

Insurance and Reinsurance Review

June 2010

Eruptions and Disruption But No Indemnification

This article explains the liability faced by air carriers arising out of the closure of most of Europe's airspace for six days in April 2010, the lack of insurance to cover that loss and the new products being considered to cover such eventualities in future.

Europe is now reflecting on the lessons to be learned from the closure of most of its airspace for almost a week as a result of the eruption of Iceland's Eyjafjallajökull volcano that had been dormant for over 200 years. Whilst many will focus on the role of governments and regulators in closing the airspace, much has also been said and written about the losses suffered by airlines and the lack of available insurance to cover that loss, as well as the losses of hundreds of thousands stranded travellers. The International Air Transport Association's (IATA) estimate of the cost to the worldwide airline industry is US\$1.7 billion.

Insurance for Stranded Travellers

The usual reaction of a traveller faced with the

effects of a natural disaster is to look to their travel insurer to provide indemnity for their losses. However, it is rare that the terms of the insurance are read before the cover is called upon and this results in a mismatch between the expectations of the insured and the cover they have purchased. While the media often paints insurers as the villain, this does not reflect the fact that the insurance was priced to cover the specified perils. There are three matters of which potential claimants should be aware:

- Coverage is triggered under most policies following a delay caused by (a) strike, civil commotion, riot, or (b) mechanical failure or breakdown of the relevant public transport, or (c) weather. Under ordinary rules of interpretation, it is unlikely that volcanic ash in the atmosphere would be treated as a weather phenomenon. It may nevertheless be argued that weather is synonymous with atmospheric or meteorological conditions, which should include changes caused by volcanic ash.
- Cover is often excluded where the withdrawal of public transport is by order or recommendation of a regulatory authority or government. Policies with such a provision would bar coverage in this instance. This exclusion is often present in delay and cancellation or curtailment insurance (where a trip is cancelled or curtailed prior to departure).
- The available limits of cover will almost always be insufficient to cover the actual loss incurred and will usually provide a fixed benefit up to a few hundred pounds. Accordingly, even if the claim is covered, the insurance is likely to provide a partial indemnity only.

Insurance and Reinsurance Practice

New Attorneys

We are pleased to demonstrate the commitment of EAPD to its international insurance and reinsurance practice, as illustrated by two recent high-level hires:

Francis Mackie joined EAPD's London office as a Partner in June 2010, bringing with him a wealth of knowledge and experience in contentious insurance and reinsurance matters.

Eric Hermanson joined EAPD's Boston office as a Counsel in May 2010, adding strength in the areas of insurance and reinsurance coverage, commercial tort, construction defects and environmental and product liability litigation.

In addition, four Associates have joined the Department in Boston and New York this month.

INSURE

REINSURE

EDWARDS
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REALLY SURE

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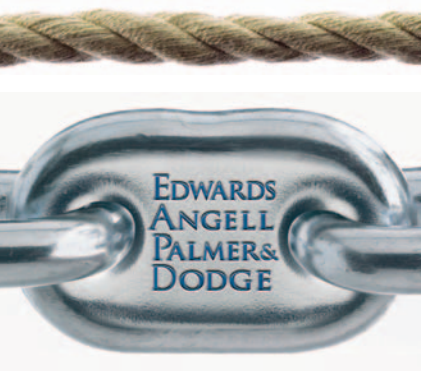
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By Mark Meyer
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“Notwithstanding the pitfalls, captive insurance structures can provide greater flexibility than traditional insurance arrangements.”

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The Liability of Air Carriers

The European Union (EU) brought in legislation across Member States in February 2005 providing care and compensation for passengers affected by flight cancellations, delay or denied boarding (EC Regulation 261/2004). The Regulation applies to community carriers, ie carriers licenced in any Member State, and to non-community carriers for cancelled flights from the country of a Member State. There are two elements to the compensation for a cancelled flight: the necessity to provide hotel accommodation, meals, travel to the airport and reimbursements of certain phone or internet costs (referred to as care) and monetary compensation of up to 600 Euros per passenger depending on the length of the flight. The second element of the compensation is subject to an “exceptional circumstances” defence, which almost certainly applied in this instance. The first element applied to all cancelled flights and airlines cannot contract out of it. It is a mandatory provision. Airlines are also obliged to provide written notice of the compensation available to passengers. The results of this provision can be arbitrary. For example, a British Airways passenger stranded in San Francisco receives the benefit of this Regulation. Had the passenger flown on a US carrier, the Regulation would not apply. However, a passenger that had flown on a US carrier to London and then had the return flight cancelled would fall within the Regulation, as the affected flight was to depart from an airport within the EU. Airlines face criminal sanctions if they fail to comply with the Regulation. It is usually the Civil Aviation Authority in the relevant EU country that is tasked with enforcement.

Airline Insurance

Generally, airline liability policies require some form of legal liability to passengers for bodily injury or death and/or property damage. That was absent in this instance and it is very unlikely that the standard airline liability coverages would be triggered.

Many airlines purchase Business Interruption (BI) insurance, but such policies almost always also require some form of property damage to be triggered. Coverage for airline BI was in the spotlight following the attacks of September 11 2001, and the contrasting experiences of United Airlines and US Airways are informative. The US Federal Aviation Administration ordered the closure of Washington’s Reagan National Airport in the immediate aftermath of the World Trade Center attacks, fearing that the US Capitol may be attacked. The airport was closed prior to the attack at the Pentagon. As a result of the closure, both airlines claimed for lost income under their BI policies. United failed to recover under its policy but US Airways did recover. The contrasting outcomes were the result of nuances in their respective wordings. United’s policy was triggered if access to the insured’s property was prohibited by order of a civil authority as a direct result of “damage to adjacent premises”. The US

Airways’ policy provided coverage if access to the insured’s property was prohibited by order of a civil authority “as a direct result of a peril insured against”. Understandably, the Federal Appeals Court in the United case did not consider the Pentagon (a building 3 miles away) to be adjacent to United’s property. Conversely, a Virginia State Court concluded that US Airways’ policy did not require actual damage or loss of the insured’s property to invoke coverage but only the risk of actual damage. The closure of the airport was due to the risk of an imminent attack at the airport which housed US Airways’ property.

The Market Response

It is unprecedented for airlines to incur a US\$1.7billion loss from a single occurrence and find that there is no insurance to compensate the loss. This has produced a rush to develop a policy that might respond to a similar natural catastrophe in the future at a price that is affordable and provides reasonable coverage.

In this section, we consider the key provisions that might be included in such coverage and how the policy could be structured to make it more affordable.

Scope of Cover

Brokers have offered BI insurance to aviation companies for many years and will be cognisant of the key provisions of such cover. It is nevertheless to be expected that such policies will need to be tailored to the risk posed by volcanic eruptions and other events that prevent an airline flying its planes. The key provisions for such policies are as follows:

- Coverage triggers should not be linked to physical damage but to an event or occurrence resulting in a necessary ban or suspension of flights. The way this is expressed is not necessarily encompassed by force majeure, which may be interpreted as covering events like severe weather or industrial action. Many insurers will not want to cover such perils but instead limit coverage to natural events. Also, the wording should address whether cover is triggered as a result of a prohibition against using airspace or perhaps a lesser standard of the airspace being impaired by closure or the withdrawal of air control services in a region that ordinarily provides such service. This would cover the situation that occurred over Europe, where there was no legal bar to flying but no air traffic control was provided, effectively grounding all commercial flights. One might also consider whether cover should be triggered by the inability to operate from a serviced airfield due to regulatory restrictions, eg avian flu.
- A waiting period after which coverage is triggered, eg 48 hours. This would reflect ISO wording for BI policies.
- A limitation on the period of closure for which cover is available.

- Extra expense coverage – the cost of “caring for” passengers and/or compensating them pursuant to a legal obligation on an air carrier and the cost of operating extra flights to return stranded passengers to their destinations.
- Denied ingress/egress cover.
- An agreed methodology for calculating how the loss is valued, eg a combination of the airline’s revenue per passenger mile and revenue per available seat mile.
- Confidential arbitration to resolve disputes within a specified timeframe.

The Use of a Captive or Mutual Insurer

One of the limitations on buying BI insurance as outlined above is the perceived expense of such cover and many in the market believe that the cost of a policy for force majeure-type situations would be prohibitive. An effective method of reducing premium costs is the use of a captive insurer and this model has been employed successfully in other lines of insurance business. However, it is not without difficulties. The advantages of a captive insurance structure are clear. It retains the profit that might be made in a traditional insurance arrangement within the group of companies setting it up and any underwriting surplus can be retained to increase capacity in the future. Also, it allows investment income to be earned on the premiums paid, the capital payments setting up the captive are tax deductible and if suitably located, the captive will benefit from favourable tax and regulatory regimes. For example, IATA member carriers (and perhaps the Airports Council International) could set up an off-shore captive insurer to cover force majeure and/or natural catastrophes. The captive would offer specified limits of cover which may need to scale depending on claim volumes. The captive is likely to require extensive reinsurance in the early years and that reinsurance may well have a high attachment point. The terms of cover provided by the captive are likely to be broader than those provided under traditional BI policies. Above the captive’s policy limits, carriers or airports could buy high level excess cover.

Other benefits of using a captive include:

- a reduced risk of “moral hazard”, as there is an obvious incentive on covered parties to minimise their loss.
- it is more likely that the wording used will be sufficiently broad to cover the perils for which cover is sought, but it will need to be acceptable to reinsurers.
- there is less likelihood of disputes over what it is intended to be covered.

As with all types of insurance or reinsurance, there are pitfalls. The captive is a company in its own right and its directors will owe fiduciary duties to it. Accordingly, premiums will need to be commercially priced. There will be substantial start up costs together with the cost of capitalising the captive and installing a professional management team. The financing would need to come from the policyholders. The captive would also be heavily exposed to risk aggregation, whereas commercial insurers are spread over many companies and lines of business.

