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THE BRITISH CHAPTER OF AIDA,  
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FOR INSURANCE LAW



# NOTICEBOARD

## **Lunchtime Lecture Dates**

All commence at 13.00 and are held in the Old Library at Lloyd's  
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18 November, 2011

9 December, 2011

20 January, 2012

17 February, 2012

16 March, 2012

20 April, 2012

18 May, 2012

15 June, 2012

20 July, 2012

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# EDITORIAL

## **Welcome to Victoria Anderson**

I am very pleased that Victoria Anderson of Edwards Wildman Palmer UK LLP has agreed to become deputy editor of the BILA Journal. She and I worked together on the preparation of this issue.

## **BILA book and article prizes**

The BILA book and article prizes were announced at the Annual General Meeting on 14 October 2011. The book prize was won by Dr Judith Summer for “Insurance law and the Financial Ombudsman Service” which was reviewed in issue 121 (March 2011) of the Journal. The article prize was won by Nina Tulloch of Hogan Lovells International LLP for her article “Pleural plaques: the North South divide” which appeared in issue 122 (June 2011). Congratulations to both these lawyers for their outstanding achievements.

The rules for both prizes, which are awarded on an annual basis, will be found inside the back cover.

## **Articles in this issue**

### *Regulatory reform*

The first article in this issue is by Laura Hodgson and Simon Baker of Norton Rose LLP. It describes and comments on the government’s proposals for a new financial services regulatory regime, which will include insurance.

This is followed by an article by Chris Finney of Wragge and Co, which completes the picture, as it were, by describing the new European insurance regulatory framework and preparations for the Solvency II regime.

My own contribution on the subject of late payment of insurance claims comes in naturally here, since it considers whether reform of the relevant law should be achieved by statute or by regulation. It discusses the political as well as the legal issues.

### *Cyber risk presentations and mock trial*

BILA held a half day event on 22 June focusing on cyber risk. It included presentations on legal and technical aspects of the subject and the acting out of a cyber risk “fact scenario” at Freshfields Bruckhaus Deringer LLP. This was followed by a mock trial on that scenario at the Law Courts, presided over by Sir Richard Aikens.

Laura Crowley of 4 Pump Court describes this event in her article. Sir Richard has kindly approved the transcript of the “judgment” which he gave in the case (which of course has no official status). Videos of the presentations and of the mock trial are also accessible on the BILA web site at <http://www.bila.org.uk/about/video.asp>.

### *Consumer insurance and the duty of disclosure*

Peter J Tyldesley traces the historical background to the duty of disclosure which arises in, among others, consumer insurance contracts. He questions whether such a duty should ever have been imposed on consumers.

It is hoped to include an article on the Consumer Insurance (Disclosure and Representations) Bill (or Act as it may be by then, depending on its progress) in the next issue.

### *Environmental issues*

There are two articles on environmental issues. Tim Hardy describes the work that he and his colleagues have done within the Association Internationale de Droit des Assurances (AIDA) on legal issues arising from climate change.

Daniel Saville of Reynolds Porter Chamberlain discusses the insurance and reinsurance issues arising from the 2011 Japanese earthquake. He focuses on their treatment under the Japanese Insurance Act. He has previously covered these topics at a BILA presentation earlier this year.

### *Litigation funding*

James Fallon of TheJudge Limited considers options for transferring litigation risk using a variety of techniques, including after the event insurance, third party funding and litigation buyout insurance. His article follows a lunchtime BILA presentation by his colleague James Blick earlier this year.

### *Marine insurance*

Finally there is an article by James Barriga, a student at Southampton University, which discusses the judgment of the Court of Appeal in *Masefield v Amlin* on the subject of cover for piratical seizure and the law of total loss.

**Jonathan Goodliffe**  
**Editor**  
**journal@bila.org.uk**

## **Insurers and the “twin peaks” regulatory system – are two heads really better than one?**

By Laura Hodgson and Simon Baker, Norton Rose LLP

### **Summary**

Following the catastrophic collapse of financial markets in 2008, both national and regional governments, as well as international organisations have entered into a soul searching re-examination of how best to supervise financial services. In the United Kingdom this has led to proposals to move towards “twin-peaks” regulation, abandoning the one size fits all approach of the Financial Services Authority (FSA) in favour of two bodies: one with oversight of prudential supervision, the other supervising all conduct of business. This article considers the proposals and the likely impact upon insurers.

### **Proposals**

The Conservative Party first set out its plans to reform the regulation of financial services in the UK in July 2009. The proposals published at that time included abolishing the tripartite system whereby the Bank of England, the Treasury and the FSA share responsibility for national financial stability. In its place, the Conservative Party proposed that both macro and micro-prudential oversight should be given to the Bank of England which, it was argued, was best placed to monitor systemic issues across the financial services sector.

In his first Mansion House speech delivered in June 2010, Chancellor of the Exchequer George Osborne announced that the Coalition Government would move to address what he considered the “spectacular regulatory failure of the City”. He announced that the tripartite regime would be abolished and the FSA would cease to exist in its current form. A new prudential regulator would be created, operating under the supervision of the Bank of England, and an independent Financial Conduct Authority (FCA) would be established to regulate the conduct of firms providing services to consumers. The Government proposed that the process of dismantling the current regulatory system be completed by 2012.

Throughout the consultation period the Government has signalled its adherence to a 2012 deadline. In February 2011, the Treasury Select Committee urged the Government to revisit the Financial Services and Markets Act 2000 (FSMA) in its entirety to ensure a coherent piece of reforming legislation. Later in the same month, the Government published *A new approach to financial regulation: building a stronger system*, in which it confirmed that the reforms would be implemented by amending FSMA. According to the Government, the decision was taken so that the changes could be implemented with greater speed, whilst minimising the disruption to firms that would arise from repealing FSMA and starting with an entirely new Bill. Additionally, the FSA took its first step towards the new regulatory structure in April 2011 by conducting an internal

reorganisation in which the existing Supervision and Risk business units were replaced with a Prudential Business Unit and a Conduct Business Unit.

The proposed reforms have been criticised for failing to pay adequate regard to the regulation of the insurance industry. In light of this criticism the Government has recently given more detail on its plans for insurers. For example, when Hector Sants, FSA Chief Executive, gave a speech on the future of insurance regulation<sup>1</sup>, he was at pains to reassure his audience that he understood the important difference between regulating banks and insurers.

### **The Financial Policy Committee**

One of the main failures in regulatory oversight, identified following the financial crisis, was a lack of macro-prudential scrutiny. To address this perceived failure to spot systemic risks in financial markets, the July 2010 consultation paper entitled *A new approach to regulation: judgement, focus and stability*, proposed the establishment of a body within the Bank of England with primary responsibility for the oversight of financial stability. The Financial Policy Committee (FPC) will have a number of macro-prudential tools available to address systemic risk, including capital and liquidity tools. In response to the Government's proposals, the Treasury Select Committee stressed the need for clarity about what such 'stability' means and cautioned that ensuring the overall stability of the financial system should not mean that no firm will ever fail. Given that the most recent white paper *A new approach to financial regulation: the blueprint for reform* accepts that firm failure is always a possibility, these comments appear to have been noted.

Both the Treasury Select Committee and industry commentators have expressed concerns that the membership of the FPC is too heavily weighted towards banking. The Government has commented that it will gather views on the issue over the period of pre-legislative scrutiny. It has also stressed that, in collaboration with the Bank, it is committed to ensuring an appropriate balance and breadth of experience for both the interim FPC and the permanent body that will replace it. Stakeholders have welcomed the Government's views on the importance of ensuring that external members of the FPC have recent and relevant financial services experience in non-banking areas like insurance.

In order to bring both the macro and micro-prudential oversight of financial institutions within one body, the Prudential Regulation Authority (PRA) will be a subsidiary of the Bank of England. Where the FPC identifies wider market issues which need addressing, it will request that the PRA take regulatory action to address any concerns with individual firms.

### **The Prudential Regulation Authority**

The PRA will be responsible for the micro-prudential regulation of, among others, all deposit taking institutions, insurers and banks. For insurers, its remit will be the oversight of those firms with permission for effecting and/or carrying out contracts of insurance.

A new section will be inserted into FSMA specifying the PRA's insurance objective. This requires the PRA to contribute to the securing of an appropriate degree of protection for those who are, or may become, policyholders. It complies with the Solvency II Directive which requires the protection of policyholders to be the primary objective of supervision. The application of the objective to those who may become policyholders has the potential to cause confusion and it will be interesting to see how it applies in practice. The City of London Law Society has also suggested that further clarification is required on the term "appropriate degree of protection".

The Bank of England and FSA joint paper entitled *The Bank of England, Prudential Regulation Authority - Our approach to insurance supervision* confirms that the PRA will have a concurrent objective under which it will seek to minimise the adverse impact that either the failure of an insurer, or the way it carries out its business, could have on the stability of the system. The objective further demonstrates that under the new regulatory landscape, regulators will not act to prevent firm failure in all circumstances. As the PRA's general objective of promoting the safety and soundness of PRA authorised persons is given the same status as its insurance objective, the "primacy" of the insurance objective has arguably not been achieved.

The PRA will employ a "judgement-based" supervisory approach. Practically, this means that the nature and intensity of the PRA's supervision will be commensurate with the level of risk a firm poses to policyholders and to the stability of the system. The joint paper lists some of the factors that the PRA will consider when judging the risk posed by a firm. For example, whilst there is an acceptance that insurers are not systemic in the same way as banks, the combination of insurance and banking in a single group may give rise to system-wide risk if the failure of the insurer threatens the financial condition of the bank. Furthermore, the investment decisions of insurers can accentuate movements in asset prices and groups containing an insurer may undertake non-insurance activities that bring risk to the system.

Policyholders will be protected by the PRA and the FCA. Essentially, the PRA will look to ensure that an insurer is likely to have sufficient financial resources to meet its obligations to policyholders as they fall due, whereas the FCA's role as conduct regulator will aim to ensure that consumers are treated fairly in all their engagements with insurance firms.

### **The Financial Conduct Authority**

The FCA will have a single strategic objective of protecting and enhancing confidence in the financial system in addition to three operational objectives, namely: securing an appropriate degree of protection for consumers; promoting efficiency and choice in the market for financial services; and, protecting and enhancing the integrity of the financial system. The Government has also proposed that, so far as it is compatible with its

objectives, the FCA must discharge its general functions in a way that promotes competition. There will also be a free-standing duty to have regard to the importance of taking action to minimise the extent to which regulated business may be used for a purpose connected with financial crime. These objectives and the principles to which the FCA should have regard to in discharging them reflect the Government's new approach to regulation in the wake of the financial crisis. Notably, the requirements that the regulator considers the desirability of facilitating innovation and maintaining the competitive position of the UK are no longer included in FSMA. The deletion has been criticised by the Confederation of British Industry (CBI), who have suggested that a regulator that does not need to consider the competitiveness of the market might produce regulation that enhances stability or promotes good conduct while also damaging the market's competitiveness.

In addition to having responsibility for conduct issues, the FCA will be responsible for the prudential regulation of around 24,500 firms that are not regulated by the PRA. This means that insurance intermediaries will be solely regulated by the FCA. The British Insurance Brokers' Association and the Institute of Insurance Brokers have been openly critical of the current regulatory regime stating that the style and intensity of regulation is inappropriate for insurance brokers. They have argued that fundamental reform is essential to allow the FCA to deliver discernable value to regulated firms and their customers. Furthermore, the CBI has cautioned that the differing objectives of the FCA and the PRA could give rise to the potential for differences in their approach to prudential regulation. This could create a two tier regulatory regime for firms within the same industry and may damage competition between firms that are close to the dividing line between being supervised by the FCA or PRA.

The FCA was originally to have been named the Consumer Protection and Markets Authority and was branded a "strong consumer champion". This label was heavily criticised by the Treasury Select Committee who considered it to be inappropriate, confusing and dangerous. The crux of their argument was that the promotion of a regulator as a consumer champion would lead consumers to falsely believe that all financial products are risk free, potentially creating moral hazard. Whilst the Government has renamed the authority it has stressed that the term "consumer champion" should be viewed in the context of the FCA's role as a focused and proactive conduct regulator that is entirely independent and impartial.

The FSA recently published a document entitled *The Financial Conduct Authority: Approach to Regulation*, which confirms that the FCA will focus more closely on wholesale conduct and adopt a more issues and sector-based supervisory approach when compared to the FSA. This will build on changes which the FSA has already made, or to which it has signalled commitment. The essence of the new approach can be illustrated by considering the FSA's response to the mis-selling of payment

protection insurance (PPI). Whilst the FSA intervened robustly to secure redress of consumer detriment, in the future the FCA will look to ensure that fewer such problems develop in the first place. These sentiments signal a commitment to the approach discussed in the FSA's discussion paper *DPI1/1: Product Intervention*, which advocated a supervisory strategy involving earlier regulatory intervention and discussions with firms to ensure that new products serve the needs of the customers to whom they are marketed. The document also considers how the FCA will work effectively with the PRA.

### **Facilitating effective regulatory coordination between the new authorities**

Effective coordination between the FCA and the PRA will be a vital part of the new regulatory framework. To this end, the Government has legislated for a variety of general coordination mechanisms including a statutory duty to coordinate the exercise of the authorities' functions (to be contained in a Memorandum of Understanding), cross-membership of boards and a veto mechanism for the PRA. This is with a view to reducing the risk of regulatory actions by the FCA threatening financial stability or the disorderly failure of a firm.

The general principle underpinning the Government's model of dual regulation will apply to insurance regulation. The FCA will be responsible for supervising the day-to-day conduct of insurance firms in dealing with their customers and clients whilst the PRA will look to promote their long-term soundness and stability. There are, however, certain areas which require further consideration.

### **The regulation of with-profits business**

The Government has inserted a section into FSMA which gives the PRA sole responsibility for securing an appropriate degree of protection for the reasonable expectations of policyholders in regard to their returns under with-profit policies. This necessarily covers conduct as well as prudential issues.

The Government recognises that this is a complex area and emphasises that the PRA will need to consult with the FCA on matters relevant to achieving an appropriate balance between the interests of policyholders and the prudential position of the firm. The Government is in the process of considering whether explicit legislative provision is necessary to ensure efficient coordination between the PRA and the FCA, or whether current provisions in the draft Bill, such as the Memorandum of Understanding, are sufficient.

What remains unclear from the draft legislation is the division of responsibilities between the FCA and the PRA in relation to the Conduct of Business Sourcebook (COBS) 20<sup>2</sup>, some aspects of which might lie more naturally within the remit of the FCA.

## **The regulation of Lloyd's**

In the Government's original consultation paper, the Society of Lloyd's was hardly mentioned and Lord Myners described the consideration given to the regulation of Lloyd's as an "afterthought"<sup>3</sup>. This lack of thought was criticised by the Treasury Select Committee in *Financial Regulation: a preliminary consideration of the Government's proposals*, in which it was argued that Lloyd's merited greater focus than the consultation provided.

The Government has now provided more information on its proposals for the Society. The PRA will be lead regulator for Lloyd's as a whole and the FCA will play a role by regulating member's agents and brokers. The Society of Lloyd's and Lloyd's managing agents will be dual-regulated firms with the PRA responsible for prudential regulation and the FCA responsible for conduct. The FCA will be tasked with the oversight of market conduct and consumer protection.

The division of responsibility will largely follow the division of interests in relation to insurance business or activities but will also have regard to the unique nature of Lloyd's, including the way it operates as a specialist financial market and the distinctive roles played by certain participants in the market. The Memorandum of Understanding, which is yet to be agreed, will set out precisely how the two new regulators will coordinate the exercise of their functions.

## **The authorisation of insurers and approval of individuals**

Firms must apply to the PRA for authorisation if they wish to effect or carry out contracts of insurance. The PRA will administer the application and be responsible for granting authorisation. Authorisation to carry out regulated activities will not be granted unless both the PRA, as prudential regulator, and the FCA, as conduct regulator, are satisfied that it should be. Before granting authorisation, the PRA will assess whether the firm satisfies the relevant statutory threshold conditions.

Interestingly, FSMA has been amended to include a new threshold condition, the so-called "business model" requirement, under which an applicant will need to demonstrate that their strategy for doing business is suitable, having regard to the regulated activities that they seek to carry on. The Bank of England and FSA joint paper explains that the importance of scrutinising firms' business models is one of the key lessons learnt from previous episodes of insurer distress. The requirement is designed to prevent insurers attracting business through aggressive pricing, without setting aside sufficient claim reserves (as occurred in the case of HIH Group and Independent Insurance) and to ensure that a firm's business model does not run ahead of its capital potential (as was the case in Equitable Life). Whilst interesting to note, the practical effect of the amendment may be negligible as firms seeking authorisation are already required to submit a business plan alongside their application.

The PRA will lead on the authorisation process for dual-regulated firms. The PRA and the FCA will seek to minimise the administrative burden on firms of the new authorisation procedures. The joint paper states that there will be a single administrative process with a single application form and timetable for decisions by each authority. Essentially, the paper attempts to provide reassurance to firms that the importance of ensuring that the authorisation process is both clear to applicants and handled efficiently is fully recognised.

In relation to the approval of individuals, it is the responsibility of an institution's board of directors to ensure that individuals appointed to senior management positions are competent to fill such roles. Given the risks that poor management can pose to the financial soundness of a firm, the PRA will wish to satisfy itself that key individuals running the firm are "fit and proper" to do so.

The PRA will lead on the process for approving individuals for roles with a bearing on the safety and soundness of firms, in close co-ordination with the FCA. The FCA will be responsible for approving individuals to conduct-focused roles. The joint paper states that a full list detailing which functions will be approved by each authority will be published in due course. The PRA and the FCA will design a simple and transparent process for approving individuals to "significant influence functions" which minimises the administrative burden on individuals and firms.

### **The regulation of Part VII transfers**

The process currently detailed in Part VII of FSMA sets out a framework to enable the transfer of insurance business from firm to firm. Under the current Part VII mechanism, the courts are ultimately responsible for sanctioning or rejecting an application for a business transfer, while the FSA has the right to make representations to court and is responsible for approving the necessary documentation. The Government does not intend to alter the substance of the current framework.

The PRA will be primarily responsible for the process but the FCA also has an interest and will need to satisfy itself that, as a minimum, the transfer will not adversely affect the customers of the firms involved in the transfer. Both authorities will be able to make representations to the court during the transfer process. Whether the involvement of both regulators will create administrative problems for insurers remains to be seen.

### **Cooperation with overseas regulators and supervisory colleges**

For firms passporting out of the UK, the Government has confirmed that the relevant prudential authority will be responsible for issuing all relevant notices. In relation to insurers this will be the PRA. It is clear that the PRA needs to oversee the entire financial system in the UK, including parts made up of branches passporting in from other countries. Nevertheless, prudential supervision under European single market directives

remains within the remit of the home state regulator, with only conduct issues regulated by a host state under the “general good” provisions. Accordingly, the PRA will need to build close working relationships with overseas regulators and supervisory colleges supervising large firms passporting into the UK.

Notifications from overseas regulators in relation to the Reinsurance Directive, the Consolidated Life Assurance Directive and the First, Second and Third Non-Life Insurance Directives will go to the PRA, in order to mirror its responsibilities on a domestic basis. Notifications in relation to all other directives will go to the FCA. As conduct is regulated under the “general good” provisions, the draft legislation requires the PRA to give a copy of any notice received to the FCA without delay.

In their joint paper, the Bank and the FSA accept that the PRA’s policies and supervisory actions will take place within an international context and that much of the PRA’s proposed approach in relation to insurers will be achieved through the application of Solvency II. The joint paper states that the PRA will play an active and constructive role in shaping the development of the common framework for regulation and supervision at a global level and in the EU. As noted above, many international insurers operate in the UK and the PRA will collaborate with other organisations including the European Insurance and Occupational Pensions Authority (EIOPA) and the International Association of Insurance Supervisors to ensure that it is able to address risks that non-UK insurers may pose to its statutory objectives.

The Government has explained that the PRA will represent the UK in EIOPA. The PRA and the FCA will work together to ensure that the other regulator and any other relevant authorities are kept fully informed of any matters due to be discussed which fall within their sphere of responsibility. When another body has an interest, the PRA may bring along a non-voting representative of that national body. The regulators will be required to state in the Memorandum of Understanding how they will manage their engagement with foreign regulatory bodies. This is a particularly important point as conduct issues (such as the review of the Insurance Mediation Directive) fall within the scope of EIOPA. It is of vast importance that the regulators are able to effectively influence the European regulatory regime and the CBI has suggested that the legislation should provide for the establishment of an executive level international coordination committee, directly accountable to the boards of the regulatory bodies and ultimately to the Treasury.

### **Additional issues**

Aside from the need for effective regulatory coordination between the two organisations, there are other issues that are worthy of note. For example, the power of the regulators to publish warning notices at an early stage of any enforcement action has been widely publicised. FSMA originally imposed a general prohibition preventing a regulator from publishing or giving details of any notice. The Financial Services Act 2010 lifted the

prohibition in relation to decision notices and the FSA utilised this power for the first time in May 2011.

The Bill now amends FSMA in order to relax the general prohibition against the publication of warning notices and the FCA and the PRA may publish information following consultation with persons to whom the notice is given or copied. According to FSMA, the FCA may not publish a decision or warning notice if, in its opinion, publication of the information would be: unfair to the person against whom the action was taken (or was proposed to be taken); prejudicial to the interests of consumers; or detrimental to the stability of the financial system. The PRA will apply different criteria in considering whether to publish a notice. Again, it will not publish a notice if this would be unfair to the person against whom the action was taken but it will also consider whether publication will be prejudicial to the safety and soundness of PRA authorised persons or to securing the appropriate degree of protection for policyholders.

