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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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Introduction

In this edition of *Insurance focus* Tyler Dillard in our London office considers the revolution of the sharing economy and reflects on how insurers have an opportunity to benefit from this growing market.

Following the announcement that the European Commission is minded not to renew the Insurance Block Exemption regulation, Mark Tricker in our London office considers the challenges that the insurance market might face without the benefit of the competition safe-harbour.

From our Amsterdam office, Floortje Nagelkirke, Nikolai de Koning and Recep Altun consider the scrutiny of ‘integrity risk’ being undertaken by the Dutch Central Bank.

In our quarterly review of cases we include two recent cases from Australia that consider section 54 of the Insurance Contracts Act 1984; we review ‘Wellington Motions’ under the law of Quebec; from Texas we consider the scope of the Prompt Payments Act and finally, we consider the likely impact of a recent German Supreme Court case on brokers’ role in the payment of claims.

In our regular international focus section we provide updates from both the London and Australian markets.

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Insuring collaborative consumption: Sharing emerging risks and evolving in a sharing economy

It's not a fad. It's an unstoppable and sustainable force. Now generating around US$15 billion in global annual revenue according to a recent PwC report, the ubiquitous sharing economy has experienced explosive expansion in the wake of the financial crisis and revolutionised a number of industries, with no indication of decelerating in the short or long term.

Driven largely by a fundamental shift amongst consumers from private ownership to shared usage and access, the sharing economy emphasises the collective – 'collaborative consumption' providing economic (and societal) benefits through the shared consumption of goods and services. The rapidly developing segments in the sharing economy – car sharing and peer-to-peer (P2P) travel accommodation – have leveraged unprecedented advances in technology to match cultural trends and the evolving needs and demands of their customers successfully (and profitably).

Inherent in the commercial activities of sharing companies, however, are a wave of risks, which potentially leave their customers vulnerable on the question of coverage, not least because of a lack of products from larger insurers which are fit for purpose and appropriate to the risk being underwritten. Armed with innovative and cost efficient solutions and hard cash from VC firms (who, since 2010 have funnelled an astonishing US$2 billion into the insurance tech industry), startup P2P insurance firms and insurance intermediaries in the telematics space are now bridging the gaps between personal and commercial coverage left by traditional policies, and radically disrupting our industry. Perhaps unwittingly, they are also shifting the paradigm back to a fundamental mutuality of loss-sharing reminiscent of the historic origins of the Lloyd's market.

Part of a wider series on the sharing economy, this article:

- considers the insurability of selected risks presented by the sharing economy, using an example from car sharing
- explores certain innovative products (and the new breed of competition championing them) that have emerged to insure against such risks.

Identification and insurability of risks

A basic transaction within the sharing economy can generate a myriad of legal complexities, raising difficult questions around liability and coverage, as illustrated by the below example.

A driver for a car sharing platform strikes a family, killing a young boy. The driver was not carrying a passenger at the time. He was, however, logged into the smartphone app, meaning that prospective customers could still summon a ride. As such, there is an argument that he was still deriving a commercial benefit from the app at the time of the tragedy.

Given that commercial ride sharing is a common exclusion in traditional motor policies, the driver's own personal policy would almost certainly not cover losses arising from tortious claims brought against him. From the insurer's perspective, the driver was operating a business from the point he accessed the app, regardless of whether or not passengers were also in the vehicle. Moreover, it is possible that the driver's personal policy would be invalidated in any event, had he failed to disclose to his insurer that his vehicle was simultaneously being used for commercial ride sharing.

As a matter of UK insurance law, the driver would have been required to have some form of commercial private hire vehicle insurance, which may have been offered through an agreement with the platform. However, traditional policies of this type have historically only provided coverage from the point the insured driver accepts a ride, not when the insured is merely 'logged in' and looking for business. The driver is therefore potentially left personally exposed to uninsured losses during this period and injured parties would be exposed accordingly.

The digital intermediary itself is also in a vulnerable position under its own commercial policy. The above example is not entirely dissimilar to an incident in the US, where the victim's family brought a wrongful death lawsuit, naming not only the driver but also the sharing company as defendants. Depending on the terms of its own commercial policy, the sharing company could also potentially be left to pay-out for losses as a result of a failure to screen drivers on its platform.

Such gaps in coverage have led to a surge in new startup P2P insurance firms and the unveiling of innovative products (including from a handful of larger insurers), in particular 'top-up', 'pay-as-you-go' and 'pay-per-mile' policies, that would have provided greater protection to our driver in respect of the additional risks to which he was exposed from his participation in the platform. There are also tangible opportunities beyond personal lines of business, in particular for the platforms themselves, who have started to build exclusive relationships with larger insurers for their own commercial lines.

New products; new players; new relationships

Personal and commercial lines offered by traditional insurers are simply not underwritten or priced to cover the risks associated with car-sharing and P2P accommodation, where people are swapping between personal and commercial use of personal assets. The algorithms applied in standard pricing models are calculated on the basis of assumptions of the insured driver or homeowner, not the risk profiles of passengers and guests or even the combined personal-commercial risk profile of the insured himself. P2P insurance and micro-insurance, however, are challenging the traditional models and seeking to interact with consumers more effectively to collect risk data, tailor products and price competitively.

One such UK-based P2P motor insurer seeks to reduce the cost of insurance by sharing insurance needs within a group of other drivers, usually family members and friends, enabling the cohort to co-manage its own pool of money and claims. The premium is calculated on the basis of the regular criteria and goes towards the group's insurance fees and the group's pool. Claims are paid out from the pool throughout the year, with the group's insurance fees providing the buffer, should the pool run out of funds. Money is distributed to the group's members at the end of the year in the absence of claims. Interestingly, this structure reflects a modern yet natural extension of the original concept from time immemorial – groups of individuals coming together to insure another individual, underpinned by a focus on personal responsibility and a readiness to trust and share losses – and all without the need for large intermediaries.

Similar platforms have proliferated in Canada, Germany, New Zealand and the US. Due to launch later this year, US platform Lemonade is backed heavily by VC firms Aleph and Sequoia Capital. Given the underlying equity structure of some of these startups and the current soft market, it will be interesting to see how their emergence will impact insurance M&A activity in the next three years.

