GLOBAL INSURANCE INDUSTRY
YEAR IN REVIEW
2019
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Insurance M&A activity in the life and annuity sector remained strong in 2019. According to data compiled by S&P Global Market Intelligence, 22 deals were announced or closed in 2019 with total deal value of $9.3 billion. The fourth quarter of 2019 witnessed the strongest quarterly deal volume in the past year, largely due to New York Life’s announced transaction with Cigna as discussed below. Many of the transactions announced during 2019 underscore the continuing theme of publicly-traded life and annuity carrier groups disposing of non-core or legacy business, particularly capital-intensive lines. In contrast to 2018, this year did not witness any major publicly-announced transactions in the long-term care or variable annuity lines.

Significant Deals

In December 2019, New York Life agreed to acquire Cigna’s US group disability and life insurance business for $6.3 billion. The deal is expected to close in the third quarter of 2020. This transaction marks the largest disclosed deal value among insurance M&A transactions in the life sector in 2019. New York Life stated that the acquisition will enhance its portfolio of strategic businesses and add an experienced management team and qualified workforce to New York Life. For Cigna, the transaction is an opportunity to divest a non-core asset.

Also in December 2019, Resolution Life announced an agreement to acquire the in-force individual life business of Voya Financial, Inc. for a total value of $1.25 billion. The deal is structured as a combination of the acquisition of Security Life of Denver Insurance Company, Midwestern United Life Insurance Company and certain other affiliates, and the reinsurance of Voya Financial’s remaining in-force individual life and annuity blocks. The acquisition adds a growth platform in the US for Resolution Life, which, along with Resolution Re in Bermuda and AMP Life in Australia and New Zealand, strengthens Resolution Life’s stated global strategy. Resolution Life noted in its press release that the transaction is further evidence of the continuing restructuring of the life insurance sector in the US and globally, and that major life insurance groups continue to reduce their exposure to legacy in-force business and to release trapped capital and resources.

2019 also saw a steady stream of block reinsurance transactions. As one example, in June 2019 Reinsurance Group of America (“RGA”) announced its completion of a $2.9 billion annuity reinsurance transaction with Horace Mann Life Insurance Company. A subsidiary of RGA will reinsure a seasoned
block of US annuity business of Horace Mann, and Horace Mann will continue administering the policies. In entering into this reinsurance arrangement, RGA explained that it expects to expand and strengthen its partnership with Horace Mann and advance its long-term strategy to grow asset-intensive business. Notably, we continue to see many block reinsurance transactions run as auction processes, often with multiple serious bidders.

**Continued Interest from Private Equity Investors**

Private equity investors are now firmly entrenched as significant investors in the US life and annuity space. Increasingly, private equity investors have entered into significant asset management arrangements with affiliated or third-party asset managers to manage both traditional and alternative investments backing acquired life and annuity businesses. As one example, in January 2019, an investment partnership funded by affiliated entities of Elliott Management Corporation, operating principals of Wand Partners, Inc., and Anurag Chandra, CEO of Prosperity Life Insurance Group, LLC, acquired majority equity interests in Prosperity Life from its previous majority shareholders, including funds managed by Reservoir Capital Group, LLC and Black Diamond Capital Partners.

Another example was the November 2019 announcement that The Carlyle Group (“Carlyle”) and T&D Holdings had agreed to acquire 76.6% ownership interest in Fortitude Group Holdings from American International Group, Inc. for approximately $1.8 billion. After the closing, Carlyle and its fund investors will own 71.5% of Fortitude Re, T&D Holdings will own 25% and AIG’s ownership interest will be reduced from 80.1% to 3.5%. The parties expect the transaction to provide Fortitude Re with access to Carlyle’s investment expertise and T&D Holdings’ industry and international expertise, which will help Fortitude Re pursue global opportunities to acquire and manage legacy insurance portfolios.

In May 2019, Athene Holding Ltd. signaled its intent to continue to pursue inorganic growth by establishing a long-duration, “on-demand” capital vehicle named Athene Co-Invest Reinsurance Affiliate (“ACRA”). ACRA is expected to participate in qualifying transactions by drawing two-thirds of the required capital for such transactions from third-party investors. Athene reports that ACRA will be managed to the same investment, risk and capital standards as all other Athene subsidiaries, and will have access to a pool of third-party capital, targeted at up to $4 billion in total.

**Outlook for 2020**

We expect that in 2020 sellers will continue to consider divesting non-core, lower-return and/or capital-intensive businesses. This will be facilitated by an expanding universe of private equity-backed and other prospective buyers, with a heavy emphasis on asset management.
The largest deal by value in the European life sector was Phoenix Group Holdings Limited’s purchase of ReAssure Group Plc from Swiss Re Ltd and MS&AD Insurance Group Holdings Inc. for a total consideration of £3.25 billion. The combined Group post-acquisition is expected to be the largest life and pensions consolidator in Europe, with completion expected to occur in mid-2020.

The announcement of the purchase of ReAssure itself came four months after the announcement, in August 2019, of the £425 million purchase of Old Mutual Wealth Business Service Ltd. by ReAssure from Quilter plc. in a deal that saw approximately 200,000 UK-based customers transfer to ReAssure.

2019 also saw the announcement of the £500 million purchase of VIVAT Schadeverzekeringen N.V. by NN Group N.V. from Athora Holding Ltd.

Generali was particularly active, agreeing to sell its UK life legacy business to Reinsurance Group of America in May 2019, a month after it had signed an agreement to take over the entire life, non-life and composite insurance portfolios of three entities of ERGO International AG in Hungary and Slovakia, continuing for another year the reform strategy identified in our 2018 Year in Review.

Also, as outlined in the 2018 Year in Review, Monument Re, the Bermuda-based reinsurance consolidator, continued to actively expand its European life insurance offering through multiple M&A transactions, acquiring: in Belgium, a closed book of life business from Curalia OVV and a runoff portfolio of traditional life and credit life business from Alpha Insurance SA; Inora Life DAC from Société Générale through its Irish subsidiary, Laguna Life d.a.c.; also in Ireland, a €140 million portfolio of annuities from Rothesay Life Plc, and Cattolica Life, a life insurer domiciled in the country, from Cattolica Assicurazioni; Nordben Life and Pension Insurance Co. Limited from BenCo Insurance Holding B.V.; a runoff portfolio of linked and traditional business from MetLife Europe d.a.c.; and Robein Leven N.V. from Amerborgh Financial Services B.V.

Another deal of note was the transfer of Equitable Life’s policies (other than Irish and German policies) to Utmost Life and Pensions on 1 January 2020; the Irish and German policies remain with Equitable Life, which has become a subsidiary of Utmost Life and Pensions, drawing a line under a long-running, high-profile collapse of Equitable.

Following on from a deal highlighted in the 2018 Year in Review, Standard Life Aberdeen’s sale of its insurance business to the Phoenix Group for £3.3 billion, 2019 saw the disposal by Standard Life, through its subsidiary Standard Life (Mauritius Holdings) 2006 Limited, of 3.33% of its interest in HDFC Life Insurance Company Limited.
Hong Kong
In June 2019, FWD Management Holdings Limited announced its acquisition of MetLife Limited and Metropolitan Life Insurance Company of Hong Kong, which are both wholly-owned subsidiaries of MetLife Inc (US). The deal is estimated to be valued at just shy of US$400 million. MetLife Hong Kong, which provides innovative products and operates a strong distribution network, is said to be highly complementary to FWD’s existing business and the acquisition of Metlife’s Hong Kong operations is a step towards FWD’s ambition to build a leading pan-Asian life insurance platform.

