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NORTON ROSE FULBRIGHT

Insurance focus

Our analysis of key legal developments in the insurance industry over recent months

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In this issue:

Introduction

In this edition of *Insurance Focus*, we continue our review of legal and regulatory issues connected to the rise of 'InsurTech'. Tyler Dillard from our London office writes about some of the challenges insurers face in using social media data in their underwriting.

From Amsterdam, David de Roos, Nikolai de Koning and Floortje Nagelkerke discuss the results of the Dutch Central Bank's investigations into the compliance of insurers with the Dutch sanctions rules, while Dominic Stuttaford and Susie Brain in London consider the new corporate criminal offences introduced into the UK of failing to prevent facilitation of tax evasion.

In our quarterly case law review, we consider the recent English Court of Appeal decision in *Great Lakes Reinsurance (UK) SE v Western Trading Limited* regarding an insured's entitlement to a reinstatement indemnity. In addition, we reflect on two decisions from the Canadian Supreme Court concerning litigation privilege for communications with a claims adjuster and the interpretation of insurance policies. We also consider one of the most closely watched US insurance cases of 2016 in which the Florida Supreme Court ruled that concurrent causes are covered.

In our regular international focus section we provide market updates from Australia, South Africa, Singapore, the United Kingdom and the European Union.

For more information contact:

Maria Ross
Partner, London
Tel +44 20 7444 3557
maria.ross@nortonrosefulbright.com

Susan Dingwall
Partner, London
Tel +44 20 7444 2349
susan.dingwall@nortonrosefulbright.com

Laura Hodgson
Senior knowledge lawyer, London
Tel +44 20 7444 3985
laura.hodgson@nortonrosefulbright.com

To like or not to like – navigating the pitfalls of using social media in underwriting

Constrained by unfavourable macroeconomic factors (including historically low-level interest rates), lower premiums, more claims, the harsher regulatory capital requirements imposed by Solvency II and the Prudential Regulation Authority and a soft market inundated with excess capital, insurers are under increasing pressure to price more competitively and estimate reserves more precisely, which means assessing risks more accurately.

These broader market and regulatory conditions, coupled with changing consumer preferences and wider cultural trends, have led insurers to harness the power of technology to reduce risks, cut costs, profit and grow. These objectives are at the centre of attempts by the industry to harness the power of "Big Data" – the aggregation of large amounts of data derived from exploitable data sources – to analyse consumer behaviour. The sources of such data, in particular social media platforms, and how that information could be used to fulfil customer expectations and to set premiums are matters which regulators and lawmakers are struggling to address in a coherent and modern way.

Computer algorithms can be used as proxies for underwriting calculations. Previously untapped data can be analysed to get a richer and more accurate assessment of an individual as a risk. For example, the use of a potential insured's social media posts can be digitally analysed in order to determine whether or not that person would be conscientious behind the wheel. The concept is simple: if the data retrieved from social media and other sources indicate that the prospective insured is a careful driver, the premium can be adjusted to reflect the risk. "Posts" and "likes" can give the insurer insight into personality traits that it associates with good driving. But, where should the boundary lie between consensual use of personal data and an intrusive use of personal information? Certainly, falling on the wrong side of this line might lead to insurers and brokers that use personal data being subjected to a barrage of public criticism, not least from human rights campaigners, data privacy and digital rights groups, but also from consumers and regulators, the combined effect of which could sink Big Data initiatives involving social media and impact profits.

The appetite within the insurance industry to see how Big Data might be mined to price products more accurately attuned to individual consumer behaviour is inescapable. However, the notion of harvesting and using social media data – which may include "personal data" heavily regulated by national and EU legislation – to determine insurance eligibility and set premiums raises a number of legal (and policy) concerns. Given the speed of exponential technological advancement, the law and regulation can only address these issues up to a point, begging the question: what regulatory boundaries and ethical parameters will, in the future, be applied to insurers in the deployment of data derived from unconventional sources like Facebook, Twitter or Instagram? This article seeks to answer this question by:

- Examining the use of Big Data by insurance firms to assess risks and set premiums.
- Exploring the ethical parameters and regulatory boundaries around the use of Big Data by insurers and the possible impacts of such initiatives.
- Considering the general regulatory response to Big Data to date.
- Analysing the response to genetic testing in pricing life insurance to predict what restrictions may, in the future, be set by the trade association, the Association of British Insurers (ABI), around the use of social media (and other Big) data.

Mining Big Data sources

Big Data is part of the wider ecosystem of "InsurTech", the developing union between insurance and technology. The most prevalent sources for Big Data are the ubiquitous "connected" devices like telematic (or "black-box") sensors installed in vehicles, location-based sensors fitted in offices and homes, and wearable devices such as watches and step counters. These devices, now regularly offered alongside motor, home and life polices, are capable of collecting, storing and transmitting vast quantities of real-time, objective and unfiltered data, which can be used to construct an individual profile of a policyholder's behaviour and the risks associated with his habits.

In addition to the information received from telematic devices which provide data on physical hazard, insurers are naturally interested in data sources that also provide information on moral hazard – what makes the insured tick, how they perceive risk, their honesty and likelihood of committing fraud. Accordingly, data sources such as social media can be used to produce a "personality-based risk assessment" constructed from an applicant's interests and purported levels of organisation and other characteristics. "Liking" a particular athlete, writing in concise sentences, publishing lists and using exclamation marks are amongst data that one UK insurer considered using to generate a personality type on a prospective policyholder and then determine how safely his driving habits would be – for example a customer's posts which featured superlatives like "always" or "never" may have implied overconfidence, a trait at least one study has concluded is emblematic of risky driving. Insurers could seek to rely on such data (and the science purportedly linking personality traits to driving) to adjust premiums. A number of major UK insurers have taken similar moves by offering reduced premiums (a) in return for more data derived from connected devices and (b) as a reward for good driving and healthier lifestyles.

Legal, regulatory and ethical concerns for insurer and insured

Although consumers are likely to be drawn to the prospect of the reduced premiums that access to Big Data has the potential to offer, there are a number of legal concerns which merit careful consideration, principally in the areas of data privacy, confidentiality, cyber security, intellectual property and even competition. Though these matters are outside the scope of this article, it is worth noting that some of the data that would be analysed might constitute "personal data" under the Data Protection Act 1998 (the DPA). As data processors under the DPA, insurance companies must take care in how they obtain the data and be transparent about its usage. The market will soon be subject to a stricter regime in the form of the EU General Data Protection Regulation, which sets out more robust obligations on companies harvesting data, including from digital sources like Facebook.

Beyond data protection law, use of social media raises regulatory concerns over pricing practices and risk segmentation. Extensive usage of Big Data (as well as the transmission of data over connected devices) in underwriting has the potential to segregate the risk pool, resulting in certain consumers being unable to obtain or afford insurance. Big Data initiatives could also penalise loyal (and inert) customers, who, satisfied with their existing policies, may be less likely to "shop around" for more competitive quotes. To the extent that gathering and using social media data were to become commonplace in underwriting, the transfer of such data between firms could become a logistical and regulatory nightmare, for example, on a portfolio transfer.

Data mining from social media, in particular, could result in indirect discrimination unwittingly creeping into underwriting decisions. Scouring through social media and classifying a Facebook post or tweeted information as "high risk" could reproduce unconscious bias against structurally disadvantaged groups of people with protected characteristics like race, sex, religion, disability, sexual orientation or gender identity and exaggerate existing inequalities facing those groups. There is also the potential for data derived from social media to be used to charge a certain category of customer higher premiums which do not reflect his actual risk profile or the cost of providing the insurance (e.g., simply because the customer has the willingness or ability to pay more for his insurance).

