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Insurance & Reinsurance Industry Group: Corporate Insurance & Regulatory Bulletin – Monte-Carlo Rendez-Vous Special

Introduction

As there will be a team of us from Mayer Brown attending this year's forthcoming Rendez-Vous in Monte-Carlo, comprising lawyers from some of our offices in the US, UK and Germany, we have put together this Bulletin as a special edition for the Rendez-Vous.

The world was quite a different place the last time we all gathered in Monte-Carlo for the Rendez-Vous. Of course, a week or so after last year's Rendez-Vous, Lehman Brothers collapsed. How many saw that coming?

There has been plenty of commentary and debate about the reasons for the global financial crisis. A consumer society living beyond its means, inadequate regulatory supervision, a bonus culture which incentivised excessive risk-taking, a lack of understanding of the risk inherent in mortgage-backed securitisation. The list goes on.

With the odd exception, the insurance industry appears to have weathered the financial storm better than the banking industry. Of course, insurance business balance sheets have been hit hard and a number of businesses have raised capital, often by way of a rights issue, in order to strengthen balance sheets. Most, if not all, businesses have taken steps to reduce their cost base, and this has seen an increase in the outsourcing of back-office and non-core business functions.

Inevitably, there has been an increased focus on risk and capital management. There has also been some evidence of an increased appetite for more simple business models and products. The insurance industry is also fearful of being caught up in a regulatory backlash, although to date there does not appear to have been any obvious knee-jerk reaction by any of the world's leading regulators.

Lloyd's of London has, by all accounts, benefitted from the more risk-averse world in which we now find ourselves, with its strong name, "chain" of security, and syndication of underwriting risk being particularly attractive to investors and policyholders alike.

Last year's market turmoil has piqued interest in all manner of transactions at the intersection of reinsurance and the capital markets. While the immediate fallout of Lehman's collapse was a drought in insurance-linked securitisation (along with every other type of structured product and asset-backed securitisation), a new crop of cat bonds and other ILS transactions took root quickly this year after the dust settled. Insurance-linked risk is, of course, not correlated to market or macro-economic risk. This has been borne out during the credit crisis as cat bond pricing has generally held steady.

M&A activity has been patchy to say the least. There are some potential buyers sitting on cash but who remain unconvinced that prices have hit rock-bottom. At the same time, some potential sellers are waiting on the sidelines for market conditions to improve. As and when confidence does return, and there is more debt funding available for those who need it, there is likely to be an increase in M&A activity. The big question is when this is likely to be. The impending introduction of Solvency II may also encourage an increased level of M&A activity.

No doubt, some or all of these issues will be topics of conversation in the cafes, bars and foyers at this year's Rendez-Vous. So too will issues such as whether there are any clear signs of a hardening market, and the outlook for convergence of the insurance and capital markets.

To contribute to the general debate, we have put together this Bulletin which we hope will contain some topics of interest to you.

Analysis of Obama Administration Proposals for an Office of National Insurance

Our May bulletin included an analysis of the National Insurance Consumer Protection Act (H.R. 1880) ("**NICPA**"), which was introduced in the U.S. House of Representatives by Representatives Melissa Bean (D-Ill.) and Ed Royce (R-CA) in April. NICPA would create an optional federal charter for insurance companies, agencies, and insurance producers and would apply to life insurance, property and casualty insurance and reinsurance. Although NICPA garnered considerable attention when it was first introduced, it has not made progress in any of the House committees to which it was referred, nor has companion legislation been introduced in the U.S. Senate. It is fair to say that NICPA has been eclipsed by the federal insurance regulatory initiatives that were announced as part of the Obama Administration's "Financial Regulatory Reform" ("**FRR**") proposals in June and embodied in a draft "Office of National Insurance Act of 2009" (the "**Act**") that was released by the U.S. Department of the Treasury ("**Treasury**") on July 22.

