

INSURANCE AND REINSURANCE

NewsWire

March 2011

Dear Reader,

The markets — financial and insurance — are still coming to terms with the implications in particular of the succession of natural catastrophes that have plagued 2011, and we will be addressing these separately. In the meantime, the insurance industry must also keep pace with legal and regulatory changes and in this issue of the NewsWire Chadbourne lawyers consider a number of significant developments on both sides of the Atlantic.

In this issue:

- ⊙ Following up on a previous article, **Richard Liskov**, Special Counsel in Chadbourne's New York office and **Don Mros**, Counsel in the Washington, D.C. office, examine the implications of the U.S. "Dodd-Frank" Act, and in particular what is required for the Federal Deposit Insurance Corporation to exercise its so-called "back-up authority", as well as some novel issues raised by potential federal-level intervention into the area of insurance company liquidations.
- ⊙ The English High Court sent a clear warning to insurance brokers earlier this year when they ruled in favour of the insured in a case which saw the broker being held responsible for obtaining a policy which did not meet the insured's needs. **Mark Pring**, Partner and **Anita Fisher**, Legal Assistant in Chadbourne's London office, discuss the case.
- ⊙ **Patrick Devine**, Legal Consultant in Chadbourne's London office, looks at the growing trend for companies to use 'cloud computing', with particular emphasis on the benefits, risks and regulatory implications for insurance companies.
- ⊙ Finally, insurance law can often seem complex and confusing. The English and Scottish Law Commissions have for some time been seeking to clarify a number of areas of law. **Rebecca Huggins**, Associate in Chadbourne's London office, considers the implications for the insurance industry of proposed reform to the law on the scope of an insured's "duty of good faith" after it has entered into a contract."

We hope that you find these articles of interest and welcome any feedback or suggestions for future editions.

Mark Pring
Editor

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Does “Dodd-Frank” allow for a federal liquidator of an insurance company?

by Don J. Mros and Richard G. Liskov

The short answer to the title question is “no.”

However, under the Dodd-Frank Wall Street Reform and Consumer Protection Act (“Dodd-Frank” or the “Act”), the Federal Deposit Insurance Corporation (“FDIC”) has limited “back-up” authority to place into liquidation an insurance company that (i) meets certain criteria as respects the nature of its business and (ii) is essentially “too big to fail.” This liquidation proceeding would, however, still be under the relevant state insurance liquidation laws.¹

We outline below what is required for the FDIC to exercise this “back-up authority” and will touch on some novel issues raised by this possible federal entry into the area of insurance company liquidations.

1. An Insurance Company Would First Have To Be A “Financial Company” Under “Title II” Of Dodd-Frank

Title II of Dodd-Frank, providing for the liquidation of certain financial companies, has application to insurance companies that constitute a “financial company” under Title II. An insurance company is considered a financial company if it is incorporated or organized under any provision of federal or state law and has “predominantly engaged in activities that the Board of Governors [of the Federal Reserve System] has determined are financial in nature or incidental thereto for purposes of section 1843(k) of this title [12 U.S.C. § 1843(k)]” 12 U.S.C. § 5381(a)(11)(A) and (B)(iii).

Title II further provides that:

¹ Insurance companies are not subject to the United States Bankruptcy Code and any receivership of an insurance company is under state law, usually the state law of the domicile or home state of the insurer. 11 U.S.C. § 109(b)(2).

no company shall be deemed to be predominantly engaged in activities that the Board of Governors has determined are financial in nature or incidental thereto for purposes of section 1834(k) of this title, if the consolidated revenues of such company from such activities constitute less than 85 percent of the total consolidated revenues of such company, as the [FDIC], in consultation with the Secretary [of Treasury], shall establish by regulation.

12 U.S.C. § 5381(b) (emphasis added).

While the meaning of “financial company” under Title II still needs to be further defined by regulations promulgated by the FDIC, 12 U.S.C. § 1843(k) provides that the following activity shall be considered “financial” in nature: “insuring, guaranteeing, or indemnifying against loss, harm, damage, and acting as principal, agent or broker for purposes of the foregoing, in any State.” 12 U.S.C. § 1843(k)(4)(B). (This activity is considered a “financial activity” as part of the determination by the Board of Governors of the Federal Reserve System as respects whether a financial holding company can engage in the activity under the Bank Holding Company Act as amended by the Gramm-Leach-Bliley Act of 1999.)