In May 2019, Hong Kong-based asset manager Ion Pacific invested US$7.3 million in Singapore’s digital life startup, Singapore Life. The investment gives Ion Pacific an exposure to Southeast Asia’s life insurance market, as it continues to strive to provide creative financing solutions to the global innovation economy.

Earlier in January 2019, Sun Life Hong Kong completed a strategic investment in Bowtie Life Insurance, which became the first virtual insurer in Hong Kong last year. The investment is part of Sun Life’s digital transformation strategy to make investments in early stage businesses with potential to transform the insurance industry, reflecting its belief in technology and innovative protection solutions.

Despite the escalating civil unrest throughout the second half of the year, Hong Kong witnessed some noteworthy developments in the insurance industry in 2019. Since April this year, Hong Kong residents have become eligible for the government’s new Voluntary Health Insurance Scheme (“VHIS”), which aims to encourage residents to use private healthcare services through individual indemnity hospital insurance. Under the scheme, participating insurers must develop certified plans which satisfy the benefit standard prescribed by VHIS. With the new scheme in place, Hong Kong expects to see relief on the overburdened public healthcare system in the next few years.

As a result of the ongoing protests in the city, Hong Kong’s insurance sales have taken a hit as purchases by mainland Chinese customers declined in the third quarter of the year as they avoid visiting the troubled city. According to the Hong Kong Insurance Authority (“HKIA”), mainland Chinese purchases of insurance and related investment policies in the third quarter of this year declined by 18% to HK$9.7 billion from the previous year. The hit has more adversely affected niche companies which sell health, medical or retirement packages to mainly Chinese customers.
In October 2019, the HKIA granted its first virtual general license to Avo Insurance as the regulator continues to encourage wider use of technology among Hong Kong’s insurers. In December 2018, Bowtie Insurance was granted the first virtual life insurance license which permitted the sale of medical and accident insurance products. Avo’s general license will allow them to sell a range of products including property, travel, fire and car insurance cover. The increasing number of virtual licenses being granted in the city helps boost Hong Kong’s insurtech sector, which enhances overall customer experience.

Also in October 2019, HSBC Life partnered with Preferred Global Health (“PGH”) to provide Global Medical Care Services to customers of the HSBC Health Goal Insurance Plan, an innovative health protection and savings insurance plan. This value-added service allows customers facing a critical illness diagnosis of stroke, heart disease or cancer to access personalized care and consultation services from experts amongst the top-ranked hospitals in the US, including over 6,700 specialists. The partnership reflects a tie between HSBC Life’s commitment to enhance Hong Kongers’ health and wellness and PGH’s mission to improve medical outcomes for patients.

Hong Kong / Malaysia

In March 2019, Hong Kong-based FWD Group successfully acquired HSBC Insurance (Asia Pacific) Holdings Ltd.’s 49% stake in HSBC Amanah Takaful (Malaysia) Berhad and is now the largest shareholder in the joint venture, marking FWD’s ninth market entry in the region. The Malaysian operation is now renamed to FWD Takaful. With FWD’s new takaful business, FWD will leverage on its pan-Asian experience to develop and offer takaful solutions to consumers in Malaysia.

China

2019 saw a handful of transactions that suggest an opening up of the PRC market to foreign insurers. Based on official statistics, the life insurance premium income contributed by foreign insurance companies in Zhejiang grew rapidly at a rate of 37% in the past five years. In September 2019, HSBC Life Insurance expanded its footprint in China by opening a new branch in its fourth-largest province, Zhejiang. On top of offering insurance solutions, including annuity, whole life, critical illness and unit-linked insurance products, the life insurer also launched a new product called the “HSBC Yu Man Jin Sheng Annuity Insurance” which aims to address wealth management and retirement needs of HSBC’s high-net-worth and affluent Chinese customers.

In September 2019, Shenzhen-listed courier company STO Express (“STO”) announced plans with China’s social media giant Sina Weibo to establish an insurance venture, Sina Life, as part of STO’s diversification strategy. The joint venture will be headquartered in Ningbo and have a registered capital of RMB1.5 billion, but approval from the Chinese insurance regulator is still pending.

As a further indication of the Chinese regulator’s openness to foreign investors, the life joint venture between Cigna and CMB Asset Management recently became the fourth foreign-funded insurance asset management firm in China. The other three new entrants which started operations in 2019 are ICBC-AXA Asset Management, Bocomm Life Asset Management and CITIC-Prudential Asset Management. In the coming years, the liberalization in mainland China is likely to transform the insurance asset management industry landscape, as insurance funds of foreign-owned life joint ventures were historically entrusted to local Chinese asset management companies.

In November 2019, Swiss Re, a minority shareholder of Hong Kong-based FWD Group since 2013, confirmed that it was considering buying a stake in China Pacific Insurance (“CPIC”), which is said to be part of Swiss Re’s plans to build partnerships overseas. This follows reports in the previous month suggesting that Swiss Re was in discussions with Chinese authorities about an investment in China’s Anbang Insurance Group. However, no definitive agreement between Swiss Re and CPIC has yet to be announced.

In June 2019, China Insurance Group (“China Insurance”) and China’s technology giant, Tencent, signed a strategic cooperation agreement to enable the digital transformation of China Insurance as well as to promote Tencent’s leading digital technology capabilities. The cooperation between the two companies will cover cloud computing
architecture, big data, insurance technology, etc. China Insurance will be adopting Tencent’s rich digital interfaces and digital toolboxes in promoting its diverse product services as part of its digital transformation.

China / Malaysia

Throughout 2019, ZhongAn Online continued to invest in research and development for insurtech, which has yielded 405 patent applications in the first half of 2019 alone. With the latest technologies in hand, ZhongAn’s automation rate of claim underwriting and settlement exceeded 99% and 95%, respectively. Earlier in 2019, ZhongAn International and Grab, Southeast Asia’s ride-hailing giant, set up a joint venture, GrabinSure, to expand their online insurance distribution business in the region. In July 2019, GrabinSure launched a usage-based online motor insurance product in partnership with 14 leading property and casualty insurers in Malaysia, who acted as the underwriters.

Japan

As was the case in 2018, Japanese insurers continue to expand into new markets overseas. 2019 saw a string of new developments, particularly in Southeast Asia, which has clearly emerged as an attractive market for Japanese insurers.

The decision taken by the government of Myanmar to approve the formation of insurance joint ventures between foreign and local insurers saw Japanese insurers play a dominant role from the outset in the nascent local market, with Dai-Ichi Life Holdings receiving provisional approval to enter the market via the establishment of a wholly-owned Myanmar subsidiary, while Nippon Life Insurance Company and Taiyo Life Insurance Company announced plans to acquire 35% stakes (the maximum permitted stockholding for foreign life insurers) respectively in Grand Guardian Insurance Holding Public Company for ¥2 billion (US$18 million) and Capital Life Insurance for ¥760 million (US$7 million). Additionally, Meiji-Yasuda Life announced a tie-up with Citizen Business Insurance through Thailand-based insurer Thai Life Insurance, in which it owns a 15% share.

July 2019 saw the US$90 million acquisition of a 25% stake by Sumitomo Life Insurance Company in Singapore Life Pte. Ltd, the first locally-based independent life insurer to be fully licensed by the city-state’s Monetary Authority since 1970, while the year drew to a close with the acquisition of an additional 4.61% for VND 4.012 trillion (US$173 million) in Vietnam’s largest domestic insurer, Bao Viet Holdings, increasing Sumitomo’s stake in the company to 22%. Mitsui Sumitomo Insurance also acquired an additional 30% stake in PT Asuransi Jiwa Sinarmas MSIG Tbk, one of the major life insurance companies in Indonesia, bringing their total holdings in the company to 80%. Nippon Life Insurance also announced its intention to acquire the entire remaining stake held by Reliance Capital in India-based mutual fund Reliance Nippon Life Asset Management, which will raise the Japanese insurer’s share to the 75% cap that was approved by the Competition Commission of India.

