unable to support this assertion with anything other than cases involving two concurrent interdependent causes.

The judge held that as a general rule the "but for" test was a necessary condition for establishing causation however there may be cases in which fairness and reasonableness required that it should not be a necessary condition.

The judge stated that there was considerable force in OEH's submission, but in this case, it could not be established that the tribunal erred in law in adopting the "but for" approach to causation which they did. He did so on three grounds:

- It was a Policy under which it had been agreed that a "but for" approach to causation should be adopted to the assessment of loss of revenue.
- The question of whether "fairness and reasonableness" required that the "but for" test should not be applied was a matter for the tribunal of fact, rather than for the court on an appeal limited to questions of law.
- He was not satisfied that it had been shown that "fairness and reasonableness" required that the "but for" test should not be applied, specifically, that none of those alternatives contemplated *"would appear to be more fair and reasonable than the "but for" test adopted by the Tribunal, still less so as to require the discarding of that test."*

The Trends Clause

The Trends Clause provided that loss adjustments were to be made *"to provide for the trend of the Business and for variations in or special circumstances affecting the Business either before or after the Damage or which would have affected the Business had the Damage not occurred so that the figures thus adjusted shall represent as nearly as may be reasonably practicable the results which but for the Damage would have been obtained during the relevant period after the Damage."*

The Tribunal had rejected OEH's submissions on this point stating that it was not necessary *"to go behind the Damage and consider whether the event which caused the Damage also caused damage to other property in the City."* The Tribunal added that *"the fact that there was other damage which resulted from the same cause does not bring the consequences of such damage within the scope of the cover."*

On appeal, OEH made a number of submissions, none of which found force with the judge who held that he agreed with the tribunal. The judge agreed that *"the clause is concerned only with the Damage, not with the causes of the Damage. What is covered are business interruption losses caused by Damage, not business interruption losses caused by Damage or "other damage which resulted from the same cause"* [emphasis added]. The judge held that *"[t]he assumption required to be made under the Trends Clause is "had the Damage not occurred"; not "had the Damage not occurred and whatever event caused the Damage not occurred.""*

The judge held that OEH's construction required words to be read into the clause or for it to be re-drafted. The judge found that the Tribunal's construction and application of the Trends Clause was correct.

Impact of the Case

The decision is of interest because it is a rare, reported decision on an issue often covered in arbitration. Despite finding that as a general rule the "but for" test was a necessary condition for establishing causation in fact, there are circumstances where fairness and reasonableness may require that the "but for" test should not be applied. However, those circumstances were not present in this case and the decision offers little in the way of guidance to insurers in assessing when to depart from the general position.

By Nick R. Pearson
New York

De-Risking the Book

As their balance sheets have come under stress, insurers have exited or are considering exiting non-core lines of business where acquisition costs and disappointing results do not justify continued dedication of assets. Insurers have two powerful tools for de-risking their book - novation and assumption transactions, and loss portfolio transfers. The only way for a company to legally and statutorily eliminate the liabilities associated with books of business is through a novation and assumption transaction (often referred to as "assumption reinsurance").

"Assumption reinsurance and LPT's are powerful tools for insurers to transfer liabilities."

This entails substituting another insurer for the issuing carrier and in almost all circumstances requires consent of the insureds. The other option for companies seeking to transfer the liabilities associated with discontinued operations are loss portfolio transfers ("LPT"s), which are a form of reinsurance and therefore do not legally cut off the issuing carrier's liability to the insureds but can result in transfer of the past liabilities for statutory accounting purposes.

Assumption Reinsurance

An assumption reinsurance transaction is one in which the original contract of insurance between Insurer A and the Insured is extinguished and replaced by a new contract between Insurer B and the Insured, typically granting the Insured the same rights against Insurer B as it had against Insurer A, with Insurer A having no further obligation to the Insured. A novation and assumption contract therefore operates as a release between Insurer A and the Insured with respect to all rights, duties and obligations under the novated policy.

