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NORTON ROSE FULBRIGHT

Insurance focus

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

December 2018

In this issue:

Introduction

In this edition of *Insurance Focus* we take stock of the red-lines, breakthroughs, bust-ups and backstops in the United Kingdom's attempts to secure a financial services deal before exiting the European Union. We consider the "known knowns" and "known unknowns" and set out what contingency planners for insurers need to understand.

Following the legalization of cannabis in Canada, we consider the potential impact for insurers of the legalization of cannabis in South Africa following a recent landmark judgment in the Constitutional Court.

We also consider the impact of new legislation that aims to combat aggressive tax planning and improve tax transparency in the EU. We look at how the new "DAC 6" tax cross-border reporting requirements may affect insurers.

In our regular case notes feature we consider a recent decision in respect of which losses can be claimed under an All Risks cargo policy, a recent Australian Federal Court decision in favor of insurers' right to avoid the policy and not advance defense costs under an adjudication clause and whether a breach of a performance guarantee should be subject to insurance under Quebec law. We also consider the impact of a recent UK decision in respect of the practice known as "offshore looping".

We also include our regular feature of interesting legal and regulatory updates from across our offices.

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Brexit: known knowns and known unknowns in the divorce of the decade

On March 29, 2017, the UK Government triggered Article 50 of the Treaty on European Union. In the 18 months since, we have seen red-lines, breakthroughs, bust-ups and backstops. As we near the climax of the negotiations on the terms of the UK's exit from the European Union uncertainty remains acute for the European insurance industry, in which many groups conduct business on a cross-border basis. We set out below the "known knowns" and the "known unknowns" from an insurance regulatory perspective which contingency planners should take into account.

The withdrawal process

In the absence of unanimous agreement from all member states of the EU to an extension of the negotiating period, at 11pm on March 29, 2019, the UK will leave the EU (Exit Day).

The UK and the EU have negotiated the terms of exit (the Withdrawal Treaty). The Withdrawal Treaty includes the terms of an "implementation period" which would maintain the status quo until December 31, 2020 (the Implementation Period). Although the Withdrawal Treaty has political agreement there remains considerable doubt whether it will pass through Parliament. Accordingly, fears of a no-deal Brexit have mounted.

There is immense timetable pressure on these negotiations: the Withdrawal Treaty must be ratified by the European Parliament, a qualified majority of the EU member states at the European Council and the UK Parliament (which, under the European Union Withdrawal Act 2018, must also approve a framework on the future trading relationship between the UK and the EU). It has been widely considered that the Withdrawal Treaty must be agreed prior to the European Council summit on December 13–14, 2018 to ensure ratification prior to Exit Day.

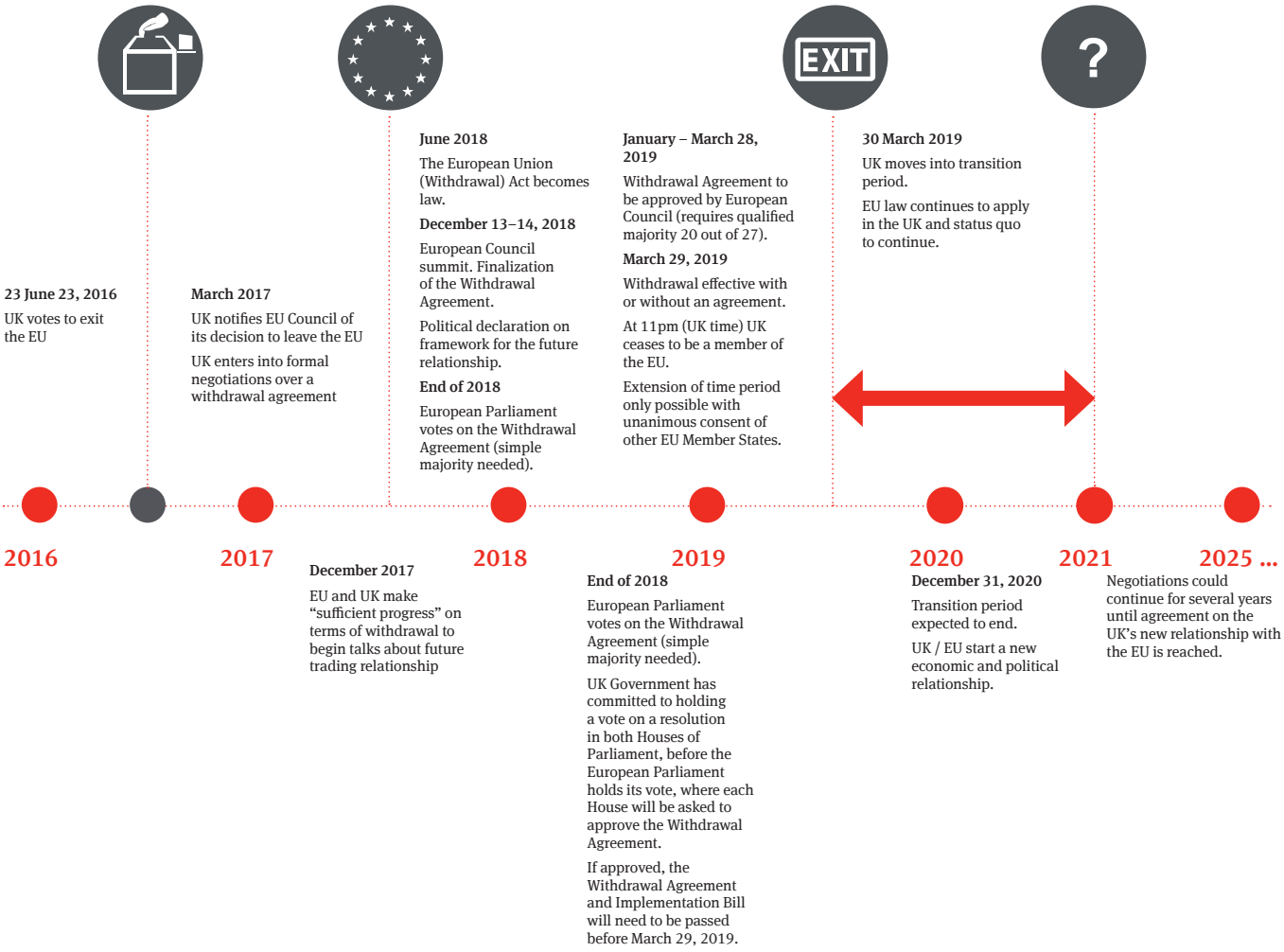
Loss of passporting rights

Over £8 billion of premium is brought annually to the London market by brokers on behalf of European customers.[1] Global insurance programs are frequently written out of the UK, covering UK, other EEA and non-EEA exposures. The biggest impact of Brexit on the European insurance industry is the likely loss of the passporting rights which enable such business to be concluded across the European Economic Area.