From the perspective of insurers, there is an inherent risk from using social media data, as customers may eventually "game" the system as they learn what types of information to publish on social media, in order to procure a lower premium, which would seriously undermine the underwriting process.

Regulatory uncertainty

The Financial Conduct Authority (the FCA) considered several of these issues in its September 2016 Feedback Statement on the use of Big Data in the retail general insurance sector. However, with the exception of this publication, the corresponding "Call for Inputs" from stakeholders on the issue and various speeches, there has been a palpable lack of responsiveness from the regulator on the increasing use of Big Data by insurers, which, initially, seems surprising, given the

complex and heavily regulated nature of insurance. This should not, however, imply a lack of regulatory interest in the area. Rather, it is reflective of the inability of law and regulation to match the pace of technological innovation. The FCA's full-scale regulatory market studies, which take months to produce, are simply not viable options. As they continue to develop and launch their Big Data and other InsurTech plans, insurance firms are looking for sufficient comfort now that they are not falling foul of the rules to which they are subject. This need for expediency could result in the publication of industry-specific Codes of Practices from the ABI as guidance on the parameters for using social media (and Big Data more generally) in assessing and pricing risks, an approach adopted by the market in relation to predictive genetic testing a few years ago.

Have we been here before? The example of predictive genetic testing for life insurance

The current uncertainties and concerns set out in this article are not entirely dissimilar to those identified at the time predictive genetic test results were increasingly being used in the market to price life insurance. Predictive genetic tests can be used to predict future illness – such data is rich for insurers, as it enables them to assess the policyholder's risk more accurately and set a level of cover more closely aligned to that risk. However, as is the case with using social media, there is a natural risk of risk segmentation and disparate pricing practices.

In its joint 2014 *Concordat and Moratorium on Genetics and Insurance* with the Government, the ABI promulgated an overarching policy framework for cooperation between the Government and insurers on the use of genetic information within the underwriting process. The Code, though not legally binding, set boundaries which the industry agreed not to cross – in particular that (a) predictive genetic tests should not be taken into account when deciding cover unless it was to the insured's advantage and (b) use of such tests must be transparent, fair and subject to regular review to ensure that consumers have rights of access to life insurance. The Code further addresses the delicate balance between this right of the insured and the right of the insurer to information material and relevant for underwriting the risk (i.e., disclosure). Of particular application to Big Data social media initiatives is the Code's approach to the relationship between data and insurance underwriting – namely that it must be proportionate and based on robust evidence. Therein lies a primary concern where dubious information such as whether a policyholder prefers Beyoncé to Dolly Parton or uses "LOL" in the social media vernacular could be used to determine whether the insured is a precarious driver. Despite the alleged link between personality traits and driving, the data which firms may be tempted to use cannot predict the same level of certainty on policyholder habits as a genetic test or even the level of exercise transmitted to an insurer from a technology wearable. It is this lack of sound evidence, together with the regulatory and ethical concerns highlighted above, that may sink attempts to rely on algorithms for character type and risk in underwriting.

Comment

The use of data from social media could enable long-term and general insurers to offer more personalised coverage to consumers and for a premium aligned more closely to the customer's actual risk profile. Given the regulatory uncertainties, it is not surprising that insurers are treading carefully and, at present, are only offering *reduced* premiums to reward good habits. Indeed, there are numerous challenges to navigate before insurers can even think of requiring consumers to pass on more data as a condition precedent to underwriting the risk at a normal premium or using the data to impose unjustified exclusions. As technology continues to advance, the boundaries are likely to be set by a Code of Practice and each insurers' own policies. In the interim, insurers will continue to launch their Big Data initiatives; however, they will need to ensure that such plans are fair, reasonable and transparent; otherwise, they could risk losing customers, regardless of how admirable or beneficial to the insured it may initially appear to be.

For more information contact:

Tyler Dillard
Partner, London
Associate
Tel +44 20 7444 3881
tyler.dillard@nortonrosefulbright.com

UK corporate criminal offences: Failing to prevent facilitation of tax evasion

The Criminal Finances Bill currently going through the UK Parliament includes new offences of failing to prevent facilitation of UK and non-UK tax evasion. Royal Assent is anticipated in Spring 2017 with the new offences expected to come into effect in Autumn 2017. Now that the proposals and associated guidance are in near final form, businesses should start assessing their response. While the rules apply to all businesses, financial services groups are a particular focus, both in relation to their own tax affairs and those of their customers (including policyholders).

There is a statutory defence where at the time of the offence the relevant body had reasonable procedures in place to prevent associated persons facilitating tax evasion. An 'associated person' is a person who performs services for or on behalf of the relevant body. The concept is deliberately broad and can pick up agents and sub-contractors as well as employees.

New draft guidance has been published. Formal guidance is promised after Royal Assent. This is then expected to be supplemented by government-endorsed sector-specific guidance from industry bodies.

Organizations are expected to have identified major risks and priorities and to have a clear implementation plan when the regime comes into force. Some procedures such as training programmes and IT systems will take time to put into place and what it is 'reasonable' to expect will change over time. Prevention procedures planned (but not yet in place) at the time of an offence will be taken into consideration. Risk assessment and development of prevention procedures is important ahead of these offences coming into force, as 'rapid implementation' is expected.

The new offences have to be seen in the context of the Government's strong commitment to combat tax avoidance and evasion, as well as other forms of economic crime. This mirrors international moves in this area and a growing use of the criminal law to stamp down on so-called tax abuses.

The new offences

The new offences are a reaction to the Government's frustration at the difficulty in attributing criminal liability to companies and partnerships where tax evasion has been facilitated by employees or other associates. The offences are 'strict liability' meaning that they do not require proof of involvement of the 'directing mind' (effectively senior management).

Fines are unlimited and disclosure may also be required to professional regulators. Conviction may prevent organizations being eligible for public contracts as well as lead to wider reputational damage. While financial services, legal and accounting sectors are expected to be most affected, all companies and partnerships are potentially within scope. Both UK and international businesses are potentially subject to it.

The *UK domestic offence* is split into three components, referred to as 'stages'

Criminal *evasion* of tax by the *taxpayer*

This picks up the offence of cheating the public revenue and all other statutory offences involving dishonestly taking steps with a view to, or being 'knowingly concerned in' the fraudulent evasion of tax.

Anything falling short of a criminal offence at taxpayer level will not count. There need not be an actual criminal conviction against the taxpayer.

Criminal *facilitation* of the tax evasion by an '*associated person*' of the relevant body who is acting in that capacity

Committing a 'UK tax evasion facilitation offence' requires deliberate and dishonest action to facilitate taxpayer level evasion.

Referrals and sub-contracting are discussed in the draft guidance.

- Straightforward referral will not give rise to the requisite association.
- If services are sub-contracted the position is different. An example is given of a foreign tax adviser instructed by a UK financial services firm to provide tax advice to a client: that foreign tax adviser is an 'associated person' of the UK firm and its advice to the client could attract liability for the UK firm.

The draft guidance accepts there may be little direct control over sub-contractor staff. This will be a factor in considering what constitutes 'reasonable' procedures. It may be sufficient to include a term requiring the sub-contractor to provide the necessary controls. This is something seen in the context of the Bribery Act and equivalent foreign regimes.

Failure by the relevant body *to prevent* that facilitation

Reasonable prevention procedures must be in place to benefit from the statutory defence.

The *foreign offence* starts from the premise that a UK-based relevant body should not escape liability simply because the foreign country suffering the tax loss is unable to bring a prosecution against it.

In addition to the 3 stages above, the foreign offence requires a 'UK nexus' and 'dual criminality'.

UK Nexus

This will exist where the relevant body:

- Is incorporated or formed under UK law
- Carries on business in the UK or
- Where any of the foreign tax evasion facilitation takes place in the UK.