The Administration's FRR proposals would establish an Office of National Insurance ("**ONI**") within Treasury. At first glance, the role of the ONI envisioned by the FRR proposals seems modest: "to gather information, develop expertise, negotiate international agreements, and coordinate policy in the insurance sector." On closer examination, however, the FRR proposals are replete with explicit and implicit criticisms of the existing state-based system of insurance regulation in the United States, which suggests a broader agenda. For example, the FRR document asserts that the state-based system "has led to a lack of uniformity and reduced competition across state and international boundaries, resulting in inefficiency, reduced product innovation, and higher costs to consumers." It also calls for "a modern regulatory framework for insurance," implying that the existing regulatory framework is not modern, i.e., outmoded. So it is too early to tell whether the ONI, once established, would be merely an information gathering and coordinating agency, or a step toward federalization of insurance regulation in the United States.

The FRR proposals outline the following six principles for insurance regulation:

1. Effective systemic risk regulation with respect to insurance

   The ONI would have the authority to "monitor all aspects of the insurance industry, including identifying issues or gaps in the regulation of insurers that could contribute to a systemic crisis in the insurance industry or the United States financial system." In particular, the ONI could recommend to the Federal Reserve that it designate an insurer, including its affiliates, as an entity subject to regulation as a Tier 1 financial holding company ("**FHC**") under the Bank Holding Company Act of 1956. FHCs and their subsidiaries would be subject to supervision and regulation by the Federal Reserve and to a federal resolution regime, similar to that of the Federal Deposit Insurance Corporation, that could take control of an FHC and its subsidiaries in a crisis situation.

2. Strong capital standards and an appropriate match between capital allocation and liabilities for all insurance companies

   The FRR proposals state that any insurance regulatory regime "should include strong capital standards and appropriate risk management, including the management of liquidity and duration risk." Initially the ONI's role in furthering that objective would be informational and consultative: receiving and collecting data and information on and from the insurance industry and individual insurers, analyzing and disseminating data and information, issuing reports regarding all lines of insurance (except health insurance) and consulting with state regulatory authorities.

3. Meaningful and consistent consumer protection for insurance products and practices

   The FRR proposals assert that consumer protections currently vary widely among states, creating a need to "enhance consumer protections and address any gaps and problems that exist under the current system, including the regulation of producers of insurance." It is unclear how the ONI intends to go about this task. Significantly, the proposed Consumer Financial Protection Agency ("**CFPA**") Act of 2009 (another component of the Administration's FRR initiatives) would exclude from the scope of the CFPA's authority all insurance activities except for credit, mortgage and title insurance.

4. Increased national uniformity through either a federal charter or effective action by the states

   The FRR proposals declare: "Our current insurance regulatory system is highly fragmented, inconsistent, and inefficient. While some steps have been taken to increase uniformity, they have been insufficient." The Act (in contrast to NICPA) does not include provisions for a federal charter, so it appears that, once again, the ONI's role initially will be limited to gathering and analyzing data and formulating recommendations. The question is: where will that process lead?

5. Improve and broaden the regulation of insurance companies and affiliates on a consolidated basis, including those affiliates outside of the traditional insurance business

   The FRR proposals cite AIG as an example of how the problems of an insurance company's affiliates "can grow to threaten the solvency of the underlying insurance company and the economy" and concludes that any new regulatory regime "must address the current gaps in insurance holding company regulation." The FRR proposals assume that federal regulation of insurance holding companies would be more robust than current state regulation. One wonders, however – since in the early stages of the AIG crisis, it was the federal authorities who were encouraging state insurance regulators to override state insurance holding company restrictions to allow the extraction of insurance company assets to bail out AIG's troubled financial products segment.

6. International coordination

   The FRR proposals note: "The United States is the only country in the International Association of Insurance Supervisors (IAIS – whose membership includes insurance regulators and supervisors of over 190 jurisdictions) that is not represented by a federal insurance regulatory entity able to speak with one voice." The Act would grant the ONI specific powers to remedy this deficiency. The ONI would represent the United States in the IAIS and assist the Treasury in negotiating International Insurance Agreements on Prudential Measures. The ONI would also be authorized to determine that specific state insurance measures are pre-empted if they treat a non-US insurer that is subject to an International Insurance Agreement on Prudential Measures less favourably than a US-domiciled insurer or are otherwise inconsistent with an International Agreement on Prudential Measures.

