Is Insurance About to Lose Its Sex Drive?

The recent decision of the European Court of Justice (ECJ) in the test case of *Association Belge des Consommateurs Test-Achats ASBL and Others v Conseil des Ministres C-236/09* (Test-Achats) threatens to cause upheaval in the insurance industry. From 21 December 2012 insurers no longer will be able to use gender as a factor when pricing insurance contracts. Motor insurance, life insurance and annuities will be the hardest hit but the full effects could be far-reaching. Industry outrage at the decision has been voluminous, but is there any need to panic?

**Sex, the Law and the ECJ**

Equal treatment for men and women is a fundamental right under European Law (Article 6 of the EU Treaty). Expanding on that principle, in December 2004, the Gender Directive (2004/113/EC) was adopted requiring EU member states to legislate for equal treatment in access to and supply of goods and services. Article 5 of the Directive provides that in insurance contracts, the use of sex as a risk factor should not result in differences in premiums or benefits to an individual.

“Article 5(2) was invalid because the exemption focussed on gender-based statistical differentials and did not take proper account of other factors influencing risk...”

However, as the Directive recognised, the use of actuarial factors related to gender was widespread in insurance when the Directive was adopted in 2004, so a transitional period was incorporated that gave until 21 December 2007 for the differences to be abolished. Further, an exemption under Article 5(2) allowed premium and benefits differences where gender is a determining factor in the assessment of risk based on relevant and accurate actuarial and statistical data. In practice, this applies to motor, life and health insurance and annuities. However, the Directive included no long stop date for an end to this exemption.

Implementation and Implications

After digesting the ECJ decision, the European Commission plans to meet with insurers to discuss the industry implications. It will then draft an amending directive to be implemented into domestic law by national governments.

As the change will not be retroactive, and as the UK is likely to introduce the amendment as late as possible, insurers will be able to continue relying on the Article 5(2) exemption up to and including 20.12.2012. With the exemption eliminated, Article 5(1) of the Gender Directive prohibits “the use of...”
sex in the calculation of premiums and benefits”. This appears to apply not to an existing contractual relationship between insurer and policyholder, but to the underwriting decision immediately prior to inception of the contract. It should therefore not affect contracts incepting before the cut-off.

After 20 December 2012, all new insurance contracts will be required to be priced and to provide benefits on a unisex basis, not differentiated by gender. It is thought that contracts entered into before 21 December 2012 that have premiums or benefits payable after the cut-off date will not have to be changed if the premiums or benefits are fixed as at 21 December 2012, although this should be clarified in the domestic implementing legislation. If however the premiums or benefits in such contracts are reviewable by the insurer after 20 December 2012, it may be that such reviews must be conducted on a unisex basis. The situation is similarly uncertain for deferred annuities purchased before 21 December 2012 but with payment due after.

The most obvious impact of the ECJ decision is on motor and life insurance and annuities. It has widely been predicted that women’s motor insurance premiums will rise as they cross-subsidise men, who are (according to actuarial data) more accident-prone. Conversely, women’s annuity payments could rise because insurers will no longer be able to pay them lower benefits on the basis that they will generally live longer. The opposite effects should of course be true for men.

However, many feel that the removal of gender as a pricing factor will merely result in premium increases (and benefit reductions) for all as insurers must reassess data, alter their income structures, and change policy terms and marketing materials. Any ‘cross-subsidy’ of the type mentioned above would have to be delicately managed as it would require specific percentages of one sex taking out the policy as against the other sex in order to work. Using alternative lifestyle factors such as occupation to calculate risks could be complicated and problematic; concentrations of women doing care jobs or men in construction could lead to challenges that occupation is a form of indirect sex discrimination. And any companies that are tempted to adapt early to the amended legislation may suffer for their efforts. Customers are likely to desert insurers that raise premiums ahead of time, thus penalising efficient compliance departments by leaving their companies with less market share.

Where From Here?
The ECJ decision is final and cannot be appealed. As mentioned above, the European Commission now takes control of the process and will meet with stakeholders before amending the Gender Directive. It is conceivable that insurers’ views will be taken on board at that stage, particularly if it can be shown that in some instances the situations of men and women with regard to insurance premiums and benefits are not always comparable as is assumed under the Gender Directive. It may also be argued that unisex premiums would themselves be discriminatory where there is a clear difference in risk because of gender, as the cross-subsidies may be considered a form of indirect discrimination against one sex.

The decision could also have wider-reaching impacts. Pension schemes are not covered under the Gender Directive and so are unaffected by the Test-Achats case but they are clearly a prime candidate for a similar legal challenge based on sex-specific factors. Other risk factors used by insurers could also be challenged on the same basis as in Test-Achats; of most concern to insurers would be age.

But the country whose consumers brought the Test-Achats case can also allay concerns about its practical consequences: Belgium has had unisex motor insurance since 2007 but has not seen the practical consequences: Belgium has had unisex motor insurance since 2007 but has not seen the

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- The Insurance Industry’s Role in National Security and Counterterrorism
- Dodd-Frank and its Impact on the Insurance Industry: FSOC, FIO and Beyond

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New York Enacts Legislation to Merge the Insurance and Banking Departments

New York Governor Andrew Cuomo released a bill on February 1, as part of his 2011-2012 budget, proposing to merge the State’s Insurance and Banking Departments. On March 31, 2011, the Governor signed the budget into law, including the final version of the merger legislation, entitled the Financial Services Law (the FSL), which, effective October 2011, will consolidate the Insurance and Banking Departments into a new, single agency to be known as the Department of Financial Services (the DFS). This article describes some of the provisions of the adopted legislation most likely to affect individual entities or the industry as a whole.

Establishment of the DFS and the DFS Superintendent
Effective October 2011, the FSL will consolidate the existing Insurance and Banking Departments, as well as the enforcement powers provided under existing insurance, banking and financial services law, into and under the DFS. It will create a new office of the Superintendent of the DFS (the DFS Superintendent) to assume the responsibilities of the existing insurance and banking superintendents, as well as new and heightened oversight responsibilities with respect to financial products and services. For example, the DFS Superintendent will have the authority to issue regulations and guidance with respect to a variety of financial products and services. The FSL contemplates that the DFS will consist of two divisions, the insurance and banking divisions, each of which will be overseen by a deputy for insurance and a deputy for banking, respectively...

Expanded Authority to Regulate Financial Products and Services
The FSL grants the DFS and the DFS Superintendent authority to regulate financial products and services, which are defined to include any financial product or service provided by any person regulated or required to be regulated under the banking or insurance law, or any financial product or service offered to consumers. The last point expands the new agency’s scope beyond that of either of the two original agencies. However, the following financial products and services are expressly carved out of this definition:

- products or services regulated under the exclusive jurisdiction of a federal agency or authority,
- products or services regulated for the purpose of consumer or investor protection by any other state agency, department or public authority, and
- products or services where rules or regulations promulgated by the Superintendent on such products or services would be preempted by federal law.

The definition also expressly excludes certain products and services when offered by a provider of consumer goods or services.

Footnotes
1. FSL, Part A, Section 1, Article 1, §102.
2. FSL, Part A, Section 1, Article 3, §302.
3. FSL, Part A, Section 1, Article 2, §§202 & 203.
4. FSL, Part A, Section 1, Article 1, §104(2)(B).
5. FSL, Part A, Section 1, Article 1, §104(2-a).
6. FSL, Part A, Section 1, Article 1V, §401 et seq.