Overseas head office operations would be brought within scope by a UK branch.

'Dual criminality'

The requirement for 'dual criminality' will be met where both the actions of the taxpayer and the facilitator would be an offence in the UK and the overseas jurisdiction also has equivalent offences at both taxpayer and facilitator level: the offence cannot be committed in relation to an act that would not be illegal in the UK.

This means that there will be no offence where the facilitation was inadvertent or negligent.

Establishing a defence: 'Reasonable prevention procedures'

Because of the financial and reputational risk stemming from any suggestion of an offence, businesses are looking to see what prevention procedures should be put in place.

What constitutes 'reasonable prevention procedures' is informed by six guiding principles. These follow the guiding principles identified in guidance to the Bribery Act 2010.

There may be some efficiency in developing procedures alongside those already in place (such as for the Bribery Act 2010) but it will not be a matter of piggybacking: an entity must put in place 'bespoke prevention measures' based on the 'unique facts of its own business' and the risks identified.

The six guiding principles

Principle 1 – Risk assessment

Organizations must assess the nature and extent of their exposure to risk: 'sit at the employee's desk' and ask whether they have a motive and opportunity to facilitate tax evasion.

Financial services, tax advisory and legal sectors are identified as sectors with particular risk.

Principle 2 – Proportionality of risk-based prevention procedures

To be 'reasonable' prevention procedures must be proportionate to risks. Procedures are expected to evolve with the relevant body's activities and the risk climate.

Principle 3 – Top level commitment

Procedures must demonstrate commitment of top-level management to prevent engagement in facilitation of tax evasion and foster an atmosphere in which it is unacceptable.

Principle 4 – Due diligence

The draft guidance recognizes that substantial due diligence is already undertaken in high risk sectors but notes that this will not necessarily be correctly targeted: the risk assessment will determine what is required.

Principle 5 – Communication (including training)

The focus is on effective internal communication including whistleblowing channels.

What is required from training is an understanding of the scope of the offences and the associated risks and of how to seek advice and raise concerns rather than a detailed understanding of tax rules.

Principle 6 – Monitoring and review

Review might be undertaken on a formal periodic basis but might also be prompted by market developments or the identification of criminal activity: the risk assessment will guide what is reasonable.

Implementation will be a large task for many organizations, particularly those operating globally. The first step will be for groups to identify risk areas and to work out what procedures are appropriate and how best to implement them, so that commitment is demonstrable. The draft guidance includes a number of basic examples relating to branch and subsidiary situations which highlight the need for adequate prevention procedures to be implemented wherever staff and associated persons act and not just in the UK. Establishing 'reasonable prevention procedures' will also involve revisiting contracts with sub-contractors to ensure that those contracts require them to have necessary procedures in place.

For more information contact:

Dominic Stuttaford
Head of tax, Europe, Middle East, Asia, Brazil, London
Tel +44 20 7444 3379
dominic.stuttatord@nortonrosefulbright.com

Susie Brain
Senior knowledge lawyer, London
Tel +44 20 7444 3717
susie.brain@nortonrosefulbright.com

Non-life insurers and their compliance with the Dutch Sanctions Act

Over the last four years, the Dutch Central Bank (*De Nederlandsche Bank*, DNB) has investigated the compliance of insurers (both life and non-life) with the Dutch sanctions rules and regulations. Recently DNB published its findings stating that during this period improvements were made, but that there is still a lack of awareness among insurers of the risks that they face in the sanctions domain.

In this article, we will consider the results of DNB's investigations. We will also address a number of topics that have been addressed in a recently published Q&A by DNB on compliance with the Dutch Sanctions Act (*Sanctiewet* 1977, the Sanctions Act) by non-life insurers. This article concludes with DNB's most recent investigation into branches of non-Dutch EEA insurers operating in the Netherlands.

DNB's investigations

Compliance with the Sanctions Act by insurers has been a subject of special attention of DNB since 2012, when it first launched its first investigation into this topic. At the end of 2012, DNB organized a seminar, where it published the results of its investigation. Deficiencies were detected at two out of three insurers and DNB announced that it would become more stringent in ensuring compliance with the Sanctions Act.

In October 2014, on the heels of the sanctions measures that were imposed in relation to the conflict between Russia and the Ukraine, DNB launched another investigation into compliance with the Sanctions Act. The first results of this investigation caused the DNB to conduct a follow-up investigation and to make compliance with the Sanctions Act a thematic project for 2015. As part of DNB's thematic investigation entitled Compliance Sanctions Act, insurers were required to complete questionnaires and a number of insurers were investigated on-site. In November 2015, DNB published an update on its thematic investigation in which it indicated that, among other things, some insurers had difficulties in implementing adequate measures to ensure compliance with the Sanctions Act, while others had implemented excessive measures.

In March 2016, DNB published the final results of its two year thematic investigation. DNB concluded that compliance with the Sanctions Act was still generally inadequate. For example, DNB indicated that the insurers' systematic integrity risk analysis (SIRA) was inadequate and that sanction rules and regulations were scarcely addressed in training programmes for employees. In addition, DNB noted a number of other problems, including but not limited to the following:

- Many non-life insurers failed to record their clients' ultimate beneficial owners (UBOs); as a result, it has been impossible to screen against sanctions lists.
- Little to no screening took place if a sanctions list was updated.
- Insurers only periodically updated the lists used for sanctions screening, rather than at the time that a sanctions list was updated. This means it is possible that clients included in an updated sanctions list may have been inadvertently accepted by insurers.
- Knowledge of the sanction regulations is inadequate for part of the insurance sector.

DNB's Q&A

In August 2016, DNB published a Q&A on the Sanctions Act for non-life insurers (the Q&A). The Q&A aims to clarify the obligations non-life insurers have under the Sanctions Act and offer guidance on implementing measures. The Q&A also provides for a number of good practices. Below we set out a selection of topics that are addressed in the Q&A.

Intent and awareness

DNB indicates that the issue of sanctions should be part of the SIRA that non-life insurers have to perform. In addition, DNB recommends as a matter of good practice that non-life insurers perform an internal audit every three years in compliance with the Sanctions Act. This also includes insurers perceived to be low-risk.

Accepting relationships

The Sanctions Act defines a 'relation' as "anyone involved in a financial service or financial transaction". This definition includes, among others: policyholders, insureds, beneficiaries, representatives and UBOs.

The Sanctions Act requires every non-life insurer to identify its 'relations'. Although the Sanctions Act does not require non-life insurers to subsequently verify the identity, in practice non-life insurers generally do this (e.g. by requesting a valid identification document) to limit the risk that in reality they might be dealing with a different person.

DNB also states that non-life insurers cannot simply rely on information provided by third parties in respect of the screening of relations. Outsourcing the screening against sanctions lists is only allowed where outsourcing agreements have been clearly documented.

For business relationships, a non-life insurer needs to identify the UBO(s) of the party they are dealing with. Pursuant to the Sanctions Act, an UBO is any natural person that holds 50 per cent or more of the ownership rights of, or has control over, the relevant company. A large number of non-life insurers use a so-called UBO-statement (UBO-verklaring) to identify the UBO of a company. DNB is of the opinion that solely using an UBO-statement is susceptible to fraud. Therefore, DNB considers it good practice to conduct additional research into the relevant UBO(s). In the case of charities (stichting) and other non-profit organizations, it is relevant to determine who has ultimate control over the organization. In practice, this will often be the directors and/or representatives.

Controlling and screening

A non-life insurer that operates in the Netherlands is required to screen its relationships against the Dutch sanctions list, EU sanctions lists and certain other foreign sanctions list. The Sanctions Act prescribes that a non-life insurer needs to 'regularly' screen its relationships against these sanctions lists. The frequency of screenings can be determined on a risk basis. Low-risk relationships can generally be screened less frequently than relationships with a high-risk profile.