Reinsurance purchased by the captive would need to be “as original” or “back to back”. However, specific words of incorporation would be needed to ensure that jurisdiction and choice of law provisions are the same as between the captive’s policy and the reinsurance. The notice and claims co-operation provisions in the reinsurance will need to be adapted to reflect the captive structure. One might also consider including a “conflicts of interpretation” clause and a payment obligation under the reinsurance on the day the captive makes payment. Notwithstanding the pitfalls, captive insurance structures can provide greater flexibility than traditional insurance arrangements.

Insurance is nothing if not responsive to the commercial environment and the challenge posed by the eruption in Iceland has set the global insurance market the challenge of finding a solution. It is only a matter of time until it does so.

VIDEO PRESENTATION

International Public Company D&O: *Status & Trends* – Canada

Class action securities claims are a perennial topic of interest for attorneys and companies around the world and across industries.

To learn more on the recent Canadian experience in class action securities claims, please visit: <http://www.insurereinsurevideos.com/> for a video presentation by EAPD’s **Mary-Pat Cormier** presenting her paper on International Public Company D&O: *Status & Trends* - Canada.

Securities class action claims are new to Canada. The recent addition of provisions in certain provinces’ Securities Acts has created the ability of plaintiffs to file class actions for continuous disclosure obligations in connection with publicly traded securities.

These statutory changes, coupled with recent Canadian decisions interpreting these new laws, including *Silver v. IMAX Corp.*, *Green v. CIBC*, and *McKenna v. Gammon Gold, Inc.*, serve as a wake-up call for Canadian companies that trade on any Canadian or U.S. stock exchange. This presentation provides details on the types of claims that these companies are now facing in the wake of these changes, including the shift of allegations in securities class action filings over the past few years.

EAPD London Office Move

1 June 2010 - EAPD’s UK (London) Office Moves to the Centre of the City

Our London office has moved from its previous premises on Fetter Lane to a newly-renovated building - Dashwood - which is in the heart of the City of London.

This move was driven by a desire to move us closer to where many of our London clients operate and to provide space for the expansion of our London teams. It was also motivated by our firm’s strong commitment to the environment (Dashwood is a green, low-energy building with an ‘Excellent’ BREEAM (BRE Environmental Assessment Method) rating, the highest available).

Our address effective 1 June 2010 is:

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By James A. Shanman and
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Issues Arising from Reinsurance of Captives

Reinsurance of captive insurers may present a variety of issues not usually present in the reinsurance of non-captive entities. These issues may appear at every stage of a reinsurance transaction from placement to claims handling, payment or rejection of a claim, and resolution of a dispute. There is little U.S. law specifically relevant to these issues to provide guidance. In this article, however, we suggest some questions for consideration and some possible practical solutions.

In considering the issues, it is important to keep in mind that “captives” are not a homogeneous group, and that much depends upon the factual context. Thus, there are a number of different types of captives; for example, single owner captives, group captives and association or industry captives. Depending on its ownership structure and purpose, a captive may have substantial underwriting expertise and rigorous underwriting standards, or it may accept whatever business comes its way from its parent(s). Similarly, a captive may have a professional claims-handling staff with well-defined procedures for investigation and payment, or the handling of claims may be largely a function fulfilled by the parent or parents or by a third-party administrator (TPA). In other words, insurance by a captive may be a totally arm’s-length transaction, or it may fall considerably short of that standard.

Placement Issues

Implicit within the duty of utmost good faith, which is applicable to every reinsurance transaction, are various disclosure obligations in connection with placement of the risk.¹ In most reinsurance transactions, this duty to disclose falls solely upon the cedent; the underlying policyholder has no duty to the reinsurer (although it certainly has such a duty to its insurer).² In the captive case, however, where the underlying policyholder and its insurer, the ceding captive, are related, and the policy has not been underwritten on an arm’s-length basis, does the policyholder then assume a direct duty of disclosure to the reinsurer?

Consider the following hypothetical. A reinsurer of a captive cedent seeks to avoid payment of a claim on the ground that material information concerning the risk was withheld from it at the time of placement. The withheld information, however, was never in the possession of the cedent; rather, it was withheld from the cedent by its parent policyholder. In this situation, does the reinsurer have a valid defense to the claim, or does the duty of utmost good faith devolve only upon the cedent, despite the fact that it is a captive? If our hypothetical situation did not involve a parent and captive, the answer would be fairly simple. If the cedent neither knew nor had reason to know

that information had been withheld by its insured, it might have a defense to payment of a claim, but that defense would not benefit the reinsurer if the cedent, in good faith, decided to pay the claim. Therefore, the issue is whether that result might be changed if the cedent is a captive of the original insured.

In the absence of any case law on point, a number of approaches might be applicable. For example, a court or arbitration panel might simply decide that the reinsurer took its chances by failing to underwrite the risk properly. Under some circumstances, the captive cedent might be viewed as simply an agent for the parent insured.³ Or an arbitration panel - not bound by strict rules of law - might simply ignore the corporate formalities as a matter of equity.

The imposition of a duty of disclosure on the insured parent, however, might lead to problems for the reinsurer. In the typical reinsurance transaction, there is no privity of contract between an underlying insured and a reinsurer, and thus the insured has no direct right of action against the reinsurer.⁴ The relatively few cases that hold otherwise generally involve situations where the reinsurer becomes directly involved in the handling of an insured’s claim or otherwise has direct interaction with an insured.⁵ If an insured is held to have a direct duty to a reinsurer, it could be argued that that duty might provide the missing privity of contract and thus allow the insured to sue the reinsurer directly.

Also, from the standpoint of the reinsurer, since it is well known that the issuance of policies by captives to their parents is sometimes done on something less than an arm’s-length underwriting basis, is there a duty to inquire how and by whom the reinsured risks were underwritten? In theory at least, the duty to disclose material underwriting information in utmost good faith is absolute. However, whatever a court might decide, and we are aware of no U.S. case law on this issue, in an arbitration – the forum in which most reinsurance disputes are decided – it is entirely possible that a panel would be reluctant to grant relief to a reinsurer who knew or could easily have discovered that its captive cedent had not rigorously underwritten the risk but, without inquiry, nonetheless assumed that risk.

Endnotes

1. See, e.g., *Compagnie De Reassurance D’ile De France, et al., v. New England Reinsurance Corp., et al.*, 57 F.3d 56, 80 (1st Cir.1995); *Christiania General Ins. Corp. of New York v. Great American Ins. Co.*, 979 F.2d 268, 278-79 (2d Cir.1992).
2. *Republic Ins. Co. v. Masters, Mates & Pilots Pension Plan*, 77 F.3d 48 (2d Cir.1996).
3. A third party generally has no action against an agent in a disclosed principal situation because the contract is with the principal. *Citibank v. Nyland Ltd.*, 878 F.2d 620, 624 (2d Cir.1989) (citations omitted).
4. *Travelers Indem. Co. v. Scor Reinsurance Co.*, 62 F.3d 74 (2d Cir.1995).
5. See *Allstate Ins. Co. v. Administratia Asigurarilor De Stat*, 948 F. Supp. 285, 307-08 (S.D.N.Y.1996).
6. *Commonwealth Ins. Co. v. Thomas A. Greene & Co.*, 709 F. Supp. 86, 88 (S.D.N.Y.1989) (holding that the reinsurance intermediary owes a duty of utmost good faith to each of the parties in the reinsurance relationship).
7. *North River Ins. Co. v. Philadelphia Reins. Corp.*, 797 F. Supp. 363, 369 (D.N.J.1992).
8. *Compagnie De Reassurance D’ile De France v. New England Reinsurance Corp.*, 57 F.3d 56, 74-75; 1995 U.S. App. LEXIS 15037 (1st Cir.1995).
9. Fed. R. Civ. P. 19.
10. Fed. R. Civ. P. 45.
11. See, e.g., *Life Receivables Trust v. Syndicate 102 at Lloyd’s of London*, No. 07-cv-1197 (2d Cir. Nov. 25, 2008); *Hay Group v. E.B.S. Acquisition Group*, 360 F.3d 404, 407 (2d Cir. 2004); *Matria Healthcare, LLC, et al. v. Duthie, et al.*, No. 08-cv-5090 (N.D. Ill. Oct. 6, 2008); *Atmel Corp. v. LM Ericsson Telefon*, 371 F. Supp. 2d 402 (S.D.N.Y. 2005); *Odjfell ASA v. Celanese AG*, 328 F. Supp. 2d 505 (S.D.N.Y. 2004); *In re Arbitration Between The Proctor and Gamble Co. and Allianz Ins. Co.*, 2003 U.S. Dist. LEXIS 26025, at *5 (S.D.N.Y. Dec. 3, 2002).
12. See, e.g., *In re Sec. Life Insurance Co. of Am.*, 228 F.3d 865, 870-71 (8th Cir. 2000); *Am. Fed’n of Television and Radio Artists, AFL-CIO v. WJBK-TV*, 164 F. 3d 1004, 1009 (6th Cir.1999); *Festus & Helen Stacy Foundation v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 432 F. Supp. 2d 1375, 1379 (N.D. Ga. 2006); compare *Hay Group, Inc.*, 360 F.3d at 408, 410-11; *Liberty Mut. Ins. Co. v. White Mountains Ins. Group Ltd.*, No. 06-11901 (D. Mass. Feb. 28, 2007), reported in Mealey’s Reporter: Reinsurance, Volume 17, Issue 22, March 22, 2007.
13. See *Mentor Ins. Co. v. Brankasse*, 996 F.2d 506, 517 (2d Cir. 1993).
14. *Independence Insurance Co. v. Republic National Life Insurance Co.*, 447 S.W.2d 462 (Tex. Civ. App. 1969).
15. *Michigan Millers Mutual Insurance Co. v. North America Reinsurance Corp.*, 182 Mich. App. 410, 452 N.W.2d 841 (1990).
16. *Thomson-CSF, S.A. v. Am. Arbitration Ass’n*, 64 F.3d 773, 776 (2d Cir.1995).
17. *ACE American Ins. Co. v. Huntsman Corp.*, 255 F.R.D. 179; 2008 U.S. Dist. LEXIS 74431 (S.D. Tex. 2008).

