EDWARDS ANGELL PALMER & DODGE

# Insurance and Reinsurance Review

December 2009


## Solvent Schemes of Arrangement: The Scottish Lion Mauled

Scottish Lion Insurance Company is attempting for the second time to promote a solvent scheme of arrangement to bring its insurance business to an early close. The first attempt was abandoned in 2005 when the company was ordered by the Scottish Court to disclose to one objecting creditor a list of all its scheme creditors, whereupon the proposed scheme was withdrawn.

Earlier this year meetings of scheme creditors were convened (there was a separate meeting of IBNR creditors) to approve the second scheme put forward by the company, now under new ownership. This second scheme has been described by some as being particularly aggressive and, in spite of an apparent vote by the requisite majority in favour of this scheme at each of the creditors' meetings, it was opposed at the sanction stage by a group of US creditors. The principal grounds of objection were that the valuation of votes by the Chairman and the Independent Vote Valuer was flawed, so that in reality the requisite majority was not obtained at each meeting; that the estimation methodology was improper and, in particular, was seeking to impose an "all sums net of contribution" methodology on policyholders whereas the policies were governed by US law and under the law of some or all of the relevant states a pure all sums basis was to be applied; and finally that it was unfair for the company to seek to transfer the risk back to the policyholders by terminating the cover and paying to the policyholders a sum which might in the end not prove adequate.

*"This second scheme has been described by some as being particularly aggressive..."*

Lord Glennie dismissed the petition at a Case Management Conference in October 2009, after having delivered an Opinion in September 2009 which did not purport to be final but contained two very significant rulings. On the valuation issue, he ruled that the Court was entitled to examine the valuation of votes both in favour of and against the scheme, because if the requisite majority has not in fact been obtained, there is no jurisdiction to sanction the scheme. This ruling is no surprise. There are no express rules for the conduct of meetings to approve schemes under Part 26 of the Companies Act 2006, and in particular for the acceptance and valuation of disputed claims for voting purposes, but an analogy may be found in the Insolvency Rules relating to meetings convened to approve voluntary arrangements, another case where a 75% majority in value is required. These rules expressly provide that if there is a dispute as to the validity or amount of a claim for voting purposes, the Chairman of the meeting should admit the vote but mark it as objected to and, if it is material, the Court will decide the matter, after hearing all the evidence, and is not restricted to whatever evidence might have been presented to the Chairman of the meeting at or before the time of the meeting.

In this case the basis for valuation affects both the valuation of claims for payment purposes in the scheme if it becomes effective, and also the question of whether the 75% majority in value was achieved.

On the question of fairness, Lord Glennie echoed the remarks of Mr Justice Lewison in the *British*

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By Peter Fidler
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**Note:**
**Peter Fidler** contributed the chapter on Schemes of Arrangement in the 2nd Edition (2004) of *Fletcher Higham and Trower on Corporate Administrations and Rescue Procedures*.

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*Aviation Insurance Company* (BAIC) case ([2006] 1 BCLC 665), who considered that it was unfair for insurance companies, which are in the risk business, to terminate cover and retransfer the risk back to dissenting policyholders who are not in the risk business. Lord Glennie also expressed the view that where a company is solvent, "creditor democracy" should not be allowed to prevail and a scheme could not be forced upon dissenting creditors unless there was a particular problem to be solved or the scheme had benefits for the creditors. He followed the view taken by Lewison J that what were described in the scheme document as advantages of the scheme were in reality advantages for the company, not for the scheme creditors.

Different considerations apply where a particular issue needs to be addressed, such as the guaranteed annuity rate issue in the Equitable Life case, and pools have problems of their own, which can mean that any solvent scheme will have benefits for the policyholders.

Lord Glennie in his Opinion formally left it open to the company to come back to Court to demonstrate some benefits for the creditors, whilst making it clear that in the absence of any such benefits he would not sanction the scheme. The decision is under appeal and the appeal is due to be heard on 1 to 4 December. It seems that the company considered that there was no point in taking this issue further at first instance and that it would be better to proceed straight to appeal on this issue. He has still to rule on the valuation issues. These will have to be addressed if the appeal on the general fairness issue succeeds.

This is a Scottish case, and so not binding on an English judge, although it would be persuasive and, if the appeal process goes all the way to the new Supreme Court, its judgment would be binding in England. Lord Glennie's view about creditor democracy would seem eminently appealable, as it appears to fly directly in the face of the express provisions of Part 26 of the Companies Act 2006 which provide that if a compromise or arrangement is agreed by the requisite majority, in both number and value, and the Court sanctions the scheme, it becomes binding on dissenting creditors.

That, of course, presupposes that the Court does sanction the scheme. It is accepted law that the Court will not merely rubber stamp the view of the majority, but if a scheme is one that an intelligent and honest man, acting in the interest of the group which he purports to represent, could reasonably approve, the Court would not normally withhold sanction. This all goes to the issue of fairness, which was one of Lewison J's principal objections to the BAIC scheme. In the final analysis it may boil down to whether it is fair to estimate unmatured liabilities. On this actuaries have differing views. It would not be expected that an insurance company would promote a solvent scheme to bring its insurance business to a close unless the remaining liabilities could, in the view of its actuaries, be fairly estimated. Such schemes have been approved by significant majorities of creditors in other cases, suggesting that there are many policyholders who do consider them fair. The issue on the appeal will be whether objecting creditors, who do not wish to have the risk compulsorily transferred back to them, can successfully block any solvent scheme in the absence of demonstrable advantages for the creditors or an issue that is causing problems.

The FSA's process guide for insurance schemes requires that policyholders should be no worse off under the scheme, and it is noteworthy that the FSA did not object to this scheme, preferring to leave it to the commercial judgement of the scheme creditors.

Prophets of doom are already heralding this decision as the death of solvent schemes. That view is almost certainly premature. Quite apart from the question of an appeal in this case, the pessimists said the same about BAIC in 2005, and yet the same Lewison J sanctioned a scheme drafted by the current author just two months after his BAIC judgment. Schemes which are restricted to reinsurance claims may be less exposed to this criticism. Since (re)insurer creditors are also in the risk business it is not obvious that they are unable to assess for themselves whether a scheme is fair.


## Thirteen EAPD Lawyers Recognized in 'Guide to the World's Leading Insurance & Reinsurance Lawyers' 2009/10 Edition

Edwards Angell Palmer & Dodge is delighted to have 13 of its lawyers recognized in the 2009/10 legal directory *'Guide to the World's Leading Insurance & Reinsurance Lawyers'*. Only one other firm worldwide has as many individuals included.

This Guide is created by Legal Media Group's *'Expert Guides'* series. The publisher commissioned its independent research teams to carry out a 12-month study of experts in the field of Insurance & Reinsurance worldwide. The full results of the 8th edition are now in print and are available at www.expertguides.com.

Over 4000 questionnaires were sent to senior practitioners or in-house counsel involved in Insurance & Reinsurance work in 60 jurisdictions, asking them to nominate leading practitioners based on their work and reputation. The results were then analyzed and screened for firm, network and alliance bias. The list of experts was then discussed and refined with advisers in legal centers worldwide.

**This has resulted in EAPD having an impressive thirteen nominees. They are:**

John P Dearie Jr
Richard Hopley
John A Houlihan
David Kendall
Alan J Levin
Martin Lister
Mark Meyer
Neil (Nick) R Pearson
John B Rosenquest III
James A Shanman
Richard Spiller
Michael P Thompson
Vincent J Vitkowsky

# Federal Insurance Regulatory Round-Up: Goals to Reform U.S. Insurance Regulatory System Sidetracked by Busy Congressional Agenda

By Michael T. Griffin and
Alfred J. Kritzman
Hartford

The worldwide financial meltdown in the fourth quarter of 2008 caused many to call for broad reforms in the regulation of the U.S. financial services industries. Systemic problems encountered by some of the largest and most well recognized U.S. insurance holding company groups led to renewed calls to reform the existing state based system of insurance regulation. Many industry observers predicted that the financial crisis would serve as the catalyst that would cause Congress to adopt insurance regulatory reform measures that it has been discussing for the last several years.

2009 started with considerable discussion in Congress regarding reforms of the regulation of the financial services industry generally and the U.S. insurance industry specifically. The attention of the Congress, however, was gradually diverted by other high profile issues including the financial crisis and federal bailout proposals, the wars in Iraq and Afghanistan, climate change and, of course, health care reform. Despite the overwhelming agenda facing the 111th Congress, several bills to reform the U.S. insurance regulatory system were proposed in Congress. This article summarizes and provides the status of some of the more prominent proposals. We do not address, however, the various proposals to reform the U.S. health care and insurance systems, as this multi-faceted and emotionally charged topic does not lend itself well to summarization.