If the Withdrawal Treaty is not agreed prior to Exit Day, the United Kingdom will automatically become a "third country" under European law. As a result, UK (re)insurers will lose their existing authorizations to write or service (re)insurance business across the EEA or in respect of risks situated in the EEA on a freedom of services basis and/or freedom of establishment basis under the Solvency II Directive (2009/138/EC) and UK insurance intermediaries will also lose their similar rights granted under the Insurance Distribution Directive (2016/97/EC). European insurers and insurance intermediaries will likewise no longer be authorised to carry on regulated activities in the UK.

1 London Market Group *A Brexit Roadmap for the UK Specialty Commercial Insurance Sector*' March 9, 2017.

Brexit: current political process



Regulated activities are not entirely consistent across the EEA due to variations in Member States' implementation of EU law. However, broadly, they span the product cycle, from a broker arranging a policy on behalf of a policyholder and advising it on the terms of cover, to an insurer underwriting the cover, administering the policy by processing mid-term adjustments and ultimately settling and paying claims. In the United Kingdom, conducting regulated activities without authorization is a criminal offence, and this position is mirrored in many other European jurisdictions.

Approaching the cliff-edge

The European authorities and their UK counterparts are taking divergent approaches to the risks of a No-Deal Brexit.

The European Insurance and Occupational Pensions Authority (EIOPA) expects insurers to plan on the basis of a No-Deal Brexit, as set out in formal opinions dated December 21, 2017 and June 25, 2018.[2] The position of EIOPA and the European Commission is that existing contracts will remain valid and it is for businesses to take the necessary steps prior to Exit Day to prevent their insurance activities being undertaken without authorization and to ensure service continuity for existing contracts.[3]

In response, many insurance groups, including the Lloyd's market, which currently access the European (re) insurance market from the UK have or are in the process of establishing new European carriers prior to Exit Day, either to act as a new hub for European business or to act as a fronting insurer for their UK capacity (Brexit Vehicles).

2 Opinion on service continuity in insurance in light of the withdrawal of the United Kingdom from the European Union, EIOPA-BoS-17/389, December 21, 2017;

3 This is also an obligation upon (re)insurance undertakings in Article 41(4) and Article 46(2) of the Solvency II Directive.

Many insurance intermediaries are also restructuring their operations to route EEA business through an existing or newly-established Brexit Vehicle within their group.

The extent to which these Brexit Vehicles can leverage existing UK capacity, expertise and governance structures varies from jurisdiction and is often subject to negotiation with the relevant local regulator. To pre-empt regulatory arbitrage amongst EEA jurisdictions competing for UK market business, EIOPA has published an opinion in July 2017 warning European regulators not to permit large-scale outsourcing of critical and important functions (such as underwriting and claims handling) where it would "deplete the corporate substance of the EU entities with repercussions on the adequacy of their management and on the effectiveness of supervision" by European regulators. EIOPA also indicate that there should be a minimum of ten per cent of the business written retained in the Brexit Vehicle. The implication is clear: letter-box entities will not be acceptable.

A number of insurers have also drafted "contract continuity" endorsements which would novate the policy to an EEA-licensed insurer in the event of a no-deal Brexit. However, there is a risk such clauses may on exercise trigger a requirement to undertake a court-sanctioned transfer of insurance business under Part VII of the Financial Services and Markets Act 2000, particularly where they novate exposures in existing contracts. Insurers, brokers and policyholders, should seek legal advice on such terms.

The current European approach to contract continuity has led many UK insurers to undertake a Part VII Transfer of existing policies relating to EEA-situated risks to a carrier licensed in an EEA jurisdiction. This process can take up to 12-18 months, and so there is a material risk that such transfers, unless commenced well in advance of a No-Deal Brexit, will not be completed prior to Exit Day.

The UK solution: a Temporary Permissions Regime

The UK approach is conversely predicated on the assumption that "it will be difficult, ahead of March 2019, for firms on their own to mitigate fully the risks of disruption to financial services".[4] Accordingly, the UK Government has unilaterally committed to address the risks of a No-Deal Brexit for European insurers and insurance intermediaries operating in the UK through the implementation of a "Temporary Permissions Regime" (TPR). The UK Government has also agreed a commitment with the government of Gibraltar to agree measures for continued mutual market access for financial services. The FCA has announced that Gibraltar-based firms that passport into the UK will not need to use the TPR and will be able to continue to operate as they do now post-Brexit until 2020, when a bilateral framework will be put in place.

The TPR would allow European firms, subject to making a notification prior to Exit Day, to continue to write new business and service existing business in the UK for up to three years after Exit Day on the basis of their current passporting permissions. The PRA and FCA will allocate participating firms a three month period in which to submit an application for full UK authorization, known as "landing slots".

Both the FCA and the PRA have published consultation papers on how they will regulate participating firms. Broadly, they intend to use temporary transitional powers to ensure that participating firms do not immediately need to fully comply with UK regulations applicable to third country firms (e.g., the localization of assets to meet branch solvency and minimum capital requirements).

The UK Government has also stated that it will make separate statutory provision for EEA firms which will not be establishing a UK branch to wind down their UK regulated activities, including any outstanding contractual obligations.