Many states have adopted a version of the National Association of Insurance Commissioners Model Assumption Reinsurance Law, which generally requires insured consent to the novation and assumption. In addition, in those states that have not adopted the Model Act, there is often case law establishing that a novation requires the consent of the insured. The law of the state in which the insured is found will determine whether and by what means the insured's consent is required. The consent requirement can make assumption reinsurance transactions difficult and costly to implement, particularly for large books of personal lines business. This has acted as a deterrent to their more widespread implementation.

Typically, in an assumption reinsurance transaction the assuming insurer will be licensed in the jurisdiction where the insured is located, as the new insurer will be deemed to be transacting insurance in that jurisdiction. However, in some commercial transactions if the insured is willing and the placement satisfies the requirements, the replacement insurer could be a surplus lines writer, or even an unauthorized insurer if the insured was willing to travel to the jurisdiction where insured is licensed so that the policy could be written as a direct placement. Alternatively, there are some states that have industrial insured exemptions to their insurer licensing laws, which could be applicable depending upon the location of the insured and whether it qualifies as an "industrial insured" under the statute.

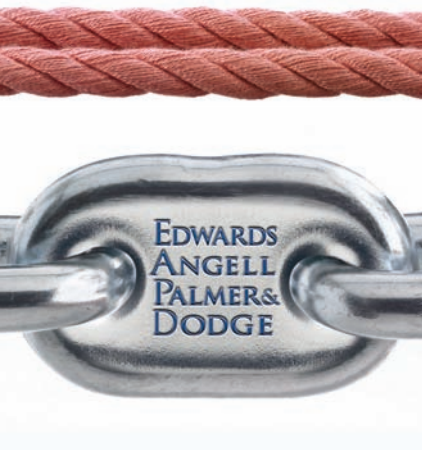
Regulators

These possible alternatives to a licensed assuming insurer may make it easier for the issuing carrier to find a replacement insurer willing to assume these risks at a more favorable price. However, it should be kept in mind that the insureds must be willing partners and may be adverse to insuring with an unlicensed carrier.

Whether or not insurance department approval will be required for an assumption reinsurance transaction will typically depend upon its size. Many states regulate bulk reinsurance transactions, which require approval if certain thresholds are tripped. For example, New York requires approval if, during any consecutive 12 month period, a domestic P&C insurer were to cede an amount of insurance for which the total gross reinsurance premiums are greater than 50% the company's unearned premium on the net amount of its in-force book at the beginning of the period. New York exempts reinsurance "made in the ordinary course of business reinsuring specified individual risks under reinsurance agreements relating to current business" from this calculation. The law of the domiciliary jurisdiction of the issuing carrier should always be consulted to determine whether regulatory approval is required. Of course, a company in solvent runoff under regulatory oversight will probably have more stringent approval requirements imposed upon it.

Loss Portfolio Transfers

Under LPT agreements, the issuing carrier remains legally liable to its insureds, but would transfer



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to the assuming reinsurer(s) 100% of the liabilities associated with known losses and IBNR. LPT's are always retrospective in nature, which differentiates them from contracts for new business. New York's definition of a loss portfolio transfer is illustrative:

> *Loss portfolio transfer* means an agreement: (1) by which a transferer increases its surplus to policyholders as a result of payment of consideration to a transferee for undertaking any loss obligation already incurred in excess of the consideration paid; or (2) where the consideration paid by the transferer, in connection with transferring any loss obligation already incurred, is derived from present value or discounting concepts based upon anticipated investment income. (*See* New York Regulation 108.)

In order to realize the economic benefit of LPT agreements to transfer the liabilities relating to the insureds' reserves, the issuing carrier would need to be able to take statutory statement credit for the liabilities ceded, or obtain qualifying collateral to set off against those liabilities. The same premium volume criteria as discussed in connection with novation and assumption agreements will apply to LPT's in determining whether departmental approval is required.