Financial Frauds and Consumer Protection Unit
The FSL recognizes that fraud can occur across industries, and is detrimental to the social and economic wellbeing of New York’s citizens. As such, it calls for the consolidation of the insurance frauds bureau and the criminal investigations bureau, which currently investigate fraud in the insurance and banking industries, respectively, into a new bureau, to be known as the Financial Frauds and Consumer Protection Unit.

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“The merger contemplated by the FSL is scheduled to go into effect in October 2011.”

Footnotes
7. FSL, Part A, Section 1, Article IV, §404. 8. FSL, Section 1, Article IV, Section 406 & 408. 9. FSL, Part A, Section 1, Article IV, Section 408. 10. N.Y. Ins. Law § 332. 11. N.Y. Ins. Law §§ 332(a). 12. FSL, Part A, Section 1, Article 2, §206(a).

Protection Unit (“FFCPU”), under the supervision of the DFS Superintendent. Prior versions of the legislation also contemplated merging the consumer financial protection activities of the Consumer Protection Board into the FFCPU, but this was not included in the final, adopted version.6

Once formed, the FFCPU will be charged with investigating and prosecuting fraud involving financial products and services as defined above. Prior versions of the legislation expressly created a new, defined offense of “financial fraud.” The original version defined “financial fraud” expansively to cover “any fraud, intentional misrepresentation or deceptive act or practice involving a financial product or service or involving any person offering to provide or providing financial products or services” and included certain specified conduct, including any violation of the Martin Act, which does not require proof of a violator’s intent to defraud. The second draft of the legislation narrowed the definition of “financial fraud” significantly by removing the references to the Martin Act, and “deceptive acts or practices” from activities that constitute financial fraud, thereby raising the standard for proving a violation. The adopted FSL has removed the defined offense of “financial fraud” altogether and, instead, gives the FFCPU and the DFS Superintendent general authority to investigate violations of the insurance and banking laws, as well and violations of new law created by the FSL.7 In instances where the FFCPU has reason to believe that a person or entity has engaged, or is engaging, in prohibited conduct, the DFS Superintendent will have authority to investigate such activities and impose penalties.8 The DFS Superintendent will be authorized to levy a civil penalty of up to $5,000 for each intentional fraud or misrepresentation, or up to $1,000 for each violation of the FSL and applicable regulations issued under it. However, unlike previous versions of the legislation, the adopted FSL makes it clear that these penalties will not apply to persons regulated under the Insurance Law; such persons will be subject to penalties provided under the Insurance Law.9

Authority to Levy Assessments on Insurance Companies
Another area of interest to insurance companies is the new assessment provision included in the FSL. Currently, the Superintendent of Insurance is granted broad discretion to levy assessments on insurance companies to cover the operating costs of the Insurance Department.10 The assessment is calculated in proportion to the gross direct premiums and other considerations, written or received by each insurer in New York.11 Under the adopted FSL, effective April 1, 2012, the existing assessment law will be repealed and replaced with a provision which generally continues to provide a pro rata assessment. However, in response to industry concerns that insurance company assessments will be siphoned off to cover expenses that are not primarily insurance-related, the adopted FSL expressly limits assessments on insurance companies to cover only “operating expenses of the department solely attributable to regulating persons under the insurance law.”12 Prior versions of the legislation did not contain this limitation.

The merger contemplated by the FSL is scheduled to go into effect in October 2011. New York is not the first state to pursue a unified financial regulatory system. However, because New York is a global financial center, changes in its regulatory environment are significant to both domestic and international companies conducting business in New York. The full effect of the merger will become more apparent as the year progresses and the DFS becomes operational.

Supreme Court Confirms Reduced Scope of Inherent Vice Exclusions

In the March 2010 edition of the Insurance and Reinsurance Review, we reported on the Court of Appeal’s decision in the Celandor MoPu (Global Process Systems Inc & Anor v Syarikat Takaful Malaysia Berhad [2009] EWCA Civ 1398), which overturned the first instance decision of Mr Justice Blair and significantly reduced the scope of inherent vice exclusions, found in many marine cargo and general property insurance contracts.

The case has recently come before the Supreme Court (Global Process Systems Inc & Anor v Syarikat Takaful Malaysia Berhad [2011] UKSC 5), which handed down its decision in February this year. The Supreme Court upheld the decision of the Court of Appeal and found for the insured, Global Process Systems (GPS), albeit for slightly different reasons. This article will briefly cover the decisions of the lower courts (which are covered in more detail in the earlier article in the March 2010 edition) before considering the decision of the Supreme Court.
Facts

GPS purchased an oil rig, the Celandor, in May 2005, with a view to converting it into a mobile offshore production unit. The rig was to be transported from Texas, around the Cape of Good Hope, to its new home off the coast of Malaysia. It was to be carried on a barge with its legs extended 300 feet in the air.

During the voyage, the starboard leg of the rig succumbed to fatigue cracking, caused by the repeated bending of the legs under the motion of the barge as it was towed. Within hours, the remaining two legs had also broken off, and all three fell to the bottom of the sea, leaving the rig in need of substantial and costly repairs. GPS claimed on its insurance with Syarikat Takaful Malaysia Berhad (Takaful). Incorporating Institute Cargo Clauses (A), the insurance was stated to cover “all risks of loss or damage” except that “caused by inherent vice or nature of the subject matter covered”.

A similar inherent vice exclusion is also included in s55(2) of the Marine Insurance Act 1906 (MIA), which states that “...the insurer is not liable for ordinary wear and tear, ordinary leakage and breakage, inherent vice...”. There is no statutory definition of “inherent vice” in the MIA, but it was accepted by the parties that Lord Diplock’s statement in Soya GmbH Mainz KG v White (1983) 1 Lloyd’s Rep 122 HL represented the correct definition of inherent vice:

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

Therefore, the principal issue to be determined at first instance, the Court of Appeal and the Supreme Court was the same - whether the proximate cause of the loss was a “fortuitous external accident” (which in this case would be the weather conditions experienced on the voyage, i.e. a peril of the sea) or the inherent, internal characteristics of the rig itself.

Decision at First Instance

Mr Justice Blair held that the proximate cause of loss was inherent vice; the legs were, by their very nature, not capable of withstanding the conditions experienced (which were alternative causes of that loss) “would be bound to occur as the ordinary incidents on any normal voyage of the kind undertaken.” It was held that this was simply not the case on the present facts. Although with the benefit of hindsight, the “leg breaking wave” may have been highly probable, that “high probability was unknown to the insured and that was a risk against which the appellants insured.”

Lord Clarke stated, “it is not the state of the sea itself which must be fortuitous but rather the occurrence of some accident or casualty due to the conditions of the sea”.

On the present facts, as determined by Blair J at first instance, there had been a single “leg breaking wave” which had caused the first leg to fracture. Lord Collins commented that “the sudden breakage of the first leg...occurred under the influence of a leg breaking wave of a direction and strength catching the first leg at just the right moment, leading to increased stress on and collapse of the other two legs in turn.” The Supreme Court held that this single wave constituted an external fortuitous event which caused the loss in question. Inherent vice, therefore, could not be said to be the cause of the loss.

Decision of the Supreme Court

Takaful appealed to the Supreme Court, which ultimately upheld the decision of the Court of Appeal. Although four of the five justices (Lords Saville, Mance, Collins and Clarke) gave reasoned judgments, and each of their reasoning was slightly different, it is clear that the focus of the Supreme Court was not, as it had been at first instance and in the Court of Appeal, on the probability or severity of the weather experienced (whether it be “reasonably to be expected” or “bound to occur”), but was rather placed on whether some fortuitous external event could be identified as the cause of the loss.