There has also been a rise in micro-insurance products which are more attuned to the behaviours of their customers. Based in the US, Metromile offers a usage-based product, centred on a 'pay-per-mile' insurance model. Supported by an app and a tracking device installed in the vehicle, Metromile charges its customers a monthly base rate and an additional amount based on the miles actually driven. Recently, the insurance intermediary has integrated with Uber to offer Uber drivers its product, where the platforms interact with one another to automatically detect the beginning and end of a journey, thereby distinguishing between personal miles (covered by Metromile) and commercial miles (covered by Uber's own commercial policy) driven. The product is tailored broadly enough to cover specific risks in the period whilst an Uber driver is looking for a ride and would have been particularly useful to our driver in the above scenario.

There are also some sharing companies that have aligned with a number of established insurers to fill coverage gaps by creating partnerships, like the BlaBlaCar/AXA and Lyft/MetLife relationships announced last year.

Whilst it presents its own unique set of risks, P2P accommodation has also seen a rise in similar top-up policies, including from Belong Safe, a UK fintech platform founded last year. Such on-demand, ‘pay-as-you-go’ policies are gaining popularity amongst the AirBnB community, where a growing number of hosts are finding their traditional home insurance policies being invalidated for failing to disclose that their homes are being used for profit, leaving them to pick up the losses in the event of damage to their homes or where a guest injures himself during a stay.

Conclusion

Clearly, there is enormous yet unexploited potential within the sharing economy for insurers and intermediaries alike to reshape our industry. This will, however, require a new approach to meet the dynamic needs and changing behaviours of a millennial generation which shares and manages risks in new and innovative ways. Whilst a cohort of new alternative providers are quickly emerging in response to these demands, traditional insurers face a stark choice on how to react and adapt their internal processes and underwriting models to embrace these changes. A small number of major players have engaged, but others who remain blinkered to the new opportunities risk being left behind.

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Putting a premium on certainty? Insurance Block Exemption unlikely to be renewed by European Commission

Since 1992 certain arrangements between insurers that might otherwise restrict competition in the internal market have been declared to fall within an industry-wide exemption that enables limited cooperation to take place. This arrangement looks likely to come to an end shortly.

What has happened and what are the next steps?

Two years into its three year long consultation process, on March 17, 2016, the European Commission has announced that its 'preliminary view' is not to replace the Insurance Block Exemption Regulation (IBER) when the current iteration expires on March 31, 2017.[1]

A stakeholder meeting will take place in Brussels on April 26, 2016 to discuss the reaction to this preliminary conclusion and two further studies have been commissioned (one into asset switching between different insurance products, of relevance to defining the appropriate market for pools, and the other looking into the impact on competition of forms of co(re)-insurance other than pools). A final decision on whether to renew the IBER is expected in early 2017.

1 Report From The Commission To The European Parliament And The Council On the functioning of Commission Regulation (EU) No 267/2010 on the application of Article 101(3) of the Treaty on the functioning of the European Union to certain categories of agreements, decisions and concerted practices in the insurance sector, published March 17, 2016.

What is the IBER?

The IBER currently provides comfort to insurers that certain types of cooperation between insurance companies will not be regarded as anti-competitive (and so result in an infringement of Article 101 of the Treaty on the Functioning of the European Union). The IBER covers both joint compilations, tables and studies,[2] and co(re)insurance pools.[3] Parties to such agreements do not need to further self-assess whether the agreement meets the general criteria for exemption from the prohibition on anti-competitive agreements.[4]

2 The IBER covers compilations (calculation of the average cost of covering a specified risk in the past); studies (which assess the probable impact of general circumstances external to the interested undertakings, either on the frequency or scale of future claims for a given risk or risk category or on the profitability of different types of investment); and tables (mortality tables and frequency tables relating to of illness, accident and invalidity),

3 Coinsurance pools are defined as groups set up by insurance undertakings either directly or through brokers or authorised agents, with the exception of ad-hoc co-insurance agreements on the subscription market, whereby a certain part of a given risk is covered by a lead insurer and the remaining part of the risk is covered by follow insurers who are invited to cover that remainder, which: (a) agree to underwrite, in the name and for the account of all the participants, the insurance of a specified risk category; or (b) entrust the underwriting and management of the insurance of a specified risk category, in their name and on their behalf, to one of the insurance undertakings, to a common broker or to a common body set up for this purpose. Co(re)insurance pools is similarly defined.

Why has the Commission reached its preliminary conclusion?

There are very few sector-specific block exemptions still in force (aside from insurance, only maritime liner shipping and motor vehicle distribution benefit from such an exemption). The Commission's view is that there should be very good sector-specific reasons to justify keeping such block exemptions. Its preference is to provide guidance to an industry (which is more flexible and more easily amended).

In its report, the Commission has accepted that the two types of cooperation covered by the IBER 'appear to be specific to the insurance sector'. However, it doubts that these types of agreement merit the rigid safe harbour afforded by the IBER.

The Commission considers that joint compilations, tables and studies are a manifestation of pro-competitive

4 These criteria are set out in Article 101(3) of the Treaty on the Functioning of the European Union and require that the agreement:

- contributes to promoting technical or economic progress or to improving the production or distribution of goods
- allows customers a fair share of the resulting benefit;
- contains no more restrictions of competition than are strictly necessary
- does not eliminate competition in a substantial part of the relevant market.

information exchange, which one might observe in a large number of industries. As such, they are covered by the Commission's Horizontal Guidelines[5], and in particular its chapter on information exchange. The principles in the Guidelines mirror those of the IBER, and therefore, the Commission doubts that removing the IBER would have any deleterious effect on legal certainty.

The position in respect of co(re) insurance pools is a little more complicated. The Commission considers that there are very few of them, that there is uncertainty amongst insurers over exactly what the IBER is supposed to cover, that there are many other forms of co-operation that have emerged in recent years (e.g. broker-led co(re)-insurance or line slips) and, most importantly, that there are doubts whether some traditional pools necessarily merit an exemption from the competition rules at all (particularly if the same benefits can be achieved less restrictively through other forms of co-operation). Taken together, the Commission considers these factors suggest that pools should no longer benefit from automatic exemption under the IBER.

Where does this leave the insurance industry?

The proposal not to renew the IBER will remove the final two areas of co-operation within the industry from the automatic exemption bestowed by such block exemptions. However, the practical impact of this will, it seems, differ significantly between the two areas.