In light of the TPR, inbound EEA firms can plan with more certainty than UK insurers and insurance intermediaries. In the absence of political agreement with the EU on contract continuity, the choice faced by UK insurers upon a no-deal Brexit will be to "break the contract or break the law". The Bank of England has suggested that up to 48 million European policyholders could be affected.[5]

The Future Trading Relationship

The UK Government's so-called "Chequers plan", set out in the July 12, 2018 white paper, accepts that UK firms "can no longer operate under the EU's 'passporting' regime". The UK Government's proposal for the Future Trading Relationship in financial services instead focuses on autonomous but aligned markets based on a principle of "expanded" equivalence. [6]

As a first step, the UK Government has targeted recognition of existing equivalence under Solvency II. This concept of equivalence does not,

4 https://www.parliament.uk/documents/commons-committees/treasury/Morgan-to-Hammond-Brexit%20-Insurance-Contracts-140917.pdf.

5 https://www.bankofengland.co.uk/events/2018/july/treasury-select-committee-hearing-on-the-work-of-the-pra; https://uk.reuters.com/article/uk-britain-eu-finance/eu-and-boe-clash-over-fate-of-financial-contracts-after-brexit-idUKKBN1K11MX.

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/734939/2018-08-17_Financial_Services_Slide_FINAL.pdf.

however, primarily relate to market access. In addition, while the UK will be equivalent in practice on Exit Day, the formal adjudication process can be lengthy and highly political. In addition, while substantive changes to the UK regulatory regime appear unlikely, a future government could seek to create competitive advantage for the UK market by moving away from the Solvency II position.

The UK hopes that existing equivalence can be expanded to "the most mutually beneficial activities for the economy". This is implied to include the London speciality insurance market. However, it is not clear what such equivalence would mean for market access given that the EU is unlikely to be receptive to any attempt to replicate the substance of passporting. The UK also wants any withdrawal of such access to be a structured process, with clear timelines and notice periods, and arrangements for contract continuity in the event that equivalence is withdrawn. However, the EU may be unwilling to offer additional rights to the UK on the equivalence process than it offers to currently equivalent jurisdictions, such as Bermuda and Japan. The UK's request for formalized regulatory and supervisory cooperation, however, is unlikely to be controversial.

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The effect of legalization of cannabis on the insurance industry

The legalization of private cultivation, possession and the use of cannabis in South Africa, following a landmark judgment handed down on September 18, 2018 by the Constitutional Court has had the effect of changing the law which will undoubtedly require transformation in the insurance industry.

The Constitutional Court declared the provisions of sections 4(b) of the Drugs and Drug Trafficking Act, 1992 read with Part III of Schedule 2 of that Act and the provisions of section 22A(9)(a)(i) of the Medicines and Related Substances Control Act, 1965 read with its Schedule 7 inconsistent with the right to privacy which is entrenched in section 14 of the Constitution and, therefore, invalid to the extent that they make the use or possession of cannabis in private by an adult person for his or her own consumption in private, a criminal offence.

The court considered the right to privacy, the use of cannabis for medical and religious reasons, and the fact that other countries, such as Canada, have recently adopted a similar approach. It was held that the right to privacy entitles an adult to cultivate, possess and use cannabis for personal consumption and that the provisions referred to above had the effect of limiting that right. Parliament has been given 24 months to remedy the defects in the current laws and at least, until then, adults are free to use, possess or cultivate cannabis for private use.

There is little doubt that the legalization of cannabis, to the extent that it has been confirmed by the Constitutional Court, is likely to see changes in the insurance industry. Below are some of the areas where the legalization of cannabis should be considered.

Home insurance

Homeowners' insurance in South Africa does not provide coverage for claims which result from illegal activities even where a criminal act is committed without intent to cause the resulting damage. A claim for physical loss of or damage to cannabis is not currently covered under a homeowners' insurance policy. Insurance companies may now be faced with claims for damage, loss and theft of a private supply of cannabis. It is therefore important for insurers to carefully review the current wording of homeowners' insurance policies by taking into account the legalization of the use, possession and cultivation of cannabis by adults for private use. Insurance companies will also have to consider whether coverage will be provided on an all perils basis or a named peril basis, which categories of users and cultivators will be exempt from coverage and how the value of losses will be established. It may therefore be necessary for the legislature to place certain limitations when remedying the defects contained in the current legislation.

Motor insurance

It is unclear how driving while under the influence of cannabis will be treated by insurance companies. Driving under the influence of cannabis is said to have similar effects to driving while under the influence of alcohol. An individual's faculties are impaired at the time which results in the individual being a hazard to himself or herself and to other road users. The National Road Traffic Act states that no person may drive a vehicle or occupy the driver's seat of a motor vehicle of which the engine is running on a public road while under the influence of intoxicating liquor or an intoxicating drug which has a narcotic effect. Insurance companies are largely dependent on the blood alcohol level test results of drivers when deciding whether to pay out a claim for driving a vehicle while under the influence of alcohol. Motor policies usually exclude liability if the driver is under the influence of intoxicating liquor or drugs.

A person who is found to have traces of cannabis in their system while driving can be arrested and prosecuted. It is not certain what means of testing the authorities can employ to determine whether a person is under the influence of cannabis other than performing an oral fluid or blood test. Tetrahydrocannabinol (THC), which is found in cannabis, can remain in the bloodstream for more than a month. This means that a person who tests positive for cannabis might not necessarily be under the influence at the time of driving. The reliability of this method of testing is also dependent on the frequency of the individual's use of cannabis. The results of this method of testing might therefore be inconclusive.

Cannabis usage as a risk factor

The consumption of cannabis by an individual may affect the manner in which insurance premiums are determined. Insurance companies may wish to increase premiums for cannabis users due to the increased risks associated with driving or performing other activities while under the influence of cannabis.