Given the potential for reputational damage, this amendment will be of concern to an insurer. In the past, there have been examples of FSA enforcement actions that have not been taken forward or that have been challenged and it is unlikely that the publication of a notice of discontinuance will repair the damage that has been caused. How “fairness” will be interpreted in regard to publication of warning notices remains to be determined but it is likely to go beyond the impact of such a notice upon a listed company’s share price. The recent decision of the Upper Tribunal in *7722656 Canada Inc and Peter Beck v the FSA [FS0017&0018] Upper Tribunal (Financial Services), 28 July 2011*, suggests that the Tribunal is unlikely to consider arguments based on necessity, fairness and privacy as compelling reasons to prevent publication of a notice unless exceptional circumstances apply.

Finally, it should be noted that the Government has confirmed that there will be no joint rulebook (analogous to the current FSA Handbook) as each authority should have the autonomy to make rules specific to their individual objectives and duties. It is anticipated that the current FSA Handbook will be divided into two regulatory strands with prudential rules being moved to the PRA and conduct rules being the preserve of the FCA. There is likely to be a gradual process of deletion and replacement of rules by both regulators. With many Solvency II requirements being introduced through delegated acts and other legislative instruments having direct-effect, rulebooks will not need to elaborate on many prudential requirements<sup>4</sup>. However, with Solvency II still some way off insurers face an interim period where FSA prudential standards will most likely be adopted by the PRA.

## **Conclusion**

The finalised regulatory framework is expected to be in place by the end of 2012. The timing of these upheavals could not be more challenging for the insurance industry with the change to a new financial regulatory regime coinciding with preparations for Solvency II, the Retail Distribution Review and other initiatives affecting the insurance industry

(such as the FSA with-profits review and changes in the taxation and accounting regimes, including the move to International Financial Reporting Standards (IFRS) Phase II).

Coupled with concerns regarding timing is the worry that the reforms place an overemphasis on the banking sector. The Government has attempted to assuage these concerns by explaining that as the lessons of financial crisis have predominantly focused on the micro and macro-prudential regulation of the banking sector, it is inevitable that the presentation of proposals for improving regulation should focus on banking. Whilst this proposition is generally accepted, it is still concerning that the Government is yet to finalise all of its proposals relating to insurance. For example, the FSA is currently required to agree to any voluntary winding-up of a life insurer. The original aim of this provision was to protect policyholders but there are clear prudential and possible financial stability implications associated with the winding up of a life insurer. In its February consultation paper, the Government confirmed that it will consider the most appropriate division of responsibilities between the PRA and the FCA in this area. However, as yet a definitive statement has not been forthcoming.

In addition, until the mechanisms for cooperation are published (including the Memorandum of Understanding) and firms have experienced the operation and culture of the new authorities first hand, they face the uncertainty of not knowing whether the division of responsibilities will have a noticeable impact on supervision. The coordination between the two organisations has the potential to be a serious concern, as a simple consultation could lead to layers of bureaucracy, stifling quick commercial decisions. At present, the balance of power and the inclination of each authority to take enforcement action suggests that the FCA is likely to be of more relevance to a firm's day-to-day activities, with the PRA taking the lead on matters relating to solvency and risk management. However, more clarity is needed and it is hoped that the Government will provide additional information in the near future.

***Laura Hodgson is a professional support lawyer specialising in insurance law and Simon Baker is a paralegal. Both work in the London office of Norton Rose LLP.***

## **Endnotes**

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<sup>1</sup> In February 2011:

[http://www.fsa.gov.uk/pages/Libraiy/Communicationi/Speeches/2011/0209\\_hs.shtml](http://www.fsa.gov.uk/pages/Libraiy/Communicationi/Speeches/2011/0209_hs.shtml)

<sup>2</sup> FSA Handbook Conduct of Business Sourcebook (COBS) 20:With-profits.

<sup>3</sup> See *House of Commons Treasury Select Committee, Financial Regulation: a preliminary consideration of the Government's proposals. Seventh Report of Session 2010-11, Vol. II, Evidence 21.*

<sup>4</sup> See, Finney, C. "The path to Solvency II implementation – rocks and hard places" in this issue of the BILA Journal, page 13

## **The path to Solvency II implementation – rocks and hard places**

By Chris Finney

### **Introduction**

Solvency II will create a new prudential regime for insurers.

When the Solvency II Directive<sup>1</sup> was made, the new regime was being created under the Lamfalussy process. The Directive gave us the Level 1 text. We were expecting a Level 2 directive, Level 3 guidance and binding technical standards to complete the regime. We were also expecting compliance to begin on 1 November 2012.

This began to change when the Treaty for the Functioning of the European Union came in to force<sup>2</sup>. That change was accelerated by the EIOPA Regulation<sup>3</sup>. The Omnibus 2 Directive will complete it<sup>4</sup>.

Today, we are expecting Omnibus 2 to amend the Solvency II Directive. We are also expecting delegated acts instead of a Level 2 directive<sup>5</sup>, and regulatory and implementing technical standards instead of binding technical standards. We are still expecting Level 3 guidance, but there might be rather less of it than we thought. Formal compliance will not begin until 1 January 2014.

This article analyses the new European Union legislative process and the Solvency II difficulties it creates. It also looks at the current notional Solvency II timetable, before explaining why the United Kingdom is stuck between a rock and a hard place, and what that means for firms.

### **The Treaty for the Functioning of the European Union**

Like its predecessors, the Treaty for the Functioning of the European Union (the “Treaty”) gives the European institutions the power to adopt regulations, directives, decisions, recommendations and opinions. Regulations, directives and decisions are legally binding. Recommendations and opinions are not<sup>6</sup>.

Regulations are legally binding in the Union’s Member States. Directives bind the Member States. Each directive requires the Member States to make laws that will achieve a particular outcome, but leaves it to individual States to decide how to do that. Decisions are only binding on those to whom they are addressed<sup>7</sup>.

### **Legislative acts**

The Treaty describes regulations, directives and decisions as “legislative acts”. Legislative acts are usually made when they are adopted jointly by the European Parliament (the “Parliament”) and the Council on a proposal from the European Commission (the “Commission”)<sup>8</sup>, and they come in to force on the date specified in them.

## **Delegated acts and implementing acts**

Legislative acts can be used to give a power to the Commission to adopt “delegated acts”.

Delegated acts can only be used to supplement or amend the non-essential elements of the legislative act that gives the Commission this power. The legislative act must specify the objectives, content, scope and duration of the delegated power. It must also lay down the conditions to which it is subject. One possible condition is that the Parliament and Council may revoke the power to make relevant delegated acts at any time. Another is that the delegated act cannot enter into force if the Parliament or Council object to it within a particular period<sup>9</sup>.

Legislative acts can also be used to give the Commission the power to make “implementing acts”. This power can only be given if “uniform conditions for implementing [legislative] acts are needed”<sup>10</sup>. If the Parliament and Council give the Commission a power to make implementing acts, they must use a regulation to allow the Member States to control the way the Commission uses it<sup>11</sup>.

## **The European Insurance & Occupational Pensions Authority: standards & guidance**

The European Insurance and Occupational Pensions Authority (“EIOPA”) was created by regulation<sup>12</sup> (the “Regulation”). The Regulation sets EIOPA’s tasks and gives it the powers it needs to carry them out.

In particular, the Regulation gives EIOPA the power to draft Regulatory Technical Standards (“RTS”), draft Implementing Technical Standards (“ITS”) and give guidance.

### *Regulatory Technical Standards*

If the Parliament and Council use a regulation or directive to give the Commission a power to adopt RTS as delegated acts, the Regulation automatically gives EIOPA the power to develop draft RTS for possible adoption by the Commission. RTS must be genuinely technical. EIOPA is not empowered to make strategic decisions or policy choices<sup>13</sup>.

EIOPA must publicly consult on the draft RTS it prepares. EIOPA must also ask the Insurance and Reinsurance Stakeholder Group (the “Stakeholder Group”) for an opinion on its draft RTS and analyse the RTS costs and benefits, unless it would be disproportionate to do so or the matter is urgent<sup>14</sup>. When that process is complete, EIOPA must submit its draft RTS to the Commission.

The Commission has three months from the date of receipt to decide whether to endorse EIOPA’s draft RTS or not. It also seems to have the power to adopt EIOPA’s draft at any time during this period<sup>15</sup>.

If the Commission intends not to endorse a draft RTS, or to endorse it in part or with amendments, it must return it to EIOPA explaining why. EIOPA then has six weeks to

respond. If EIOPA amends the draft in the way the Commission has proposed and resubmits it, the Commission will probably adopt it. (The Regulation does not seem to require it to do so.)

If EIOPA does not submit an amended draft, or it submits a draft that does not match the Commission's amendments, the Commission may adopt an RTS with the amendments it considers relevant or reject it. However, it is probably only entitled to amend EIOPA's draft RTS and to adopt that version if it is in the European Union's interests to do so<sup>16</sup>. Perhaps strangely, it seems to be for the Commission to decide what is in the Union's interests, and what is not.

If EIOPA submits a second draft RTS, which is not in the form suggested by the Commission, and the Commission rejects it, it must give its reasons for doing so. The Parliament and Council may then invite the European Commissioner and the chair of EIOPA to attend an ad hoc meeting of a Parliamentary committee to present and explain their differences<sup>17</sup>. The Regulation does not say what should happen after that. There is, perhaps, an implied assertion that the committee meeting will lead to resolution and RTS adoption. Whether or not that is right, the Regulation seems to assume these differences will rarely emerge.

If the Commission chooses to adopt an RTS, it must do so by regulation or decision. The adopted regulation or decision will be published in the Official Journal and come in to force on the date specified in it<sup>18</sup>.

The Parliament and Council used the Regulation to give the Commission the power to adopt RTS, and the Regulation allows them to withdraw that power at any time.<sup>19</sup> The Regulation also provides that, if the Commission adopts an RTS, it will not come in to force if the Parliament or Commission object to it within three months of the Commission adopting it. The Parliament or Council may extend this time limit by three months on their own initiative. However, each of these time limits is reduced to one month if the Commission adopts EIOPA's first draft of an RTS<sup>20</sup>.

### *Implementing technical standards*

Legislative acts can also give EIOPA a power to develop ITS for possible adoption by the Commission as implementing acts.<sup>21</sup>

The process for making ITS is identical to the process for making RTS, save that, where the process for making RTS gives the Commission three months to decide whether to adopt an RTS and a power to extend the initial period by three months, the Commission may only extend the process for making ITS by one month. In addition, there is nothing in the Regulation that allows the Parliament or Council to revoke the Commission's power to adopt ITS and there are no objection provisions either.

## *Guidance*

The Regulation gives EIOPA the power to issue guidance and recommendations to Member States and financial institutions. The guidance and recommendations should be used to establish consistent, efficient and effective supervisory practices and to help ensure the common, uniform and consistent application of Union law<sup>22</sup>.

If EIOPA is proposing to issue guidance or a recommendation, it is required to consult on its proposals and to analyse their costs and benefits (if it is appropriate to do so). It is also required to ask the Stakeholder Group for an opinion on its proposals<sup>23</sup>.

The supervisory authorities in the Member States and the relevant financial institutions are required to make every effort to comply with EIOPA's guidance and recommendations. Within two months of the issue of guidance or recommendations, supervisory authorities must tell EIOPA whether they comply, or intend to comply. If they do not comply or intend to comply, they must explain why. If the guidance or recommendations require it, relevant financial institutions must also report whether they comply or not<sup>24</sup>.

## **Omnibus 2**

If Omnibus 2 is adopted by the Parliament and Council in its present form<sup>25</sup>, it will require the Commission to adopt delegated acts to further specify:

- The information each firm must give to its supervisor to enable effective supervision<sup>26</sup>;
- When a capital-add on can be imposed and how it should be calculated<sup>27</sup>;
- The elements and standards required of the firm's governance arrangements, risk management and internal control systems, internal audit and actuarial functions and the conditions under which outsourcing may be performed<sup>28</sup>;
- The information to be included in a firm's Solvency and Financial Condition Report, when the report must be disclosed and how<sup>29</sup>;
- The methods and assumptions to be used to value assets and liabilities and calculate technical provisions<sup>30</sup>;
- The criteria to be applied when a supervisor considers whether to approve a firm's assessment and classification of its own funds, the use of ancillary own funds and, in each case, the quantitative limits to be applied to the different tiers of capital<sup>31</sup>;
- The methods, assumptions, adjustments and parameters to be used when calculating the Solvency Capital Requirement ("SCR") or basic SCR (as the case may be)<sup>32</sup>;

- The tests an internal model must meet before approval can be given, and the process to be followed when an application for approval is being considered<sup>33</sup>; and
- The Minimum Capital Requirement calculation<sup>34</sup>.

Omnibus 2 also allows the Commission to adopt delegated acts specifying quantitative limits and asset eligibility criteria to address risks not adequately covered by the SCR sub-modules, if that is necessary<sup>35</sup>.

Omnibus 2 requires EIOPA to prepare draft ITS. Most of EIOPA's ITS will add detail to the delegating acts prepared by the Commission, although some will supplement the Solvency II directive without delegated acts intervening. EIOPA is required to prepare its ITS to a timetable, which requires the first drafts to be submitted by 30 September 2012, with the balance to follow by 31 December 2014 or 31 December 2016 (the date varies according to the subject matter).

Omnibus 2 does not currently require EIOPA to develop any RTS, although the final version will probably do so<sup>36</sup>.

The Commission's power to adopt delegated acts lasts for five years from the date Omnibus 2 comes in to force (expected to be early 2012); but it is automatically renewed in five year periods, unless it is revoked by the Parliament or Council.

The Commission's power to adopt draft ITS is not time limited.

## **Omnibus 2 and the path to implementation**

Omnibus 2 lays out a basic Solvency II implementation timetable, which is designed to ensure that all Member States and all relevant firms progress towards implementation day and Solvency II compliance together. The implementation timetable requires<sup>37</sup> Member States to:

- Adopt and publish the laws they will use to implement the Solvency II Level 1 directive by 31 March 2013;
- Adopt and publish laws by 1 April 2013 that will require each relevant firm to submit an implementation plan to its supervisor by 1 June 2013. The plan must evidence the firm's progress towards Solvency II compliance and explain how it will ensure full compliance by implementation day;
- Switch some of their implementing rules on so that, from 1 June 2013, firms can apply for and (if appropriate) secure an approval which is effective from 1 January 2014 to:
  - Count ancillary own funds as capital;
  - Secure supervisory approval of their own fund assessments and classifications;
  - Use undertaking specific parameters when they calculate their SCR;

- Use a full or partial internal model;
- Require relevant firms to comply with Solvency II from 1 January 2014.

### **So when will Solvency II compliance have to begin?**

The European Authorities have not published a comprehensive implementation timetable for Solvency II. From what has been published, and what seems to have been said (or at least implied) by European officials, most commentators now expect:

- The Presidency, the Council and the Parliament's Committee on Economic and Monetary affairs to agree a final version of Omnibus 2 before the end of 2011;
- The Parliament to vote on and adopt Omnibus 2 in December 2011 or January 2012;
- Omnibus 2 to be published in the Official Journal shortly after Parliamentary adoption, and to come in to force the same day;
- The most implementation critical delegated acts to be published in the first quarter of 2012, with adoption of the final texts to follow from September 2012;
- EIOPA's draft Level 3 guidance to be published from the first quarter of 2012 (EIOPA cannot publish its draft Level 3 guidance until after the Commission has published the relevant delegated acts);
- EIOPA's draft RTS and ITS to be published according to the Omnibus 2 timetable;
- The most implementation critical RTS and ITS to be adopted by the Commission from October 2012;
- Solvency II compliance to begin on 1 January 2014, 14 months after the Solvency II directive envisaged.

In strict legal theory, the delegated acts, and draft RTS and ITS cannot be developed and published until after Omnibus 2 has come into force - it is only at that stage that the Commission and EIOPA will have the powers they need to do the work. Some commentators have suggested that the Parliament and Council have already given the Commission and EIOPA special dispensation so they can start work much sooner than the law would allow and that must be right - otherwise, meeting the timetable would be impossible. Those commentators have also suggested that a dispensation will also be given so that implementation critical delegated acts can be published before Omnibus 2 comes into force. Whether that is also right remains to be seen.

Either way these arrangements create many problems for firms. In particular, requiring them to comply with Solvency II from 1 January 2014 is both too soon and too late.

It is too soon because, even if EIOPA and the Commission keep to the current timetable, the last of EIOPA's draft ITS will not be available until 31 December 2016, and they will

not be adopted until 2017 or 2018. That means it could easily be another seven years before Solvency II is fully made and in force (even if potential transitional arrangements are left to one side). One consequence is that policyholders and their beneficiaries will have to wait for the enhanced protection Solvency II is intended to give them. Another is that firms and their supervisors will have a wide margin of discretion when Solvency II first comes in to force, but that margin will gradually be eroded as EIOPA's RTS and ITS are adopted. This phasing may help some firms, but it will be inefficient and wasteful for others.

It is too late because many firms' Solvency II preparations are very advanced. It will be expensive for those firms to continue to comply with the current regime and to delay formal Solvency II compliance until 2014. Implementation fatigue means that it will also be difficult and frustrating to try.

### **The FSA's path to implementation – rocks and hard places**

In recognition of these issues, or in spite of them, on 4 October 2011 the FSA changed its implementation assumptions.

The FSA now intends to transpose the Solvency II Directive into FSA rules by 1 January 2013, and to require firms to comply with them from 1 January 2014. The FSA also expects to be able to receive applications:

- From 1 January 2013, from firms that will use the standard formula to calculate their SCR but still need other supervisory approvals by 1 January 2014 (for example, approval to 'count' ancillary own funds or to use undertaking specific parameters in the SCR calculation instead of the standard parameters); and
- Between 30 March 2012 and mid-2013, from firms that want to use an internal model to calculate their SCR. Firms that are already in the pre-application phase of the internal model approval process will be given a submission slot. If they want the FSA to consider their application for approval to use an internal model and (if appropriate) to grant it before 1 January 2014, these firms must submit a complete set of applications for approval during their slot. For these purposes, a complete set of applications means the application for approval to use the internal model and any other applications the firm would like the FSA to grant before 31 December 2013. This will allow the FSA to consider the firm's applications as a package and (if appropriate) to grant them on consistent and appropriate terms.

This creates other difficulties. The FSA has pressed firms hard, at the behest of the Commission and others, to prepare for Solvency II compliance on 1 January 2013. Firms have worked hard and spent a great deal of money preparing for compliance by that date. Many have also begun to restructure their groups and change their investment strategies in ways that will deliver better outcomes under Solvency II than will be available under

the current regime. Many of these firms will be left wondering why the FSA has chosen to “punish” them for their “good behaviour” by delaying implementation by a year instead of allowing or requiring them to comply from 1 January 2013 in any event.

The same firms will also be wondering what happens now. There is a significant risk, which has not been publicly addressed by the FSA, that these firms will have to comply with the current regime (including preparing their Individual Capital Assessments (“ICA”) and responding to the FSA’s Individual Capital Guidance (“ICG”)) and Solvency II (if they want to embed, refine and keep their internal models up to date for reliable use in 2014).

Things are not much easier for the FSA. It has diverted scarce resource away from considering firms’ ICAs and giving ICG so that it can be used to develop and implement Solvency II. Cranking ICA/ICG back up would be wasteful, but failing to do so could be negligent. Allowing some firms to comply with the current regime and others to opt in to Solvency II would also generate risk as firms choose the regime that gives them the best outcome and makes meaningful comparisons between firms all but impossible in the meantime.

The FSA is almost certainly considering how best to resolve these issues today. It has already said it will take a pragmatic approach to Solvency II implementation when it can. Doing that here might mean allowing firms that want to use an internal model to “opt in” to Solvency II from 1 January 2013 to avoid “double regime” costs, complications and risks. Whether that can be done seems to depend on the availability of European policy and relevant firms being able to satisfy the FSA that their models meet the relevant (but only partially available) Solvency II tests. Success would save time and money for these firms and that might be a just reward for the time and effort they have invested. But will it also lead to ICG “lite” and even less FSA interaction for standard formula firms, as the FSA focuses on internal model approvals?