5 Guidelines on the applicability of Article 101 of the Treaty on the Functioning of the European Union to horizontal co-operation agreements.

In respect of joint compilations, tables and studies, what is acceptable now should be acceptable in the future. In that respect, the impact of the removal of the IBER should be similar to the impact (or lack thereof) on agreements for standard (non-binding) policy conditions when this aspect of the IBER was not renewed in 2010. It was clear that, although no longer included in the IBER, in substance, any agreement on policy conditions that merited exemption under the old IBER would be considered compatible with competition law going forwards. The same should apply to joint studies now. In addition, the Commission has suggested that it might issue revised Guidelines to assist insurance companies in self-assessing the legality of information exchange going forwards.

The position regarding pools (and other forms of co(re)-insurance) is less clear and the Commission's position introduces a little more uncertainty into what might be considered acceptable co-operation and what might not. There are hints that the Commission no longer considers (some?) pools (even where the members of the pool meet the market share thresholds set out in the IBER) to be worthy of exemption from the prohibition on anti-competitive agreements. Coupled with the study currently being undertaken into other forms of co(re)-insurance and the effects of these forms of co-operation on competition, there is still some work for the Commission to do in clarifying its approach to a significant aspect of the insurance industry. This is particularly the case given concerns that have been raised in past studies regarding, for example, broker-led pools. It may be that there is a greater need for guidelines on this issue than on the issue of information exchange in the future.

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Dutch market faces ongoing ‘integrity risk’ scrutiny

In early 2015, the Dutch Central Bank (*De Nederlandsche Bank*, DNB) launched a thematic investigation into integrity risk analyses (*integriteitsrisicoanalyses*) in the Dutch financial sector. As part of its investigation, DNB investigated over 170 integrity risk analyses of insurers, banks, payment institutions, trust offices and pension funds. In the summer of 2015, DNB concluded that over 80 per cent of the integrity risk analyses performed were deemed inadequate by DNB.

In February 2016, DNB stated that it will continue to focus on integrity risks for various financial institutions, including insurers. In particular, DNB indicated that corruption through conflicts of interest and bribery continues to pose a significant integrity risk to insurers, but is often underestimated or insufficiently addressed. DNB concluded this on the basis of the outcome of its thematic investigation into corruption in the Dutch insurance sector. According to DNB, corruption poses a serious threat to insurers’ integrity and ethical and sound business operations.

In this article, we first provide a brief overview of the requirement for Dutch insurers to perform an integrity risk analysis and what DNB considers such an analysis should entail. Following this, we will discuss DNB’s findings and good practice guidance on how insurers should be dealing with corruption.

Integrity risk analysis

Pursuant to the Act on the Financial Supervision (*Wet op het financieel toezicht, AFS*), both life insurers (*levensverzekeraars*) and non-life insurers (*schadeverzekeraars*) must ensure a systematic analysis of ‘integrity risks’. An integrity risk is defined as a:

> ‘threat to the reputation of, or the current or future threat to the capital or the results of a financial institution due to insufficient compliance with the rules that are in force under or pursuant to the law.’

Examples of integrity risks are market manipulation, fraud, terrorist financing, money laundering, unethical behaviour of the insurer’s personnel (or third parties hired by or affiliated to the insurers), cybercrime and corruption (bribery).

In order to be able to map, and subsequently mitigate, integrity risks and to achieve risk-based compliance with integrity legislation, insurers need to perform an effective integrity risk analysis. This will require a thorough overview of the insurer’s entire organisation, which includes, amongst other things, the roles that departments or staff members play within the organisation, the market(s) in which the insurer operates and the third parties (customers, agent, suppliers) that the insurer deals with. It is apparent that insurers will only be able to create effective procedures and take effective measures if they are fully aware of the integrity risks that they are, or may possibly be, facing.

Good practices: integrity risk analysis

DNB published a document entitled ‘Integrity risk analysis – More where necessary, less where possible’ (the Good Practices Document).

In the Good Practices Document, DNB sets out how financial institutions, including insurers, should make an integrity risk analysis, perform the analysis and the consequences that must be attached to the outcome of the analysis. According to DNB, an insurer needs to take the following steps to ensure that an integrity risk analysis is comprehensive and effective:

Step 1: preparation and identification

- Make an inventory for each business unit, branch office, subsidiary of the organisation with respect to customers, countries, products, staff and third parties. This will require mapping of the different areas of the insurer's organisation.
- Assess which integrity risks the insurer is likely to face, which factors play a role for each risk and what form they may take.
- Develop a scoring system, allowing it to determine how to assess the likelihood and impact of each integrity risk.

Step 2: risk analysis

- Determine the likelihood of each risk manifesting itself and the resulting impact of each risk.
- Assess the gross risk and verify whether this is within the boundaries of the insurer's risk appetite. Likelihood and impact together constitute gross risk. The insurer's risk appetite is a framework that is developed by the insurer's board and senior management, which prescribes the type and level of risk that the institution is prepared to accept.
- List and assess the control measures that are necessary for each scenario/ gross risks.

Step 3: assessment and measures required

- Determine the net risks for each scenario by subtracting the level of control from gross risk. The net risk is the residual risk remaining despite having fully effective control measures in place.
- Determine whether the net risk is within the boundaries of the insurer's risk appetite.
- If the net risk is not within the boundaries of the insurer's risk appetite, the integrity risk in question should be reduced or, if that is impossible due to the nature of the risk, additional measures should be taken.

Suitable measures to be taken by insurers

At the end of February 2016, DNB emphasised that corruption through conflicts of interest and bribery continues to be underestimated by insurers. This is based on its thematic investigation into corruption in the Dutch insurance sector. It has, amongst other things, become clear that almost all insurers fail to identify third party risks. For example reputational risk for insurers as a result of their connection with relevant third parties such as tied agents and consultants. DNB expects insurers to be able to identify this corruption risk and take suitable measures in order to control this risk. However, according to DNB, third party due diligence is still not a standard practice in the insurance sector.

The investigation also revealed that large insurers, in general, inadequately monitor conflict of interest risks connected to the personal networks of their directors. According to DNB, there is a risk that directors through their additional functions and in particular because of their individual financial interests end up or appear to end up in situations whereby their individual interests prevail over that of the insurer.