As such, the relevant investigation to be made was whether there could be shown to be an external event which could be considered fortuitous, which caused the loss. If this was so, inherent vice could not be said to be the cause of the loss. In the words of Lord Saville:

“...all or virtually all goods are susceptible to loss or damage from the fortuities of the weather on a voyage; this does not mean that such loss or damage arises from the nature of the goods; it arises from the fact that the goods have encountered one of the perils of the seas.”

Significance of the Decision

Although the reasoning of the Supreme Court differs somewhat from that used by the Court of Appeal, its ultimate decision has not altered in any significant way the message sent out by the Court of Appeal – the Celandor MoPu narrows the test for inherent vice and broadens the range of events which may be considered fortuitous external accidents. It is likely that the courts will now be reluctant to find that inherent vice is the proximate cause of a loss where there are other plausible external fortuitous events which may have caused the loss. It is also clear that a peril of the sea will be construed widely – the question will not be whether the waves or the weather were ordinary, or were those which were to be reasonably expected or bound to occur, but rather whether the effect of the waves and the weather was fortuitous. As such, the scope of weather conditions which may be considered to be “perils of the sea” may now be quite extensive.

The Supreme Court decision means that any insurers operating in markets where inherent vice exclusions are common (for example marine cargo and property insurance) should be cautious if they intend to rely on such exclusions. This is particularly so where, as in the Celandor MoPu, there are other external fortuitous events, whether they be perils of the sea or otherwise, that may have caused the loss.
Insurers Can Thwart Terrorists

It has been almost ten years since the terrorist attacks of 9/11. Since then, over 30 planned attacks against the U.S. have been thwarted or failed, two through sheer luck. Other countries have not been so fortunate. There have been horrific attacks in London, Madrid, Mumbai and elsewhere. More broadly, several nations in the Middle East and North Africa are in transition, and some are in turmoil. Rogue nations are trying to acquire weapons of mass destruction, disrupt our economy, and gain geopolitical advantage. New threats continually arise.

The good people of the insurance industry are in this struggle. Terrorists use life insurance and annuity products to launder money and finance their activities. They need auto insurance to drive car bombs to their intended targets. Malevolent nations and their parastatals transport lethal materials in international commerce, build facilities to develop weapons of mass destruction and seek commercial insurance to protect their projects.

One way insurers and reinsurers can help is by carefully observing the restrictions created by the economic sanction programs administered and enforced by the Office of Foreign Asset Control (OFAC) of the U.S. Department of Treasury. As the Treasury Department has stated, “these programs are a frontline defense against foreign threats to our national safety, economy and security.”

OFAC actively enforces its restrictions and imposes penalties, which for the most part are based on strict liability. That is, even unintentional violations may result in penalties. Penalties can be imposed not only on companies, but also on individuals involved in underwriting, administration and claims, even if they work for non-U.S. companies. Penalties can be civil or criminal, with fines as high as $10 million for each violation, and prison terms of up to 30 years. There have been approximately 50 enforcement matters involving insurance transactions. One company paid a $2.4 million penalty for issuing life reinsurance covering Cuban nationals.

OFAC has publicly expressed a growing interest in the insurance industry, especially with respect to the facilitation of insurance placements, and has stepped up its enforcement in the industry. Sanctions were recently imposed on three insurance entities in just a few weeks, and others are anticipated. For example, a Texas-based reinsurance broker was fined for allegedly facilitating the placement of a facultative retrocession reinsurance agreement covering the construction risks of a petroleum project on Kharg Island in Iran. The retrocedent and retrocessionaires were European.

OFAC currently administers 21 separate programs, and the specific restrictions and penalties vary for each of the programs. But broadly, OFAC prohibits the issuance of insurance and reinsurance involving nations, companies, organizations, individuals or vessels that are subject to a sanctions program (OFAC Targets). Under some programs, OFAC also prohibits actions approving, guaranteeing, financing or facilitating these transactions. OFAC also requires that any funds in which an OFAC Target has a direct or indirect interest must be “blocked,” i.e., premiums must be deposited into a U.S. bank in a separate interest bearing account. Claims cannot be adjusted or paid. Exemptions or exceptions can be made only by obtaining a license from OFAC.

The complete list of OFAC Targets includes about 6,000 companies, organizations, individuals and vessels on a “Specially Designated Nationals and Blocked Persons List” (the SDN List), which is continually updated.

The obvious cases are straightforward. Clearly, a company should not issue a life insurance or auto insurance policy involving an SDN. It should not provide liability insurance for a construction project in a sanctioned nation. Challenges arise, however, because OFAC Targets can appear in transactions in many ways, such as insureds and additional insureds, policyholders, payers of premium, beneficiaries, loss payees, intermediaries and administrators of all variety, banks as lien holders, and banks to which premiums and claims payments are deposited or routed.

Issues also arise whenever a claim involves an OFAC Target in any way. For example, a properly insured vessel may collide with a vessel listed, owned or controlled by an OFAC Target. This means that potential payees, including third-party liability claimants, should be checked against the SDN List. An insurer may not pay amounts related to damage mitigation or prevention, or amounts to evaluate and adjust claims, defend an insured, or reimburse an insured party or a third-party liability claimant. Any claim payments due or to be deposited to or transferred through a bank that is an OFAC Target must be stopped.

Most OFAC restrictions apply to “U.S. persons.” These include insurers, reinsurers, agents, brokers, reinsurance intermediaries and third-party administrators. They also include the overseas branches of U.S. companies, but not overseas subsidiaries (except that the Cuba and North Korea programs do include overseas subsidiaries). They include individuals who are U.S. citizens or permanent residents, wherever they are located, and whoever they work for. Also, non-U.S. persons outside the US may be prosecuted for conspiracy with a U.S. person.

One program of great current interest to insurers is the Comprehensive Iran Sanctions, Accountability and Divestment Act (CISADA) enacted in 2010. The CISADA program extends sanctions to the non-U.S. insurers and non-U.S. ship owners who provide insurance or transportation services for certain trade
OFAC restrictions also present coverage issues in claims by insureds. Some violations are unintentional. Unfortunately, others are not. For example, in the last few years, there have been several high profile enforcement actions involving non-U.S. banks, which allegedly designed processes to deliberately disguise transactions to avoid OFAC restrictions. These transactions have had aggregate values as high as $800 million, and the banks have paid penalties as high as $500 million. It appears that eight banks are still under current investigation.

Insureds have also been fined and prosecuted for payments made in other contexts. Some companies made payments, which they assert were in the nature of required extortion payments, to the left-wing Revolutionary Armed Forces of Columbia and the right-wing United Self-Defense Forces of Columbia, both of which were SDNs. When claims against insureds arise from scenarios including intentional violations of OFAC restrictions, there may be grounds to resist coverage, warranting careful consideration by insurers and reinsurers.

An insurer may seek exemptions by applying to OFAC for a general or specific license. A company may have a compelling reason to issue coverage that might involve an OFAC Target, such as insuring humanitarian relief or missionary expeditions. Or there may be other reasons why the transaction would promote security.