Further afield, Sony Financial Holdings Inc. announced that its subsidiary Sony Life Insurance agreed to acquire the remaining 50% stake in Japan-based AEGON Sony Life Insurance Co., Ltd. and Bermuda-based SA Reinsurance Ltd., owned by AEGON International N.V., a subsidiary of AEGON N.V., a Netherlands-based insurance group. 2019 also saw T&D Insurance Group enter into a capital and business alliance with Paris-based asset management and investment group Tikehau Capital, in which T&D Insurance Group will, among other things, acquire Tikehau Capital’s outstanding shares.

The year drew to a close with Tokio Marine Group announcing an agreement to sell a 75% stake in its Egyptian health and life insurance subsidiary, Tokio Marine Egypt Family Takaful to local financial services company EFG Hermes and contract auto manufacturer GB Auto for E£ 84.8 million (US$5.3 million).

Malaysia

Malaysia was also in the news in the latter half of 2019 when it was reported that Allianz Malaysia Bhd. ended talks to acquire Malaysia’s second-biggest car insurer AmGeneral Insurance Bhd (an AMMB Holdings Bhd. and Insurance Australia Group Ltd. joint venture) in September 2019, due to regulatory disapproval. The two insurers
already command a large share of the same market segment, making it unlikely for Bank Negara Malaysia to provide its consent.

In December 2019, RHB Bank also announced that it has ended negotiations to sell its insurance arm to Tokio Marine Asia. In July 2019, RHB Bank announced that Bank Negara Malaysia had granted it a six-month window to negotiate the proposed sale of up to 94.7% of its general insurance business to Tokio Marine. This marked the first significant formal negotiation to acquire a local insurer in the country since the government announced its intention to enforce a 70% foreign ownership cap last year.
Overview

The market for insurance carrier property and casualty ("P&C") deal-making cooled in 2019, in comparison to the energetic market of the last few years, with the number of announced M&A transactions in 2019 involving US and Bermuda P&C insurance targets falling from 2018 levels, in terms of both quantum and value. The relatively steep decline in overall deal value is attributable to the decline in numbers of mega-deals, compared to 2018 which saw AXA acquire XL Group ($15.4 billion), AIG acquire Validus ($5.6 billion), Apollo Funds acquire Aspen ($2.6 billion), and The Hartford acquire The Navigators Group ($2.1 billion). By contrast in 2019, only a handful of P&C deals exceeded $500 million. The largest-value P&C deal of the year was in the specialty market, namely the acquisition of Privilege Underwriters and its specialty insurance subsidiaries, known as Pure Group, for $3.1 billion by Tokio Marine, which was announced in October 2019.

By contrast with activity in the P&C carrier space, demand for P&C producer deals remains at an all-time high with 2019 setting an annual record of 625 announced transactions, according to research by Marshberry, which also found the top 25% of these distribution transactions for 2019 averaged 11.39x EBITDA in base purchase price, with a maximum transaction value of 15.81x EBITDA. These high multiples evidence the demand which is primarily driven by private equity capital but new types of investors are entering the space, including sovereign wealth and pension funds. Of particular note this past year was Carlyle’s acquisition of a majority stake in The Hilb Group for an undisclosed sum.

2019 is also notable for the emergence of M&A as an exit strategy for maturing insurtech ventures across all lines. [See “Insurtech” articles beginning on page 93]. As predicted in our 2018 Year in Review, while the deal value of these acquisitions has generally been small, the potential for the targets to be transformative to the acquirer means that they are of interest to the wider market.

Big Movements in Specialty Insurance

The specialty market proved to be one of the most active for P&C deals, with established players looking to consolidate and other insurers looking to add diversification to their books of more traditional P&C insurance lines.

As noted above, the biggest US P&C deal of the year was the acquisition of high net worth individual insurer Privilege Underwriters and its specialty insurance subsidiaries, known as Pure Group, for $3.1 billion by Tokio Marine from investors led by Stone Point Capital and KKR, which was announced in...
October 2019. Pure Group’s insurance operates the Privilege Underwriters Reciprocal Exchange, which is the risk-bearing entity and owned by policyholders. The newly-acquired Pure Group receives management fees for managing all the operations of the reciprocal exchange.

In August 2019, Canadian carrier Intact Financial Corporation acquired multi-line specialty insurer, The Guarantee Company of North America and its affiliate managing general agent, Frank Cowan Company Limited, from Princeton Holdings Limited for approximately $750 million. The deal was the second major acquisition by Intact of a carrier in the last two years. In 2017, Intact closed its $1.7-billion acquisition of OneBeacon Insurance Group Ltd. (as to which see our 2017 Year in Review).

In another late-in-the-year deal, in November 2019, the reinsurance arm of Arch Capital Group, Arch Reinsurance, confirmed that it was acquiring Aspen Reinsurance’s global credit and surety reinsurance business after Aspen Re decided to exit the line. It was also announced that, in addition to acquiring the renewal rights on the portfolio, Arch and Aspen have agreed to initiate additional discussions about the potential novation of the existing book.

Other Notable M&A Deals

American Family Mutual Insurance Co. S.I. agreed to acquire the auto and home business of Ameriprise Financial Inc. for approximately $1.1 billion in April 2019, as Ameriprise looked to focus on its core growth areas of advice and wealth management and asset management and free up capital that had been dedicated to backing up its insurance offering.

In September 2019, Phoenix-based mutual holding company CopperPoint Insurance acquired the privately-held parent company of workers’ compensation and liability insurer, Alaska National Insurance Company. CopperPoint and Alaska National are both leading workers’ compensation insurers in their respective geographic markets and the combined insurance operations will represent approximately $625 million in forecasted written premium and total assets of approximately $5 billion.

AmTrust Repositions Itself

In our 2017 Year in Review and 2018 Year in Review, we discussed the travails of AmTrust Financial Services, Inc. following its announcement of the need to restate its financials dating back to 2012. Since AmTrust completed its $2.95 billion going private plan in November 2018, AmTrust has accelerated its strategic repositioning as a privately held specialty commercial P&C insurer through a number of divestitures in the US and in Europe. [See “UK and Europe” article on page 11]. In the US, in April 2019, AmTrust agreed to sell both its surety and trade credit businesses to Liberty Mutual and AmTrust Agriculture Insurance Services, a crop insurance managing general agency, to Tokio Marine. The respective deal values were not disclosed.

Runoff and Legacy Market

Proactive runoff management remained a key objective for P&C insurers in 2019 with the runoff sector continuing its tremendous decade-long growth. North America continued to dominate the runoff market in terms of size, which AIRROC, IRLA and PricewaterhouseCoopers has valued at approximately $364 billion. The principal driver of increased deal activity in the P&C runoff space in the US has been the increasing number and maturity of the specialist acquirers in the market, which has allowed for carriers to shed increasingly large blocks of discontinued business, many of which have only recently been put into runoff. In addition, improving regulator interest in the virtues of legacy book management and the benefits of runoff restructuring transactions is resulting in the potential addition of new runoff deal structuring tools (e.g., the increasing number of US jurisdictions adopting insurance business transfer or corporate division laws) which may in turn fuel deal activity in the market further. [See “Update on US Insurance Business Transfer and Division Legislation” on page 59].