DNB has published measures in the Good Practices Document that insurers could take to control their integrity risks:

- Creating the right tone from the top. Senior management should invariably emphasise the importance of compliance and integrity, and corruption in particular.
- When engaging new employees (particularly for positions with a higher risk of corruption), attention should be paid to personality characteristics affecting corrupt behaviour. The brochure mentions the following examples: narcissism, self-confidence, independence and emotional instability 'combined with the social circumstances of employees'.
- Screening employees (periodically) with regard to any criminal and financial antecedents, where it concerns employees who are in a position to affect the bank's sound conduct of business.
- Giving training with regard to integrity, fighting corruption, conflict of interest and related topics.
- Establishment of a whistleblowing policy and an incident reporting scheme.
- Investigation (due diligence) of the background, activities and reputation of third parties before engaging them.

In the Good Practices Document DNB has supplemented the above measures with some additional good practices. DNB attaches significant value to internal communication about integrity and the insurer's anti-corruption policies. It is for instance recommended that firms communicate the right tone from the top to all employees via newsletters and awareness e-mails. Furthermore, DNB notes that it should be clear for all employees what the sanctions are for corrupt behaviour.

DNB attributes an important role to senior management. The tone at the top referred to above is an example of this, but also the recommendation to let senior management play an active role in anti-corruption training and the subsequent discussions. It is proposed to let senior management also sign the code of conduct, in addition to all other employees.

Several good practices relate to (the hiring of) new employees. For instance, it is proposed to establish a separate job application panel focussing on the suitability of the applicant from an integrity perspective. DNB suggests further that extra background checks should be performed on applicants for integrity-sensitive jobs. In addition, it is recommended to give anti-corruption training to new employees shortly after commencement of their employment. These training sessions should be repeated periodically.

With regard to reporting corruption, DNB makes clear that it should be clear throughout the entire organisation who is responsible for the implementation of the anti-corruption policy and that integrity incidents should be recorded (including near misses). In periodic compliance reports attention should be paid to the anti-corruption theme. These reports should also be provided to the supervisory board or the audit committee (if in place).

In relation to third party risk, DNB states that all payments to third parties should be approved by two persons and that these payments should be reviewed and assessed whether they are in accordance with market conditions.

Comment

The continuous attention that DNB is giving to the integrity risk analyses performed by insurers (and other financial institutions active in the Dutch financial sector) shows the importance of the requirement to have a solid integrity risk analysis in place and to translate this into effective policies. We expect that financial institutions, including insurers, will continue to face regulatory scrutiny in 2016 when it comes to integrity risks and that if insurers do not take appropriate action, DNB will consider imposing enforcement measures.

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Case notes

A hard 'act' to follow

Insurers both in Australia and those overseas have often scratched their heads trying to come to terms with section 54 of the Australian Insurance Contracts Act 1984 (Cth) (ICA). Section 54 prevents an insurer from denying a claim solely on the basis of an act (or omission) of the insured or another person which occurred after the time the contract was entered into (provided the act did not cause the loss). Recently, both the Federal Court of Australia and West Australian Court of Appeal have weighed in on what is meant by the requirement for an 'act' under section 54(1) of the ICA. The two cases draw a useful dividing line between when section 54 will come to the aid of an insured and when it will not.

Case 1: Insurer runs aground on section 54

The first case, *Pantaenius Australia Pty Ltd v Watkins Syndicate* 0457 at Lloyds[1], involved a marine insurance policy for a luxury yacht which was wrecked off Cape Talbot, Western Australia. This policy contained an exclusion clause limiting coverage under the policy to damage that was sustained by the yacht while in Australian territorial waters. Under the terms of the clause, coverage was suspended from the time the yacht cleared Australian Customs and Immigration for the purpose of leaving Australian waters until the yacht cleared Australian Customs and Immigration upon its return. While the yacht ran aground within Australian waters, at the relevant time it was returning from Indonesia and had not cleared Australian Customs and Immigration. The insurer, therefore, denied the claim, grounding its refusal on the exclusion clause.

After review of the insurance policy in light of the relevant authorities, Foster J concluded that the exclusion clause must be read in light of the underlying purpose of the policy. In his Honour's opinion, this was to only extend coverage to the yacht while it was in Australian waters. As the exclusion clause did not go to the nature of the risk covered by the policy, the question became whether there had been an 'act' as contemplated by section 54(1).

Upon considering the cases put forward by both the insurer and the insured in regard to the relevant 'act', Foster J rejected both in favour of his own interpretation. According to his Honour, the relevant 'act' of the insured was the act of departing Fremantle harbour with an intention to leave Australian waters and clearing Australian Customs and Immigration at the commencement of the voyage. His Honour based his reasoning for this decision on the fact that this act was a necessary pre-condition to the suspension of the insurance policy under the exclusion clause.

As the insured's act did not cause the loss and the insurer suffered no prejudice, given the loss occurred in Australian territorial waters, section 54 operated to prevent the insurer from refusing the claim.

Case 2: A better 'state of affairs' for insurers

The decision by the Federal Court in *Pantaenius* can be compared with the recent decision of the West Australian Court of Appeal in *Allianz Australia Insurance Ltd v Inglis*.[2] This case involved a claim on a home insurance policy following injuries sustained by a ten-year-old girl, Miss Georgia Inglis, who was accidentally run over by a ride on lawnmower while playing. The persons claiming indemnity under the policy were the father and brother of the injured girl. Significantly, the home insurance policy excluded coverage for 'injury to any person who normally lives with you'. The insurer declined to indemnify the insureds based on this exclusion.

At first instance, the Western Australian District Court found that Miss Inglis was a person who normally lived with the father and brother and that this was an act for the purposes of section 54(1). The insurer, therefore, was not entitled to rely on the exclusion clause in denying indemnity.

1 [2016] FCA 1.

2 [2016] WASCA 25.

On appeal, the court considered the District Court's interpretation of an 'act' and concluded that living with another person is not an 'act'. In the Court of Appeal's opinion, the relevant facts were more appropriately defined as a 'state of affairs' or a 'description of a relationship'. This situation was to be inferred from the conduct of all relevant persons over a prolonged period of time and did not depend on any single act of a particular person on the day that the insurable event occurred. The conduct, therefore, could not amount to an 'act' within the meaning of section 54(1) and the insurers succeeded on appeal.