In the same vein, if a broker is involved in the transaction, does the broker have a duty to inquire as to how the risk was underwritten?⁶

Claims Issues

A cedent clearly has a duty to cooperate with the reinsurer in the handling of a claim.⁷ This duty may be expressed through a formal claims cooperation clause, a notice of loss clause, an access to records clause and/or a clause giving the reinsurer the right to associate in defense of a claim. However, in a captive situation, the captive cedent may be unable to offer effective cooperation with its reinsurer, even if it wishes to do so. The underwriting and claims records may be in the hands of its parent or a TPA; similarly, the claim may actually be handled by the parent rather than the captive. It might be argued that if the captive entered into a reinsurance agreement providing for these duties, knowing that it would be unable to fulfill them, there has been a breach of the duty of utmost good faith.⁸ Conversely, the situation might be such that it could be argued the reinsurer had forfeited any right to cooperation by entering into a contract when it knew that the other party was incapable of extending the necessary cooperation.

In this situation, there are a number of possible strategies a reinsurer might employ. First, if the matter is in litigation, it might seek to join the parent insured or TPA as a party, assuming there is a basis for jurisdiction.⁹ This might also be accomplished in an arbitration but, as we explore below, the prospects of joining in an arbitration a party who has not agreed in writing to arbitrate is uncertain. Assuming the parent can not be joined, it may be possible to obtain information from it through third-party discovery. Third-party discovery is, of course, normally available in litigation, but in arbitration there is less certainty.¹⁰ Some federal courts have upheld the right of arbitrators to subpoena non-parties for pre-hearing depositions under the Federal Arbitration Act; others have held there is no such right.¹¹ Similarly, the courts are split on whether an arbitration panel can order pre-hearing document discovery from non-parties.¹² Finally, a reinsurer might attempt to get an order from the court or arbitration panel requiring the captive to seek the necessary information from its parent or TPA. However, the prospects for obtaining such an order are uncertain, and it is equally uncertain what sanctions, if any, can be imposed upon the captive cedent if it can show that it is legitimately unable to comply.

Follow the Settlements

The follow the settlements (or follow the fortunes) doctrine requires a reinsurer to

pay claims submitted by its cedent as long as those claims are within the terms of the underlying policy and the reinsurance agreement and the claim was resolved in good faith and in a business-like manner.¹³ An unwritten premise of the doctrine is that the cedent and its insured deal with each other in a professional manner at arm's length.¹⁴ For example, if a cedent settles a claim that has no merit for the sole reason of enhancing its business relationship with its insured, follow the settlements should not require payment by the reinsured. Thus, it is often said that the doctrine requires the reinsurer to follow the insurance fortunes of its cedent, not its overall business fortunes.¹⁵

There are a number of possible follow the settlements issues that may emerge from reinsurance of a captive. For example, in settling a claim, did the captive exercise its own informed, professional judgment or did it, in essence, follow the instructions of its parent? Indeed, was the captive substantially involved in settlement of the claim or was that handled by the risk management department of the parent or a TPA retained by the parent? Similarly, there are issues regarding burden of proof. Generally, the reinsurer will have the burden of demonstrating that it should not be bound by follow the fortunes. However, in the captive situation where, for example, the claim was in reality handled by the parent or a TPA reporting to the parent, it might be argued that the burden of proof should be shifted to the captive cedent to demonstrate that the claim was in fact handled in a good faith and business-like manner.

We are speaking here of claims settlements that are not a product of outright collusion between the parent and captive. If in fact there was such collusion, presumably the reinsurer should prevail.

Compelling the Parent to Arbitrate

The parent is not a party to the reinsurance agreements between the captive and its reinsurers and would not ordinarily have the right or obligation to arbitrate pursuant to the reinsurance agreements. However, courts have explained that parties who are not signatories to an arbitration agreement may be required to arbitrate under certain circumstances. Six theories for binding a nonsignatory to an arbitration agreement have been recognized: (a) incorporation by reference; (b) assumption; (c) agency; (d) veil-piercing/alter ego; (e) estoppel; and (f) third-party beneficiary.¹⁶

In a recent case,¹⁷ the court found that the reinsurers had alleged facts that would support the theory that the parent acted to receive direct benefits from the reinsurance certificates in

ways that would support applying direct-benefits estoppel, such as relying on the signatories' performance of the contract containing the arbitration clause, asserting that monetary compensation is owed under the contract with the arbitration clause and receiving monetary compensation flowing from obligations under the contract with the arbitration clause. The reinsurers' allegations that the parent dealt directly with the reinsurers and sought payment directly under the reinsurance certificates alleged a plausible basis for the reinsurers to show that the parent received direct benefits under the reinsurance certificates and could be bound to the arbitration clause.

Regardless of whether or not one of the exceptions applies, the dispute itself must be arbitrable under the relevant contract. Arbitration clauses vary considerably in scope and a narrow arbitration clause may not cover all the claims in a consolidated arbitration.

Steps for the Reinsurer

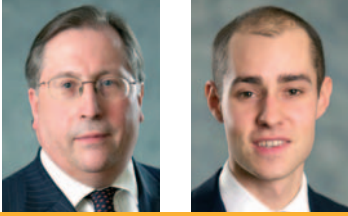
Given the uncertainties that are frequently inherent in reinsurance of a captive, it will be prudent for the reinsurer to take whatever steps are necessary to protect itself under the circumstances. First, the reinsurer must investigate the situation thoroughly and satisfy itself that it has all relevant information, both as to the risk and the claims handling process. Second, if possible, the reinsurer should consider attempting to make the parent insured a party to the agreement and, in the agreement, clarify the responsibility of each party for providing underwriting information and claims handling. The agreement should also clarify the standards to be used in underwriting business and settling claims. In part, this might be accomplished by a cut-through, but the wiser course would be to include more detail of the sort discussed above. It is true that bringing the insured into the transaction might create a direct liability on the part of the reinsurer, but in many, or most, cases, it is best to eliminate the maximum number of uncertainties. Another approach might be to obtain representations in the agreement regarding how the risk was underwritten and how claims will be handled.

In short, obtaining the maximum clarity and certainty up front will inure to the benefit of all parties.

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Once More Unto the Breach: the UK Data Protection Regime and Action in the Event of a Data Breach

Any breach of the UK data protection regime can be very damaging to the business and reputation of the organisation concerned. The strength of enforcement of data protection laws and regulation is increasing, and regulated financial services firms and their executives face the threat of significant penalties from two regulators following a breach.

“...implementing measures to ensure compliance prior to a data breach will be considerably less costly, hurried and stressful than implementing them after one.”

This article looks at the current regime and action that can be taken to minimise the business costs and risk of enforcement action following a data breach. Compliance, and action in the event of a data breach, is of particular significance for UK (re) insurance companies, brokers and Lloyd’s managing agents because of the quantities of personal data regarding policyholders that they are likely to manage in the course of their business. For health, life and other types of insurance, personal data may include medical and other types of sensitive data regarding policyholders, in respect of which stricter rules apply and the consequences of a breach may be taken more seriously by regulators.

The UK Data Protection Regime

The Data Protection Act 1998 (DPA), which implemented the EU Data Protection Directive, established a framework of rights and duties designed to safeguard information (personal data) relating to identifiable individuals (data subjects). Under the DPA, any firm that determines the purposes for which and the manner in which any personal data are to be processed (a data controller) must comply with eight data protection principles (DP Principles).

Of particular importance to data controllers, because of the potential consequences of its breach, is the seventh DP Principle, which requires them to take appropriate technical and organisational measures against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data. This also includes ensuring such measures are in place at any third-party processor. Other DP Principles include ensuring that personal data are not excessive in relation to the purposes for which they are processed, keeping personal data accurate and up to date and not retaining personal data for longer than is necessary. The Information Commissioner’s Office (ICO) is responsible for ensuring compliance with, and bringing enforcement action for breaches of, the DPA.

Regulated financial services firms, such as banks and insurance companies and brokers, must also comply with the relevant rules prescribed by the Financial Services Authority (FSA). The FSA requires a firm to make appropriate assessments of the risks of financial crime in relation to the customer data it holds in line with its Principles for Businesses (FSA Principles), in particular, FSA Principle 2 (requiring a firm to conduct its business with due skill, care and diligence) and FSA Principle 3 (requiring a firm to take reasonable care to organise and control its affairs responsibly and effectively, with adequate risk management systems). In addition, SYSC 3.2.6R of the FSA Handbook requires firms to take reasonable care to establish and maintain effective systems and controls for countering the risk that the firm might be used to further financial crime.

Enforcement

In the past, the ICO’s enforcement powers were limited to issuing enforcement notices requiring the data controller to take specific action or, in the most serious of cases, to refrain from processing personal data, and to imposing fines of up to £5,000. Likely to have been of greater concern to regulated firms were the FSA’s enforcement powers, which include private censure, removal of authorisation, withdrawal of approved person status and potentially large fines. In the future, firms will need to pay greater attention

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EAPD Partner Appointed to NY Insurance Exchange Working Group



Nick Pearson, a partner in EAPD’s Insurance and Reinsurance Department, has been appointed by New York Insurance Superintendent James Wrynn to serve on the New York Insurance Exchange Working Group. The Working Group will report back to the Superintendent on the feasibility of recreating the Exchange. Recreating the New York Insurance Exchange is one of the Governor’s most important initiatives, as it would help reaffirm New York’s status as the focal point of international trade and finance.

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to the ICO: from 6 April 2010 it has had a new power to impose fines of up to £500,000 where there has been a serious contravention of the DP Principles and where certain other requirements are met.