As of this writing, the Act stands a high likelihood of being enacted into law by the current Congress. While the most immediate results of the creation of the ONI would be in the area of systemic risk regulation and international coordination, the Act may also have a longer-term impact in terms of increasing the federalization of insurance regulation in the United States.

The FSA focus on City bonuses

The FSA has increased its focus on remuneration practices within regulated firms as part of the fallout from the credit crunch. For example, this now forms part of its Arrow Programme. An important element of this is the eagerly awaited FSA Code of Practice on remuneration policies, which was published last Wednesday. Whilst the final version of the Code does not contain any surprises, the FSA has watered down several proposals.

The Code will be of particular interest for larger banks, building societies and broker dealers as it applies specifically to them. However, the Code is also an important issue for all FSA regulated firms, trade bodies and consumer groups as it sets out the FSA's position on financial services pay practices. Many financial institutions will want to be seen to be exercising good practice even if the Code does not apply to them directly. In addition, in October 2009, the FSA will report on whether to extend the Code to apply directly to all FSA regulated firms.

What impact does the Code have?

The main principles remain broadly the same as the draft consultation published in March 2009. However, the FSA has given firms greater leeway in devising remuneration packages than anticipated. As a result the final version of the Code is much less prescriptive than the March draft. The key aim remains to get firms to establish remuneration policies that are consistent with and promote effective risk management.

The FSA has softened its approach on the implementation of low risk remuneration structures by reducing the applicability from all employees to employees in a "senior influence function" or employees whose activities could have a material impact on the firm's risk profile. In addition three of the Code's proposed "rules" have been amalgamated and their status reduced to "guidance". Whilst there may now be scope for firms to interpret this guidance more widely, it must still be taken into account when deciding how to meet the rule.

Three key highlights of the Code on remuneration structures are:

- firms must not offer guaranteed bonuses for more than one year;
- at least two thirds of any bonus payment should be deferred and spread over at least a three year period for senior employees in circumstances where such bonus is significant when compared with the fixed part of such employee's remuneration; and
- remuneration awards should be based on an appropriate combination of factors including the future performance of the firm and a division or business unit.

The FSA has stated that it intends to police compliance with the Code and enforcement action will be taken where appropriate.

Who is effected by the Code?

The FSA believes the Code will apply to around 26 banks, building societies and broker dealers operating in London rather than the 47 originally anticipated. The Code will not apply to UK branches of firms headquartered elsewhere in Europe as responsibility for controls in those cases is for the appropriate home country authorities. However, the Code will apply to overseas branches of UK firms (both inside and outside Europe) where certain tests are satisfied. Concerns have been raised that the Code could have adverse competitive implications for the UK, if other countries do not implement similar or identical principles.

At present the FSA has not published a list of the firms affected but will contact them in writing shortly. Firms who believe that are caught by the Code, but who do not receive a letter, should contact the FSA.

When does the Code take effect?

The implementation date has been delayed from 6 November 2009 to 1 January 2010. The FSA expects changes to policies and procedures to be fully in place by 1 January 2010 and changes to remuneration structures and contracts being implemented with effect from the same date.

Some additional time is offered for terms in contracts of employment, which were entered into before 18 March 2009, where these are not compliant with the Code. These must be amended by 31 March 2010, with all offending practices ceasing by 31 December 2010.

Prior to the implementation date, affected firms will need to submit remuneration policy statements to the FSA by 31 October 2009. These will have to be signed off by remuneration committees and are intended to enable the FSA to check compliance with the Code.

Wider implications

The extent to which the City bonus culture contributed to the ongoing market turmoil has been the subject of much debate and discussion. The FSA concedes that the Code is not going to change "bonus culture" overnight. Commentators have questioned whether the Code will make any impact on remuneration practices at all.

Hector Sants, Chief Executive of the FSA, appeared to shift responsibility for controlling City pay away from the FSA to the Government. In a recent interview on BBC Radio 4, he stated that "there may well be a debate as to whether bankers should be paid multiples of [the pay of] doctors or others but that debate is for Government". It has been suggested that the only way to stop the City maintaining the "bonus culture" is for Parliament to adopt legislation dealing with the issue. With reports circulating of certain banks anticipating large bonus pools for 2009 we are certain that this issue will continue to generate debate and further scrutiny.