It bears mention that the European Union has its own economic sanctions regime, frequently consisting of legislation implementing resolutions of the U.N. Security Council. These apply to all persons and companies doing business in the E.U., and E.U. nationals and entities doing business outside the E.U. Unfortunately, E.U. restrictions are not always consistent with other sanction regimes. In fact, one of the special challenges is the existence of an E.U. Council Regulation “blocking statute,” which makes it illegal for any E.U. company to comply with certain specified U.S. sanctions.

First Director of Federal Insurance Office Named

Illinois Insurance Commissioner Michael T. McRaith, has been selected by the Secretary of the Treasury as the first Director of the Federal Insurance Office (FIO), which was created by the Dodd - Frank financial reform legislation instituted last year. He begins his new duties in June. Commissioner McRaith has served as the Illinois Insurance Commissioner since 2005 and was previously a private practice attorney representing insurers and financial institutions.

As Director, he will have a non-voting seat on the Financial Stability Oversight Council. He brings to the post the benefit of substantial experience with both the regulation of insurance and the business of insurance.

The FIO has no regulatory authority over the business of insurance. However, the FIO is charged with specific reporting obligations, including an annual report to the President and Congress on the insurance industry and, significantly, a report due not later than 18 months from enactment of the bill on “how to modernize and improve the system of insurance regulation in the United States.” One of the specific issues the report must address is potential federal regulation of insurance. The FIO’s functions include:

- Monitoring all aspects of the industry, including identifying any aspects of insurance regulation that could contribute to a systemic crisis in the insurance industry or the U.S. financial system, and the extent to which affordable insurance is available to under-served communities and consumers, minorities, and low and moderate income groups.

- Recommending to the Financial Stability Oversight Council that an insurer and its affiliates be subject to regulation as a nonbank financial company by the Federal Reserve Board of Governors.

- Assisting the Secretary of the Treasury in administering the Federal Terrorism Insurance Program.

- Coordinating and developing federal policy on international insurance issues, including representing the U.S. in the International Association of Insurance Supervisors, assisting the Secretary of the Treasury in negotiating international agreements on insurance or reinsurance and determining whether state insurance measures are preempted.

- Consulting with the states and their insurance regulators on insurance matters of national and international importance.

The FIO’s oversight extends to all lines of insurance except health insurance, long-term care insurance, and crop insurance under the Federal Crop Insurance Act.

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Florida Supreme Court Preserves Attorney-Client Privilege in First-Party Insurance Bad Faith Actions

Insurers doing business in Florida will be relieved to learn that the Florida Supreme Court has finally put to rest a long-unsettled question: whether communications between an insurer and its attorneys regarding a policyholder’s claim are discoverable during first-party bad faith litigation brought by the policyholder.

The Court’s decision in Genovese v. Provident Life and Accident Ins. Co., which held that the attorney-client privilege protects such communications from discovery, settles a long-running dispute between attorneys for policyholders on one side, and attorneys for insurers on the other, over the proper scope of the Florida Supreme Court’s 2005 decision in Allstate v. Ruiz.

The Significance of the Genovese Decision
For any insurer with experience in defending against claims of insurer bad faith, the importance of the Genovese decision is obvious. An insurer communicating with its counsel about an insurance claim expects to have a private and uncensored discussion of issues. Under that veil of privacy, the insurer and counsel may consider the legal aspects of an insurance claim from a variety of angles. When such communications are disclosed to a policyholder’s counsel during litigation, the policyholder’s counsel may then sift through them to try to find language with which to raise an inference of bad faith. In situations where there were factors militating both in favor of and against coverage, and the insurer, considering the totality of the circumstances, ultimately decided that a claim was not covered, this practice by policyholder’s counsel may be especially problematic for the insurer.

Notably, the Genovese decision does not apply to materials prepared in anticipation of litigation. As described below, under the 2005 Ruiz decision, such materials are discoverable by policyholders in a Florida first-party bad faith lawsuit.

Ruiz and the History of the Dispute Over Attorney-Client Communications in Discovery
Florida law recognizes causes of action for both third-party insurance bad faith and first-party insurance bad faith. Third-party bad faith involves allegations that the insurer acted in bad faith in handling the defense of its insured against claims brought by a third party. In contrast, first-party bad faith involves allegations that the insurer acted in bad faith when it denied, delayed, or underpaid a claim for the insured’s injuries or losses. Historically, Florida courts have applied different treatment to the two types of bad faith claims when examining the attorney-client privilege and work product doctrine.

In the third-party bad faith context, Florida courts have reasoned that the policyholder (as well as the injured third party, who can bring the third-party bad faith claim and who “stands in the shoes” of the policyholder for that purpose) is entitled to review all records related to his or her representation. Thus, a plaintiff in a third-party bad faith case, seeking to review underlying claims and litigation files, usually can trump the insurer’s assertion of the work product doctrine and attorney-client privilege, even if the insured third party brings the action directly against the insurer. There is an exception to this general rule: an insurer may successfully assert the attorney-client privilege with respect to communications between the insurer and separate counsel retained solely to represent the insurer’s interest.

In contrast, for years Florida courts protected both work product materials and attorney-client communications from disclosure in first-party bad faith lawsuits. In 1989, the Florida Supreme Court distinguished between the discovery available to plaintiffs in first- versus third-party bad faith claims in Kujawa v. Manhattan Life Ins. Co. Reasoning that the relationship between policyholder and insurer in a first-party dispute is purely adversarial, the Court in Kujawa held that an insurer could invoke the work product doctrine and attorney-client privilege in first-party bad faith litigation.

However, in 2005, the Florida Supreme Court revisited the issue and overturned Kujawa – at least partially. In its decision in Allstate v. Ruiz, the Court, when considering whether the work product doctrine
shielded the insurer’s documents from discovery in a first-party bad faith lawsuit, held that any distinction between first-party and third-party bad faith lawsuits is “unjustified” and “without support.”

Because the documents typically found in claims files are virtually the only direct evidence of how the insurer handled the insured’s claim, the Court held that “all” materials created before or on the date when the underlying dispute was resolved should be produced in a first-party bad faith action, just as they are in a third-party action. Material pertaining in any way to coverage, benefits, liability, or damages is currently discoverable in a Florida bad faith action – even if the insurer argues that such materials were “prepared in anticipation of litigation.” Thus, at least with respect to the work product privilege, Ruiz removed the distinction between the discovery that insurers must provide in first- and third-party bad faith actions.

Although the Court in Ruiz was only considering the issue of work product doctrine, attorneys for policyholders have been arguing ever since – sometimes successfully – that its holding applies to attorney-client communications as well. Appellate court and federal district courts in Florida have disagreed as to the reach of Ruiz, with some deciding that Ruiz applies only to the work product doctrine, while others siding with policyholders’ counsel in holding that attorney-client communications are likewise subject to disclosure.

For insurers, the result of the debate over Ruiz has been anxiety over whether their confidential communications with attorneys will be disclosed during the discovery phase of first-party bad faith litigation – not to mention the expense of engaging in motion practice and appeals regarding an unsettled area of law.

Genovese Limits the Reach of Ruiz

With the Florida Supreme Court’s decision in Genovese, the anxiety is finally over. With limited exceptions an insurer’s communications with its attorneys will remain shielded from disclosure in Florida first-party insurance bad faith actions.

In Genovese, the plaintiff, holder of a disability income policy, sued his insurer for statutory first-party bad faith after the insurer terminated the policyholder’s monthly payments. The parties engaged in a dispute as to whether attorney-client communications of the insurer would be produced in discovery. The trial court, like many such courts in the six years following the Ruiz decision, settled the dispute by issuing an order compelling the insurer to produce the documents.

