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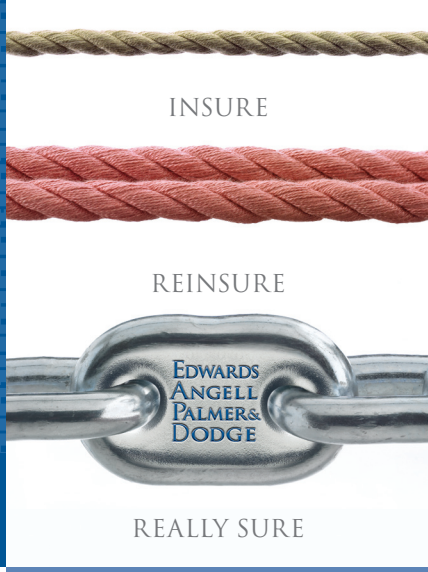
Insurance and Reinsurance Review

March 2010



Financial Services Regulatory Reform's Impact on the Insurance Industry: Food for Thought

Insurers and reinsurers will be impacted directly and indirectly by proposals to modernize regulation of the financial services industry so as to prevent or soften the impact of future financial crises. Even, if new regulators and new powers and authority granted to existing regulators are not targeted directly at the insurance business, subsidiaries, customers, counterparties, service providers, lenders and investors of, to and in the insurance industry will be.

The new landscape of the financial services industry can be expected to force insurers and reinsurers to manage their business more effectively for systemic risks and implement strategic risk management initiatives. In a worst case scenario, insurance holding companies will divest commercial banking and securities businesses and assets, global financial services firms will separate or spin-off their US operations from their global operations, US insurers will seek to new production channels and/or the transfer of insurance risks to the capital markets will become more costly.

As 2010 began, there appeared to be less focus on federal regulation of insurance in the US. Regulators and Congress for some time have been more concerned with the health of commercial banks and investment banks, and professed little interest in tinkering with the relatively healthy insurance industry. During most of 2009, Congress and the Obama Administration were also forced to prioritize agenda items in the push to enact broad healthcare reform and induce economic recovery. However, healthcare reform may no longer be front-and-center given recent political developments in the 2009 state elections and the Massachusetts special election for the late Sen. Kennedy's seat. Meaningful financial services regulatory reform will get much attention in 2010 and insurers and reinsurers should expect some scrutiny of their roles in the industry.

Despite the very public fall of AIG and the near meltdown of the financial services industry in the last two quarters of 2008, the global insurance industry as a whole appears to have weathered the last two years in remarkably good shape. The other two ingredients of the financial services industry, commercial banking and investment banking, have not fared as well.

Commercial banks and investment banks have teetered on the edge of insolvency due to liquidity concerns, trading losses and deteriorating consumer and commercial loan portfolios. Some like Lehman Brothers and IndyMac did not survive. Others like Bear Stearns, Merrill Lynch and Wachovia have been forced into shotgun marriages with "stronger" firms like JPMorgan, Bank of America and Wells Fargo. Most commercial banks and investment banks in the US and Europe received and, in some cases, were forced to accept, government support whether through direct investment, such as the takeover of Royal Bank of Scotland by the British government, or through government loans and guaranties, such as TARP and commercial paper backstops provided by US bank regulators.

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By Geoffrey Etherington
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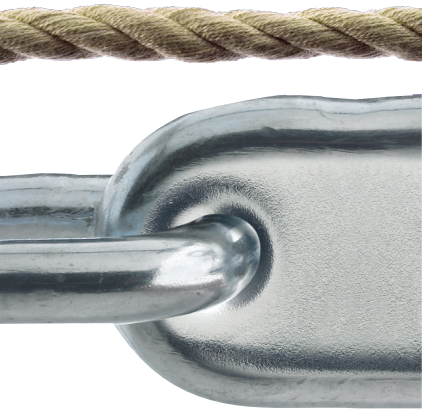

The growing appetite of governments and regulators to exercise control and oversight over the operations of financial services firms suggests that they will continue to play an active role in directing financial services firms. Insurers and reinsurers should be wary about the long-term implications of greater government involvement in and control of financial services firms and be prepared to live within new constraints and take advantage of new opportunities created by limitations on the operations of other financial services firms.

Clearly, the insurance industry has been challenged particularly by large losses in its investment portfolio. Yet, populist furor in the US has for the most part focused on the compensation excesses and reckless risk-taking of Wall Street and large commercial banks. Indeed, Congress, regulators and the press have generally lauded insurers and reinsurers for being immune or at least resistant to the malaise and ill-health of commercial banks and investment banks. Despite this goodwill towards the insurance industry, since mid-2009 there have been loud calls in the US and Europe to dramatically overhaul the regulation of the financial services industry within which insurers and reinsurers are inextricably entwined. Changes in law intended to address perceived abuses that precipitated the recession of the last two years and therefore prevent future instability of the global financial services system will clearly impact the insurance industry.

There have been a number of recipes for financial services reform advanced in the US over the last year. In June 2009, President Barack Obama and the US Treasury, under the new leadership of Timothy Geithner, proposed a broad overhaul that, among other matters, focused on regulation of systemic risk.[1] Others have called for reinstating some or all of the Depression-era barriers among insurers, banks and securities firms.[2] This unscrambling of the omelet that the financial services industry has become over the last decade may, depending on its scope, create major challenges to some insurers and reinsurers.

The insurance industry has much at stake as legislators and regulators begin to formulate a new approach to the regulation of the financial services industry. Insurance holding companies that own banks, securities firms, investment banks and commercial lenders face uncertainties as to new restrictions and perhaps outright prohibition on certain activities. Many insurers rely on producers owned by bank holding companies or investment banks to deliver personal lines products like auto and homeowners insurance, life and annuity policies, and commercial coverages to small and medium-sized businesses. Limitations on ownership or activities of such producers could impact premium volume. Lastly, the forced divestiture by financial services firms, including insurers and reinsurers, of certain financial services businesses could dramatically erode profitability and capital.

It is unlikely that Congress will completely turn back the clock to a pre-Gramm-Leach-Bliley era, but it is worth reviewing how different the financial services industry was at that time because there will continue to be calls to bring back some of limitations on affiliations of insurers, commercial banks and investment banks, and permitted activities by each.

Before the adoption of the Gramm-Leach-Bliley Act (GLB), commercial banks were prohibited under federal and many state laws from engaging in most insurance activities or being affiliated with insurers.

"Current legislative proposals seek to address both risk management and rating agency regulation. Some form of federal regulation of systemic risk should be expected..."

This of course meant that a bank holding company could not only own an insurance company, but that an insurance holding company could not own a bank. Banks were extremely limited as to insurance brokerage activities, generally being permitted to sell only property and casualty and life insurance products in connection with credit transactions to provide for repayment of loans.

While generally there were few restrictions on the affiliation of insurers and securities firms, the Glass-Steagall Act, which was repealed by GLB, did not permit commercial banks to engage in or be affiliated with securities firms engaged in underwriting securities. It seems quite likely that Glass-Steagall barriers will be re-erected in part.

What Might Some of the Impacts on the Insurance Industry Be?

If those in the US calling for a separation of commercial banking, insurance and securities underwriting win the day in whole or in part, insurers like MetLife, who have built successful banking franchises, may have to divest those businesses at a time when there may be fewer buyers or investors interested in the banking business. It may be difficult for insurance firms to recover their investments in banking firms reducing their capital and hampering efforts to pursue business plans and strategies.

In addition, large global firms like Credit Suisse, Swiss Re and Allianz may face difficult decisions to ensure continued access to the US market. Will they be forced to separate or spin-off US insurance, investment banking and commercial banking operations from each other? Such regulatory-driven divestitures may create strategic opportunities for some insurers and reinsurers and may lead to reduced capacity in some markets. Even, if global firms are able to comply with US restrictions through isolating domestic insurance businesses from global banking or securities activities, they will not be able

Endnotes

1. The Treasury Department subsequently released detailed proposals to implement the Administration's proposals in the summer and fall before Congressional committees.
2. The US House of Representatives passed the Wall Street Reform and Consumer Protection Act of 2009 (H.R. 4173) on December 14, 2009. This House bill proposes the creation of a Consumer Financial Protection Agency, new regulation of derivatives markets, systemic risk regulation measures, new restrictions on credit rating agencies, the creation of a Federal Insurance Office and a hedge fund registration requirement. Sens. John McCain (R-Arizona) and Maria Cantwell (D-Washington) proposed on December 16, 2009 the repeal of the Gramm-Leach-Bliley Act (GLB) and in January 2010 the Obama administration suggested that the Glass-Steagall Act, one of the laws repealed by GLB, be revived.