The proposals introduced in Congress this year seeking to reform the U.S. insurance regulatory system generally fall into two categories:

(1) proposals to create an optional federal system of insurance regulation; and
(2) targeted proposals to reform specific aspects of the current U.S. insurance regulatory framework.

## 1. Optional Federal Charter

### *National Insurance Consumer Protection Act of 2009*

On April 2, 2009, Representatives Melissa Bean (D-IL) and Ed Royce (R-CA), introduced H.R. 1880, the National Insurance Consumer Protection Act of 2009 (the NICPA) in the U.S. House of Representatives. The NICPA, much like its predecessors the National Insurance Act of 2006 and the National Insurance Act of 2007, would establish an optional system of federal regulation and supervision of insurance under the newly created Office of National Insurance (ONI). As part of the U.S. Department of the Treasury, the ONI would be headed by a National Insurance Commissioner, which would be a Presidential appointment requiring the confirmation of the Senate.

The NICPA would be similar to the dual bank regulatory system in the U.S. under which banks can be chartered and regulated under federal law or state law. Under the NICPA, insurance companies and entity producers could obtain a national charter and be regulated and licensed by the ONI as a national insurer or national insurance agency. Individual licensed insurance producers could also select to be licensed and regulated by the ONI as national insurance producers. Alternatively, insurance companies, entity and individual producers could be licensed and regulated under state law.

The ONI would supervise national insurance companies and individual and entity producers by setting rules and regulations and issuing orders and interpretations with regard to their financial activities and market conduct. The ONI would consist of several offices and divisions. The Division of Consumer Affairs would (i) act as a liaison between the ONI and consumers; (ii) receive questions or complaints from consumers regarding national insurance companies and national entity and individual producers; and (iii) take actions in response to such questions and complaints. The Office of the Ombudsman would act as a liaison between the ONI and national insurance companies and national entity and individual producers that are adversely affected by the supervisory or regulatory activity of the ONI. The Division of Insurance Fraud would carry out investigations of insurance fraud.

Under the NICPA, state regulators would maintain responsibility for supervising state-licensed insurance companies and producers while nationally chartered and licensed entities would be regulated primarily by federal law, with the exception of: (i) state tax laws; (ii) state unclaimed property and escheat laws; (iii) state laws related to participation in assigned risk plans, mandatory joint underwriting associations, or any other mandatory residual market mechanisms;

*"Many industry observers predicted that the financial crisis would serve as the catalyst that would cause Congress to adopt insurance regulatory reform measures ..."*

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## HIGHLIGHTS

- **Laurie Kamaiko** (New York) and **Mark Schreiber** (Boston) were panel members at the seminar on Privacy and Data breach risks that EAPD co-hosted with the New York Chapter of the Association of Corporate Counsel at EAPD's New York office on 22 September 2009.
- **Bob Brener** (Madison, NJ) and **Laurie Kamaiko** (New York) were co-presenters at the seminar *"Up Against a Chinese Drywall"* presented at the Reinsurance Association of America's ReClaims program on 24 September 2009 in New York City.
- **Laurie Kamaiko** (New York) moderated the panel *"Insurance Industry Exposure to Privacy and Data Breach, What a Nightmare!"* held at the 40th Anniversary conference of the Excess and Surplus Lines Claims Association, held in Bermuda on 14 October 2009.
- **Nick Pearson** (New York) and **Mark Everiss** (London) attended the AIRROC/Cavell Commutation & Networking Event in New Jersey from 19 October 2009. Nick participated in an Education Session panel at this event and EAPD hosted a golf outing for delegates.
- **John McCarrick** (New York) attended the PLUS International Conference in Chicago on 11-13 November 2009.
- **James Shanman** (Stanford), **John Rosenquest** (Providence), **Mark Meyer** (London) and **Paul Kanefsky** (New York) attended the ARIAS-US 2009 Fall Conference and Annual Meeting in New York City on 12-13 November 2009.

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(iv) state laws that prescribe compulsory coverage of workers' compensation or motor vehicle insurance; (v) state laws mandating participation of insurers in an advisory or statistical organization, except to the extent such law mandates a national insurer to use any particular rate, rating element, price, or form; and (vi) participation in state guaranty funds.

The NICPA establishes standards and would provide the ONI with the authority to place financially impaired national insurers into receivership for rehabilitation or liquidation. Also under the direction of the ONI would be the newly created National Insurance Guaranty Corporation (the NIGC). National insurance companies would be required to participate in the NGIC and pay assessments. Assessments would be used to pay claims pursuant to the terms and limits of the Post-Assessment Property and Liability Insurance Guaranty Association Model Act of the National Association of Insurance Commissioners (NAIC), for property and casualty claims, and the NAIC Life and Health Insurance Guaranty Association Model Act, for life and health insurance claims. National insurance companies would also be required to participate in state guaranty associations.

The ONI would also have supervision over national insurance holding companies – companies that control a national insurance company or national entity producer – to monitor them for activity that the ONI determines to pose a significant risk to the solvency of a national insurer, jeopardizes the interests of the policyholders, or is incompatible with the public interest.

Under the NICPA, the President would designate a Systemic Risk Regulator (the SSR), which would be separate from the ONI. If the SSR identifies conduct of a national insurance company that could potentially have adverse effects on economic conditions or financial stability, it would make recommendations to the ONI or state insurance regulatory authorities regarding corrective actions. If the ONI or state insurance authority should fail to implement such corrective action, the SSR may issue rules or orders to address the conduct that poses the risk. Additionally, the SSR, in consultation with the ONI, is charged with the duty to determine if an insurer is systemically important, and if so, whether the insurer should be required to be chartered under the NICPA.

The NICPA also contemplates the creation of a Coordinating Council for Financial Regulators (the Council). The Council would serve as a forum for financial regulators to identify, consider, and make recommendations regarding issues related to the regulation and supervision of financial services firms, including the stability and integrity of financial markets, investor and consumer protection, and the efficiency and effectiveness of regulation and supervision. The eleven person Council would consist of the Secretary of the Treasury as its chair, the Chairman of the Board of Governors of the Federal Reserve System, the Chairman of the Securities and Exchange Commission, the Chairman of the Commodities Futures Trading Commission, the Comptroller of the Currency, the Director of the Office of Thrift Supervision, the Chairman of the Federal Deposit Insurance Corporation, the Commissioner of the ONI, and three individuals (one banking, one insurance, and one securities expert) appointed by the President with the advice and consent of the Senate. In addition, the Council, by a two-thirds vote of its membership, would be able to determine that corrective action by the SSR is necessary if it would mitigate or avoid an impending serious adverse effect on economic conditions or financial stability in the United States.

The NICPA was referred to the House Committee on Financial Services, the Judiciary Committee and the Energy and Commerce Committee and is awaiting review. Although introduced with much fanfare in the spring, with other consumer protection bills filling the Congressional calendar, it appears unlikely that the NICPA will advance out of committee for a floor vote by year-end.

### 2. Targeted Reform Proposals

#### *National Association of Registered Agents and Brokers Reform Act of 2009*

On May 21, 2009, three important pieces of insurance industry legislation, which failed to pass both the House and the Senate in previous years, were reintroduced in the House. One of the three, H.R. 2554, the National Association of Registered Agents and Brokers Reform Act of 2009 (NARAB), was introduced by Representative David Scott (D-GA). The bill is similar to its 2008 predecessor in that it seeks to amend the Gramm-Leach-Bliley Act to establish a national association to provide multi-state licensing to insurance producers. While the proposed legislation aims to make uniform the qualifications and conditions to obtain an insurance producer license, it retains the authority of the states to regulate insurance producers, including the licensing, supervision, trade practices, discipline, and licensing fees applicable to producers. Under the proposal, once an insurance producer becomes a member of NARAB, the insurance producer will be authorized to sell, solicit, negotiate, effect, procure, deliver, renew, continue, or bind insurance in any state for all lines of insurance authorized under the insurance producer's home state license.

NARAB is widely supported with 44 co-sponsors and is currently being reviewed by the House Financial Services Committee. Although this bill has the support of the NAIC, the Independent Insurance Agents and Brokers of America (IIABA), the National Association of Insurance and Financial Advisors (NAIFA), and the Council of Insurance Agents and Brokers (CIAB), it is unlikely that it will be passed into law this year due to the busy Congressional agenda.

#### *Nonadmitted and Reinsurance Reform Act of 2009*

The second insurance regulatory bill reintroduced in the House on May 21, 2009 was H.R. 2571, the

Nonadmitted and Reinsurance Reform Act of 2009. The bill is sponsored by Representative Dennis Moore (D-KS), and on June 25, 2009, its companion bill, S. 1363 was reintroduced into the Senate by Senators Evan Bayh (D-IN) and Mel Martinez (R-FL). On September 9, 2009, the House passed H.R. 2571, making it the third straight time the House has voted to pass a version of this legislation.