On appeal, however, Florida’s Fourth District Court of Appeals quashed the trial court’s order. The appellate court also certified the following question to the Florida Supreme Court:

Does the Florida Supreme Court’s holding in Allstate Indemnity Co. v. Ruiz, 899 So. 2D 1121 (FLA. 2005), relating to discovery of work product in first-party bad faith actions brought pursuant to Section 624.155, Florida statutes, also apply to attorney-client privileged communications in the same circumstances?

The Florida Supreme Court answered the certified question in the negative. First, the Court revisited its decision in Ruiz, and explained that the issue under review had been limited to the work product doctrine. The Court next explained the fundamental differences between the work product doctrine and the attorney-client privilege, and why those differences led the Court to allow disclosure of work product materials while protecting attorney-client communications from disclosure.

Conclusion

The decision in Genovese should relieve some of the anxiety regarding discovery in Florida first-party bad faith actions. The traditional protections from disclosure enjoyed by attorney-client communications have been preserved for insurers in such lawsuits. However, given the exceptions to the attorney-client privilege as noted by the Florida Supreme Court, insurers should still take precautions, particularly where insurers retain attorneys both to investigate claims and render legal advice.

Endnotes

1. No. 5C06-2508, 2011 Fla. LEXIS 621, 36 Fla. L. Weekly 597 (March 17, 2011).
2. 899 So. 2d 1121 (Fla. 2005).
6. 541 So. 2d 1168 (Fla. 1988).
7. Ruiz, 899 So. 2d at 1128.
8. E.g., 30 Specialty Ins. Co. v. Aircraft Holdings, LLC, 929 So. 2d 578 (Fla. 1st DCA 2006).
9. E.g., Genovese, 2011 Fla. LEXIS 621 at *1.
10. Genovese, 2011 Fla. LEXIS 621 at *1. 11. at *8.
12. Id., citing, Qureshi & Brady L.P. v. Birdsell, 802 So. 2d 1205, 1206 (Fla. 2d DCA 2002).
13. Id., citing, Qureshi & Brady (internal quotation marks omitted).
14. Id. at *9-10.
15. Id. at *10.
16. Id.
17. Id.
The liquidator of Onslow Ditching Ltd (ODL), sought a declaration against two directors (on three grounds), seeking damages/fines or a contribution of assets from each director for:

- Misfeasance and breach of fiduciary duties by failing to act honestly in the best interests of the company and its creditors;
- Wrongful trading, for failing to act in the best interests of creditors when it was clear that insolvency of the company was unavoidable; and
- Failing to exercise their roles as directors with reasonable skill and care.

ODL was created as a special purpose vehicle by the two directors, Peter Frohlich and Godfrey Spanner, for the sole purpose of acquiring and developing a piece of land. The liquidator argued that the venture was doomed from the early days: the directors treated a ‘casual conversation’ with the chairman of a development company, FCL, as if it were a quotation for business units, and it was on this loose and vague proposition that the construction costs and cashflow forecasts for the site were based. These were then presented to the bank in order to obtain financing to acquire the site and a further development loan.

Problems began to emerge once the site was acquired. The development facility from the bank was contingent on certain conditions, including there being a fixed-price contract in place with FCL to develop the site on a build-to-order basis based on pre-sales, rather than a speculative development of the whole site. This accorded with the initial intentions of the directors, who intended never to be exposed to more than two units unsold at any one time. In fact, there was no contract negotiated between ODL and FCL at this point, and negotiations and a Letter of Intent reflected the intention of the parties not to enter into a fixed-price contract at all.

The judge held that the initial approach to the bank, stating the existence of a fixed-price contract and the rolling development programme, as well as the costs estimates, overstated the position of ODL; it “did not accord with reality”, and “the confusion between aspiration and reality was apparent at many points during the course of the evidence”.

While there was no contract and so the conditions of the development facility could not be met, the directors still instructed FCL to commence development works under the Letter of Intent. The bank honoured some of the initial costs but, not being satisfied of compliance with the conditions, froze the rest of the amount and effectively starved the company of further funds.

The judge was careful to distinguish this point in time: had the directors properly acted then, the land could have been sold, paying off all the creditors and realising some profit. Instead, knowing that they could not fulfil the terms of the bank loan (but still informing the Bank that “all pre-requisites were in place”), and having no other credible source of funding (following an abortive take-over bid by another company), the directors instructed FCL to undertake further development works, which FCL duly did, accumulating more than £1m in fees and costs.

Upon realising that no payment would be forthcoming, FCL suspended work and took the matter to adjudication, where it was awarded £1.6m. The directors then placed ODL into administration, selling the land and repaying the site loan and the balance on the development facility (an aggregate of £1.42m), but leaving further significant liabilities owing to unsecured creditors, including FCL.

In terms of liability, the judge in the case was careful to distinguish between two points in time: 1) when the directors’ views of the company’s prospects were perhaps overly optimistic and not entirely realistic; and 2) when the insolvency of the company was a very real prospect which the directors did nothing to aid or avoid in their actions.

“The director of a company owes numerous duties which arise from the common law and statute. Claims may be brought by, amongst others, shareholders and creditors of the company, government and regulatory agencies, and liquidators.”
The judge further cited the judgment in *Gwyer v London Wharf (Limehouse) Ltd* [2002] EWHC 2748 (Ch) that, “where a company was insolvent, or of doubtful solvency, or on the verge of insolvency”, and it is the creditor’s money at risk, the directors, in exercising their duties, “must consider the interests of the creditors as paramount”, and that, in this context, the interests of the company “are in reality the interests of the existing creditors alone”.

By the time it was clear the loan conditions could not be met, and with no alternative avenue for funding, the decision to authorise further development was irrational and based on “wilful blindness… a deliberate decision not to enquire or consider lest an unpalatable truth be exposed”. At this point, the judge held “the only honest thing to do was to stop the development”. Therefore, at the later point in time, the directors were in breach of fiduciary duty to the company and its creditors. The directors were further liable of wrongful trading as the company was clearly insolvent on a balance sheet basis, yet they used credit extended to it to trade when, but for their wilful blindness, they ought to have concluded that there was no realistic prospect of avoiding insolvent liquidation. On the question of reasonable skill and care, the judge held that a reasonably diligent director would have realised the ‘extremely short’ time horizon for the company, and acted accordingly, halting the development and selling the land to repay creditors, and failing to do so further constituted breach.

While the judge was careful to acknowledge the fact that “risk is an inherent part of economic activity”, in excusing liability at the earlier point in time, this did not stop the finding of liability once funding was clearly not to be provided.

**Directors and Officers Liability Insurance Cover?**

Directors and Officers (D&O) liability insurance cover is designed to protect a company’s directors and officers from a wide range of claims brought against them arising from their actions or decisions. A director of a company owes numerous duties which arise from the common law and statute. Claims may be brought by, amongst others, shareholders and creditors of the company, government and regulatory agencies, and liquidators.

From a D&O perspective most policies will pay for the costs of any regulatory investigations and may in certain circumstances pay for the defence costs of any court proceedings brought by the liquidator. In the event that the directors were found to have been at fault and fraudulently trading, then most D&O policies would require that those defence costs be paid back to the insurer.