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to offer customers a broad menu of services, reducing the value of US operations.

Firms such as Aon, Swiss Re and Allianz have been active in cat bonds and other risk securitizations building on their insurance and investment banking expertise to transfer risk to the capital markets. Efforts to separate insurance and investment banking businesses could make cat bonds more challenging to structure and more expensive to bring to market.

Many of the largest insurance producers in the US today are affiliated with commercial banks and thus important sources of premium volume to insurers. As noted above, commercial banks pre-GLB were limited from selling many lines of insurance. Insurers would have to develop more expensive production channels if banks had to scale back their broker businesses. For example, private banking operations of commercial banks and broker/dealers are key sources of high face life and annuity business to life insurers. If bank or securities firm employees were limited in their ability to hold insurance producer licenses, it would be difficult for banks and insurers to form effective marketing alliances and joint ventures targeting high net worth individuals.

Seemingly industry-neutral regulation of derivatives requiring disclosure and/or registration of transactions may discourage development of proprietary swap structures or impose burdensome margin requirements that may limit the ability of insurers and reinsurers to hedge risks in the capital markets. As a result, the capacity of some insurance markets may be reduced as reinsurers lose the ability to redeploy surplus to support certain insurance lines.

After the financial services industry staggered in 2008, many suggested that flawed approaches to risk management and over-reliance on financial modeling were a root cause of the sudden evaporation of value and disappearance of liquidity. Criticisms were also leveled at ratings agencies for conflicts of interests. Current legislative proposals seek to address both risk management and rating agency regulation. Some form of federal regulation of systemic risk should be expected. It is unclear what approach will be adopted for rating agencies, some have suggested encouraging the establishment of more ratings firms and others regulation to eliminate past economic incentives to grant higher ratings. Regulation of systemic risk is likely to require more detailed reporting by large insurers and reinsurers and more extensive internal risk management structures addressing financial and counterparty exposures. Any changes to the current rating systems may be inconsistent with state laws and regulations and accounting rules relating to admitted assets and risk-based capital. Insurers will be challenged to comply with state laws that rely heavily on ratings of securities at a time when federal regulators may be discounting or questioning ratings. Any substantive change in how ratings agencies operate may require the NAIC's Securities Valuation Office to reconfigure its rating criteria.

For the US insurance industry the next twelve months may well be transformative. Regulation will change, some business may need to be discontinued or divested and relationships with partners, customers and investors may need to be substantially reworked. However, firms may have new opportunities to grow and expand, as their competitors must also deal with the changed landscape.

Equitas v R&Q – A Summary Analysis

The recent decision of Mr Justice Gross in *Equitas v R&Q* addressed specific aspects of two original LMX market catastrophe losses, Kuwait and Exxon Valdez, and the effect of those losses on the LMX spiral. The losses entered the spiral in 1990 and 1989 respectively but had since been judged to be "tainted" because they contained incorrectly aggregated (Kuwait) and irrecoverable (Exxon) elements.

The question for Mr Justice Gross was whether Equitas could establish that its claims fell properly within the scope of cover of its reinsurance contracts with R&Q. This involved a two stage analysis: first (i) whether the actuarial modelling approach was permissible as a matter of law and, if so, (ii) whether the Equitas models provided evidence of the claims such as to satisfy the burden of proof ie on the balance of probabilities – a question of fact.

The loss settlement provision in the contracts provided the starting point. This was the same "double proviso" loss settlement provision (ie requiring the loss to fall within the terms both of the reinsurance and of the original insurance), addressed by the House of Lords in *Hill v M&G*.

Justice Gross decided that a reinsured could, as a matter of principle, choose the evidence it deemed appropriate to seek to prove its claims. That could include an actuarial model.

The reinsured was not required to prove liability under each and every underlying contract. Consequently, the inability of Equitas to reconstruct the LMX spiral and to provide evidence of the untainted Exxon and Kuwait claims through it, on a contract by contract basis, was not fatal to its claim.

On the question of fact, Mr Justice Gross decided that the Equitas models were "both capable of making the transition from the general to the particular and [did] go on to provide a reasonable representation of reality". The models assisted "in doing practical justice in this case", demonstrating his desire to "kickstart" the LMX spiral.

Immediately following the judgment, R&Q stated that it was considering bringing an appeal. However that possibility has been eliminated by the settlement between Equitas and R&Q, announced publicly on 14 December 2009.

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A more detailed analysis of this case by the same author appears in an article featured in the March 2010 issue of *Insider Quarterly (IQ)*. Please contact the editors if you would like further information on this decision.

Data Security Developments for the Insurance Industry

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In this article, we briefly review several recent developments in the data security requirements that affect insurance companies and producers with operations in the United States and Europe. The issue of data security is increasingly important to insurers and producers, as data breaches, and related fines and litigation, are revealed on a regular, almost daily basis. Insurance companies and producers have their own burdens and exposures relative to the personal information[1] of their insureds, employees and agents. They also have opportunities to offer coverage to other companies that have exposure to data security risks.

January 1, 2010

State requirements in the US continue to evolve. On January 1, 2010, a new amendment to the Nevada privacy law became effective. This amendment requires any company doing business in Nevada that accepts payment cards to comply with the Payment Card Industry Data Security Standards (PCI DSS). Prior to this amendment, the obligations of PCI DSS to secure certain personal information of payment card users were imposed contractually by the payment card industry to require encryption and other onerous safeguards. Violations of the these standards were subject to fines and other contractual sanctions. With the Nevada amendment, however, these standards are now also imposed by law. In addition, the amendment requires companies doing business in Nevada that may not accept payment cards, but otherwise collect data, to adopt encryption technologies to protect certain stored and transmitted data.

February 17, 2010

Effective February 17, 2010, the reach of the HITECH Act will be expanded to impose substantial parts of the HIPAA privacy and security requirements related to the protection of health information directly on "business associates," which are defined to include any person providing services to a healthcare provider involving the use or disclosure of individually identifiable health information. The newly effective provisions of the HITECH Act also restrict the use and disclosure of protected health information for marketing purposes and contain other amendments. By the effective date for these provisions, covered entities should consider putting new business associate agreements in place to reflect these new privacy and security requirements, as well as data breach notification obligations.

February 22, 2010

HIPAA imposes a breach notification requirement for covered entities and business associates, and for personal health record vendors and their contractors, which will be fully enforced beginning February 22, 2010.

March 1, 2010

On March 1, 2010, the Massachusetts Security Regulation is scheduled to take effect, after several postponements and amendments. While requirements for encryption and certain other technical requirements have been relaxed since this Regulation was first proposed, the basic requirements for any company or person that owns or licenses certain personal information of any Massachusetts resident remain specific and relatively burdensome. These requirements apply regardless of whether the company is doing business in Massachusetts. Central to the Massachusetts Security Regulation is the requirement that each such company adopt a Written Information Security Program (WISP) containing specific elements to ensure the security of personal information.

Due to the nature of these requirements, most companies and persons owning or licensing personal information of any Massachusetts resident, whether because they have one or more Massachusetts employees, agents or insureds, or otherwise, are making a corporate-level decision to comply with these requirements nationally, and in some cases globally, because the cost and risk related to culling out personal information of Massachusetts residents and treating it differently from other information owned or licensed by the company is too high.

It should also be noted that under the Massachusetts Security Regulation, companies and persons must amend their vendor contracts pursuant to which certain personal information of Massachusetts residents is transmitted to and stored or processed by vendors. Contractual provisions requiring compliance with the Massachusetts

EAPD Associate M. Machua Millet selected to participate in the Greater Boston Chamber of Commerce's "Boston's Future Leaders" Program 2010

Machua Millet will join a prestigious class noted for their high potential as leaders in the Boston community. Now in its seventh year, "Boston's Future Leaders" is a key initiative of the Chamber. The initiative includes leadership development programs at the Harvard Business School and the Suffolk University Sawyer Business School. The Greater Boston Chamber is committed to driving economic growth, creating new opportunities for members and building a more inclusive community.

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Security Regulation must be included in contracts entered into on or after March 1, 2010. Contracts entered into before that date must be amended to comply by March 1, 2012.

June 1, 2010

The Red Flags Rule promulgated by the Federal Trade Commission requires that financial institutions (essentially banking institutions) and "creditors" that maintain "covered accounts" develop and implement written Identity Theft Prevention Programs to detect, prevent and mitigate identity theft. For this purpose, "creditors" and "covered accounts" are very broadly defined, and would include insurance companies and producers that provide insurance coverage and bill premiums afterward, whether or not interest is charged. While financial institutions have had to comply with the Red Flags Rule since November 28, 2008, creditors that maintain covered accounts must comply by June 1, 2010.