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## Endnotes

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<sup>1</sup> Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking up and pursuit of the business of Insurance and Reinsurance (the “Solvency II Directive”)

<sup>2</sup> The Treaty for the Functioning of the European Union (the “Treaty”) is sometimes called the Lisbon Treaty. It was agreed in Lisbon in 2007 and came in to force on 1 December 2009

- <sup>3</sup> Regulation (EU) No 1094/2010 of the European Parliament and of the Council of 24 November 2010 establishing a European Supervisory Authority (European Insurance and Occupational Pensions Authority), amending Decision number 716/2009/EC and repealing Commission Decision 2009/79/EC
- <sup>4</sup> At the moment, the Omnibus 2 directive is at the proposal stage: Proposal for a Directive of the European Parliament and of the Council amending Directives 2003/71/EC and 2009/138/EC in respect of the powers of the European Insurance and Occupational Pensions Authority and the European Securities and Markets Authority – institutional file 2011/0006 (COD)
- <sup>5</sup> For a long time, we were expecting a Level 2 Regulation, and an implementation date of 1 January 2013. The Commission prepared a draft of the Level 2 Regulation, and has distributed for pre-consultation to Member State Regulators on a confidential basis. That draft is now available publicly (<http://217.71.145.20/TRIPviewer/show.asp?tunniste=E+177/2010&base=ueasia&palvelin=www.eduskunta.fi&f=WORD> - You have to go through about 18 pages in Finnish before you get to it. You can also access it via the PDF icon at the top of the page). The draft Regulation is likely to be used as the base text for the Commission's delegated acts.
- <sup>6</sup> Article 288 of the Treaty
- <sup>7</sup> Article 288 of the Treaty
- <sup>8</sup> Article 289(3) of the Treaty
- <sup>9</sup> Article 290 of the Treaty. A Parliamentary objection must be a majority. A Council objection must be by a qualified majority
- <sup>10</sup> This probably means the power can only be given to the Commission if the Parliament and Council want to be sure their legislative acts are implemented and applied in the same way across the Union
- <sup>11</sup> Article 291 of the Treaty
- <sup>12</sup> See footnote 3
- <sup>13</sup> Article 10(1) of the Regulation
- <sup>14</sup> Articles 10(1) and 37 of the Regulation
- <sup>15</sup> Article 13(1) of the Regulation
- <sup>16</sup> Articles 10(1) and 13(1), and recitals 22 and 23
- <sup>17</sup> Article 14 of the Regulation
- <sup>18</sup> See Article 10(4) of the Regulation
- <sup>19</sup> See Article 12 of the Regulation
- <sup>20</sup> Per article 13(1) the one month time limit applies if “the Commission adopts [an RTS] which is the same as the draft [RTS] submitted by [EIOPA]. Per article 10(1), paragraph 6, the resubmitted draft must be “in the form of an opinion”. In other words, it is different to (and may no longer be) “a draft”
- <sup>21</sup> See Article 15 of the Regulation and Article 290 of the Treaty

<sup>22</sup> See Article 16(1) of the Regulation

<sup>23</sup> See Article 16(2) of the Regulation

<sup>24</sup> See Article 16(3) of the Regulation

<sup>25</sup> By this, I am referring to the proposal for a Directive of the European Parliament and of the Council amending Directives 2003/71/EC and 2009/138/EC in respect of the powers of the European Insurance and Occupational Pensions Authority and the European Securities and Markets Authority – Presidency Compromise text dated 21 September 2011

<sup>26</sup> Article 2(4) of Omnibus 2 and article 35 of the Solvency II Directive

<sup>27</sup> Article 2(5) of Omnibus 2 and article 37 of the Solvency II Directive

<sup>28</sup> Article 2(7) of Omnibus 2 and articles 41 to 49 of the Solvency II Directive

<sup>29</sup> Article 2(10) of Omnibus 2 and articles 51 to 56 of the Solvency II Directive

<sup>30</sup> Articles 2(14) and (16) of Omnibus 2 and articles 76 to 85 of the Solvency II Directive

<sup>31</sup> Articles 2(17) to (19) of Omnibus 2 and articles 86 to 99 of the Solvency II Directive

<sup>32</sup> Articles 2(20) and (21) of Omnibus 2 and articles 100 to 111 of the Solvency II Directive

<sup>33</sup> Article 2(22) and (23) of Omnibus 2 and articles 112 to 127 of the Solvency II Directive

<sup>34</sup> Article 2(27) of Omnibus 2 and articles 128 to 130 of the Solvency II Directive

<sup>35</sup> Article 2(21) of Omnibus 2

<sup>36</sup> On 23 September 2011, the Committee on Economic and Monetary Affairs of the European Parliament published its proposed amendments to the Presidency's Omnibus 2 compromise text (the Presidency's Omnibus 2 proposal is referenced in end note 25). The Committee's proposed amendments include changing the implementing technical standards on capital add-ons, the valuation of assets and liabilities and the calculation of the standard formula SCR into regulatory technical standards

<sup>37</sup> Articles 2(72) to (74) of Omnibus 2

## **Late payment of insurance claims: a legal or a regulatory issue?**

By Jonathan Goodliffe

### **Summary**

In most insurance claims on the wholesale market there is no cause of action for damages for late payment of the claim, as opposed to a claim for interest. If late payment has, for instance, resulted in the claimant losing a business deal, damages might be considerably greater than interest, even interest at a commercial rate.

The Law Commissions of England and Wales and of Scotland, as part of their more general project for reforming insurance law, have recommended (subject to consultation) that this rule be reversed. The recommendation is made in their issues paper 6, “Damages for late payment and the insurer’s duty of good faith”. The issues paper is expected to be followed up by firmer recommendations.

This article is not primarily concerned with the merits of the Law Commissions’ recommendation, which BILA<sup>1</sup> and I broadly support, but with the question of whether the recommendation is best achieved by primary legislation or by regulation. This question incidentally raises points on the interaction and overlap between insurance law and regulation.

In their issues paper, the Law Commissions assume that primary legislation is required to achieve their recommendation. That assumption may prove to be correct, since the outcome of the project depends more on politics than law. However, the paper did not consider what I suggest may be an alternative regulatory approach to reform. This may prove ultimately to be more politically viable, although the regulatory approach itself may have problems. These raise some interesting issues about how rulemaking powers can and should be exercised. I discuss these points below.

### ***Sprung v Royal Insurance***

In *Sprung v Royal Insurance (UK) Ltd* [1999] 1 Lloyd’s Rep IR 111, the Court of Appeal held that damages are not recoverable for late payment of an insurance claim. The reasoning was that an insurance claim is itself a claim for damages. Damages cannot be claimed upon damages. The Law Commissions’ paper is primarily aimed at reversing this decision.

Since the judgment, however, The Financial Services Authority (FSA), has taken on responsibility for the supervision and regulation of insurance mediation and more generally the conduct of insurance business. It has adopted new rules relating to non-investment insurance now contained within its Insurance Conduct of Business Sourcebook (ICOBS).

## ICOBS

The handling of claims otherwise than fairly and promptly in respect of non-investment insurance is now a regulatory breach under ICOBS 8.1.1R<sup>2</sup> which provides<sup>3</sup>:

“An *insurer* must:

- (1) handle claims promptly and fairly;
- (2) provide reasonable guidance to help a *policyholder* make a claim and appropriate information on its progress;
- (3) not unreasonably reject a claim (including by terminating or avoiding a *policy*); and
- (4) settle claims promptly once settlement terms are agreed.”

This is the case regardless of whether the *policyholder* is a business, a consumer, a human person or a legal person<sup>4</sup>. A cause of action for damages, however, in respect of a rule breach under section 150 of the Financial Services and Markets Act 2000 (FSMA) only normally accrues for the benefit of a *private person*. The meaning of this expression was required under FSMA to be “prescribed” by regulations laid before Parliament. The cause of action also accrues only to the extent that the FSA does not otherwise “specify” in its rules under section 150(2). The effect of such a “specification” is to “switch off” the right to damages in particular cases.

In the case of ICOBS 8, the right to sue under section 150 has not been switched off. For some other rules it has. An example is the FSA’s Principles for Businesses, which include its “flagship” Principle 6, requiring its regulated firms to treat their *customers* fairly.

### What is a “*private person*”?

The meaning applied by the Financial Services and Markets Act 2000 (Rights of Action) Regulations 2001 (the Rights of Action Regulations) to *private person* is highly counter-intuitive and the policy underlying it is unclear. It includes both human persons and legal persons. So a limited company can be a *private person*. In the case of human persons the loss may, among other things, be suffered in the course of a business (other than a FSMA regulated activity). In the case of legal persons (including partnerships) the loss must have been suffered otherwise than in the course of carrying on a business of any kind.

So persons entitled to sue for breach of ICOBS 8 would include, for instance:

- the plaintiff in *Sprung* (who was a human person) if his claim had arisen after ICOW came into force in 2005 (this point was not picked up by the Law Commissions in their issues paper),

- human persons operating on a solo business basis (including for example all barristers in private practice, since they invariably operate as sole practitioners),
- professional businesses in relation to their pro bono or social activities, and
- charitable corporations carrying on non-business activities.

It is thus not correct to say (as the Law Commissions do at para 5.19 of their paper) that “these claims are not open to businesses”. They are open to most businesses in limited circumstances and to some businesses in all circumstances.

For non *private persons* the right to sue under section 150 may be “switched on” under section 150(3), but this can only be done in “prescribed” (rather than “specified”) cases. The “prescription” must be made by regulations to be laid before Parliament.

This is a less flexible tool than the FSA rules, since the drafting of the rules is the responsibility of the FSA’s sponsoring department, HM Treasury (HMT), and the rules might be blocked by Parliament. The FSA and HMT’s respective policy agendas may not always coincide, as is apparent from HMT’s description of the FSA’s exercise of its functions as being “a tick-box approach”<sup>5</sup>. HMT is also very busy in its various other more mainstream functions and no doubt does not want to be regularly promoting regulations under section 150(3).

### **Ways of changing the law**

Nonetheless regulations are themselves a less unwieldy tool for changing the law than statutes, because Parliament is also very busy. Each parliamentary bill has to compete with many others in the government or private members’ agendas. Bills before Parliament are more likely to be controversial, especially if the Government does not apply a whip. Difficulties with getting proposed legislation before or through Parliament are a major reason why many previous proposals for reforming insurance law have not succeeded.

The government has recently promoted the Consumer Insurance (Disclosure and Representations) Bill to implement some of the Law Commissions’ recommendations. However, that was a measure aimed at advancing the interests of consumers. It therefore had vote winning potential.

More technical changes to the law to advance the specialised interests of wholesale policyholders are another matter. A member of parliament may well ask him or herself why he should be concerned with such issues, when they are within the powers of the regulator.

### **Regulatory reform**

A major project<sup>6</sup>, currently taking up a large part of HMT’s time and due to take up a large part of Parliament’s time, involves making major reforms to the financial services

regulatory regime. It will, among other things, split the FSA's current functions between two new regulators, the Prudential Regulatory Authority (PRA) and the Financial Conduct Authority (FCA). None of these proposals, however, will, as currently framed, affect the substance for present purposes of the power to make conduct of business rules. These will include what will be the FCA's ability to switch off the right of *private persons* to claim damages for rule breaches and the ability to switch on the rights of non-*private persons* by regulation.

### **Switching on the rights of non *private persons***

In fact the power to switch on the rights of action of non *private persons* has been exercised very sparingly since the FSMA came into force in 2001. The cases in which the right arises were expressed in general terms in article 6 of the Rights of Action Regulations. Most importantly they include cases where the rule that has been contravened prohibits an authorised person from seeking to make provisions excluding or restricting any duty or liability.

Since 2001 article 6 has only been amended once, to allow non *private persons* to sue for breach of ICOBS 8.2.9R. This rule requires motor insurers to pay interest at a specified rate on compensation. This rule would have been ineffective and therefore an inadequate transposition of article 22 of the Consolidated Motor Insurance Directive 2009/103/EC if the right to sue had not been switched on.

Why has the power to switch on the right to damages, say for breach of the requirement to give best execution of a market transaction under COBS 11.2, not been exercised more often? In many cases it does not need to be because businesses usually do not need to rely on FSA rules. They are more likely to rely on their contractual rights or to refuse to deal with a firm that does not give best execution. HMT and/or the FSA may also have determined as a matter of policy against a more general use of the power.

### **Regulatory case for the award of damages for late payment**

There are, however, some persuasive reasons, aligned with the regulatory regime, arguing in favour of the use of this power more generally and specifically in relation to the late payment of insurance claims:

- the Law Commissions have noted<sup>7</sup> that even business policyholders, particularly small businesses (including in order of increasing size, *small businesses*, *micro-enterprises* who are eligible to make claims to the Financial Ombudsman Service and *small and medium sized enterprises* ("SME")) need protection against the market power of the insurance industry and, like consumers, are usually in no position to negotiate with an insurer over its standard policy terms,
- some protection of "consumers" or policyholders (who, within FSMA, include business policyholders and even cedants) is included in the regulatory objectives of the FSA and the proposed objectives of the PRA and FCA. In any event a

right of action for late payment of insurance claims is not something that people look out for when choosing insurance. It only becomes a problem if and when a claim arises and the insurer has poor claims management systems. So there is a case for protecting even wholesale policyholders,

- the Law Commissions' insurance law project is ambitious and extensive, yet the political momentum to give effect to it in relation to the wholesale market is questionable. It makes sense for the Law Commissions to use Parliamentary time on aspects of its programme (such as reforming the law on insurance fraud) which cannot be given effect through the regulatory regime,
- the policy that insurers should deal with claims promptly is already provided for in the regulatory regime: the focus should be on developing and enforcing that policy and not developing a parallel set of rules,
- it is pointless to have a rule requiring the prompt handling of insurance claims unless there is an effective way of enforcing it. Whilst it is often best for the regulator to take enforcement action or claim compensation for rule breaches on behalf of a class of retail policyholders (such as those within a with-profits fund), with business policyholders it is best to let them, the insured, get on with the claim,
- areas of regulation outside FSMA rules may be open to enforcement by actions for damages as well as fines or regulatory penalties. An example of this is the competition rules (which apply to insurers among others) under the Treaty for the Functioning of the European Union and the Competition Act 1998, as amended by the Enterprise Act 2002. The existence of this right of action no doubt provides additional encouragement for compliance.

It is perhaps a little surprising that there has not been more study of how the claims of people affected by rule breaches can contribute to the functioning of the regulatory regime. In my article in the December issue of the BILA Journal I suggested<sup>8</sup> that if the Financial Ombudsman were a little less ungenerous with its awards of compensation for distress, that might provide additional motivation for firms to avoid complaints.

At one time the FSA seemed to be touching on this subject with its "Harnessing market forces" initiative<sup>9</sup>, but that never bore fruit. This question may merit further attention, since in the lead up to its transformation into the FCA, the FSA will be focusing more on the wholesale market than it has done previously<sup>10</sup>. It might benefit from using a further regulatory tool, an incidental effect of which may be to save on its own resources.

There may therefore be a case for regulations to "prescribe" in much wider terms a class of rule where a non *private person* can sue, or for the power to switch on the right to damages of non *private persons* to be exercised by the FCA through its own rules.

## Contractual exclusion of the right to damages

If the Law Commissions make a final recommendation in favour of reversing *Sprung* it may well suggest that the right of action for damages for late payment should not apply in all cases. It may be unnecessary to apply it at all for specific classes of insurance or insurer. It may be appropriate that the right should be capable of being excluded where the claimant is larger than, say, an SME.

In theory the operation of an FSA rule cannot be excluded by contract. The same effect can, however, be achieved by limiting the application of the rule. So ICOBS 8.1.1R might be preceded by the following additional rule:

“ICOBS 8.1.1R applies where the *person* making the claim is:

a *private person*;

a *small or medium sized enterprise*; or

any other *person* to the extent that the application of ICOBS 8.1.1R has not been expressly excluded by contract.”

Cutting down on ICOBS 8.1.1R in this way would not exclude the regulatory duty to treat *customers* fairly under Principle 6. In relation to that principle rights of action under section 150 have, as noted above, been and would remain excluded in their entirety.

There may be a problem here. I am not aware of any precedents of rules in the FSA Handbook which are expressed in such “adjectival” rather than “substantive” terms. Such a proposal is likely to raise eyebrows at the FSA and require a persuasive case. The way to answer the doubters may be ask how the rule is to be enforced in the wholesale market if not by civil rights of action. Should it be there at all in its application to the wholesale market unless there is a practical way of ensuring that it is respected? If it is to be respected in the wholesale market it must be expressed in workable and commercial terms.

Even if these arguments were not to find favour it should at least be possible to identify a point at which the right of action should apply on a non excludable basis. Limiting it at the SME level makes much more sense than at the *private person* level. Application of the rule more widely on an adjectival basis would then require a statute. A very long wait for this to happen can be expected.

It would be necessary for a further “prescription” by statutory instrument to add a further sub-paragraph to Regulation 6(3) of the Rights of Action Regulations, providing for another case in which rights of action would arise for the benefit of non *private persons*. It might read as follows:

- “(e) the rule that has been contravened requires an insurer to handle claims promptly and fairly and not unreasonably to reject a claim (including by terminating or avoiding a policy)”

This would switch on ICOBS 8.1.1R(1) and (3). Rights of action are probably inappropriate for (2). In relation to (4) claimants would be able to sue in contract in any event and the *Sprung* problem would cease to apply.

### **Which is the appropriate route to take?**

If I am right in arguing that a combination of FSA rules and “prescription” under section 150(3) of FSMA can confer on non *private persons* a workable right of action for damages for late payment of insurance claims, the question nonetheless arises whether that is a better way of proceeding than by promotion of a Parliamentary bill.

Progress through regulation requires the co-operation of the FSA, which like HMT and Parliament is very busy on other matters, such as its recreation as the PRA and the FCA, with-profits insurance reform, Solvency II, and a number of other major projects in the insurance and other sectors. Reducing the late payment of wholesale insurance claims may advance regulatory objectives but may not be a major policy priority for the FSA or the FCA.

This may be partly because the FSA would doubtless be delighted for the Law Commissions to get the project through Parliament and therefore not take up its own valuable and scarce resources. Busy as the FSA and HMT no doubt are, however, the time of Parliament is surely the most valuable. A reason for moving the question up the FSA agenda is that it will save Parliamentary time, much of which is in any event going to be spent over the next few years on the government’s proposed regulatory reforms.

The Law Commissions may also have missed out on the opportunity to get the FSA on board by focusing more closely on the regulatory perspective and making a case for the FSA to use its powers. Perhaps they did put the case to the FSA, since they accepted in general terms at an earlier stage of the insurance law project<sup>11</sup> that some reforms could be achieved through regulation. The brief and incomplete regulatory analysis in their issues paper 6, however, suggests that they probably did not, or that, if they did, it was not as persuasive as it might have been. It is not too late for them to start.

I may have to eat my words if Parliament in less than, say, 3 years does actually give effect to this reform. Nonetheless perhaps what I have said will prompt more discussion of the overlap between insurance law and regulation.

*Jonathan Goodliffe is a solicitor and the honorary editor of the BILA Journal. He was also a member of the BILA sub-committee which considered and responded to the Law Commissions’ issues paper 6. The views expressed in this article are his alone, however, and are not necessarily shared by other members of that sub-committee.*

## Endnotes

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- <sup>1</sup> See “Damages for late payment and the insurer’s duty of good faith: BILA views, Michael Mendelowitz and Jonathan Goodliffe, BILA Journal issue 120, page 19.
- <sup>2</sup> ICOBS, which was adopted in 2008, superseded the original FSA insurance conduct of business rules in ICOB, which were adopted in 2005. The differences between the two rulebooks, however, are immaterial for present purposes.
- <sup>3</sup> In this article I follow the FSA Handbook convention of italicising defined expressions in the FSA Handbook glossary.
- <sup>4</sup> The rule does not apply, however, to reinsurance activities (see ICOBS 1 Annex 1, part 2, para 1.1)
- <sup>5</sup> As in, for instance, the speech by The Financial Secretary to the Treasury, Mark Hoban MP, on 26 July 2010.
- <sup>6</sup> As described by Laura Hodgson and Simon Baker in their article at page 3 of this issue of the BILA journal
- <sup>7</sup> “Insurance contract law: a joint scoping paper”, 2006.
- <sup>8</sup> “The price of unfair treatment” BILA Journal issue 120, page 6.
- <sup>9</sup> Referred to in the FSA’s policy document “A new regulator for the new millennium” in January 2000.
- <sup>10</sup> “The Financial Conduct Authority: approach to regulation”, para 1.10.
- <sup>11</sup> “Insurance contract law: a joint scoping paper”, 2006.

## **The BILA cyber risk mock trial**

By Laura Crowley, barrister, 4 Pump Court

### **Introduction**

On 22 June, the British Insurance Law Association (BILA) and the Professional Liability Underwriting Society (PLUS) joined forces to stage a mock trial which focused on the highly topical issue of cyber risk. The mock trial took place in Court 4 at the Royal Courts of Justice, Strand, before Lord Justice Aikens and was attended by a full-capacity audience. The counsel involved were Michael Douglas QC and James Leabeater of 4 Pump Court and Tom Weitzman QC and Nicholas Hill of 3 Verulam Buildings.

### **Cyber crime**

Cyber crime is the fastest growing area of organised crime and the insurance industry has reacted rapidly in response to this. “Cyber is one of the key transformational areas of insurance in that its growth is being driven by generational changes in commerce and our social environment”, observed Rick Welsh, Cyber Liability Underwriter at ANV insurance, and one of the participants in the event. “The way we have globally embraced technology to communicate and facilitate commerce means that cyber is emerging as a class of insurance with great growth potential. A once in a generation opportunity, if you like, for the insurance market.”

While there have been a number of high-profile breaches such as the Sony hack, as yet there have been no reported claims in this country which have gone to trial. The event was designed to educate and inform attendees, in an entertaining format, about some of the main issues arising in relation to insurance policies covering this type of risk, both on the underwriting and claims sides. The audience included a number of experts in the field but there were also many who were new to this area and who were there to learn.

### **Cyber liability and cover**

The event began with a preliminary afternoon session in the auditorium at Freshfields Bruckhaus Deringer LLP, it was chaired and guided through by Stephen Lewis of Clyde & Co, the Chairman of BILA. This was designed to explain the basic nature of cyber liability and cover. Ken Munro of PenTest Partners used a Playstation 3 to demonstrate some of the techniques commonly deployed by hackers. This was followed by a panel discussion on the underwriting of cyber risks. Rick Welsh and Pat Donnelly, the Chief Operating Officer of AON Broking Financial Services Group, looked at the product from a real-life perspective and highlighted a few aspects where it differs from the facts in the mock trial scenario. For example, the underwriter would have employed his own cyber expert to examine the risk at the underwriting stage, rather than simply relying on the policyholder’s disclosure. David Nayler, the Head of UK FSG Legal & Claims Practice at Aon Financial Services Group, discussed the product from the claims perspective.