2. An Insurance Company That Is Deemed A Financial Company Would Have To Pose A Systemic Risk Under Title II

The second requirement before the FDIC can act is a determination that the relevant insurer poses a systemic risk if it were to be in default or in danger of default. 12 U.S.C. § 5383. This determination is made on the recommendation of the Director of the Federal Insurance Office (“FIO”) and the Board of Governors of the Federal Reserve System, either on their own initiative or at the request of the Secretary of Treasury. A recommendation of systemic risk has to be approved by a two-thirds vote of the Board of Governors and additionally has to be approved by the Director of FIO in consultation with the FDIC. Id. § 5383(a)(1)(C). These procedures also apply to an insurer that is a subsidiary of a financial company where the insurer is the largest subsidiary of the financial company as measured by total assets as of the end of the previous calendar quarter. *Id.*

The factors that shall be considered in making such a systemic risk determination for an insurer include the following: (i) the insurer is in default or in danger of default; (ii) the failure of the insurer would have serious adverse effects on financial stability in the United States; (iii) no viable private sector alterna-

tive to liquidation is available; (iv) the effect of liquidation on the claims of creditors, counterparties or shareholders of the financial company; (v) and whether liquidation would mitigate the adverse effects, including potential adverse effects on financial stability in the United States. *Id.* § 5383(b).² Obviously, for there to be a systemic risk determination under this section, an insurer would have to be a very large entity whose default or possible default would have an adverse effect on the United States economy. *See* 12 U.S.C. § 5383(a)(2).

3. The FDIC Can Only Act Where The Insurance Department With Supervisory Authority Does Not Act Within 60 Days Of The Systemic Risk Determination

While other financial companies would be liquidated under the provisions of Title II, the receivership of an insurer (including an insurer that is a subsidiary of a financial company) would still be conducted under the applicable state law. 12 U.S.C. § 5383(e)(1). The State insurance regulator could still institute the proceeding, either rehabilitation or liquidation, but the FDIC is authorized to act in the insurance department's stead where:

if after the end of the 60-day period beginning on the date on which a [systemic risk] determination is made . . . , the appropriate regulatory agency has not filed the appropriate judicial action in the appropriate State court to place such company into orderly liquidation under the laws and requirements of the State, the [FDIC] shall have the authority to stand in the place of the appropriate regulatory agency and file the appropriate judicial action in the appropriate State court to place such company into orderly liquidation under the laws and requirements of the State. *Id.* § 5383(e)(3).

² Under Title II,

... a financial company shall be considered to be in default or in danger of default if
 (A) a case has been, or likely will promptly be, commenced with respect to the financial company under the Bankruptcy Code;
 (B) the financial company has incurred, or is likely to incur, losses that will deplete all or substantially all of its capital, and there is no reasonable prospect for the company to avoid such depletion;
 (C) the assets of the financial company are, or are likely to be, less than its obligations to creditors and others; or
 (D) the financial company is, or is likely to be, unable to pay its obligations (other than those subject to a bona fide dispute) in the normal course of business.

12 U.S.C. § 5383(C)(4) (emphasis added).

Under this provision, the FDIC can act where the insurance department does not do so within the 60 day time frame, but the FDIC can only seek to place the company into liquidation, not rehabilitation. In contrast, an insurance department has the discretion to place the insurer into either rehabilitation or liquidation under 12 U.S.C. § 5383(e)(1). Presumably, once the FDIC has instituted the proceeding, the liquidation would then proceed under the state law as if the insurance department had instituted the proceeding, with the insurance commissioner acting as the liquidator.

The Limited Authority Of The FDIC Opens A Pandora's Box Of Potential Issues

The limited authority of the FDIC raises a number of unprecedented potential issues:

- First, the FDIC must define with greater precision when an insurance company would be deemed a "financial company" for purposes of Title II.
- Second, it is not clear how the FDIC would interact with State insurance regulators who may have a much different view on whether liquidation is necessary. Under Title II, the FDIC can only place the insurer into liquidation, not rehabilitation. State insurance departments, however, often prefer to place a company into rehabilitation, at least initially, or to exercise supervision regarding a financially troubled insurer.
- Third, no one can predict the effect of an FDIC-initiated liquidation on the state guaranty funds which would likely be triggered, and which would face a large strain, since an insurer that is "too big to fail" would surely be a large institution with millions of policyholders nationwide. Because the assessments which insurers pay to guaranty funds are tax-deductible in many states, an FDIC decision to liquidate an insurer likely would also have major implications for state tax revenues.