Given the overlapping jurisdiction of the ICO and FSA, there is a risk of regulated firms being subject to enforcement proceedings, including fines, by both bodies following a data breach. In reality, the two bodies will likely work together to avoid this and ensure a consistency of approach. In other cases where the roles of the FSA or ICO and another regulator coincide, the relevant regulators have often put in place a memorandum of understanding governing their relationship.

Dealing With Regulators

According to guidance issued by the ICO, if a large number of people are affected by or there are very serious consequences of a breach, the data controller should immediately inform the ICO and seek its advice on appropriate remedial actions. In such circumstances, regulated firms should also notify the FSA. The ICO has warned that organisations may face tougher sanctions if they fail to report security breaches which subsequently come to light. Whilst notifying data subjects is not an absolute legal requirement, the ICO regards it to be best practice where, amongst other factors, it helps such individuals to manage their risk following a breach.

The ICO may refrain from issuing an enforcement notice in view of remedial measures taken by a data controller following a breach and in consideration of undertakings given by a data controller regarding its future data management. Firms giving undertakings will need to ensure that they and their sub-contractors are capable of fully complying with all of the ICO's terms of such undertakings. If necessary and appropriate, adaptations can be sought to the terms.

Most data breach cases handled by the FSA do not result in enforcement notices and fines, suggesting that the FSA will generally utilise other enforcement measures available to it, such as private censure and undertakings from firms. However, the position may be different where a firm has committed prior breaches or received warnings from the FSA.

The HSBC Case

In July 2009, the FSA fined an insurer, insurance broker and actuarial consultancy in the HSBC Group a total of £3.19m for information security failings, including sending unencrypted customer details through the post to third parties, leaving

confidential information about customers in unlocked cabinets and not giving staff sufficient training on how to identify and manage risks like identity theft.

According to the FSA, key to the severity of its enforcement action in this case was a failure to respond to earlier breaches, that the breaches occurred following a period of heightened awareness, and an FSA campaign, regarding the risks of financial crime within the financial services sector and that the firms were aware of such risks but failed to act.

To ensure that similarly severe action by regulators is not warranted, firms should ensure that they have robust security policies in place and that, following a data breach, they promptly take appropriate remedial action.

Other Jurisdictions

Consideration must be given to any other jurisdictions in which a breach may have occurred, for example where a number of group companies use the same third-party processor, at which there has been a loss of personal data. In addition, if affected data subjects are located outside the UK, a UK data controller may have to notify regulators in these countries. The requirements relating to notification of regulators and affected data subjects following a data breach vary widely by jurisdiction, including within the EU, notwithstanding the degree of common approach introduced by the EU Data Protection Directive.

Practical Action Following a Data Breach

Measures that can be taken following a breach to minimise the possibility of damage to data subjects and enforcement action by regulatory authorities include:

- communicating promptly with affected data subjects, providing practical guidance on steps for them to take to limit their risk of loss and dealing with their queries in a timely manner, such as by setting up a dedicated hotline for questions;
- implementing technical measures to improve data security and prevent unauthorised access, such as encryption and secure means of physical transfer of media containing personal data;
- adopting written procedures on managing data security and effective risk assessment and compliance monitoring;
- introducing or improving training programmes, such as making data protection training mandatory at staff induction; and
- taking appropriate disciplinary action in

respect of employees, and other actions in respect of third-party processors, involved in the breach.

Notification to data subjects and regulators should only be taken following careful consideration as to an organisation's planned response to a breach. It may be appropriate to engage public relations advisers to help reduce the risk of negative publicity.

Business Cost

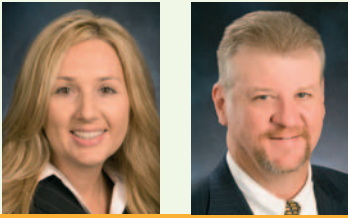
In addition to any fines levied, a study published in January 2010 by the Ponemon Institute, a US-based organisation which conducts independent research and advises organisations on privacy, data protection and information security, put the average business cost for UK-based companies of a data breach at £1.68 million. This included costs incurred in relation to detecting and reporting breaches, notifying affected data subjects, implementing special measures following a breach, legal costs and, representing the greatest component of such costs, the cost of lost business associated with the diminished trust and confidence of customers. According to the Ponemon study, data breaches involving third-party processors were common and tended to be more costly. Organisations that notified affected data subjects quickly experienced lower costs associated with a breach.

Conclusion

All firms should already have in place appropriate technical measures to ensure data security and prevent unauthorised access, as well as organisational measures, such as effective risk assessment and compliance monitoring, data security training programmes for staff and written procedures on the secure storage and transfer of data. Compliance officers should bear in mind that implementing measures to ensure compliance prior to a data breach will be considerably less costly, hurried and stressful than implementing them after one.

If a data breach does occur, a quick but considered reaction is needed to manage the consequences, including minimising business costs and the risk of enforcement proceedings. Following a breach, the ICO and, for regulated financial services firms, the FSA, will want to see a commitment to improving technical and organisational measures to ensure data security in the future. Enforcement action may be severe should a firm fail to make such improvements and another breach occur.

EAPD have an International Privacy and Data Protection Group – see www.eapdlaw.com.



By Julia Karen Ulrich and
Dennis O. Brown
Hartford/New York

The Cigarette Rule – Up in Smoke?

A Connecticut jury recently awarded nearly \$15 million to a class of automotive body shop plaintiffs¹ based on the jury's finding that the insurance company defendant violated the Connecticut Unfair Trade Practices Act.² The plaintiffs may get far more than they bargained for, however, if their lawsuit actually results in a seismic shift in the law that ultimately *restricts* potential plaintiffs' ability to bring similar actions in the future. Such a shift would align Connecticut with an emerging trend and possibly influence other jurisdictions to follow suit, a development which could dramatically reduce the exposure of insurance companies and their insureds.

The shift would occur if, as expected, this becomes *the* case that finally forces the issue of whether the so-called "Cigarette Rule," used to determine whether an act or practice is "unfair" within the meaning of CUTPA, has been superseded by a newer, narrower federal standard. The resolution of this issue could dramatically change the face of statutory bad faith claims in the "Insurance Capital" state and potentially, result in new law far more favorable to defendants.

In *Artie's Auto Body et al. v. Hartford Fire Ins. Co.*, four named plaintiffs, on behalf of a class of 1,500 Connecticut auto body shops that have performed physical auto body repairs paid for by The Hartford Fire Insurance Company (The Hartford) under automobile insurance policies, alleged that The Hartford engaged in a pattern of unfair and deceptive acts and practices in violation of the Connecticut Unfair Trade Practices Act, or "CUTPA."³ CUTPA prohibits any person from engaging in unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce.⁴ The *Artie's Auto Body* plaintiffs alleged that The Hartford engaged in unfair trade practices by using incentives to wrongfully steer its insureds and other insurance claimants to auto body repair shops favored by The Hartford. The plaintiffs also alleged that The Hartford used positive and negative employee incentives prevailed upon its own independent appraisers to establish an artificially low standard of hourly labor rates for auto body repair work in Connecticut.⁵ Although the plaintiffs had to establish that The Hartford engaged in unfair acts or practices to prove their CUTPA claim, oddly enough, CUTPA does not articulate what an "unfair" act or practice actually entails.

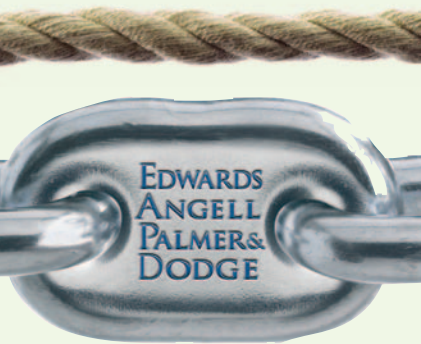
The CUTPA statute does, however, explicitly state the legislative intent that, in construing the statute, the courts of Connecticut "*shall* be guided by interpretations given by the Federal Trade Commission and the federal courts to ... the Federal Trade Commission Act..., as from time to time amended."⁶ Consistent with the intent of the

legislature, the Connecticut Supreme Court adopted, many years ago, the so-called "Cigarette Rule" to guide courts in their construction of what constitutes an "unfair" act or practice.⁷ The Cigarette Rule, which is a product of a 1964 Federal Trade Commission (FTC) policy statement related to the requirement of warning labels on cigarette packaging,⁸ is comprised of three criteria used to determine whether an act or practice is unfair to consumers: (1) whether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statute, the common law, or otherwise—whether, in other words, it is in at least the penumbra of some common law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; and (3) whether it causes substantial injury to consumers, competitors or other businessmen.⁹ In Connecticut, a practice may be unfair under CUTPA because of the degree to which it meets one of the criteria, or because, to a lesser extent, it meets all three.¹⁰

On November 17, 2009, after the completion of the *Artie's Auto Body* trial, the court charged the jury regarding all three prongs of the Cigarette Rule, and the jury returned a plaintiffs' verdict in the amount of \$14.7 million on the first-Cigarette-prong labor rate claim.

The Hartford, however, did not acquiesce to the court giving a presumably standard three-prong Cigarette Rule charge to the jury on the CUTPA claim and, in fact, had engaged in motion practice before the trial requesting that the court deliver a different charge.¹¹ The Hartford asked the court *not* to charge on the Cigarette Rule on the basis that the long-standing rule is now obsolete, replaced by a narrower, more recent federal standard that focuses exclusively on the third "substantial injury" prong.

More specifically: The Hartford raised, with the trial court, the issue of whether a 1980 FTC policy statement, and its subsequent codification in the Federal Trade Act, superseded the FTC's own Cigarette Rule as the go-to guide for "unfair" acts or practices. In the 1980 policy statement



“Insurers are currently faced with a unique opportunity to try to reshape statutory bad faith laws, both in Connecticut and in all those states still applying the original Cigarette prongs without yet evaluating their continuing viability.”