According to medical evidence put before the Constitutional Court, the uncontrolled consumption of cannabis poses a risk of harm to the user, Medical evidence does, however, suggest that there is a level of consumption that is safe and which is unlikely to pose a risk of harm to the user. However, it is unclear what level of consumption is safe. Consumers of cannabis may be required by insurers to disclose their use of cannabis to insurance companies when entering into or renewing a contract of insurance. A contract of insurance is concluded as one of good faith. The insured is under a legal duty to disclose all facts which are material to the risk for which cover is sought. Disclosure may be requested regarding the use of cannabis which might result in insurance companies increasing premiums for life cover and citing reasons such as lifestyle factors and the possibility of excessive consumption of cannabis resulting in increased medical costs. Any failure on the part of the insured to disclose such requested information will result in claims being rejected or cancelled.

Business coverage

The Constitutional Court has stated that dealing in cannabis is strictly prohibited. However, the judgment makes provision for an individual to grow cannabis for private use. This then raises the question as to how individuals will go about growing cannabis without purchasing resources to enable them to grow cannabis. This question will open up a whole new platform for debate which might result in the laws being reformed further to allow producers of cannabis to become licensed merchants which is something the commercial insurance industry may wish to cater for.

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DAC 6: how the new EU tax reporting requirements may affect insurers

The proposals for the amendment of Council Directive 2011/16/EU on administrative cooperation in the field of taxation (commonly referred to as "DAC 6") originally announced by the European Commission in June 2017, are now in force. The legislation aims to combat aggressive tax planning and improve tax transparency in the EU.

Although not yet implemented at the national level, the disclosure obligations need to be treated as "live" since they provide for implementation with retrospective effect from June 25, 2018.

DAC 6: disclosure requirements for taxpayers and intermediaries

DAC 6 imposes mandatory reporting of "reportable cross-border arrangements" affecting at least one EU Member State to their home tax authority. The home tax authority will then automatically exchange the reported information with tax authorities in other Member States.

Although its stated objectives are to target aggressive tax planning and to improve visibility for tax authorities on such activities, the deliberately wide drafting of the Directive means that it can potentially apply to certain standard transactions which may not have any particular tax motive. Ordinary transactions, including certain types of insurance and reinsurance structures, may be considered reportable cross-border arrangements. This is because the transaction is with a party in a "low-tax jurisdiction". There is no safe harbor for arrangements having a legitimate underlying commercial purpose.

The reporting obligations fall on "intermediaries", or in certain circumstances, the taxpayer itself. The reportable cross-border arrangements must fall within one of a number of "hallmarks": broad categories setting out particular characteristics identified as potentially indicative of aggressive tax planning.

The scope of the Directive is very wide and the detail is left to local implementing law and guidance.

Although the first notification will be due in August 2020, the Directive provides that notifications should be made in respect of arrangements dating back to June 25, 2018.

Notwithstanding Brexit, it is anticipated that the UK will implement the Directive. Those potentially within scope will need to work out how they will respond before they are given any guidance or detail by the local implementing authorities. This will be particularly challenging in the context of the wide scope of the Directive.

Who is an "intermediary"?

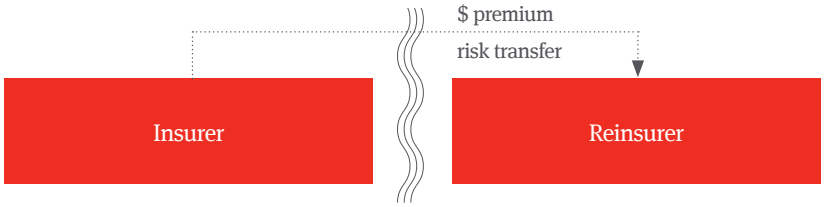
Anyone who designs, markets, organizes, or makes available or implements a reportable arrangement or anyone who helps with reportable activities and knows or could reasonably be expected to know that they are doing so would be considered an "intermediary" under the Directive.

The scope of the definition is broad, and could include consultants, accountants, financial advisers, lawyers (including in-house counsel), holding companies and insurance intermediaries.

A single transaction will involve multiple intermediaries. Take for example a reinsurance transaction. The potential intermediaries involved would include lawyers (including in-house counsel), underwriters, capital providers, insurance brokers, accountants and financial advisers. There is no carve-out for non-tax people, and there is no exclusion from the reporting obligations for in-house advisers.

An example of a common structures that are potentially reportable

Reinsurance transactions with low tax jurisdictions



Arrangements involving cross-border payments and transfers (including to third party reinsurers) may require disclosure under Category C hallmarks.

To fall within the disclosure rules, the intermediary must have some connection to the EU. This is established by

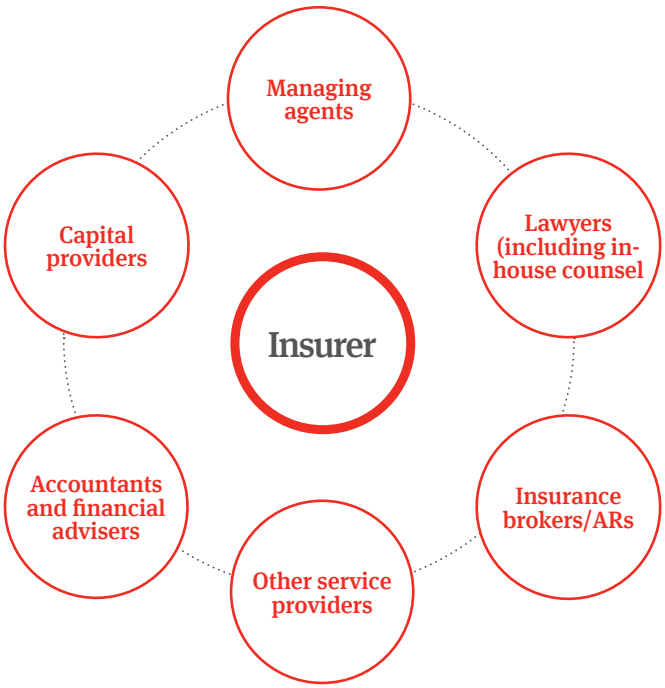
- Tax residence or place of incorporation.
- The presence of a permanent establishment or branch connected with the provision of the relevant services or
- Being registered with a tax, consultancy or legal professional association in the EU.