Again, the court also noted that a provision in a contract of insurance is to be informed by its context and the nature or type of the insurance.

How to act

The above decisions provide some clarity in regard to the operation of section 54 in a post *Maxwell v Highway Hauliers Pty Ltd*[3] landscape. Although, as demonstrated in *Pantaenius*, section 54 continues to be applied broadly by the courts, Inglis illustrates that it is not a panacea for all claims.

The cases also operate as a timely reminder that the court will determine the meaning of a policy provision, including an exclusion provision, by reference to the text, context and purpose of the provision and the policy as a whole. Insurers, therefore, should approach the task of defining the limits of a policy with extreme care.

3 [2014] HCA 33.

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External evidence presented in the context of Wellington Motions in Quebec

Quebec law on motions to compel an Insurer to defend its insured under a liability policy, also known as 'Wellington Motions,' has evolved over the years. The Quebec Court of Appeal recently added to this body of law by rendering a judgment that overturned a Quebec Superior Court decision allowing the introduction of external evidence to support a liability Insurer's denial of coverage.[4] The Court of Appeal, in this case, shed more light on how Wellington Motions should be viewed.

The facts

The plaintiffs, the Quebec Government and a school board, were claiming from a series of defendants damages from a fire allegedly caused by welding operations on the roof of a school. One of the defendants, Technologies CII Inc. (CII), was the contractor in charge of installing heating and ventilation components for the school. CII's work involved some welding operations on the roof, and a fire broke out while CII's employees were working at the school. The fire caused approximately C$16 million in damages.

Northbridge Financial Corporation (the Insurer) was also named as a co-defendant as CII's Insurer. In the context of the proceedings, the Insurer filed its plea stating that there was no coverage for CII for this loss because CII's employees had breached one of the warranties included in the policy by neglecting to use fireproof screens or blankets during the welding operation. In support of its plea, the Insurer had filed a copy of its statutory examination of CII's president, who admitted that CII's employees did in fact breach this warranty.

Shortly after the Insurer filed its plea, CII filed a Wellington Motion to compel the Insurer to defend the claim.

Quebec Superior Court decision

The first question addressed by the Superior Court was whether the Insurer was allowed to submit 'external' evidence to support its denial of coverage based on the breach of warranties. As an example, the Insurer wanted to show, using CII's president's statutory examination, that CII's employees failed to use any fireproof shielding.

The court determined that, in the context of this hearing, the Insurer could provide the court with such external evidence to support its decision to refuse to defend CII. However, the court added, this should be done in a strict and summary procedural context, which must not become a 'trial within a trial.' The court therefore concluded that it should look to the evidence already submitted by plaintiffs and the Insurer, including

4 *Technologies CII Inc. v Société d'assurances générales Northbridge*, 2016 QCCA 41 (Que. C.A.).

the statutory examination of CII's president. Moreover, the court held that it should consider as true all the facts that flow from this external evidence.

After a lengthy debate as to whether the warranties included in the Insurer's policies were indeed known by the insured, the court determined that the Insurer was successfully able to show that its insured had indeed breached one of the warranties in the policy. The court based its finding largely on the statements of CII's president during his statutory examination. As a result, the court found that the Insurer had no duty to defend the claim made by plaintiffs against CII seeing as, at the stage of the proceedings, it had not been shown that the policy applied to the loss.

Court of Appeal decision[5]

On appeal, the Court of Appeal unanimously overturned the trial judge's decision. In a very short judgment, the panel found that the first judge should not have concluded, based on the external evidence provided by the Insurer, that the fire that damaged the building was necessarily caused by the welding operations that were the focus of the warranties in the Insurer's policy.

Moreover, the court found it was not clear from that evidence that CII's employees were actually conducting welding operations on the building shortly before the fire. More importantly, the Court of Appeal noted its 'surprise' at the first judge's decision to allow external evidence (i.e., most likely referring to CII's president's admissions in his statutory examination) to be considered in the context of the Wellington Motion. The court reiterated that only a minimal amount of evidence should be heard at that stage, since the insured is not afforded the right to respond to the evidence put forward by the Insurer. The Court of Appeal therefore struck down the first judgment and ordered the Insurer to defend the claim against CII.

5 *Québec (Procureure générale) v Services énergitiques Ecosystem inc.*, 2015 QCCS 1988 (Que Sup Ct).

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Further defining the scope of the Texas Prompt Payment Act

In *Health Care Service Corporation v Methodist hospitals of Dallas*, no. 15-10154[6], the Fifth Circuit grappled with whether the Texas Prompt Payment Act ('TPPA') applies to third-party administrators of self-funded ERISA (i.e. Certain employer-provided health benefit) plans.

The Texas Prompt Payment act

The TPPA requires insurers to pay unproblematic, or 'clean' claims submitted by preferred providers within 45 days for non electronically-filed claims or 30 days for electronically-filed claims. The TPPA applies to 'each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of coverage ...'. It further defines 'insurer' as 'a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501 [of the Texas Insurance Code], that is authorised to issue, deliver, or issue for delivery in this state health insurance policies.'

6 5th cir. Feb. 10, 2016.

The dispute and its resolution

In anticipation of Methodist filing suit for purported violations of the TPPA, Health Care Service Corporation d/b/a Blue Cross Blue Shield Texas (BCBSTX), filed suit requesting a declaration that: (1) the TPPA does not apply to third-party administrators of self-funded ERISA plans; and (2) ERISA pre-empts the TPPA such that the third-party administrators of self-funded ERISA plans cannot be held liable for TPPA violations. Methodist counterclaimed for over US$31 million in penalties, interest, and attorneys' fees. The trial court sided with BCBSTX.

On appeal, Methodist argued that the TPPA applied to BCBSTX because it was an 'insurer' subject to the TPPA. BCBSTX argued that while it does act as an insurer, the actions complained about by Methodist were undertaken by BCBSTX in its role as a third-party administrator under Chapter 4151 of the Texas Insurance Code, not in its role as an insurer under other chapters of the Texas Insurance Code.

Methodist argued further that the word 'provides' in the TPPA was broad enough to encompass not only the entity with the ultimate financial burden of payment, but to the third-party administrator who facilitates that payment. Moreover, Methodist contended, BCBSTX maintains a 'health insurance policy' by maintaining administrator agreements and preferred provider network agreements.