## **The scenario for the mock trial**

The scenario for the mock trial was introduced in a role play session in which several experienced lawyers and insurance professionals gamely agreed to participate. The nature of the product and the risk were explained in a broker pitch and the placing broker gave an insight into the information an underwriter would be looking for when writing this type of business.

The scenario was based around several real claims and so was particularly instructive in illustrating the sort of issues that arise. It involved a claim brought by “JustCard,” a small pre-paid card processing business against its insurer, “Cybersafe,” for indemnity under a Cyber-Policy for losses caused as a result of a cyber attack. The cyber attack involved 50 counterfeit prepaid cards being used to withdraw £15.8 mill from ATMs in 30 countries. The method used by the cyber gang was a variant of the so-called “buffer overflow” technique. The losses included the initial £15.8 mill cost of reimbursing customers for sums taken from their cards and £24 mill crisis management costs, with £5 mill in long-term remediation costs and £3mill other potential liabilities. Such losses would be quite typical.

The role of the CEO of the policyholder was played by Christine Williams, a barrister working as a claims specialist at Xchanging Claims Services; the risk manager by Jacquetta Castle, a partner in insurance law at Fishburns and a former chairman of BILA; the underwriter was played by Rick Welsh; and the broker by Patrick Donnelly.

## **The mock trial**

The event culminated in a mock trial in a packed courtroom in the Royal Courts of Justice in London, attended by about 160 delegates, at which Lord Justice Aikens presided. JustCard was represented by Michael Douglas QC and James Leabeater of 4 Pump Court and Cybersafe was represented by Tom Weitzman QC and Nicholas Craig of 3 Verulam Buildings.

The arguments in the case raised issues which could potentially arise in such policies. JustCard had chosen not to upgrade its security software to the most recent version for purely financial reasons. It was not asked and did not inform the underwriter that this was the case, although it provided the technical documentation about the software it owned.

CyberSafe argued that it was entitled to avoid the policy for material non-disclosure. It argued in the alternative that it was entitled to decline indemnity on the basis of an exclusion clause which required JustCard to “use best efforts to install commercially available software product updates and releases”. (Interestingly, in the panel discussion Pat Donnelly had said that he would never have allowed this exclusion clause to pass through as it was). Arguments were also raised as to the recoverability of specific types of cost, based on the policy wording, if cover as a whole could not be resisted.

Some lively and persistent cross-examination of the witnesses, played by Rick Welsh, Christine Williams and Jacquetta Castle, ensued. This provided an engaging and entertaining means of exploring the facts of this particular case. In the course of evidence, it became clear, for example, that information about upgrades did not, on the evidence of the underwriter, influence him. Counsel delivered closing submissions, interspersed with searching questions from Lord Justice Aikens.

### **The outcome**

At the close of proceedings, Lord Justice Aikens delivered a clear and concise judgment, an approved transcript of which appears at page 34. The judge held that, based on the underwriter's evidence, CyberSafe was not entitled to avoid for material non-disclosure. However, since JustCard had made no attempt to upgrade their software or explore alternatives, cover was excluded by the exclusion clause. A victory for insurers on this occasion, which greatly pleased the audience! The evening rounded off with a garden party at Gray's Inn.

### **Comment**

This was an extremely informative event about an area which is likely to increase in significance. "The key to this great potential is understanding how cyber insurance is as relevant to our clients as insurance for tangible property", concluded Rick Welsh. "The BILA/PLUS Cyber Mock Trial was useful in helping to do that. Recent attacks such as the Sony data breach have so much relevance to this new class and the event was a useful forum to help articulate that."

From a BILA/ PLUS perspective, it was also a very successful collaboration, which brought together the underwriting, broking and legal communities.

The event was filmed for educational purposes. Video clips of the event at Freshfields, the mock trial and the judgment are accessible on the websites of BILA and PLUS .

*An earlier version of this article was previously published in the 8 July 2011 issue of "Insurance Day"*

## ***JustCard plc v Cybersafe Ltd mock trial: judgment***

By Sir Richard Aikens

**Note: this “judgment” is not to be regarded as an official view on either the facts or the construction of the terms considered. For the background to the mock trial see the article by Laura Crowley at page 31.**

1. This is a claim on a policy called a cyber protection policy which came into effect on 1 January 2011 for 12 months. The claimant is JustCard plc, which is a small pre-paid card processing business. It uses its own processing system called “ProcessSys”. The defendant, the insurer, is Cybersafe Ltd, who wrote this policy through their underwriter, Mr. Frye, who gave evidence before me.
2. There was a cyber attack on JustCard’s system in February 2011. As a result unauthorised ATM withdrawals totalling £15.8 million were made. This attack occurred by means of 10,000 individual withdrawals in some 30 countries. The underwriters were notified of these unauthorised withdrawals very soon thereafter. The system, ProcessSys, was shut down. Lawyers, public relations consultants and an information systems specialist were appointed by the assured to conduct an investigation into the system, the company’s infrastructure and all the processes. The clients of JustCard had their accounts reimbursed with all their losses within a matter of 3 days.
3. However, JustCard claim losses totalling some £73 million. They say that the initial fraud losses were those represented by the repayments that they had to make to the customer accounts. They say they incurred “crisis management” costs of £24 million. There were other costs under 3 heads of £26, £5 and £3 million respectively which I need not detail.
4. The defences to the claim are these: first it is said that there was non-disclosure of material facts. Secondly it is said that Exclusion 2A of the policy applies to exclude all liability.
5. If those defences fail then underwriters have two defences in relation to two particular claims. First, they say that the initial fraud losses are not within the terms of the insuring agreement 3. Secondly, they say that the crisis management costs are not within the terms of insuring agreement 6. Those are the relevant insuring agreement terms under which those particular claims have been made.
6. I heard evidence from two witnesses on behalf of the claimant. They were Miss Hancock, who is the CEO of the claimant, and Glenda Avery, who is the risks manager. They gave their evidence clearly and concisely. I am satisfied that they were telling the truth.
7. I heard evidence from Mr. Frye, the underwriter. I am satisfied that in general terms

he also gave clear, concise and truthful evidence. There is, however, one respect in which his evidence under cross-examination did not accord with that which he gave in his witness statement. In his witness statement, paragraph 9, he says that had he been told in December 2010 that JustCard had not upgraded its software to edition 3.17 “...I would have required as a condition of cover that this upgrade be installed because out of date security protection materially increases the risk of a cyber attack being successful”. When he gave answers to the questions in cross-examination he said that he did not ask about upgrades, but he did not do so because it was not in his thinking at the time.

8. The basis for the non-disclosure defence is that the underwriters were not told about the fact that JustCard had decided, for entirely commercial reasons, that they would not upgrade the software for their system because it was going to cost them £2 million to do so. Miss Hancock was frank in saying that under normal circumstances she would have wished to have upgraded to the system 3.17 and that she recognised that upgrades were needed to prevent attacks by hackers. Similarly Miss Avery accepted in cross-examination that, from a pure security perspective, an upgrade should have been made.
9. In my judgment there is no doubt that the fact that the assured had made this decision not to take the upgrade is a material fact. It is something which a prudent underwriter would want to know and it is a question that the prudent underwriter would be interested in for the purposes of this type of insurance. However, I am not convinced, having heard Mr. Frye, and seen him in the witness box, that he was influenced by this non-disclosure and in any sense “induced” by the non-disclosure of the decision not to up-grade to enter into the insurance. That is because, it seems to me, the evidence that he gave in the witness box more accurately reflected his position as underwriter, at the time that the risk was written, than that which is said in the carefully crafted paragraph 9 of his witness statement.
10. Accordingly I am not satisfied that the non-disclosure defence succeeds.
11. I turn then to Exclusion 2A. This exclusion will only be of assistance to the underwriters if it can be established that any claim was “directly or indirectly arising out of or attributable to the failure to use best efforts to install commercially available software product updates and releases”. So far as the second part of that quotation from the exclusion wording is concerned, I am satisfied that the assured used no efforts whatsoever to use commercially available product updates. Indeed they made a positive decision not to do so.
12. The key question, therefore, is whether or not any claim “directly or indirectly arises” out of the fact that the assured made no effort to install commercially available software product updates and releases. The argument of the insurers is that, on the facts, if the update had been installed the type of attack which was in fact used would have been

prevented. However, it is, I find, clear that cyber attackers could have used other methods which would have been successful. So the question is whether or not the opening words “We shall not be liable for any claim directly or indirectly arising out of or attributable to the failure ...” means that in this case there is no cover, or rather cover is excluded.

13. I have come to the conclusion that this exclusion does operate in favour of the insurers. This is because the exclusion must relate to the particular claim with which the insurers are faced. Any claim cannot just be put in the abstract. This is a claim based on this particular type of cyber attack and the particular methods that were in fact used by the attackers. That attack and those methods would have been prevented if those best efforts have been used by the assured to install the up to date software.
14. I find, therefore, that this claim is excluded in total. I will, however, go on briefly to deal with the two further matters which were argued before me.
15. I should say that the argument, and indeed the presentation of the case generally, and the handling of the witnesses were all accomplished with considerable expertise and dispatch by all counsel, to whom I am extremely grateful.
16. I deal first, then, with the question whether or not, had there been cover, there would have been a right to be indemnified in respect of the costs to the assured of reimbursing the client accounts. This depends upon the correct construction of insuring agreement 3. It states that the insurers will pay on behalf of the assured all damages which the assured becomes legally obliged to pay as a result of any claim made against the assured as a result of one of the insured events.
17. The problem for the claimants is that there is no loss that was incurred by the clients and there are no damages which the assured have become legally obliged to pay. The position was, before the attack, that the assured were debtors of their clients to the extent of the credit on each of their clients’ accounts. That remained precisely the position after the attack. The fact that there was a cyber attack made no difference to the position as between the assured and their clients; the first was the debtor of the second.
18. So, in my opinion, the reimbursement of the client accounts is not a claim which falls within the terms of the cover. There is no claim for damages that a client has made against the assured as a result of an insured event. In any event there has been no “claim” within the definition of that phrase in the policy. Accordingly I would have, in any event, rejected that claim.
19. The second head of claim that is in question is the claim for crisis management costs. Here the boot is on the other foot. The underwriters say that before there can be any liability, the crisis management costs that are claimed have to have been approved by them before the costs are incurred. For this purpose they rely upon the definition of crisis management costs at page 9 of the policy wording.

20. I cannot accept that argument. In my view the correct construction of insuring agreement 6 is that there is a liability for crisis management costs as a type of expense, provided that those have been incurred following a security breach and provided that the security breach has been notified by the assured in writing to the underwriter, in accordance with the policy terms.
21. It is only when one turns to the question of “how much crisis management costs?” that the definition of that term becomes relevant. And it is in those circumstances that the assured can only recover any fees reasonably incurred by him, which fees have been approved by underwriters, i.e. at the point when questions of quantum arise. Those fees have to have been incurred for the purpose of the employment of a public relations consultant, etc.
22. I do not accept the argument that “approved by us” means that there has to be prior approval before liability can even be incurred. If it was such a pre-condition one would expect it to be in clear terms in the insuring agreement clause. It is not.
23. Accordingly I would have accepted that there was liability in principle for such costs. This hearing, however is not dealing with quantum, so I have no need to go into that in any event.
24. But, as I have already indicated, in fact the underwriters succeed in their defence on the exclusion clause. Therefore this claim must fail.

*Sir Richard Aikens is a Lord Justice in the Court of Appeal and the deputy president of BILA.  
His participation in the cyber risk mock trial was in an unofficial capacity.*

# Consumer insurance and the duty of disclosure

by Peter J Tyldesley<sup>1</sup>

## Summary

The landmark report by the British Insurance Law Association (“BILA”), *Insurance Contract Law Reform*, published in September 2002, was a significant influence in persuading the Law Commissions to start their current review of insurance law.<sup>2</sup> On 15 June 2011 the first measure resulting from that review—the Consumer Insurance (Disclosure and Representations) Bill—received its second reading in the House of Lords. The Bill is currently being scrutinised by a Special Public Bill Committee. If enacted, it will abolish the duty of disclosure in consumer insurances. This article looks at the history of the duty of disclosure and questions whether such a duty should ever have been imposed on consumers.

## 1. *Lambert v Co-operative*

The perceived weaknesses of the current law are well illustrated by the experience of Mrs Lambert, who made a claim under an all-risks policy covering her jewellery (*Lambert v Co-operative Insurance Society Ltd* [1975] 2 Lloyd’s Rep 485). The claim was rejected by the insurer on the grounds that Mrs Lambert had breached the duty of utmost good faith by failing to disclose that her husband had been convicted of handling stolen goods. No doubt this came as something of a shock to Mrs Lambert. She had held the policy for over nine years and at no time had the insurer asked her any question about convictions. It is likely that she would have been even more surprised to learn that in rejecting her claim the insurer was relying on law set down in a case concerning a French raid on the Island of Sumatra during the Seven Years War.

## 2. *The French attack Fort Marlborough*

On 29 March 1760, Roger Carter, Governor of Fort Marlborough on Sumatra was faced with an unsettling sight. Two hostile French vessels, a 44 gun warship, the *Condé*, and an 18 gun frigate, the *Expédition*, had sailed into the bay outside the fort. Carter had earlier received reports that French vessels were carrying out attacks along the west coast of Sumatra and so had feared their arrival.

Fort Marlborough was an East India Company trading post with a garrison constructed to withstand attack by the native population of the island, not by a European enemy. Accounts of the forces available for its defence vary considerably, but there were probably no more 100 Europeans, 300 Malay mercenaries and 100 slaves. The strength of the garrison really lay in the difficulty of a close approach by sea, hampering any attempt to bring fire to bear from attacking vessels. Furthermore Carter was merely a mercantile not a military Governor. He had nevertheless made some hasty preparations for a defence. On

27 March 1760 an East Indiaman, the *Denham*, under Captain William Tryon had arrived at Fort Marlborough. At Carter's insistence this 499 ton vessel had remained to assist in resisting any French attack.

The French vessels were under the command of the Comte d'Estaing. D'Estaing had begun his career as a soldier. Following the outbreak of the Seven Years War, he fought with the rank of Brigadier General under the Comte de Lally in India and was at the siege of Fort George at Madras. On 14 December 1758 English forces under Lieutenant-Colonel William Draper conducted an unexpected sally from the fort. In the ensuing mêlée, D'Estaing was thrown from his horse. At the point of being sabred by two drummers, he was saved by an English officer, who took him into the fort to be held prisoner. After the siege was broken, d'Estaing gave his parole and was freed to make his way to England to surrender to George II. His parole was apparently in the usual terms, that is "not to serve directly or indirectly against the British during the present war, or until he should be regularly exchanged".

Regrettably, d'Estaing rapidly broke his word. Entering the service of the French East India Company he took command of four French ships. On 13 May 1759 he landed to the west of Gombroon and launched an attack on the English factory there. Capitulation was swift, and the terms agreed involved the English handing over the factory, its contents and a large sum of money. Next d'Estaing sailed to the west coast of Sumatra. In the north the English settlement of Natal was the first to be attacked and surrendered on 7 February 1760. On 15 February 1760 Tappanooly suffered the same fate having withstood a cannonade for three days. D'Estaing then moved south to Fort Marlborough.

On 29 March 1760, Carter decided that rather than forming part of a defence the *Denham* should be offloaded and then destroyed by fire. Accordingly the *Denham* was set ablaze the following day. For the crew, this was a troubling time. Many lost possessions which it had proved impossible to remove from the ship prior to its destruction. In addition there was doubt over their wages—their mariners' contracts provided that they would only be entitled to the initial imprest and one month's wages in every six should the ship "by danger of the sea or any other accident be destroyed, and shall not return safe to England".

Carter met with the Council of Fort Marlborough and it was agreed that the trading post should be surrendered. On the night of 31 March 1760, with morale deteriorating rapidly, the English left the fort and set off into the interior of Sumatra. The flight was chaotic, with inadequate supplies and no discernible plan. After four days, news reached the fugitives that the French had pursued them and were close by. Miserable, hungry and fearful of ill-treatment from the native inhabitants of the island, the English surrendered. Despite commitments from d'Estaing further humiliation followed – and for some, illness and death:

“...the fugitives surrendered to the enemy, in order to avoid being cut to pieces by the natives, which they had reason to expect if they

continued in that defenceless condition. The French commander promised that their effects and private property should be secured for them, but his proceedings were quite the contrary; he allowed his soldiers and sailors, who came thither in rags, to plunder and ransack all the houses, and put on the cloaths of the inhabitants, as well as to steal and put on board the ships all the moveable effects they could find. In June they were sent away to Batavia, and from thence to Bengal; but before they arrived at this place many died of the flux, occasioned by the bad food which they had from the French.”<sup>3</sup>

The French remained at Fort Marlborough for at least 3 months. Two English vessels, the *Norfolk* and the *Duke of Richmond* called at Fort Marlborough on 21 July 1760 but left when the crew of the boats they sent to shore were promptly taken prisoner.

D’Estaing later attempted to return to France as a passenger on the *Boulogne*. On 6 January 1762 an East Indiaman, the *Venus*, under Captain Harrison attacked the *Boulogne*, seizing it after an hour-long battle. For a second time, d’Estaing was a prisoner of the English. He was taken to Plymouth where he was formally identified by Draper, his old adversary from Madras, who was there by mere chance, awaiting the fitting out of a ship. As he had broken his parole, d’Estaing was sent to the common prison. There was little English sympathy for d’Estaing, given his conduct. Indeed, Admiral Boscawen, then commander-in-chief in India, reportedly said that if ever he should get “the villain” in his power again, he “would chain him upon the quarter-deck and treat him like a baboon”.

Nevertheless d’Estaing’s stay in prison was short-lived. From secret correspondence between the Earl of Egremont and the Duc de Choiseul it appears that by 7 March 1762 he had been released at the wish of George III following the intercession of Louis XV. This was a decision the English would regret. On 13 April 1778, having achieved the rank of Vice Admiral, d’Estaing sailed from Toulon in command of 26 ships—the first French fleet sent to assist America in its War of Independence.

### **3. *Carter v Boehm***

Roger Carter had been concerned about the possibility of an attack on Fort Marlborough and the risk this would pose to his trading goods. On 22 September 1759, he had therefore written to his brother, George Carter, in London asking him to arrange a suitable insurance policy. Cawthorne, a broker instructed by George Carter, obtained cover of £10,000 at a rate of 4 per cent with a well-known London merchant and insurer, Charles Boehm. The insurance, signed on 9 May 1760, was to run from 16 October 1759 to 16 October 1760 “for the benefit of Governor Carter, and to insure him against the taking of the fort by a foreign enemy.”

After the French took Fort Marlborough, Roger Carter, who had lost goods valued at £20,000, made a claim under the policy. That claim was rejected by Boehm. After a period

in Chancery, where a jury gave a decision in favour of Carter, the matter came before Lord Mansfield. Boehm argued that the earlier decision should be set aside as the state and condition of the fort and the content of three letters had not been disclosed to him at the time the policy was effected. One of these letters had been sent to Roger Carter by a Mr Winch in February 1759, and mentioned that the French had planned an attack on Fort Marlborough in the previous year. Another was written by Roger Carter to the East India Company in September 1759 warning that this plan might be revived. The third was the letter written by Roger Carter to his brother in the same month asking him to arrange insurance, and expressing fears of an attack given the difficulties the French would have in intervening in the conflict elsewhere.

Although it is clear that the duty of disclosure had been recognised long before 1766, the decision of Lord Mansfield is the first clear exposition of the obligations on insurer and prospective insured alike. We have the advantage of two reports of the case, one by Sir William Blackstone (*Carter v Boehm* 1 Black W 593) and the other by Sir James Burrow (*Carter v Boehm* (1766) 3 Burr 1905).<sup>4</sup> It is Lord Mansfield's words as noted by Burrow which have been most widely quoted:

“Insurance is a contract upon speculation. The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only; the under-writer trusts to his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge, to mislead the under-writer into a belief that the circumstance does not exist, and to induce him to estimate the risque, as if it did not exist.

The keeping back such circumstance is a fraud, and therefore the policy is void. Although the suppression should happen through mistake, without any fraudulent intention; yet still the under-writer is deceived, and the policy is void; because the risque run is really different from the risque understood and intended to be run, at the time of the agreement.

The policy would equally be void, against the under-writer, if he concealed; as, if he insured a ship on her voyage, which he privately knew to be arrived: and an action would lie to recover the premium.

The governing principle is applicable to all contracts and dealings.

Good faith forbids either party by concealing what he privately knows, to draw the other into a bargain, from his ignorance of that fact, and his believing the contrary.

But either party may be innocently silent, as to grounds open to both, to exercise their judgment upon.”

Subsequent cases, notably *Pan Atlantic v. Pine Top* [1995] 1 AC 501, have further clarified the law. It is now firmly established that a policy of insurance is a contract of the utmost good faith and that a prospective insured is therefore under a pre-contractual duty of disclosure to volunteer all material facts to the insurer. A material fact is one which would have an effect, not necessarily decisive, on the mind of a prudent insurer in assessing the risk. If the insurer is induced to offer cover by the non-disclosure of a material fact it may, on becoming aware of the true position, avoid the policy and reject any claims which have been made. This is so regardless of whether the non-disclosure was fraudulent, negligent or entirely innocent.