In addition, depending upon the domiciliary jurisdiction of the cedent ("transferer") LPT contracts generally need to meet some or all of the following criteria in order to obtain statutory statement credit:

- The agreement shall provide that the obligations of the transferee are payable on the basis of the liability of the transferer without diminution because of the insolvency of the transferer.
- The agreement shall be noncancellable, except at the discretion of the superintendent acting as rehabilitator, liquidator or receiver of the transferer or transferee.
- The agreement shall not contain terms permitting, or operate to permit, the transferee to exercise influence over the claim settlement practices and procedures of the transferer by delay of payment of balances due or otherwise, except that, subject to the ultimate responsibility of the transferer, the transferee may participate in the defense of claims in a manner that shall not constitute unfair claim settlement practices.
- Recoveries due the transferer must be available without delay for payment to losses and claim obligations incurred under the agreement, in a manner not inconsistent with orderly payment of incurred policy obligations by the transferer.
- The agreement shall constitute the entire contract between the parties, and must provide no guarantees of any kind to the transferee by or on behalf of the transferer, whether directly, by side agreement, or otherwise.
- The agreement must provide for quarterly reports by the transferer to the transferee, setting forth the transferer's total loss and loss expenses reserves on the policy obligations subject to the agreement, so that the respective obligations of transferer and transferee will be recorded and reported on a consistent basis in their respective annual and interim statements required to be filed in New York.
- The consideration to be paid by the transferer for the loss portfolio transfer must be a certain sum stated in the agreement.
- Direct or indirect commissions to the transferer or transferee are prohibited.
- Any provision for subsequent adjustment on the basis of actual experience in regard to the policy obligations transferred, or on the basis of any other formula, is prohibited in connection with a loss portfolio transfer, except that provision may be made for the transferer's participation in the transferee's ultimate profit, if any, under the agreement.

Assumption reinsurance and LPT's are powerful tools for insurers to transfer liabilities. However these transactions require careful attention to detail in order to ensure they achieve the economic benefits desired and do not run afoul of regulatory requirements.

By Victoria Anderson and Francis Mackie (London)

Insurance Contract Law Reform – Proposed Amendments to the Duty of Good Faith

The Law Commission continues to make great strides in proposing insurance contract law reform. Its latest offerings are two papers which consider the duty of good faith: Issues Paper 6, *Damages for Late Payment and the Insurer's Duty of Good Faith*; and Issues Paper 7, *The Insured's Post-Contract Duty of Good Faith*. We touched briefly on both these topics in our December 2009 issue of *Insurance and Reinsurance Review*.

"The Law Commission has identified two broad approaches to reform. Firstly an amendment could be made to Section 17 of the MIA, so as to provide policyholders with damages where an insurer has acted in bad faith. Secondly the decision in Sprung could be reversed..."

Issues Paper 6 – Damages for Late Payment and the Insurer's Duty of Good Faith

This Issues Paper was published on 24 March 2010. In it, the Law Commission considers whether a policyholder should be entitled to damages where the insurer has refused to pay a valid insurance claim, or has paid only after considerable delay. Failure by insurers to provide a prompt indemnity, for example, following a fire at commercial premises, can lead to disastrous financial consequences on the part of the insured, which can include a total loss of the business. Under English law, there is no recompense, save for the discretionary award of interest which will often not reflect the policyholder's true loss.

In American jurisdictions of course, the position is very different. Under the law of most states, insurance companies owe a duty of good faith and fair dealing to the persons they insure. This duty is often referred to as the "implied covenant of good faith and fair dealing" which automatically exists by operation of law in every insurance contract. If an insurance company violates that covenant, the policyholder may sue the company on a tort claim in addition to a standard breach of contract claim. The contract-tort distinction is significant because as a matter of public policy, punitive or exemplary damages are unavailable for contract claims, but are available for tort claims. The end result is that a plaintiff in an insurance bad faith case may be able to recover an amount *larger* than the original face value of the policy, if the insurance company's conduct was particularly egregious.

The Problem with Sprung

Under English insurance law it is established law that a claim under an insurance policy is a claim for damages and there is no right to damages for late payment of claim/indemnity, as held in *President of India Lips Maritime Corporation (The Lips)* [1988] AC 395 and followed reluctantly by the Court of Appeal in the key case of *Sprung v Royal Insurance (UK) Limited* [1997] CLC 70.