Given this trend, capital continued to pour into the P&C runoff sector. For example, in February 2019, Randall & Quilter Investment Holdings Ltd. raised approximately $140 million from new investors and existing shareholders. In addition, in November 2019, a newly created Carlyle-managed fund and, Japan-based, T&D Holdings Inc. partnered to acquire a 76.6% ownership interest in AIG’s
legacy book and runoff play Fortitude Re for approximately $1.8 billion. Fortitude Re comprises a rebrand of AIG’s legacy carrier, DSA Re, and was launched by AIG and Carlyle in November 2018, with Carlyle taking a 19.9% stake and entering into a strategic asset management relationship whereby Fortitude Re and AIG would allocate $6 billion of assets into various Carlyle managed strategies across corporate private equity, real assets, and private credit. The Carlyle-managed fund will pay about $1.21 billion to get a 51.6% ownership interest in Fortitude Re, while T&D will pay $585.9 million for a 25% stake.

Outlook for 2020

Notwithstanding the relatively docile market for major P&C transactions in 2019, many of the same dynamics that drove the red hot market of previous years remain in place. In particular, notwithstanding uncertainties in global economic outlook, inbound interest from international acquirers remains strong and the 2018 US tax reforms seem likely to further drive consolidation among Bermuda-based companies. In addition, the continued prevalence of major catastrophe events is likely to also drive consolidation as small- to medium-sized carriers look to increase geographical diversification and achieve greater enterprise risk management.

We also anticipate carriers continuing to pursue return-enhancing block transactions involving runoff business. In November of 2019, the Commissioner of the Oklahoma Insurance Department authorized the submission of an IBT plan to the District Court of Oklahoma County for approval, which is the final step in effectuating an IBT under the Oklahoma law. If that transaction completes smoothly and successfully, we expect other players in the P&C runoff space to begin cautiously embracing the opportunities presented by such laws.

In addition, insurance carriers are cognizant of the need to adapt to an increasingly disrupted market and insurtechs are increasingly being recognized as the innovation labs of the industry and we expect to continue to see carriers look to develop insurtech investment portfolios and acquire maturing insurtech players. [See “Insurtech” articles beginning on page 93].
The continuing attractiveness of the European market to overseas buyers was again shown when Samsung Fire & Marine Insurance Co., Ltd, the listed South Korea-based non-life insurance company, agreed to acquire a “significant” minority stake in Canopius Group AG, a Switzerland-based insurance company, for an undisclosed consideration. Samsung stated a belief that the acquisition would enable Samsung to become a competitive, “world class” P&C insurance business.

2019 also saw the Beijing-headquartered Anbang Insurance Group Co., Ltd purchase Fidea NV, the Belgium-based non-life insurance company, from Baloise Holding AG for £414 million in a deal that completed in July. We expect the trend of continued interest in the European market from Asia-based buyers to continue into 2020.

The year also finished with PJSC Sovcombank announcing that a deal had been agreed with Liberty Mutual Group, Inc. for the purchase of Liberty Insurance JSC, the Russia-based provider of insurance services, for an undisclosed consideration from Liberty Mutual Group, Inc., the world’s fifth-largest P&C insurer. The acquisition is expected to close in the first quarter of 2020, subject to applicable regulatory approvals and other customary closing conditions.

As we have noted in previous years, many of the largest cross-border, multi-jurisdictional transactions include European market operations. An example of this is the purchase by the Bermuda-domiciled Watford Holdings of the French P&C insurer Axaer IARD, a transaction that had the stated aim of helping Watford develop new insurance business opportunities throughout the European Union.

2019 also saw Spanish-listed Banco Santander, S.A. agree to acquire a 60% stake in the Spain-based Allianz Popular SL, offerors of both life and P&C insurance, from the German-listed Allianz SE, for a total consideration of £837 million.

A month earlier, Allianz SE had announced that it was to acquire a 30.1% stake in the general insurance business of Liverpool Victoria Friendly Society Limited after LV exercised its put option, receiving total consideration of £365 million for this shareholding.

Finally, 2019 also saw Legal & General Group plc dispose of its general insurance business, announcing in May that it was selling this business to Allianz Holdings plc for a total consideration of £242 million, continuing a trend of recent years that has seen Legal & General actively seek to dispose of its non-core general insurance businesses. Allianz has once again been an active participant in the European market scene.
Lloyd’s of London

Canopius and Amtrust completed a Lloyd’s merger in October 2019; with effect from 1 January 2020, Canopius has merged Syndicate 4444 with AmTrust Syndicate 1861 under Canopius Managing Agents. AmTrust Financial Services Inc. is also set to become a significant minority shareholder in Canopius at that time.

Arch Capital Group Ltd. completed the acquisition of Barbican Group Holdings Limited on 2 December 2019; the deal includes Barbican Managing Agency Limited, Lloyd’s Syndicate 1955, Lloyd’s Syndicate 1856, Lloyd’s Special Purpose Arrangement 6132, Castel Underwriting Agencies Limited and other associated entities. Barbican had been the subject of a number of sale processes over the years and it draws a line under a challenging period of ownership for the selling shareholders.

In September, Charles Taylor plc and The Standard Club announced the sale, subject to regulatory approval, of the Lloyd’s of London managing agent, Charles Taylor Managing Agency (and its associated companies, including The Standard Syndicate Services Limited and The Standard Syndicate Services Asia Pte. Ltd.) and the Lloyd’s corporate names to a subsidiary of Premia Holdings Ltd. Premia was also active in the UK legacy company market, acquiring Dominion Insurance.

Finally, in the 2018 Year in Review, we noted the $2.1 billion acquisition by Hartford Financial Services Group Inc. of The Navigators Group Inc.; this deal received all requisite regulatory approvals, and completed in May 2019.

Runoff and Legacy Market

2019 ended with a number of Lloyd’s syndicates being placed into runoff; the Lloyd’s managing agent, Neon Underwriting, was put into runoff by its parent company, American Financial Group, which made the decision to exit the Lloyd’s of London insurance market in 2020 due to Neon “failing to achieve AFG’s profitability objectives”. Similarly, MS Amlin had previously announced that it was exiting nine business classes, including UK P&C, in late September.

Likewise, in November the board of VIBE Syndicate Management also announced that, with effect from 31 December 2019, its Syndicate 5678 at Lloyd’s was to be placed into a planned runoff, having failed to raise the capital that they believed was necessary to expand the syndicate to the scale needed to achieve desired profitability.

It was announced in December 2019 that a number of ex-Vibe underwriters would be moving to Argenta Syndicate 2121 to help develop a book of casualty, financial and professional lines business.

This type of transaction is likely to become more frequent as a consequence of Lloyd’s ongoing review of syndicate business plans overall, and including individual books of business, which will continue to lead to individual books, lines, teams and syndicates as a whole facing a cessation and looking for a new platform on which to service clients and ongoing business.

As described in “Overview” below, the impact of the Neal proposals will resonate for some years to come.

November also saw Pioneer Underwriters decide to put its Lloyd’s Syndicate 1980 into runoff after completing an examination of “strategic and capital options for 2020”. That month, Hamilton Insurance Group also announced that it was placing its Acappella Syndicate 2014 into runoff, citing an expected inability to produce adequate returns and adding a further name to the growing list of Lloyd’s syndicates consigned to runoff.

Broker and Intermediary M&A

Following the strong end to 2018 with the announcement of the JLT-Marsh merger, 2019 was comparatively quiet as regards to large-scale M&A of broker and intermediary firms. The most financially significant deal in this sphere saw CVC Capital Partners Limited acquire a majority shareholding in April Group SA, the leading wholesale broker in France, from Evolem SA, for £765 million.

The aforementioned £4.9 billion purchase by Marsh & McLennan of JLT completed in April 2019. Of note later in the year was the subsequent sale by JLT of its aerospace business to Arthur J. Gallagher & Co. for £190 million, with completion occurring in June 2019. Early in 2020 saw Gallagher announce the buy-out of Capiscum Re, the Graham Chiltern-backed reinsurance broker.
Another major acquisition of a brokerage firm was the £500 million purchase of BMS Group Limited by British Columbia Investment Management Corporation, the Canada-based investment management firm, and Preservation Capital Partners Limited, the UK-based private equity firm, who completed the purchase from Minova Insurance Holdings Limited in October 2019.