As the UBO(s) of a company can change, it is important to frequently check whether the information provided in respect of the UBO(s) is still up-to-date. DNB considers it good practice to annually check whether the UBO(s)-information is still correct in respect of high-risk relationships. A low- or medium-risk relation can be checked once every two years. An additional screening needs to take place when new names are published on a sanctions list.

DNB believes it to be good practice for non-life insurers to establish a screening ratio of between 70 per cent and 85 per cent names against sanctions lists. Although non-life insurers are free to determine their own screening ratio, DNB considers it to be bad practice if 100 per cent of names are screened.

Payment

According to DNB the use of thresholds in respect of checks relating to payments is not allowed. Thresholds are only allowed in combination with other factors which enable the non-life insurers to be entirely sure that the risk is very low (e.g. payment to individuals with a Dutch bank account or payment to a Dutch governmental body).

Where a non-life insurer pays a third-party directly, it must screen the third-party, as well as the client. This obligation also includes the screening of a potential UBO. If a non-life insurer makes use of a co-insurer, it is not necessary to conduct the required checks, if it is clear that the required checks have already been performed. If a payment is made to a legal person, a non-life insurer needs to check whether the entity is controlled or owned by a person on a sanctions list.

Investigation into non-Dutch EEA branches

Recently DNB has launched a new investigation focusing on compliance with the Sanctions Act by the Dutch branches of non-Dutch EEA insurers, as these branches were not fully in scope during the previous investigation. DNB commenced its investigation in November 2016 by contacting branch offices directly. Once the investigation is complete, DNB will determine its strategy towards branches of non-Dutch EEA insurers.

Our take

The continuous attention that DNB is giving to compliance with the Dutch sanctions rules and regulations by insurers shows the importance of having robust policies and procedures in place in order to assess whether a certain transaction is in breach of those rules and regulations. In its ongoing scrutiny, DNB will now also focus on non-Dutch EEA branches. Because of the high number of publications by DNB on this topic, we believe that DNB will impose enforcement measures if insurers or the Dutch branches of EEA insurers do not comply with the Sanctions Act.

For more information contact:

Floortje Nagelkerke
Partner, Amsterdam
Tel +31 20 462 9426
floortje.nagelkerke@nortonrosefulbright.com

Nikolai de Koning
Associate, Amsterdam
Tel +31 20 462 9407
nikolai.dekoning@nortonrosefulbright.com

David de Roos
Associate, Amsterdam
Tel +31 20 462 9376
david.deroos@nortonrosefulbright.com

Case notes

Great Lakes Reinsurance (UK) SE v Western Trading Limited [2016] EWCA Civ 1003

In most cases where an indemnity is claimed under a property insurance policy which requires the insured to reinstate, the cost of reinstatement is the insured's loss. However, over the years, there have been occasional examples of a different measure of indemnity being adopted. In this case, an unusual difficulty had arisen because the value of the insured property had substantially increased as a result of a fire. As a result, the insurer argued that the insured had suffered no loss but that, in any event, the insured had no intention to reinstate (and therefore no entitlement to the cost of reinstatement). The Court of Appeal confirmed that the insured was entitled to a reinstatement indemnity if there was a clear intention to reinstate that was 'genuine' as well as 'fixed and settled'. However, in this case, the necessary intention would have to be demonstrated by the insured proceeding with the reinstatement hence the appropriate remedy was a declaration that the insured would be indemnified if the works were undertaken.

Background

The insured was the manager of a Grade II listed former factory (the 'Property') owned by the insured's director and principal shareholder, Mr Singh. In 2012, the Property was destroyed by fire. At the time of the fire, the Property was derelict and could not be profitably developed due to its listed building status. Though of limited value in its pre-fire condition, the Property was insured against (amongst other matters) fire damage for £2.1 million, which was the likely cost to reinstate, and the indemnity was conditional on the insured incurring the cost of reinstatement. After the fire, the Property's listed building status was removed, significantly enhancing its development potential, and therefore its value. However, no steps were taken to reinstate. As a result, no payment was made under the policy, and the insured subsequently commenced proceedings seeking damages or a declaration 'in respect of the losses it has suffered'.

The first instance decision

At first instance, the insurer argued that the insured's claim failed due to lack of insurable interest, material misrepresentation/non-disclosure and breach of warranty. However, the Mercantile Court rejected these defences and granted the declaration sought by the insured.

The Court of Appeal's decision

The insurer accepted the Mercantile Court's decision in relation to insurable interest, material misrepresentation/ non-disclosure and breach of warranty. However, the insurer was granted leave to appeal on two grounds:

- First, the insurer argued that the declaration was pointless because the insured had not suffered a loss (because the value of the Property had increased as a result of the fire) and would not suffer a loss (because the Property would not be reinstated).

- Second, the insurer argued that the Mercantile Court had wrongly decided that where the insurer repudiates the policy, it cannot rely on a condition that the costs of reinstatement will only be repaid once they have been incurred.

On the first issue, the Court of Appeal agreed that the declaration was flawed because it referred to 'losses' and none had been suffered. However, it remained the case that the insured was contractually entitled to the cost of reinstatement. Accordingly, the issue was not whether the Property had gone up or down in value as a result of the fire. Rather, it was whether the insured had a genuine intention to reinstate that was 'fixed and settled'. If the insured has this intention, it was entitled to the cost of reinstatement. However, if the court considered there was a realistic prospect that the reinstatement would not happen, it could decline to award damages and either order a declaration or postpone

deciding the issue until the position became clearer.

In this case, the Court of Appeal decided the insured's intention would only be apparent when the reinstatement works started. On that basis, the appropriate remedy was a declaration that the insured would be indemnified if and when that happened.

On the second issue, the Court of Appeal held the Mercantile Court had actually decided (correctly) that, in a policy such as this one, the insured's obligation to reinstate does not arise until the insurer confirms it will indemnify.

Comment

The Court of Appeal's decision confirms that, in most cases where the policy requires the insured to reinstate the damaged property, the right to an indemnity is contingent on the insured showing a clear intention to reinstate. In cases such as this where there is a real possibility that the property will not be reinstated, that threshold will only be met when the works takes place. However, until the insured positively decides not to proceed, an indemnity for the cost of reinstatement should still be available unless the policy indicates otherwise.

For more information contact:

Charlie Weston-Simons
Senior associate, London
Tel +44 20 7444 2261
charlie.weston-simons@nortonrosefulbright.com

The Supreme Court of Canada confirms the possibility for an insurer to invoke litigation privilege for communications with a claims adjuster

On November 25 the Supreme Court of Canada rendered its decision in *Lizotte v Aviva Insurance Company of Canada*, 2016 SCC 52.

In this case, the professional order supervising claims adjusters in Quebec was investigating the conduct of a claims adjuster. In the context of its investigation, it asked an insurer for a copy of its claim file pertaining to one of its insureds.

The request of the order was based on Section 337 of the *Act respecting the distribution of financial products and services*, which provides the order with the right to obtain 'any document' that is relevant to its inquiry.

According to the order, the law did not allow it to require the disclosure of documents protected by solicitor-client privilege. However, the same protection was not afforded to documents falling under litigation privilege.

The order argued that the protection afforded by litigation privilege had been expressly set aside by the wording of section 337 of the *Act respecting the distribution of financial products and services*.

In a unanimous decision, the Supreme Court rejected the order's arguments on the grounds that a legislative provision that simply refers to the communication of 'any document' is not sufficiently explicit to set aside litigation privilege.