The present law has in some respects departed from the principles expounded by Lord Mansfield. Most obviously, Lord Mansfield considered that the obligation to act in good faith was applicable “to all contracts and dealings”, whereas it has subsequently been restricted to limited classes of transactions, including insurance policies. Lord Mansfield also recognised the distinction between a concealment which the duty of good faith prohibited and mere silence.<sup>5</sup> And he was clear that in some cases a failure of the insurer to ask questions might amount to a waiver of information:

“The underwriter knew the insurance was for the governor. He knew the governor must be acquainted with the state of the place. He knew the governor could not disclose it, consistent with his duty. He knew the governor, by insuring, apprehended at least the possibility of an attack. With this knowledge, without asking a question, he underwrote.

By so doing, he took the knowledge of the state of the place upon himself. It was a matter as to which he might be informed various ways: it was not a matter within the private knowledge of the governor only.”

Not only has the law become onerous for prospective insureds, the terminology has also changed. The fact that a policy of insurance is a contract of the utmost good faith is one of the first lessons drummed into anyone taking up employment in insurance. Leaving aside the question of whether there can be degrees of good faith, Lord Mansfield appears never to have used the phrase, referring instead simply to good faith. It is possible that the addition of “utmost”, which took hold in the latter half of the 19<sup>th</sup> century, is a development from a passage from the first edition of the second volume of Blackstone’s Commentaries relating to marine insurance:

“Thus much may however be said; that, being contracts, the very essence of which consists in observing the purest good faith and integrity, they are vacated by any the least shadow of fraud or undue concealment...”

This volume was published on Friday 3 October 1766—some months after the hearing of *Carter v Boehm* on 1 January 1766.<sup>6</sup> No authority is given for the use of the word “purest” nor does it appear in Blackstone’s report of *Carter v Boehm*, published

posthumously in May 1781.<sup>7</sup> The first edition of Park's "A System of the Law of Marine Insurance" published in December 1786,<sup>8</sup> also refers to purest good faith, but does not give Lord Mansfield as the source—rather it cites Blackstone and other writers.<sup>9</sup>

#### **4. The position of consumers**

Should a duty of disclosure ever have been imposed on consumers? Like many other aspects of insurance law, the rules relating to disclosure have been hammered out largely in commercial insurance cases, including disputes between insurers and reinsurers. Applying the same rules without modification to consumer insurances inevitably produces less than satisfactory results. In particular, six main criticisms may be made of the law:

- The test of materiality requires the consumer to look into the mind of a prudent underwriter—few will have the expertise to do so.
- In law there is no obligation on the insurer to ask any questions.
- The degree of culpability of the consumer is irrelevant—even innocent non-disclosure may lead to avoidance.
- Once a policy has been avoided, any claim can be rejected, even if there is no connection between the non-disclosure and the loss.
- The law encourages poor underwriting practice. An unscrupulous insurer may limit the questions it asks when a policy is sold, but if a claim is made it can search for a non-disclosure to escape liability.
- When a policy is avoided the consumer faces a triple whammy—loss of cover, loss of any claims and a future of serious difficulties obtaining cover at a manageable premium.

Lord Mansfield gave his judgment in a very different world, where mass-market consumer insurance policies did not exist. The first motor insurance policy was not issued until 1896, and certain other lines of business are much more recent—for example critical illness insurance was not available in the UK until 1984. Those personal lines products which did exist in 1766 were the preserve of the wealthy and the cover was of a rather different nature. Household policies, for instance, had been available from the 17<sup>th</sup> century but were typically limited to fire risks. With the exception of industrial branch penny policies there were no mass-market products until well into the 20<sup>th</sup> century. Current sales channels are also markedly different to those which existed in 1766. Lord Mansfield was familiar with face-to-face commercial insurance transactions in the coffee houses of Georgian London. Would he have thought that the same rules should apply to consumers buying insurance by telephone or over the internet?

Commercial insureds may value pragmatism and certainty. However, in other areas modern law recognises that consumers are deserving of a measure of protection and an approach grounded in fairness. There are at least seven factors which might lead one to question whether the duty of disclosure should apply to modern consumer insurance transactions:

## **Expertise**

In the 18<sup>th</sup> century the sharing of risk was commonplace in the City of London; a merchant might be an insurer one day and an insured the next. Consequently it was not unreasonable for prospective insureds to be expected to understand what needed to be disclosed. Contrast this with the position of a modern consumer who will typically have no knowledge of insurance law or practice.

## **Knowledge**

Lord Mansfield suggested that “the special facts...lie most commonly in the knowledge of the insured only”. This carries more truth where custom policies on business risks are concerned. For standard consumer risks, insurers have access to a wide range of databases, research results and loss statistics. For example, 95% of the household insurance market is covered by the Claims and Underwriting Exchange, a system which records previous losses and claims and will often prove more accurate than a consumer’s memory.

## **Bargaining power**

In *Carter v Boehm*, Lord Mansfield was settling the rules to be applied to business insurances, where a prospective insured may have broadly similar bargaining power to the insurer. Nowadays, it is common for larger commercial insureds to insist that the impact of non-disclosure is modified by contractual term (see, for example, the “innocent non-disclosure” clause in *Arab Bank Plc v Zurich Insurance Co* [1999] 1 Lloyd’s Rep 262). Indeed in June 2011 the Association of Insurance and Risk Managers in Industry and Commerce published a standard wording to be used for this purpose. A consumer simply does not have this bargaining power and will typically contract on the basis of standard policy wordings drafted by the insurer.

## **Communications**

In 1759, it might take a year or more for a letter to be sent by packet ship to Sumatra and for a reply to be received. Indeed the state of communications was such that unknown to the parties in London, Roger Carter’s policy was arranged more than a month after the loss had occurred. Boehm had no opportunity for a discourse with Roger Carter—writing insurance at such a distance would have been totally impracticable unless the prospective insured could be relied upon to disclose the relevant information. Nowadays questions can rapidly be posed and answered over the web, by telephone, email, fax or post.

## **Absence of advice**

Roger Carter’s policy was arranged by a broker. In contrast, modern consumer policies are frequently purchased over the internet or telephone without the benefit of a broker’s advice.

## Misuse

It is often overlooked that Lord Mansfield found in favour of Carter. In doing so, he recognised that the remedy of avoidance carried risks of misuse: “If the defendant’s objections were to prevail, in the present case, the rule would be turned into an instrument of fraud”. What, one wonders, would Lord Mansfield have made of an insurer promising to give “careful and sympathetic consideration” to medical records when in reality its sole purpose was to seek any entry which might give grounds for avoiding or invalidating the policy (*Cuthbertson v Friends Provident* [2006] CSOH 74)? Or the insurer who rejected a leukaemia claim under a critical illness policy for the failure to disclose mild unrelated hearing loss (Ombudsman News 27, Case 27/5)? Most insurers act decently most of the time. Nevertheless, given the relatively weak position of consumers and the potential impact of avoidance, is the risk that the duty of disclosure will be misused simply too high?

## Reciprocity

Lord Mansfield considered that the duty of disclosure was reciprocal. However over subsequent years, the obligations on a prospective insured appear to have become more onerous whilst the duty of disclosure on insurers has proven to extend only to matters affecting the risk or recoverability of a claim (*Banque Financière de la Cité SA v Westgate Insurance Co Ltd* [1990] 1 QB 665). Furthermore the only remedy available for non-disclosure—avoidance of the policy—is valuable to insurers as it removes the liability to pay claims, but unattractive to consumers who would prefer damages to a mere return of premiums.

## 5. Absence of judicial intervention

Given these factors one might wonder why the judiciary has not been successful in developing a separate set of rules for consumers. In *Lambert v Cooperative* the Court of Appeal was plainly unhappy with the decision it felt bound to reach – as evidenced by the comments of Mr Justice McKenna:

“The present case shows the unsatisfactory state of the law. Mrs. Lambert is unlikely to have thought that it was necessary to disclose the distressing fact of her husband’s recent conviction when she was renewing the policy on her little store of jewellery. She is not an underwriter and has presumably no experience in these matters. The defendant company would act decently if, having established the point of principle, they were to pay her. It might be thought a heartless thing if they did not, but that is their business, not mine.”

In part the lack of judicial intervention may result from an earlier sparsity of opportunity. For many years it was common for consumer insurance policies to include *Scott v Avery* (1856) 10 ER 1121 arbitration clauses, giving insurers the right to insist that all disputes

on liability were referred to arbitration (for which legal aid was not available) rather than the courts. As a result of negotiations during the review of insurance contract law conducted by the Law Reform Committee from 1954 to 1957, the British Insurance Association (BIA) and Lloyd's agreed the industry would cease to use such clauses.<sup>10</sup> However, in more recent years the existence of successive ombudsmen schemes has continued to throttle the flow of consumer insurance cases to the courts.

## **6. Self-regulation, regulation and ombudsmen**

The flaws in the law on disclosure have been recognised in a series of initiatives over many years. In 1975 the English and Scottish Law Commissions published their Second Report on Exemption Clauses, complete with draft Bills. Although the Law Commissions had always intended that insurance policies would be within the ambit of the proposed legislation, this possibility was opposed by the BIA. In 1977, the Government agreed that it would exempt insurers from the main provisions of what was to become the Unfair Contract Terms Act 1977, in return for the BIA promulgating two codes of practice for consumer insurances—the Statement of General Insurance Practice (SGIP) and the Statement of Long-Term Insurance Practice (SLIP).

Both SGIP and SLIP required insurers to ask clear questions about those matters generally found to be material and to provide a warning regarding the consequences of non-disclosure. SGIP indicated that an insurer should not unreasonably repudiate liability for innocent non-disclosure which had not materially influenced its judgment. SLIP provided that claims should not be rejected for non-disclosure of a matter outside the knowledge of the consumer. However, the codes were not legally binding and initially there was no ombudsman to provide a means of enforcement. The limited impact of these arrangements caused one academic to comment that “it all seems a rather pointless exercise”.<sup>11</sup>

More dramatically, on 3 December 1980 the Guardian Royal Exchange (GRE) circulated an internal memorandum stating that for consumer non-life insurances it would no longer rely on the duty of disclosure.<sup>12</sup> The move was driven by Mike Harris, Assistant General Manager, who explained his reasoning in a letter published by the Post Magazine on 14 May 1981:

“You cannot import into the way we handle bulk insurance products now the close contractual relationship derived from the time a ship or cargo owner dealt directly with an underwriter in a coffee house 300 years ago and bargained over a single voyage....

Defence of the traditional duty implies that although for many years we have handled hundreds of millions of transactions we still do not know all the right questions to ask. If this be so, then surely many of us should be seeking a living in some less demanding walk of life? I do not believe it is so.”<sup>13</sup>

The GRE reviewed this approach in 1984 and concluded it should be maintained as it had caused no difficulties in practice. With effect from 15 June 1984 the GRE also abandoned the use of basis of the contract clauses in non-life consumer insurances.

In 1986 SGIP and SLIP were enhanced as part of a deal between the Association of British Insurers (successor to the BIA) and the Government, this time to avoid implementation of the English Law Commission's proposals for reform published in 1980. Under the claims section of the amended SGIP, for instance, paragraph (b)(ii) provided that an insurer would not repudiate liability to indemnify an insured on grounds of non-disclosure of a material fact which an insured could not reasonably be expected to have disclosed. Again the academic reaction was not encouraging with the changes being described as representing "a minimalist attitude to the problem of abuses".<sup>14</sup>

Nor was there any movement with the introduction of statutory conduct of business regulation. SGIP, for example, was withdrawn with the introduction of ICOB—the Insurance Conduct of Business rules—on 15 January 2005. Some, but by no means all of its provisions were imported into the rules in modified form and are now to be found in ICOBS. On the duty of disclosure, ICOBS 8.1.2 largely follows paragraph (b)(ii) of SGIP but adds the odd proviso "except where there is evidence of fraud".

The real leap forward in this area must be credited to successive ombudsmen. On 31 March 1981 the Insurance Ombudsman Bureau (IOB), brainchild of Mike Harris of the GRE, opened for business. Membership was voluntary, but grew rapidly until it included nearly all insurers offering consumer policies. One major advantage of the IOB compared with the courts was that it was empowered to look beyond the strict law in making its decisions. In particular, the Ombudsman's Terms of Reference allowed him to take into account codes of practice, good insurance practice and, after an amendment initiated by the second ombudsman, Dr Julian Farrand, what was "fair and reasonable in all the circumstances". Farrand indicated that he would apply a proportionate approach in cases of unintentional non-disclosure. His successor, Laurie Slade, seemed to go further, suggesting that in the absence of clear questions at inception or renewal an insurer would be taken to have waived the requirement of disclosure<sup>15</sup>.

In 1994 the handling of complaints relating to investment business moved to the Personal Investment Authority Ombudsman Bureau (PIAOB), which regrettably had no "fair and reasonable" power. However in 2001 both the IOB and the PIAOB were replaced by the Financial Ombudsman Service (FOS). Under section 228 of the Financial Services and Markets Act 2000 the ombudsman is obliged to make

decisions under her compulsory jurisdiction in accordance with what she regards as fair and reasonable in all the circumstances. As set out in Ombudsman News 46 as long ago as 2005, the FOS does not allow insurers to rely on the duty of disclosure—if an insurer requires information it must ask a clear question. This approach has operated successfully for a number of years, and has been adopted by all the better insurers.

In 2006–07, the last year for which figures are available, the FOS closed 1,047 complaints from consumers about issues of non-disclosure and misrepresentation. However, the FOS is not a complete remedy to the ills of the law. It cannot make binding awards in excess of £100,000 (£150,000 from 1 January 2012) and a consumer with a loss in excess of this figure must abandon the balance of their claim or face the full harshness of the law in the courts (*Andrews v SBJ Benefit Consultants* [2010] EWHC 2875). In addition the DISP Sourcebook provides a range of grounds on which cases may be dismissed without consideration of the merits.

Furthermore, the overall impact of these conflicting layers of law, self-regulation, statutory regulation and ombudsman guidance is the risk of some confusion.

## 7. Conclusion

The anticipated abolition of the duty of disclosure in consumer insurances is to be welcomed. It is hardly surprising that law developed in commercial litigation may result in injustice and damaging publicity for the industry when applied to modern mass-market consumer policies. Successive ombudsmen have declined to allow insurers to rely on the duty of disclosure in consumer cases. Like the earlier bold experiment by the GRE this has caused no problems in practice. The reforms in the Consumer Insurance (Disclosure and Representations) Bill will sweep away the muddled patchwork of archaic law, FSA rules, industry codes and FOS guidance, providing in its place simple, clear and fair law. BILA is to be congratulated for the part it has played in initiating this measure.

## Endnotes

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- <sup>1</sup> Peter Tyldesley is Senior Research Fellow in Law at St Mary's University College, Twickenham and is undertaking a PhD in insurance law under the supervision of Professor John Birds at the University of Manchester. He is indebted to Saira Paruk of Quadrant Chambers for commenting on an earlier draft of this article; any errors remain his own.
- <sup>2</sup> Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation 2009 (Cm. 7758), page 2.
- <sup>3</sup> An Impartial History of the Late War, John Almon, 1763.
- <sup>4</sup> It is clear that some of the factual details in the reports are incorrect—for example, at [1906] Burrow confuses the two Carter brothers. For the purposes of this paper reliable contemporary records have been preferred where available.

- <sup>5</sup> See the comments of Lord Justice Rix in *HIH Casualty and General Insurance Limited v Chase Manhattan Bank* [2001] EWCA Civ 1250.
- <sup>6</sup> *Gazetteer and New Daily Advertiser*, Wednesday 1 October 1766.
- <sup>7</sup> *St. James's Chronicle or the British Evening Post*, 22–24 May 1781.
- <sup>8</sup> *Morning Chronicle and London Advertiser*, 25 December 1786.
- <sup>9</sup> At page 195.
- <sup>10</sup> From 1 July 1995 such clauses were in any event likely to be regarded as unfair and therefore not binding on the consumer by virtue of the Unfair Terms in Consumer Contract Regulations 1994. See now Schedule 2 para 1(q) of the Unfair Terms in Consumer Contract Regulations 1999 and section 91 of the Arbitration Act 1996.
- <sup>11</sup> *The Statement of Insurance Practice – A Measure of Regulation of the Insurance Contract*, John Birds, 40 *Mod Law R* 1977, page 677.
- <sup>12</sup> I am grateful to Nick Feldman for a copy of this memorandum, which he drafted in his role as Accident Manager (Planning) at the GRE.
- <sup>13</sup> *Why wait for Godot?*, S M F Harris, *Post Magazine*, v 142, no 20 (1981).
- <sup>14</sup> *A D M Forte, The revised statements of insurance practice: cosmetic change or major surgery?*, *Mod Law R*, 1986, p 754.
- <sup>15</sup> Annual Report 1995, page 37.

## **Climate change and insurance law**

By Tim Hardy<sup>1</sup>

***“Climate change is an issue of justice as much as of economic development”***

**Gordon Brown, while UK Chancellor, at G8 meeting of environment and development ministers**

**15 March 2005**

***“You get justice in the next world; in this world you have the law”***

**William Gaddis, A Frolic of his Own<sup>2</sup>**

### **1. Introduction**

With the onset of the global economic downturn, continuing widespread uncertainty in the financial markets and the distractions of political upheaval in many strategically sensitive territories, it is perhaps understandable that for many the issue of climate change has temporarily slipped down their immediate political, economic or business agenda<sup>3</sup>. Yet, the combined effect of growing unpredictability of events, a current underwriting year of major “natural disaster” losses and the need to continue to comply with a raft of existing measures directed at adaptation to, and the mitigation of, the effects of climate change, all means that few current business decisions remain immune from the phenomenon of climate change.

The insurance industry was not slow to recognise that concerns about climate change were not mere abstract scientific hypotheses, particularly when gaining political and public attention and support<sup>4</sup>. Such concerns threaten to have a major impact both upon insurers’ and their clients’ own businesses. Proven climate change itself, and any physical impact it may generate, may both yet lie some years ahead. Precise predictions will be difficult. Disputes over scientific proof and legal attribution will abound. It is not, however, hard to see that taking stock of the fast-changing landscape of regulation, legislation and rulings about liability, from local to global levels, is already having an early significant impact upon most traditional classes of insurance across all property, liability, life and personal lines. For many insurers, any parallels drawn with asbestos or tobacco litigation are enough to make them fear any “worry later” approach.

Insurers and reinsurers have already taken a series of both defensive and innovative steps in the form of policy and underwriting provisions, “green” product initiatives, exploring how best to cover, prevent, contain or even exclude from cover many new perceived exposures. This extends to developing new forms of coverage or methods of risk transfer or containment and securing other funding sources for traditional as well as new technology risks emerging<sup>5</sup>.

In current conditions it should perhaps be no surprise that renewed attacks have been made upon the science upon which has been based the predicted effect of climate change and any responsive measures introduced<sup>6</sup>.

Much has already been written upon the speculation and worries about the threats. Also, upon many of the opportunities such developments may present to insurers. In contrast relatively little time and energy has yet been devoted to the legal aspects of quite how insurers may more specifically be affected.

## **2. AIDA climate change General Report and Working Party**

AIDA<sup>7</sup> is an international association of nearly sixty national insurance law associations (including the British Insurance Law Association (BILA)). It saw the need to identify the most important insurance law issues posed by the phenomenon of climate change.

It adopted “*Climate Change and Insurance Law*” as one of its two major themes to study at its XIIIth World Congress in Paris in May 2010. A questionnaire was prepared by Professor Marcel Fontaine of L'Université Catholique de Louvain in Belgium. Responses gathered over two years by associations operating in over 20 countries served to inform both discussions at the Congress and the General Report published earlier this year by Prof Fontaine.<sup>8</sup>

From the information obtained among the areas considered most to merit comparative study were the following:

- a. Analysis of reports on climate change (and insurance implications) generated by governments, industry, associations, research groups etc.
- b. Identification/consideration of significance of legislation and other regulatory measures/protocols/ initiatives (at national, regional and international level) implemented to combat the effects of climate change.
- c. Evolution of climate change litigation in the US and elsewhere.
- d. Impact of climate change upon traditional lines of insurance and reinsurance (and legal issues arising).
- e. Creation/development of new lines/types of (re)insurance and other products (and legal issues arising) and classification of certain existing products (such as weather derivatives) in the insurance/financial markets.
- f. Special interest topics: i) Carbon Capture & Sequestration/Storage (CCS); ii) Use of cat bonds/ART for weather/carbon market risks etc; and iii) Large-scale natural hazard/pollution liability issues.

To embark upon this task an AIDA Climate Change Working Party was formed last November. Since then much has occurred.

### 3. Events of 2011

As the Working Party's new chair, I was invited to participate this January in the 1<sup>st</sup> Climate Change Summit for Asia's Insurance Industry in Singapore. Then to travel on to Australia to address meetings of three regional sections of the Australian Insurance Law Association (AILA) held in Perth, Sydney and Brisbane.

In Singapore, at the event co-hosted by the Asia Insurance Review and the Geneva Association<sup>9</sup>, the phenomenon of huge new concentrations of potential insured losses becoming established in increasingly climatically-vulnerable locations was identified as a major insurance concern in Asia. Large-scale developments were rapidly appearing in many countries in exposed coastal regions. Mass urbanisation was sweeping the region at remarkable speed and on an unprecedented scale. The diversity of the challenges faced in Asia was also striking. The significance is obvious of any roles played in world level climate discussions by countries of the size of China and India. Concerns about deforestation have particular pertinence in countries where economies are heavily dependent upon timber and logging. Microinsurance may offer a lifeline for many in less developed countries, where physical and economic vulnerability to the impact of extreme weather events is particularly acute.