The Law Commission considers that *Sprung* is out of line with the principles of ordinary contract law. The general position is that a defendant is required to compensate the claimant for any loss flowing naturally from the breach of contract or any special loss which he ought to have known would flow from the breach. Insurance law is the exception because the sums due under the insurance policy are in the form of damages for breach of the insurers' undertaking to *"hold the insured harmless"* by way of indemnity and therefore payable on the occurrence of the insured peril. As the Law Commission points out, this is a pure fiction as it means that insurers are automatically in breach of contract if the assured suffers a loss.

The Law Commission also has the following objections to the decision of *Sprung*:

- the law is unfairly weighted in favour of insurers because the assured has no remedy if insurers choose to pay late. By contrast, policy terms may impose onerous obligations on the assured with draconian remedies for the insurers if the obligations are not complied with.
- the law does not support efficient and TCF compliant insurers and as such provides no incentive for an inefficient and poorly-run insurer to change its ways.
- the law can result in unjust decisions and consequences.

Breach of Insurers' Duty to Act in Good faith

It could be argued that late payment is a breach of the insurer's utmost good faith, but there is a problem in that it is well established that the only remedy for such a breach is avoidance *ab initio* and return of the premium by the insurer (*Banque Financière v Westgate Insurance Co* [1991] 2 AC 249). This is unlikely to be of much use to the insured particularly if it has suffered a significant loss.

Alternative Remedies

However, an insured does have limited remedies available if it has suffered loss as a result of the late payment of a claim:

- ***Interest*** – there is the possibility of an award of interest under Section 35A of the Senior

Courts Act 1981, but that is a remedy only awarded by the court following a judgment

- ***The FOS*** – The Financial Ombudsman Service (FOS) is available to help those cases falling within its jurisdiction, namely consumer and small business cases. It has proved itself willing to award damages for distress and inconvenience (although such awards are primarily for consumers and do not involve large sums) and also for financial loss flowing from business interruption.
- ***Breach of statutory duty*** – The Financial Services Authority (FSA) requires insurers to handle claims promptly and fairly. If not, the FSA may take disciplinary action against the insurer and may impose a fine. In addition, consumer policyholders may bring a claim for damages for breach of statutory duty under Section 150 of the Financial Services and Markets Act 2000. However, these claims are not open to businesses and in practice, policyholders instead rely upon The FOS route.
- ***The tort of deceit*** – In theory, if an insurer lies to an insured, it would be liable for any losses which result. However, this tort is unlikely to be available in the vast majority of cases. The insurer must make a representation of fact which it knows to be false (or does not care whether it is false). Inaction will not suffice; nor would a mere statement of opinion that a claim is invalid. Further, the policyholder must rely on the representation to their detriment. In most cases involving late or non-payment, the policyholder is unlikely to have acted on an insurer's false statement in this way. For these reasons, the tort is unlikely to help most policyholders when their valid claims are paid late or not at all.
- ***Reinstatement*** – often policies allow insurers to choose between paying a sum of money or reinstating (that is, repairing or replacing) the property damaged. If an insurer elects to reinstate, it acquires obligations in relation to the quality of that reinstatement. Delays in reinstating property may give rise to a claim for damages, including damages for distress and inconvenience.

The Proposals

The Law Commission has identified two broad approaches to reform. Firstly an amendment could be made to Section 17 of the MIA, so as to provide policyholders with damages where an insurer has acted in bad faith. Secondly the decision in *Sprung* could be reversed, so as to make an insurer liable for a failure to pay a valid claim within a reasonable time.

If these changes took place, it is clear from what the Law Commission has said that:

- the policyholder should be required to prove his loss caused by a declinature or unjustifiably delayed payment
- the consequential loss must have been foreseeable (in the mind of insurer/policyholder) when the policy was entered into
- that the policyholder has been reasonable by trying to limit the loss.

The Law Commission is therefore proposing that insurance contracts be treated in the same way as ordinary contracts. In addition it has proposed that the core duty of good faith should be non-excludable (as you would expect in a contract of *uberrimae fidei*). However, in business insurance, the parties would be free to agree to contract terms excluding liability for failure to pay within a reasonable time. It has also proposed that damages for distress, inconvenience and discomfort should be made available for delayed payments.