Unlike the specific requirements of the Massachusetts Security Regulation, the approach of the Red Flags Rule is much more flexible, but very comprehensive. There are no specific technologies, techniques or contractual requirements, for example, but creditors must implement a comprehensive program that would detect, prevent and mitigate identity theft.

European Developments

In addition to complying with US data protection, most US insurance companies and producers with subsidiaries in the European Union need to be aware of the data protection laws in the EU, enforcement, and the penalties for non-compliance. There are new penalties for data protection violations and breaches in Germany, and a recent increase in penalties in the UK, as noted below. Further, those publicly traded firms implementing whistleblowing programs for subsidiaries in the EU in order to comply with two important US laws, the Sarbanes-Oxley Act of 2002 and the Foreign Corrupt Practices Act, should also take note of recent important whistleblower decisions, guidelines or directions in France, Denmark, Sweden, Portugal, Austria, and Hungary.

The Information Commissioner's Office (ICO) in the UK has recently been granted increased statutory powers to impose fines up to £500,000. The new powers, which are expected to come into force on April 6, 2010, apply when the ICO is satisfied that: (i) there has been a serious breach of one or more of the data protection principles of the organizations; and (ii) the breach was likely to cause substantial damage/distress, i.e., if the breach was deliberate or the organization knew or should have known there was a risk, such as by the reckless handling of personal data. As some data breaches may include individual names in other countries, the fine levels of those authorities becomes increasingly important.

The German Federal Parliament passed comprehensive amendments to the Federal Data Protection Act, effective September 1, 2009, that cover a broad variety of data protection issues and give fine authority of € 50,000 for simple violations and € 300,000 for serious violations. The data protection authorities have been given these new powers to enable them to impose higher fines for failure to comply with data protection requirements, especially on the security side.

1. For purposes of this article, we use the term personal information to include the financial, health and other nonpublic personal information generally covered by these federal and state requirements.

Solvent Schemes of Arrangement Revisited: The Scottish Lion Revived

Readers of our December 2009 issue will recall that we wrote about the Scottish court decision on the Scottish Lion Insurance Company scheme of arrangement. Just before this issue went to press the decision of the Scottish court of appeal (the Inner House of the Court of Session) on the issue of whether "creditor democracy" would be allowed to prevail or whether unanimity was required became known. English lawyers familiar with schemes of arrangement will not be surprised that the Inner House decision has overturned Lord Glennie on this point.

The case has been sent back to Lord Glennie to decide the substantive issue of whether to exercise the discretion in favour of sanctioning the scheme. This will have to involve a review of the valuation of the votes, because the court will have to decide whether the statutory majority has in fact been obtained. If it decides that it has, the size of the majority will, according to the Inner House ruling, be a factor, but only one of a number of factors, relevant to the court's decision.

Lord Glennie had had obvious sympathy with the observations of Mr Justice Lewison in the *British Aviation Insurance Company* case ([2006] 1 BCLC 665) where he had considered it unfair for insurance companies, who were in the risk business, to terminate cover and transfer risk back to dissenting policyholders, who were not. Although these comments were obiter, it would appear that the company will have a hard task in persuading Lord Glennie to sanction this scheme in the face of determined opposition from the opposing creditors. An early hearing is improbable as it would seem likely that substantial evidence will be required on the valuation issue. Even if the decision on the preliminary issue is not taken to the Supreme Court, it is not hard to imagine that the decision on whether to sanction the scheme might well be appealed. The ultimate decision on the issues in this case this would appear to be some way away.

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By Victoria Anderson
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UK Insurance Contract Law Reform: Draft Consumer Insurance (Disclosure and Representations) Bill

In our December 2009 issue of *Insurance and Reinsurance Review* we reported on the contents of the draft Consumer Insurance (Disclosure and Representations) Bill as previewed by the Law Commissioner, David Hertzell, at a discussion before the British Insurance Law Association on 16 October 2009. On 15 December 2009, the English and Scottish Law Commissions published their draft Bill and we can now review their proposals in detail.

"There is wide consensus that consumer insurance law is in urgent need of reform and so it is likely that the draft Bill will be passed in time."

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The draft Bill applies only to consumer insurance contracts, ie contracts of insurance bought by individuals for purposes wholly or mainly unrelated to their trade, business or profession. It also only deals with the issue of what a consumer must tell an insurer before entering into or varying an insurance contract.

The Insured's Duty to Take Care Responding to Questions

The current law requires a consumer to volunteer information about anything which a "prudent insurer" would consider relevant. The Law Commission believes this no longer corresponds to the realities of a modern mass consumer insurance market. Most consumers are unaware that they are under a duty to volunteer information. Even if they are aware of it, they usually have little idea of what an insurer might think relevant the Law Commission has stated that it is clearly important that insurers receive the information they need to assess risks. Most insurers, however, now accept that they should ask questions about the things they want to know.

The draft Bill abolishes the duty currently imposed on consumers to volunteer material facts and replaces it with a duty to take reasonable care to answer the insurer's questions fully and accurately. Where a consumer does make a mistake on an application form, the insurer is entitled to avoid the policy entirely, as if it never existed, only in certain circumstances dependant on the consumer's state of mind.

The draft Bill distinguishes between mistakes which are "reasonable", "careless" and "deliberate or reckless":

- Where a misrepresentation is honest and reasonable, the insurer must pay the claim. The applicant is expected to exercise the standard of care of a reasonable consumer, bearing in mind a range of factors, such as the type of policy and the clarity of the question. The test does not take into account the individual's own subjective circumstances (such as knowledge of English), unless these were, or ought to have been, known by the insurer.
- Where a misrepresentation is careless, the insurer has a compensatory remedy. This is based on what the insurer would have done had the consumer taken care to answer the question accurately and completely. For example, if the insurer would have added an exclusion, the insurer need not pay claims which fall within the exclusion, but must pay all other claims. If the insurer would have charged more, it must pay a proportion of the claim.
- Where the misrepresentation is deliberate or reckless, the insurer may avoid the policy. The insurer would also be entitled to retain the premium, unless there was a good reason why the premium should be returned.

Industry Presence: Highlights

- **Mark Meyer** (London) moderated and **Mary-Pat Cormier** (Boston) and **John Hughes** (Boston) presented the EAPD seminar *'Directors and Officers Liability: an International Perspective'*, which took place in EAPD's New York office on 2 February 2010. Tom Ielapi of Beazley (London) and Lüder Kaiser of Munich Re (Munich) were also speakers at this EAPD seminar.
- EAPD sponsored and were in attendance at the Professional Liability Underwriting Society (PLUS) D&O Symposium, which took place in New York on 3-4 February 2010.
- **Mark Everiss** (London) chaired a panel debate entitled *'No More Feathers For Your Bed – Is Traditional Run-Off in Free-Fall?'* at the ARC Discontinued Business Seminar & Convention, which took place in London on 23 February 2010.
- **Antony Woodhouse** (London) and **Craig Stewart** (Boston) spoke on Arbitration Issues and the Use of Experts in Bad Faith Litigation respectively at the American Bar Association: Tort Trial and Insurance Practice Section Insurance Coverage Litigation Committee's 18th Annual Mid-Year Meeting, which took place in Arizona on 27 February 2010.
- **Theodore Augustinos** (Hartford) and **Charles Welsh** (Hartford) will attend the Bank Insurance & Securities Association Annual Convention, which takes place in Florida on 6-9 March 2010.

For a misrepresentation to be considered "deliberate or reckless", the insurer must show on the balance of probabilities that the consumer knew the following:

- that the statement was untrue or misleading, or did not care whether it was or not
- that the matter was relevant to the insurer, or did not care whether it was or not.

However, if a reasonable person would have known that the statement was untrue, the burden of proof would fall on the consumer to show that he or she had less than normal knowledge. Similarly, if the question was clear, it would be up to the consumer to show why he or she did not think the matter was relevant.

The Law Commission believes that these new requirements reflect the approach already taken by the Financial Ombudsman Service (FOS) and are generally accepted as good practice within the industry. It believes that the proposed reforms would, however, make the law simpler and clearer, allowing both insurer and insured to know their rights and obligations. Insurers would therefore be less likely to turn down claims unfairly, and consumers would have greater confidence in the insurance industry.

Intermediaries

The Law Commission has tackled the controversial issue of intermediaries and who they act for in consumer insurance. It has recommended a statutory code, based largely on the existing law, as supplemented by FOS practice and industry understanding. The aim of the proposals is to give greater guidance, while retaining flexibility for the FOS and the courts to adapt to new arrangements.