In doing so, the Supreme Court confirmed the possibility that an insurer might invoke litigation privilege in respect of communications with a claims adjuster. This question had been previously discussed at court of appeal level, but never by the Supreme Court.

For example, in *Union canadienne (L'), compagnie d'assurance c. St-Pierre*, 2012 QCCA 433, the insured asked for a copy of the investigation report prepared by the claims adjuster at the request of the insurer. The Quebec Court of Appeal dismissed the demand of the insured on the grounds that the report was protected by litigation privilege.

In *Lizotte v Aviva Insurance Company of Canada*, the Supreme Court of Canada confirmed the possibility for the insurer to invoke litigation privilege, not only against the insured, but also against the professional order supervising claims adjusters.

For more information contact:

Dominic Dupoy
Partner, Montreal
Tel +1 514 847 6102
dominic.dupoy@nortonrosefulbright.com

Charles A. Foucreault
Partner, Montreal
Tel +1 514 847 6072
charles.foucreault@nortonrosefulbright.com

Supreme Court of Canada provides guidance on interpretation of insurance policies

The Supreme Court of Canada has provided important guidance in *Ledcor Construction Ltd. v Northbridge Indemnity Insurance Co.*, 2016 SCC 37 on interpreting insurance policies, particularly in the context of construction projects.

Background

The source of this litigation was the construction of a 28-storey office building in downtown Edmonton, Alberta, Canada. As one of the final steps in the project, the general contractor retained a sub-contractor to clean the tower's exterior windows for C$45,000. Unfortunately, the subcontractor used improper tools and methods and ended up scratching the tower's windows to the point where they had to be replaced at a cost of C$2.5 million.

The general contractor and subcontractor made a claim under the project's builder's risk policy for the cost of replacing the scratched windows. The policy covered all risks of direct physical loss or damage to the property undergoing construction, subject to certain exclusions. The insurer denied the claim on the basis that it fell under the following exclusion for the 'cost of making good faulty workmanship':

This policy section does not insure ... [t]he cost of making good faulty workmanship, construction materials or design unless physical damage not otherwise excluded by this policy results, in which event this policy shall insure such resulting damage.

Trial judge and Alberta Court of Appeal

At trial, the insureds argued that the exclusion for the 'cost of making good' only referred to the cost of redoing the cleaning work, while the insurer argued it also included the cost of replacing the scratched windows. The trial judge found that the exclusion clause was ambiguous because the interpretations of the insureds and insurer were equally plausible. The trial judge accordingly found that the policy covered the cost of replacing the windows because any ambiguity in an insurance policy in Canada will always be resolved to the benefit of the insured.

The Alberta Court of Appeal reversed the trial judge's decision. The court developed a new 'physical or systemic connectedness test' to determine whether the scratched windows were the result of 'faulty workmanship' (excluded) or 'resulting damage' (covered). Under this novel test, the court found that damage to the windows was the result of 'faulty workmanship' because it occurred during the intentional scraping and wiping of windows. The court accordingly found that the policy excluded the replacement cost of the windows.

Supreme Court of Canada

The Supreme Court of Canada granted the insured's appeal and found that the policy covered the cost of replacing the windows. In coming to this decision, the court provided important guidance on interpreting insurance policies:

- The court *found that the decision of a trial judge on the interpretation of an insurance policy is not typically owed any deference on appeal*. The court noted that the use of the correctness standard of review for insurance policies and other standard form contracts was an exception to the general rule the court had recently affirmed in *Sattva Capital Corp. v Creston Moly Corp.*, 2014 SCC 53 that appellate courts should review the interpretation of contracts using the palpable and overriding error standard of review. A palpable error is one that is plainly seen. An appellate court should only apply this more deferential standard of review to insurance policies in exceptional cases where, for instance, the parties actually negotiated the terms of the policy[1].
- The court rejected the Alberta Court of Appeal's new 'physical or systemic connectedness test' as unnecessary and affirmed that *trial courts should rely on the general rules of interpretation for insurance policies that the Supreme Court had established in prior cases*. In short:
  - The insured has the onus of establishing that the damage falls within the initial grant of coverage. The insurer then has the onus to establish that one of the exclusions to coverage applies, with the onus then shifting back to the insured to apply any exception to the exclusion.
  - If the policy's language is ambiguous, the court may consider the reasonable expectations of the parties, as long as that interpretation is supported by the language of the policy, does not give rise to results that are commercially unrealistic, and is consistent with the interpretations of similar insurance policies.

1 Justice Cromwell concurred with the result but found that there was no reason to depart from the general rule in *Sattva* for the interpretation of standard form contracts.

On the claim before it, the court agreed with the trial judge that the exclusion clause was ambiguous and accordingly turned to the reasonable expectations of the parties.

The court found that the purpose of a builder's risk policy is to provide broad coverage for construction projects, providing 'certainty, stability, and peace of mind' in exchange for 'relatively high premiums.' In this context, the court found that the insureds would be deprived of the very thing they had contracted for if the exclusion clause removed coverage for the cost of replacing the windows merely because the windows were the part of the project on which the sub-contractor had worked. The court accordingly found that while the policy would not cover the cost of redoing the sub-contractor's work, it did cover the cost of replacing the scratched windows.

Conclusion

This decision provides guidance to Canadian lower courts on the proper interpretation of insurance contracts in Canada by removing the temptation to come up with novel ways of resolving coverage disputes. This should lead to greater certainty for insureds and insurers on the interpretation of insurance policies. However, it could also increase the temptation to appeal lower court decisions since appeal courts will generally consider the matter anew.

This decision could also cause an increase in claims under builder's risk policies as insureds latch on to the Supreme Court of Canada's generous interpretation of the reasonable expectation of parties involved in construction projects. All insurers that write builder's risk policies in Canada need to review their policy wording to ensure any exclusionary language is free from the ambiguity found in Ledcor Construction.

For more information contact:

Jamie A. Macdonald
Partner, Ottawa
Tel +1 613 780 8628
jamie.macdonald@nortonrosefulbright.com

Florida Supreme Court: Concurrent Cause doctrine governs in first-party context if no efficient proximate cause can be determined

Plaintiff John Sebo bought a house in Florida in April 2005. Defendant American Home Assurance Company (AHAC) provided homeowners insurance from the time of purchase. The AHAC policy (the 'Policy') provided over US$8 million in coverage for damage to the home and other permanent structures on the premises. It also provided coverage for loss of use of the home. The Policy excluded losses caused by defective construction.

Extensive roof leaks were reported as early as May 2005, and Hurricane Wilma exacerbated the damage in October 2005. Sebo reported water intrusion to AHAC in December 2005. AHAC investigated but denied coverage for most of the claimed losses in April 2006. AHAC tendered its US$50,000 limit for mold damage, but took the position that 'damages to the house, including any window, door, and other repairs, is not covered' as defective construction contributed to the loss.

The residence could not be repaired and was demolished. In January 2007, Sebo filed suit against the home's previous owners, architect, and builder. In November 2009, Sebo amended his complaint, adding AHAC as a defendant and seeking coverage under the Policy. A jury eventually found in Sebo's favour, and the trial court entered judgment against AHAC.

On appeal, Florida's Second District Court of Appeals noted the lack of any dispute 'that there was more than one cause of loss, including defective construction, rain, and wind.' The Second District then disagreed with the trial court's application of Florida's concurrent causation doctrine in a 'case involving multiple perils and a first-party insurance policy.' The Second District therefore reversed and remanded for a new trial 'in which the causation of Sebo's loss is examined under the efficient proximate cause theory.'

Efficient proximate cause or concurrent cause?