Australia was experiencing highly varied and volatile weather conditions. As I left Perth the Western Australian authorities were contending with the ravaging effects of bushfires tearing through some parts of the state. In Sydney there was much pre-occupation with the devastating effects of flooding sustained in Victoria, southern Australia and most seriously, Queensland. Large parts of Brisbane, including my final scheduled speaking venue, had been left under several feet of water with opinion already stormily divided over whether this had actually constituted a "flood".

A new venue in Brisbane was found, but a remaining concern was whether we, and much of Queensland, would then escape the impact of Cyclone Yasi, fast heading towards the shoreline. Also, whether insurers, lawyers, politicians and local water company bosses alike would require safe passage from the resulting waves of anger events had generated.

Within weeks came the earthquake in Christchurch, the tsunami and later horrors befalling Tohoku in Japan, then the Puyehue volcanic eruption in Chile, among other events. In a challenging year for insurers each has provided an illustration of just how complex issues of causation, liability, peril definition and proof (and measure) of loss all may be when a natural disaster strikes. It is not the physical effects of weather- or climate-related events which may cross national borders. Supply, manufacturing and delivery lines in any enterprise affected may increasingly commonly involve operations in several countries, even continents. Legal issues arising may become yet more challenging if there is already public concern or a dispute over the adequacy or expense of preventative measures demanded to combat the effects of alleged anthropogenic contributory causes of climate change.

Against this background, two working party meetings have so far been held: in Amsterdam this May and in Tel Aviv in early September. Further meetings have already been scheduled for Istanbul on 3 May 2012 and for London on 13 September 2012 (the latter on the occasion of the IVth AIDA Europe Conference to be staged in London for the first time)<sup>10</sup>. There is much to occupy us.

#### **4. Tensions abound**

Many battle lines are apparent at a global, down to the most local, level. A potentially critical stalemate exists between many developed and developing countries over what financial responsibility should be assumed for past emissions. Who should bear what share of the full economic cost of growing nations averting future emissions? What role is to be accepted by the likes of the US and China? Within nations, as we have seen, calls to act in the best long-term national interest can prove highly divisive if one state or region is currently prospering from exploiting valuable mining contracts, while a neighbouring region without such resources is being bailed out – in more ways than one.

Public spending on expensive projects, such as desalination plants, can all too easily be deferred by politicians succumbing to the need for short-term ballot box popularity or prey to economic jitters. Any perceived economic prudence of saving such costs, perhaps by expecting local water companies or dam operators instead to manage water levels much more efficiently (and so help protect communities against the effects of both drought *and* major inundation) will inevitably be viewed in a less flattering light in the wake of a national disaster which, with hindsight, it may be said could have been averted. Accusations proliferate. Was the policy or its operation flawed? Was any loss genuinely unavoidable? Consumer lobbies might persuade politicians that standard wordings for flood cover or cross-subsidised levels of premium should be resisted as anti-competitive. When, in the wake of a disaster, homeowner policyholders suffer the rejection of claims, for losses not deemed covered by specific peril definitions, blame is passed in all directions.

When the Commission appointed to investigate the 2010/11 Queensland Flood events finally reports<sup>11</sup> no doubt their findings will be of great interest to more than just those with any immediate financial interests at stake or with potential legal actions pending. Their findings, like those of other such commissions appointed to investigate major weather-related losses may yet have a direct bearing upon how liability issues continue to evolve and their impact upon many classes of insurance.

Other tensions – or distractions or the temporary relegation of longer-term concerns about climate – are currently evident in many areas, such as carbon trading, renewable energy subsidies for CCS projects, wind farms and the like, as well as the future role of nuclear energy. Hopes are muted over how much top-level progress may be made at Durban in December, when the UN COP17/CMP7 convenes, following disappointments for many in Copenhagen in 2009 and then Cancún last December.

As has already been seen, however, any delay in the advancement of treaty obligations or the enactment of legislation at national or regional level does not of itself delay the need for concern, nor often the commencement of litigation. In many instances, and in a growing number of countries, litigation has been commenced *because* of such lack of action. For insurers it remains as essential as ever to monitor all current disputes over alleged responsibility for any exacerbation of losses arising from natural disasters or other major events. Particularly, all attempts made in presently financially straitened times for any burden to be shifted to those seen simply to have the deepest pockets.

## **5. Insurance and Legal Issues Arising**

### **5.1 *Impact of climate change and responses around the world***

Our Working Party was established in response to the widely held expectation that the physical impact of climate change would be felt in two ways: first, by making weather patterns more variable and extreme weather events potentially more intense and unpredictable; secondly, by causing more gradual phenomena, such as rising sea levels, temperatures etc. however unevenly experienced around the globe<sup>12</sup>.

The likely effect upon most forms of property coverage has been readily identified. Equally, there is an impact upon many liability risks. All enterprises, in the public or private sectors, have had to reappraise their responsibilities owed to regulatory authorities, shareholders, investors or even the public at large. These may variously be imposed by legislation, regulation or by courts. Personal lines of insurance may similarly be affected by impact on health and mortality rates.

Attempting effectively to address legal issues arising across such a broad sweep of exposures and territories is a considerable challenge.

We must use our energies and resources wisely: to gather and analyse information from lawyers and insurers around the world, but not simply to replicate work already done by others, nor dwell too much upon mere speculation. We are seeking to select issues of either fundamental importance or of acute concern at any one time and to benefit from astute collaboration with other interested parties.

Insurers' responses to the phenomenon have already been striking in their range. In many respects the market has been highly innovative, with initiatives involving a mixture of awareness-raising, information-gathering, the conducting of research and development into new products and the tailoring of existing products to cater for, or to counter, new or aggravated exposures.

A number of legal issues have been identified. A particular difficulty for insurers is to distinguish what, in coverage or exclusion terms, precisely constitutes the new or aggravated element of risk arising from the phenomenon of climate change for which

provision is to be made. There are problems of both definition and causation. Both “climate” and “weather” may be distinguished and defined, but few existing definitions of “climate change”<sup>13</sup> may be adopted with ease into policy terminology. Contract provision is always harder where invariably, as here, a combination of causes will be responsible for losses. Are risks intended to be included or excluded where a climate change-attributed loss (how determined?) has been exacerbated by a separate human or corporate failure (to maintain, comply etc)? Familiar limiting phrases such as “*exclusively* attributable to...” may prove much harder for insurers to rely upon when seeking to confine their coverage obligations where issues of attribution and causation may be complex. It is to be hoped that the market will permit sufficient access to examples of policy drafting currently in use to help us in any quest to analyse wordings and to help enhance and develop appropriate provisions.

The scale of exposures and the potential size of climate change-related losses readily prompt the question whether such losses are actually insurable in the private market. If insurers do cap or exclude exposure even with reliance upon reinsurance markets, then in many jurisdictions recourse may be made to the use of schemes of various kinds. Risks may be pooled, made the subject of mandatory cover or the government may stand behind risk-bearers as a reinsurer of last resort. We have already begun to examine differences in approach in different jurisdictions to existing “flood” provision. Strict liability regimes exist in some contexts and are being considered. Compulsory insurance is commonly resisted by the private market, but it has been aired in the context of environmental damage (and suggested as essential for new risks such as carbon capture and storage – see further below – where risks may otherwise prove uninsurable).

## 5.2 *Climate change liability and litigation Issues*

Even confining oneself to exposures arising under voluntarily-purchased insurance covering fault-based liability, there is already much to address from a legal perspective. A review of climate-related litigation filed over the past fifteen years across the world records a dramatic rise in the past five years in the number and variety of actions commenced, reaching record levels by 2010<sup>14</sup>. One may see that already a number of fundamental issues are being tested.

Many of the most headline-catching claims brought to date have been by environmental pressure groups, local authorities or regulators for injunctive relief against major emitters, rather than necessarily seeking any compensation, although both of course may be pursued. Many insurers remain sanguine that courts in most jurisdictions, even in the United States, will remain reluctant to extend the boundaries of those who are customarily entitled to compensation. Actions founded in nuisance or negligence variously require the establishment of an identifiable duty owed to any injured party by a defendant. It is unwise however to assume that the pressures being brought to bear upon

legislators, regulators or local authorities – or any more willing accommodation of class action or mass tort arrangements – may not yet affect how such issues may be interpreted or developed by the courts over time.

Certainly a series of cases in the US involving appeals to the Supreme Court in the course of 2010 and 2011 has merited particularly close attention<sup>15</sup>. In that of *Comer v Murphy Oil* (2009) (concerning claims of residents and landowners that the defendants' emissions made Hurricane Katrina more ferocious and damaging), a claim for mandamus was defeated, but a new action for damages, based in nuisance and negligence, has since been filed. In late June in the case of *State of Connecticut v American Electric Power* (2005, 2009) (an action brought against one of the largest greenhouse gas emitters in the US) the Supreme Court did **not** decide the question, which had divided the lower court, of whether emissions levels were rather a matter for government policy makers, nor whether the claimants had any requisite standing. Instead, they declared the issue was wrongly brought. Since the commencement of the action this was now governed by the Clean Air Act legislation and so a matter for the regulator, if always subject to judicial review. Consequently, with no dismissal of the claimants' standing grounds, other environmental nuisance claims may yet have to decide whether such claims may succeed.

The issue of standing is but one of a number of difficult legal hurdles a party must expect to clear to establish a claim for damages. The boundaries of tortious duty are bound to be tested. Will insured defendants be able to argue that they were permitted to cause emissions until ordered to desist? Will it not be enough simply to argue that they complied with minimum standards? In terms of establishing foreseeability of damage, from what date will parties be taken to have known of damage from emissions being likely? How might this realistically have been averted? The issue of when or whether any physical damage has actually been suffered by a claimant so as to trigger policy coverage has already been raised in litigation. Cases have already been seen where the major economic losses involved take the form of dropped property values, especially in coastal areas, in anticipation of any physical impact of climate change still yet to arise. If planning consents or urbanisation schemes have failed to address all necessary climate change concerns, losses and alleged failures may be inevitable.

A major task for the Working Party will be to try to track not just the progress of such litigation issues around the globe, but also any effect these may, or indeed should, have in different jurisdictions. Are boundaries of liabilities widened? If so, with what impact upon underwriters?

### 5.3 Carbon insurance and other “new” products

In our initial studies we identified the need to address legal issues arising in respect of three broad categories of so-called “new” products. First, “green” policies, not covering any new type of loss linked to climate change, but designed primarily to encourage a reduction in

greenhouse gas emissions, notably in respect of motor, buildings etc. “Adapted” policies representing traditional property or liability lines of cover, but designed specifically to take into account climate change issues. Finally, genuinely “new” policies catering, perhaps in traditional fashion, for a range of activities involved with alternative energy sources (such as wind farms) through to exposures arising from the “cap and trade” carbon market itself and carbon offsetting. More specific forms include microinsurance. Also, those designed for the largest scale schemes intended to help fund and underwrite Carbon Capture & Storage (CCS) and other still quite embryonic projects.

From promotional market literature alone we experienced great difficulty in identifying the exact nature of many so-called “new” products. One needs to study specific forms and terms used. It became clear that there was a gap in many cases between what was anticipated or promoted and what had yet come to fruition. An invaluable piece of work<sup>16</sup> conducted by one of our Working Party members, Cedric Wells of SCOR in Paris, with support from many market practitioners, helped to identify some of the issues and difficulties in this regard. This also helped to demonstrate how significantly the start of the economic downturn had slowed progress in the funding and advancement of many new projects and insurance products alike.

Concerns for the healthy continuation of the whole existing “cap and trade” carbon market and the evolution of further schemes in other areas of the world have already been mentioned. In the context of carbon capture & storage (CCS) earlier pledges by major countries to commit to the development of pilot CCS projects are under threat<sup>17</sup>. Nonetheless a number of new products continue to appear<sup>18</sup>. The need to monitor progress and the form of any new insurance contractual provisions appearing in market circulation nonetheless remains every bit as vital as before.

#### ***5.4 Reinsurance/ART/funding for weather/carbon-market risks and regulatory treatment***

Over and above the traditionally important role played by reinsurance in catastrophe risk coverage, a variety of alternative risk transfer products have emerged in recent years. These include the likes of weather derivatives (put options, caps and swaps) and catastrophe bonds. They are designed to help to spread the risks of climate change by ‘insuring’, by means of the capital market, risks that are uninsurable within the insurance market. Second, by doing so, enhancing prevention.

From an insurance law perspective an area of particular interest lies in how any such products are to be legally characterised. The markets regularly serve as both end-users and as offering issuers. To some extent the rapid expansion of weather derivatives has more recently turned this resource into a threat for the insurance industry, given the fierce competition many new players have represented. If such products are deemed to be insurance policies, at present in many places only a licensed insurance intermediary may

sell the instrument. Any derivative's counterparty, if not licensed, may thereby be acting unlawfully.

## 6. The Future

The four broad categories outlined immediately above have been adopted by the AIDA Climate Change Working Party as our principal workstream areas. They should help guide our work in advance of our further scheduled meetings in 2012. Also, to help structure the growing body of materials we are collecting on our Working Party website page<sup>19</sup>.

Of particular importance in the coming few months will be our monitoring of legal and coverage developments in the wake of the major Australian and Japanese losses. We shall also analyse the progress of climate-related litigation more widely. We are seeking to align ourselves with those doing important research work at the Geneva Association<sup>20</sup>. Also with those engaged in maintaining valuable databases at Columbia Law School and elsewhere. This should allow us to monitor most effectively many essential litigation, legislation and liability issues of interest to insurers through and beyond the high-level Durban talks this December.

We shall look to draw upon the resources of AIDA's large number of national insurance law associations around the world. In the coming twelve months it is hoped that a number of new important Asian national associations will be joining AIDA. Not least among these are associations forming in the People's Republic of China and India. Equally critically, to make our work most relevant, we must encourage input from active market participants.

Particularly anyone with a market involvement who is interested in participating in, or nominating someone to support, the Working Party's work, is invited to make contact.<sup>21</sup> Similarly, if they identify any specific issue or any materials which they believe merit attention. With so many interesting developments in prospect and with London being the venue for the AIDA Climate Change Working Party meeting for the first time in just under a year<sup>22</sup>, any such assistance would be both very timely and greatly welcomed.

## Endnotes

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<sup>1</sup> Chairman, AIDA Climate Change Working Party; AIDA Assistant Secretary-General-Administrative Affairs; BILA Vice President and Charitable Trustee; currently non-practising solicitor and CEDR accredited mediator.

<sup>2</sup> Taken from "*The Finance of Climate Change*" Myles Allen, Chap 29: The Spectre of Liability

<sup>3</sup> In his 3 Oct 2011 speech to the Conservative Party Conference the UK Chancellor revealed clear divisions within the UK's coalition government over its pledge to continue to position the UK as a leader in the low carbon economy. With the UK responsible for only 2% of the world's carbon emissions and said to be "bearing the cost of a decade of environmental laws adding to energy bills", he said the UK should resolve to cut its emissions "no faster than other European countries".

- <sup>4</sup> Of course support for past or future measures may still dramatically ebb and flow. At the time of writing it has been observed by the FT that while the carbon markets (valued by the World Bank in 2011 at \$142bn) are kept alive by a confidence that climate change fears will inevitably prompt more, not less, global action to limit greenhouse gas emissions that underpin demand for carbon credits, there is no absolute certainty even that the whole Clean Development Mechanism (CDM) itself will necessarily continue after Dec 2012.  
<http://www.ft.com/cms/s/0/6d3796fe-e8e6-11e0-ac9c-00144feab49a.html#ixzz1ZRuCWGRL>
- <sup>5</sup> Inevitably the speed of innovation here is dependent upon both available capital and market confidence, neither of which has been in plentiful supply of late.
- <sup>6</sup> For an interesting recent discussion of the dispute over the merits of the “science” of climate change, see *Climate Change Denial, Haydn Washington and John Cook, Earthscan, April 2011 • 224 pages • ISBN 9781849713368*
- <sup>7</sup> Association Internationale de Droit des Assurances (The International Insurance Law Association) founded in 1960 ([www.aida.org.uk](http://www.aida.org.uk))
- <sup>8</sup> The full text of the Report may be found on the AIDA Climate Change Working Party website page: [http://www.aida.org.uk/workpart\\_climatechange.asp](http://www.aida.org.uk/workpart_climatechange.asp)
- <sup>9</sup> Whose work, including their establishment of a Climate Risk + Insurance Project, is of particular interest and with whom the AIDA Climate Change Working Party is keen to establish a productive working relationship – see [http://www.genevaassociation.org/Home/Climate\\_Risk.aspx](http://www.genevaassociation.org/Home/Climate_Risk.aspx)
- <sup>10</sup> Full details of all the WP meetings, presentations and future events are to be found on the Climate Change Working Party website page, see above.
- <sup>11</sup> The Queensland Floods Commission of Inquiry was appointed on 17 January 2011. It delivered its interim report on 1 August 2011 making recommendations to be implemented before the next expected wet season. It is scheduled to deliver its final report on 24 February 2012 (<http://www.floodcommission.qld.gov.au/home>).
- <sup>12</sup> In response to a recent suggestion that in its General Report (and subsequent work) AIDA had too unquestioningly accepted the majority view held about climate change – see the introduction to *Forum de l'Assurance*, special issue of February 2011, pp. 21-51 (Anthemis, Louvain-la-Neuve, Belgium) – Prof Fontaine presented a short paper at our most recent Tel Aviv meeting on 7.9.11 – “*Global Warming or Climate Change?*” ([http://www.aida.org.uk/workpart\\_climatechange.asp](http://www.aida.org.uk/workpart_climatechange.asp)). In this he recognises the need for us to take account of all research being conducted, but also to acknowledge the current prevailing view that insurance risks are at least likely to be aggravated by climate change, irrespective of whether this is manifested by any warming or cooling in any region.
- <sup>13</sup> UNFCCC definition of “climate change” is “... a change of climate which is attributed directly or indirectly to human activity that alters the composition of the global atmosphere and which is in addition to natural climate variability observed over comparable time periods...”
- <sup>14</sup> See *Gerrard, Climate Change Litigation, Geneva Association Etudes et Dossiers no. 367* for a table of

filings and other useful reference sources. (An updated chart since records cases filed in 2011 by June to be headed for at least a second highest year ranking.)

- <sup>15</sup> *State of Connecticut et al –v- American Electric Power Inc (2005, 2009), Native Village of Kivalina –v- Exxon Mobil Corp et al (2009), Comer –v- Murphy Oil USA (2009) and State of California –v- General Motors Corp et al (2007) - and Steadfast Ins Co –v- AES Corp (2008)* concerning insurance exposures for the *Kivalina* claims – saw appeals lying before the US Supreme Ct upon a number of threshold questions. These included whether the cases were non-justiciable, i.e. raised policy questions over GHG emissions which ought more properly to be decided by government rather than the courts; whether the claimants had standing (were their injuries deemed fairly traceable to the defendant’s conduct and redressable by the courts?); were the claims in common law now pre-empted by statutory provisions passed?; and whether the claimants had suffered any incurred injury in fact at the time of the suit.
- <sup>16</sup> Cedric’s dissertation, “**Carbon credits and insurance: Can insurance address the current and future needs of the industries?**”, delivered to ENASS (L’école nationale d’assurances) in Paris in April 2011 and accepted with honours, served as an invaluable basis for our consideration of many issues arising in this context at the Working Party’s first meeting held in Amsterdam in May 2011: [www.aida.org.uk/workpart\\_climatechange.asp](http://www.aida.org.uk/workpart_climatechange.asp).
- <sup>17</sup> In July of this year in the US American Electric Power became the latest major energy suppliers to announce that it was “putting on hold indefinitely” any plans to build a full scale carbon capture plant at a coal-fired power plant in West Virginia. In the UK the Department of Energy and Climate Change (DECC) had originally declared they would use European funding for the development of no fewer than four CCS projects. By this October it was revealed that Scottish Power, the sole surviving bidder for the only presently remaining viable project, was threatening to withdraw its bid for a power plant scheme in Fife.
- <sup>18</sup> At our Amsterdam meeting in May 2011 the Working Party was informed of a new product issued that week by the Chartis Group designed to insure the value of government subsidies to renewable energy projects. Many projects continued to stall on account of concerns for slow financial returns deterring investors. Any support which insurance products might bring was naturally encouraged.
- <sup>19</sup> [http://www.aida.org.uk/workpart\\_climatechange.asp](http://www.aida.org.uk/workpart_climatechange.asp), already cited.
- <sup>20</sup> The Geneva Association, International Association for the Study of Insurance Economics <http://www.genevaassociation.org/>
- <sup>21</sup> My contact details, and those of the other Working Party officers, appear on the Working Party website page.
- <sup>22</sup> The meeting, as already mentioned, will coincide with the IVth AIDA Europe Conference (13-14 September 2012) which BILA is helping to stage. A large overseas attendance is anticipated. More details of this will be announced shortly on the AIDA website: [www.aida.org.uk](http://www.aida.org.uk).

# **The 2011 Japanese earthquake: how claims will be impacted by new Japanese Insurance Act**

By Daniel Saville

## **Summary**

The Japanese earthquake of 11 March 2011 and ensuing tsunami devastated the Tohoku region and caused unparalleled losses to the Japanese economy. As the area gradually recovers and reconstruction continues, the extent of losses to the Japanese and international insurance markets is becoming clearer. The large majority of the insurance claims are governed by Japanese law, so we therefore provide a profile of the losses, and highlight some adjustment issues and relevant provisions of the new Japanese Insurance Act.