Overview

2019 saw a number of factors coalesce to have a material impact on the London market generally.

Lloyd’s syndicates have continued to make releases from reserves held for prior years, thus enhancing 2016 pure year results but risking exposure to 2017 and subsequent year losses.

2017 year of account itself produced the largest percentage loss on capacity since 2010, with losses also being forecast for 2018 year of account (albeit on a smaller scale). On the upside, losses have resulted in the closure of underperforming syndicates and lines of business, premium rates have risen in a hardening market across many classes of business, and the proposals in John Neal’s “The Future of Lloyd’s” offer interesting opportunities for new and flexible capital models (including “syndicate in a box” and the opportunity for managing agents to offer new capital opportunities), as well as a drive to reduce Lloyd’s costs.

Against a background of cost control, underwriting discipline and new capital opportunities, investor interest in Lloyd’s continues apace, both for incoming new money and as purchasers of legacy issues.
Japan


Globally, Japanese P&C insurers continued to make overseas investments, although, with one exception, they tended to be somewhat smaller in size than in recent years as they continue to focus on growing in smaller markets, such as Southeast Asia, and in technology investments. By far the most significant acquisition was the announcement in early October by Tokio Marine Holdings of its agreement to acquire New York-based Privilege Underwriters, Inc. and its subsidiaries Pure Group for US$3.1 billion. Tokio Marine also acquired the remaining 51% of NAS Insurance Services, LLC a US-based provider of cyber and professional liability insurance in early 2019. Somewhat closer to home, Tokio Marine’s Australian subsidiary, Tokio Marine Management (Australasia), acquired (under undisclosed financial terms) the Bond and Credit Company, a specialist product insurance underwriter based in Sydney and Melbourne.

The year also saw established Japanese insurers participate in joint investments. In November, T&D Holdings announced it would participate in a joint acquisition alongside The Carlyle Group of the 76.6% stake in Fortitude Group held by AIG, with T&D slated to acquire a 25% stake in Fortitude for US$586 million. While in technology investments and tie-ups, Japan-based MS&AD participated alongside Chubb and Aflac Ventures in a US$58 million Series D funding round for CoverHound, a San Francisco-based P&C insurance platform for digital distribution. Sompo Holdings also continued to invest in fintech investments including partnering with Palantir Technologies Inc. to form a joint venture to focus on health and cybersecurity clients in Japan, and partnering with Axinan in Indonesia to provide on-demand digital insurance solutions through Igloo.

Japanese insurers continue to focus on Southeast Asia, which was given a further boost this year by the decision of the government of Myanmar to allow for the establishment of insurance joint ventures between foreign and local insurers. This paved the way for foreign insurers to penetrate what was considered the “final frontier” of the global insurance industry. Japanese casualty insurers have shown a strong interest in participating in the nascent market from the outset, with Tokio Marine Nichido announcing plans to invest approximately ¥5 billion (US$45 million) in a joint venture with Grand Guardian Insurance Public Co., Ltd, while planned joint ventures have also been announced between Sompo Holdings and AYA Myanmar Insurance (which was approved in late 2019), and between Mitsui Sumitomo Insurance and KBZ Insurance.
Hong Kong

In January 2019, Hong Kong-listed property developer, Shui On Land, formed a joint venture with China Life and Canada’s Manulife Financial to engage in investment in properties in Shanghai and other Tier 1 cities in China, such as Beijing and Shenzhen, and the management and administration of such properties. The joint venture deal is estimated to be worth US$1 billion. The formation of the joint venture is in line with Shui On’s asset-light strategy to increase its focus as a premier commercial real estate owner and operator.

Thailand

In May 2019, Allianz SE acquired a 19.21% interest in Sri Ayudhya Capital after making a tender offer to purchase 56.93 million Sri Ayudhya Capital shares (at THB3.32 each for a total of THB3.04 billion (approximately US$100 million). Following the transaction, Allianz become the largest shareholder in Sri Ayudhya Capital. The transaction also saw Allianz General Insurance and Sri Ayudhya General Insurance PCL combine to form a bigger P&C company.

Bancassurance

The bancassurance sector in Asia remained strong throughout 2019 with activity across the region. Some notable transactions in 2019 include:

- In January 2019, Allianz announced its intention to enter the general insurance sector in Vietnam through a digital joint venture (“JV”) to be set up with Vietnam’s FPT Group, a technology services company under which FPT would develop innovative digital insurance products and services to meet the protection needs of local customers. The tie-up comes as more insurers in Vietnam develop digital channels to better reach young and tech-savvy customers in the country, which boasts one of Asia’s fastest rates of economic growth.

- In June 2019, PT Sompo Insurance Indonesia partnered with Singapore insurtech firm Axinan to launch a mobile app platform aimed at providing on-demand insurance products to Indonesia’s millennial population. This demonstrated the continuous efforts of insurers in these countries to adopt up-to-date technologies in order to improve customer experiences.

- In September 2019, Prudential Vietnam Assurance signed a bancassurance agreement with Korea’s Shinhan Bank Vietnam Ltd to distribute its life insurance solutions. The exclusive partnership will enable Prudential Vietnam to distribute its life insurance solutions to Shinhan Bank’s customers around the country. Shinhan is the seventh bank in Prudential’s bancassurance network.

- In September 2019, Manulife Vietnam announced a bancassurance partnership with Ho Chi Minh City-based commercial lender Asia Commercial Joint Stock Bank (“ACB”) for the distribution of Manulife’s two key life insurance products. The bancassurance deal is expected to generate revenues of approximately VND 600 billion (US$25.85 million) in 2019 for ACB.

- In November 2019, British insurer Aviva said it was in discussions about the future of its businesses in Vietnam and Indonesia, following the sale to joint venture partner Hillhouse Capital of its 40% stake in the Hong Kong business, named Blue. Tulloch
declined to disclose the terms of the sale. Allianz, Nippon Life, MS&AD Insurance, Sun Life Financial and Manulife Financial Corp are all reportedly looking to acquire Aviva’s Vietnamese business. Aviva holds a 50% stake in VietinBank and has signed an exclusive 18-year agreement to distribute life insurance products through VietinBank’s network.

- In November 2019, FWD Hong Kong announced that it had entered into a Distribution Agreement with Joint Stock Commercial Bank for Foreign Trade of Vietnam (“Vietcombank”), to establish an exclusive 15-year bancassurance partnership under which Vietcombank will distribute FWD’s life insurance products. The deal is reportedly valued at about US$400 million. As part of the transaction, FWD also agreed to purchase Vietcombank-Cardif Life Insurance, a life insurance joint venture between Vietcombank and BNP Paribas Cardif, subject to final regulatory approval. In July 2019, Siam commercial Bank entered into a sale and purchase agreement in order to sell 99.17% shares in SCB Life Insurance PLC to FWD Group Financial Services Pte. Ltd for THB92.7 billion (approximately US$3.09 billion) consideration. Following the closing, Siam Commercial Bank will enter into distribution agreement with FWD for distributing FWD’s life insurance products in Thailand. These high-profile acquisition deals demonstrate FWD’s continuous expansive strategy across the Asia region throughout 2019.
It is difficult to overstate the impact that transactional liability insurance continues to have on the US M&A market. In nearly every M&A transaction involving private companies, transactional liability insurance—often in the form of representations and warranties insurance (“RWI”) or tax liability insurance—will be considered, pursued, or be a prerequisite. In the past year, the use of RWI remained strong, existing trends in the RWI market strengthened and some new trends emerged.