Administration fees in respect of insurance contracts

The High Court has ruled in the recent case of *Homeserve Membership Limited v HM Revenue & Customs* that insurance premium tax ("**IPT**") was not payable on an "arrangement and administration" fee which was separately identified to the customer and which was paid under a separate contract with an insurance intermediary.

Under the Finance Act 1994, IPT is charged on payments under taxable insurance contracts. There is, however, an exception for amounts charged under a separate contract which are separately identified in writing to the customer.

Homeserve arranges and administers domestic plumbing and electrical breakdown insurance policies on behalf of insurers. In 2004, it restructured its contractual arrangements; it sent marketing material to its customers explaining that they would have one contract with Homeserve which covered the arrangement and administration of the insurance policy (for which a fee would be charged) and a separate contract of insurance with the insurer.

The Tribunal found that the arrangement and administration fee payable under the contract between the customer and Homeserve was subject to IPT on the basis that it was not economically separate from the insurance contract and therefore did not fall within the exception discussed above. The High Court, however, has allowed Homeserve's appeal, finding that the phrase "separate contract" had no special meaning. Provided that the contract between the customer and the policy administrator is separate from the contract of insurance with the insurance provider (and provided that the separate amount is identified in writing to the customer), the fee charged under the former contract should not be subject to IPT.

This decision would appear to be welcome news for insurance intermediaries and insurance providers which have made use of similar contractual arrangements. HM Revenue & Customs ("**HMRC**") has announced that it will not appeal the High Court's decision and has stated that claims by businesses which have adopted such structures will be honoured subject to the normal rules. However, it also stated that "where fees are artificially carved out of what would be taxable insurance premium, IPT is properly due" and stated its intention to "close the loophole exposed by the outcome of the Homeserve litigation". What will now be acceptable to HMRC is far from clear. It is also unclear whether HMRC intends to legislate to reverse the Homeserve decision.

There will be a period of consultation with the insurance industry before the changes to the legislation are announced.

HM Treasury's "Vision for the insurance industry in 2020"

On 27 July 2009, the Insurance Industry Working Group ("**IIWG**") published a well publicised report providing its views and recommendations on how to enhance the UK insurance industry in light of the medium to long-term challenges and opportunities facing the insurance sector.

In the report, the IIWG has agreed a vision for the UK's insurance industry in 2020. The IIWG wants "the UK to be the leading global insurance centre with an unsurpassed reputation for excellence, a deep and constructive relationship with its customers and a close and effective partnership with Government".

The IIWG recommendations to achieve this vision are underpinned by the following four main themes:

1. creating a more customer-focused approach to increase customers' confidence and trust in the insurance industry (as well as furthering customers' awareness of their own personal responsibility);
2. producing a broad range of risk management solutions, which provide customers with the products they need at a competitive price;
3. for the insurance industry to act in partnership with the Government to explore options to increase savings and protection provision and to help consumers manage financial distress; and

4. ensuring the UK insurance industry's competitive position in the global marketplace is maintained and enhanced, and that capital can earn a competitive return, in order to encourage capital flows into the UK insurance industry.

The report builds on these themes and sets out numerous recommendations to both the Government and the insurance industry. These recommendations include, amongst others:

1. developing a more co-ordinated approach to financial literacy and education and raising awareness of the need for appropriate levels of personal savings and protection amongst consumers;
2. as far as possible, allowing time for existing initiatives to be implemented and to start having an effect before introducing any further significant new retail regulation initiatives;
3. that legislative and/or regulatory changes support the industry's ability to price according to risk factors;
4. that industry and the Government assess the scope for a greater industry role in helping people deal with risks such as unemployment, ill-health, and the need for retirement income or long-term care;
5. that the Government should continue to work with industry to ensure a stable, predictable and competitive tax system for the medium to long-term, which is aligned to the Vision for 2020 and takes account of increasing global competition in a world in which capital is highly mobile;
6. that the industry should develop and attract the best talent to ensure there is a deep pool of insurance professionals with the right skills in insurance, technical and managerial disciplines; and
7. that the Government should proactively support the UK's insurance business abroad, particularly in emerging markets, and within the UK.