As with earlier versions, H.R. 2571 and S. 1363 would give regulatory oversight of nonadmitted insurance to the insured's home state, and only the home state may levy a premium tax for nonadmitted insurance or require a surplus lines broker to be licensed. The bills are intended to foster uniformity among state laws with respect to premium tax allocation and eligibility criteria for nonadmitted insurers. The bills also grant direct access to the surplus lines market for sophisticated commercial purchasers.

With regard to reinsurance, the bill proposes, in most instances, to have reinsurers subject only to the solvency rules of their state of domicile. The bill also prevents a state from denying credit for reinsurance if the domiciliary state of the insurer purchasing reinsurance allows credit for reinsurance and (i) is either an NAIC-accredited state; or (ii) has financial solvency requirements substantially similar to NAIC accreditation requirements.

While this bill has advanced further than any other bill discussed in this article, due to its history of repeatedly passing in the House, but not in the Senate, it is difficult to predict whether it will be passed this year.

### *Federal Insurance Office Act of 2009 (f/k/a Office of Insurance Information Act of 2009)*

The third piece of insurance regulatory legislation reintroduced to the House on May 21, 2009, was H.R. 2609, the Insurance Information Act of 2009, which proposes to establish an Office of Insurance Information (the OII) in the U.S. Department of the Treasury. H.R. 2609, was introduced by Representative Kanjorski (D-PA). Similar to its 2008 predecessor, this bill would allow the OII to collect and study insurance data and advise the Department of Treasury and Congress on domestic and international policy-making regarding insurance. The bill would also establish an advisory council of regulators and consumer groups to inform the leader of the OII. Representative Kanjorski released a revised discussion draft of H.R. 2609 on October 1, 2009 called the Federal Insurance Office Act.

The previous version included language stating that nothing in the proposed law "may be construed to establish a general supervisory or regulatory authority of the Office [of Insurance Information] or the Department of Treasury over the business of insurance." Aside from changing the name of the proposed office to the Federal Insurance Office (FIO), it is significant to note that the discussion draft does not include this language. Advocates of state insurance regulation have taken umbrage with this and view it as a step towards creating a federal insurance regulator.

The discussion draft also differs from earlier versions in that the FIO will recommend to the Board of Governors of the Federal Reserve System that certain insurers be designated as entities subject to regulation as a Tier 1 financial holding company under the Bank Holding Company Act.

While the previous version enjoyed wide support from industry groups including the NAIC and the National Association of Mutual Insurance Companies, according to recent testimony given before the House Financial Services Committee, the new draft has caused many supporters of the previous version to oppose H.R. 2609. Given the ire this discussion draft has created, it is uncertain whether the draft or a version that more resembles the bill introduced in May will make it out of committee and to a floor vote by the end of the Congressional session.

### *The Neal Bill 2009*

On July 31, 2009, Rep. Richard Neal (D-MA) introduced legislation to repeal a controversial tax deduction used by foreign reinsurers. The bill, H.R. 3424, is very much like its predecessor introduced in 2008 in that it would disallow tax deductions by U.S.-domiciled insurers and reinsurers for the excess reinsurance premiums ceded to affiliated insurance companies not subject to U.S. taxation. Premiums would be deemed excessive when the cessions are greater than the industry average of reinsurance paid to unrelated parties. According to Rep. Neal, by limiting the deduction to the industry average, the excess reinsurance premiums paid to affiliated reinsurers will remain in the reach of U.S. taxation and, thus, eliminate any competitive advantages for a foreign insurance group. The bill has been referred to the House Committee on Ways and Means.

While the Obama Administration continues to work to eliminate perceived off-shore tax abuses, the Neal Bill, which focuses narrowly on the insurance industry, has not received much attention in Congress. However, with Congressional leaders appearing likely to pursue legislative reform proposals relating to international taxation, H.R. 3424 may make it out of committee for a floor vote or perhaps be integrated into similar proposals that address the taxation of related party transactions.

### *Repealing the McCarran-Ferguson Act*

On March 18, 2009, Representative Gene Taylor (D-MS) introduced H.R. 1583, the Insurance Industry Competition Act of 2009. H.R. 1583 seeks to remove the anti-trust exemption for insurers from the McCarran-Ferguson Act and give the Department of Justice and the Federal Trade Commission the authority to apply federal antitrust laws against insurers for purported anticompetitive behavior. H.R. 1583 was referred to the House Judiciary Committee, the Energy and Commerce Committee and the Financial Services Committee and is awaiting review.

Similar to H.R. 1583, but narrowly tailored to health insurers and medical malpractice insurance issuers, is the Health Insurance Industry Antitrust Enforcement Act of 2009, which was introduced into both the House as H.R. 3596 by Representative John Conyers (D-MI) and the Senate as S. 1681 by Senator Patrick Leahy (D-VT) on September 17, 2009. According to Representative Conyers, the proposed legislation would "specifically prohibit price fixing, bid rigging, and market allocation in the health insurance industry." Using S. 1681 as a tool to force the hand of health insurers in the debate over national healthcare reform, Senator Leahy stated on the Senate floor that "the health insurance industry currently does not have to play by the same, good-competition rules as other industries."

While the fate of healthcare reform appears to depend on highly politicized subjects such as a public option or "death panels," a partial repeal of the McCarran-Ferguson Act could possibly find its way into any one of the proposed healthcare reform packages if Congressional leaders find it necessary to achieve the goal of providing coverage to people without health insurance and lowering the cost of healthcare in the United States.

## Outlook

Representative Barney Frank (D-MA), chairman of the House Financial Services Committee, has consistently maintained that major financial services industry reform legislation will be brought to the House floor for a vote by year-end. This could be either in the form of a single sweeping bill or several smaller pieces of legislation. Senator Christopher Dodd (D-CT) has maintained similar hopes. However, both have publically acknowledged that a crowded legislative agenda means that a vote on many of the current proposals may likely be moved to 2010.

By Helen Clark
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# UK Insurance Contract Law Reform: Reflections and the Road Ahead

Since we last reported to you in our December 2008 issue, there have been some important developments in the Law Commission's project for insurance contract law reform. As the year draws to a close, a key phase in the reform of consumer insurance law will be completed, with the publication of a final report and draft bill in December. In this article, we look back on the reasons for reform, key milestones in the project to date and what we can expect in the coming year. We also look briefly at a parallel project underway in Europe designed to enable insurance companies to provide their services throughout the European Union based on uniform rules, establishing a high standard of policyholder protection.

*"A key aspect of the proposals has been the decision to deal with consumers and businesses separately."*

## Background

UK insurance contract law has been widely criticised as being needlessly complex, out of step with modern industry practice and unduly harsh on policyholders. What has been needed, for the UK to remain competitive in the European market, is a wide ranging review of the law applicable to consumer and business insurance contracts. This began in 2006 and the proposals that have emerged so far will undoubtedly bring UK insurance law much closer to the latest continental models.

## Distinction Between Consumers and Businesses

A key aspect of the proposals has been the decision to deal with consumers and businesses separately. Consumers invariably contract on standard terms which they lack the bargaining power to alter, they are unlikely to have the level of expert advice available to larger businesses and they are typically less sophisticated and able to understand the technicalities of insurance contract law. The new laws relating to consumer insurance will be mandatory, so the parties will not be free to contract out, unless the relevant terms are more favourable to the insured. However, for business insurance, it is proposed that a new default regime will apply, based on accepted good practice. This means that, with certain formal safeguards, the parties will be free to agree a different set of contractual rules; if they do not, they will be subject to the default rules.

## Misrepresentation, Non-disclosure and Warranties

The Law Commission Consultation in 2007 and 2008 on proposed reforms to the law of misrepresentation, non-disclosure and breach of warranty generated an excellent response, with over 100 insurers, brokers, buyers, academics and lawyers setting forth their views. There was overwhelming support for consumer law reform and general agreement on the terms of that reform. This then became the Commission's immediate priority.

There was far less consensus as to the reforms appropriate for the business insurance sector, with divergent views on key issues such as the appropriate remedies for misrepresentation and non-disclosure and the definition of materiality. The Commission recognises that it needs to consult further on this subject and a further Policy Statement on non-disclosure, misrepresentation and warranties in business insurance is expected in 2010.

## The Consumer Insurance Law Proposals

Although the final report and draft bill have, at the time of writing, yet to be published, the Law Commissioner, David Hertzell, led a discussion on 16 October 2009 before the British Insurance Law Association, at which he previewed the contents of the Draft 2009 Consumer Bill.

The duty of disclosure for consumers is to be abolished. Insurers will need to ask consumers clear questions about any matter that is material to them. This is in contrast to business insurance, where most consultees agreed that the duty of disclosure had become part of the way the London business (re)insurance market works and should remain. For consumers, while the duty of disclosure has been abolished, insurers may still have a remedy for misrepresentation, matched against the conduct of the policyholder. If the insured has behaved honestly and reasonably, the insurer will have no right to refuse the claim. If the misrepresentation is careless, the Commission introduces a new concept under English law of proportionality, whereby the insurer is placed in the position it would have been in had it known the true facts. Thus, where an insurer would have charged more premium for a risk, the claim should be reduced proportionately to the under-payment of premium. Only where the consumer has effectively acted dishonestly – by making a deliberate or reckless misrepresentation – will the insurer be entitled to treat the policy as if it did not exist and refuse all claims under it.