All of these issues will hopefully cause the FDIC to be judicious in exercising its authority to seek the liquidation of insurance companies that it does not regulate. We note in this context that Congress directed the FDIC to engage in extensive consultation with insurance regulators in exercising its authority under Title II, 12 U.S.C. § 5384(c), and those consultations will be key to avoiding possible confusion and disruption.

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Dodd-Frank

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Conclusion

We may never know (and hope not to learn) how this aspect of Dodd-Frank will work in practice, as it would require the default or danger of default of a major insurer, which would then pose the risk of serious adverse effects on the financial stability of the United States. Regardless, the limited authority afforded to the FDIC does present the possibility of increased federal oversight of insurance companies.

(Additional aspects of Dodd-Frank that may apply to insurance companies were addressed in a previous NewsWire article in the November 10, 2010 issue, authored by Richard Liskov: *Federal Financial Regulatory Reform: What Congress Has Done In Respect Of (Re) insurance (So Far).*)

Should you require any further information on the matters addressed in this article, please do not hesitate to contact the authors at dmros@chadbourne.com and rliskov@chadbourne.com. ©

The approach of brokers to disputes between insured and insurer under English law

by Mark Pring and Anita Fisher

A recent case in the English High Court¹ highlights the continuing importance of the broker in ensuring an adequate flow of information between an insured and an insurer. It also demonstrates the risks to which brokers who fail to achieve this may be exposed.

¹ *Ground Gilbey Ltd v Jardine Lloyd Thompson UK Ltd* [2011] EWHC 124 (Comm.)

The Facts

The owners of Camden Market in north London, Ground Gilbey Ltd (the insured), brought a claim against their former insurance brokers, Jardine Lloyd Thompson (JLT), following a major fire in part of the market on 9 February 2008 that caused almost £6m of damage. The fire was the result of a liquefied petroleum gas portable heating appliance (PHA) being left on and subsequently setting light to clothing from one of the market stalls.

The relevant “Property Owners’ Policy” insurance policy was underwritten by Fusion Insurance, as agent for the insurer (Aviva/Norwich). The March 2005 cover stipulated the removal of PHAs from the market, but PHAs continued to be used in the market by the stallholders, even in breach of their tenancy agreements.

Shortly after the renewal of cover in 2006, Fusion carried out a further “Risk Improvement Survey” on behalf of the insurer, requiring “confirmation that all unacceptable heating appliances have been removed” and that these steps were to be “implemented immediately”. This information was forwarded to the insured by JLT.

Shortly before the 2007 renewal, a further survey was carried out in the presence of a representative from JLT. This survey report noted that, despite reminders, the stallholders were still using PHAs.

The renewal policy issued in March 2007 contained a new endorsement (the Survey Condition): “cover under this Policy is conditional upon” receipt of acceptable survey reports and also “completion to the Underwriters’ satisfaction of all requested risk improvements within timescales stipulated by the Underwriters”. In addition, the insurer expressly reserved the right to amend the terms of the cover, including the withdrawal of cover if either condition was not satisfied. This was not specifically drawn to the insured’s attention by JLT.

Further, in October 2007 Fusion sent an email to JLT that stated that “all PHAs are to be removed from the premises ... Completion: Immediate”. Critically, JLT failed to forward this email and the latest risk improvement measures to the insured. JLT accepted this was in principle a breach of duty on its part.

Several emails were exchanged between Fusion and JLT between October 2007 and January 2008 regarding the continuing use of PHAs in the market. During a meeting in January 2008, the negotiations focused on the possible use of alternative, safer PHAs, but this was not resolved before the fire took place.

The insured’s claim under the 2007/08 policy was eventually

settled for £3.8m, approximately 70% of the full claim value. The insured then issued proceedings against JLT to recover the remaining portion of its loss. JLT denied liability.

The Scope of JLT's Duty

In broad terms, the insured argued that if JLT had advised it in October 2007 that, unless all PHAs were removed from the market immediately, there might be no insurance in the event of a loss, then it would have taken appropriate steps to ensure the removal of the PHAs.

JLT's contrary position was that, even if it had specifically advised the insured that its cover might be in jeopardy following the 2007 survey, this would not have made any difference to the stallholders' conduct. JLT relied upon the fact that the results of the 2006 survey and required "risk improvements" had been previously communicated to the insured with a warning that the heaters should be removed immediately. They therefore argued that even though the requirements arising out of the second survey report had not been forwarded along with any advice regarding the consequences of non-compliance, to the insured, it was already fully aware of the substance of the required risk improvements and, notably, had done nothing to ensure compliance during 2006/2007 or thereafter.

JLT's arguments were rejected by the Judge (Mr. Justice Blair).