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(reprinted in a 1984 FTC opinion), the FTC moved away from the first “public policy” prong, did away with the second “immoral conduct” prong, and focused almost entirely on the third “substantial injury” prong of the original Cigarette Rule.¹² Pursuant to the new “Unjustified Injury Test,” as it has been called: (1) the practice must cause a substantial injury to consumers, competitors or other businessmen; (2) the injury must not be outweighed by countervailing benefits to consumers or competition that the practice produces; and, (3) it must be an injury that consumers themselves could not reasonably have avoided. A codification by Congress of the Unjustified Injury Test in a 1994 Amendment to the Federal Trade Act went even further and eliminated the second public policy prong as an independent basis for unfairness altogether. The act now provides that: “The Commission shall have no authority under this section or section 57a of this title to declare unlawful an act or practice on the grounds that such act or practice is unfair unless the act or practice causes or is likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition. In determining whether an act or practice is unfair, the Commission may consider established public policies as evidence to be considered with all other evidence. *Such public policy considerations may not serve as a primary basis for such determination.*”¹³

Yet, despite the FTA’s revamping of its own Cigarette Rule, the codification in the Federal Trade Act of an even narrower standard than the FTC proposed, and CUTPA’s memorializing of the legislative intent that courts’ decisions “shall” be guided by the FTC and federal court interpretations of the Federal Trade Act, the *Artie’s Auto Body* court denied The Hartford’s request not to charge the jury on all three original Cigarette prongs. The court explained that the “cigarette rule has consistently been used by the appellate courts and trial courts in Connecticut before and after the 1984 FTC policy statement and the Connecticut legislature has not amended CUTPA to codify that policy statement as did the U.S. Congress... Until such time as the appellate courts or the legislature speak to the contrary this court will be bound to apply the ‘cigarette rule’ as the test of an unfair trade practice.”¹⁴ The verdict against The Hartford, based on the jury’s finding that a first-prong public policy violation of CUTPA had occurred,¹⁵ would not have presented a viable CUTPA claim under the standard of unfairness adopted in the Federal Trade Act.

Notably, Hartford did not present a novel idea, but rather, one which the Connecticut Supreme Court appears somewhat eager to decide. In 2005, the court acknowledged awareness of the FTC Policy Statement, and the uncertain continued application of the Cigarette Rule, when it made an unsolicited statement that: “Although we have consistently followed the cigarette rule in CUTPA cases, we also note that, when interpreting ‘unfairness’ under CUTPA, our decisions are to be guided, pursuant to General Statutes §42-110b(c), by the federal trade commission and federal court interpretations of the Federal Trade Act. Under those authorities, a serious question exists concerning whether the cigarette rule remains the guiding rule utilized by the federal trade commission. Nevertheless, because neither party in the present case has raised or briefed this issue or asked us to reconsider our law in this area, it is appropriate that we wait until the issue has been squarely presented to us for determination.”¹⁶ Even Connecticut’s federal courts appear to be waiting for the state courts to shed light on the issue.¹⁷ Oddly enough, however, despite the fact that Connecticut courts have thus far been unwilling to acknowledge that the Unjustified

Injury Test supersedes the Cigarette Rule, the courts do include it as a subset of the existing three-prong Cigarette Rule, creating a sort of hybrid law, where all three original prongs are still valid but, the third substantial injury prong is governed by the new rule.¹⁸

Not surprisingly, there is no uniformity among the other states with similar unfair trade practices statutes and who, at one time, adopted the original Cigarette Rule. A few states, like Maine, have viewed the enactment of the Unjustified Injury Test in the same manor that The Hartford does, and have altogether replaced the Cigarette Rule with the new, more narrow test.¹⁹ Other states, like Massachusetts, have yet to move at all and are still applying the Cigarette Rule.²⁰ And still others, like Illinois (and, thus far, Connecticut), are going with the hybrid method. In those states, the courts still consider all three Cigarette prongs to be valid, but apply the Unjustified Injury Test to the third “substantial injury” prong.²¹ Finally, other states, like Iowa, have outright codified the new federal definition of “unfairness” right into their own state statutes.²²

So What Does This All Mean for Insurers? For starters, since the November verdict in the *Artie’s Auto Body* case, the parties to that

Footnotes

1. *Artie’s Auto Body et al. v. Hartford Fire Ins. Co.*, FST-CV03-0196141-S, 2009 WL 3737931 (Conn. Super., Sept. 22, 2009).
2. Conn. Gen. Stat. §42-110a et seq.
3. *Artie’s Auto Body*, supra.
4. Conn. Gen. Stat. §42-110b(a).
5. *Artie’s Auto Body*, supra.
6. Conn. Gen. Stat. §42-110b(c). (Emphasis added.)
7. *Conaway v. Prestia*, 191 Conn. 492-93 (1984); *McLaughlin Ford, Inc. v. Ford Motor Company*, 192 Conn. 558, 568 (1984).
8. Federal Trade Commission in Statement of Basis and Purpose of Trade Regulation Rule 408, “*Unfair or Deceptive Advertising and Labeling of Cigarettes in Relation to the Health Hazards of Smoking*,” 29 Fed. Reg. 8355 (1964).
9. *Artie’s Auto Body*, supra, citing *McLaughlin Ford, Inc. v. Ford Motor Company*, 192 Conn. 558, 568 (1984).
10. *Ramirez v. Health Net of the Northeast, Inc.*, 285 Conn. 1, 18-19, 938 A.2d 576 (2008).
11. *Artie’s Auto Body*, supra.
12. *Artie’s Auto Body*, supra, citing Commission Statement of Policy on the Scope of the Consumer Unfairness Jurisdiction (December 17, 1980) reprinted in *In Re Int’l Harvester Company*, 104 FTC 949, 979 app. (1984).
13. 15 U.S.C. § 45(n) (emphasis added).
14. *Artie’s Auto Body*, supra.
15. Scheffey, Thomas B., “*Getting Hammered*,” The Connecticut Law Tribune, Nov. 23, 2009.
16. *American Car Rental, Inc. v. Commissioner of Consumer Protection*, 273 Conn. 296, 305, n. 6, (2005); see also *Votto v. American Car Rental, Inc.*, 273 Conn. 478, 484, n. 3 (2005) (“We note that we recently have recognized that a question exists as to whether the cigarette rule remains the guiding rule utilized by the Federal Trade Commission. ... In the present case, however, neither party has raised or briefed this issue or asked us to reconsider our law in this area, and, accordingly, we will wait to consider this question until it has been presented to us for determination.”)

17. *A&R Body Specialty v. Progressive Casualty Insurance Co.*, No. 3:07-cv-0929, 2008 WL 2229888 (2008) (“Defendants contend that the issue on which certification is sought is one that the Connecticut Supreme Court has indicated that the state of the law is in flux. Specifically, the Supreme Court has recently remarked that the ‘cigarette rule,’ ... may be of limited continuing vitality. The current state of the law ... is that the cigarette rule governs this issue. Until such time as the Supreme Court abandons the rule, it remains the guiding principle for this Court to follow as state and federal courts in Connecticut still follow and apply it. ... As the Connecticut appellate courts and this Court are in agreement as to what test to apply at this point in time, the Court will deny defendants’ request for certification.”)
18. “The cigarette rule contains three factors: (1) [w]hether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise ... (2) whether it is immoral, unethical, oppressive, or unscrupulous; [and] (3) whether it causes substantial injury to consumers, [competitors, or other business persons] The third factor of ‘substantial injury’ is itself subject to a three-part test: (1) the injury must be substantial; (2) the injury must not be outweighed by any countervailing benefits to consumers or competition that the practice produces; and (3) it must be an injury that consumers themselves could not reasonably have avoided.” *Health Communications, Inc. v. Chicken Soup for the Soul Publishing, LLC*, 2009 WL 579227, 25 (Conn. Super. 2009).
19. *Searles v. Fleetwood Homes Of Pennsylvania, Inc.*, 878 A.2d 509, 519 (Me. 2005).
20. *Bodycote IMT, Inc. v. NALCO Chemical Company, Inc.*, 2005 WL 6190785 (Mass. Super. 2005).
21. *Robinson v. Toyota Motor Credit Corp.*, 201 Ill.2d 403, 416 (2002); *Case v. Ameritech Services*, 2004 WL 73524, 5 (Ill. Cir. 2004).
22. The Iowa Code explicitly defines unfair practice as “an act or practice which causes substantial, unavoidable injury to consumers that is not outweighed by any consumer or competitive benefits which the practice produces.” Iowa Code, § 714.16(1)(n).

lawsuit have been briefing their post-trial motions²³ and, it has been reported that, “[i]f those are unsuccessful, the insurer plans to appeal” and, “[o]n appeal, the continued vitality of the three-prong Cigarette Rule is expected to be highly contested.”²⁴ Thus, an appellate-level determination may finally be made, in Connecticut, as to the continued viability of the Cigarette Rule.

Additionally, statutory bad faith claims against insurers in Connecticut could potentially change if the Cigarette Rule is abandoned and the Unjustified Injury Test is adopted. In Connecticut, a private cause of action exists under CUTPA to enforce alleged violations of the Connecticut Unfair Insurance Practices Act, or “CUIPA.”²⁵ This is largely how statutory bad faith claims are made against insurers by individual consumers. Not only are CUIPA claims *permitted* under CUTPA but, where a lawsuit involving a CUTPA claim also involves the insurance industry, the CUTPA claim *must* be based on a violation of CUIPA.²⁶ In those CUTPA/CUIPA insurance cases, the Connecticut courts have established that, when a CUTPA claim is based on public policy, “it is the CUIPA violation that is the equivalent of CUTPA’s ‘cigarette rule.’”²⁷ Hence, if Connecticut adopts the new definition of unfairness, which eliminates

the first and second prongs of the Cigarette Rule, including the public policy prong upon which all CUIPA/CUTPA actions are based, will such a cause of action survive the modification?