The draft Bill states that an intermediary is considered to act for the insurer if:

- the intermediary is the appointed representative of the insurer
- the insurer has given the intermediary express authority to collect the information as its agent
- the insurer has given the intermediary express authority to enter into the contract on the insurer's behalf.

In other cases, the intermediary is presumed to act for the consumer unless it appears that it acts for the insurer. Schedule 2 to the draft Bill sets out factors which tend to show whether the agent is acting for either the insurer or the insured.

Examples of factors which may tend to confirm that the agent is acting for the consumer are:

- the agent undertakes to give impartial advice to the consumer
- the agent undertakes to conduct a fair analysis of the market
- the consumer pays the agent a fee.

Examples of factors which may tend to show that the agent is acting for the insurer are:

- the agent places insurance with only a small proportion of the insurers who provide insurance of the type in question
- the insurer provides the relevant insurance through only a limited number of agents
- the insurer permits the agent to use the insurer's name in providing the agent's services
- the insurance in question is marketed under the name of the agent;
- the insurer asks the agent to solicit the consumer's custom.

The Law Commission was conscious that in some transactions, it is common for intermediaries to *"change hats"* during the transaction, acting for the consumer in advising on the choice of insurer, and acting for the insurer in binding it to cover. The focus is on the intermediary's capacity at the time of the action in question. In addition, it states that this list of factors is "*indicative and non-exhaustive"* and that flexibility is key.

Basis of the Contract Clauses

The draft Bill abolishes "basis of the contract" clauses by stating that any representation made by a consumer is not capable of being converted into a warranty by means of any provision of the contract. The draft Bill, however, does not abolish warranties and is remains possible for insurers to include specific warranties within their policies.

Group Schemes

The draft Bill makes special provisions for group schemes providing that where a misrepresentation is made by a group member there are only consequences for that individual rather than the whole group.

Life Insurance Policies

Where one person takes out insurance on the life of another person and that individual (who is not a party to the contract) makes a misrepresentation (such as regarding their age or health) the Bill imposes the same duties upon the person whose life is insured as upon the policyholder. Where the individual makes a misrepresentation the insurer will be entitled to the same remedies as had they been a party to the contract.

No Contracting Out

The draft Bill prevents insurers from contracting out of the changes to the detriment of consumers.

Comment

There is wide consensus that consumer insurance law is in urgent need of reform and so it is likely that the draft Bill will be passed in time. However, in light of the impending General Election, it is unlikely that anything further will happen until Autumn of this year.

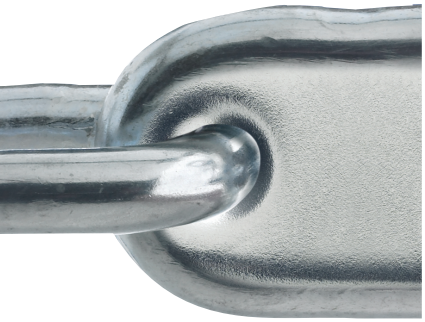
- **John McCarrick** (New York) will be speaking on *"What are the Risks to European D&O Insurers From Class and Derivative Actions in the US?"* at the C5 18th D&O Liability Insurance Forum conference, which takes place in London on 16-17 March 2010.
- **Theodore Augustinos** (Hartford), **Alan Levin** (Hartford/New York) and **Nick Pearson** (New York) will attend the National Association of Insurance Commissioners (NAIC) meeting in Denver, Colorado on 26-29 March 2010.
- **David Kendall** (London) will speak at the DIMA European Insurance Forum 2010, which takes place in Dublin on 29-30 March 2010.
- **Mohana J.P. Terry** (New York) will attend The Retirement Industry Conference, which takes place in Washington, DC on 11-13 April 2010.
- **Michael Thompson** (Stamford) will be speaking at the Strain Reinsurance and Contract Wording Textbook Training Course, which takes place in New Jersey on 20-23 April 2010.
- **Paul Kanefsky** (New York) will be a speaker and panelist at the annual Reinsurance Agreements program of American Conference Institute, which takes place in New York on 27-28 April 2010.
- **James A. Shanman** (Stamford) will participate in a panel on 'Strategies for Resolving Disputed Quickly and Cost-Effectively' at the American Conference Institute's International Advanced Forum on Run-Off and Commutations, which takes place in New York on 29-30 April 2010.
- **Vincent Vitkowsky** (New York) will participate in a panel entitled *'Reforms without Subscribers: Good Ideas Not Implemented'* at the ARIAS-US Spring Meeting, in Colorado on 4-7 May 2010.

For further details on any of the above please contact Kalai Raj at: KRaj@eapdlaw.com

By Eric D. Fader
New York

Extraterritorial Applicability of Medicare Secondary Payer Reporting Requirements to Foreign Insurers

All US insurance companies that make direct claims payments to US residents who are Medicare beneficiaries are, or will soon be, required by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) (Section 111) to report these payments to the Centers for Medicare & Medicaid Services (CMS). Although CMS states that Section 111 applies equally to foreign carriers, it is not clear whether the requirements will be enforceable against them.



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Background

Section 111 added new mandatory reporting requirements for group health plans (GHPs) (42 U.S.C. 1395y(b)(7)) and for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation plans, collectively referred to as "non-group health plans" (NGHPs) (42 U.S.C. 1395y(b)(8)), pertaining to when claims involving Medicare beneficiaries need to be reported to CMS. Section 111's purpose is to reinforce Medicare's status as a secondary payer for coordination of benefits purposes, and to prevent Medicare from paying for the same services for which reimbursement is available under other plans.

Section 111 became effective July 1, 2009, and all GHP "responsible reporting entities" (RREs) were required to begin reporting electronically by October 1, 2009. NGHP RREs are currently in a testing period and all will be required to begin reporting between April 1, 2010 and June 30, 2010, based on a schedule determined by CMS's Coordination of Benefits Contractor.

There are many policy, procedural and technical issues still to be resolved relating to Section 111, and CMS has been accepting emailed comments and questions and holding frequent "Town Hall Teleconferences" in its effort to identify gaps and ambiguities in its published guidelines. Some of the more important issues have been addressed by CMS in a series of Alerts.

Applicability to Foreign Insurers

One of the most interesting unresolved legal issues is whether Section 111 gives CMS the right to assert extraterritorial jurisdiction on foreign liability insurance companies who make direct claims payments to US residents. Although Section 111 itself is silent regarding its potential applicability to foreign carriers, CMS has stated that Section 111 applies to them. CMS's December 29, 2009 Alert ("Registration Guidelines for Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation Responsible Reporting Entities (RREs) Who Are Foreign Entities") states:

> Foreign entities will follow the same registration and reporting procedures, and have the same responsibility and accountability for data as domestic RREs. The delay in registration for foreign entities does not change the July 1, 2009 reporting date requirements associated with "Ongoing Responsibility for Medicals" (ORM) or the January 1, 2010 reporting date requirements associated with "Total Payment Obligation to Claimant" (TPOC) amounts.

The CMS Alert further "encourages foreign entities that do not have a U.S. TIN [Tax Identification Number] or EIN [Employer Identification Number] to apply at this time for a U.S. EIN" in order to be ready to register by April 1, 2010 for reporting, which will presumably be required of them later in 2010.

Analysis

There is a long-standing presumption in the US

against extraterritorial jurisdiction, dating back to the Supreme Court case *Foley Bros., Inc. v. Filardo*, 336 U.S. 281 (1949), and federal courts have consistently followed *Foley* in denying extraterritorial application of statutes without a clear congressional expression of intent to the contrary. Notwithstanding CMS's understandable interest in having Section 111 apply to all insurers, wherever located, it is not clear how the law could be enforced against a foreign insurer that pays claims to US residents but that has no official US presence. If the insurer does not market its products within the US or to US residents, even being publicly identified as a scofflaw might have little effect on its business. The issue would become more complicated, however, and the range of potential consequences successively more difficult to predict, in the following scenarios:

- A Section 111 violator domiciled in another country could have a US branch, or a related legal entity that is domiciled or does business in the US
- The foreign insurer could have a broker or agent doing business in the US
- The foreign insurer could have, under the same corporate umbrella, a technically unrelated sister entity that does business in the US
- The foreign insurer could use a US-based third party administrator to process its claims[1]

In any of the foregoing fact situations (and undoubtedly others), even if the courts were to deny extraterritorial application of Section 111, it remains to be seen whether a foreign insurer might be subject to indirect enforcement of Section 111 through an affiliate or agent. In addition, a foreign insurer that markets its products in the US, which might otherwise be inclined to ignore its Section 111 reporting responsibilities, might be justifiably concerned that a technical violation of Section 111 would result in its name appearing on a list of violators and tarnish its reputation.