Finally, he found that JLT's duty was to obtain cover appropriate to the insured's needs and, following inception, to communicate to the insured any information that might affect the coverage.

The Judge also held that on the facts there were three breaches of duty by JLT: a failure to obtain a policy that allowed the use of PHAs; a failure to provide advice regarding the 2007 Survey Condition; and a failure to forward to the insured the email of 9 October 2007. He ultimately accepted that the effect of JLT's failures "was to deny the claimants the opportunity to enter into a constructive and detailed dialogue with the insurer regarding PHAs, by failing to impart the insurers' views and the importance of the subject".

Finally, he found that, as a result of JLT's breach of duty, the insured found itself "with doubtful or uncertain rights against insurers when [it] should have had a clear, unequivocal right to indemnity for a loss".

The Settlement

These findings underpinned the Judge's view of the settlement reached by the insured with the insurer. He considered that the

settlement figure of 70% "was within the range of settlements which reasonable commercial people might have made ... albeit towards the edge of the range".

Having already found that there was a breach of duty by JLT, the Judge considered that it was therefore right that the insured should recover the settlement shortfall of approximately £1.7m from the broker.

Implications

It is now well-established under English law that a broker owes its insured client a (continuing) duty (1) to take reasonable steps to obtain a policy which clearly meets the insured's needs and (2) to protect the client against unnecessary legal disputes with the insurer.

Should you require any further information on the matters addressed in this article, please do not hesitate to contact Mark Pring at mpring@chadbourne.com. ☺

Cloud computing: the UK regulatory implications for the insurance industry

by Patrick Devine

The current economic circumstances have brought into sharper focus the efficiencies and cost-cutting opportunities presented by "Cloud computing". This is a form of outsourcing by which vendors can supply computer services to multiple customers over the Internet.

At its core, Cloud computing envisages that hardware and software will be provided remotely to customers as a service and only as required. At the same time, Cloud services can be delivered to customers regardless of their location, via a PC, laptop or other handheld device.

High-profile Cloud services for consumers include Gmail, Hotmail, YouTube and Facebook. Business services are only now gaining a similar profile, but a January / continued on page 6

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2011 report by the Centre for Economics and Business Research in the UK concluded that the widespread adoption of Cloud computing could provide the top five EU economies with a US\$1 trillion (£645 billion) boost over the next five years.

Benefits

The potential benefits of Cloud computing for businesses, including insurance companies, cover:

- **Cheaper computing power:** with end-users having the flexibility of only paying for what they use in terms of the bandwidth and server and, again, a single I.T. provider can host services for multiple companies.
- **Financial savings:** there is no need to purchase (or maintain) servers or company data storage facilities and the costs of power, security, lighting and other services are shared between customers.
- **Energy efficiency (and environmental credibility):** since overall carbon dioxide emissions should be reduced.
- **Long-term flexibility:** in terms of the end-user being able to adapt storage and processing power as the business grows.
- **Better-coordinated security systems:** to minimise the risk of any company data being lost or stolen.
- **Time savings:** it does not require data back-up on individual computers (since it will automatically be stored on the Cloud application).

For the service providers, the servers can be located anywhere in the world, but often in countries with a favourable tax regime, lower costs or both.

Yet while its commercial benefits have been recognised for some time, the legal, regulatory and other risks that Cloud computing presents are only now beginning to be adequately explored and understood.

Risks

The potential purchase of Cloud computing services also brings into play, however, a host of contractual, intellectual property and data protection issues.

At the contractual level, providers of these services inevitably seek to limit their exposure.

The major providers in particular seek to keep their performance assurances and warranties to a minimum and retain their right to suspend their services at any time in case of “unanticipated” downtime or unavailability.

The “public” Cloud providers (i.e., those selling services to anyone on the Internet) seek indemnities against claims occurring as a result of information passed on their Cloud service which may have infringed a third party’s intellectual property rights.

Other common indemnities covering public, private and “hybrid” Clouds include: protecting suppliers against losses as a result of a customer’s breach of a services agreement, failure to secure their passwords or permitting a third party unauthorised access to the Cloud service.

Finally, many providers try to exclude liability for the security of any data and require that the **customer** retains full responsibility for data safety.

Customers must also address issues such as what will happen to company data located in the supplier’s data centres if the relationship is brought to an end and whether the service provider has any right to see and access customer data.

The centralisation of services can of course offer more scope for damage to customers if a Cloud data store should be compromised (as opposed to, for instance, a stand-alone server).