Mr Andrew Moss, the Industry co-chair and Group Chief Executive of Aviva, highlighted in his forward that "Our recommendations should not be broken off and implemented piecemeal. To maximise their effectiveness they should be taken forward as a package. The recommendations complement each other, build on each other's strengths, and together create a virtuous circle." The report suggests that the ABI is best placed to take the recommendations in the report forward and that an initial meeting between the ABI and the Treasury should take place to agree the next steps.

Finally, the report also highlights the benefits of a more co-ordinated approach between the Government and the Industry and the IIWG has asked the ABI to review possible methods of doing this going forward (e.g. a cross-industry forum meeting a few times a year to examine common issues). As highlighted by both Alistair Darling and Andrew Moss in their forewords, an effective partnership between the insurance industry and Government is key to the UK fulfilling its potential as the leading global insurance centre.

To view the entire IIWG report, please click here.

Audit liability and fraudulent corporate vehicles – the House of Lords opines

In a judgment delivered on 31 July, the House of Lords has upheld the Court of Appeal judgment of 18 June 2008 by which it struck out the claim of Stone & Rolls Ltd against its auditors. The Judgment is important for auditors and will be of interest to companies, their creditors and directors and their insurers in relation to the circumstances in which knowledge of wrongdoing on the part of a company's management may prevent the recovery of money from third parties.

THE FACTS

The essence of the claim brought by Stone & Rolls Limited (in liquidation) (the "**Company**") against its auditors Moore Stephens (the "**Firm**") was that the Firm had negligently failed in the course of its various audits to detect the fraudulent behaviour of Mr Zvonko Stojevic. Mr Stojevic, the sole directing mind and will of the Company, had used the Company to commit a letter-of-credit fraud against banks. The fraud consisted of the presentation by the Company of false documents to the banks, the receipt of funds by the Company and the payment away of those funds to other parties, leading to a claim in the region of $174 million pursued by the liquidator in the name of the Company.

THE ISSUES AND JUDGMENT AT FIRST INSTANCE

At first instance before Langley J, the Firm submitted in its defence that the Company was never in any real sense deprived of its money by the fraud but was simply used as a conduit for the passage of funds. In essence, the Company's claim involved it seeking to rely upon and recover a loss caused by its own fraud – as such, on the basis of the maxim ex turpi causa (no action will arise out of an illegal or immoral act), the Company could not claim losses suffered as a result of its own criminal conduct, the claim was doomed to failure and should be struck out. The Company, in turn, submitted that Mr Stojevic's dishonesty was not to be attributed to the Company, which was not, therefore, relying upon its own fraudulent conduct in bringing the claim; alternatively, the Firm could be liable because the Company's illegal conduct was the 'very thing' that the Firm was under a duty to prevent.

Whilst finding that Mr Stojevic was the directing mind and will of the Company such that his knowledge and wrongdoing was properly attributable to the Company; and that there was no compelling reason in these circumstances why the Company should not be subject to the ex turpi causa principle, Langley held that the principle could not prevent a claim founded on fraud that would not have occurred had the Firm properly complied with their "very duty" as auditors of the company (which included the discovery and reporting of fraud). In such a situation, the conscience of the ordinary citizen would not find the pursuit of the claim so repugnant that it ought to be prevented "by use of the unforgiving and uncompromising operation of the ex turpi maxim".

THE JUDGMENT OF THE COURT OF APPEAL

The Court of Appeal reversed this decision and ordered that the Company's claim be struck out.

- Ex Turpi causa

  The Court of Appeal noted that there was no dispute on the facts of this case that the Company's claim relied upon, was based substantially on and was inextricably linked with the fraud that was perpetrated on the banks. In such circumstances, the victims of the fraud were the banks. There was no prospect of establishing at trial that the Company was the victim of the fraud.