As the Florida Supreme Court put it, "[w]e are confronted with determining the appropriate theory of recovery to apply when two or more perils converge to cause a loss and at least one of the perils is excluded from an insurance policy." The Court described the competing theories as follows:

[Efficient Proximate Cause or EPC theory] provides that where there is a concurrence of different perils, the efficient cause—the one that set the other in motion—is the cause to which the loss is attributable.

...

[Concurrent Cause Doctrine or] CCD provides that coverage may exist where an insured risk constitutes a concurrent cause of the loss even when it is not the prime or efficient cause.

The Court illustrated its understanding of efficient proximate cause doctrine with a prior case deciding coverage under an all-loss fire policy that excluded loss caused by an explosion. The Court there distinguished between

a fire causing an explosion which causes a loss—a covered loss—and an explosion causing a fire which causes a loss—a non-covered loss.

In contrast, the Court illustrated its understanding of concurrent cause doctrine with the case followed by the trial court, *Wallach v. Rosenberg*,527 So.2d 1386 (Flo. 3d DCA 1988) . There, the Rosenbergs' sea wall partially crumbled due to a combination of the neighbour's sea-wall collapsing and a storm. The Rosenbergs sought coverage under their homeowner's policy. Their insurer denied the claim on the basis of an exclusion for loss caused by earth movement or water damage (i.e. the storm), even though it was undisputed that the neighbour failed to properly maintain his sea wall, and that the neighbour's failure contributed to the Rosenbergs' loss. Florida's Third District Court of Appeals there held that "[w]here weather perils combine with human negligence to cause a loss, it seems logical and reasonable to find the loss covered by an all-risk policy even if one of the causes is excluded from coverage.

The Sebo holding: concurrent cause doctrine applies in favour of coverage when no efficient proximate cause can be determined

The Florida Supreme Court granted review based on the conflict between Wallach and the Second District's decision, which explicitly rejected Wallach. Before handing down its decision, the Court noted the parties' agreement "that the rainwater and hurricane winds combined with the defective construction to cause the damage to Sebo's property." The Court noted further that "there is no reasonable way to distinguish the proximate cause of Sebo's property loss—the rain and construction defects acted in concert to create the destruction of Sebo's home."

The Court then held that "it would not be feasible to apply [efficient proximate cause] doctrine because no efficient cause can be determined." The Court then opined that because nothing in the Policy undermined application of concurrent cause doctrine and no efficient proximate cause could be determined, concurrent cause doctrine applied in favour of coverage for the loss. Thus, under Florida law, a loss is generally covered under a first-party policy if: (1) no efficient proximate cause can be determined; (2) covered and excluded causes jointly cause a loss; and (3) the policy does not contain an applicable anti-concurrent cause provision.

This approach stands in contrast to some other states, like Texas. Texas follows its own, more insurer-friendly, variation of concurrent cause doctrine: "when covered and non-covered perils combine to cause a loss, the insured is entitled to recover only that portion of the damage caused solely by the covered peril." See, e.g., *Travelers Indemnity Co. v McKillip*, 469 S.W.2d 160, 162 (Tex. 1971). In other words, the insured bears the burden of segregating covered damage (i.e. damage due to a covered cause) and non-covered damage (i.e. damage due to a non-covered or excluded cause).

What's next?—and how insurers can protect themselves

Sebo is in some ways unsurprising. The loss fell within the Policy's insuring agreement, and "it w[as] not feasible to apply [efficient proximate cause] doctrine because no efficient cause c[ould] be determined." Accordingly, AHAC could not prove that an excluded cause was the proximate cause of the loss, and the insuring agreement's broad grant of coverage therefore governed.

What Sebo leaves open, however, is the issue of what happens when an excluded cause precedes and gives rise to a covered cause, and both later cause a loss. If a case with those facts reaches the Court, the Court may well carve out an exception from concurrent cause doctrine in favour of efficient proximate cause doctrine such that the loss would be excluded from coverage.

We also note in closing the Court's implicit approval of insurance policies' use of anti-concurrent cause language to avoid application of concurrent cause doctrine and thereby narrow the scope of coverage. In "disagree[ing] with the Second District's statement that [concurrent cause doctrine] nullifies all exclusionary language," the Court "not[ed] that AHAC explicitly wrote other sections of [the] [P]olicy to avoid applying [concurrent cause doctrine]." Thus, the Court held, "[b] ecause AHAC did not explicitly avoid applying [concurrent cause doctrine], we find that the plain language of the [P]olicy does not preclude recovery in this case." Accordingly, an insurer seeking to avoid AHAC's fate in Sebo would do well to include anti-concurrent cause provisions in its first-party policies.

For more information contact:

Stephen P Pate
Partner, Houston
Tel +1 713 651 5132
stephen.pate@nortonrosefulbright.com

Jim Hartle
Associate, Houston
Tel +1 713 651 5695
jim.hartle@nortonrosefulbright.com

A High-Water Mark in Section 54's Voyage to Certainty?

If the High Court's signal in *Highway Hauliers* was not clear enough, the Full Court of the Federal Court has further affirmed the pervasive remedial nature of section 54 of the Australian Insurance Contracts Act 1984 (ICA).

Watkins Syndicate v Pantaenius concerned an appeal from a decision handed down in January this year (See http://www.insurancelawtomorrow.com/2016/10/section-54-of-the-insurance-contracts-act-a-hard-act-to-follow). In dismissing the appeal, the Full Court reaffirmed the general position that s 54 may apply provided that a restriction or limitation is not inherent in the claim and observed that this requires an analysis of the essential character of the policy.

A claim on the rocks

Watkins concerned a luxury yacht which sank off the coast of Cape Talbot, WA, while returning to its home port following completion of the Fremantle to Bali yacht rally.

The yacht was insured under two policies. The first was held with, Pantaenius Australia Pty Ltd (Pantaenius Policy). The second was underwritten by the Appellant, Nautilus Marine Agency Pty Ltd (Nautilus Policy).

The Pantaenius Policy responded to the loss, but the Nautilus Policy excluded losses occurring outside a defined geographical zone, being 250 nautical miles off the Australian mainland or Tasmania. Under this exclusion, coverage was suspended from the time the yacht cleared Australian Customs on its outward voyage until it cleared Customs on its return.

At the time the yacht sank it was within 250 nautical miles of the Australian mainland but had not cleared Australian Customs following its return from Bali.

Pantaenius made a claim for contribution on Nautilus, arguing s 54(1) nullified Nautilus' exclusion clause. Justice Foster, at first instance upheld the application and ordered contribution.

Was s 54 engaged?

On appeal, the first issue was determination of whether s 54 was engaged. Following a close examination of the relevant High Court authorities, the Full Court concluded this task involves identifying the nature and limits of the risks that are intended to be accepted, paid for, and covered under the policy. The Full Court observed:

"The process of understanding what are the restrictions or limitations that are inherent in the claim is one that involves the construction of the policy, not merely as to what its constituent words mean, but in a broad sense so as to characterise as a matter of substance what is the essential character of the policy. Once that essential character is decided upon, the restrictions or limitations that necessarily inhere in any claim under such a policy (to which s 54 does not apply) and the restrictions or limitations that do not necessarily inhere in any claim under such a policy (to which s 54 may apply) can be ascertained."

Perhaps unsurprisingly, their Honours held that the essential character of the Nautilus Policy was to provide coverage for damage occurring while the yacht was within 250 nautical miles of mainland Australia or Tasmania. As the insured's yacht was within this geographical limit at the time it sunk, the insured's claim necessarily incorporated a physical dimension that was part of the essential character of the policy. The suspensory limitation created by the particular wording of the exclusion clause (i.e. the requirement to clear and re-clear Australian Customs) was therefore a qualification on, or collateral to, the policy's essential character. As such, s 54 was engaged.

Did s 54 prevent refusal of the claim?