## **Overview of losses**

The 9.0 strength earthquake is the costliest natural catastrophe of all time, with overall economic loss estimated at approximately US\$ 210bn. The Japanese Government predicts that the insured losses will reach 2.7 trillion Yen (USD 34.2bn) in total, which is less than the US\$ 41bn insured loss from the 9/11 terrorist attacks and US\$ 65bn from Hurricane Katrina.

Compensation paid to date is estimated at approximately 1.8 trillion Yen (USD 22.8bn), of which Japan's non-life insurance industry has paid approximately 58%, an estimated 1.05 trillion Yen (US\$ 13.2bn), with much of the balance paid by the Kyosai mutual insurers. Whilst the majority of insured losses have been incurred by the Japanese market, it is estimated that approximately US\$ 12bn of losses, around 35%, are reinsured internationally.

The life insurance sector has paid approximately 130 billion Yen (US\$ 1.65bn) in life and personal accident claims, a figure lower than initially anticipated. It is at present unclear whether this shortfall is due to difficulties in processing claims or because the loss of life was lower than had initially been feared.

Contingent business interruption losses from the events on 11 March have affected businesses worldwide. The scale of losses appears to be substantial but is currently the largest unquantified element. Nevertheless, reports suggest that the earthquake has triggered large numbers of enquiries about business interruption cover for non-owned property damage.

## **Adjustment issues**

Following the losses, the General Insurance Association of Japan (GIAJ) (equivalent to the UK Association of British Insurers (ABI)) came under pressure from the Japanese

Government for its members to pay claims as quickly as possible. This caused logistical difficulties for insurers given the limited number of loss adjusters in Japan. Although there is no official requirement for loss adjusters to be registered in Japan, insurers are expected to use GIAJ “Registered Property Loss Appraisers” unless there is a specific reason otherwise.

The key issues under any property insurances will be adjusting claims where policies exclude or provide different levels of cover for earthquake, tsunami and/or flood damage, or where exclusions for pollution or contamination may apply. Given problems with accessing certain areas, and the limited number of loss adjusters, this has resulted in losses under homeowner policies in certain regions being certified from satellite and aerial photographs rather than by a conventional adjustment process. Whilst most properties in these areas are likely to be subject to a total loss, this high level claim handling may result in regular adjustment issues being overlooked.

Similarly, given the number of people who are missing, and the records which have been destroyed, the Life Insurance Association of Japan announced soon after the loss that contractual indemnification provisions would not be applied. Therefore instead of the usual requirements to present a death certificate and medical report, most insurers have paid claims in respect of individuals who have been reported on a database of missing persons established after the earthquake.

These pragmatic and humanitarian responses to the earthquake are understandable given the scale of devastation caused. However, local insurers cannot rule out issues being raised when they seek to recover losses under their outwards reinsurances. It will therefore be interesting to see if a broader interpretation of what constitutes “proper and businesslike” adjustment of claims in these circumstances will be applied in respect of the reinsured’s obligations under any follow the settlements clauses. Overall, it is in both parties’ interests for insurers to keep their reinsurers informed as to the adjustment procedures in place and to provide regular claim updates.

### **Business Interruption**

The adjustment of business interruption (BI) losses for commercial risks will inevitably give rise to familiar issues for large losses involving devastation over a wide area. Japan’s tourist industry is one of the worst affected sectors, which is likely to raise similar issues to those illustrated in the English High Court’s judgment in *Orient-Express Hotels v Assicurazioni Generali SPA (UK)*, [2010] EWHC 1186 (Comm). The case was an appeal from an arbitration award in respect of loss to a hotel in New Orleans, Louisiana, arising from Hurricane Katrina.

In that case, the policy provided for the loss to be adjusted so that it would represent “*the result which but for the Damage would have been obtained during the relevant period*”. ‘Damage’ was defined under the relevant policy as the damage to the premises in question.

Therefore, the loss was adjusted as if the hotel itself had not been damaged but the surrounding area had still suffered from Hurricane Katrina. The policy wording operated to the insured's detriment due to the loss of tourism resulting from the Hurricane, which allowed insurers to argue that even if the hotel had remained fully open it would have attracted few guests.

Whilst the *Orient Express* case was decided according to the specific wording in question, BI claims in general will be carefully assessed against the backdrop that the Japanese economy was in recession before the earthquake, and that the car manufacturing industry had been in decline since at least eight months before.

Other complex issues have been raised under contingent business interruption (CBI) policies covering insureds worldwide. These policies cover loss sustained to the insured's business by reason of one of its suppliers or customers suffering damage at their premises. Issues commonly arise as to the definition of "supplier", and whether this has to be a direct supplier or may include suppliers further away in the supply chain. As with regular BI losses, the physical damage must be of a type insured by the policy, so nuclear-related losses are likely to be excluded. The territorial limits must also be checked; for insureds with global organisations, it can be unclear whether CBI losses would be classified as occurring in Japan or in the place of the insured's affected operations, which may affect the level of cover provided.

### **Japanese Insurance Act**

The adjustment of losses will be impacted significantly by the Japanese Insurance Act, which came into force in April 2010. This major piece of legislation replaced the Commercial Code of 1899, and the application of its provisions has not yet been tested in the Japanese courts.

Japanese culture has led to a strong aversion to litigation, which applies equally to the insurance environment. In addition, many insurers subscribe to an alternative dispute resolution scheme for financial institutions, which reduces court litigation further. As a result, there are only a handful of reported insurance law cases in Japan.

Given the unprecedented scale of the recent losses and devastation, it appears that local insurers are taking a pragmatic approach to dealing with claims, where the strict policy terms may not be applied. The vast majority of losses incurred by international (re)insurers arise under reinsurances of Japanese insurers, in respect of direct policies governed by Japanese law. The new Act applies to any (re)insurance policies subject to Japanese law, with exemptions for certain marine, aviation, cargo and nuclear risks.

Chapter 2 of the Act governs damage insurance contracts, which include most property and casualty policies. There are separate chapters of the Act covering life, personal accident and medical insurance classes. (Re)insurers should be aware that the mandatory provisions in the Act will overrule express policy terms. For consumer insurance, the Act also

introduces unilateral mandatory provisions, which will only overrule express terms where the mandatory provisions are in the insured's favour.

Some key provisions are as follows.

**Non-disclosure and cancellation** – Article 4 provides that an insured has a duty to disclose material information, although this is to be defined largely by the questions an insurer asks in the proposal process. Under Article 28, non-disclosures which are grossly negligent or in bad faith are actionable and entitle an insurer to cancel; however, a mere negligent non-disclosure would not. There is a one-month time limit for an insurer to exercise an actionable right of cancellation from the time it becomes aware of relevant facts. By Article 31, cancellation of policies (under Article 28) will only be retroactive where a claim has arisen in respect of damage caused by facts which were not disclosed at inception.

**Mitigation of loss** – Article 13 imposes an obligation on policyholders to mitigate any losses, requiring them to respond proactively to any damage. Whilst no remedy is stated for failure to mitigate, it would follow that the claim should be reduced by the net amount which could have been saved by mitigation. Article 23 imposes a parallel obligation on insurers to indemnify any related mitigation costs, although there is no guidance to specify that such costs should be necessary or reasonable.

**Notice of claims** – Under article 14, the insured has a general obligation to notify claims without delay, although no remedy is specified for a failure to do so. This could be significant where there are ongoing business interruption exposures, and it remains to be seen whether the courts will allow insurers to claim damages for delay in notification in such a situation.

**Sequential/Concurrent Cause** – Article 15 could prove to be important for the earthquake losses, as it provides that a sequential uncovered or excluded loss will not prevent an insurer being liable to indemnify damage which was first caused by a covered peril. Therefore, insurers could still be liable for damage if an excluded cause of loss, such as contamination or radiation exposure, follows a covered cause of loss, such as the earthquake or tsunami. It remains to be seen whether such loss will be apportioned between the covered and excluded perils. This provision is mandatory, and so will override any wording which seeks to exclude all losses with concurrent causes.

**Deliberate acts** – A potentially controversial provision is set out in article 17, which excludes losses caused by the insured's deliberate or grossly negligent acts. In principle, this term would clearly favour insurers, so it will be interesting to see how it is applied in practice.

**Over-insurance** – Where values have been agreed for insured items, these will in principle apply as the basis of any indemnity payment. However, insurers are given some protection by article 18, which provides that where the agreed value significantly exceeds the insurable value, the insurable value will apply.

**Partial insurance** – The concept of partial insurance is recognised by article 19 and is commonly used in Japan; for example, many household insurance policies will provide 50% cover in respect of earthquake losses. The article appears to provide for the indemnity to be adjusted in a similar way to adjustments by average where there is under-insurance, although in this case the partial insurance is intentional.

**Contribution** – The principle of contribution in the event of multiple insurances is enacted by article 20. This provides that when two or more insurances exist, each insurer would be liable for the full amount under their respective insurance contract if the other insurer has not paid the claim.

**Subrogation** – Subrogation principles and formulas are enacted via articles 24 & 25. Insurers may be surprised by the limitations imposed on the extent of their possible recovery, in particular where the insured amount is less than the amount of loss.

**Time for payment** – Under article 21, insurers are required to make prompt payment of losses, and will be liable for any delay after a reasonable period given the circumstances of the claim. By way of guidance, Standard Policies developed by an official insurance body state that payment must be made within 30 days of the necessary claim documents being presented, which is extended to 60 days if the Disaster Relief Act has been declared to apply.

**Statute of limitations** – Under article 95, the insured's right to demand payment of a claim, or a premium refund, will expire after three years from the date of loss. This is generally considered to be a mandatory provision which would override any shorter time limits in the policy.

Many of the above provisions of the Act are open to interpretation, so any guidance provided by the Japanese courts in disputes arising from earthquake-related claims will be valuable. In order to ensure a common understanding of claim handling procedures and how the Act will apply, international reinsurers are recommended to be proactive in requesting information and initiating discussions with local cedants. Reinsurers should also keep their retrocessionaires updated of the adjustment process so that any potential differences in approach can be resolved at any early stage.

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## Options for transferring litigation risk

By Fallon Turner

Little more than a decade since After the Event (ATE) Insurance first came into being, its existence in its current form is already under threat following Lord Justice Jackson's recent proposals for reform. The Government has gone full circle from the introduction in April 2000 of the Access to Justice Act 1999, which allowed for the recovery of Conditional Fee Agreement (CFA) success fees and ATE premiums from the unsuccessful party (a measure aimed at counterbalancing the restriction of legal aid), to the proposed Legal Aid, Sentencing and Punishment of Offenders Bill, which plans to end such recoverability and instead places an emphasis on the successful party's damages. Nevertheless, litigation funding does still have an important role to play and it is a market which is constantly evolving, both in reaction to the changing political landscape, as well as in response to the burgeoning need for parties to off-set their cost risks in areas where previously funding has been ill-utilised. This article will explore the various tools available, most notably ATE Insurance and Third Party Funding. It will focus on the benefits and the potential limitations of these means of funding and will provide a snapshot of the market today, as well as a look at what the future may hold in the wake of the Jackson reforms.

### 1. ATE Insurance

Perhaps the most widely-used method of litigation funding, ATE Insurance is, as the name suggests, available *after* a dispute has arisen and can on occasions be obtained a mere few weeks before trial is due to commence. In effect, the insurer agrees to indemnify the insured in respect of legal costs in the event that the claim does not succeed, subject to a specified limit of indemnity. The policy will typically provide cover for the potential liability for the opponent's costs or "adverse costs", the policyholder's own disbursements (including expert reports, Counsel's fees and court fees) and potentially some or all of the policyholder's own legal fees. However, ATE does not provide cover on an interim basis (with the possible exception of interim adverse costs awards) and consequently the client must be able to provide the necessary cash flow to finance the litigation until its conclusion, whether by funding the costs privately, reaching an agreement with their legal team regarding deferral of costs or entering into a funding agreement with a third party.

While ATE has historically been utilised hand-in-hand with lawyers' CFAs in personal injury and clinical negligence cases to remove all or nearly all of the client's costs exposure, it is now a well-established product through which high value commercial claims are funded. While as a general rule insurers like to see another party (either the client and/or the solicitor firm) carrying some part of the risk, it is understood that CFAs are far less common when dealing with the more complex, higher value cases, and as a result the market has now evolved to a point where the lack of such an agreement is by no means a bar to obtaining insurance. Furthermore, in circumstances where the solicitors are acting

on a partial or discounted CFA, or alternatively where there is no CFA in place, the insurance can cover either a portion or even potentially the entire element of the solicitors' fees. The possibility of insuring the policyholder's own solicitors' fees creates a range of different fee structure options for a client keen to manage risk. For example, the solicitor may be willing to defer payment of a proportion of base fees, which can then be insured, creating the effect of a more heavily discounted CFA, whilst guaranteeing a workable level of fee income for the law firm.

A crucial and interesting feature of the current ATE insurance market is the way in which the premium is typically charged. Payment of the ATE premium is generally deferred until the conclusion of the case and contingent upon success (or "self-insured"). Therefore, there is no premium to pay when the policy is taken out and no premium to pay if the case is lost. Furthermore, if a costs order is made in the insured's favour, under the current regime in England and Wales the premium can be recovered from the opponent<sup>1</sup>, subject to assessment by the court of its reasonableness<sup>2</sup>. Additionally, ATE premiums are often structured so that the premium increases as the case progresses, commonly on a stepped or staged basis. The opponent must be notified of any premium increase 'trigger points' via the Notice of Funding (form N251). Notice of the insurance and premium stages under the current regime can often provide a tactical advantage, by encouraging the opponent to settle early to minimise their potential liability for the premium.

Looking to the future, it would seem almost certain that the way in which premiums are currently recovered will come to an end. In the meantime, there is a degree of uncertainty in relation to premium recoverability. In an early decision, the courts expressed reluctance in interfering with the setting of premiums<sup>3</sup>, although in light of Lord Justice Jackson's recommendations and the so-called "compensation culture" which provoked them, this attitude seems to be changing. Thus in subsequent cases, the courts have helped define the parameters of what constitutes a reasonable premium. For example, in *Jonathan Rogers v Merthyr Tydfil County Borough Council*<sup>4</sup> Lord Justice Brooke accepted that when testing the proportionality of the premium, the appropriate relationship is that between the premium and the costs exposure, not the premium and the financial value of the claim. The court suggested that several factors should be taken into account when making a decision on the reasonableness of the cost of insurance cover. These include:

- the level and extent of the cover provided.
- the availability of any pre-existing insurance cover<sup>5</sup>.
- whether any part of the premium would be rebated in the event of early settlement (the general consensus being that a staged premium is more likely to be reasonable than a flat rate).
- the amount of commission payable to the receiving party or his legal representatives/agents.

Nevertheless, whilst willing to stamp some authority on this issue, the courts are still largely deferential. For instance, in *Kris Motor Spares Ltd v Fox Williams LLP*, the opponent (KMS) was served with a Notice of Funding on the first day of the Preliminary Issue hearing. The judgment was decided in Fox Williams' favour and KMS then sought to challenge the premium, which they believed Fox Williams had unreasonably taken out at such a late stage and which was in any event excessive (being approximately one third of the total costs sought by Fox Williams). The Court held that "there is no principle that the premium on a late incepting policy is irrecoverable as an unreasonable cost" and that "where the issue is raised as to the size of the premium there is an evidential burden on the paying party to advance at least some material in support of the contention that the premium is unreasonable"<sup>6</sup>.

A final issue to consider in relation to recoverability is whether the cost of the work undertaken by the firm in setting up the insurance can also be recovered from the opponent in the event of a success. This was answered in the affirmative by the Court in *Motto and others v Trafigura Limited and another*, where it was held that this is work "properly undertaken by the solicitors, for which they are entitled to charge"<sup>7</sup>.

It is generally advisable to shop around when trying to obtain ATE Insurance. A market search can be undertaken by an independent broker, by the prospective policyholder's solicitor or by the prospective policyholder themselves (although insurers will typically wish to liaise with the insured's legal team prior to making any offers of insurance).

The key reason for undertaking a market search is to maximise the chances of securing suitable insurance. If a single, preferred, insurer is approached but declines to offer terms for any reason (and the reasons can often be relatively subjective or linked to the insurer's specific appetites, rather than issues with the underlying case), the fact of this rejection will have to be disclosed to a subsequent insurer. A case which has been seen and rejected by other insurers will always appear less attractive to underwriters than a case which is presented 'afresh'.

Furthermore, evidence of market comparables (or indeed a lack of alternative options) obtained following a market search will generally provide compelling evidence of the reasonableness of any premium incurred, which may prove extremely useful should the paying party seek to challenge the level of premium at Detailed Assessment.

Defining 'success' in the litigation is of paramount importance to insurers when considering whether or not to provide cover, as the premium payment will generally be conditional upon achieving 'success'. Where the applicant is a claimant, the definition of success will frequently include either a settlement or a judgment/award whereby the opponent accepts a liability to pay or is ordered to pay a money sum to the claimant. However, this issue is much less straightforward when dealing with defendant cases as insurers will wish to avoid a potential moral hazard situation whereby the existence of ATE Insurance may impede nuisance or commercial settlement. For example, if 'success' were defined as the defendant's net liability to the claimant being below a certain sum, it

may be in the defendant's interest to pay slightly more than this amount to avoid a "success" and thereby avoid liability for the premium. Nevertheless, as the ATE market has evolved, various solutions have been formulated to get around these issues. Moreover, there are obviously a variety of circumstances, for instance where a claimant is seeking non-monetary relief, where the issue of a moral hazard does not arise and insurers are consequently willing to consider covering a defendant free of these concerns.

There are a few further factors that need to be considered when making an application for ATE Insurance. For example, where there is a question mark over the financial stability of the opponent, insurers may be unwilling to offer terms due to concerns over recovering their premium, or may require comfort that the policyholder will assume responsibility for the premium to the extent that it cannot be recovered. Another important point to note is that an ATE insurance policy is unlikely to provide adequate security for costs<sup>8</sup>. However, certain insurance providers have the capacity to provide a bond or Deed of Indemnity, which effectively guarantees payment of the Defendant's costs. Insurers will typically charge an additional fee for providing a bond. A final point to bear in mind is the potential requirement to disclose the ATE policy (although the amount of the premium should not be disclosed<sup>9</sup>). Whilst there is conflicting authority on this point<sup>10</sup>, it may be preferable to provide voluntary disclosure of the policy terms in certain circumstances.

## **2. Third Party Funding**

Third Party Funding is procured via a professional investor (often a bank or hedge fund), who in return for funding the litigation will demand a success fee or contingency fee to be paid out of the "proceeds" of the claim. Because this fee cannot be recovered as part of costs, it will be taken from the client's damages (in the event of a successful outcome) and it is therefore crucial to have a sufficient margin between the level of funding required and the expected level of damages. However, should the claim be unsuccessful, the funder will simply lose their investment and no payment is due. As with ATE, the funder's success fee is determined on a case-by-case basis, however it is generally expressed either as a multiple of the investment or an agreed percentage of the damage recovered, or more commonly a combination of the two.

Funded cases will generally have certain key features, which limit the availability of funding to a relatively small pool of cases. The following criteria provide a general guide:

- strong prospects of success
- substantial (monetary) claim
- a credit worthy defendant (i.e. no issues as to recovering damages and costs from the opponent)
- an understanding about how any potential adverse costs exposure is going to be paid, typically requiring the involvement of ATE Insurance

It is also worth noting that where there are numerous stakeholders involved in the litigation, a Deed of Priority may be drafted to cater for a situation where the client's recovery is insufficient to discharge all of its liabilities.

The concept of third party funding would historically have been unlawful due to the doctrine of maintenance and champerty – a concept which was introduced in the medieval period to prevent those who do not have an interest in a claim from interfering in the court process. Champerty and maintenance were decriminalised and eliminated as torts in the Criminal Law Act 1967, however even today a champertous agreement can be declared unlawful and therefore unenforceable by the courts. In *R (Factortame Ltd) v Secretary of State for Transport Local Government and the Regions (no. 8)* [2003] QB 381<sup>11</sup> and the later case of *Arkin v Borchard Lines Ltd & Ors* [2005] EWCA Civ 655<sup>12</sup>, the courts were prepared to recognise the legitimacy of third party funding, provided that the funder does not unduly seek to interfere with or control the litigation.

### **3. Litigation Buyout Insurance**

A third way of managing litigation risk is Litigation Buyout Insurance (LBI) (sometimes known as “defendant outcome hedging”), which provides an alternative option for a Defendant facing the possibility of a substantial claim. This is effectively a stop loss insurance policy which caps the Defendant's potential liability at a certain level. LBI is not legal expenses insurance and can therefore cover both damages and legal defence costs. The insured must retain an element of risk (i.e. an excess or retention) and the insurer will provide cover for any liability over this excess, up to a specified limit of liability.

This form of insurance is most commonly used in the context of mergers and acquisitions where pending or threatened litigation presents a barrier to completion of the transaction or creates valuation difficulties. However, it can also be used to cover ongoing litigation (subject to the proviso that if the litigation is advanced, insurers may consider the level of risk to be substantial, which may inflate the excess and premium or make it more difficult to secure commercially viable terms), or to “top up” existing insurance arrangements. Unlike ATE Insurance, premium payment is made on inception of the policy and the premium is not conditional upon success, nor is it recoverable under s.29 Access to Justice Act 1999. In high risk scenarios, the premium can be substantial and LBI is therefore typically used where there is a commercial reason to cap litigation risk.