Industry Feedback

Responses to this Issues Paper were invited by 24 June 2010. The industry, whilst generally accepting that reform of the law is needed and that injustices such as that demonstrated in *Sprung*, need to be avoided, has voiced a number of concerns, namely the possible increase in costs (when there are commercial pressures not to increase premiums), and the possible increase in "satellite" disputes (for example what is a "reasonable" time for an insurer to investigate a claim? At what point does delay in payment become unjustified?).

Some commentary relates to the limitations of the Law Commission's proposals. For example, the singling out of insurers from insureds and other commercial entities for special treatment. It is not clear why any change in the law cannot apply to all debts. In addition, if breach of the duty of good faith by an insurer has a remedy in damages, this should be extended so that either party to the contract is entitled, in the event of breach by the other party, to elect either for avoidance from the date of the breach or for damages.

Other aspects which insurers feel strongly about are that they should be permitted to have a reasonable period of time to investigate the claim, that any legislation should affect insureds and insurers alike and be spelt out clearly, and that it should be permissible to exclude the duty of good faith.

A full consultation paper is planned for early 2011 and it will be interesting to see what affect these industry considerations will have on the current proposals. The Issues Paper can be viewed at http://www.lawcom.gov.uk/docs/late_payment_issues.pdf.

Issues Paper 7 - The Insured's Post-Contract Duty of Good Faith

According to figures released by the ABI, 1.4% of claims were refused for fraud in 2008, amounting to 4.2% of the value of claims. Issues Paper 7 considers the law of fraudulent claims, focusing in particular on what remedies should be available to insurers if policyholders act fraudulently.

Express Terms

The current law permits the use of express "fraud clauses" setting out the consequences of making a fraudulent claim, provided they are in clear, unambiguous terms. Public policy does not however permit a party to exclude liability for his or her own fraud. The Law Commission agrees with this position. The law is unclear, however about whether a party may exclude or limit liability for the fraud of its agents. Whilst it is unlikely that an insurer will wish to assume the risk that the insured's agent is fraudulent, the Law Commission queries whether the law should prevent an insurer from doing so if the parties so wish.

Absence of an Express Term

At present if a policyholder suffers a legitimate loss but then adds a fictitious claim to that loss, the policyholder will lose its entire claim. Whilst the Law Commission considers that this is correct, it believes the law on fraudulent claims to be unnecessarily confusing. As with Issues Paper 6, the problem lies with the fact that Section 17 of the MIA provides only one remedy, that of avoidance of the contract from the start (ie that the insurer is not on risk for that claim). In theory, this entitles an insurer to require the policyholder to repay all past claims under the policy even though all of those claims are genuine. The courts have dealt with this problem by holding that a fraudulent policyholder should forfeit the fraudulent claim, leaving the rest of the contract unaffected.

The Law Commission considers this to be the correct approach albeit that it is incompatible with what Section 17 says. As such, it has tentatively suggested that Section 17 be amended to reflect the current common law position. In addition, it has suggested that the insurer should be entitled to damages from a policyholder for the costs of investigating a fraudulent claim.

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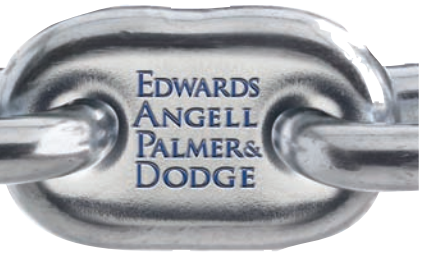

"There appears to be a general consensus that the remedies available under English law for a breach of the duty of good faith are out of step with today's commercial realities and can be unclear and confusing."

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Joint and Group Insurance

Issues Paper 7 also considers fraudulent claims in joint and group insurance. With respect to joint insurance (taken out by two or more people to cover joint interests, commonly couples) the law finds that the fraud of one policyholder affects the other. The Law Commission has proposed that where two or more people act together to insure their joint interests, there should be a presumption that any fraud committed by one party is done on behalf of all the parties. However, it would be open to an innocent party to rebut this presumption and if he or she produces evidence that the fraud was not carried out on their behalf or with their knowledge, then the claim should be paid. Recovery should be limited to the innocent party's particular loss, and the guilty party should not benefit.