What are cross-border arrangements?

The DAC 6 reporting requirements apply to "reportable cross-border arrangements". An arrangement will be "cross-border" if it concerns a Member State and either another Member State or a third country. The connection with the jurisdiction is clearly established by the presence of tax resident entities or of branches but the carrying on of an activity which does not give rise to a permanent establishment is also within scope.

This does not necessarily require a cross-border transaction to take place. A domestic transaction which has tax implications for another EU Member State will fall within scope. Purely domestic arrangements which do not impact tax in another jurisdiction are not the target of this regime.

Potential intermediaries in an insurance transaction



Which arrangements are reportable?

Arrangements are reportable if they fall within any of five "hallmarks", broad categories setting out characteristics identified as potentially indicative of aggressive tax planning. These are widely drawn and there is as yet little guidance on whether many standard commercial transactions and structures will be considered reportable.

A number of the hallmarks apply only if the "main benefit" threshold is met, i.e. where one of the main benefits expected from an arrangement is a tax advantage. The UK guidance in respect of a similar test under the domestic reporting regime is relatively low, with "a main benefit" being any benefit that is "not incidental". Accordingly, if the tax outcome is of significance in the way that an insurance or reinsurance arrangement is structured, disclosure would be the default course of action.

Category C hallmarks apply broadly by reference to features which may well be present in ordinary commercial transactions not driven by tax motives. These hallmarks pick up, for example cross-border payments or transfers between associated enterprises where the recipient is in a low, no tax or blacklisted jurisdiction or where the receipt is tax exempt. Transfers to blacklisted countries do not need to meet to the "main benefit" test but the application of the test will need to be considered on a case by case basis in all other cases.

Other hallmarks are designed to identify marketed tax avoidance schemes and technical features typically seen in tax avoidance planning and also look at arrangements which undermine tax reporting or transparency or involve features identified as high risk for transfer pricing.

There is no de minimis threshold for reportable arrangements. Although domestic implementing legislation may confine the scope of the potentially reportable arrangements, there has as yet been little indication of what this might entail and given the reciprocal nature of information exchange regimes attempts to do so may be challenged.

The "when", "what", "who" and "where" of reporting.

When

Once the Directive is implemented, reports need to be filed within 30 days of the earlier of

- The day on which the arrangement is made available for implementation.
- The day it is ready for implementation.
- The day the first step in implementation is made.

What

The information to be reported is listed in the Directive and includes

- The identities of all taxpayers and intermediaries involved, including tax residence; their name, date and place of birth (if an individual); tax identification number; and where appropriate, the associated persons of the relevant tax payer.
- Details of the relevant applicable hallmark(s).
- A summary of the arrangement, including a summary of relevant business activities.
- The date on which the first step in implementation was or will be made.
- Details of the relevant local law.
- The value of the reportable cross-border arrangement.
- The identities of relevant taxpayers or any other person in any Member State likely to be affected by the arrangement.

Who

Reports need to be filed by the intermediary. Where there is no intermediary or the intermediary is subject to legal professional privilege, the report must be made by the taxpayer. Where there are multiple intermediaries, showing that another intermediary has reported the arrangement can exempt an intermediary from his reporting obligations.

Where

The Directive sets out a hierarchy to determine the Member State in which disclosures should be made. This is determined, in descending order by

- Tax residence.
- The location of a permanent establishment connected with the provision of the relevant services.
- The place of incorporation and location of a tax, consultancy or legal professional association with which the intermediary registered.

Failure to report can result in penalties being imposed by the relevant Member State. In the UK, HMRC has indicated that penalties will be aligned with those under the UK's Disclosure of Tax Avoidance Schemes (DOTAS) regime which allow for a maximum penalty of £1 million.

What practical steps need to be taken?

- Arrangements from June 25, 2018 need to be monitored. It is prudent at this stage to give a wide interpretation to the Directive when considering which arrangements may be reportable.
- Maintaining a record of potentially reportable arrangements, identifying the potentially applicable hallmark, the relevant arrangement, the transaction value and the intermediaries involved is important in order to be ready to report in 2020.

- In-house teams need to be aware that the fact that there is no discussion of tax does not mean that the transaction is out of scope. Having a list of the type of relevant transactions undertaken by an organization will assist in-house teams. Once the domestic legislation and guidance becomes available, these records can be examined to determine which reports in fact need to be made.

- Where multiple intermediaries are involved, agreement is needed between them as to who will report Putting this in place early on in a transaction will be helpful.

If you would like any further information on the challenges presented by DAC 6 or to discuss how these could be implemented in your business please contact your usual Norton Rose Fulbright advisers or one of the contacts listed below.

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Introducing Parker – our IDD chatbot

Parker is our new chatbot trained in answering various questions regarding the Insurance Distribution Directive (IDD). Taking just over four months to build, Parker has honed his IDD knowledge and responses to allow for competent and helpful information to be delivered to clients quickly and accurately.

The purpose of Parker Insurance is to answer questions regarding the IDD which was implemented on October 1, 2018. Parker has knowledge relating to definitions, requirements, and application; users can find out information including how the IDD applies to them and whether they have any requirements to adhere to. As a result, Parker can be used as a reference guide for the European regulation. Where he is not able to answer a question, he will direct you to a member of staff who can.

Parker is a prime example of how the legal sector is embracing new technology. Much of the legal tech in use is currently internal, with innovative processes cutting time and increasing efficiency behind the scenes every day. Parker shows how legal technology can also be client facing. The knowledge of our lawyers in specialist areas can now be accessed by anyone, at anytime and anywhere.

Parker Insurance was built using IBM's Watson Assistant which allows users to build, test and deploy a virtual assistant. IBM's Watson Assistant is an online application with which you can build a solution that understands natural-language and uses machine learning to respond to customers in a way that simulates a conversation between humans. It has a visual dialogue builder to help users create natural conversations between Watson and users.