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The test for materiality of information is to be assessed according to the standard of the reasonable insured rather than a prudent insurer, the current test. Finally, the much criticised legal device of *"basis of the contract"* clauses, whereby all answers in a proposal form are given warranty status, will be abolished. Where a consumer makes a statement of past or current fact, it will be treated as a representation rather than a warranty, with the insurer's remedy depending upon the character of that incorrect representation.

### Micro Businesses: the Very Smallest Businesses

The Commission is currently considering whether the very smallest businesses, with up to nine employees, should be treated as consumers when they buy insurance. There are 4.5 million such business enterprises in the UK, at least half of whom buy directly from insurers without a broker and many of whom are no more sophisticated than consumers. In April 2009, the Commission published an Issues Paper on this topic and intends to publish a summary of responses before the end of the year. In a preview, it has indicated that 60% of the consultees agreed that micro businesses should be treated as consumers. One of the key issues has been the appropriate definition for micro-businesses and the Commission is keen to reach a landing on a simple test for establishing whether a business is micro. Two of the definition tests it put forward, based on either number of employees or annual turnover, were both dismissed by consultees as far too simplistic and uncertain in practice. 80% of the consultees, however, agreed that the test should instead be tied to the Financial Ombudsman Service (FOS) jurisdiction, so that if a business is entitled to take a claim to the Ombudsman, it will be defined as a micro-business. The FOS's jurisdiction is currently set at fewer than ten employees and a turnover of less than €2m. The Commission recognises that in addition to the basic test, there will need to be sophistication filters to prevent sophisticated businesses, such as Special Purpose Vehicles, from being defined as micro-businesses.

### The Status of Intermediaries

Earlier this year, the Law Commission published a Policy Statement explaining the principles that should apply to the question of for whom an intermediary acts in transmitting pre-contract information from consumer to insurer. The Commission has confirmed its intention to include these principles within the Draft 2009 Consumer Bill. The new statutory code will be based largely on the existing law and will have a direct effect in cases concerning faults in the transmission of pre-contractual information in consumer insurance. The Commission has concluded that it is not possible to have a single test; rather who an intermediary acts for must depend on a range of factors. Some factors will be *decisive*: for example an intermediary will be considered to act for the insurer if the intermediary has authority to bind the insurer to cover or the intermediary is the appointed representative of the insurer.

There will also be *persuasive* factors which will not be binding but may help the courts in deciding for whom an intermediary acts. Generally, the intermediary will act for the consumer unless there is a close relationship between the intermediary and the insurer, so as to indicate that the insurer has granted the intermediary implied or apparent authority to act on the insurer's behalf. Persuasive factors suggesting such a close relationship would include where the intermediary only places insurance with a limited number of available insurers or permits the intermediary to brand its services with the insurer's name. Persuasive factors indicating that an intermediary acts for the consumer would include where the consumer pays the intermediary a fee and where the intermediary undertakes to act in the consumer's interest by, for example, giving him impartial advice or providing a fair analysis of the market.

### Damages for Late Payment

Failure by insurers to provide a prompt indemnity, for example, following a fire at commercial premises, can lead to disastrous consequences, 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 since in most States, the claimant is permitted to seek damages for late or non-payment of insurance money.

The problem arises because in English law, a claim under an insurance policy is a claim for damages and there is no right to damages for late payment of damages, as the Court of Appeal reluctantly found in the key case of *Sprung v Royal Insurance (UK) Limited* [1997] CLC 70. The Court of Appeal urged there to be early consideration to the reform of the law in similar cases.

The Commission proposes to publish an Issues Paper on this topic in the first half of 2010 but has already indicated that one option would be legislation to amend section 17 of the Marine Insurance Act 1906 which provides that insurance contracts are contracts of mutual good faith. While the duty is mutual, at present the only remedy available to an insured for a breach of good faith on the part of the insurer is avoidance, which is of little use to the insured in the case of an insurer who is dilatory in settling claims. The Commission suggests that the insurer could be made liable for breach of good faith obligations to the insured where there was dishonesty, malicious conduct or maladministration on the insurer's part, albeit only for losses which were foreseeable when the contract was made. We will look again at these proposals, once more detail becomes available next year.

### Principles of European Insurance Contract Law

The European Commission is concerned about the lack of cross-border insurance products and services, believing that the matrix of laws and regulations in each of the 27 member states act as a barrier. In response, the Project Group for the Restatement of European Insurance Contract Law has for the last ten years been working on a set of Principles of European Insurance Contract Law (PEICL) which were launched publicly in September 2009. It is proposed that the Principles operate as an *"optional instrument"*, allowing insurers and policyholders to apply the principles to their contracts instead of the relevant national insurance contract law. As is the case for UK consumers under the Law Commission's proposals, the Principles limit the insured's duty of disclosure to responding to clear and precise questions put by the insurer. Also mirroring the Law Commission's proposals, the Principles introduce a proportionate approach to remedies. An EU regulation will be required in order for the Principles to become binding and the Project Group still has some drafting work to do. There are however good political indications that the European Commission is firmly behind the Project and that in future, legislation will be introduced to allow the Principles to operate.

### Conclusion

The Law Commission has made great strides with respect to the reform of consumer insurance law. Just as in Europe, reforms have been proposed which are intended to give policyholders confidence in insurance by ensuring that it meets their reasonable expectations, while protecting the legitimate interests of insurers. For those in the business insurance community, the wait will continue well into 2010 to see how a better consensus can be achieved amongst the different sectors of the market on the most appropriate way forward for reform. We will continue to closely monitor the project both on InsureReinsure.com and through this publication.

By E. Paul Kanefsky and Robert W. DiUbaldo, New York

# Notable 2009 U.S. Reinsurance Arbitration Decisions

While 2009 has not been a momentous year for United States case law involving, or having an impact on, reinsurance arbitrations, there have been interesting developments in the following key areas: (1) a party's ability to challenge arbitration awards arising under the Federal Arbitration Act (the FAA); (2) arbitrator appointment; and (3) enforceability of arbitration agreements. These developments are summarized below.

## Challenging Arbitration Awards

Courts continued to struggle in 2009 with whether the doctrine of manifest disregard of the law remains a valid basis for challenging arbitration awards arising under the FAA, in light of the U.S. Supreme Court's decision in *Hall Street Associates, L.L.C. v. Mattel, Inc.*, 128 S.Ct. 1396 (2008).

In *Hall Street*, the Supreme Court held that the statutory grounds for vacating and modifying arbitration awards are "exclusive" under the FAA, and thus cannot be expanded, even if expressly agreed upon by the arbitrating parties. Subsequent to that decision, federal courts have reached varied conclusions as to whether that decision eliminated the judicially-created doctrine of manifest disregard of the law as a basis for challenging arbitration awards. For example, while courts in the Second, Sixth and Ninth Circuits have continued to find that manifest disregard of the law survived *Hall Street*,[1] the Fifth Circuit held that this doctrine has been abrogated by that decision.[2]

The U.S. Supreme Court has yet to clarify whether it intended that *Hall Street* be interpreted to eliminate the doctrine of manifest disregard of the law as grounds for challenging awards. Moreover, it does not appear that the Supreme Court is in a hurry to do so, having recently denied writs of certiorari in three cases which examined whether manifest disregard of the law remains valid, including the decisions from the Sixth and Ninth Circuits referenced above.[3] Insurers, reinsurers and practitioners should stay tuned for developments in this area of the law, including whether jurisdictions continue to treat manifest disregard of the law differently going forward.

## Arbitrator Appointment

Two notable decisions in 2009 concerned the appointment of replacement arbitrators during the course of a hearing.

First, in *WellPoint, Inc. v. John Hancock Life Ins. Co.*,[4] the Seventh Circuit ruled that a party seeking to challenge the appointment of a replacement arbitrator must do so at the time of the appointment, or else lose its ability to make such a challenge.

During the course of the arbitration, plaintiff obtained new counsel and requested that its party-appointed arbitrator resign. After plaintiff proposed two separate replacement arbitrators, who were rejected by defendant, defendant's party-appointed arbitrator suggested that the remaining panel members propose three replacement arbitrators from which plaintiff could choose. Plaintiff agreed to this procedure and chose one of those replacements. Defendant agreed that the arbitrator chosen by plaintiff satisfied the prerequisites for service on the panel.