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**New Jersey and Indiana Join New York and Florida in Relaxing Credit for Reinsurance Collateral Requirements**

New Jersey and Indiana have enacted legislation granting their insurance commissioners discretion to reduce the amount of collateral required from unauthorised and unaccredited reinsurers in order for domestic cedents to receive full financial statement credit for reinsurance.

To be eligible for reduced collateral, both states require such reinsurers to have surplus in excess of $250,000,000; however there are several distinctions between the New Jersey and Indiana enactments.

**New Jersey**

New Jersey’s Reinsurance and Surplus Lines Stimulus and Enhancement Act (A2670/S2010, enacted as P.L.2011, c.29, the “NJ Act”) was enacted March 22, 2011 in an effort to grow New Jersey’s economy and create jobs. Accordingly, to be eligible for reduced collateral, reinsurance must be negotiated at least in part by a reinsurance intermediary or representative of the reinsurer acting in New Jersey. In addition, in determining whether credit should be allowed, the Commissioner is required to consider the reinsurer’s and its affiliates’ use of New Jersey professional service providers, along with other factors, which largely relate to the reinsurer’s solvency and the adequacy of the reinsurer’s domiciliary regulator.

The New Jersey Department of Business and Insurance is expected to issue regulations providing additional standards, as the only eligibility requirements imposed by the NJ Act are that the reinsurer maintain $250,000,000 in surplus and that the reinsurance be negotiated at least in part by a New Jersey intermediary. We anticipate that those regulations will include specific credit rating requirements as a condition to lower collateral postings.

Reduced collateral is available under the NJ Act for reinsurance contracts entered into or renewed on or after March 22, 2011, with the exception of life reinsurance contracts, which are not eligible for reduced collateral until the earlier of March 22, 2013 or the date upon which the NAIC implements principles-based standards for life insurance reserving.

**Indiana**

For eligibility under Indiana’s HB 1486 (enacted as PL 11, 2011, the “IN Act”), effective April 6, 2011, reinsurers must meet a number of requirements in addition to maintaining surplus or equivalent in excess of $250,000,000. For example, such reinsurers must agree to be subject to the jurisdiction of U.S. courts and must submit an application and annual filings to the Commissioner. In determining whether credit should be allowed, the Commissioner is required to consider certain factors enumerated in the IN Act relating to the reinsurer’s financial strength and the adequacy of its domiciliary regulator. Like New York, Indiana restricts the level to which collateral may be reduced based upon the financial strength ratings of the reinsurer. In addition, the Commissioner is required to publish a list of alien jurisdictions whose reinsurers may be approved for reduced collateral and to monitor such jurisdictions on an ongoing basis.

With this change, New Jersey and Indiana become the third and fourth states to relax their reinsurance collateral requirements. As the NAIC has endorsed such reduced collateral requirements in its Reinsurance Regulatory Modernization Framework and is considering amending its Model Credit for Reinsurance Law and Regulation in a similar manner, it is likely that other states will soon follow suit.

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For breach of fiduciary duty, the judge noted that a director would have a ‘harder task’ to persuade a court that he honestly believed to be acting in the company’s interests, “if the act undertaken resulted in substantial detriment to the company”. The judge further cited the judgment in *Gwyer v London Wharf (Limehouse) Ltd* [2002] EWHC 2748 (Ch) that, “where a company was insolvent, or of doubtful solvency, or on the verge of insolvency”, and it is the creditor’s money at risk, the directors, in exercising their duties, “must consider the interests of the creditors as paramount”, and that, in this context, the interests of the company “are in reality the interests of the existing creditors alone”.

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Sienkiewicz: Another Decision About the UK’s “Special” Mesothelioma Jurisprudence

The Supreme Court’s decision in Sienkiewicz v Greif ([2011] UKSC 10) is a detailed analysis of the “special” jurisprudence applicable to liability for causing mesothelioma. The UK’s highest appeal court was reviewing the application of the “Fairchild exception” to single rather than multiple asbestos exposure cases.

The Fairchild Exception

In 2002, the House of Lords’ decision in Fairchild v Glenhaven Funeral Services ([2003] 1 AC 32) introduced an “exception” to the normal rule of causation. A victim would normally have to prove that on a balance of probabilities a defendant’s negligence caused a disease; this is the “but for” test. Mesothelioma is for all practical purposes caused only by exposure to asbestos fibres. However, in circumstances where a victim has been tortiously exposed by different parties (multiple exposures), the limits of medical knowledge mean that it is impossible to identify which exposure or exposures in fact caused the mesothelioma. In Fairchild, the court relaxed the rule of causation. That relaxation was developed in the subsequent House of Lords’ decision in Barker v Corus ([2006] 2 AC 572). The position was further varied by section 3 of the Compensation Act 2006.

The Supreme Court set out the Fairchild exception in its current form as follows: when a victim contracts mesothelioma each person who has, in breach of duty, been responsible for exposing the victim to a significant quantity of asbestos dust and thus creating a “material increase in risk” of the victim contracting the disease, will be held to be jointly and severally liable for causing the disease. In broad terms, where a victim would normally have to prove that it is more likely than not that the defendant caused the injury, a mesothelioma victim can succeed by proving only that a party’s negligence might have caused the disease.

In Sienkiewicz, the court looked at two cases where there had been only a single negligent occupational exposure; and that exposure had been relatively “small”. The only other exposure had been “environmental exposure”, a "low-level exposure to asbestos in the general atmosphere" for which no one is responsible. The Supreme Court held that the Fairchild exception applied in such single exposure cases. The victims merely had to show that the tortious exposure created a material increase in the risk. In the case of one of the victims, the negligent occupational exposure had been found to increase the risk to which environmental exposure subjected her by only 18%.

Material Increase in Risk

The court made it clear that a low threshold would apply when considering what constituted a “material increase in risk”. The court commented that “material” in this context means any exposure that is more than de minimis, but that it was not possible to define in quantitative terms what is de minimis. This remains a question for the judge on the facts of a particular case. In his leading judgment, Lord Phillips said: “The reality is that, in the current state of knowledge about the disease, the only circumstances in which a court will be able to conclude that wrongful exposure of a mesothelioma victim to asbestos dust did not materially increase the victim’s risk of contracting the disease will be where that exposure was insignificant compared to the exposure from other sources”. The court referred to the expert evidence that there is no known lower threshold of exposure to asbestos that is capable of causing mesothelioma. Lord Phillips noted a case in which a defendant had conceded that a week’s exposure would not be de minimis.

The court rejected the argument that a mesothelioma victim should prove that the tortious exposure more than doubled the existing risk. The “doubles the risk” test is usually applied to epidemiological evidence. The potential value of such evidence was the subject of lengthy discussion. The rationale of the test is that if the action of a wrongdoer more than doubles the risk that a victim would suffer injury, then it follows that it is more likely than not that the wrongdoer caused the injury. The judges showed varying degrees of doubt that epidemiological evidence alone could ever be the basis for a finding of causation. The essential shortcoming of such evidence is that it demonstrates only a statistical association rather than a causal relationship. The Supreme Court pointed to at least one previous decision in which a court appeared to have incorrectly muddled the principle of “material increase in risk” with the “doubles the risk” test.

Section 3 of the Compensation Act

The court reviewed the scope of section 3 of the Compensation Act 2006. The Fairchild principle was refined in the decision in Barker, in which the House of Lords held that each defendant held responsible under the Fairchild test for causation was liable only for that proportion of the damages which represented his contribution to the risk that the employee would contract mesothelioma. Within a few months, section 3 had been enacted, reversing this aspect of the Barker decision by providing that any party found liable for causing mesothelioma is jointly and severally liable for the whole of the damage.