After discussions about Parker Insurance's scope, we used the application to input numerous question variations and answers in relation to the IDD, as well as to create an element of flowing conversation. Small talk and niceties were also added to ensure Parker's conversational elements were less robotic. After we were happy with Parker's range, a stage of testing and amending lasting a few weeks commenced to ensure that Parker was ready to face the public.

While chatbots are only an artificial presentation of intelligence, they still have a multitude of uses. They can be used, as in Parker Insurance's case, to give out information about certain subjects upon request including definitions, explanations, and other factual information which might be expensive or time-consuming to ask lawyers through natural conversation. In other uses, chatbots can assist people with navigating through various applications. DoNotPay is a bot which has overturned more than 200,000 parking fines in London and New York. This chatbot also uses IBM's Watson Assistant but in this case to gather information from users. The chatbot asks a series of questions and uses the responses to determine the right application form, which it then auto-fills with further information gathered from the user.

The possibilities with chatbots are endless: where objective responses can be given, chatbots can be used.

Try using Parker Insurance on our website.

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Holly Tunnah is a Knowledge paralegal based in our Newcastle office. The Newcastle team use cutting edge approaches to supporting legal practice.

Case notes

The need for a physical loss in All Risks cargo policies

In *Engelhart CTP (US) LLC v Lloyd's Syndicate 1221 for the 2014 Year of Account & 6 others* the court has confirmed that construction of an All Risks cargo policy does not extend cover to paper losses unless specifically provided for in the policy itself.

The facts

The insured, part of a large trading group, shipped copper ingots to a purchaser in Hong Kong. On arrival the containers were found not to contain the copper ingots but slag of a nominal commercial value. It was agreed that no copper ingots had, in fact, been shipped in the containers and no such cargo ever existed. The bills of lading, packing lists and quality certificates were therefore fraudulent.

The insured claimed for the loss under its cargo policy on the basis it provided All Risks cover of the very broadest kind. This was declined by insurers who argued that none of the clauses in the policy provided cover for economic losses resulting from acceptance of fraudulent documents for a non-existent cargo.

"Something must exist to be physically lost"

With reference to various authorities from both the English and New York courts Sir Ross Cranston observed that, when construing an All Risks cargo policy, one starts with the presumption that the purpose of All Risks cargo insurance is to cover physical loss of or damage to goods. In this case, there had been no physical loss or damage to the goods on account of the fact they had never existed – "something must exist to be physically lost". As a result, the losses suffered by the insured were economic losses through the acceptance of fraudulent documents.

The question then was whether the policy as a whole could be construed more widely to include cover for paper losses. In particular, the policy included a provision stating that "the broadest coverage shall apply". On the facts, and by giving the clauses in the policy their ordinary meaning, Sir Ross Cranston acknowledged that there were significant extensions to cover included in the policy beyond what is contained in a standard, entry level All Risks policy. However, ultimately, he was unconvinced that such extensions went so far as to displace the presumption previously stated.

Comment

Sir Ross Cranston made it clear that, where there is an intention to extend cover under an All Risks cargo policy beyond physical loss of or damage to goods there must be clear words stating the intention to do so. It is not clear yet whether this decision will be appealed; however, it provides some helpful clarification to both insurers and insured alike when it comes to considering the scope of cargo cover for anything beyond physical losses.

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VAT recovery for brokers and "offshore looping"

Insurers and brokers are generally unable to recover VAT incurred on their costs, as the supply of insurance services is exempt for VAT purposes. However, some insurers have developed arrangements whereby brokerage operations are based in the UK, but the risk is written offshore, even if the insured is UK based. HMRC see this as "offshore looping" and may argue that this is established to give rise to an input tax recovery where, if the insurer were in the UK, no recovery would be possible.

Such an arrangement was recently the subject of an appeal before the UK courts. In *Hastings Insurance Services Ltd v HMRC* [2018] UKFTT 27 (TC) a UK insurance service provider was successful in arguing that it should be able to recover input VAT that was attributable to supplies of broking, underwriting support and claims-handling services supplied to a related

non-EU insurance company, which then provided supplies of insurance to UK customers.

Although HMRC have indicated that they intend to appeal that decision, the UK Government has decided to legislate to put the issue beyond doubt and to prevent the use of such arrangements in the future. As a result, on July 26, 2018, the UK Treasury published a draft order for consultation.

The UK Budget 2018 announces that changes to tackle this type of arrangement will be brought into effect (although in a more targeted manner than in the original draft order). From March 1, 2018, a company supplying insurance intermediation services will only have a right to recover VAT on its costs if the transaction which is being intermediated is itself an exempt supply of insurance services to a consumer of the insurance services that does not belong in the UK.

The UK Treasury has indicated that, following the decision in *Hastings*, some insurers made it clear that, if the competitive "distortion" arising from this type of arrangement was not addressed, those other insurers would themselves have to adopt similar practices.

Insurers which have "offshore looping" or similar intermediary arrangements in place will be impacted by these changes, and they are advised to review their activities in order to assess the impact on their businesses.

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Can a breach of a performance guarantee be subject to insurance under Quebec law? The Superior Court takes a stand

On May 17, 2018, Justice Danye Daigle of the Superior Court of Québec dismissed a Wellington motion filed by LeProhon Inc. against its insurer, Federated Insurance Company of Canada (Insurer). The Superior Court of Québec's decision in 9071-3975 Québec inc. v Leprohon inc.[1] gives guidance on whether coverage under a commercial general liability policy (CGL Policy) and a professional liability/errors and omissions policy (E&O Policy) applies when the essence of the claim arises from a breach of the insured's obligations under a letter of performance guarantee.

Nature of the underlying claim and denial of coverage

The plaintiff 9071-3975 Québec Inc. (Lucyporc) operates in the pork processing industry. After LeProhon performed work on behalf of Lucyporc, the latter filed an action against LeProhon mainly alleging a breach of the obligations set forth in a letter of performance guarantee attached to the agreement entered into between LeProhon and Lucyporc.