Moreover, even if Connecticut abandons the traditional Cigarette Rule while somehow preserving the public policy-based CUIPA/CUTPA action, insurers will still be affected because Connecticut courts have allowed CUTPA claims to independently stand even when a CUIPA count has been stricken, provided that the plaintiff has pleaded sufficient facts to establish unfair and deceptive trade practices.²⁸ Thus, in those instances, claimants would lose the ability to bring CUTPA claims against insurers based on public policy grounds or on the basis that the conduct was immoral, unethical, oppressive, or unscrupulous. Only those actions alleging a CUTPA violation based on an unfair practice that caused substantial injury, and passed the three-part Unjustified Injury Test, would present a valid cause of action.

Insurers are currently faced with a unique opportunity to try to reshape statutory bad faith laws, both in Connecticut and in all those states still applying the original Cigarette prongs without yet evaluating their continuing viability. This important issue should be followed in

the industry. Additionally, motivated insurers may consider filing *amicus* briefs should the opportunity arise in *Artie’s Auto Body* or similar appeals in other states. Alternatively, insurers may consider blazing the trail and setting up their own *Artie’s-esque* claim with a pending CUTPA lawsuit to force the issue to the forefront in those jurisdictions that have not yet determined whether the time has come to stomp out the Cigarette Rule.

Footnotes

23. <http://civillinquiry.jud.ct.gov/CaseDetail/PublicCaseDetail.aspx?DocketNo=FSTCV030196141S>.
24. Scheffey, Thomas B., “Getting Hammered,” The Connecticut Law Tribune, Nov. 23, 2009.
25. Conn. Gen. Stat. §38a- 815 et seq.; *Mead v. Burns*, 199 Conn. 651, 663 (1986).
26. *Mead v. Burns*, 199 Conn. 651 (1986); *Thomas v. Biller Associates Tri-State, Inc.*, 2009 WL 3086547, 1 (Conn.Super.2009).
27. *Engelman v. Connecticut General Life Ins. Co.*, Superior Court, judicial district of New Haven, Docket No. 337028 (August 12, 1997) (Barnett, J.) (20 Conn.L.Rptr. 331).
28. *Palmieri v. Nationwide Mutual Ins. Co.*, Superior Court, judicial district of Fairfield, Docket No. CV 07 5012326 (January 29, 2009, Tobin, J.); *Don Beach Movers, Inc. v. Transguard Ins. Co. of America, Inc.*, Superior Court, judicial district of New London, Docket No. CV 05 4002395 (Conn. Super. 2006); *Pusztay v. Allstate Ins. Co.*, 2009 WL 2357958, *9 (Conn.Super.2009).



By M. Machua Millett
Boston

The Chile Earthquake: Emerging Compliance and Claims Issues Arising from the Most Expensive Insured Event in Latin American History

Even if insured losses fall somewhere in the middle of the current \$2-\$12 billion range of estimates, the Chile earthquake will easily outpace Hurricane Wilma as the most expensive insured event in Latin America’s history. These figures are more likely to rise than fall as a clearer picture of business interruption losses emerges. Of further concern to the international (re) insurance market, such losses will not be limited to the local market.

For additional information on the Chile earthquake, please feel free to view our webcast on the topic (available at <http://www.insurereinsure.com/BlogHome.aspx?entry=2398>) or contact:

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To the contrary, most of the earthquake cover in Chile was reinsured with international reinsurers based in the United States, Europe and Bermuda. Numerous individual reinsurers from these areas have already released significant loss estimates that in total easily exceed US \$3 billion. In addition, many of these individual loss estimates were based off of earlier total damage estimates, which have continued to rise in the ensuing weeks.

Although it is still very early in the claims

adjustment and handling process, some compliance and coverage issues have begun to emerge from Chile as investigation of losses progresses. In addition, Chile’s insurance regulator, the Superintendencia de Valores y Seguros (SVS), has issued two decrees since the earthquake that modify the usual claims process.

Claims Adjustment Regulations

Chilean law requires that losses be investigated

and estimated by personnel of the insurance company providing coverage or by local licensed and registered independent “liquidators.” Performance by non-authorized (including foreign) adjusters of any of the duties reserved for such licensed professionals can lead to fines, difficulties supporting loss estimates and coverage determinations and further regulatory penalties in extreme cases. Although rules for noticing claims and adjusting losses are quite strict under both local regulation and most local policies, the SVS and the local insurers’ association have both recognized the difficulties posed by the earthquake’s devastation. Therefore, the insurers’ association agreed to relax requirements for timing (now generally 90 days) and means of notice (essentially any means now permissible) for insureds affected by the earthquake, a move acknowledged in a decree from the SVS (notably, the insured must demonstrate that its ability to make notice was impacted by the earthquake in order for it to avail itself of the relaxed claims notice process). The SVS also relaxed adjustment regulations for homeowners policies, instituting an abbreviated investigation and claim determination process designed to allow homeowners prompt notice of the coverage determination and valuation of their loss.

Does the Insured Even Have Earthquake Coverage?

In the scramble to adjust the flood of claims arising from the earthquake and subsequent tsunami, it is important not to lose sight of one basic question: did the insured purchase earthquake coverage? As in most jurisdictions internationally, earthquake coverage is not a standard part of most homeowners and commercial property policies in Chile. Instead, where it exists, earthquake coverage is generally provided by endorsement. It is generally understood that most large corporations with operations in Chile did carry earthquake coverage. Likewise, homeowners with a mortgage were generally required to purchase such coverage as a prerequisite to obtaining a loan. However, medium-sized companies (PYMES) and homeowners without mortgages may well not have purchased earthquake coverage, either purchasing standard property policies or eschewing insurance coverage altogether. A basic, initial review of the insured’s coverage before further investigation is therefore advisable.

Insurer’s Duties to the Insured and the Reinsurer

Given the strict local regulation of time periods for coverage determinations and other aspects of the claims adjustment process, it is likely

that local insurance companies will encounter instances where conflicts arise between their duties to their insureds and their duties to their reinsurers (which may have various rights under claims control, cooperation or similar provisions contained in the parties’ reinsurance agreements). For example, an insurance company may have only ten days to accept or reject a liquidator’s report on coverage and magnitude of loss, but may be obligated to allow the reinsurer a longer period to consider and direct acceptance or denial of the claim. Should the insurer comply with its obligation to its insured and grant coverage within ten days, it may later find itself in a dispute with its reinsurers. Should the insurer delay its coverage determination while awaiting word from its reinsurers, it may waive its right to deny coverage and/or find itself in a dispute with its insured. Nonetheless, the Chilean regulator and courts have shown little difficulty in the past holding insurance companies responsible for complying with both sets of duties or for violating either.

Business Interruption Losses

There is significant concern in Chile that, as seen with the Northridge earthquake in 1994, business interruption losses may continue to grow, eventually dwarfing actual property damage losses in many instances. Business interruption losses pose additional difficulties for adjusters (and forensic accountants) given the need to rely upon the insured’s financial records. Furthermore, determination of the extent to which business interruption is attributable to damage to the insured’s property as opposed to damage to public infrastructure (which was significant in Chile) may impact coverage determinations and insured loss calculations.

Failure to Build to Code

In a number of publicized instances, damage to private buildings and public infrastructure exceeded expectations given the magnitude of the Chile earthquake and the strictures of local building codes. Such instances indicate that some structures may not in fact have been built up to code. Any such failure would pose significant coverage issues as it would potentially implicate relevant exclusions as well as form the basis for potential rescission of the policy where the application contained representations as to construction compliance.

Earthquake vs. Tsunami Damage

Particularly on the coast and islands, many properties suffered damage from both the earthquake tremor itself and from the subsequent tsunami. In such circumstances, depending upon policy language, there may be some question whether tsunami damage is covered at all (posing issues similar to the wind/water disputes seen with Hurricane Katrina), and, if so, whether the tsunami and the tremor represent separate claims (potentially with separate deductibles and limits). The various subsequent tremors experienced in Chile may pose similar single claim vs. multiple claim issues.

Conclusion

The issues discussed above represent just a few of the complications that may arise in investigating, adjusting and handling claims resulting from the Chile earthquake. It is therefore important for reinsurance companies with exposure in Chile to closely monitor local claims handling in conjunction with qualified local and international counsel.

COMPLIMENTARY WEBINAR PROGRAM

Compliance and Claims Issues for Foreign (Re) Insurers Arising from the Chile Earthquake

EAPD offered this complimentary webinar on April 12 aimed at foreign (re)insurers to discuss the developing issues that these companies should be considering in their handling of their relationships with Chilean losses and local insurance companies.

Internet access and audio are all that is required to view this webinar. The duration is 60 minutes.

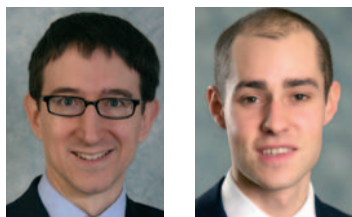
TO ACCESS THIS WEBINAR:

Go to <http://www.eapdlaw.com/events/>. Click on the heading **Compliance and Claims Issues for Foreign (Re)insurers Arising From The Chile Earthquake** and follow the online instructions.

This webinar is available to view for 12 months from April 2010.



AVAILABLE
NOW



By Becket McGrath and
Theo Godfrey
London

The New Insurance Block Exemption Regulation

On 1 April 2010, a new block exemption regulation for the insurance sector came into force in the EU. The new block exemption reduced the categories of agreements covered by the previous exemption (and therefore protected from the prohibition of anticompetitive agreements) from four to two. It also made a number of changes to the scope of the exemption covering the remaining two categories of agreements. Parties to agreements which are no longer block exempted will now have to make their own assessment of whether such agreements fall foul of EU law or equivalent provisions in the domestic law of an EU Member State.