- Attribution

  It followed that the next question was whether in these circumstances Mr Stojevic's fraud could properly be attributed to the Company. On this issue, the Court of Appeal held that, where Mr Stojevic "owned the Company and controlled it in its every relevant act", his dishonest intention could properly be attributed to the Company which could be as much a wrongdoer as the individual involved. In such circumstances, the claim by the Company could be met by the plea of ex turpi causa which would afford a complete defence to the claim, subject only to consideration of the Company's second submission that this principle could not provide a complete defence when the detection of dishonesty was "the very thing" that the Firm was retained to do.

- "The Very Thing"

  The Court of Appeal accepted the submissions of Jonathan Sumption QC, on behalf of the Firm, that "the very thing" concept arising before the Court of Appeal in Reeves v Comr of Police of the Metropolis [1998] 2 All ER 381 is a concept that is about causation and does not displace the operation of the ex turpi causa defence so as to enable the bringing of a claim that relies on the claimant's illegality.

In the words of Lord Justice Mummery, "it is contrary to all common sense to uphold a claim that would confer direct or indirect benefits on the corporate vehicle, which was used to commit the fraud and was not the victim of it, and the fraudulent driver of the fraudulent vehicle."

THE JUDGMENT OF THE HOUSE OF LORDS

The Law Lords have dismissed the Company's appeal and so its claim against its auditors remains struck out – but only by a majority of 3:2. The judgments are lengthy and complex and vary in their reasons (with two of those upholding the decision of the Court of Appeal doing so on different grounds to the lead judgment in that Court). It is nevertheless possible to draw some themes from the majority judgments:

- the Company's claim for compensation was defeated by the ex turpi causa principle because the perpetrator of the fraud was also the sole directing mind and will and beneficial owner of the Company, which could not properly be treated as also being a victim of the fraud and the Court will not assist a Claimant to recover compensation for the consequences of his own illegal conduct

- the Court of Appeal decision had been described as limiting the application of the ex turpi causa principle to 'one-man' companies. The Lords' majority make it clear that it may apply in situations involving more than one director or shareholder, as long as all are complicit in the fraud (including by way of reckless indifference). This may include circumstances in which other directors or shareholders are subservient to a dominant personality; and where there are two or more individual directors and shareholders acting closely in concert
- it appears that their Lordships were not persuaded that ex turpi causa would defeat a claim by a company against its auditors in circumstances in which there were "innocent" directors and shareholders – but that was not the situation in this case
- caution should be adopted in seeking to establish general propositions from this case of wider application to different sets of facts. In concluding that it was in his judgment appropriate for summary disposal, Lord Walker noted that it was "...a rare and extreme case...".

majority (Lords Phillips, Walker and Brown) differed in their reasoning as to why the "blunt instrument" of ex turpi causa should not be overridden. Lord Walker and Lord Brown agreed that the principle in Hampshire Land (that it would be "unjust to its innocent participators (honest directors who were deceived, and shareholders who were cheated)" to fix a company with its directors' fraudulent intention) did not apply where there were no honest directors or shareholders and "ex hypothesi no innocent participator". They also agreed with the submissions made by Jonathan Sumption QC in the Court of Appeal as to why ex turpi causa is not trumped by "the very thing" argument.

Lord Phillips, however, giving the lead judgment, preferred to analyse the issue in terms of the scope of an auditor's duty of care – i.e., not whether the fraud should be attributed to the Company but whether ex turpi causa should defeat the Company's claim for breach of the auditor's duty, which "in turn depends, or may depend, critically on whether the scope of the auditor's duty extends to protecting those for whose benefit the claim is brought". In this case, the ultimate beneficiary of a successful claim would be those that the company defrauded, the banks. It was clear that Lord Phillips saw no prospect of (or did not wish himself to contemplate) an expansion of the present law so as to extend the duty of care owed by auditors for the benefit of those that a company might defraud. He concluded that all whose interests formed the subject of any duty of care owed by the Firm to the Company in this case, namely the Company's sole will and mind and beneficial owner Mr Stojevic, were party to the illegal conduct that formed the basis of the company's claim and it was on this basis that ex turpi causa provided a defence.