**Use of RWI in M&A transactions continues to grow; US underwriters remain the most active**

Data from several market studies and anecdotal evidence strongly suggest that both the numbers of RWI policies and aggregate RWI policy limits written each year have almost doubled every two years since at least 2013. We can see evidence of this growth in statistics on the M&A market generally. For example, estimates from Aon, a leading RWI broker, for 2018 (the most recent year for which data is available) indicate that approximately one-third of all North American M&A transactions used RWI and 75% of all deals involving financial sponsors utilized RWI.

While financial sponsors have historically been the greatest users of RWI and that trend continues, increased usage of RWI among corporate/strategic buyers was a trend that continued in 2019. For first-time buyers of RWI, the benefits of using RWI frequently justify the steep learning curve and additional hurdles that can be required to obtain RWI—such as more detailed due diligence reporting. As noted above, acceptance of RWI as a deal term is often a prerequisite for participating in competitive auction processes.

Issuance of RWI policies continues to be greatest in the Americas versus the rest of the world, and most of this activity is in the US. Drilling down into the activity across the Americas, RWI policies are being issued in Latin America, but the terms of these policies typically have more exclusions, higher premiums and overall narrower coverage. In addition, there are far fewer insurers that will issue policies in Latin America, and based on country-specific risks (real or perceived), RWI policies may not be available to cover transactions in certain countries.
US insurance markets – and insurance coverage – have expanded and become more sophisticated

While there are market norms that have evolved and some standardization in RWI policies and coverage, many insurers have developed the flexibility and expertise—and willingness—to step outside of those standard terms to modify coverage to address specific transaction issues on a case-by-case basis. While premiums will often increase to reflect elevated or novel risks, transactions that are truly uninsurable have become relatively rare in the market.

In addition, market capacity has expanded to provide greater per-transaction coverage. RWI coverage limits in the market can now extend into the mid-to-high nine figures with multi-insurer towers. On the other side of the market, we have seen insurers expand to cover deals in the lower middle market as well. For example, the lower end of the deal value spectrum has seen RWI policies issued for deals with enterprise values of $50 million or less, with RWI coverage limits as low as $3 million-$4 million. While these policies are not the norm, there are insurers with an appetite to write policies for these deals—often without the same level of extensive diligence that is the norm on larger deals.

Another area of growth is tax insurance policies. In fact, numerous insurers and brokers have cited tax insurance as the area of greatest interest from clients. These are bespoke insurance policies—separate from RWI policies, which often are obtained in tandem—that cover specific tax risks related to a M&A target or transaction. Coverage limits for these policies frequently exceed $1 billion with several insurers providing excess coverage. These policies also typically require thorough due diligence with experienced tax advisors.

Claims data continues to reinforce existing trends

Overall, market information and anecdotal evidence show trends in frequency of RWI claims that are consistent over the past several years, with claims made on roughly one in five RWI policies. However, there are signs that these trends may be evolving to reflect more potentially larger claims.

For example, data reported by AIG, one of the largest RWI issuers, noted an increase in its annual statistics for frequency of claims notifications on large deals and the severity of claims noted overall. AIG’s data showed an increase in claims notifications (to 26%) for deals between $500 million and $1 billion in size. However, overall claims frequency across deal sizes remained approximately 20%, which is consistent with the past several years of AIG’s reporting. Separately, in its latest report AIG noted that the severity of claims grew as well, with the proportion of material claims over $10 million growing from 8% to 15% since the prior year. AIG also reported that the average claim size remained at approximately $19 million, consistent with prior year’s average pay-out for the most material claims.

In addition, studies and our market intelligence continue to indicate that certain types of representations—for example, representations regarding the financial statements, tax matters, compliance with laws and material contracts—are the most frequent bases for claims. This trend has remained relatively constant for the past several years and these areas continue to be high priorities for underwriters issuing RWI.

Looking forward

The expansion and adoption of transactional liability insurance has continued in tandem with the expansion of strong M&A and equity markets in recent years. Even if valuations or M&A activity plateau (or decline), we expect appetite and usage of RWI and other types of transactional liability insurance to continue to be strong. Given the widespread adoption of this type of insurance and its potential benefits to buyers and sellers, it is unlikely that it will lose its place as a key component of risk allocation in M&A transactions, regardless of market cycles. However, we continue to expect an eventual meaningful increase in claims to test underwriting practices and spur consolidation among RWI insurers, although we cannot (and will not) predict when those events might occur.
Corporate

Year on year, in a trend that shows no signs of abating, the use of warranty & indemnity insurance ("W&I Insurance") continues to develop into an increasingly large part of the UK and European M&A market. In response both to this growing demand and to increased competition amongst a larger pool of insurers, insurers and brokers in the W&I market are continually innovating and expanding their product offering.

In this article, we highlight some of the trends and changes that we have seen over the last year when acting both for insurers of W&I Insurance policies and for buyers of the product in M&A transactions.

**US-STYLE POLICY ENHANCEMENTS ARE BECOMING THE NORM**

Policy enhancements have been offered by insurers for a few years now, so as to provide buyers with the option of broader coverage at an increased premium (essentially “add-ons” to standard policy terms). This trend has been pushed by US private equity houses buying entities within the UK and European markets and their desire to move closer to a US-style transaction, which tend to provide broader protection to buyers. Sellers in the UK and European markets are not yet willing to offer those US-style terms, meaning that insurers are stepping in to fill that gap. Examples of these enhancements include non-disclosure of the Data Room, removal of the *de minimis* on claims and damages being made on an indemnity basis in the event of a warranty breach (rather than a contractual basis). The benefit for buyers is that they can agree on UK/European-type provisions with sellers but gain additional protection via a W&I policy. We have seen the use of these enhancements increase in 2019, and insurers becoming more willing to offer some enhancements as standard and at no extra premium. Enhancements can be a very useful tool to increase buyer protection and provide more comfort that they will be compensated for losses that they incur; in our view, there is a cost-benefit analysis that buyers should conduct in order to understand the real value of an enhancement, which will, of course, differ for every deal.

**SELLERS ARE CAPITALIZING ON A BUSY MARKET**

Sellers know the developing W&I market well and can, in this current M&A environment, dictate aggressive terms in deals for attractive assets, particularly in auction scenarios where they know that even on very large transactions they can cap their liability at £1 and achieve a true “clean break”—meaning more buyers than ever are having to turn to the W&I market to take that risk. We have seen...
more and more non-traditional buyers of insurance this year—particularly corporate and strategic buyers turning to W&I Insurance and using the terms of the product as a means to make their offer more attractive, whereas historically they have tended to use a combination of self-insurance and negotiation of meaningful seller caps on liability. This is a trend that has continued from 2018 into 2019.

THE NUMBER AND SCOPE OF EXCLUSIONS ARE DECREASING

Typically, US-style policies have much fewer “market standard” exclusions than UK and European policies. Insurers are moving towards this model by removing exclusions that historically were ‘no go’ issues for insurers if adequate diligence has been undertaken and the risk appears low. Examples include anti-bribery and corruption issues which most insurers seem to consider covering save for certain problematic jurisdictions which can prove “difficult” from an ABC perspective. In addition, insurers are increasingly covering tax matters such as transfer pricing risks and condition of assets, and we have also seen insurers move to cover more SPA provisions, for example, purchase price adjustments, that would not traditionally be dealt with by way of warranty claim and therefore not covered by a W&I insurance policy.

SYNTHETIC DEALS – WILL THEY EVER HAPPEN?