Plaintiff ultimately prevailed in an arbitration against defendant and later petitioned the District Court for confirmation of the award. Defendant cross-moved to vacate the arbitration award, on the grounds that the arbitration panel exceeded its authority by accepting the resignation of plaintiff's initial arbitrator and subsequently filling the vacancy in a manner not specified in the arbitration agreement. The District Court confirmed the panel's award, and denied defendant's cross-motion to vacate. Defendant then appealed.

The arguments raised by defendant to the Seventh Circuit in support of its motion to vacate were identical to those addressed by the District Court. The Seventh Circuit rejected this argument, relying upon Section 5 of the FAA, which sets forth a rule that applies to the "mid-stream" loss of an arbitrator. That section provides that, in "filling a vacancy," as well as in other circumstances, the court can appoint an arbitrator upon the application of either party to do so. Thus, having failed to object to the replacement arbitrator at the time of appointment, defendant had effectively waived its right to do so, and the arbitrators acted within their authority by filling the vacancy.

The Seventh Circuit further rejected defendant's argument that a party may also challenge an arbitrator's "mid-stream" appointment under Section 10(a)(4) of the FAA after the conclusion of an arbitration, noting that this would improperly permit an objecting party to wait until after the proceeding

## Footnotes

1 *See, e.g., Comedy Club, Inc., v. Improv West Assoc.*, 553 F.3d 1277, 1290 (9th Cir. 2009); *Coffee Beanery, Ltd. v. WW, L.L.C.*, 300 Fed. Appx. 415, 418-19 (6th Cir. 2008); *Idea Nuova Inc. v. GM Licensing Group, Inc.*, No. 08-civ.-8595 (S.D.N.Y., Aug. 19, 2009); *Global Reinsurance Corp. of America v. Argonaut Ins. Co.*, 2009 WL 928014 (S.D.N.Y., Mar. 3, 2009).

2 *See Citigroup Global Markets, Inc. v. Bacon*, 562 F.3d 349, 350, 358 (5th Cir. 2009). In 2008, the First Circuit also found that manifest disregard of the law is no longer a valid basis for vacatur or modification of arbitration awards. *See also Ramos-Santiago v. UPS*, 524 F.3d 120, 124 n.3 (1st Cir. 2008).

3 *See, e.g., Improv West Assoc., v. Comedy Club Inc.*, 2009 WL 1648924 (Oct. 5, 2009); *Coffee Beanery, Ltd. v. WW, LLC*, 2009 WL 1342336 (Oct. 5, 2009); *Grain v. Trinity Health*, 2009 WL 1421117 (Oct. 5, 2009).

4 576 F.3d 643 (7th Cir. 2009).

5 No. 08-cv-7003 (S.D.N.Y.).

6 129 S.Ct. 1896 (2009).

7 No. 08 Civ. 3435 (S.D.N.Y. Mar. 26, 2009).

8 No. 08-cv-3515 (E.D.N.Y. April 20, 2009).

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to make such a challenge, resulting in delay and inefficiency. Rather, defendant's own participation in the substitution process estopped it from later challenging the replacement arbitrator's appointment, despite the fact that defendant specifically reserved its right to do so.

The second noteworthy decision, *In the Matter of the Petition of Ins. Co. of North America against Public Service Mut. Ins. Co.*,[5] involved an arbitrator who resigned from a panel for health reasons prior to the rendering of an award. Because the arbitration agreement did not specify how to deal with appointing a replacement, the U.S. District Court for the Southern District of New York held that the arbitration had to start over from the beginning, with each party having the opportunity to select its own party-appointed arbitrator.

Thereafter, upon learning from one of the parties that the previously ill arbitrator's health had improved such that he was actively seeking employment, the court granted the plaintiff's motion for relief pursuant to Fed. R. Civ. P. 60(b)(2) and (6), and vacated its prior ruling. The court noted that had it been aware of this fact at the time of its previous order, it could have reappointed the arbitrator under Section 5 of the FAA, because the arbitration clauses in the reinsurance contracts at issue were silent with respect to the procedure to be followed to fill a vacancy created by the death or resignation of an arbitrator. Accordingly, pursuant to that statute, the court reappointed the "resigned" arbitrator to the panel and ordered the parties to continue the arbitration proceedings as they were before the arbitrator's initial withdrawal.

### Enforceability of Arbitration Agreements

Several decisions from 2009 illustrate that courts continue to adhere to the strong presumption in favor of enforcing arbitration agreements, even where one of the parties to the dispute is a nonsignatory to the relevant arbitration agreement.

In the most notable decision, *Arthur Andersen LLP, et al. v. Carlisle, et al.*,[6] the U.S. Supreme Court resolved a split among federal circuit courts and held that a nonsignatory to an arbitration agreement has standing to stay an action in favor of arbitration under Section 3 of the FAA, so long as the governing state law allows a contract to be enforced by or against nonsignatories to a contract based upon principles of assumption, piercing the corporate veil, alter ego, incorporation by reference, third-party beneficiary theories, waiver and/or equitable estoppel. The Supreme Court found that the Sixth Circuit's ruling that nonsignatories to an arbitration agreement are categorically barred from such relief under the FAA was in clear error.

Similarly, in *Cooke & Partners, Ltd. v. Certain Underwriters at Lloyd's, London,*[7] the U.S. District Court for the Southern District of New York compelled the assignee (Cooke) of a Liquidator's claims to arbitrate its disputes with the reinsurers of the liquidated company, finding that there was a clear connection between Cooke's claims and the reinsurance contracts containing the subject arbitration clauses. In so holding, the District Court rejected Cooke's argument that it was exempt from arbitration, finding that the defendant's inability to compel the Liquidator to arbitrate did not preclude the arbitration of Cooke's claims, as the contract providing for the assignment was silent on this issue.

Finally, addressing the reverse scenario, a federal court in New York held, in *Utopia Studios Ltd. v. Earth Tech Inc.*,[8] that a signatory to an agreement containing an arbitration clause can compel a nonsignatory to arbitrate where the nonsignatory enters into a separate contract that incorporates that clause.

# Directors' Duties: Taking Responsibility

By Ashwani Kochhar and Melissa Oxnam
London

In our previous article in the December 2007 issue, we wrote about the codification of directors' duties under English law into "general duties" under the Companies Act 2006 (the 2006 Act). All sections of the 2006 Act (Part 10) relating to directors' duties have since been implemented. In the present financial climate, there is a renewed emphasis on directors' general duties under the 2006 Act and on their obligations under the Financial Services Authority's (FSA) "approved persons" regime. This article highlights a director's individual responsibility in complying with those duties and obligations.

### Duties Under the 2006 Act

Section 170 of the 2006 Act makes clear that the general duties of directors, as codified in the 2006 Act, are derived from the previous equitable and common law rules. The codification is not only intended to provide greater clarity about what is required of directors and to make the law more accessible and easier for directors to understand, but also to make developments in the law of directors' duties more predictable. To what extent this proves to be correct will depend on future case law.

There is no doubt that over time we will see new case law clarifying the meaning of the general duties. Prime areas for clarificatory case law are

*Continued on page 10*

the new duty to promote the success of the company for the benefit of its members (section 172 of the 2006 Act), and the new procedures for dealing with conflicts of interest (sections 175, 177 and 182 of the 2006 Act). Directors should keep abreast of developments in the case law in order to avoid breaching their general duties inadvertently.

The consequences of breaching the general duties under the 2006 Act are broadly the same as for a breach of the corresponding common law. Consequently, directors may face removal from office; imposition of civil and criminal penalties; personal liability for their acts or omissions; or to protect the public interest, may be disqualified from acting as a director (for up to 15 years) if found unfit.

The general duties under the 2006 Act are duties owed by directors to the company of which they are a director; in the majority of instances it is the company which will take action in respect of any breach of the general duties. Even where a shareholder brings a derivative action pursuant to section 11 of the 2006 Act, the right of action must reside with the company and the relief must be sought on behalf of the company. The 2006 Act does not however represent the whole picture for the directors of an FSA-regulated firm; such directors must also comply with FSA rules which govern the director's relationship with the FSA and customers of the regulated firm.

## Senior Management Responsibility

The FSA's supervision and enforcement powers use individual responsibility and accountability as a core feature. Indeed, senior management responsibility has been a fundamental feature of the regulatory regime introduced by the Financial Services and Markets Act 2000 (FSMA 2000). The perceived shortcomings in the governance and risk management of some regulated firms, which were exposed by the current economic crisis, are only likely to reinforce the FSA's propensity to hold senior management responsible.

The premise is that individuals with significant responsibility should be fit for the positions they hold, and so will be held to account for any failure to maintain the standards set by the FSA. The FSA seeks to achieve this through its approved persons regime.

### *Approved Persons Regime*

Under the FSMA 2000 authorised firms must ensure that individuals who carry out so called "controlled functions" (certain key functions carried on in relation to regulatory activities specified in section 59 of the FSMA 2000) obtain approval from the FSA before performing such functions. After coming under much criticism following the onset of the financial crisis, the FSA is keen to assert an overtly strong regulatory approach.