After receiving a notice of the action, the Insurer refused to take up LeProhon's defense pursuant to the issued insurance policies. The Insurer determined that the grounds of Lucyporc's claim, which was based on LeProhon's failure to satisfy the performance guarantee, did not trigger application of the insurance policies' coverage.

Coverage not applicable

After going over the general principles that apply in the context of Wellington motions, the Court reviewed the insurance policies that the Insurer issued to LeProhon to determine whether the coverage could apply.

The E&O Policy

The Court concluded that Lucyporc's claim was explicitly subject to the exclusions set forth in the E&O Policy, more specifically the "manufacturer's express warranty" exclusion, because it referred to delays, refusals to complete work and the breach of the performance guarantee.

CGL Policy

The CGL Policy specifically provided that property damage should result from an occurrence in order for insurance coverage to be triggered. The CGL Policy defined occurrence in the usual manner, which is "[translation] an accident, including continuous or repeated exposure to substantially the same risks."[2]

Relying on the Supreme Court of Canada's teachings on the notions of "occurrence" and "accident" in *Progressive Homes*, the Court determined that the breach of a performance guarantee does not constitute an accident or repeated exposure to certain conditions, despite giving a broad and liberal interpretation to the CGL Policy. Consequently, the Court ruled that

1 2018 QCCS 3434.

2 *Ibid*, para. 48.

the insurance coverage under the CGL Policy was not triggered by the claim.

Conclusion

In sum, this decision emphasizes that insureds can't offer co-contractors a performance guarantee in the belief that they can fall back on their insurance coverage in the event of a breach. The courts must examine the reasons for which insureds breach their obligations under a contract to determine if the loss is attributable to an insured risk, otherwise insurers would be bound by every single one of their insureds' undertakings. As the Court so carefully summarized, "[translation] this would distort both the nature and the objectives of insurance contracts."[3]

This decision has not been appealed.

The author wishes to thank articling student Sandrine Raquepas for her help in preparing this legal update.

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Fraudulent non-disclosure, avoidance and refusal to advance – Australian Federal Court decides insurers can avoid advancing defense costs to Cranston and Onley

The full court of the Federal Court has considered a question that by some has been considered a "sleeper issue" which had not previously received judicial attention. The question was whether a final adjudication clause in a conduct exclusion prevents underwriters from relying on their statutory right to avoid a policy for fraudulent non-disclosure. If the answer was "yes" underwriters would be required to advance defense costs until a finding was made which triggered the conduct exclusion.

The Federal Court decision of *Onley v Catlin Syndicate Ltd* as the Underwriting Member of Lloyd's Syndicate 2003 (the Insurer) determined that the answer to that question is "no" and the Insurer is not prevented from avoiding the policy.

Background

Indemnity proceedings were brought by Adam Cranston and Jason Onley (who are being pursued by the ATO in one of Australia's biggest cases of tax fraud), against their management liability insurer. The Insurer had exercised its statutory right to avoid the policy under Part IV of the Insurance Contracts Act, refusing to advance Cranston & Onley's costs of defending ongoing civil and criminal proceedings against them by the Australian Federal Police and the ATO.

This case is particularly noteworthy given that the facts which were the subject of the non-disclosure (and which the Insurer relied on to avoid the policy) i.e. corporate arrangements that would facilitate the fraud, hold similarities to the facts that are the subject of the proceedings for which Cranston and Onley sought funding of their defense costs.

The separate question

The separate question issue was whether the final adjudication clause in the dishonesty exclusion meant that underwriters had somehow waived their entitlement to avoid the policy on the basis of fraudulent non-disclosure.

Cranston and Onley argued that

- The interaction of these provisions precluded the Insurer from exercising its statutory right to avoid.
- The Insurer had agreed to "pay now" and "claw back later" and that by avoiding the policy, it was pre-judging the outcome of the proceedings which were unproven until the proceedings were resolved.
- The substance of their non-disclosure could not be determined until wrongful conduct (as defined under the policy) had been established.

In response, the Insurer agreed that the exclusion comes into play if the policy is validly on foot. But in circumstances where its existence is based on fraudulent non-disclosure, the Insurer argued that the exclusion cannot apply because the policy is avoided at inception.

3 *Ibid*, para. 60.

The Insurer argued that it wasn't necessary to await final adjudication as there was sufficient information available about the business model of Plutus Payroll, of which Cranston and Onley were allegedly the masterminds, to establish a real risk that the ATO would come after those involved in the business, including Cranston and Onley, to recover any unpaid tax. As has been much-reported, that business model involved Plutus Payroll (another Insured under the policy) being set up in a way which enabled Cranston, Onley and others to benefit from payments which were due to the ATO, leaving the ATO no option to recover the tax debt but from a string of phoenix companies with straw directors.

The Insurer argued that this business model, which wasn't disclosed prior to policy inception, was material to their decision to underwrite the policy. The Insurer therefore exercised its statutory right to avoid the policy.

The Federal Court's Decision

The court agreed with the Insurer, answering the separate question in the negative.

The court held that "there can be little doubt" that there were "matters which were fraudulently non-disclosed" and also that "one need only set out the business model in these basic terms to appreciate that it is fraught with the risk that the ATO may seek to recover its lost tax revenue from those involved in the scheme."

The full court held that underwriters did not have to extend payment for defense costs to Cranston and Onley in accordance of the defense costs extension because

- As a matter of construction, the defense costs extension does not diminish or contractually qualify the Insurer's statutory right to avoid the policy consequent upon Cranston and Onley's non-disclosure.

- As a matter of public policy, courts will not allow a party to contract out of the consequences of his/her own fraudulent conduct.

Public policy considerations

Clearly, the court was not prepared to allow the insureds to obtain a benefit from their alleged fraud. It held that if the separate question was determined in Onley and Cranston's favour, it would risk a situation of the duo benefiting from the fraud, stating: "even to require the insurer to defer acting upon its claim of fraudulent non-disclosure whilst the question of whether the Applicants committed Wrongful Conduct is adjudicated could give the applicants the benefit of their own fraud. To accept such a proposition would be to undermine the common law's historical abhorrence of such conduct."