THE DISSENTING JUDGMENTS

In contrast to Lord Phillips, the dissenting judgments of Lord Mance and Lord Scott postulate that a duty is owed by auditors (as officers of the company) for the benefit of innocent creditors in the case of a company that is insolvent or threatened with insolvency and that ex turpi causa should not defeat a claim brought for their benefit. There is a lack of clarity in the judgments as to whether this would amount to a departure from or at least an extension to the long established principles laid down

by the House of Lords in Caparo Industries v Dickman [1990] 2 AC 603. That case established that the duties of an auditor are owed to the company in the interests of its shareholders as a body. No duty is owed directly to individual shareholders (because the shareholders' interests as a whole are protected by the duty owed to the company), and no duty is owed to creditors.

Lord Mance in particular was clearly influenced by policy considerations around some of the high profile frauds discovered in the current financial crisis. He points out that many large financial enterprises are run by one person and states that these are the very companies which auditors should be the most vigilant to protect. Referring, earlier in his Judgment, to auditors as watchdogs if not bloodhounds, he concludes that the decision of the majority of the Law Lords "will weaken the value of an audit and diminish auditors' exposure in relation to precisely those companies most vulnerable to management fraud".

IMPLICATIONS

The decision of the House of Lords and the judgments of the majority are obviously helpful to auditors. Whilst its application is clearly fact sensitive and will depend on the degree to which, in any given case, it is established that those responsible for the perpetrated fraud effectively amount to the "sole directing mind and will of the Company involved", its effect is not limited to so called 'one man' companies, so long as all those involved are complicit in the fraud and there are no "innocent participators". It is important to note that the case does not interfere with the principles of attribution derived from Hampshire Land whereby the intention of a dishonest agent who is not the directing mind and will of a company will not generally be attributed to it for the purposes of claims against others or so as to prevent indemnification of the innocent parties.

The claim in this case was one of the first significant claims to use commercial third party funding. It will be interesting to see if the result discourages similar claims or whether the absence of conformity of reasoning on the part of the majority, combined with powerfully expressed dissenting judgments and their emphasis on wider public policy factors, will instead encourage potential claimants and their backers in the current environment still to bring claims.

Wasa v Lexington [2009] UKHL 40

BACK TO BACK?

It may have been thought safe to assume that cover under a facultative contract of reinsurance, incorporating the terms of the underlying insurance contract, and cover under the insurance contract, will be back to back, even if the laws by which they are governed differ. The long awaited decision of the House of Lords in Wasa v. Lexington clarifies the limits to when this assumption may be relied upon.

THE FACTS

Lexington issued an "All Risks Difference in Conditions" Property Damage Insurance Policy (the "**Policy**") to the Aluminium Company of America ("**ALCOA**") for the period 1 July 1977 to 1 July 1980.

The Policy was not subject to an express choice of law provision but contained a US Service of Suit clause, requiring Lexington, at the request of ALCOA, to "submit to the jurisdiction of any Court of Competent Jurisdiction within the US".

Lexington reinsured the risk covered under the Policy under a proportional facultative reinsurance contract (the "**Reinsurance Contract**"). The Reinsurance Contract, like the Policy, was for the period 1 July 1977 to 1 July 1980. It contained the following full reinsurance and follow the settlements wording: "Being a reinsurance of and warranted same gross rate, terms and conditions as and to follow the settlements of the Company...".

The parties agreed that the Reinsurance Contract was subject to an implied choice of English law.

In the early 1990s, ALCOA was required by the US Environmental Protection Agency to clean up pollution and contamination at various manufacturing sites used by ALCOA.

ALCOA sought to recover the costs from its insurers, including Lexington, with which ALCOA had cover in the period during which the damage had occurred - some fifty years dating back to 1942. ALCOA issued proceedings against these insurers in the State of Washington. The trial court in Washington found that the damage in respect of which ALCOA sought an indemnity had accrued over many years, including between 1977 and 1980. Therefore, the question arose of how the loss should be allocated between the different insurers and years of cover.

The trial court held that the law applicable to determining coverage was the law of Pennsylvania. The trial court further held that the loss could be allocated pro rata by dividing the total cost by the number of years during which the damage had accrued. Allocated in this way, the loss for which Lexington was held liable was only a small percentage of the total loss.