Over the course of 2019, there has been some movement in respect of the use of synthetic warranties and synthetic tax deeds. These types of policies are provided by the insurer independently and do not involve underwriting an agreement with the seller, allowing the warranties and tax indemnity being covered to sit outside of the SPA, thereby creating an even more competitive bid for the buyer. We did not see this develop in 2019 as much as we thought we might; it seems that buyers and insurers are not quite ready to take sellers completely out of the picture in this regard.

LOOKING FORWARD

Looking to 2020, we expect to see more “merging of the markets” whereby European and US terms will come ever closer, and buyers will expect to be able to achieve more aggressive deal terms from insurers.

Claims

In our 2018 Year in Review, we noted that the tremendous increase in W&I business was leading to an inevitable increase in the number of claims being handled in the London and Continental European markets. We also noted that one of the most significant issues for Insurers and Insureds in managing the W&I claims process is the practical approach to measuring the loss suffered by the Insured.

Loss issues continue to be a challenging aspect of W&I business, both in relation to the negotiations of the scope of loss that W&I insurance should pay for, and the investigation and presentation of the relevant facts and expert analysis when loss does occur.

Under English law, absent any specific contractual arrangements, the Insured’s recoverable loss as a result of breach of warranties made by the Seller is the difference in the value of the shares as warranted (the “warranty true” value) and the actual value of the shares that are acquired (the “warranty false” value), the aim of this contractual damages measure being to put the claimant in the position it would have been in had the warranty been true; the usual rules on mitigation and remoteness also apply. However, we observe that the damages calculation method may vary significantly between different jurisdictions.

In 2019, the English courts have considered a few cases affirming and elaborating on this basic proposition, two of which we explore in greater detail below.

When considering these cases it is important to bear in mind that, in addition to warranties, a Seller frequently offers to provide the Buyer with a specific contractual indemnity, i.e. a contractual promise to reimburse the claimant in respect of loss suffered by the claimant. Tax liabilities, for example, are frequently the subject of specific indemnities. The purpose of an indemnity is to provide pound for pound compensation in respect of a specific loss and it is advisable to expressly exclude the rules relating to remoteness and mitigation to achieve that result.

The use of indemnities in transactional business seems to have given rise to the colloquial use in the W&I market of
the term “indemnity measure of damages”. However, the two concepts are quite distinct: the amount that is payable under a contractual indemnity is determined by the terms of the written agreement; whereas the amount that is payable under the contractual measure of damages principles is determined by the common law and is the amount required to put the claimant in the position it would have been in, had no breach occurred.

**OVERSEAS-CHINESE BANKING CORPORATION LTD v ING BANK NV, MARCH 2019**

The OCBC v ING case is an important affirmation of the correct basis for the measure of damages for a breach of warranty in relation to the sale of shares. It also highlights that if some other measure is intended by the parties—either under the SPA or for the purposes of a W&I policy—express provision for that alternative measure of damages will be required.

The problems in this case arose because the Target had entered into equity derivative transactions with Lehmans. These transactions required the Target to deposit cash collateral with Lehmans. When Lehmans filed for bankruptcy, the Target terminated the derivative contracts, which resulted in liability to pay a termination fee. The Target netted off the cash collateral held by Lehmans from the termination fee it owed, along with sums owed by Lehmans to another ING entity. Lehmans disputed the validity of setting off, and the dispute was settled by way of payment by the Target of the sum of US$14.5 million in November 2012. The Buyer sought recovery of this sum from the Seller ING.

The Buyer argued that ING had warranted that the 2008 Accounts gave a true and fair view of the state of affairs of the Target; the derivatives gave rise to a contingent liability that should properly have been recorded in the 2008 Accounts; and so the financial statements warranties had been breached. However, the Buyer did not allege that the breach of warranty—that the non-disclosure of the true liabilities to Lehmans—had caused a diminution in the value of the Target’s shares. Instead, the Buyer’s position was that, if the contingent liability had been recorded in the Accounts, it would have sought and obtained an indemnity to cover the full amount of the liability of US$14.5 million. The Buyer argued, therefore, that it should be able to recover as damages the amount of the indemnity it (hypothetically) would have obtained and that diminution in value of shares is not the only measure of loss available for breach of warranty in a share sale context.

In its defence, ING relied on the existing line of authorities as setting out the correct approach for the measure of damages for breach of warranty on a sale of shares, which is as we set out above. The High Court agreed with ING: the basic principle in contract is that the claimant is entitled to be put into the position it would have been in if the contract had never been broken. The actual (rather than warranted) value of liabilities goes to the diminution of the value of the asset (i.e. the shares) and there is no basis for saying that the measure of a damages claim could be a hypothetical indemnity.

If parties to a transaction, or Insurers under the scope of what is covered by a W&I Policy, wish to agree an alternative measure of loss, that agreement will need to be expressly set out in the SPA and/or the Policy.

Increasingly, we are seeing both SPAs and W&I Policies that depart from the contractual “default” position, allowing the Insured to recover, essentially, the balance sheet loss to the Target. For example, if there were an undisclosed liability, the Insured is expressly able to claim the amount of that liability; and the Insured does not need to establish that there has been a reduction in the value of the shares that it acquired. This approach means that there would be no debate as to what impact a breach of warranty had on the value of the shares. We expect this to be a feature of more W&I Policies going forwards, which may help to streamline the claims handling process and reduce the number of disputes around quantum and measure of loss.

**CARDAMON LTD v MACALISTER, MAY 2019**

Insurers, brokers and regular users of W&I Insurance will be familiar with underwriting questions around valuation methodology and how the purchase price was agreed. Typically, the Court assumes that the “warranty true” price for a Target is the price paid by the Buyer, but
questions around valuation may become even more relevant following the decision in Cardamon, a case which considers a situation where the Buyer achieved a “bargain” price for the Target.

The Target company, Motorplus, was a provider of add-on insurance products, like insurance for lost keys that can be added to home insurance. The Sellers themselves valued the business to be sold at £5 million, but sold it for £2.39 million for a quick sale and on the basis that the Buyer carried out no diligence.

The Sellers’ lawyers advised the Sellers to have a de minimis for warranty claims under the SPA that reflected the discount the sellers were giving to the buyers. The solicitor warned the Sellers—if you choose to give the warranties blind, you need to increase the minimum value of any claim that can be made for breach of warranty, explaining: “it would still leave you exposed—whatever is the difference between the value of the company and price being paid should be the de minimis, if the buyer is getting the benefit of a cheap price for no due diligence then you should get the same in the de minimis …. What is the point of selling at a discounted price to have it chipped away even more by unknown issues in relation to the warranties.”

The Sellers’ representative made the point in negotiations that the buyer wants a cheap price and all the protection, so the de minimis (i.e. the amount that needs to exceeded before the buyer can substantiate a claim for breach of warranty) needs to be set properly to reflect that commercial bargain. So, it was agreed that the de minimis would be £500,000 and, if the value of a claim for breach of warranty exceeded £500,000, then the Sellers would be liable for sums over £500,000.

After the transaction, the Buyer alleged breaches of financial statements warranties in relation to both the Accounts and Management Accounts. The Sellers argued the “warranty true” price was the agreed sale price, but the Buyer argued this was a “bargain” price and that they should be able to recover the difference between the actual (much higher) value of the business as warranted and the “warranty false” value. The Court agreed with the Buyer. While it’s the usual assumption that where a transaction is made on an arm’s length basis, the purchase price is the “warranty true” price, the Court can depart from that assumption if there is good reason (and, we would say, convincing evidence) to do so.