Customers should also be aware of the legal consequences of such data storage problems. There may be jurisdictional challenges arising out of security and privacy concerns; for instance, if one customer suffers from a data breach, who would investigate the potential crime (or civil offence)? Further, it would need to be addressed whether other companies’ data was also compromised and how that would impact on any investigations and wider jurisdictional issues.

Finally, the extent to which a customer has audit rights needs to be clarified. Equally, there needs to be careful management of third party access to data by means of, for instance, disclosure/discovery exercises in legal proceedings.

These are fundamental issues that the relevant regulators are already examining.

The UK’s Information Commissioner, who has the power to impose fines of up to £500,000 for breaches of the Data Protection Act 1998, has issued guidance on the storage of personal information on a third party’s equipment and has

advised that an entity must not relinquish control of the personal data they have collected or expose it to security risks that would not have arisen had the data remained in their possession in the UK.

The Commissioner has also noted that it is good practice to encrypt the data before it is transferred to the Cloud service provider, so as to render the data useless to hackers without the relevant “key”, irrespective of the jurisdiction it is in or who is processing it. The transfer of any “personal data” to, for example, the U.S. will (as it is outside the EEA) have to be subject to a data transfer agreement with the Cloud computing company and should comply with the Commissioner’s “good practice” recommendations.

At a wider level, the European Commission’s consultation on its approach to modernising EU data protection law closed on the 15th January 2011. The Commission specifically emphasised the new challenges for data protection posed by Cloud computing and new EU wide legislation is expected during 2011.

It is therefore clear that gaining access to the advantages of Cloud computing is not simply a question of calculating the financial benefits and entering into an appropriate agreement. For certain sections of the economy there are considerable hurdles to be overcome and satisfied if the perils of regulatory intervention, loss of reputation and substantial fines are to be avoided.

UK Regulatory Implications for the Financial Services Sector

Whilst the Commission’s approach to the challenges posed by “Cloud computing” continues to evolve, the financial services sector is presently subject to a mature, well-established regulatory environment which dictates its approach to participation in Cloud computing from planning through to the execution and delivery of services to private individuals and companies alike.

I.T. systems are at the core of the regulated financial services sector banking, investment and insurance. With regard specifically to the insurance industry, there are a number of key constraints on Cloud computing that are imposed upon (re) insurance companies and insurance intermediaries authorised by the UK’s Financial Services Authority (“FSA”).

The FSA’s rules have their origin in related EU Directives and, as a result, the principles addressed below can be expected to apply to a greater or lesser degree to regulated financial services firms in all 27 EEA states. They also provide a best practice template that can be adopted on a volun- / continued on page 8



Patrick Devine, Legal Consultant

Whilst our traditional London profile has been strongest in relation to claims management and dispute resolution, the London practice now also includes prominent practitioners in the fields of corporate, transactional regulatory and risk management work.

We profiled Heidi Lawson in our previous edition. Patrick Devine, Legal Consultant in the London office, is another key member of our growing team.

Patrick is a corporate insurance specialist with extensive experience advising insurance industry clients on a range of matters:

- corporate
- regulatory and compliance
- regulatory enforcement
- transactions including:
 - commercial agreements
 - contract interpretation
 - contract drafting
 - alternative risk transfer mechanisms, and
 - litigation support

Patrick’s recent core expertise includes advising on the establishment and operation of (re)insurance vehicles including all aspects of corporate governance, regulation, product development, distribution and exit strategies for start ups, branches, agencies, captives, mutuals, special purpose vehicles and intermediaries.

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tary basis by entities not subject to financial services regulation.

In essence, while a regulated firm may engage a Cloud service provider to undertake certain functions, the firm remains liable to ensure that those functions are carried out in accordance with the FSA's rules, even when undertaken by a Cloud service provider in another country.

The UK regulatory implications of Cloud computing include, but, are not limited to, obligations regarding:

- **Outsourcing:** rules relating to outsourcing generally, and the outsourcing of I.T. systems in particular, directly affect corporate governance and the terms of the contract with the Cloud services provider.
- **Systems and Controls:** all regulated firms are under an overarching obligation to maintain such effective "systems and controls" as are appropriate to their business. Failure to do so can lead to direct regulatory intervention.
- **Record Keeping:** regulated firms are subject to specific rules regarding the maintenance of appropriate records and access to them, including access by the FSA.
- **Disaster Recovery — Business Interruption:** there are further obligations regarding disaster recovery and access to records where there has been a critical systems failure. These should be built in to the service level agreement with the Cloud service provider.