In order to be approved to perform a controlled function an individual must for the duration of his performance of that function:

- satisfy the FSA that he can meet and maintain the criteria for approval (the fit and proper test); and
- perform his controlled function in accordance with a set of standards (the Statements of Principle and the related Code of Approved Persons (identified as APER in the High Level Standards Section of the FSA Handbook)).

*"The consequences of breaching the general duties under the 2006 Act are broadly the same as for a breach of the corresponding common law."*

### *Controlled Functions*

All directors must be approved to perform the director function and non-executive directors must be approved to perform the non-executive director function. Other "significant influence" functions (certain of the "controlled functions" which involve the person performing them exercising significant influence over the firm and its regulatory affairs) include the chief executive function; apportionment (see below for an explanation) and oversight; compliance oversight; actuarial function; systems and control function; and the significant management function.

### *The Fit and Proper Test*

The fit and proper test is the benchmark used by the FSA to assess an individual's suitability to perform a controlled function. The most important considerations for individuals are:

- honesty, integrity and reputation
- competence and capability
- financial soundness.

The Statements of Principle (the Statements) require approved persons to act with integrity (Statement 1), with due skill, care and diligence (Statement 2) and to observe proper standards of market conduct (Statement 3). They must also deal with the regulator in an open and fair way (Statement 4). The related Code of Practice helps determine whether or not an approved person is compliant with the Statements.

### *Senior Management Arrangements, Systems and Controls*

The FSA considers that having a single coherent framework in relation to the training and competence of staff working within the financial services industry, including insurance, is an essential component of the UK financial services regulatory regime. Having properly trained and educated staff not only makes good business sense but from the FSA's perspective it reduces the risks posed to consumers for example, by reducing the chance of mis-selling. Firms must ensure that their employees have the necessary skills, knowledge and expertise for the discharge of the responsibilities allocated to them (Section 5.1.1R of The Senior Management Arrangements, Systems and Controls Handbook (SYSC Handbook)). Senior management will be responsible for ensuring that employees are assessed prior to recruitment and regularly throughout their employment.

Firms must also take reasonable care to maintain a clear and appropriate apportionment of significant responsibilities among its directors and senior managers (SYSC 2.1.1R) and they must establish and maintain appropriate systems and controls for their business (SYSC 3.1.1R). It is the senior management of firms who will be held responsible if firms fail to comply with these regulatory obligations.

## Recent Developments

Several extensions to the scope of the approved person regime came into force in August 2009 with a six month transitional period to 6 February 2010 in order to give firms time to comply with the extended rules. The director (CF1) and non-executive director (CF2) controlled functions now include directors and non-executive directors of an unregulated parent whose decisions, opinions and actions are regularly taken into account by the governing body of an FSA authorised firm and are therefore likely to have a significant influence on the conduct of the authorised firm's affairs.

Insurance firms will therefore be required to expend time assessing which additional individuals in the group need to be approved persons of regulated firms. Applications will need to be made for approval and individuals will need to be trained to ensure they understand the ongoing regulatory

consequences of being an approved person. In addition the approved person regime has been extended so that the majority of the controlled functions apply to UK branches of non-EEA firms.

Since 2008 the FSA has become increasingly involved in the hiring by firms of senior management, in particular by interviewing potential recruits. In October 2009 the FSA issued a "Dear CEO" letter (a letter to all chief executive officers of regulated firms) clarifying its approach to approving and supervising those carrying out significant influence functions. The FSA expects that "high impact" firms recruiting a new chairman, chief executive or senior independent executive will engage with the FSA early on in the recruitment process. As interviews will only take place after receipt by the FSA of a fully completed form, firms need to bear this in mind when recruiting to fill vacant positions and when making appointments to newly acquired businesses. It is incumbent on firms to provide sufficient information to the FSA to satisfy it of the "fitness and propriety" of a potential candidate. In connection with those already carrying out significant influence functions, the FSA proposes to assess critically the competence of such individuals during ARROW visits.

### Discipline and Sanctions

An approved person is guilty of misconduct if he or she has failed to comply with a Statement or if the relevant authorised firm has knowingly contravened a requirement imposed on the firm by the FSA. Based on the approved person's misconduct, the FSA may issue a private warning, a fine, public censure and/or ban an individual from performing a controlled function. Factors the FSA may take into account when deciding whether to take disciplinary measures against an approved person include:

- the approved person's position and responsibility
- whether disciplinary action against the firm rather than the approved person would be a more appropriate regulatory response
- whether disciplinary action would be a proportionate response.

The FSA has stated that it will use enforcement action against firms or individuals as a strategic "credible deterrence" tool. The FSA is not reticent to use these powers and there are numerous examples of the FSA imposing bans on individuals exercising significant influence functions, recent examples include:

- The ban of two directors of the insurance broker, FHI (Northern) Limited, for three years from performing significant influence functions or carrying out regulatory activities, for failing to ensure their firm complied with the FSA client money rules (November 2008).
- The prohibition of Graham Darby, director of insurance broker Ambrose Darby, for failing to control the business of the firm adequately. The order banned Darby from performing significant influence functions at any authorised financial firm. A winding up order was also granted in relation to the firm (July 2009).

The FSA fined both the firm and members of senior management for failure to implement adequate systems and controls in an action taken against Land of Leather (for failure to train staff adequately to sell payment protection insurance) and a separate action taken against Sindicatum Holdings Limited (for failure to have adequate anti-money laundering systems and controls in place). Both actions evidence the FSA's enforcement philosophy of individual responsibility and accountability.

Repeat regulatory breaches, for example in the payment protection insurance market, have led the FSA to believe larger fines are necessary to achieve its deterrence aim. Hence in its consultation paper CP09/19 *"Enforcing Financial Penalties"* the FSA proposed much larger fines, in some instances treble those that are currently issued. The FSA hopes that the increased probability of enforcement action together with larger fines should encourage better governance, improved competence and ultimately better outcomes for consumers.

### Conclusion

Insurance firms need to be aware of their duties under the 2006 Act and must meet the standards required of their senior executives under the FSA's approved persons regime. Whilst individual responsibility and accountability have always been a core part of the FSA's approved persons regime, in the wake of the financial crisis compliance is being assessed and breaches enforced with renewed vigour. Never has it been more important for the senior management of insurance firms to ensure that they are fully aware of their duties under the 2006 Act and under FSA regulation, through appropriate advice, training, circulation of information and other methods.

*"The FSA has stated that it will use enforcement action against firms or individuals as a strategic 'credible deterrence' tool."*

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## REMEDI, the Re/Insurance Mediation Institute, Formed to Promote Mediation

Several prominent mediators have come together to create REMEDI, the Re/Insurance Mediation Institute, to foster the development of mediation as a tool for resolving reinsurance and insurance disputes. The Chair and Chief Executive Officer is Kathy Billingham. The Vice-Chair and President is Peter Scarpato. The Secretary and Treasurer is Andy Walsh. The other Founding Directors are Larry Monin, Jonathan Rosen, David Thirkill and Elizabeth Thompson. The other founding members are Paul Dassenko, Richard Waterman, and Jim Stinson aswell as **Vince Vitkowsky** and **Jim Shanman** of Edwards Angell Palmer & Dodge LLP. Edwards Angell Palmer & Dodge LLP serves as pro bono outside general counsel.

**For further information, visit www.ReMedi.org**

By M. Machua Millett
Boston

# Costa Rica: Opportunity and Risk in a "New" Market

While relatively small in comparison to the major Latin American insurance markets, Costa Rica is the largest insurance market in Central America (excluding Panama). The country also has a uniquely diversified economy for the region, has experienced rapid annual growth in the insurance market (between 15% and 46% annual growth in recent years) and still has a relatively low insurance penetration rate (2.6%). Prior to 2008, however, the country had maintained a government monopoly over the insurance and reinsurance market through the Instituto Nacional de Seguros (INS).

In August 2008, new legislation was passed in Costa Rica and signed into law by president Dr. Oscar Arias Sanchez that ended the more than eighty-year-old state-sponsored monopoly over the Costa Rican (re) insurance business. While the new Ley Reguladora del Mercado de Seguros opens the insurance market to private competition from domestic companies and foreign companies with local branches, it also contains prohibitions and increased penalties that may come as a surprise to any foreign (re)insurers that do not carefully review their activities in connection with any Costa Rican risks.

## Market Trends and Characteristics

Due to dependence upon the United States and European economies, Costa Rica's insurance market growth is expected to remain flat for 2009. This plateau is expected to be only temporary, however, and comes on the heels of 28% growth in 2007 and double digit growth in the prior years. Furthermore, Fitch predicts continued growth in both the general economy and in the insurance market specifically well in to the future. Fitch based its recent opinion of the Costa Rican economy on the nation's high per capita income, strong governance indicators, net external creditor position, improved public finances and relatively diverse economy and the full implementation of the Dominican Republic-Central America Free Trade Agreement (DR-CAFTA) and its accompanying legislation, which should help sustain these trends over the medium to long-term. As to Costa Rica's insurance market, Fitch expects continued premium growth and increased market penetration as private companies enter the market and increase price competition.