The Competition Regime

Under Article 101(1) of the Treaty on the Functioning of the European Union (Article 101(1)), previously known as Article 81(1) of the EC Treaty, all agreements between undertakings, decisions by associations of undertakings and concerted practices which may affect trade between Member States and which have as their object or effect the prevention, restriction or distortion of competition within the internal market are void and legally unenforceable. The European Commission (the Commission), which is responsible for enforcing Article 101, can impose fines on the parties to such agreements of up to 10% of their annual worldwide group turnover. National competition authorities, such as the UK's Office of Fair Trading, may also enforce Article 101, as well as equivalent national law provisions. In addition, third parties that have suffered harm because of an anticompetitive agreement may sue the parties in the courts for damages or other relief.

Agreements that restrict competition, contrary to Article 101(1), may nevertheless be exempt under Article 101(3) if they deliver certain efficiency benefits that outweigh any restriction. Block exemptions are an instrument of European competition law that define certain categories of

agreements that are presumed to meet the requirements of Article 101(3) and are therefore automatically exempt from the prohibition set out in Article 101(1). A block exemption in respect of certain types of agreements in the insurance sector was adopted by the Commission in 1992. Following its expiry, a new regulation was adopted in 2003, which expired on 31 March 2010.

An agreement not covered by a block exemption, because it is not of a category of agreement presumed to meet the requirements of Article 101(3), may still be exempt from Article 101(1) if the parties can show that it does in fact deliver sufficient efficiency benefits to satisfy Article 101(3). In addition, a restrictive agreement between small firms, whose market share is below specified de minimis levels, may not have an appreciable effect on competition and therefore fall outside Article 101(1) altogether.

Since 1 May 2004, firms have no longer been required or able to apply to the Commission for an individual exemption from Article 101(3). Where a firm is party to an agreement not covered by a block exemption, it must form its own view on whether such an agreement may be exempt from or fall outside of Article 101(1), based on the factual circumstances.



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Industry Presence

COME FIND US

- **Vincent Vitkowsky** (New York) will be participating in a Mock Mediation at the BILA Mediation Seminar on June 22, 2010 in London.
- EAPD once again is a proud sponsor of the Reinsurance Association of America (RAA) Re Contracts Seminar, where **Vincent Vitkowsky** (New York) will be presenting on July 20-23 in New York.

HIGHLIGHTS

- EAPD hosted a women's networking event in Bermuda for the insurance business

professionals on May 16, the Bermuda High Tea for Women. Several of EAPD's women attorneys participated in the event.

- **Vincent Vitkowsky** (New York) spoke on a panel, *Reforms without Subscribers* at the ARIAS Spring Conference in Coronado, California on May 6.
- EAPD was a proud sponsor of the Taglich Brothers 7th Annual Small Cap Equity Conference.
- **Michael T. Griffin** (Hartford) and **John G. Stretton** (Stamford) spoke about Effective M&A Strategies for the Buyer and Seller at the National Underwriter Company and Hales & Company's joint seminars to insurance professionals on creating and enhancing shareholder value. The

seminars were held in New York, Chicago, Dallas and San Francisco throughout the month of May.

OTHER NEWS

- EAPD is closely watching the developments of the SEC Life Settlements Task Force and the Senate Committee on Aging and their inquiries of the life settlement industry, with the help of our Public Policy and Government Relations professionals. We issued an advisory to our clients, available on our blog at: <http://www.insurereinsure.com/BlogHome.aspx?entry=2421>.

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From Four to Two

The previous block exemption exempted four categories of insurance agreements, relating to: (i) the compilation and exchange of statistical information for the calculation of risks; (ii) the creation and operation of insurance pools; (iii) the establishment of standard policy conditions; and (iv) specifications for security devices.

As anticipated in the draft block exemption published in October 2009, the new block exemption has reduced the categories of agreements covered by the exemption to two, namely:

- the joint compilation and exchange of information necessary for the calculation of the average cost of covering a specified risk in the past; the construction of tables relating to risks associated with death, illness, accident or invalidity; or joint studies relating to future risks or investment; and
- the creation and operation of co-insurance and co-reinsurance pools.

Agreements relating to the establishment of standard policy conditions and to specifications for security devices are no longer block exempted. Under transitional provisions, however, such existing agreements will remain exempt until 30 September 2010, in order to give firms sufficient time to comply with the changed law.

A number of insurance trade associations expressed concern that the removal of agreements relating to standard policy conditions from the block exemption would increase costs for insurers and reduce competition. According to the communication accompanying the new block exemption, the Commission considers that in many cases standard policy conditions can give rise to positive effects for competition, and may therefore be individually exempt. To raise concerns with the Commission or a national competition authority, standard policy conditions would have to restrict competition. In many cases, they will not have this effect, particularly if they do not address terms such as pricing and are not mandatory.

As noted above, agreements that are no longer covered by the block exemption may be individually capable of exemption, if countervailing economic benefits can be demonstrated, or may not give rise to an appreciable restriction of competition in the first place. The Commission has recently published draft guidance on the assessment of such agreements' compatibility with Article 101, as part of its review of its Guidelines on horizontal cooperation agreements.

The Remaining Categories

The new block exemption made a number of changes to the scope of the remaining two

categories of exempted agreements.

Information Exchange Agreements

In relation to information exchange agreements, two new conditions for exemption have been introduced. First, the information must not contain any indication of the level of commercial premiums. Second, subject to public security considerations, information must be made available on affordable and equal terms to consumer and customer groups which request it "in specific and precise terms for a duly justified reason".

Insurance Pools

In relation to insurance pools, the Commission has made a number of changes to the exemption:

- A revised definition of pools clarifies that the new block exemption does not cover ad hoc co-insurance or co-reinsurance involving a leader and followers in the subscription market. This change appears to have been linked to concerns over the operation of subscription markets that the Commission expressed in its report on the business insurance sector inquiry. On the sector inquiry, the Commission has confirmed that it will be sending out questionnaires soon to assess the extent to which the practices that it identified as raising concerns persist on the subscription market.
- Compared with the previous block exemption, the definition of "new risks" has been widened to include any risk whose nature, objectively, has changed so materially that it is impossible to know in advance what subscription capacity is needed to cover the risk. As was the case under the previous block exemption, an exemption is granted to pooling arrangements created for the co-insurance or co-reinsurance exclusively of new risks, and only for the first three years of their existence.
- The market share thresholds below which pools that have existed for over three years may benefit from the block exemption remain the same as under the previous exemption. However, under the new block exemption, the Commission has changed the way in which the combined market share of the members of a pool is calculated. Under the previous block exemption, only the combined market share within the pool was taken into account. Under the new block exemption, members of a pool need to consider their combined market share both inside and outside the pool. Account must be taken of the market share of each member within the pool itself, the market share each member has in other pools in the same relevant market, and the market share held by each member in the same relevant market outside the pool.
- There has been an increase in the market

share bands which determine the grace period during which the exemption continues to apply, applicable to members of a pool covering non-new risks whose aggregate market share has grown to exceed the maximum threshold.

- Modifications have been made to two of the conditions for the exemption of pools. The notice required from members to withdraw from a pool must now be reasonable and is no longer restricted to a maximum of one year. Also, the rules of the pool must not restrict any participating undertaking from-insuring or re-insuring outside the pool.
- One of the conditions for the exemption of pools under the previous block exemption no longer applies. Under the new block exemption, it is no longer prohibited for a member of a pool or an undertaking with a determining influence over the commercial policy of the pool also to be a member of, or have a determining influence over the commercial policy of, another group active in the same relevant market.

Withdrawal of the Block Exemption

Agreements covered by a block exemption are presumed to meet the requirements of Article 101(3), although this presumption may be rebutted. The benefit of the new block exemption may be withdrawn by the Commission, or a national competition authority, if an agreement to which the new block exemption applies has effects which are incompatible with Article 101(3). In particular, the recitals to the new block exemption state that the anti-competitive effects that may derive from links between a pool and/or its members and other pools and/or their members in the same relevant market will be of particular importance in deciding whether to withdraw the benefit of the block exemption. This suggests that, while individual agreements relating to pools may meet the requirements of Article 101(3), the cumulative effect of such agreements in the same market may not.

Conclusion

Firms which are parties to agreements no longer covered by the block exemption will now have to make their own assessment of whether such agreements might be caught by Article 101(1) and, if they might, whether they would survive scrutiny by the Commission, a national competition authority or court. In the case of insurance pools, because of the number of changes that have been made, agreements apparently covered by the remaining categories in the block exemption should also be reassessed to confirm that they have not been affected by the changes to the exemption's scope.



By Brian J. Green and
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Microinsurance Going Macro, Especially in Latin America

In the days after the January earthquake in Haiti, some staggering numbers were reported in the media. There was approximately \$14 billion in property damage, most of which occurred in Port-au-Prince, the largest city in Haiti, and 250,000 people were killed, either directly or indirectly, by the earthquake. The total amount of insured losses, however, was expected to be less than \$20 million, or only 1% of the total loss. By comparison, more than one-third of the losses suffered in Hurricane Katrina were insured.

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EAPD Launches Latin American (Re)insurance Regulatory Update Service

The service would entitle you to:

- receive four issues per year of the update;
- receive immediate electronic alerts concerning particularly significant legal or regulatory changes impacting the business of international insurers, reinsurers and (re)insurance intermediaries in any of the 19 Latin American jurisdictions covered;
- provide input to EAPD as to topics of particular significance to your company that you would like monitored and reported upon in the update and alerts.

Furthermore, EAPD attorneys (and our local counsel) would of course be available to assist you with any further questions, inquiries and/or necessary follow-up on any issues posed by the developments discussed in the quarterly update and real-time alerts.

To view a complimentary, introductory copy of a quarterly update, please visit our website eapdlaw.com. For further information on this service please contact Machua Millett at MMillett@eapdlaw.com.