The fifth circuit disagreed with Methodist. The court held that, even if BCBSTX were an 'insurer,' it did not 'provide[ ] ... For ... Payment.' The court focused on the fact that when discussing third-party administrators, the TPPA describes their function as 'process[ing] or pay[ing] claims,' which the court said suggests that the 'provides ... For ... Payment' phrase does not encompass payments by others that are facilitated or distributed by a third-party administrator.

Perhaps more importantly, the court found that even if BCBSTX 'provide[d] ... For ... Payment,' it did not do so through its 'health insurance policy.' The TPPA defines 'health insurance policy' as 'a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.' The court noted that, 'any benefits [BCBSTX] furnished to beneficiaries derive[d] from the plans of others, wholly independent of any contractual relationship with BCBSTX' and held that 'BCBSTX, as an administrator, [did] not confer any benefits for medical expenses on beneficiaries and therefore does not provide for payment through its 'health insurance policy.''

The court also rejected the argument that the TPPA applied to BCBSTX by way of a provision extending the TPPA's application to 'a person ... With whom an insurer contracts to' perform certain administrative services. The court highlighted the fact that in order for the TPPA to apply to BCBSTX by way of this provision, it would have to contract with an insurer. The court opined that self-funded health benefit plans and state government-sponsored health benefit plans did not fall within the aforementioned definition of 'insurer' because: (1) those plans do not operate under any of the insurance code chapters mentioned in that definition; and (2) the plans are not authorised to 'issue, deliver, or issue for delivery' health insurance policies in Texas. In other words, while self-funded and state government-sponsored benefit plans do provide health benefits to employees, they are not technically 'insurance.'

The broader context: the ongoing controversy over the TPPA's scope

This case is yet another chapter in the book of controversies over the breadth of the TPPA's scope. Plaintiffs' lawyers regularly test the boundaries of its scope, in large part thanks to the windfalls they can secure in the form of statutory penalties and the shifting of attorneys' fees to a losing defendant.

A major success for the plaintiffs' bar in this regard was *Lamar Homes, Inc. v Mid-Continent Casualty Company*, 242 s.w.3d 1 (Tex. 2007). There, the dispute focused on a different portion of the TPPA, which applies to 'first-party claim[s],' and is not limited to claims submitted by preferred providers in the health insurance context. The Texas Supreme Court held that this provision of the TPPA applied to defence costs an insured incurred in defending a lawsuit and for which the insurer was later found to have wrongfully denied coverage.

The court explained that its past decisions distinguished between a first-party claim, which 'is stated when "an insured seeks recovery for the insured's own loss,"' and a third-party claim, which 'is stated when "an insured seeks coverage for injuries to a third party"' ... 'based upon that distinction,' the court held, 'a defense claim is a first-party claim because it relates solely to the insured's own loss.' Accordingly, the court held that a wrongful denial of a defense can lead to penalties under the TPPA.

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Looking for a new act? The WA Court of Appeal tells us where to look

In *Allianz Australia Insurance Ltd v Inglis* [2016] WASCA 25, the West Australian (WA) Court of Appeal clarified the meaning of 'act' in s54 of the Insurance Contracts Act 1984 and reminded us how to construe insurance contracts.

Key points

- Section 54(1) of the Insurance Contracts Act 1984 prevents an insurer from refusing indemnity solely on the basis of an act of the insured or another person which occurs after the inception of the policy.

- In this context, 'act' means something done or being done by a person. It does not include a state of affairs or the description of a relationship. 'Normally living with' another person is not an act.

- The general principles of contractual construction apply to insurance contracts and there is no general rule that exclusion clauses are to be construed strictly or narrowly, absent ambiguity.

Facts

Stephen Sweeney drove a mower into Georgia Inglis, injuring her seriously.

Georgia Inglis sued Stephen Sweeney and his parents in the WA District Court. The Sweeneys then sued Georgia's father and brother, Stuart and James Inglis, claiming an indemnity, alternatively a contribution, on the basis that their negligence had caused Georgia's injuries.

Stuart and James Inglis sought indemnity under the legal liability section of their home insurance policy, which covered them for legal liability to pay compensation in respect of bodily injury occurring during the policy period.

Allianz declined indemnity on the basis of an exclusion in the policy that provided, 'We will not cover your legal liability for injury to any person who normally lives with you'.

WA District Court decision

The WA District Court found that Georgia Inglis was a person who normally lived with Stuart and James Inglis within the meaning of the exclusion. However, that fact was an 'act' for the purposes of s54(1) of the ICA which (in the absence of any prejudice) prevented the insurer from declining cover.

WA Court of Appeal decision

The Court of Appeal considered several issues but it was its interpretation of 'act' under s54(1) that effectively disposed of the appeal. The court held that living with another person is not an 'act', but a 'state of affairs' or a 'description of a relationship'. Here, the facts depended on an inference to be drawn from the conduct of all relevant persons over an extended period of time and did not depend on a single act of a particular person on the relevant day. So they could not amount to an 'act' within the meaning of s 54(1).

McClure P also considered two matters of contractual construction.

The policy defined the insured as Linda and Stuart Inglis and 'you' or 'your' as:

> 'the person(s) named in the current schedule as the insured and those persons who live with you permanently who are any of the following:
>
> - any member of your own family and your spouse's or de facto family.'

The Inglises argued that the exclusion relied upon by Allianz did not apply as 'you' meant all the insureds and so 'any person' had to mean any person other than an insured (including Georgia Inglis).

McLure P rejected the argument. After setting out the relevant principles of contractual construction, her Honour held that the meaning of 'you' was informed by its context and the nature or type of the insurance. At its widest, 'you' meant all the insureds under the policy severally. However, for the purposes of the relevant insuring clause, the context required that it meant only those insureds who were legally liable to pay compensation in respect of the bodily injury. In the present case, that meant Stuart and James Inglis, not all the insureds, and 'you' and 'your' had the same meaning in the exclusion. So Georgia Inglis qualified as 'any person'.

The second issue was whether a contribution claim was a claim which gave rise to a legal liability 'for injury' within the meaning of the exclusion. Having regard to the text, context and purpose of the insuring clause and the exclusion, McLure P held that it was.