Conclusion

The possible extraterritorial application of Section 111 is but one of the difficult legal questions that will need to be addressed by CMS, and perhaps the courts, in the months and years ahead. All foreign insurers who pay claims to US residents would be well advised to monitor CMS's forthcoming public releases for further guidance on these complex issues.

1. Section 111 provides that TPAs are RREs only for GHPs, and not for NGHPs.

Ringing the Changes: The Third Party (Rights Against Insurers) Bill and Proposed Reform of the Third Parties (Rights Against Insurers) Act 1930

On 23 November 2009, the Third Parties (Rights Against Insurers) Bill (the Bill), sponsored by Lord Bach, was introduced to the House of Lords. The Bill gives effect, with some minor modifications, to the recommendations set out in the Law Commission report on "Third Parties – Rights against Insurers" (Law Com No. 272). The report highlighted the deficiencies of the current regime under the Third Parties (Rights against Insurers) Act 1930 (the Act) and proposed a number of changes aimed at making it easier, quicker and less expensive for a third party claimant to recover compensation from the insurer of a defendant who is insolvent or subject to an insolvency procedure.

Background

Under general legal principles, if a party incurs an insured liability to a third party, the third party usually will be able to sue the insured, and that liability be covered by the relevant insurance policy. However, if the insured is insolvent or becomes insolvent before the third party is paid, under insolvency law the insurance money becomes an asset in the insolvent estate of the insured and is instead used to increase the amount paid to other creditors. The purpose of the Act was to resolve this problem by transferring the insured's rights against the insurer to the third party.

However, since 1930, both insurance and insolvency law has evolved and the Act now does not work as well as it should. The Bill seeks to address the Act's shortcomings and create a system which does not place such onerous obligations on the third party.

Proposed Reforms

Some of the key changes proposed by the Bill are outlined below.

Proceedings

Under the Act, a third party must first issue proceedings against the insured in order to establish its liability before being able to proceed against the insurer for payment. The Bill allows the third party to issue proceedings directly against the insurer and resolve all issues (including the insured's liability) within those proceedings. It does specify, however, that before enforcing its rights, the third party must establish the insured's liability but, as stated above, the liability of the insured and the insurer may be established in a single set of proceedings. This means that a third party will not be deterred by the prospect of initiating two sets of proceedings which can be costly and time-consuming.

Where the Insured is a Defunct Company

Under the Act, if the insured is a defunct body (that is, a company which has been struck off the register of companies), and was struck off before liability was established, the third party must first take steps to restore the company to the register before issuing proceedings against it. The Bill removes this requirement and in so doing, prevents further wasted time and cost for the third party.

Rights to Information

Under the Act, whether or not the third party is entitled to have access to certain information regarding the insured's policy has been the subject of some judicial debate. The Bill improves and clarifies this position by setting out a detailed procedure by which the third party can obtain information before commencing proceedings against the insurer.

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By Antony Woodhouse and Sarah North
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"There is some doubt as to whether the Bill will complete this process before the next general election and so the long-anticipated reform to the Act may well be waiting in the wings for some time to come."

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The third party will be entitled to request information from parties other than the insurer and the insured, which will therefore include, most significantly, brokers. This means that the third party will be able to make an informed decision as to whether or not to proceed with the claim and is therefore likely to reduce speculative and unfounded claims. This will, however, impact on the insurer who will, in all likelihood, take on the administrative burden of providing such information.

Defences Available to Insurers

The provisions of the Act ensure that the third party is not in a better position in relation to the insurer than the insured itself would have been. This means that the insurer can rely on the same defences in defending any claim by a third party as it would have done against the insured. The position remains the same under the Bill, with three notable exceptions which remove some of the more technical defences upon which an insurer may currently rely:

- Where there is a condition requiring the insured to take specific action (such as, for example, giving notice of a claim), it will be deemed satisfied if the third party takes that action.
- Where there is a condition requiring the insured to provide ongoing information and assistance to the insurer once the insurer has notice of the claim, if the insured is incapable of fulfilling such a condition (for example, because it is a company that subsequently has been dissolved, or a person who has died), the rights transferred to the third party will not be subject to that condition.
- Where there is a "pay first" clause, requiring the insured to pay sums due to the third party as a result of liability before any right to indemnity from the insurer can arise, the clause will not apply to the rights transferred to the third party.

Preservation of Rights

Limits on Rights Transferred

The Bill preserves the limitation on the rights of the third party which prevent it from recovering any amounts in excess of the insured's liability. The rights of the insured are preserved in respect of any amount that is due under the insurance policy, but not payable to a third party – for example, where the insurer is obliged to indemnify the insured in full as well as to reimburse it for costs incurred in mounting a defence to the third party's claim or in seeking advice on whether a third party's claim is likely to be successful. Such costs would be payable under the policy, but are not recoverable by the third party.

Set Off

The Bill preserves the insurer's right to deduct sums owed to it (for example, as a result of unpaid premiums) from the amount payable to the third party, to the extent that it would have been entitled to do so had the claim been brought directly by the insured.

Scope of the Bill

The provisions of the Bill apply not only to cases where the insured has become insolvent, but also when it is facing financial difficulties and enters into certain alternatives to insolvency, such as voluntary arrangements between the insured and the insured's creditors. Such changes reflect the development of insolvency law since 1930.

The Bill clarifies the doubts surrounding coverage of voluntarily-incurred liabilities, such as legal expenses insurance, health insurance and car repair insurance. Under the Act it is unclear whether such liabilities are covered.

The Bill specifically states that it does not apply in cases where the liability is incurred under a contract of reinsurance.

Future of the Bill

The Bill received its second reading in the House of Lords on 9 December 2009 and has now been committed to a Special Public Bill Committee. The Bill was scheduled to pass the committee stage and move to the report stage on 22 February 2010 and then receive its third reading in the House of Lords. Only then will it be sent to the House of Commons for consideration. There is some doubt as to whether the Bill will complete this process before the next general election and so the long-anticipated reform to the Act may well be waiting in the wings for some time to come.

Lehman Case Blows a Hole in FSA's Client Money Rules


By Peter Fidler, Melissa Oxnam and Kendall Evans
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Protecting clients' money and assets has been a pillar of the UK financial regulatory regime. The obligation on regulated entities to *"...arrange adequate protection for clients' assets when it is responsible for them"* is enshrined in Principle 10 of the Principles of Business Sourcebook of the Financial Services Authority (FSA) Handbook. The FSA has made rules to protect client money by requiring FSA regulated entities to hold such money in trust accounts (the Client Money Rules). Client money held in a trust account is protected in the event of the insolvency of the regulated firm because it is ring fenced and does not form part of the insolvent estate available to pay the general pool of creditors.

The Client Money Rules are contained in the FSA's Client Assets Sourcebook (CASS). CASS chapter 5 contains the client money rules that apply to firms carrying out insurance mediation activities and, broadly, CASS chapter 7 contains the rules applicable to firms carrying out investment services and activities.

The recent case of *Lehman Brothers International (Europe) v CRC Credit* [2009] EXHC 3228 (Ch) has highlighted that the Client Money Rules are patently flawed and ultimately only provide protection for client money to the extent that firms comply with the rules. Whilst the case considers CASS 7 and is therefore directly relevant to investment firms and their clients, a number of the issues equally apply to CASS 5 and therefore insurance intermediaries and their clients.

The *Lehman* Case

Mr Justice Briggs' judgment in the *Lehman* case considered issues relating to the identification and distribution of the client money held by Lehman Brothers International (Europe) (LBIE) when it was placed into administration. At that time LBIE had credit balances totalling US$2.16 billion in accounts exclusively for segregating client money. When segregating client money LBIE used the so-called "alternative approach" allowed by CASS 7. This involved LBIE receiving and paying client money into and out of its house accounts on the basis it was obliged to perform daily reconciliations of client money and to transfer money to top up or reduce the sums held in its segregated client accounts.

However, LBIE was extremely lax when reconciling client money for its affiliates. Mr Justice Briggs has described its failure as "truly spectacular" and involving "shocking underperformance". The judgment limits the recovery of claims in the LBIE insolvency by clients who may have assumed that their assets were protected. We consider below a number of the key issues and the extent to which they undermine the protection afforded by the Client Money Rules.