Implications for insurers

Courts won't limit the statutory right of insurers around fraudulent non-disclosure without express language in the policy. The presence of a final adjudication clause in a dishonesty exclusion is not enough to waive insurers' statutory rights to avoid. The court also emphasized that it won't read a policy in a way that risks giving insureds who have fraudulently induced an insurer to enter a policy by reason of non-disclosure a way to benefit from that fraud.

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International focus

Australia

AFCA becomes one-stop-shop for financial services disputes

On November 1, 2018, the Australian Financial Complaints Authority (AFCA) replaced the Financial Ombudsman Service, Credit and Investments Ombudsman and the Superannuation Complaints Tribunal. The AFCA is now the ASIC approved External Dispute Resolution (EDR) scheme for consumer and small business complaints for Australian financial and credit industries.

All financial firms should now be members of the AFCA, as the deadline to register was September 21, 2018. For insurance industry participants, this includes holders of an Australian Financial Services Licence including insurers, brokers and other intermediaries.

The creation of the AFCA comes at a pivotal time, with a record number of 43,684 disputes received by the FOS in 2017–2018 (FOS Annual Review 2017–2018). This is an 11 per cent increase on the previous year. The top two categories of complaints received by FOS in 2017–2018 related to credit and general insurance, having a share of 43 per cent and 32 per cent respectively.

The AFCA will consider complaints about credit, insurance, banking deposits and payments, investment advice, and superannuation products. In relation to insurance, this includes the following products

- Home and contents insurance
- Car insurance
- Travel and ticket insurance
- Pet insurance
- Sickness and accident insurance
- Strata title insurance
- Medical indemnity insurance
- Life insurance
- Small Business Insurances including farm insurance.

The AFCA will also consider complaints about warranties (e.g. extended warranties on consumer goods) issued (not just administered) by financial firms that are members of the AFCA.

The AFCA creates a one-stop shop for financial services disputes and has increased monetary limits and compensation caps. Previously, the monetary limit and compensation caps for most non-superannuation disputes were A$500,000 and A$323,500 respectively. These have now increased to a A$1 million monetary limit and A$500,000 compensation cap.

European Union

New distribution rules in effect in the European Union

The Insurance Distribution Directive came into force on October 1, 2018 replacing the Insurance Mediation Directive which had been in effect since January 2005. The IDD places emphasis upon “product governance” – the design of insurance policies and their suitability for a target customer.

Insurers and intermediaries distributing to customers in the European Union must comply with the overarching obligation to act at all times in the best interests of customers and ensure that information is fair, clear and not misleading.

The new regime imposes significant sanctions upon businesses that breach the IDD rules – businesses can pay up to five per cent of annual turnover in fines.

South Africa

Competition Commission proposes tough measures on motor insurers

In August 2018, South Africa’s Competition Commission called for final comments on its far-reaching Code of Conduct for Competition

in the Automotive Industry. The code will materially impact a range of stakeholders, including motor insurers. Following the consultation, stakeholders will have to decide whether or not to sign up to the code and be subject to extensive monitoring obligations.

Although the code primarily targets original equipment manufacturers, it also places material obligations on insurers. The code is voluntary in nature but, once a party becomes a signatory, it will impose binding obligations that can be relied upon by third parties (including service providers and consumers).

As part of its advocacy function under the Competition Act, the Commission has been developing the code since early 2017. An initial draft was published in late 2017 that contained a number of far-reaching proposals that, despite the consultation, reflect the Commission's own policy. While some concessions have been made, the latest code still contains sweeping reforms to the service, maintenance and repair of vehicles.

Under the latest code, insurers must

- Fairly allocate work amongst service providers such as vehicle repairers.
- Broaden the allocation of work to entities either owned or operated by historically disadvantaged individuals.
- Publish a list of all approved service providers on their websites and/or other suitable media.
- Offer consumers a choice of approved repairers within their geographic area.
- Refrain from appointing any service provider for excessively long periods.
- Refrain from continuously renewing the appointment of the service provider.

Insurers must submit annual reports to the Commission in order to demonstrate compliance with the code. As part of these reports, insurers must confirm their aggregate annual spend and volume allocated to historically disadvantaged service providers.

The Commission says that it is pursuing the code as an alternative to enforcement action because it receives a material number of complaints alleging anti-competitive practices throughout the automotive aftermarket sector. Some of these complaints have apparently focused on the allegedly unclear and unfair allocation of work by insurers for motor-body repairs.

While the code is voluntary in nature, given the time and effort the Commission has devoted to it as well as the Commission's view that these reforms are necessary, it is unclear what steps (if any) it will take if stakeholders decide not to sign up. Given that the code was positioned as an alternative to enforcement, it cannot be ruled out that the Commission will be more inclined to investigate such stakeholders should they be the subject of ongoing or future complaints.

United Kingdom

Competition authority investigates insurance "loyalty penalties"

The Competition and Markets Authority (CMA) has received a "super-complaint"from Citizens Advice in respect of price discrimination against long-term customers. Citizens Advice is seeking a response from CMA including a commitment to initiating a market study to identify remedies to end overpricing for disengaged or loyal customers.

Super-complaints can be made under the Enterprise Act 2002 by certain UK consumer organizations, including Citizens Advice, requiring an investigation into markets or practices that significantly harm consumers.

Home insurance is included amongst the markets that Citizens Advice identify as penalizing existing customers. The percentage increase in the cost of home insurance can be as much as 70 per cent for long-standing customers.

The margins that firms can earn on new customers is often low. Attractive offers for new customers are sustained by offering longer term customers higher prices. Citizens Advice suggests that loyalty can cost home insurance customers as much as £900 per year.

In particular, Citizens Advice has identified that vulnerable consumers are disproportionately affected by loyalty penalties.

The CMA must now investigate the super-complaint and determine whether consumers' interests have been harmed by higher prices for long-term customers.

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