Having determined that s 54 was engaged, the Full Court found that cover was suspended due to an "act" of the insured (either the insured's act of clearing Australian Customs on the outward journey or the omission of not having cleared customs upon return from Bali). Therefore, as the relevant "act" did not cause or contribute to the loss suffered, Nautilus could not refuse Pantaenius' claim.

Can an insurer rely on the remedial benefit of s 54?

Finally, the Full Court confirmed that an insurer can rely on s 54 and the remedial benefit of s 54 is not reserved solely for insureds. Nautilus' argument that s 54's use of the word "claim" referred only to claims made by the insured was rejected.

Going forward

As the Full Court noted, the approach taken in Watkins represents the gradual distillation of jurisprudence on s 54 over nearly 20 years of litigation. This high-water mark in judicial interpretation, in what has previously been a difficult area to navigate, sends a clear signal to insurers. Close and careful attention must be paid to defining the limits of a policy to ensure that the scope accurately reflects the risk intended to be covered. Undue reliance should not be placed on technical exclusion or limitation clauses to remedy what is otherwise a broad or vaguely defined policy.

For more information contact:

Ray Giblett
Partner, Sydney
Tel +61 2 9330 8531
ray.giblett@nortonrosefulbright.com

Tristan Baker
Associate, Sydney
Tel +61 2 9330 8448
tristan.baker@nortonrosefulbright.com

International focus

Australia

2016 Mandatory Data Breach Notification Bill – latest update

After much anticipation, the Privacy Amendment (Notifiable Data Breaches) Bill 2016 (Cth) (Bill) was introduced into the Australian Parliament on 19 October 2016. If passed, organizations and Commonwealth government agencies subject to the Privacy Act 1988 (Cth) will be required to notify affected individuals and the Australian Privacy Commissioner of 'eligible data breaches'. This affects Commonwealth government agencies and organisations that have a turnover of more than A$3 million annually, as well as some small businesses such as private health service providers.

What's changed since the 2015 exposure draft?

As outlined in the Bill's accompanying explanatory memorandum, there have been a number of changes to the Bill since last year's exposure draft circulated by the Attorney-General's Department. Some of the key changes include:

- A change in terminology, with data breaches that are covered by the Bill now being referred to as 'eligible data breaches' rather than 'serious data breaches'.
- A change to the notification requirement threshold, with eligible data breaches only covering situations where there is a 'likely risk of serious harm' (rather than the previous 'real risk of serious harm' wording in the exposure draft).
- The removal of a requirement to notify data breaches that an entity ought reasonably to have been aware of.
- The addition of a new exception to cover situations where remedial action is taken by the entity that suffers an eligible data breach, with the effect that data breaches will no longer be considered to be an eligible data breach (and therefore notification will not be required) if the remedial action would be considered by a reasonable person to mean that there is no longer a likely risk of serious harm.
- Amendments to the factors that are stated in the Bill to be relevant to determining whether there is a likely risk of serious harm, including to recognise the use of security technologies in relation to that information.
- Clarification of when a notification must be given to affected individuals (as opposed to publishing it on the entity's website).
- Expansion of the factors which the Privacy Commissioner must take into account in assessing whether to exempt an entity from providing notification.
- Clarification of the notification requirements where two or more entities jointly and simultaneously hold information which is the subject of the data breach.

While some of the more objectionable elements of the exposure draft have been removed or pared back, the essence of the Bill remains the same. Organisations and Commonwealth Government agencies will have an obligation to notify the Australian Privacy Commissioner and affected or at risk individuals if an eligible data breach occurs. A failure to do so will be deemed to be an interference with the privacy of the individual(s). Civil penalties of up to A$360,000 for individuals and A$1,800,000 for bodies corporate may apply for serious or repeated interferences of privacy.

What does this mean for you?

As the introduction of a mandatory data breach notification scheme has previously received bipartisan support, it is possible that the Bill could pass relatively quickly through the Parliament. Although the Government has previously committed to passing the Bill in the Spring 2016 Parliamentary session, it remains to be seen whether this occurs.

If passed, the Bill will likely commence 12 months after receiving Royal Assent (if not sooner). While this may seem like a long time away, entities should start preparing for the proposed notification requirements now.

In its current form, the Bill will require entities to act quickly in assessing whether notifications need to be made. Upon becoming aware of a suspected eligible data breach, entities will have 30 days to confirm whether an eligible

data breach has occurred and if it has, entities will be required to notify as soon as practicable thereafter.

Given the fast paced and constantly evolving nature of data breaches (and other cyber-incidents), there is little opportunity for 'learning as you go'. Please contact us should your organization require any assistance in preparing for, or responding to, a cyber incident.

For more information contact:

Tricia Hobson
Global Vice Chair; Chair, Australia
Sydney
Tel +61 2 9330 8609
tricia.hobson@nortonrosefulbright.com

John Moran
Partner, Sydney
Tel+61 2 9330 8674
john.moran@nortonrosefulbright.com

Reece Corbett-Wilkins
Associate, Sydney
Tel+61 2 9330 8735
reece.corbettwilkins@nortonrosefulbright.com

South Africa

Is anti-competitive behavior insurable?

The August 2016 first-of-its-kind judgment against South African Airways (SAA) in favour of Nationwide Airlines, for damages arising from conduct that was held to be an anti-competitive exclusionary act preventing Nationwide from entering into or expanding within the travel market, raises the interesting question whether the loss is insurable by the company and the directors.

SAA paid bonuses and gave free air tickets as incentives to travel agents to direct more flight bookings to it. The Competition Act enables a person to sue anyone found by the competition authorities to have engaged in prohibited anti-competitive conduct for damages.

The principle is that an insurer is not bound to indemnify deliberate unlawful behavior. This includes indirect intent.

The company sued would claim under its public liability policy. Standard policy wordings exclude fines, penalties, punitive, exemplary or vindictive damages but not all damages arising from unlawful conduct. Policies often cover negligence for instance. Every case will have to be looked at on its facts to see whether there was intentional unlawful activity.

In the competition setting, cartel behaviour is normally deliberate unlawful conduct. In the case like the SAA case the incentives may have been given in the bona fide belief after taking legal advice that they were lawful and insurers could be exposed if those are the facts. The competition authorities do not have to find a subjective intention so further evidence may be needed to consider the insurance claim.

Cover under a directors and officers (D&O) policy is for unlawful acts. The Companies Act prohibits a company, and its insurers, from indemnifying a director for wilful misconduct or wilful breach of trust and for carrying on business with gross negligence or with intent to defraud or for any fraudulent purpose. Once again it will be a question of fact whether the director or prescribed officer was guilty of the kind of conduct that is excluded as a deliberately dishonest or fraudulent act under the policy.

Under a liability policy the insured must be 'legally liable to pay' which could be when the final damages judgment of the high court comes out. The anticipated loss should of course be reported or disclosed earlier. Under the D&O policy it will usually be claims-made cover.

Is this a threat or an opportunity? Insurers should decide whether they want to create specific liability under their policies or to exclude liability under their policies to deal with claims relating to anti-competitive behavior. Many liability policies already have exclusions for liability arising from breach of the Competition Act.

For more information contact:

Patrick Bracher
Director, Johannesburg
Tel +27 11 685 8801
patrick.bracher@nortonrosefulbright.com

Singapore

Consultation Paper on introducing re-domiciliation provisions into the Singapore Companies Act issued by Ministry of Finance and Accounting and Regulatory Authority of Singapore

A Consultation Paper on the Introduction of an Inward Re-domiciliation Regime was jointly issued by the Ministry of Finance (MOF) and the Accounting and Corporate Regulatory Authority of Singapore (ACRAS) on 26 October 2016.