### **4. The Future of Litigation Funding**

Looking forward, the form that litigation funding takes in the future will undoubtedly be irrevocably altered following Lord Justice Jackson's 2010 Review of Civil Litigation Costs and its prospective implementation via the Legal Aid, Sentencing and Punishment of Offenders Bill. The draft legislation seeks to end the recoverability of CFA success fees and ATE premiums from the losing party. While limited concessions have been made, such as

allowing solicitors to enter into “damages-based agreements” and potentially the ability to recover ATE premiums in clinical negligence cases where policies are limited to covering the client’s own disbursements (i.e. medical reports), in reality the impact of the reforms, if implemented in full, will be far-reaching, with several personal injury ATE providers already hinting that they may withdraw from the market post-implementation.

Nevertheless, while some ATE providers may exit the market, the use of ATE Insurance in relation to civil and commercial cases is likely to continue to grow, albeit in an adapted form. Though premiums will have to be drawn from damages (and will thus be problematic for clients with smaller value claims where the costs to damages ratio is narrow), this will inevitably put a downward pressure on price and in many cases will still provide a more attractive option than pursuing a claim uninsured. Third Party Funding, on the other hand, has been left relatively unscathed. The primary changes suggested in this arena include a voluntary code of regulation (already acknowledged by the industry as a welcome modification), which will include limited capital adequacy requirements. As with ATE, market forces and the growing number of providers in this space are likely to bring with them an increasing pressure to decrease pricing, although it may be some time before Third Party Funding becomes a viable solution for small and medium-sized claims.

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## Endnotes

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<sup>1</sup> s.29 Access to Justice Act 1999

<sup>2</sup> Practice Direction 44.4 Civil Procedure Rules.

<sup>3</sup> *Callery v Gray* [2002] UKHL 28. It was also held in this case that it is reasonable to take out insurance on day one bearing in mind that it may not otherwise be available further down the line or if insurance is offered at a later stage the premium is likely to be substantially more expensive.

<sup>4</sup> paras 105-106; [2006] EWCA Civ 1134

<sup>5</sup> The existence of Before the Event (BTE) Insurance does not necessarily render an ATE premium unreasonable, and while enquiries into the existence of BTE cover should be made, “The solicitor is not obliged to embark on a treasure hunt”: *Sarwar v Alam* [2001] EWCA Civ 1401 at para 46

<sup>6</sup> Paras 41 and 44 [2010] EWHC 1008 (QB). This does not, however, reverse the burden of proof and if there is any doubt as to the reasonableness, that doubt should be resolved in favour of the paying party.

<sup>7</sup> Para 463 in [2011] EWHC 90201 (Costs)

<sup>8</sup> At paras 35-36 in *Al-Koronky and another v Time-Life Entertainment Group Limited and another* [2006] EWCA Civ 1123 it was held that while in some circumstances an ATE policy might provide adequate security for costs, where a case (as it did here) depends entirely on which side is telling the truth and the policy is rendered void in the event that the insured has brought a fraudulent or dishonest claim, then clearly the policy will be inadequate as a method of security.

The Court went one step further in *Michael Phillips Architects Limited v Riklin and another* [2010] EWHC 834 (TCC) in deciding that because the insurer was able to cancel the policy if in good faith it forms the view at any time that the Claimant's claim is unlikely to be successful, the policy was consequently inadequate security, despite an endorsement confirming that the insurer "will not refuse to pay on a claim which is found to be fraudulent or false".

- <sup>9</sup> Coulson J at paras 48 and 52 in *Barr and others v Biffa Waste Services Ltd* [2009] EWHC 1033 (TCC) held that while the ATE policy itself was a disclosable document and was not covered by litigation privilege, the amounts of the premiums should be redacted for fear that they could be said to reflect the legal advice as to the Claimants' prospects of success.
- <sup>10</sup> In *Arroyo v BP (the Ocesa Pipeline Group Litigation)* [2010] EWHC 1643 (QB) it was held that the Claimants did not have a duty to disclose their ATE policy. Special weight was given to the fact that it was a bespoke policy and the very fact that the terms of the policy were negotiated suggested that it took into account specific litigation risk factors as well as the views and tactics of Claimants' lawyers.
- <sup>11</sup> At para 36 the Court emphasised that it was necessary in each case to decide whether the agreement "might tempt the alleged champertous maintainer for his personal gain, to inflame the damages, to suppress evidence, to suborn witnesses or otherwise to undermine the ends of justice".
- <sup>12</sup> In this case, the Court discussed the funder's potential liability for adverse costs and concluded, at para 41, that "a professional funder, who finances part of a claimant's costs of litigation, should be potentially liable for the costs of the opposing party *to the extent of the funding provided.*"

## **Insurance claims for loss by piratical seizure: *Masefield v Amlin* in the Court of Appeal**

By Roberto Barriga<sup>1</sup>

### **Summary**

The insurance market has received confirmation of the consequences of piratical hijack of a vessel in the Court of Appeal's judgment in *Masefield v Amlin*<sup>2</sup>, handed down on 26 January 2011. Upholding the decision a year before by Mr. Justice David Steel in the Commercial Court, the Court rejected an appeal by the cargo interest. The Court thus held that the seizure of a vessel and its cargo by Somali pirates for the purpose of obtaining a ransom payment did not constitute either an actual or a constructive total loss, as the elements of irretrievable or likely deprivation, respectively, were not present.

Lord Justice Rix gave the leading judgment in the Court of Appeal. Lord Justices Moore-Bick and Patten concurred. Lord Justice Rix addressed the problem recognized by Mr Justice Steel, as to whether the payment of ransom was contrary to public policy, and as a consequence whether the possibility of recovering the cargo by its payment could not be taken into consideration when assessing its total loss. Lord Justice Rix stated that payment of a ransom cannot be regarded as illegal or contrary to public policy.

Finally, the Court also looked into the issue of sue and labour, i.e. the right that the assured has to recover expenses necessarily incurred as a consequence of a peril insured against, and its duty to take all reasonable measures in order to avert or minimize the loss. The decision thus clarifies the position for assureds dealing with the release of their vessels.

### **The Facts**

In August 2008, the *Bunga Melati Dua* was hijacked in the Gulf of Aden by Somali pirates while carrying biodiesel on a voyage between Malaysia and Rotterdam. The vessel was taken with her crew and the cargo into Somali coastal waters. The owners commenced negotiations almost immediately. The cargo owners were not involved in the negotiations, and on 18 September 2008, while still out of possession of the cargo, served a notice of abandonment on their insurers, who rejected it.

The vessel, her crew and cargo were released 11 days later on payment of the ransom by the shipowners. The voyage to Rotterdam was completed on 26 October 2008, by which time the cargo had missed its market, which is seasonal. It had to be sold the following year at a price substantially less than its insured value. The cargo owners gave credit for the re-sale, less expenses, and claimed for the balance of \$7,608,845.30.

The cargo owners claimed against their insurers for a total loss and the parties agreed that proceedings were deemed to have commenced on the day the notice of abandonment was served. Thus it was common ground that if the cargo owners had a good claim for total loss as of that date, the subsequent recovery of cargo when ransom was paid would not affect the claim.

### **The decision of Mr. Justice David Steel**

The assured claimed that the capture of the vessel by pirates was either an actual total loss under s57(1) of the Marine Insurance Act 1906 or a constructive total loss under s 60(1) of the Act. Total loss refers to destruction or irretrievable deprivation as a result of perils insured against. This allows the assured to recover the whole amount of his policy. In a constructive total loss, by contrast, the subject matter is not in fact totally lost, but is likely to become so. For this reason the law in certain circumstances allows the property to be treated as if it was in fact totally lost when a properly notified abandonment of the subject matter is given to the insurers. Once a constructive total loss has been proved, it is for the assured to decide whether to treat it as a partial or an actual loss for recovery purposes.

Section 60(1) of the 1906 Act sets up two criteria that need to be met to constitute a constructive total loss: a) the subject matter must be reasonably abandoned and b) an actual total loss must appear to be unavoidable, at least without an expenditure which would exceed its value. Furthermore, section 60(2) lists the state of facts, which can be considered to fall within the definition of a constructive total loss. This state of facts includes deprivation of possession of the subject matter insured.

When dealing with the cargo owners' submissions, Mr. Justice David Steel considered whether the assured had been irretrievably deprived of the cargo within the meaning of the Act. He concluded that the test for irretrievable deprivation was an objective one, which was to be assessed on the true facts at the date of the incident whether or not then known or apparent to the assured. Although it was not directly material, the Court was, in the judge's view, entitled to consider the outcome of what happened in order to discover the probabilities of recovery. In this regard, the judge stated that for an assured to be irretrievably deprived of his property it had to be legally and physically impossible to recover it, regardless of the effort or expense required. Since the cargo was likely to be recovered (as had in fact happened), no actual total loss arose.

No constructive total loss was found to arise either. The judge explained that the requirement of abandonment set out in s60 of the 1906 Act was not met by the notice of abandonment as the requirement refers to the actual abandonment of any hope of recovery, and cargo owners' intended to recover their property once the ransom was paid. In addition, the judge concluded that on the facts an actual total loss did not appear unavoidable, and thus the requirements of section 60 were not met.

Although the ground of constructive total loss was not maintained before the Court of

Appeal, Peter MacDonald Eggers QC considered this issue in a BILA evening lecture discussing the case<sup>3</sup>. Eggers raised the question whether subsections 1 and 2 of section 60 of the 1906 Act should be construed as independent provisions, which refer to different sets of circumstances. In that event reasonable abandonment would not be required in the case of deprivation or costly recovery. However, Eggers noted that clause 13 of the Institute Cargo Clauses (ICC) (A), which was incorporated into the all risks policy, restricts the test of constructive total loss and effectively excludes subsection 2 of section 60. Clause 13 states that “no claim for Constructive Total Loss shall be recoverable hereunder unless the subject-matter insured is reasonably abandoned either on account of its actual total loss appearing to be unavoidable or because the cost of recovering, reconditioning and forwarding the subject-matter to the destination to which it is insured would exceed its value on arrival”. This limits recovery under constructive total loss to reasonable abandonment under the test of subsection 1 of section 60.

Since notice of abandonment was, as stated previously, found by the judge not to fulfil the test of reasonable abandonment set in section 60(1) of the 1906 Act, the cargo owners’ claim for a constructive total loss was effectively excluded by clause 13 of the Institute Cargo Clauses (ICC) (A) and therefore it was not further pursued in their appeal.

When considering the allegation that payment of ransom was against public policy, the Judge held that it was not illegal. In most circumstances it was the only way of recovering the crew and property. He further stated that a finding to the contrary would render kidnap and ransom cover unenforceable. Such a finding would not be reconcilable with the principle that ransom payments are recoverable as sue and labour expenses.

The cargo owners appealed.

## **The appeal**

Before the Court of Appeal, two submissions were put forward by the cargo owners. First, it was argued that capture by pirates created an immediate actual total loss, irrespective of the prospects of recovery (and abandoning their claim for a constructive total loss). Secondly, payment of ransom could not be taken into account for calculating the possibility of recovery as it was something that was or should be against public policy. It was something that an assured could not be reasonably expected or required to do. Thus the property had to be considered to have been irretrievably lost, physically and/or legally where payment of ransom was the only means of recovering it.

Dealing with the actual total loss submission, Lord Justice Rix found that there was no rule of law stating that piratical seizure of a vessel was automatically an actual total loss, and that the correct approach was to ‘wait and see’. He stated that payment of ransom was not illegal or against public policy, and referred to the possibility of it being recovered under the sue and labour clause.

## **Seizure by pirates does not in itself constitute an immediate total loss**

For its proposition that capture by pirates amounted to an immediate actual total loss, the cargo owners relied mainly on *Dean v Hornby*<sup>4</sup>, a nineteenth century authority on piratical capture. In that case it was decided that loss by capture was to be construed as an actual total loss unless something occurs afterwards that restores or gives means to restore the possession to the assured. The cargo owners in *Masefield* argued that the threshold of irretrievable deprivation would be met at the moment when pirates seized the vessel. Effectively from that moment a total loss occurred which allows recovery of the whole amount insured as an actual total loss.

Whether piratical capture amounts to an actual total loss, Lord Justice Rix explained, is a question of fact, which has to be assessed in the light of s57(1) of the 1906 Act. It therefore depended on whether the assured is irretrievably deprived of all hope or possibility of recovering possession of the property insured. The existence of the doctrine of constructive total loss in marine insurance law has caused the test for an actual total loss to be applied with the utmost rigour, unlike the greater flexibility found outside marine insurance. This is because in marine insurance an assured can serve a notice of abandonment when recovery of his property is unlikely.

In the circumstances of the case, the Court found that there was a chance of recovery of the property insured by payment of ransom, and as a result there was no actual loss. Expert evidence showed that it was a common procedure of Somali pirates to release hijacked vessels after payment of ransom. Lord Justice Rix described it as a typical “wait and see” situation, which in this case would not even allow for recovery as a constructive total loss. There was no unlikelihood of recovery, as shown by the fact that the property was recovered when ransom was paid.

When presented with the allegation that the taking by pirates constituted theft regardless of their intention of returning it after payment of ransom, the Court distinguished between the incidence of a peril (either theft or piracy) and the loss caused by that peril. Lord Justice Rix explained that the test for actual total loss was not whether pirates had a deemed intention permanently to deprive according to the Theft Act 1968, but whether the assured was irretrievably deprived of its cargo. Consideration is to be centred on the possibility of recovery and not the intention of the pirates.

Thus the Court concluded that there is no rule of law that capture or seizure (even when considered as theft) is an actual total loss, and that it is always a question of fact depending on the possibility of recovery.

## **Payment of ransom is not against public policy**

Although accepting that payment of ransoms was not illegal under English law, the cargo owners claimed that it amounted to submission to extortion and that it could not be part of an assured’s duty to meet a ransom demand to preserve his property from loss.

Consequently, the cargo owners argued, because payment of ransom cannot be required from the assured, where it is the only means of recovering it, property has to be considered to have been irretrievably lost, either physically or legally. The insurers could not say that an insured had not suffered an actual total loss.

In rejecting the assured's claim, the Court relied on the decision in *Royal Boskalis Westminster NV v Mountain*<sup>5</sup>. In that case it was said that when payment is made to obtain recovery of property, and when that payment is not illegal, it can be recovered as sue and labour expenses even though the persons demanding the payment are not acting lawfully. Lord Justice Rix concluded that if payment of ransom could be recovered as a sue and labour expense, it would be difficult to categorize it as being against public policy.

The Court further relied on a report of the House of Lords European Committee<sup>6</sup> regarding Somali piracy and the consequences that rendering it unlawful could bring to life and property. It concluded that "there is no universally recognised principle of morality, no clearly identified public policy [...] which could lead the courts, as matters stand at present, to state that the payment of ransom should be regarded as a matter which stands beyond the pale, without any legitimate recognition".

### **Ransom is a suing and labouring expense**

The assured finally relied on section 78(4) of the Marine Insurance Act to argue that because there cannot or should not be said to be a duty to make a ransom payment, when the latter is the only possible means of recovery it should be disregarded, so that the test of an actual total loss was fulfilled. Section 78(4) makes it a duty of the assured to take reasonable measures to avert or minimize a loss. In dismissing this submission, Lord Justice Rix repeated that any questions of reasonableness are pertinent to a constructive total loss and not to an actual total loss. Consequently the fact that there may be no duty to pay a ransom has no relevance to whether a loss is considered an actual total loss.

The Court further stated that the fact that there may be no duty to pay a ransom does not mean that there is an obligation not to do so. The decision in *Royal Boskalis* supported this conclusion, as ransom payments can be recovered as sue and labour expenses.

When discussing section 78(4), the Court confirmed the settled scope of the duty to sue and labour. It recognized its limitation to a question of causation, i.e. when the failure to sue and labour breaks the chain of causation between the insured peril and the loss.

### **Comment**

In *Masefield v Amlin*, the cargo owners claimed for an actual total loss although they had later recovered their property. What the assured had really suffered were financial losses resulting from the delayed delivery of the biofuel to Rotterdam. Recovery under a marine all risks policy has been held to require a physical loss;<sup>7</sup> and recovery for losses caused by

delay was in any case excluded by clause 4.5 of the ICC(A). This removes from cover any loss, damage or expense caused by delay, even if the delay is caused by a peril insured against.

If not for this exclusion, the case might have been an opportunity to test how the Court would deal with a loss attributable to delay in the light of section 55(2)(b) of the 1906 Act. Loss proximately caused by delay is excluded from cover by that section. However, the causation rule of proximity set by *Leyland Shipping Leyland Shipping Co Ltd v Norwich Union Fire Insurance Society Ltd*<sup>8</sup> would result in delay being unlikely to be found to be the proximate cause of a loss when an insured peril, such as piracy, would act as a dominant cause of the loss. Had this opportunity arisen the Court might have been in a position to decide whether the insurers would escape liability in such a situation or whether, following a decision of the United States Supreme Court,<sup>9</sup> this type of losses could be recoverable unless expressly excluded.

The decision in *Masefield v Amlin* settled important issues relating to piracy, a peril that with increasing frequency affects the marine market. By finding that there is no rule of law that capture by piracy amounts to an immediate actual total loss, and further deciding that it is a question of fact depending on the irretrievability of the property, the Court has ruled out the possibility of recovery for an immediate loss and recognized that it will be a “wait and see” situation. If deprivation of property is final, and there is no possibility of recovery in sight (e.g. when pirates capture the vessel in order to be used as a “mothership” with no intention of returning it after payment of ransom) the capture may amount to an actual total loss. However, Lord Justice Rix emphasised that the test is not one of the intention of the pirates to permanently keep the property, but is one of actual proof of irretrievable deprivation according to the facts of the case.

On the other hand, the possibility of claiming for a constructive total loss in appropriate circumstances was left open by the Court. Most cargo policies incorporate clause 13 of the ICC(A) which removes the possibility of recovering for a constructive total loss in cases of deprivation, as it in fact did in *Masefield*. Moreover, it would be somewhat difficult to prove that recovery is unlikely to fulfill the requirements of section 60(2)(i)(b) of the 1906 Act. What would happen to a cargo interest in the event that the shipowner is unwilling to pay the ransom would thus depend on whether the evidence presented to the Court proves it to be a situation where recovery can be said to be unlikely.

It seems, therefore, that the main (if not the only) purpose of piracy cover relates to the recovery of ransom payments under the suing and labouring clause. The Court in *Masefield* acknowledged that there is no duty not to pay a ransom, and that it can be recovered from the insurers as sue and labour expenses along with reasonable costs. This should give some peace of mind to insured shipowners, especially to those who trade in the Gulf of Aden.

The Court hinted that section 78(4) will only be triggered in case negligence or misconduct breaks the chain of causation between the peril and the loss. Non payment of

a ransom will not generally be found to be causing the loss instead of the capture. Furthermore, as Lord Justice Rix recognized, there has never been a case where the assured has not been able to recover owing to breach of its duty to sue and labour; this perhaps also shows that insurers are not very keen to use this particular defence.

The Court of Appeal has, it may be thought, brought certainty for those who deal with the release of hijacked vessels. They can now be sure that they are acting lawfully in negotiating ransom payments. Nonetheless, the increasing frequency with which Somali pirates are capturing vessels will surely bring concern to insurers, who are now certain that ransom payments are a burden that will finally rest upon their backs. This may result in a rise in premiums for ships sailing through the Gulf of Aden. It could also cause a reconsideration of the terms of the cover to narrow or even in some cases exclude the recovery of ransom payments.

## Endnotes

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<sup>1</sup> Qualified lawyer in Ecuador, LLM student, University of Southampton

<sup>2</sup> [2011] EWCA Civ 24

<sup>3</sup> Presentation delivered by Mr Peter MacDonald Eggers QC at the BILA evening lecture entitled “MASEFIELD and CENDOR MOPU: A fresh look at the loss under the Marine Insurance Act” on Monday 21 March 2011.

<sup>4</sup> (1854) 3 El & Bl 180

<sup>5</sup> [1999] QB 674

<sup>6</sup> House of Lords’ EU Committee Report: “Combating Somali Piracy: the EU’s Naval Operation Atalanta”, April 2010, HL Paper 103.

<sup>7</sup> *Coven SpA v Hong Kong Chinese Insurance Co* [1999] Lloyd’s Rep IR 565

<sup>8</sup> [1918] AC 350

<sup>9</sup> *Lanasa Fruit Steamship & Importing Co Inc v Universal Ins Co* 302 US 256

## NOTES



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

### ***BILA Journal article prize***

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

The rules for the prize are as follows:

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



*British Insurance Law Association Journal*

## GUIDELINES FOR AUTHORS

1. The aim of the BILA Journal is to add informed discussion about subjects affecting the insurance industry.
2. Reading the BILA Journal is a voluntary activity. It is therefore important that articles are written in a readable style. Short sentences help to achieve this.
3. Whilst a substantial proportion of the readership of the BILA Journal has legal training, a substantial proportion does not. Articles should be written with this in mind.
4. The guideline length for articles is 3,000 words. If your article seems likely to be less than 2,000 words or more than 4,000 words, please have a word with the Editor.
5. References to cases cited should be provided. Notes to the text should be endnotes, not footnotes.
6. If an article has been commissioned from you, the Editor will have asked you to provide copy by a specific date. Please aim to meet it as this affects the publication timeline.
7. When submitting copy, please send it preferably by email (or on a USB/disc) to the address below.

*Address for copy:*

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