Comments

The Court of Appeal's decision clarifies the meaning of 'act' in s54(1) of the ICA. A state of affairs is not an 'act'.

The decision also provides a useful reminder that the court will determine the meaning of a policy provision, including exclusions, by reference to the text, context and purpose of the provision and the policy as a whole. Notably, here, although the policy definition of 'you' and 'your' referred to all insureds, the Court of Appeal found that this was not its meaning in the context of the legal liability cover and the exclusion.

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The Wrong Trousers: German Supreme Court rules that brokers may not settle claims on behalf of insurers

In a recent decision delivered on January 14, 2016 (case reference I ZR 107/14), the German Supreme Court ruled that a broker may not be authorised by the insurer to handle third-party claims on behalf of the insurer.

The facts of the case are as follows:

- A chain of dry cleaners had placed their third-party-liability insurance via a broker. The broker's commission included a lump sum for the ongoing review of the insured value and the claims handling on behalf of insurers. For this purpose the broker had a general power of attorney from the insurer.
- The dispute was sparked by a claim from a customer who claimed compensation for a pair of trousers that was lost by the dry cleaner. The customer claimed compensation not just for the lost trousers but also the costs of the dry cleaning, expenses for the cost of telephone calls and the bus fare for his futile attempt to collect his trousers. The broker answered the claimant with a letter on behalf of the insurer and explained that given that the claimant could not present any proof for the value of the trousers, the broker had instead estimated that value and deducted a lump sum for the fact that the trousers were used and also the costs of the dry cleaning since obviously the trousers were stained when the customer handed them to the dry cleaner. The broker then explained that for legal reasons, there would be no compensation for costs such as telephone or bus fare covering the futile attempt to collect the garment.
- The letter somehow came to the attention of the local Bar association. The Bar association filed an action for injunction and asked to prohibit the broker from handling legal matters such as the customer's claim. The first instance court and the court of appeal rejected that action, but the German Supreme Court overruled these decisions and held that the broker rendered illicit legal services and thus, had to abstain from further action.

The legal point that was determined

The legal problem behind the case can be found in the German law on legal services. In Germany, only lawyers who are duly qualified and registered with the Bar association may render legal services. Legal services is defined in a very broad way as 'any service for somebody else's business that requires a legal assessment of the particular circumstances'. The reasoning behind that law is to protect the general public from unqualified legal advice and to ensure that only duly qualified lawyers with professional indemnity insurance in place are allowed to practice the law.

The law provides for an exception to the general prohibition to render legal services, if the legal services are supplementary to another task that requires legal knowledge.

The first and second instance courts discussed the question whether the task of checking different heads of damages in relation to the loss of a pair of trousers really requires a legal assessment of the particular circumstances or whether this is a more trivial task that does not even qualify as legal services in the sense of the law. In consequence, they left this question undecided and relied on the exception that supplementary services to an allowed service do not require a full legal qualification as a lawyer. In this respect, it was decided that claims handling is a typical supplement to the business of a broker and that a broker has the relevant legal qualification to handle these questions.

In its decision of January 14, 2016, the German Supreme Court overruled the lower instances and focused more on the conflict of interest. It held that the interests of the insurer and the insured are not necessarily aligned and thus, the broker cannot act for the insurer and insured at the same time. As well, the Supreme Court held that the main obligation of the broker is to place insurance on behalf of the insured so the obligation to handle claims on behalf of the insurer cannot be 'supplementary' to this obligation, for the simple fact that the claims handling is undertaken for another principal.

The full text of the Supreme Court decision will only be published in a few months' time, but the brokers' associations who support the respondent broker in this matter have already announced to take this case to the European Court and possibly the German Constitutional Court as this decision restricts the freedom of services for foreign brokers in Germany and discriminates German brokers with regard to foreign brokers abroad who are not restricted in a similar way.

Nevertheless, the decision is final and insurers and brokers will have to review their arrangements carefully to ensure compliance with the position of the Supreme Court. A violation of the statute on legal services may be prosecuted by the Bar associations with actions for injunctions as in the case described above. In addition, the fact that a broker acting as claims handler for the insurer violates the law, renders the whole agreement between broker and insurer and the power of attorney null and void.

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International focus

UK embraces ILS structures

The UK Government has published a formal consultation in relation to a new regulatory, corporate, insolvency and tax framework for insurance linked securities (ILS) business in the UK. The Government's aim is to reinforce London's standing as the world's leading insurance market by creating the necessary legal environment to allow the domicile of ILS issuers in the UK. Part of the proposal is to create protected cell companies (PCCs), which would be one of the more radical changes to UK corporate law in recent times.

The plans are focused on the two leading forms of alternative risk transfer, cat bond ILS transactions and collateralised reinsurance.

Authorisation and supervisory framework

The first section outlines the Government's view on the authorisation and supervisory framework for ISPVs. The Government intends to apply the authorisation and supervisory framework applicable to SPVs under Solvency II to insurance SPVs (ISPVs) in the UK.

A core requirement of the applicable authorisation and ongoing supervision of ISPVs will be compliance by ISPVs with the 'fully funded requirement', a matter of growing relevance in an era of negative returns on 'safe' investments.

An industry concern has been that ISPVs will not achieve PRA authorisation in a timeframe which is commercially viable given the pace of ILS deals. The latest consultation document demonstrates that the Government is looking to address these concerns by moving towards a more streamlined approvals regime, especially for multi-issuance ISPV vehicles. However, questions remain over whether even the timeframes now envisaged will be sufficiently fast to put the UK on a level playing field with more established ILS jurisdictions, such as Bermuda, Cayman Islands, Ireland, Guernsey and Jersey.

New PCC regime applicable to ISPVs

The consultation document also proposes amending companies and insolvency law in the UK to allow for the creation of protected cell companies (or PCCs). PCCs allow pools of assets and liabilities to be segregated within a company, such that the assets of one cell cannot be used to meet the liabilities of another cell (and vice versa). PCCs would, amongst other things, make establishing multi-issuance ISPVs more feasible. Such vehicles are now common in the established ILS jurisdictions, as well as in jurisdictions such as Luxembourg where they are also frequently used for repackaging and securitisation transactions. However, PCCs would be novel under UK company and insolvency law and their introduction would be a major development in UK company law.

The consultation asks for inputs in relation to this regime on a wide number of issues (including whether the abbreviation 'PCC' could be too easily confused with 'PLC').