The consultation proposes to introduce a new set of re-domiciliation provisions to the Singapore Companies Act (SCA) to allow foreign corporations to transfer their corporate registration to Singapore.

The authorities have made it clear that re-domiciliation will only be allowed for foreign entities where there are likely prospects for a positive commercial contribution to Singapore.

Furthermore, it is proposed that re-domiciliation will only be available to foreign corporations that meet a minimum criteria, which is based on the existing criteria for the assessment of a small company under the SCA. This means that a foreign corporation will need to meet minimum requirements relating to a minimum of S$10 million in revenue and/or assets with more than 50 employees for the past two financial years.

By using this proposed re-domiciliation registration process, the foreign corporation will be able to retain its identity and history and minimise operational disruptions.

Such an inbound corporation that is re-domiciled to Singapore will become a Singaporean company and will be required to comply with the requirements under the SCA like any other Singapore company.

The public consultation will run until 16 November 2016. The proposed re-domiciliation provisions will form part of a larger Companies (Amendment) Bill to be confirmed sometime in the next two years.

For more information contact:

Magdalene Teo-Yong
Senior associate, Singapore
Tel +65 6309 5313
magdalene.teo-yong@nortonrosefulbright.com

United Kingdom

Cyber risks in the spotlight

The Prudential Regulation Authority (PRA) has published a consultation paper on *Cyber Insurance Underwriting Risk* (CP39/16), proposing a new supervisory statement setting out its expectations for the prudent management of cyber underwriting risk.

For the purposes of the draft statement, cyber underwriting risk is defined as the set of prudential risks emanating from underwriting insurance contracts that are exposed to losses resulting from a cyber-attack.

To assess these risks, the PRA carried out thematic work involving a variety of stakeholders from October 2015 to June 2016. The PRA's work focused on the underwriting risks emanating from both affirmative cyber insurance policies as well as implicit cyber exposure within all-risks and other liability insurance policies that do not explicitly exclude cyber risk, referred to as 'silent' cyber risk.

The results of this work are summarized in an accompanying 'Dear CEO' letter, which highlights the following:

- *Silent cyber risk is material*. The PRA found an almost universal acknowledgement of the loss potential of silent cyber; however most firms did not demonstrate robust methods for quantifying and managing silent cyber risk.
- *Silent cyber loss potential increases with time*. As both silent cyber insurance awareness and the frequency of cyber-attacks grow, so does the loss potential from silent cyber exposures.
- *Casualty (direct and facultative) lines potentially significantly exposed to silent cyber*, either due to the fact that exclusions are not widely used or because some policies, e.g. D&O policies, cannot reasonably exclude cyber losses.
- *Potential for silent losses in marine, aviation, transport and property lines*. Motor and aviation underwriters are comfortable providing implicit cyber coverage despite a background of continuous technological advances. Property underwriters acknowledged the potential for cyber aggregation; despite that there are currently no widespread exclusions for cyber risk.
- *The exposure and response of reinsurance contracts is uncertain*. Reinsurers are aware of the potential aggregations resulting from silent cyber and are looking to address this in the future. Currently there is no widespread use of exclusion in either property or casualty reinsurance contracts. Where wordings do exist to address the issue, these are bespoke and introduced only recently and so may later result in disputes should a claim arise.

- *Most firms lack clear strategies and risk appetites*. Boards do not own the overall strategy around cyber risk and in a number of cases a clear strategy, supported by risk appetite statements, does not exist.

- *Firm investment in developing cyber expertise is insufficient*. This is due to a combination of firms being at the early stage of their cyber offering and the lack of supply of skilled professionals with cyber underwriting expertise.

- *Affirmative cover risks are not well understood*. Firms do not sufficiently understand the aggregation and tail potential of affirmative cyber cover. Moreover using past claims data to estimate future cyber losses may not be appropriate due to data being non-stationary.

- *Risk management's ability to challenge is limited*. Risk management teams are not adequately equipped in terms of skill and expertise to provide effective challenge to the business. Input is often limited to either developing simple deterministic scenarios or reviewing and adapting widely publicized work on the topic.

- *Third-party vendor models at early stages of development*. Catastrophe modelling vendors have developed small sets of deterministic cyber scenarios to assist their clients in managing aggregation and data schemes have been developed for categorizing cyber exposures. Although these are helpful steps, the PRA considers that the market has much work to do before it can capture and manage cyber exposures effectively.

- *EU Data Directive will increase affirmative cyber exposures*. The implementation of the Data Protection Directive in 2018 will strengthen the European regulatory framework on personal data.

In light of the above, action is required across the non-life sector to mitigate the risks identified. In its consultation paper, the PRA sets out its expectations in relation to three main areas:

- *The management of silent cyber risk*. The PRA proposes that firms have the ability to monitor, manage and mitigate silent cyber risk effectively and aim to provide policyholders with greater contractual certainty as to their level and type of coverage.

- *Setting clear appetites and strategies owned by boards*. The PRA proposes that firms exposed to silent and affirmative cyber risk will have clear strategies and articulated risk appetites on the management of the associated risks. These should be owned by the board and reviewed on a regular basis.

- *Investing in cyber expertise*. Insufficient investment from firms is due to a combination of being at the early stages of development of their cyber offering and a lack of supply of skilled professionals with cyber underwriting expertise. The PRA proposes that firms have sufficient expertise to monitor and manage the risks emanating from cyber risk.

Written by Amy Teece

For more information contact:

Laura Hodgson
Senior knowledge lawyer, London
Tel +44 20 7444 3985
laura.hodgson@nortonrosefulbright.com

European Union

European Commission publishes results of Call for Evidence on EU financial services

The European Commission (the Commission) has published the results of a public 'Call for Evidence' which sought feedback on the cumulative effect of recent financial sector rules brought in since the financial crisis. The results of the Call for Evidence will be used to feed into the development of future legislative initiatives within the European Union. In this exercise the Commission has looked across all policy areas to see where existing measures are still fit for purpose and whether there is a need for improvement.

Since 2009 over 40 pieces of financial services legislation have been introduced with the aim of stabilizing markets and better protecting consumers.

Following a review of the evidence on how these reforms have worked so far, the Commission has concluded that overall there is no need to change the existing framework. However, some amendments are needed in the following areas:

- *Removing unnecessary regulator constraints on financing the economy*. The Commission believes that some results can be achieved in a more 'growth-friendly' manner so that banks and other entities can support economic growth. One such area is the prudential treatment of infrastructure and other long-term investment by insurance companies where results indicated that the risk framework laid down in the Solvency II Directive limits insurance companies' ability to finance long-term investments.

- *Enhancing the proportionality of rules without compromising prudential objectives*. There is recognition that existing rules can be a significant burden on smaller institutions. The Commission therefore will look at ways to enhance the proportionality of rules without compromising prudential objectives including insurance and asset management. Amongst the rules cited as requiring simplification are the methods, assumptions and calculations of certain modules in the Solvency II standard formula.

- *Reducing undue regulatory burdens*. Reducing duplicative or excessive regulatory reporting requirements will be included in the review. The Commission will consider how reporting requirements might be reduced or consolidated or streamlined.

- *Making rules more consistent and forward-looking*. The results of the Call for evidence have revealed certain inconsistencies between individual rules in pieces of legislation which need to be addressed – the Commission communication mentions Solvency II in this context.

Next steps

The aspects of Solvency II that require revision will be addressed in the forthcoming review of the regime. Going forward, the Commission will monitor progress in the implementation of the respective policy commitments and will publish its findings and next steps before the end of 2017.

For more information contact:

Laura Hodgson
Senior knowledge lawyer, London
Tel +44 20 7444 3985
laura.hodgson@nortonrosefulbright.com

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