With respect to group insurance (typically group schemes where an employer takes out a policy for the benefit of employees), as group members are not policyholders, there is doubt as to whether they are caught by the obligations imposed on policyholders under insurance contract law. The Law Commission has queried whether there is a need to make special provision for fraudulent claims by group members to give insurers similar remedies to those available where a policyholder acts fraudulently.

The Duty of Good Faith

The Law Commission has considered whether the insured's post-contract duty of good faith has any other effects, outside the context of fraudulent claims. In many European countries, as policies tend to last for several years, policyholders are under a continuing duty to notify the insurer of factors which aggravate the risk. The Principles of European Contract Law provide the insurer with a remedy if the policyholder fails to do so, but the remedy is limited. The insurer may only refuse payment if the loss was caused by the aggravation of the risk. Even if the loss was so caused, the insurer is usually required to pay a proportion of the claim, based on the premium it would have charged had it known the full circumstances. the insured also has a right to a premium reduction if there is a material reduction in the risk.

UK law however does not recognise an on-going duty of disclosure in the absence of a specific contract term. Even if the contract does include a notification clause, the UK courts will interpret it restrictively. The Law Commission has agreed with this approach, but has questioned whether there would be advantages to following the approach set out in the Principles of European Contract law.

Codification

Lastly, the Law Commission has looked at whether any codification of the duty of good faith should be exclusive, so that it covers only specified instances, or whether it should continue to have some general, unspecified effect. On the one hand, allowing a general duty might permit the courts to develop the law to meet new challenges, but on the other hand, it could add to confusion and uncertainty. The Law Commission has requested responses to its proposals by Monday 11 October 2010. If you would like to view the Issues Paper, please see it here: http://www.lawcom.gov.uk/docs/issues7_duty-of-good-faith.pdf.

Comment

There appears to be a general consensus that the remedies available under English law for a breach of the duty of good faith are out of step with today's commercial realities and can be unclear and confusing. The Law Commission, with these two recent Issues Papers, has attempted to strike a balance between the rights of the insured and the insurer. It remains to be seen whether or not its proposals will make it to the statute books.

We will continue to closely monitor these projects both on InsureReinsure.com and through this publication.

Getting the Deal Through

Getting the Deal Through - Insurance and Reinsurance (2010) is an annual publication for corporate counsel and legal practitioners that sets forth the comparative law on key insurance and reinsurance issues in 31 jurisdictions worldwide. New York partner **Paul Kanefsky** acted as contributing editor to this book, which was released in July 2010.

EAPD provided the annual update and analysis for the UK and US portions of the book and the uniform set of issues addressed for each country. The UK segment is authored by London-based professional support lawyer **Victoria Anderson** and London associates **Sam Tacey** and **Theo Godfrey,** and the US portion is authored by US partners **Paul Kanefsky**, **Charles Welsh**, **Michael Griffin** and **Laurie Kamaiko** and US associate **Robert DiUbaldo**.

This book is free to access online to in-house counsel worldwide. If you work in-house for a corporation, please visit www.gettingthedealthrough.com/in-house/ to register for your free Online Individual Subscription.

New Hampshire and Wisconsin Enact Life Settlement Laws: California Issues Regulations

New Hampshire and Wisconsin have joined with other states in enacting or updating life settlement laws in recent months and California's Insurance Department issued new regulations just weeks before its new life settlement law was to go into effect on July 1, 2010.

By Geoffrey Etherington
New York

New Hampshire Governor John Lynch (D) signed HB 660 effective June 14, 2010. New Hampshire's statute is primarily based on the model life settlement law adopted by the National Association of Insurance Commissioners (the NAIC), and, among other things, imposes restrictions with respect to stranger-originated life insurance transactions (STOLI):

> ...a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include but are not limited to cases in which life insurance is purchased with resources or guarantees from or through a person, or entity who, at the time of policy inception, could not lawfully initiate the policy himself, herself, or itself, and where, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy and/or the policy benefits to a third party. Trusts that are created to give the appearance of insurable interest and are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life...