ALCOA appealed against the trial court's decision. On appeal, the Supreme Court of Washington held that the Insuring Clause of the Policy (in common with policies issued by other defendant insurers) covered losses arising from damage that had occurred before inception and during the policy period, provided only that the loss was "manifest" during the policy period. On this basis, the Supreme Court found the insurers, including Lexington, to be jointly and severally liable for the total loss suffered by ALCOA.

Facing a claim of some US$180 million, Lexington settled for just over US$103 million and sought to recover from its reinsurers. Wasa issued proceedings in the Commercial Court for a declaration that they were not liable on the basis that the Reinsurance Contract was governed by English law and, as a matter of English law, only covered losses occurring from 1 July 1977 to 1 July 1980. A large proportion of the loss in respect of which Lexington had been held liable and to which the settlement of ALCOA's claim related had occurred before this period and therefore did not, on Wasa's view, fall for cover under the Reinsurance Contract.

At first instance, Simon J found in favour of Wasa. This decision was overturned by the Court of Appeal, the decision of which was the subject of the appeal before the House of Lords.

THE DECISION

The House of Lords (the leading judgment was given by Lord Collins) approached the issues raised by the appeal by recognising that the risk covered by a contract of proportional reinsurance will usually be co-extensive with the risk covered by the underlying insurance contract (absent any express indication to the contrary). This being the case, it may be assumed that the intention of the parties will be that wording of the reinsurance contract is to be interpreted as "back to back" with the insurance contract. However, a reinsurance contract is independent of the underlying insurance contract and liability under a reinsurance contract will therefore only arise in respect of risks falling within the cover created by the reinsurance. The position in this regard is not changed by follow the settlements wording. Therefore, Wasa could only be liable to Lexington if the loss in respect of which Lexington sought an indemnity fell within the cover created by the Reinsurance Contract.

In support of their position, Lexington relied on the decisions in Vesta v Butcher [1989] AC 852 and Groupama v Catatumbo [2000] 2 Lloyd's Rep 350. These decisions are authorities for the principle that, if a reinsurance contract and the underlying insurance contract are governed by different laws, the terms incorporated from the insurance contract into the reinsurance contract shall have the same meaning and effect as in the insurance contract.

The House of Lords considered that these cases only supported a principle of construction, to be applied only after taking into account all the relevant circumstances of the reinsurance. One key factor that distinguished the circumstances of Wasa from those of Vesta v Butcher and Groupama v Catatumbo was that, at the time the reinsurance contracts of concern in these earlier cases were entered into, the law by which each insurance contract was governed was readily ascertainable and would have been in the contemplation of the parties. By contrast, the Lexington Policy was not subject to an express choice of law. However, it was subject to a US Service of Suit clause and the property insured was located in a variety of different US (and non-US) jurisdictions. For these reasons, the House of Lords did not consider that the parties, at the time the Reinsurance Contract was entered into, could have ascertained under which law coverage under the Policy would be determined. Therefore, the reinsurers could not consult what was referred to in Vesta v. Butcher as a notional "foreign legal dictionary" to interpret the Reinsurance Contract in a manner differently from its ordinary meaning under English law.

The House of Lords rejected the suggestion that, because the Washington court had found that Pennsylvanian law applied in relation to coverage, this must, all along, have been the law applicable to determining questions of coverage. The basis for the House of Lords conclusion in this regard was that the Washington court's decision to apply Pennsylvanian law in relation to coverage had been driven by the requirement to adopt a law for this purpose that had a common connection with all the parties and sites involved in the litigation, which included many insurers other than Lexington and many jurisdictions. The Washington Court's decision to apply the law of Pennsylvania had been taken by reference to factors extraneous to the Policy.

COMMENT

The House of Lords ruling limits the application of the principle that, in relation to facultative contracts of reinsurance that are not governed by the same law as the underlying insurance, terms that the reinsurance incorporates from the underlying insurance are to be given the same meaning and effect as under the law by which the insurance is governed. According to Wasa, this principle will not apply if, at the time the reinsurance contract is entered into, the law by which the insurance contract is governed is not identifiable or ascertainable. This is because the reinsurer has no "foreign legal dictionary" to consult.

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