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The court found that section 3 does not create a new statutory tort of materially increasing the risk of developing mesothelioma. That legislation had been misread by the Court of Appeal. Whether and in what circumstances liability in tort attaches to a party who has materially increased that risk remains a question of common law, currently contained in the Fairchild and Barker decisions. The common law in this area is capable of further development: for example, the courts might revert to the conventional balance of probabilities test should advances in medical science make this appropriate. Section 3 has limited scope: it is relevant only in circumstances where a defendant has first been found liable in tort in accordance with the common law; it has no relevance to the establishment of that liability.

Special Mesothelioma Jurisprudence

Several members of the Supreme Court expressed their unease at the special rules that apply to mesothelioma and warned of the consequences of tampering with the standard test of causation. Lord Phillips remarked that the combination of the Fairchild exception and section 3 has “draconian consequences” for an employer who has been responsible for only a small proportion of the overall exposure of a claimant. Lord Brown said he found the position “unsatisfactory” and that the path to the current situation was “quixotic”. There was, however, an acknowledgement that reversing Fairchild would be fruitless as Parliament would be likely to reinstate the principle.

Commentary

This Supreme Court has confirmed, with some obvious reluctance, the wide application of the Fairchild exception in mesothelioma cases. Lord Brown remarked that mesothelioma claims must now be considered “a lost cause” from the defendant’s perspective. This is of concern to defendants and their insurers, given the magnitude of this problem. The latest estimate from the UK Asbestos Working Party is that mesothelioma claims will cost insurers about £10 billion—and perhaps even double that—over the next 40 years.

While apparently expressing the general view that the Fairchild exception should apply only to mesothelioma cases, there was some desultory discussion of the exception, or at least the underlying logic of it, in the context of diseases other than mesothelioma (such as lung and other cancers) that can be caused by more than one activity or type of exposure (known as “multiple agent” cases). This analysis appears to have created a degree of uncertainty and to have identified that the exception could be argued logically to apply outside the confines of mesothelioma cases. It may be that only policy considerations would prevent the exception being applied more widely.

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**EVENTS**

- **EAPD is presenting its 10th Annual Half-Day Insurance and Reinsurance Seminar at our New York Office on June 7, 2011.** (See p. 2 for details.)
- **EAPD’s Insurance & Reinsurance Department in London is hosting a drinks reception on June 8, at the Grange St Paul’s Hotel, London.**
- **EAPD is a sponsor of HB Litigation’s 2d Annual Net Diligence Cyber Risk & Privacy Liability Forum being held June 9-10 in Philadelphia; Laurie Kamaiko (New York) and Mark Schreiber (Boston) of EAPD’s Privacy and Data Protection Group are attending, and Mark is a panelist.**
- **Paul Kanefsky and Rob DiUbaldo (New York) will speak at the IntAP Spring Conference on June 15 in Norwich, England, on “The 2010 Wave of Court Decisions in the U.S. on Follow the Fortunes.” Paul will also attend the R&Q Commutation Rendez-Vous in Norwich on June 13-15.**

**HIGHLIGHTS**

- **EAPD was a sponsor at the Insider InScope conference on May 11 in New York. Jeff Etherington, Nick Pearson, Jeanné Kohler and Amber Mills (New York) attended the event.**
- **Rob DiUbaldo and Greg Hoffnagle (New York) presented at a May 25 webinar sponsored by BRMA on “Hydrofracking Risks and Opportunities: What Insurers and Reinsurers Need to Know.” Rob and Greg will reprise their presentation for the RAA Underwriting Conference on July 20.**
- **Vince Vitkowsky (New York) and Steve Huggard (Boston) presented a webinar on May 19 sponsored by EAPD on “The Insurance Industry and OFAC Economic Sanctions.”**
- **Richard Hopley (London) spoke on May 10 at the 14th Annual Forum on Reinsurance Claims in London on “Recent Developments in Class Actions and Group Litigation in Europe.”**
- **EAPD was a featured sponsor of a series of seminars produced by National Underwriter entitled “Spotlight on Insurance Mergers and Acquisitions.” The seminars covered a variety of topics of interest to both buyers and sellers of agencies and business developers and advisors involved in agency M&A. Michael Griffin (Hartford) and John Stretton (Stamford) presented at the seminars, which were held in Orlando, New York, Los Angeles and Chicago.**
- **Nick Pearson (New York) spoke at the ARIAS US 2011 Spring Conference on Dodd-Frank’s impact on insurance and reinsurance regulation and the recent adoption by several states of relaxed collateral requirements for unauthorized reinsurers. Jeanné Kohler and Vince Vitkowsky (New York) also attended the conference.**
- **Mark Meyer (London) and Brian Green (New York) attended the May Aviation Insurance Association Annual Conference in Miami.**
- **Mark Peters (New York) spoke at the International Association of Insurance Receivers (IAIR) meeting in March on the coordination between insurance departments and insolvency receivers. Mark will be speaking at the National Council of Insurance Guarantee Funds (NCIGF) on the legal issues in insolvency in Boston on June 29.**
- **Mark Peters, Jack Dearie (New York) and Ken Levine (West Palm Beach) attended the Spring Meeting of the National Association of Insurance Commissioners (NAIC) in Austin, Texas. Ken and Nick Pearson (New York) will be attending the June meeting in Philadelphia.**

**ARTICLES**

- **J.D. Dickenson (West Palm Beach) provides an update on the Chinese drywall investigation as well as a summary of significant insurance coverage decisions to date in the May edition of the Insurance Coverage Law Bulletin.**
- **Rob DiUbaldo (New York) discusses what insurers and reinsurers need to know about hydrofracking in the June issue of Bloomberg Law Reports.**
- **Huhnsik Chung and Greg Hoffnagle (New York) discuss whether insurance will bear the risk of hydrofracking in Risk Management Magazine’s June issue.**
- **John Hughes and Greg Pendleton (Boston) discuss the FDIC’s renewed pursuit of claims against directors and officers of failed banks in the May issue of the PLUS Journal.**
- **Jack Dearie and Amber Mills (New York) discuss the advantages and risks of electronic delivery of insurance policies internationally in Business Insurance on-line.**

For further details on any of the above please contact: insuranceenquiries@eapdlaw.com.
NRRA Stokes Debate Over Federal Regulation of Insurance as States Feel the Heat

After enjoying 4 years of broad bipartisan support, the Non-Admitted and Reinsurance Reform Act (NRRA) finally became law last summer after being folded into the financial services reform legislation passed in June 2010. The federal act, which is slated to take effect July 21, ushers in a new era of surplus lines reform in the United States by establishing one-state compliance on multi-state risks and nationwide uniform requirements, forms and procedures for non-admitted insurance. But the mounting uncertainty that states will be unable to craft laws that comply with the NRRA when the federal act goes into effect could ultimately serve as the catalyst for more pronounced federal regulation of the surplus lines insurance industry in the U.S.

One-State Compliance
The NRRA grants the insured’s home state with exclusive authority to regulate placement of nonadmitted insurance. The federal act states that no state, other than an insured’s home state, may require a surplus lines broker to be licensed in order to sell, solicit, or negotiate non-admitted insurance with respect to such insured. In addition, the NRRA explicitly provides for the preemption of laws, regulations, provisions, or actions of any state that applies to nonadmitted insurance sold, solicited by, or negotiated with an insured whose home state is another state.