Failure to Segregate

First, the judge considered the time when the trust in respect of client money arose and what use LBIE could make of such money pending segregation. Did it arise when LBIE received client money or when it segregated it? If the latter, was LBIE free to use the money as it wished pending segregation? It was held that where client money was received from, or for the account of, a client, the trust arose when the monies were received by LBIE. If it had arisen only on segregation there would have been a gap between receipt and the time when the monies were segregated. Where client money is received by a firm, it does not cease to be client money on receipt and only become client money again on segregation.

Pooling of Client Money

CASS rule 7.9.6 states that client money held in each client money account of the firm is treated as being pooled on the failure of a firm. One effect of this rule is that even where a segregated client account is used specifically for one client and the whole of the money in that account belongs to that client, on the failure of the firm the money in that account is pooled with all other client money, so that if there is an overall shortfall of client money in the pool, the rights of the client who was entitled to the segregated account will reduce along with all other clients.

In the *Lehman* case, the court considered whether the client money pool included all identifiable client money or only client money which had in fact been segregated in accordance with the Client Money Rules. It held that when the primary pooling event (referred to in the judgment as a PPE) occurred, ie the insolvency of LBIE, the client money pool consisted only of client money actually held in segregated accounts.

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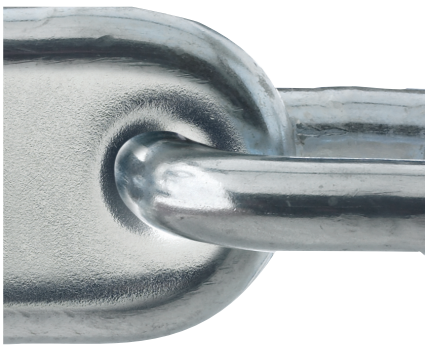

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The judge held that there was no requirement to top up the client money pool after a PPE to make good a shortfall arising as a consequence of events happening after the date of insolvency (for example, because open positions have improved since the time of last segregation), since this would cause inroads into the principle of pari passu distribution of the company's assets to unsecured creditors on an insolvency. Thus any shortfall caused by money being held outside the client money pool represented an unsecured claim against the firm except where the money was identifiable and could be traced.

Shortfalls in client money can occur in a number of different ways and, in the earlier case *Re Global Trader Europe Ltd (No* 1) [2009] EWHC 602 (Ch), a shortfall occurred for a totally different reason, namely the firm's bankers failing to effect the firm's instruction to make a balancing payment to correct a payment that was mistakenly made out of its segregated account.

Calculating Clients' Shares

The court in the *Lehman* case also considered the basis upon which clients' shares in the client money pool were to be calculated. It was held that clients' rights were to be assessed by reference to the amount of client money which had in fact been segregated (the "contribution basis"), not by reference to the amount which should have been segregated (the "entitlement basis").

Mr Justice Briggs then considered the correct date for calculating clients' shares in the client money pool. The two golden rules which apply where parties share in an insolvent fund are (i) that the same date must be used for calculating all parties' entitlements, and (ii) that the calculation should be made as soon as possible. In a company insolvency, the date for calculating claims against the fund of assets is the date of the winding-up order. The judgement followed the decision in the *Global Trader* case that in administration this was the date of the administration order.

Gains accruing because of movements in currencies or the closing of open positions after the date of administration, are pooled into the common fund and all clients benefit or lose rateably according to whether the size of the fund goes up or down.

Set off

Finally, did LBIE have any right to set off its claims against clients' entitlements to client money? The judge found that a client's proprietary right to receive a share of the money in the client money pool was a right as beneficiary against LBIE as trustee of the trust. The client money pool was a trust fund of which the clients were the beneficial owners. Insolvency set-off was only available where there was a debtor-creditor relationship in both directions, not where one of the parties had a proprietary claim for the delivery of its property. Accordingly, LBIE could not set-off its claims against clients against their client money entitlements.

The amounts at stake in the *Lehman* case are substantial and an appeal was filed on 15 January 2010.

"The FSA has concluded that there is still a significant amount of work for firms to do in order to ensure clients' money and assets are adequately protected."

HM Treasury Consultation Paper

On 16 December 2009 HM Treasury issued a consultation paper entitled *"Establishing resolution arrangements for investment banks"* (the Treasury Paper) on various proposals to improve the regime around the failure of investment firms and to protect and enhance the UK's reputation for investment banking business. The proposals include suggestions with regard to the operation of client money accounts and the protection of client assets, which are likely to result in changes to the Client Money Rules.

The Government is also considering creating a client assets agency for pre-insolvency supervision of client money.

FSA Client Money and Asset Report

Following visits over the previous six months to a range of investment and insurance broker firms, the FSA published a report (the FSA Report) on 19 January 2010, identifying a number of failings in firms' compliance with the Client Money Rules. The FSA believes that the failings identified at these firms is indicative of weaknesses across the market. Weak areas discovered included: poor management oversight and control; lack of establishment of trust status for segregated accounts; and incomplete or inaccurate records, accounts and reconciliations (especially relevant considering the *Lehman* case). As a result, the FSA intends to put in place arrangements to raise the level of awareness across the market of compliance with the Client Money Rules.

The FSA intends to work on the following in 2010:

- Increased firm visits, exercising regulatory intervention where it finds CASS failings and producing a further report of the findings later in 2010.
- Improving the standards of CASS audits. The FSA is now working with the professional standards section of the Institute of Chartered Accountants in England and Wales (ICAEW) to create referral arrangements for the ICAEW to investigate cases where the FSA has concerns surrounding the CASS audit report.
- Reintroducing client money reporting.
- Working closely with HM Treasury to publish an FSA consultation paper on amendments to the CASS rules in the first quarter of 2010 addressing the failings raised by the *Lehman* case.

The FSA has concluded that there is still a significant amount of work for firms to do in order to ensure clients' money and assets are adequately protected. Following the FSA's visits in 2009, it took a large number of regulatory actions.

Recommendations

The *Lehman* case highlights the risks associated with depositing client money with an investment firm or insurance intermediary, where the firm does not comply with the Client Money Rules. However, it should be noted that the "alternative approach" (described above) allowed for investment firms under CASS 7 is not available to insurance intermediaries under CASS 5, therefore, the risk of client money not being segregated and consequently a shortfall arising should be lower.

Pending the outcome of any appeal and probable changes to the CASS rules resulting from the Treasury Paper and the FSA Report, clients can improve their protection by carrying out the following:

- Clients may specify where client money is to be deposited, for example by requesting that money be placed in a "designated client bank account" with a specific bank that they have satisfied themselves is not at risk of insolvency. If another bank which holds client accounts for a firm fails, then the account will not be pooled. However, if the firm fails, the designated account will be pooled with other client accounts and, therefore, subject to any shortfall.
- Clients of investment firms should specify that the firm can only use the normal approach rather than the alternative approach, so that all client money will go straight into a segregated client account rather than through the firm's house account.
- Clients should carry out thorough due diligence in relation to the client money deposited, to ensure that it is being held in a segregated account.

The Attorney-Client Privilege in Ohio Bad Faith Actions: A Legislative Fix in Doubt

Many insurers with experience defending themselves in lawsuits initiated by their insureds understand that the attorney-client privilege is not absolute. There are several different contexts in which courts will allow parties involved in litigation against insurance companies to view attorney-client communications.[1] Claims of insurance bad faith present perhaps the most serious challenge to the attorney-client privilege, and for many years, Ohio courts have been in the forefront in ordering disclosure of attorney-client communications to litigants asserting insurance bad faith claims.

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Under Ohio common law, the protection for some of an insurer's attorney-client communications evaporates whenever a party merely asserts a claim of bad faith against the insurer. No *prima facie* showing of bad faith is necessary before the documents must be disclosed; it is enough that the pleadings contain the phrase "bad faith."

The potential mischief created by such a rule is self-evident. Any incautiously or inartfully phrased communication between insurer and coverage counsel, however innocent, may be seized upon as evidence of bad faith. There is a real threat of such a communication becoming a star trial exhibit, which will only serve to drive up settlement costs.

In 2007, the Ohio legislature attempted to modify Ohio common law by requiring a *prima facie* showing of bad faith before an insurer's attorney-client communications must be disclosed. Unfortunately, while the legislative intent was clear, the amendment to the statute was less so. A recent decision in the Southern District of Ohio interpreting the amended statute indicates that Ohio's broad approach to discovery in insurance bad faith cases may have survived the legislature's attempts to blunt its effect.

Boone and *Moskovitz*: A Doctrine of Broad Disclosure

In 2001, the Supreme Court of Ohio issued its decision in the case of *Boone v. Vanliner Ins. Co*[2]. In *Boone*, the plaintiff, a truck driver, brought a declaratory judgment action against his insurer when the insurer denied uninsured motorist coverage in connection with an accident. The complaint included a bad faith claim. During discovery, the plaintiff sought access to the insurer's claims file. In response, the insurer filed a motion for a protective order on the basis that (among other things) several of the documents sought were protected by the attorney-client privilege. Following an in camera inspection of the documents, the trial court ordered the insurer to disclose many of the documents containing attorney-client communications.