Not surprisingly, these economic indicators and the opening of the (re)insurance market to private and foreign competition has led to significant, if cautious, interest in the past year. Seguros del Magisterio, a Costa Rican company that formerly provided services exclusively to the nation's teachers under an exemption to the government monopoly, became the first private competitor in February 2009. Aseguradora Mundial, a Panamanian company, received initial authorization in July 2009. A number of other companies, including Qualitas of Mexico and ALICO of Panama, are also in the process of obtaining authorization.

## Recent Regulatory Developments

Under the new law enacted in August 2008, the interim (re)insurance regulator was charged with establishing an insurance regulatory authority and implementing the other mandates of the new law. While certain regulations governing the market have still not been finalized as of the time of this writing, the basic tenets of the regulatory structure, such as authorization and solvency requirements, are already in place in the form of the statute itself and several sets of regulations issued since the opening. Companies seeking to sell personal lines or general insurance will be required to have minimum operating capital of $3 million, companies wishing to sell both will be required to have minimum capital of $7 million and companies wishing to operate as reinsurers will be required to have minimum capital of $10 million. While the minimum capital requirements contained in the new law are far lower than those contemplated in earlier drafts, which ranged from $10 million to $40 million, they remain fairly high in comparison to many other developing and established insurance markets.

In addition to opening the Costa Rican insurance market to private competition, however, the new statute and regulations also established new prohibitions against "insurance activities" in the jurisdiction by non-registered foreign insurers and reinsurers and created a new framework of far more serious penalties for violations of these prohibitions. Given these new provisions, and the newly created incentives for the INS to report and the regulators to investigate any violations, the risk of adverse enforcement actions has risen significantly with the new legislation. Potential fines for illegal sales of foreign insurance (the definition of which includes marketing of foreign policies by phone, email or facsimile) appear to range as high as $360,000 per violation under the new insurance laws.

## HIGHLIGHTS

*Continued from page 4*

- **Richard Hopley** (London) spoke at the Swiss Asbestos Working Party meeting on asbestos issues in Winterthur on 13 November 2009.
- **John Hughes** (Boston) co-presented a talk at the 15th Advanced Forum on D&O Liability in New York City on 30 November – 1 December 2009.
- **Jack Dearie** (New York), **Alan Levin** (Hartford) and **Teddy Eynon** (Washington DC)will attend the NAIC Meeting in San Francisco on 5-8 December 2009.
- **Christopher Tauro** (Boston) will attend the IntAP Meeting in Cologne on 9-10 December 2009.
- **Antony Woodhouse** (London) will be presenting on arbitration issues as part of an international panel at the ABA, TIPS, Insurance Coverage Litigation Committee mid-year meeting in Phoenix, Arizona on 27 February 2010.

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

In this regard, it should be noted that, while the old law was essentially a non-solicitation statute, the new law's definition of "insurance activities" that non-registered insurers and reinsurers are prohibited from undertaking in the jurisdiction is not limited to sales solicitation. To the contrary, the definition appears broad enough to implicate any sort of claim investigation or adjusting activities, whether conducted directly or through a local agent. Therefore, while the statute does not prohibit Costa Rican person and entities from seeking insurance outside of the jurisdiction, an insurer holding such a policy would be left with little ability to investigate or adjust any potential loss.

Indeed, the interim regulator recently issued a technical note providing further guidance as to several regulatory issues of significant importance to foreign (re)insurance companies.

- The Costa Rican law applies to any person involved in the development or realization of any insurance activities, whether in the nature of insurance, reinsurance, intermediary or auxiliary services. The law applies to such activity whether it occurs within the Costa Rican territory or from abroad directed toward Costa Rica and whether such activities are conducted directly or through intermediaries.
- The public offering of insurance services, which is prohibited in the absence of proper authorization or an applicable exemption, includes any activity that procures the sale of an insurance policy or provides specific or concrete information concerning a particular insurance policy.
- Any provider of cross-border insurance services that includes a risk within Costa Rica must register with the Superintendency. This requirement does not apply to providers of cross-border reinsurance or retrocession, reinsurance intermediary services or auxiliary reinsurance service -- such entities may contract with authorized Costa Rican insurers when contacted directly by such authorized companies.
- No company may commercialize or otherwise market cross-border insurance services in Costa Rica unless the policies in question have been registered with the Superintendency, which is only permitted if such policies have been registered in the company's home jurisdiction.
- The only cross-border direct insurance services currently permitted by law in Costa Rica are those established by the CAFTA-DR treaty. As concerns direct insurance, said treaty applies only to space, maritime transport and commercial aviation insurance and only to member countries.
- Surplus lines insurance may only be purchased after local vetting and may not be publicized in Costa Rica and may only be offered through brokers.

Therefore, even for companies that opt to wait and see as to the development of the Costa Rican insurance market, it is imperative to reevaluate underwriting activities regarding risks related to Costa Rica.

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

*"...it is imperative to reevaluate underwriting activities regarding risks related to Costa Rica."*

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# Debtors Beware: There's Another Sheriff in Town

By Paul J. Labov
New York

The United States Bankruptcy Court for the District of New Jersey denied *fourteen* plans of reorganization filed by Congoleum Corporation before the court finally dismissed the case on February 27, 2009. While the Congoleum bankruptcy proceedings involve numerous issues, this article focuses generally on insurer standing and specifically, on whether Congoleum's insurers had standing to object to Congoleum's twelfth plan of reorganization.

As a manufacturer of floor tiles and other products, Congoleum faced insurmountable asbestos claims, which severely threatened the viability of the company. After exhausting coverage from its primary insurers, Congoleum sought but failed to obtain coverage from its excess insurers as well.

In an attempt to control its asbestos liabilities, Congoleum devised a pre-packaged bankruptcy plan, the cornerstone of which was a Bankruptcy Code section 524(g) injunction. If approved, the injunction would have channeled all prior and future asbestos-related claims into a trust. The trust was to be funded with Congoleum's assets, including its insurance policies and the proceeds from such policies.

The insurers and several asbestos claimants objected to confirmation of the plan on the grounds that it favored certain asbestos claimants over others and that the required judicial oversight of certain

*Continued on page 14*

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fee provisions was lacking. Congoleum argued that the insurers lacked standing to contest the confirmability of the plan and that, regardless, the plan met all of the requirements set forth in the Bankruptcy Code. The Bankruptcy Court rejected Congoleum's argument that the insurers lacked standing. The court found that the plan threatened substantial harm to their financial and contractual interests because, among other reasons, the plan pre-empted the insurer's anti-assignment and cooperation rights by allowing Congoleum to assign its rights in the policies to the trust. This alone, according to the Bankruptcy Court, constituted an injury-in-fact, made the insurers' parties in interest under the Bankruptcy Code and conferred standing upon the insurers to object to the plan. Also, the Bankruptcy Court recognized that it had the inherent power to review plans for compliance with Bankruptcy Code requirements for confirmation and that this plan did not meet those requirements. Accordingly, the Bankruptcy Court denied confirmation and dismissed the case.

On appeal, Congoleum argued that i) its insurers lacked standing to object to the plan because they were not a "party-in-interest" and ii) in any event, the plan met the requirements of Bankruptcy Code section 1129, and thus, it should have been confirmed. Not surprisingly, the insurers argued that they had standing because it was their policies that were to fund the trust, and the plan, if confirmed, would threaten substantial harm to their financial and contractual interests by eviscerating their contractual rights under the policies.

The District Court affirmed the Bankruptcy Court in holding that the insurers had standing because the plan threatened substantial harm to their financial and contractual interests. Noting the broad concept of standing afforded to litigants under Article III of the Constitution, the District Court also found that the Bankruptcy Code's concept of standing was just as broad, allowing any party-in-interest to object to a plan. The District Court, however, found that appealing from a Bankruptcy Court order required a more restrictive approach to standing and included "prudential" limitation. Thus each insurer was required to satisfy the "person aggrieved" standard by showing that confirmation would result in an injury personal to that insurer.

*"...the District Court pushed the 'prudential' requirement back to appeals of Bankruptcy Court orders as opposed to objections made at the time of confirmation."*

In addressing insurer standing, the District Court noted the important role of insurers in these types of cases. Specifically, the District Court recognized that in asbestos bankruptcy cases, claims are typically submitted in accordance with a trust's distribution procedures and often, the insurance policies and the proceeds derived from those policies are the most significant asset that claimants will look to. The District Court found that this was the seventh time a court confronted the issue of insurer standing, each time finding that insurers had standing to challenge plans due to their fundamental stake in the outcome of the bankruptcy proceedings. After stating that each of these courts had found the "injury-in-fact" requirement satisfied by "the unfairness of a plan which binds them contractually and which directly impacts their financial interests...," the District Court concluded that the insurers were parties-in-interest and had standing to challenge confirmation.