Under the federal act, only the insured’s “home state” will be permitted to collect premium taxes for nonadmitted insurance. The insured’s “home state” is defined as the state of the principal place of business for a commercial insured or the state of residence for an individual insured.

To facilitate the payment of premium taxes, the stated intent of Congress in the NRRA is to allow the states to establish a nationwide or uniform system of reporting, payment, collection and allocation of surplus lines taxes among the states. The states may establish this uniform system by entering into an interstate compact or establish other procedures for the allocation of the surplus lines premium tax. If the states fail to implement a tax allocation system within 330 days after the adoption of the NRRA, then a single state taxation system will become effective on July 21, 2011, which conceivably allows the home state to then retain 100% of the tax on the gross premium, assuming it has amended its own laws to permit taxation of the entire premium.

Uniform Standards for Surplus Lines Eligibility
The NRRA empowers the states to create uniform national requirements, forms and procedures for insurer eligibility for U.S. domiciled (foreign) surplus lines insurers. If the states do not develop a nationwide eligibility standard, the NRRA sets default standards which the states must accept. Specifically, a U.S. domiciled surplus lines insurer will need to meet two substantive requirements under the NAIC Non-admitted Insurance Model Act: 1) maintain capital and surplus of at least $15 million (or the minimum capital and surplus requirement under the law of the insured’s home state if higher); and 2) be “authorized to write in its domiciliary jurisdiction.”

With respect to alien (non-U.S.) surplus lines insurers, states may not prohibit a surplus lines broker from placing non-admitted insurance with, or procuring non-admitted insurance from, a non-U.S., non-admitted insurer that is listed on the Quarterly Listing of Alien Insurers maintained by the NAIC’s International Insurer’s Department (“IID List”).

These relaxed eligibility standards will allow easier access to all states for both U.S. and alien insurers, thus increasing competition and expanding the surplus lines market to include additional alien insurers. Surplus lines brokers will also have a more diverse market to draw from as they will be able to place insurance with all alien insurers on the IID List instead of checking the white list of eligible alien surplus lines insurers in each applicable state.

What remains to be seen is whether the states will choose to amend their laws to incorporate the NRRA requirements while keeping existing state regulations that allow them to charge filing fees or to delist an insurer based on unsound financial condition or improper claims practices. Some states have indicated that they will continue to request financial, premium or other information from foreign and/or alien surplus lines insurers on an optional basis following the effective date of the NRRA. But if a state raises the ante and brings on enforcement action against a broker or company that is expressly contrary to the NRRA, the broker or company could resist (and likely win) in court.

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“The federal act ... ushers in a new era of surplus lines reform in the United States by establishing one-state compliance on multi-state risks and nationwide uniform requirements, forms and procedures on non-admitted insurance.”
Legislative Response
With NRRA only a few weeks away from final implementation, there are two competing interstate agreement proposals now being considered by the states as a possible response to the congressional mandate. The Surplus Lines Insurance Multi-state Compliance Compact (SLIMPACT), has been endorsed by the National Conference of Insurance Legislators (NCOIL), the Council of State Governments (CSG) and the National Conference of State Legislatures (NCSL). SLIMPACT, which was amended in November and now known as “SLIMPACT-lite”, would authorize a governing commission to establish allocation formulas, uniform payment methods and reporting requirements, to ensure eligibility standards, and a single policyholder notice to replace the various forms used across the country.

“[S]tate regulators and legislators must make a high level decision whether to adopt an interstate compact or other tax allocation procedure consistent with the congressional statement of intent, or to allow the single state tax system to become effective on July 21, 2011.”

An alternative and more scaled-down proposal endorsed by the National Association of Insurance Commissioners (NAIC) is the Non-Admitted Insurance Multi-State Agreement (NIMA). NIMA is a tax-only arrangement that addresses the tax uniformity and allocation issues but offers no guidance on eligibility standards or broader regulatory themes. Specific details regarding NIMA’s governance and operation still need to be developed.

Indiana, Georgia and Kansas were the 18th & 19th and 20th states to sign into law NRRA implementation legislation and bills have been approved by legislatures in seven other states, awaiting action by governors of Alaska, Florida, Hawaii, Missouri, Maryland, Oklahoma, and Vermont. However, only six states have enacted legislation specifically to enter into the SLIMPACT-lite compact while only 2 states have adopted legislation that specifically authorizes NIMA.

There is an additional legislative hurdle that the states must also clear. Under current state laws, the premium for multi-state risks is taxed based on the portion of premium allocable to each individual state. Since the NRRA does not automatically repeal these state laws on its July 21 implementation date, the home state will continue to tax only its pro-rata portion of the premium for multi-state risks unless it adopts new legislation. This would have the unintended consequence of reducing state premium tax revenues while providing a tax savings to purchasers of non-admitted insurance. To avoid this situation, states will need to promptly update their premium tax laws to take account of the “home state” implications of the NRRA. Failing this, the full amount of non-admitted premium allocable to non-home states would be entirely tax free.

Given the intricate legislative maneuverings that need to be performed to meet the NRRA implementation deadline, the leaders of NCOIL, CSG and CSL have written an open letter to Congress requesting a year extension, until July 21, 2012, in which to comply with the surplus lines section of the NRRA. The letter suggests that while there continues to be widespread support for an interstate compact, the chances for fuller participation would be greatly enhanced if the states are given more time.

Outlook
As we reach the end of the 2011 legislative sessions, state regulators and legislators must make a high level decision whether to adopt an interstate compact or other tax allocation procedure consistent with the congressional statement of intent, or to allow the single state tax system to become effective on July 21, 2011. This will not be an easy choice as each state has its own licensing, premium tax rates, filing forms, deadlines and compliance procedures. The ensuing procrastination could quickly turn to ambivalence among the major surplus lines jurisdictions such as California and New York if they determine that an allocation formula does not necessarily inure to their financial benefit.

With competing interests such as healthcare and financial reform still high on their legislative agendas, the states will find it even more challenging to enact rules adopting an interstate compact of any form within the next few months. The fact that Congress may be unwilling to consider the request to extend the July 21, 2011 implementation deadline brings an even greater sense of urgency to state legislators and regulators.

Given the potential loss of substantial tax revenues that would result from their failure to act, the pressure on the states to develop an effective tax allocation process and uniform eligibility standards over the next few months will be enormous. If a consensus can not be reached before the current or extended NRRA deadline, then such inaction will almost certainly hasten more aggressive federal regulatory oversight of the US surplus lines market and, on a broader scale, reignite the larger debate for an optional federal charter and other forms of federal insurance regulation.

A version of this article appeared in Insider Quarterly.

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Damian joined EAPD as a partner in the Regulatory and Transactional Services team of the firm’s Insurance and Reinsurance Department on 21 March 2011. He advises on a wide range of corporate, commercial and regulatory matters, with a particular focus on mergers and acquisitions in the insurance and reinsurance industry where he has acted for insurers, reinsurers, brokers, intermediaries and other financial services companies in the UK, Europe, the Middle East, Asia and the US.

In addition, Damian has experience of restructuring solutions in both the live and the run-off insurance markets, and has advised clients in relation to transfers of insurance business and solvent schemes of arrangement, often with cross-border implications. Damian has also worked in Russia advising natural resources companies on corporate and capital markets issues.
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A list of our offices (and associated offices) and contact numbers are adjacent. Further information on our lawyers and offices can be found on our website at www.eapdlaw.com.

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

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

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