New Hampshire will require STOLI investors to wait at least five years before collecting death benefits under a policy. This restriction only applies to STOLI policies; it does not apply to policies originally purchased for an insurance protection purpose.

New Hampshire life settlement providers must obtain license and their contract forms are subject to insurance department approval. Providers must also comply with disclosure, reporting, privacy, and record retention requirements.

On May 13, 2010, Wisconsin Governor Jim Doyle signed into law Senate Bill 513 (SB 513). SB 513 is a hybrid of the NAIC Viatical Settlements Model Act and the Life Settlements Model Act of the National Conference of Insurance Legislators (NCOIL), and includes a requirement with some exceptions that life insurance policies be in force for at least five years before they can be sold in the secondary market.

Wisconsin requires life settlement providers and brokers to obtain licenses and imposes on them disclosure and anti-fraud obligations. The purchase price paid to a Wisconsin policyowner for a life insurance policy must be less than the death benefit, but more than the cash surrender value.

On June 11, 2010, the California Insurance Department issued proposed regulations, on an emergency basis, to implement Senate Bill 98 (SB 98) signed on October 11, 2009 by California Governor Arnold Schwarzenegger which was effective as of July 1, 2010. The new California law targets (STOLI) transactions. SB 98 repeals previous laws regarding viatical settlements, which only applied to life insurance policies belonging to individuals with terminal diseases. SB 98 regulates all life settlements, including sales of life insurance policies by healthy insureds.

The proposed regulations (i) define procedures for licensing California life settlement providers and brokers, (ii) specify forms for provider and broker applications and consumer disclosures and a suggested provider verification of coverage form, and (iii) set forth procedures for filing life settlement forms with the California Insurance Commissioner prior to use.

California life settlement providers are required to disclose to policyowners that (a) there are possible alternatives to life settlements, including accelerated benefits options under their policies, (b) some or all of the proceeds of a life settlement may be taxable and (c) a change in ownership of the settled policy could limit the insured's ability to purchase insurance in the future because there is a limit to how much coverage insurers will issue on one life.

Unlike New Hampshire and Wisconsin, California's updated life settlement law imposes only a two-year ban on life settlements but it establishes a statutory definition of STOLI and classifies STOLI transactions as fraudulent acts. California's law was primarily based on the NCOIL Model Act.

These recent actions by New Hampshire, Wisconsin and California are evidence of the continuing drive by legislators and regulators to significantly increase the regulation of life settlements and in many cases discourage or, at least, disfavor investments in life insurance policies by third parties (or "strangers").

"These recent actions by New Hampshire, Wisconsin and California are evidence of the continuing drive by legislators and regulators to significantly increase the regulation of life settlements and in many cases discourage or, at least, disfavor investments in life insurance policies by third parties"

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Industry Presence

COME FIND US

- EAPD will sponsor the Reinsurance Association of America Claims Conference in New York on September 15-16, 2010. **Jeanne Kohler, Marc Voses** and **Robert DiUbaldo** (New York) will be facilitators.
- **Mike Thompson** (Stamford) and **Richard Spiller** (London) are attending the Rendez Vous de Monte Carlo between September 11-16, 2010.
- **Nick Pearson** (New York) will present at the IAIR London Seminar at Reynolds Porter Chamberlain, London on September 16, 2010.
- **Laurie Kamaiko** (New York) will be a Panelist at ACI's Cyber and Data Risk Insurance Conference being held in NY on September 27-28, 2010.
- **Mary-Pat Cormier** (Boston) is a member of the faculty for the Annual D&O Liability Conference, which will take place November 30-December 1, 2010 at the Flatotel in New York City. Her presentation will be on Canadian D&O Liability Issues.
- **Nick Pearson** (New York) will be a Panelist at AIRROC/R&Q Commutations Forum, which will take place October 18, 2010 in New Brunswick, NJ. His presentation will be "Commutations: Challenges and Strategies for Runoffs". Industry Experts on challenges and strategies commuting with Runoff companies vs. ongoing entities.
- **Ambereen Salamat** (London) is attending the NAIC 14-17 August in Seattle Washington and **Jack Dearie** (New York) and **Mike Griffin** (Hartford) are attending the NAIC in October 2010 in Orlando Florida.
- **Martin Lister** (Hong Kong) is speaking at the AGM of the Hong Kong Confederation of Insurance Brokers on 17 September
- **Alan Levin** (Hartford) is attending the International Bar Association Conference 3-8 October in Vancouver, Canada
- **Paul Kanefsky** (New York), **Mark Meyer** (London) **Jeanne Kohler** (New York) and **Jim Shanman** (Stamford) are attending the ARIAS Annual Conference on 4-5 November in New York.