Even before the earthquake, Haiti was one of the world's poorest nations, with a gross domestic product of about \$2 per person, per day and approximately 80% of Haitians living in poverty. Because of this, the insurance market in Haiti never developed as it has in wealthier nations; Haitians rarely purchased life insurance or coverage for their personal belongings or business assets and few, if any, purchased business interruption insurance or other insurance to protect their income stream.

Haiti was always a prime candidate for microinsurance and now, after the devastating earthquake, the need for such cover is magnified both in Haiti and other less-developed countries. Microinsurance, somewhat analogous to but less understood than microfinance, refers to insurance products characterized by very low premium and/or low coverage limits. Other than the size of the policy, microinsurance operates in very similar manners to standard insurance sold throughout the world. Outside of public and private foreign aid, each fraught with their own problems and inefficiencies, microinsurance may be one of the only ways to improve the ability of low-income populations in underdeveloped nations to recover from natural and financial disasters.

Microinsurance Today

During the last few years, several international insurers have begun to sell microinsurance products, very often through a philanthropic arm of the corporate entity. They are not, however, the only providers of microinsurance, as there are many non-governmental organizations, community-based organizations and informal microfinance groups that sell microinsurance products. Microinsurers are writing several types of insurance, including funeral product insurance, agriculture insurance, health insurance and life insurance.

There are some notable differences between microinsurance and standard insurance. Microinsurance policies are generally written in simple language and have few, if any, exclusions. Microinsurers generally attempt to simplify the

claims handling process so that there are rarely disputes or complex investigations before claims are paid. Premiums are often paid in sporadic installments because of the potentially volatile cash-flow of the insureds. Microinsurance products are often sold in locations where they are guaranteed to garner the attention of the market. For example, some supermarkets in South Africa sell funeral insurance and insureds can pay the first premium as they pay for their meat and produce.

A number of international insurers, including Chartis, Zurich, Allianz and Swiss Re, sell microinsurance products in various parts of the world. According to various reports, these insurers have created microinsurance products to give the companies a broader platform in the various markets and in order to be the primary provider of insurance to the individual microinsureds as they move into the middle class and begin to purchase more traditional insurance products. It is too early to tell, however, whether this strategy is proving successful and whether microinsurance itself can become a profitable business line.

Latin America – Hundreds of Millions of Microinsureds?

There is a market, and a need, for microinsurance in hundreds of poor, underinsured nations across the world. One region, however, provides a microcosm of recent developments in the microinsurance world. In Latin America, approximately one-fourth of Latin America's 569 million residents live on less than \$2 per day, and many Latin Americans do not have any type of insurance. Recent trends involving microinsurance, however, may change that in the near future.

Earlier this year, the International Development Bank approved a \$3.3 million loan to the Federacion Interamericana de Expresas de Seguros (FIDES) to increase the use of microinsurance in Latin America. Ten different companies will participate in the project with the goal of designing and commercializing life, casualty and health microinsurance products. Approximately one-sixth of that amount will be dedicated to Mexico, where the potential microinsurance market is estimated to

consist of approximately 60 million people.

Late last year, Peru's insurance regulator, the Superintendencia de Banca, Seguros y AFP, announced that it had completed its drafting of new proposed regulations regarding microinsurance, which were then opened for comment. Armando Caceres, the Adjunct Superintendent of Insurance, reportedly stated that "the intention [of the project] is to generate a more flexible regulatory structure that permits the spreading of group risks, for example, by the general public without cost restrictions." Among other things, the new regulations remove maximum costs restrictions for microinsurance and permit additional modes of distribution for microinsurance products. It is hoped that the new regulations will result in millions more Peruvians purchasing microinsurance beyond the 600,000 that already own such policies.

Additionally, we are likely to see new microinsurance legislation in Brazil during the next few months as the government has prioritized its passage. A recent study indicated that there could be between 22 and 33 million

new Brazilian microinsurance customers. According to the study, only 30% of Brazil's households currently have insurance, with the major reasons cited for not having insurance being cost, distrust of the concept of insurance and lack of a philosophy of saving.

Given the existing need, and the commitment of local regulators and international companies to the development of the sector, the sale of microinsurance products is expected to grow in other Latin American nations as well during the next few years.

Future Developments

Microinsurance currently exists largely as a charitable and/or marketing tool. For that reality to ever change, and for microinsurance to truly become a profitable line of business for insurers, a few changes must take place, including the following: (1) as the reach of microinsurance products expands, the overall premium and risk volume will grow exponentially; (2) this will likely lead to a developing sophistication of the microinsurance industry, partly because more

global insurers will be issuing microinsurance products; (3) these global insurers will need to begin treating microinsurance as more akin to other types of insurance that they are writing, finding ways to develop more sophisticated underwriting, actuarial analysis, claims and other functions despite the small sizes of individual policies; (4) as more international insurers issue microinsurance, they will need to begin pooling the microinsurance risks and ceding them to reinsurers just as they cede other risks, something largely absent in the current microinsurance market.

If these changes come to pass, the microinsurance market will eventually operate more like the standard insurance market, and "microinsurance" will simply become another branch of insurance companies' "insurance" operations. If these changes do not occur, microinsurance will remain a largely charitable endeavor, greatly reducing the possibility that it will ever expand to an extent sufficient to fund significant recovery from a disaster such as the earthquake in Haiti.

Piracy does not Pay: High Court Rules on the Interpretation of Actual and Constructive Total Loss

Mr Justice David Steel handed down his judgment in the case of *Masefield AG v Amlin Corporate Member* [2010] EWHC 280 (Comm) on 18 February 2010. The judgment contains a consideration of the concepts of actual and constructive total loss under the Marine Insurance Act 1906 (the Act). A capture of a vessel by pirates does not automatically result in an actual total loss; the facts of each individual case will need to be considered.

Masefield AG (Masefield) was the owner of two parcels of bio-diesel which were shipped onboard the Bunga Melati Dua (the Vessel) owned by MISC, a state owned Malaysian company. Amlin Corporate Member (Amlin) had insured Masefield's cargo under an open cover contract. On 19 August 2008 the Vessel, a chemical/palm oil tanker, was seized by Somali pirates in the Gulf of Aden and taken to Somali waters at a position off the coast at Eyl.

Negotiations started between the owners of the Vessel and the pirates on 20 August 2008 and continued for about a month, resulting in the shipowners paying a ransom and the pirates releasing the Vessel together with cargo and crew. The recovered Vessel arrived at its original destination, Rotterdam, on 26 October 2008. On 18 September 2008, during

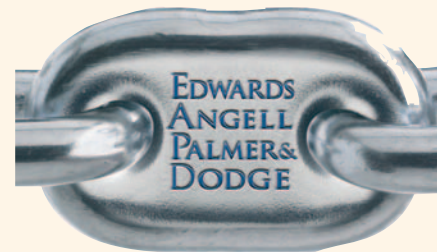
the negotiations between the owner and the pirates, Masefield had served a Notice of Abandonment on Amlin, which was declined.

Masefield's case was that on the capture of the Vessel by the pirates the cargo was an actual total loss under s57 of the Act. In the alternative, Masefield claimed that there had been a constructive total loss under s60(1) of the Act as the Vessel and cargo had been reasonably abandoned on account of its total actual loss appearing to be unavoidable.

Steel J found that there had been no actual total loss under s57 of the Act. The Act required the owner to be "irretrievably deprived" of their property. This was an objective test based on the true facts as of the date proceedings began, in this instance 18 September 2008, the date the Notice of Abandonment



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was served. Although the fact of recovery was not material, the court was entitled to consider the surrounding facts, as this could assist it in ascertaining the probability that Masefield would be irretrievably deprived of its property as of that date.

In order to ascertain this probability, Steel J considered a number of factors, including the broad history of piracy in Somalia, expert evidence from a security consultant providing advice to the international shipping community, and reports of other captured vessels. He commented that the nature of Somali piracy was such that the only realistic and effective manner of obtaining the release of a vessel was the negotiation and payment of a ransom. This was because the lack of any national administration meant that any attempt to intervene by diplomatic means was very difficult and military intervention involved a great many legal and technical difficulties. The modus operandi of the pirates was well known, they would take vessels in order to ransom them and negotiate payments with the owner or any other interested party for the release of the vessel, cargo and crew. The ransom payments normally represented an eco-

nomie proportion of the value of the property at stake.

The expert's evidence was that *"it was more likely than not that the m/v Bunga Melati Dua would be released"* and that this was likely to happen after the payment of a ransom by the owners. Reports of other vessels taken by Somali pirates also suggested that it was highly likely that the Vessel and her cargo would be released within a relatively short period of time.

After considering what degree of probability was sufficient, the judge held that *"an assured is not irretrievably deprived of its property if it is legally and physically possible to recover it (and even if such recovery can only be achieved by disproportionate effort and expense)." It was clearly not the case on these facts that recovery of the Vessel was impossible as it was common practice for Somali pirates to release vessels upon payment of a ransom.*

Mr Justice David Steel therefore rejected Masefield's submission that there was an immediate actual total loss on capture of a vessel by stating that the impact and effect of a capture is fact sensitive and that a straightforward seizure has no effect on the proprietary rights of the assured.

It was for the same reasons that Masefield's claim of constructive total loss under s60 of the Act was also rejected by the High Court. The criteria for this section are that the subject matter must be abandoned (in the sense that the owners do not hope to recover it) because an actual total loss appears unavoidable. In these circumstances the Vessel did not appear to be unavoidably lost. Both the shipowners and Masefield had every intention of recovering their property and were fully hopeful of doing so.

This judgment includes a comprehensive consideration of previous case law on actual and constructive total loss. However, the court's conclusions were drawn on the basis of the factual background and specific circumstances surrounding - this particular capture of a vessel. The case confirms that authorities on actual and constructive total loss should not be applied without taking into account the fact that the rules they provide are fact sensitive. However, the judgment does suggest that it will be difficult for an insured to recover for actual or constructive total loss where the vessel in question has been hijacked by Somali pirates, and where negotiations for the vessel's release are undertaken by the owners.

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