On the insurer's appeal of the discovery order, Ohio's Tenth District Court of Appeals found that the documents in question were protected by the attorney-client privilege, and reversed the trial court's order that the documents be disclosed. Subsequently, the Supreme Court of Ohio allowed the plaintiff to pursue an appeal of the Court of Appeals' decision.

In a 4-3 decision, the Supreme Court of Ohio reversed the decision of the appellate court and declared that the attorney-client communications in question were not protected by the attorney-client privilege. In its decision, the court relied upon its earlier decision of *Moskovitz v. Mt. Sinai Med. Ctr.*[3] In *Moskovitz*, a successful medical malpractice action, the prevailing plaintiffs sought prejudgment interest under a statute that allowed such interest if the plaintiffs could show that the defendant had not attempted to settle in good faith. The court permitted discovery of the claims file of the defendant's insurer, reasoning that "documents and other things showing the lack of a good faith effort to settle by a party or the attorneys acting on his or her behalf are wholly unworthy of the protections afforded by any claimed privilege."[4] On that basis, the court held in *Moskovitz* that in all proceedings under the prejudgment interest statute, an insurer's claims file is not protected by the attorney-client privilege.[5]

The *Boone* court found the *Moskovitz* reasoning to be applicable to claims of bad faith denial of coverage. Specifically, the court found that "claims file materials that show an insurer's lack of good faith in denying coverage are unworthy of protection." Therefore, the court held that in an action alleging bad faith denial of coverage, "the insured is entitled to discover claims file materials containing attorney-client communications related to the issue of coverage that were created prior to the denial of coverage."[6]

The *Boone* Dissent

The three dissenting justices in *Boone* criticized the majority holding (as well as the *Moskovitz* decision) as "unsupported" and lacking a "reasoned basis." Specifically, the dissent compared the rule espoused by the majority to the crime-fraud exception to the

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Endnotes

1. For a more comprehensive examination of the variety of exceptions to the attorney-client privilege, see Laurie A. Kamaiko and Sarah D. Katz, *The Eroding Privilege of an Insurer's Communications with Its Coverage Counsel*, EDWARDS ANGELL PALMER AND DODGE INSURANCE AND REINSURANCE UPDATE, June 2007.
2. *Boone v. Vanliner Ins. Co.*, 91 Ohio St.3d 209 (2001).
3. *Moskovitz v. Mt. Sinai Med. Ctr.*, 69 Ohio St.3d 638, 635 N.E.2d 331 (1994).
4. *Id.*, 69 Ohio St.3d at 661, 635 N.E.2d at 349.
5. The court made an exception for communications that go directly to the theory of defense in the underlying case in which the decision or verdict has been rendered.
6. The court reasoned that a lack of good faith in determining coverage involves conduct that occurs when coverage is being assessed; therefore, documents post-dating the denial of coverage could not be relevant to the issue and remain privileged.
7. *Boone*, 91 Ohio St.3d at 217 (*citing, State ex rel. Nix v. Cleveland*, 83 Ohio St.3d 379, 384, 700 N.E.2d 12 (1998)).
8. *Id.*
9. *Id.* (emphasis in original).
10. *Id.* at 217 and n. 8, citing, Dion v. Nationwide Mut. Ins. Co., 185 F.R.D. 288 (D.Mont.1998); *Ferrara & DiMercurio, Inc. v. St. Paul Mercury Ins. Co.*, 173 F.R.D. 7 (D.Mass.1997); *Dixie Mill Supply Co., Inc. v. Continental Cas. Co.*, 168 F.R.D. 554 (E.D.La.1996); *Tackett v. State Farm Fire & Cas. Ins. Co.*, 653 A.2d 254 (Del.1995); *Aetna Cas. & Sur. Co. v. San Francisco Superior Court*, 153 Cal. App. 3d 467 (1984); *Hartford Fin. Serv. Group, Inc. v. Lake Cty. Park & Recreation Bd*, 717 N.E.2d 1232 (Ind.App. 1999); *Maryland Am. Gen. Ins. Co. v. Blackmon*, 639 S.W.2d 455 (Tex.1982).
11. *Id.* at 218.
12. Ohio St.3d 164 (1986). *Peyko*, like *Moskovitz*, involved the issue of bad faith failure to settle under the prejudgment interest statute.
13. S. 126-117, 2005-06 Regular Session, at 15 (Ohio 2005)
14. The introductory clause was part of the statute prior to amendment.
15. The amendment is codified at Ohio Rev. Code 2317.02(A)(2).
16. The trial judge affirmed the order of the magistrate judge without further analysis of the amendment.
17. *In re Professionals Direct Ins. Co.*, 578 F.3d 432 (6th Cir. 2009).
18. *Id.*, 578 F.3d at 441.

attorney-client privilege. Under the crime-fraud exception, the attorney-client privilege does not protect communications between a client and attorney when made for the purpose of committing or continuing a crime or fraud. The dissent pointed out that in order to overcome the attorney-client privilege based on the crime-fraud exception, a party must demonstrate "a factual basis for a showing of probable cause to believe that a crime or fraud has been committed and that the communications were in furtherance of the crime or fraud."[7] In contrast, the decision in *Boone* requires "no similar *prima facie* showing of bad faith before an insurer is entitled to discover attorney-client communications of the insurer."[8] Rather, an insured "need only *allege* the insurer's bad faith in the complaint in order to discover communications between the insurer and the insurer's attorney."[9] The dissent went on to note that a number of other jurisdictions had refused to adopt such a sweeping exception to the attorney-client privilege.[10]

In closing, the dissent warned that an insurance company seeking advice from an attorney regarding a coverage issue "will now have to consider the possibility that those communications will be subject to future disclosure in the event that coverage is denied and the insured commences a bad-faith lawsuit."[11]

The Ohio Legislature Attempts to Modify the Rule in *Boone*

Following the decision in *Boone*, in 2007 the Ohio legislature passed a law to modify the section of its evidence statute addressing privileged communications. The Ohio legislature clarified that its aim was to modify the common law rule regarding attorney-client communications adopted by the Ohio Supreme Court in *Moskovitz* and extended in *Boone*. Specifically, the bill directing the statutory amendment contains the following statement of legislative intent:

SECTION 6. The General Assembly declares that the attorney-client privilege is a substantial right and that it is the public policy of Ohio that all communications between an attorney and a client in that relation are worthy of the protection of privilege, and further that where it is alleged that the attorney aided or furthered an ongoing or future commission of insurance bad faith by the client, that the party seeking waiver of the privilege must make a prima facie showing that the privilege should be waived and the court should conduct an in camera inspection of disputed communications. The common law established in Boone ... Moskovitz ... and Peyko v. Frederick [12]*... is modified accordingly to provide for judicial review regarding the privilege.* [13]

Even if the Ohio legislature had not addressed *Boone* and *Moskovitz* by name, the bill is clearly designed to address the doctrine espoused by those decisions. The bill's declaration that attorney-client communications are "worthy of the privilege of protection" is a direct echo of, and likely a response to, the statements in *Moskovitz* and *Boone* that attorney-client communications in a claim file that might contain evidence of bad faith are "wholly unworthy" of such protections. In addition, by requiring a party seeking waiver of the privilege to first make a *prima facie* showing of bad faith, the bill appears to respond to the dissent in *Boone* which pointed out that such a *prima facie* showing must be made in order to invoke the crime-fraud exception. Finally, the bill's expression of intent that the court should conduct an "*in camera* inspection of disputed communications" is a clear reference to documents.

Unfortunately, the rule in *Boone* and the blanket discoverability of claim files in bad faith disputes may not have expired with the passage of the new law. While the statement of legislative intent is clear, the actual modifications to the evidence statute are less so. The bill added the following language to the statute:

The following persons shall not testify in certain respects: [14]

An attorney, concerning a communication made to the attorney by a client in that relationship or the attorney's advice to a client, except that if the client is an insurance company, the attorney may be compelled to testify, subject to an in camera inspection by a court, about communications made by the client to the attorney or by the attorney to the client that are related to the attorney's aiding or furthering an ongoing or future commission of bad faith by the client, if the party seeking disclosure of the communications has made a prima facie showing of bad faith, fraud, or criminal misconduct by the client. [15]

The amendment to the statute is ambiguous as to whether its application is restricted to attorney *testimony,* or whether it applies to disclosure of *documents* as well. While the amendment mentions "disclosure of the communications," which seems to refer to documents, the amendment as a whole may be read as only addressing whether an attorney may be compelled to testify. Due to this ambiguity, in 2008 a federal district court applying Ohio law to an insurance bad faith action ordered the production of documents containing attorney-client communications without requiring a *prima facie* showing of bad faith – in effect, applying the *Boone* doctrine as though the Ohio legislature had not expressly modified it.