Outsourcing

A firm cannot contract out of its regulatory obligations by delegating them to the Cloud service provider and firms are required to take reasonable care to supervise the discharge of outsourced functions, including undertaking due diligence on the Cloud service provider before entering into a contract. The firm must also be able to demonstrate proper contractual arrangements for smooth transition to new or changed outsourcing arrangements.

Material Outsourcing

Further, a regulated firm must notify the FSA *before* it enters into a "material outsourcing" arrangement.

Substantive outsourced I.T. services can be expected to constitute "material outsourcing" where the services are of such importance that any structural weakness or failure would cast serious doubt on the firm's ability to satisfy its licensing requirements or the FSA's Principles for Business, such as the failure to maintain adequate "systems and controls".

Cloud service providers operating under "material outsourcing" arrangements must permit access by the FSA to inspect their business premises and this must be clearly included in the terms of the contract with the regulated firm.

There are, in addition, specific rules dealing with the outsourcing of individual activities, such as claims handling, and obligations to maintain proper supervision of the Cloud service provider.

Systems and Controls

Insurers and other FSA regulated entities must obtain sufficient information from the Cloud service provider to enable the insurer to assess the impact of outsourcing on its current "systems and controls" and to maintain appropriate arrangements to ensure that it can continue to function and meet its regulatory obligations in the event of an unforeseen interruption. By the same token, the insurer is obliged to review and consider the adequacy of the staffing arrangements and policies of the service provider and to notify the FSA of any significant failure in the Cloud service provider's systems and controls.

The insurer will also need to be able to satisfy itself that the Cloud service provider is capable of managing I.T. system risks, including confidentiality, firewall entry restrictions and verification of identity.

Remote Services

Maintaining operating processes and systems at separate geographic locations and using alternative sites for the continuity of operations may alter a firm's operational risk profile. FSA regulated firms need to understand the effect of any differences in processes and systems at each of its locations, particularly if they are in different countries. In doing so, they should also understand business operating environment of each country, for example, the likelihood and impact of political disruptions or cultural differences on the provision of services as well as the relevant local regulatory and other requirements regarding data protection and transfer.

Firms also need in particular to develop and maintain an understanding of:

- The extent to which local regulatory and other requirements may restrict their ability to meet their regulatory obligations in the UK (for example, access to information by the FSA and local restrictions on internal or external audit due to restrictions on access) and the timeliness of information flows to and from headquarters, and
- Whether the level of delegated authority and the risk management structures of the overseas operation are compatible with the firm's head office arrangements.

Record keeping

The FSA requires both a firm and its Cloud service provider to protect the processing and security of its information and each should have regard to established security standards such as ISO 17799 (Information Security Management). The Cloud service provider will be required to show at all times that it complies with this or an equivalent standard.

Disaster Recovery / Business Interruption

An FSA regulated firm is similarly required to consider the impact of a disruption to the continuity of its operations from unexpected events, including the loss or corruption of its information. To address this, appropriate protections must be put in place in order to provide adequate risk management systems and insurance. Failure by the Cloud service provider to demonstrate that it can discharge these obligations will mean that the insurer will be unable to use its services without facing sanction by the FSA.


There is a clear body of rules and standards to which regulated financial services firms are subject and which are relevant to Cloud service providers by proxy. In common with regulators elsewhere, the FSA in the UK has formally adopted a more intensive and intrusive approach to supervision. One company was recently fined £2,275,000 for failing to maintain adequate systems and controls to prevent the loss of customers' confidential information.

The Solvency II Directive, which is due to enter into force in January 2013, also contains several provisions dealing with outsourced functions and activities. Firms will be required to have written policies relating to outsourcing setting out the goals, reporting procedures and processes to be applied. It is recommended that firms maintain sufficient in-house expertise

to determine whether the service provider is delivering according to contract.

As Cloud computing becomes increasingly common in the business environment, additional regulatory attention can be expected. Regulated entities should be conscious, at all times, of their legal and regulatory obligations, whilst Cloud service providers should be able to demonstrate both their willingness and ability to provide a service that is consistent with such customers' obligations.

Should you require any further information on the matters addressed in this article, please contact the author at pdevine@chadbourne.com.

The FSA's rules on outsourcing may be viewed at <http://fsahandbook.info/FSA/html/handbook/sysc/13/9> 

The insured's post-contractual duty of good faith under English and Scottish law: an update on reform proposals

by Rebecca Huggins

The case for reform

The insurance industry has, in recent years, been a key focus of attention for the English and Scottish Law Commissions (the "Law Commissions"). As a result, a number of "issues papers" have been produced with the aim of clarifying and, in some instances, proposing reforms to the existing insurance law.