The new PCC regime is only envisaged to be available for ISPV purposes in the UK. It will be interesting though to see in the long run whether the Government would be prepared to see them used more widely.

Taxation of ISPVs

For tax purposes, the focus of the consultation is on ensuring that there is no tax leakage at the level of the ILS, while at the same time making sure that ultimately any investors pay tax at the profit they make. Imposing a withholding tax on returns would be one solution but the competitive disadvantage of this is acknowledged. The Government will introduce enabling legislation in the 2016 Finance Bill, so that the tax changes can be made later.

Overall, these proposals are a welcome step forward in making London an ILS 'hub', and creating the tax and corporate and the regulatory environment necessary to enable the UK and London to be an attractive alternative to investors and issuers in this increasingly competitive market.

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IDD: full steam ahead to 2018

The Insurance Distribution Directive (IDD) (Directive 2016/97/EU), which recasts Directive 2002/92/EC (the Insurance Mediation Directive (IMD)), has been published in the Official Journal on February 2, 2016. The IDD will come into force 20 days following publication in the Official Journal of the European Union. Firms must comply with the requirements by February 23, 2018.

The IDD will be applied to intermediaries and also to insurance and reinsurance undertakings who sell direct to their customers. The activity of insurance distribution includes advising on, proposing or carrying out work preparatory to a contract of insurance or assisting in the administration and performance of such contracts, in particular in the event of a claim.

The IDD requires that all insurance distributors should act 'honestly, fairly and professionally in accordance with the best interests of its customers'. This requirement imposes a high standard upon all distributors (including direct sellers and those distributing to professional customers) to consider the interests of customers in their business. In addition, distributors are required to ensure that they do not remunerate or assess the performance of their employees in a way that conflicts with the duty to act in the best interests of customers. The IDD also requires firms to operate and review a process for the approval of each insurance product they offer and to review any significant adaptations of existing products before they are marketed or distributed to customers.

Before the conclusion of an insurance contract, intermediaries are required to provide details about themselves and must describe to their customer the nature of their remuneration and whether the contract will work on the basis of a fee or commission (or other type of arrangement). Insurers selling directly will be required to disclose the nature of the remuneration received by its employees in relation to the contract sold (i.e. bonus payments). The IDD also enables Member States to restrict the payment of commission as has been done in the UK under the Retail Distribution Review rules, in operation since 2012.

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ASIC sounds warning on add-on insurance products

In his recent speech at the Insurance Council of Australia Annual Forum ASIC's Peter Kell delivered a scathing commentary on the state of the add-on insurance market, saying that the industry had made insufficient progress towards delivering better consumer outcomes in the area and sounded a warning: if ASIC is still raising similar concerns in 2017, ASIC's focus will be on stronger enforcement action. As Mr Kell said, 'It's time to get your houses in order'.

The speech followed the release of two reports into the sale of add-on insurance products through car yards. The findings in those reports were critical of the nature of add-on insurance products, the manner in which they are sold and the lack of oversight of distribution channels.

ASIC's focus on consumer outcomes

The consumer protection recommendations of the Financial System Inquiry (FSI) signal a philosophical shift from a disclosure-based regime, based on ensuring consumers have sufficient information to make informed investment choices, to one aimed at ensuring that the financial services environment promotes positive consumer outcomes.

Two recommendations are particularly pertinent for the insurance sector. The FSI recommended imposing an obligation on product issuers and distributors to consider and monitor a range of factors to ensure that financial products meet the needs of their target market. The purpose of the obligation is to ensure organisations are responsible for ensuring that products are designed and distributed in a way that does not create consumer detriment. The FSI also recommended that ASIC be granted a product intervention power, to enable it to take a more proactive approach to reduce the risk of significant consumer detriment. This would allow ASIC to modify, or even ban, products that are considered harmful for consumers. The Australian Government has taken on these recommendations, and intends to consult further on their implementation by the end of 2016.[1]

Ahead of their likely implementation, ASIC has been approaching its market surveillance with an eye to product design and development, with a strong focus on consumer outcomes rather than issues surrounding disclosure or misleading sales practices.

In early 2015 ASIC identified 'add-on' insurance products as a key area of concern due to the poor outcomes they generate for consumers, and has called on the insurance industry to improve practices and standards in this area. Add-on insurance is offered to consumers in a range of transactions, from taking out a credit card to buying a car.

1 Improving Australia's financial system – Government response to the Financial System Inquiry, released October 20, 2015.

The report

To demonstrate the need for reform, ASIC has recently released a report that details the deficiencies of life insurance products sold through car yards. These products commonly provide a lump sum payment of the outstanding car loan balance upon the death of the insured. The report calls on the insurance industry to take significant steps to address the low value offered to consumers, and ensure that the product is targeted only to consumers for whom it is appropriate.

ASIC performed a review of five major life insurers offering car yard life insurance, estimated to make up over 90 per cent of the market, from FY10 to FY14. The report concludes that car yard life insurance offers poor value for consumers and is often sold to consumers who have limited knowledge of, and need for, the product.

A call for change

ASIC has now done a lot of work in the add-on insurance space. Along with this current report, ASIC has conducted a consumer research study to further understand customer experiences when purchasing add-on insurance[2], and is currently conducting a similar review of general insurance sold through car dealers.[3] The report calls on insurers to proactively improve the design and distribution of add-on insurance products, as well as their procedures for monitoring the conduct of intermediaries. If they fail to do so, ASIC has indicated, not only in the report, but also through industry briefings, that it will increase its enforcement action.

If the consumer protection FSI recommendations are implemented (as is expected over the next 18–24 months), ASIC will have a broad power to actively intervene in the design and distribution of these products, including amending marketing material, restricting distribution, or even banning certain products. If the industry fails to act on this call to action before the FSI recommendations are implemented, this report, coupled with findings from related surveillance conducted by ASIC, may well provide the evidence ASIC requires of significant consumer detriment, allowing ASIC to use its new powers without delay.

2 ASIC Report 470: Buying add-on insurance in car yards: Why it can be hard to say no.

3 Regulatory update to general insurance industry', Speech by Peter Kell, Commissioner, Australian Securities and Investments Commission, Insurance Council of Australia Annual Forum 2016 (Sydney, Australia), March 4, 2016.

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