**What is so important about this case?**

Some lower courts had previously held that while insurers clearly satisfy Constitutional standing requirements, these insurers might not meet the "prudential" standing requirement and so could not challenge portions of the plan that did not affect their direct interests. In essence, these courts read the prudential standing requirement into the Bankruptcy Code, superseding the plain "party-in-interest" language set forth in the Bankruptcy Code itself. Accordingly, these courts would not allow insurers to raise general bankruptcy-related objections, as the insurers did in this case, given the need for prudential considerations in a bankruptcy case, i.e., the consideration that a myriad of divergent interests objecting all at once could clog a system designed to move cases towards a successful reorganization. Here, the District Court pushed the "prudential" requirement back to appeals of Bankruptcy Court orders as opposed to objections made at the time of confirmation. Some may argue that the Bankruptcy Court, as well as others, including the United States Trustee, are required to police a plan's compliance with Bankruptcy Code requirements, which would limit the significance of conferring standing on parties to object to a plan on general Bankruptcy Code grounds. While courts are required to police these requirements, now that insurers and other parties-in-interest are given watchdog status, at least in the District of New Jersey, a debtor may be more likely to get it right the first time.

The District Court's decision can be found at 2009 WL 2514172.

## Calling all insurance industry YOUNG PROFESSIONALS in the greater Hartford area

In February 2010 (date tbc), we will be sponsoring a kick-off event to promote and discuss ideas with regard to the formation of an insurance industry-specific young professionals organization in Hartford, the "Insurance Capital of the World."

We hope the organization will become a forum for young professionals in the insurance industry to advance professional development and interact through social, educational and other networking opportunities. There will be no entrance fee at the event and it will be open to anyone in the Hartford area who is associated with the insurance industry. One of the goals of the event is to get people involved and establish a team willing to help get this organization running. As an attendee, you will have the opportunity to become a founding member of the group.

**Please pass the word along to your colleagues and friends and please contact Julia Karen Ulrich at JUlrich@eapdlaw.com or Aubrey Ruta at ARuta@eapdlaw.com if you would like additional information regarding the event and/or the formation of the group in general. We hope to see you this winter!**

# An Introduction to the 2009 Insurance Law Reform in China

The amended Insurance Law of the People's Republic of China (PRC) came into force on 1 October 2009 (the Amended Insurance Law). This is the second revision and the most comprehensive reform of the China Insurance Law since its enactment on 1 October 1995.

By Martin Lister and Patrick Peng, Hong Kong

The amendments cover five major areas of insurance law including insurance contracts, insurance companies, insurance intermediaries, the management of insurance companies and the supervision of the insurance industry. This article focuses on the amendments which relate to the operation of insurance companies in the PRC. The Amended Insurance Law does not apply to the Special Administrative Regions of Hong Kong and Macau.

### Shareholders of a PRC Insurance Company

The Amended Insurance Law has introduced new qualification requirements for the major shareholders of an insurance company when it is established in the PRC. Under article 68(1) of the Amended Insurance Law, major shareholders of an insurance company are required to have (i) sustainable profitability; (ii) good reputation; (iii) net assets of not less than 200 million yuan; and (iv) no record of significant breach of any laws and regulations in the three years immediately preceding becoming a shareholder of the insurance company.

*"Major shareholder"* is not defined in the Amended Insurance Law, and having *"sustainable profitability"* is not explained. It is also unclear what would constitute a *"significant breach"* of the laws and regulations. Effectively, these uncertainties will give the China Insurance Regulatory Commission (CIRC), the regulatory authority for the insurance industry in the PRC, greater discretion in determining whether to approve the establishment of an insurance company in the PRC, though it is to be hoped that an understanding will in due course develop as to the meaning of these terms.

The Amended Insurance Law also grants CIRC power to restrict the rights of the shareholders of an insurance company where the insurance company engages in transactions with its related companies which may seriously jeopardise its interests or solvency. In addition, if the shareholders refuse to procure the reversal of the transactions, CIRC may compel the shareholders to dispose of their shares in the insurance company.[1] This is a significant new power for CIRC, though the Amended Insurance Law does not state how or to whom the shares should be transferred and it will be interesting to see how CIRC and the PRC courts implement this provision.

### Forms of Insurance Company

Under the former China Insurance Law, an insurance company could only be formed as a joint stock company or a wholly state-owned enterprise.[2] This restriction has now been removed by the Amended Insurance Law, but in practice it had been rendered largely redundant prior to its removal as CIRC had previously approved the establishment of foreign-invested PRC insurance companies in the form of limited liability companies. Though the removal of this restriction will have limited impact on the future establishment of foreign-invested insurance companies in the PRC, it will permit limited liability insurance companies to be established by PRC investors.

### Solvency Requirements

Where an insurance company fails to meet the solvency requirements promulgated by CIRC, CIRC is empowered to take measures against the company, including (i) ordering the company to increase its capital and obtain additional reinsurance cover; (ii) restricting the business scope of the company; (iii) restricting distribution of dividends to the shareholders; (iv) limiting the remuneration paid to its directors and senior management; and (v) ordering the company to stop writing new policies.[3] If an insurance company is, or is at substantial risk of, being restructured, taken-over or placed in liquidation, CIRC may take further measures to restrict its directors and senior management from travelling out of the PRC and disposing of their assets.[4]

### Investments

Under the former China Insurance Law, insurance companies could only invest in bank deposits, government bonds, financial bonds and other assets approved by the State Council of the PRC.[5] These were regarded as low risk and low return investments. To enable insurance companies to increase their profitability and financial strength, the Amended Insurance Law now allows insurance companies to invest in stocks, securities investment funds and real estate.[6] The prohibition against insurance companies investing in securities companies and non-insurance related companies has also been removed.

Continued on page 16

*"This is the second revision and the most comprehensive reform of the China Insurance Law since its enactment on 1 October 1995."*

## Footnotes

1 Article 152 Amended Insurance Law.
2 Article 70 former China Insurance Law.
3 Article 139 Amended Insurance Law.
4 Article 154 Amended Insurance Law.
5 Article 105 former China Insurance Law.
6 Article 106 Amended Insurance Law.
7 Article 103 former China Insurance Law.

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Although this expanded range of investment assets is now set out in the Amended Insurance Law, in practice some of these investments (eg investments in banks and infrastructure projects) had previously been permitted by the State Council. It is expected that CIRC will soon announce detailed rules regarding investment in private equity and real estate by insurance companies.

### Reinsurance Requirement

Prior to the reform, the China Insurance Law required that when seeking to reinsure their direct PRC insurance business, insurers had to give priority to reinsurance companies located in the PRC.[7] The former China Insurance Law further gave CIRC a right to restrict or prohibit insurance companies in China from reinsuring with or accepting reinsurance business from overseas insurers. These restrictions have now been removed by the Amended Insurance Law.

However, the Provisions on the Administration of Reinsurance Business promulgated by CIRC in 2005 have not been revised and are still in effect. The 2005 Provisions require that direct insurers must offer to at least two China-based professional reinsurance companies no less than an aggregate of 50% of the China-based risks to be reinsured before they may offer such business to reinsurers located outside the PRC.

CIRC has recently published draft 2009 Provisions on the Administration of Reinsurance Business which will remove these requirements. A final version of the 2009 Provisions is anticipated to come into force at the end of 2009.

### Foreign-Invested Insurance Companies

A number of new administrative regulations came into force at the same time as the Amended Insurance Law and, though these apply to all PRC insurance companies including foreign-invested insurance companies in the PRC, foreign-invested insurance companies remain principally regulated by the Administrative Provisions on Foreign-Invested Insurance Companies and the Detailed Rules on the Implementation of the Provisions on Foreign-Invested Insurance Companies which remain in effect and are unchanged. The Amended Insurance Law will therefore have limited impact on the establishment and operation of foreign-invested insurance companies in the PRC.

### Conclusion

The Amended Insurance Law provides insurance companies with more flexibility in offering new products and making investments; it also gives CIRC greater enforcement powers against an insurance company which fails to comply with the solvency requirements or other CIRC regulations. It is hoped that by elevating the requirements on the establishment and operation of insurance companies in the PRC and strengthening CIRC's ability to regulate the insurance industry, it will offer more protection to the consumer. However, many of the amendments are not in practice new to the insurance industry in the PRC but are intended to reflect and accommodate the rapid development of the PRC's insurance industry following its accession to the World Trade Organisation in 2002.

We will continue to monitor insurance developments in the PRC, particularly the regulations issued by CIRC to implement the Amended Insurance Law.

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.

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