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Good Faith

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One example of the latter relates to the imposition on an insured party of a continuing duty of good faith after a contract has been executed, in particular, a duty to act honestly when making a claim under the contract. The scope of the duty continues to be the subject of debate amongst judges and others — hence, the drive for reform.

Since the cost of insurance fraud has recently been estimated at £5.2 million per day in the UK¹, and this adds around £44 per year to the insurance costs of every UK household, this is a key issue both for insurers and insureds.

It has been suggested by some commentators that there is a moral ambivalence about insurance fraud, and that many people who would consider themselves to be honest would not, for instance, consider that “exaggerating” an insurance claim is fraudulent. This may partly be the result of the fact that most insurance fraud takes place on a relatively small scale, so although it is a criminal offence, it is not seen as a priority for police attention and is therefore rarely met with criminal sanctions. The Law Commissions’ report acknowledges this fact and seeks instead to improve the civil law position, so that insurers might have a clearer legal framework to deal with potentially fraudulent claims.

What is “fraud” in this context?

In a well-known 19th century case², fraud was described as follows: “*Fraud is proved when it is shown that a false representation has been made (1) knowingly, or (2) without belief in its truth, or (3) recklessly, careless whether it be true or false*”.

In their July 2010 “Issues Paper 7” on the subject of “The Insured’s Post-Contract Duty of Good Faith”, the Law Commissions identified six possible categories of fraudulent claims: (1) where there is, in fact, no loss, (2) where the loss is deliberately caused by the insured, who then represents falsely that the loss was caused by an insured event, (3) where the claim includes elements of genuine loss as well as false items, (4) where the loss is genuine but its value is exaggerated, (5) where the claim is presented in such a way as to disguise the fact that the insurer might have a defence to the claim, and (6) where fraudulent means are used to improve the prospects of recovery for an otherwise genuine claim. These categories are not, of course, mutually exclusive.

As to the meaning of “fraud”, the Law Commissions adopted the definition suggested by Professor Malcolm Clarke, namely that fraud must be “*substantial, wilful and material*”.

“Substantial” for these purposes means anything other than *de minimis* claim values.

The current legal position

It is possible for parties to extend in their contract the usual statutory and common law remedies available for fraud. Many insurance contracts, for instance, contain an express term prohibiting fraudulent claims and setting out the consequences of making one. Usually, the consequences are that the insured forfeits all benefits under the contract.

If there is no express term, however, the law appears less clear as to the remedies available to the insurer.

As set out in section 17 of the Marine Insurance Act 1906, insurance contracts are contracts of utmost good faith. In principle, if an insured acts dishonestly in making a claim and is deemed therefore to have breached the duty of utmost good faith, the insurer should be entitled to avoid the contract in its entirety. The English (and Scottish) courts have tended to shy away from this logic, however, in particular given the “disproportionate” impact on earlier, valid claims. Although confusion remains in the recent case law, the stronger view (based on Court of Appeal authority) appears to be that (1) if any part of a claim is fraudulent, no element of that claim is recoverable but (2) the contract itself remains in place and (3) any previous claims made in good faith are not affected.

In the most recent case relevant to these issues³, concerning a subsidence claim under a buildings insurance cover, the Judge found that the policyholder had acted fraudulently in seeking to claim the cost of renting alternative accommodation that (unknown to the insurer) he in fact owned and was vacant. As a consequence, the whole claim was forfeited, including genuine items relating to the cost of repair to the subsiding property.

One of the stated objectives of the Law Commissions, understandably, is to seek a uniform position on the impact (if any) of section 17 of the Marine Insurance Act 1906 in the context of such fraudulent claims.

The proposed reforms

The Law Commissions propose, as a general matter, that commercial law in the UK should be coherent, principled and fair in order to be justifiable to an international audience.

¹ Association of British Insurers Report, July 2009

² *Derry v Peek* (1889) LR 14 App Cas 337

³ *Aviva Insurance Ltd v Roger George Brown* [2011] EWHC 362 (QB)

As a consequence, the Law Commissions' view is that legislation is required to clarify the position and, as appropriate, to amend section 17 of the Marine Insurance Act 1906. They consider that not only would this reduce the number of disputes, but, if the rules and potential penalties for making fraudulent claims were made clearer, this should act as a more effective deterrent in the future.