HIGHLIGHTS

- EAPD was a sponsor of the Reinsurance Association of America Contracts conference in New York and **Vince Vitkowsky** (New York) presented on dispute resolution clauses. Vince along with **David Kendall** (London) also participated in a mock mediation at the British Insurance Law Association (BILA) in London.
- The London office was host to the Compliance Officers Group of the Lloyd's Market Association, who held their bi-monthly meeting. **Alan Levin** (Hartford), **Francis Mackie** and **Chris Sage** (London) were also in attendance. **Richard Spiller** (London) addressed the group on compliance matters.
- **Christopher Tauro** (Boston) presented "Emerging Trends in Asbestos Litigation", EAPD webinar on May 24, 2010.
- **Pamela Robertson** (New York) was a Panelist at the NASP-NY Legislative Town Hall Meeting: "State of the Industry – Part II" on August 4, 2010.
- EAPD hosted half-day seminars on a variety of current legal issues in the US and the UK in Boston, New York and Bermuda in June. Our participants were **Mary-Pat Cormier** (Boston), **Geoffrey Etherington** and **Paul Kanefsky** (New York) and **Antony Woodhouse** and **Melissa Oxnam** (London).

EAPD IS PROUD TO SUPPORT

- The International Association of Claim Professionals Annual Conference in Amelia Island, Florida on September 26-29, 2010. **Vincent Vitkowsky** (New York) and **Mark Everiss** (London) will be attending.
- The Vermont Captives Insurance Association (VCIA) conference on 10-12 August in Burlington, VT. **Nick Pearson** (New York) is attending.
- The Review Reinsurance Awards on 8 September 2010 at The Dorchester Hotel, London. **Jeanne Kohler** (New York) will be presenting the award for "Industry Personality of the Year" and will be accompanied by **Mike Thompson** (Stamford), **David Kendall, Mark Everiss, Ashwani Kochhar** and **Francis Mackie** (London) at the event.
- The American Bankers Insurance Assn. (ABIA) Annual Conference on 22-24 September in Phoenix, AZ. **Ted Augustinos** and **Chuck Welsh** (Hartford) will be in attendance.
- The Association of Insurance Compliance Professionals Annual Conference on 3-6 October in Dallas. **John Emmanuel** (Hartford) will be in attendance.
- The ACLI Annual Conference on 17-19 October in Baltimore. **Alan Levin** and **Chuck Welsh** (Hartford) will attend.
- The ARC Dinner on November 14 in London. **David Kendall, Mark Everiss** and **Richard Spiller** (London) will host.

For further details on any of the above contact Jennifer Topper at: JTopper@eapdlaw.com.

The Insurance and Reinsurance Department at Edwards Angell Palmer & Dodge, with experience in insurance regulatory compliance, methods of doing business, and insurance and reinsurance arbitration and litigation, stands in a unique position to guide insurers, reinsurers and other participants through the pitfalls and dangers faced by them in this highly regulated industry.

A list of our offices (and associated offices) and contact numbers are adjacent. Further information on our lawyers and offices can be found on our website at www.eapdlaw.com.

Please feel free to contact Jae Stanton, Administrator of our Insurance and Reinsurance Department at +1 860 541 7758 or JStanton@eapdlaw.com for further information or contact details for lawyers in your region.

We hope you find this publication useful and interesting and would welcome your feedback. For further information and additional copies please contact the editors:

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