The *PDIC* Discovery Order

In 2008, a Magistrate Judge in the United States District Court for the Southern District of Ohio issued a discovery order in an action entitled *Professionals Direct Insurance Co. (PDIC) v. Wiles, Boyle, Burkholder & Bringardner Co., LPA,* Civil Action No. 2:06-cv-0240 (S.D. Ohio). In PDIC, the plaintiff insurer brought a declaratory judgment action against its insured, a law firm, to resolve a coverage dispute regarding the availability of coverage for a malpractice action under the insured's professional liability policy. The insured counterclaimed for bad faith, and sought production of the claims file. When the insurer objected to producing certain attorney-client communications, the insured moved for a discovery order compelling production of the disputed documents.

The court held that *Boone* required disclosure of attorney-client communications that pre-date the denial of coverage. To the insurer's argument that the amended evidence statute required a *prima facie* showing of bad faith prior to the privilege being waived, the court responded, "On its face, [the amendment] applies only to testimony. It does not mention documents." The court did not address the statement of legislative intent, even though the insurer had cited it in its brief.

The Sixth Circuit Declines to Interpret the Amendment

Following entry of the discovery order, the insurer petitioned the Sixth Circuit Court of Appeals for a writ of mandamus to vacate the order [16]. The Sixth Circuit declined to do so [17], holding that the order of the trial court was not clearly erroneous. However, the Sixth Circuit did not expressly approve the lower court's interpretation of the amendment to Ohio's evidence statute. Rather, the appellate court found that the amendment, which became effective October 31, 2007, did not apply retroactively and thus did not apply to the *PDIC* litigation, which was filed prior to that date. Finding the amendment inapplicable, the Sixth Circuit declared that "we need not interpret its scope."[18]

An Uncertain Future

To date, the Southern District of Ohio is the only court to interpret the scope of the 2007 amendment to Ohio's evidence code. Unfortunately, due to the ambiguous wording of the amendment, the federal court preserved the rule in *Boone*. If and when an Ohio state court has an opportunity to interpret the amendment, it may choose to give the amendment a more expansive reading and fulfill the intention of the Ohio legislature that the *Boone* doctrine be modified. For now, however, an insurer handling a claim with any connection to Ohio must assume that any communications with its coverage counsel will be subject to disclosure.

Wave goodbye to inherent vice exclusions?

Global Process Systems v Syarikat Takaful Malaysia Berhad in the Court of Appeal

In late 2009, the Court of Appeal handed down a judgment which added to a large body of case-law on inherent vice. A key principle in the law of marine insurance, loss caused by inherent vice is typically excluded from cover under *"all-risks"* policies of cargo insurance. The Court of Appeal unanimously overturned the first instance decision of the Commercial Court, finding in favour of the claimant insured, and narrowing the test used to determine whether damage sustained by the cargo of a vessel was caused by inherent vice, or the covered "*perils of the sea*".

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The claimants in *Global Process Systems Inc & Anor v Syarikat Takaful Malaysia Berhad* [2009] EWCA Civ 1398 purchased a jack-up oil rig in May 2005, with hopes of converting it into a mobile offshore production unit. Carried on a barge with its legs extended 300 feet in the air, the rig was transported from Texas, around the Cape of Good Hope, to its new home in Lumut, off the coast of East Malaysia.

At some point north of Durban, the starboard leg succumbed to fatigue cracking, caused by the repeated bending of the legs under the motion of the barge as it was towed. Within hours, the remaining two legs (under increased pressure after the first leg had come apart from the rig) had also broken off, and all three fell to the bottom of the sea, leaving the rig in need of substantial and costly repairs. Expert evidence given at the trial suggested that, on its own, a developed crack would not be sufficient to cause a leg to come off. A 'leg-breaking' stress was required in addition, causing the final fracture.

Incorporating Institute Cargo Clauses (A), the claimant's insurance was stated to cover "*all risks of loss or damage*" except that *"caused by inherent vice or nature of the subject matter covered*". A dispute therefore ensued as the insurer claimed the loss of the legs was due to inherent vice, and the insured submitted that the immediate cause of loss was a leg-breaking wave (a "peril of the sea"). The key issue to be decided was whether the proximate cause of the loss was an external factor (ie the weather conditions) or the inherent vice of the rig itself.

First Instance Judgment

At first instance, Mr Justice Blair, relying on the judgment of Mr Justice Moore-Bick in *Mayban General Assurance BHD v Alstom Power Plants Ltd* (2004) EWHC 1038 (Comm), held that the proximate cause of loss was the fact that the legs were not capable of withstanding the normal incidents of the insured voyage from Texas to Lumut, including the weather *"reasonably to be expected"*.

In the absence of a statutory definition of inherent vice, Lord Diplock's definition from *Soya GmbH Mainz KG v White* (1983) 1 Lloyd's Rep 122 HL was accepted by both parties. This states that inherent vice is:

"...the risk of deterioration of the goods shipped as a result of their natural behaviour in the ordinary course of the contemplated voyage without the intervention of any fortuitous external accident or casualty."

As such, Blair J found that the loss fell within the inherent vice exclusion and was not covered by the policy.

Court of Appeal Judgment

The key issue to be decided on appeal was whether inherent vice was the sole and proximate cause of the loss, as the insurers claimed, and therefore whether or not the loss was excluded under the *"all-risks"* policy. This required an examination of other possible causes, and whether they could be considered proximate. In the shipping context of this case, the other possible causes of the loss were the conditions of the voyage, and more specifically the weather encountered by the vessel carrying the rig.

Lord Justice Waller, having considered the authorities on this point, held that *"...it is only if a peril insured against is not a proximate cause that inherent vice can be the sole and proximate cause". The most relevant "peril insured against"* in this case, was a *"peril of the sea"*, ie a fortuitous external accident or casualty caused by the weather experienced by the vessel at sea.

As noted, at first instance Blair J made reference to the inability of the legs to withstand the weather *"reasonably to be expected"*. On appeal, Waller LJ narrowed the range of weather conditions which would be considered an *"ordinary incident"* of the voyage, to those which would be *"bound to occur"*. Waller LJ explained that the answer to the question of whether a loss was caused by inherent vice:

"...cannot be found by reference to what might reasonably be foreseeable as the ordinary incidents

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PRESENTATION

Vincent J Vitkowsky will be speaking on the issue of whether Khalid Sheikh Mohammed and the other 9/11 terrorists should be tried in civilian courts or before military commissions.

Vincent will repeat this presentation in various cities across the US, including New York, Hartford, Philadelphia and Albany.

To find our more about this presentation and obtain further details on dates and locations please contact Vincent Vitkowsky directly by emailing VVitkowsky@eapdlaw.com

of that voyage, but by reference to wind or wave which, it would be the common understanding, would be bound to occur as the ordinary incidents on any normal voyage of the kind undertaken."

It was therefore only in cases where the weather encountered was *"bound to occur"* as part of the voyage in question that it could be said that inherent vice was the sole and proximate cause of the loss. In the present case, a leg-breaking wave caused the starboard leg to fall off. Although with the benefit of hindsight, this incident may have been highly probable, that *"high probability was unknown to the insured and that was a risk against which the appellants insured."* There was an external and fortuitous event which was the sole and proximate cause of the loss and therefore inherent vice could not apply to exclude cover under the policy. Accordingly the appeal was allowed and the decision of Blair J reversed.

Significance of this Decision

At the time of writing, no notice has been filed indicating an intention to appeal to the Supreme Court, and no reference was made in the judgment to permission to do so.

The judgment in *Global Process* narrows the test for inherent vice and broadens the range of events which may be considered fortuitous external accidents. It is now clear that inherent vice will not be deemed the sole proximate cause of a loss simply because the other external events experienced were *"reasonably to be expected"*. This may make it easier for an insured to defend an insurer's claim that cover is excluded from an "all-risks" policy because the loss was due to inherent vice.

Although this case concerned marine cargo insurance, the decision will have ramifications for insurers of other classes of business in which inherent vice exclusions are common, for example property insurance. Insurers should be wary of placing too much reliance on an inherent vice exclusion in circumstances where there are other events which were not *"bound to occur"* that may have caused the loss.

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