The Law Commissions' tentative conclusions in their Issues Paper are that:

- forfeiture of the fraudulent claim is the correct remedy,
- previous honest claims should not be affected,
- while a fraudulent claim **should** give the insurer the right to terminate the contract, this should not prejudice a valid claim arising between the fraud and termination, and
- an insurer should, in principle, be able to recover the reasonable costs of investigating a fraudulent claim from the insured.

The Law Commissions recognise, however, the added complexities arising in the context of, for instance, co-insurance. If the policy is expressed or deemed to be a joint (as opposed to "composite") cover, the parties' rights are inseparable. If a co-insured is found to have acted fraudulently, an honest co-insured is equally unable to recover in relation to any claim they put forward. To deal with this, the Law Commissions propose that there is a rebuttable presumption that any fraud committed by one co-insured is done on behalf of all parties, i.e., only if the honest insured can demonstrate that he was not party to the fraud, can he recover his loss.

The Law Commissions also reviewed the impact of proposed reforms on group insurance, for example, where an employer takes out a long-term policy for the benefit of all employees. If the employer, as policyholder, makes a fraudulent claim, then the usual remedies for fraudulent claims would apply; but individual employees are not policyholders and are not, in principle, subject to the same penalties. The Law Commissions propose that **each** group member should be treated as a party to the contract, so that a fraudulent claim can be dismissed.

The Law Commissions additionally considered the separate issue of whether insureds have a continuing duty to report changes which may increase the risk of loss. In Continental European insurance policies, which usually have a period of cover lasting several years, an insurer may refuse payment of a

claim where the loss was caused by a change in the risk which was not reported. In the UK, where policies are more commonly written on an annual basis, absent an express term in the policy, there is no ongoing duty to report and, where there is an express term in the policy, courts have tended to interpret this restrictively.

The Law Commissions addressed a series of questions seeking responses from interested parties on a range of related issues, including the above points.

Responses to the consultation exercise

By October 2010, the Law Commissions had received 33 responses, including from the Association of British Insurers, the Bar Council, the British Insurance Law Association, the Financial Services Authority, the Lloyd's Market Association and significant company market players, as well as academics. The vast majority agreed that the law in this area is unnecessarily complex and that it would be helpful to introduce legislation to clarify once and for all the remedies for fraudulent claims.

As to their responses:

- All but three respondents agreed that, even in the absence of an express term, insureds should be under a duty not to make a fraudulent claim and that this should be set out in statute with the remedy specified.
- Further, all but one respondent agreed that forfeiture of the tainted claim was the appropriate remedy, although it was suggested by two respondents that the courts should be able to retain some discretion in this regard.
- A majority additionally agreed that a fraudulent claim should not affect previous valid claims, although a minority took the view that there was "value" in retaining avoidance as a potential remedy in "extreme" cases.
- In relation to **future** claims, many respondents considered that fraud "*undermined the necessary trust between the parties*" and that the contract should be terminated.
- Generally, there was strong support for the proposal that an insurer should be able to recover the reasonable costs of investigating a fraudulent claim from a fraudulent insured, and it was noted that such sums can be significant. It was also considered that even if pursuing an insured for such costs would be rare and impractical, the possibility of recovering them would further */ continued on page 12*

Good Faith

continued from page 11

emphasise the potential downside of any fraud and would act as an additional deterrent.

- Most of the respondents supported the proposals concerning joint insurance, although many recognised potential practical difficulties of proof for honest insureds.
- Turning to group insurance, all but one respondent agreed that an insurer should have the same remedies against any group member as it would ordinarily have against the actual policyholder in the event of a fraudulent claim, although there was uncertainty as to how this would operate in practice.
- On the scope of the ongoing duty to disclose “material” changes in the risk, most respondents considered that clauses dealing with this should be interpreted restrictively. Equally, most did not consider it necessary to adopt the Continental European approach.
- Finally, in relation to the question of the application of a general duty of good faith, 68% of respondents thought that the duty should apply both before and after inception of the cover in the absence of express terms dealing with it, on the basis that disclosure is a unique feature of insurance contracts and “*a fluid duty of good faith was appropriate to ensure adequate protection*”. There was some strenuous opposition to this, however, from those respondents who consider that it is outdated and that as it does not apply to other commercial contracts, it should have no place in insurance contracts (or at least absent any express term).

Following the Issues Paper and the responses, the Law Commissions are developing further their proposals on fraudulent claims, and intend to publish a joint Consultation Paper during 2011. So while reform of this area of law seems likely, it will still take some time for the law to be clarified fully. Watch this space!

Should you require any further information on the matters addressed in this article, please do not hesitate to contact the author at rhuggins@chadbourne.com. ©

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