In the light of this development in the case law, Insurers may be concerned with the potential uncertainty around valuation and measure of loss. As a result, we may begin to see drafting solutions in W&I Policies that, for example, deem the “as warranted” value for the purposes of calculating loss as being no higher than the purchase price, so that the upper limit number is never higher than the purchase price the Buyer paid. That way, the Buyer cannot recover through the W&I Policy the value of any “bargain” that (arguably) has not caused them loss.
Equity Capital Markets

North America and Bermuda

In North America and Bermuda, new issuances in the equity capital markets in the insurance sector during 2019 were dominated by registered public offerings of hybrid securities, in particular non-cumulative perpetual preferred stock. According to S&P Global Market Intelligence, ten registered offerings of these hybrid securities raised over $5.1 billion by issuers such as American Equity Investment Life Holding Company ($400 million), American International Group, Inc. ($500 million), Aspen Insurance Holdings Limited ($250 million), Athene Holding Ltd., AXA Equitable Holdings, Inc. (two offerings for a total of $1.1 billion), Brighthouse Financial, Inc. ($425 million), The Allstate Corporation (two offerings for a total of $1.5 billion) and Voya Financial, Inc. ($300 million).

In terms of IPOs by insurance companies domiciled in North American and Bermuda, 2019 tracked 2018, with three companies making their US market debuts. The largest of the three offerings was by BRP Group, Inc., an independent insurance distribution firm, raising $230 million. The next largest IPO was by ProSight Global Inc., a specialty P&C insurance company owned by investment funds affiliated with Goldman Sachs Group, Inc. (49.9%) and TPG Global, LLC (48.2%). ProSight’s IPO raised total proceeds of $110 million and involved both a primary and secondary component, with the funds affiliated with Goldman Sachs and the funds affiliated with TPG each selling a 10% ownership interest. Finally, Palomar Holdings, Inc., a specialty property insurance company backed by Genstar Capital, completed its IPO in April raising gross proceeds of $84 million. Since its IPO, Palomar’s stock has increased more than threefold representing a market valuation of approximately $1.3 billion at the end of January 2020. Genstar Capital capitalized on the stock’s performance since the IPO and consummated two registered secondary offerings—one in September raising $191 million and the second in January of this year raising $245 million—as a result of which Genstar Capital’s ownership stake in Palomar was reduced from 62% following the IPO to 17.7%.

Secondary offerings, like the ones by Genstar Capital, were a common theme during 2019 as stockholders took advantage of favourable market conditions. The largest secondary offerings during 2019 were conducted by AXA SA which continued its efforts begun in 2018 to monetize its interest in AXA Equitable Holdings, Inc. AXA Equitable is comprised of the US operations of AXA SA, and its spin-off represented the second largest IPO in North American in 2018, with AXA SA receiving $2.75 billion in this purely secondary offering. AXA SA followed the IPO with an additional sale in November, raising $1.2 billion in the offering (as well as an additional $590 million pursuant to a concurrent buy-back by AXA Equitable of 30 million shares) and bringing its ownership stake in AXA Equitable to less than
During 2019, AXA SA completed three registered secondary offerings—(i) one in March raising $820 million (and raising an additional $600 million pursuant to a concurrent buy-back by AXA Equitable of 30 million shares), (ii) another in June raising $834 million, and (iii) another in November raising $3.1 billion. As a result of these sales, AXA SA had reduced its ownership stake to less than 10%. Accordingly, in January 2020 AXA Equitable amended its charter to remove “AXA” from its corporate name so that effective January 13, 2020 its official name became “Equitable Holdings, Inc.”

In March 2019, investment funds affiliated with TPG Global, LLC sold their entire 12.8% stake in Assurant, Inc. for gross proceeds of $770 million.

**UK and Europe**

Geopolitical uncertainty led to a material drop in IPOs and secondary offerings across EU markets and London in particular – down more than 50%. It is hoped, however, that a more stable backdrop into 2020 might lead to a recovery of ECM activity.

2019 began with Randall & Quilter Investment Holdings Ltd raising gross proceeds of approximately £100 million through an oversubscribed placing of new ordinary shares in the company to investors. A total of 65,359,477 new shares in the Company were placed, representing approximately 52% of the issued ordinary share capital of R&Q prior to the placing. R&Q had previously raised over £60 million through two separate equity fundraisings in 2017.

Also in Q1 of 2019, the life insurance company Just Group plc raised £75 million in an equity placing through an issue of approximately 94 million new shares, equivalent to just under 10% of the company’s already existing share capital, largely in response to stricter regulatory treatment in the UK of equity release mortgages that had seen Just Group record a pre-tax loss of £86 million in Financial Year 2018, down from a profit of £181 million in Financial Year 2017, and was seen as a necessary measure to shore up the company’s capital base.

Completing in October 2019, Prudential plc demerged from M&G plc, in accordance with plans first announced in March 2018. The newly independent M&G, focusing on the traditional UK and European life insurance and asset management markets, was valued at around £5.6 billion when its shares were admitted to trading following the demerger, whilst Prudential, although remaining listed as a FTSE 100 company, instead now focuses on its US and Asian businesses.

**Asia**

In December 2019, OneConnect Financial Technology Co., Ltd. ("OneConnect"), the fintech arm of PRC insurer Ping An Insurance (Group) Company of China, Ltd., raised US$312 million in a NYSE-listed IPO, representing a valuation of approximately US$3.7 billion. In the second half of 2019, two issuers filed Form F-1 registration statements with the US Securities and Exchange Commission for IPO transactions: Huize Holding Limited, a leading independent online long-term life and health insurance platform in the PRC to raise $150 million and TIAN RUIXIANG Holdings Ltd., a Cayman Islands registered insurance brokerage company based in Beijing to raise $15 million.

In 2019, the PRC insurance sector and foreign investors observed the PRC government’s attempts to further open up its financial sector by relaxing restrictions on foreign investment. On July 20, 2019, the Office of Financial Stability and Development Committee of the State Council of the PRC government announced Relevant Measures for Further Opening Up Financial Sector (the “Measures”). Among various measures targeted at different financial sub-sectors, the measures that specifically concern insurance and insurance asset management were the abolishment of the qualification requirement for foreign investors in insurance companies in the PRC and removal of the foreign shareholding cap in insurance asset management companies in the PRC. Following this announcement of the Measures, the State Council of the PRC announced the Amendment to the Administrative Regulations on Foreign-Invested Insurance Companies which formally codifies the Measures on October 25, 2019 (the “Amendment”).

This Amendment includes the following major revisions:
(i) removal of the requirements on establishing a foreign-invested insurance company in the PRC that a foreign insurer must have engaged in insurance business for more than 30 years and maintained a representative office in the PRC for at least two years before the establishment of such foreign-invested insurance company; and (ii) addition of a new provision allowing overseas financial institutions to invest in foreign-invested insurance companies whereas previously only the traditional foreign insurance companies were allowed to make such investment. The China Banking and Insurance Regulatory Commission (the “CBIRC”) released the Amendment to the Implementation Rules for the Administrative Regulations on Foreign-Invested Insurance Companies on December 6 to keep it consistent with the Amendment. The CBIRC also announced on December 6, 2019 that the currently applied 51% cap on foreign ownership in the PRC life insurers will be lifted as of January 1, 2020, which means foreign investors will be able to hold up to a 100% interest in PRC life insurers.
North America and Bermuda

The debt capital market for North American issuers was active in 2019, with numerous insurance companies across sectors issuing debt securities, often in multiple tranches. The purpose of many of these transactions was to raise funds for general corporate purposes or to refinance existing debt. Several issuances were related to previously announced M&A activity. For example, in August, The Hartford issued approximately $1.4 billion of senior notes, a portion of the proceeds of which were used to pay for tender offers for outstanding notes of The Hartford and The Navigators Group, Inc. (a wholly-owned subsidiary of The Hartford acquired in May 2019). In November, Centene Corporation issued $7 billion of senior notes, the proceeds of which were to be used to finance the cash consideration payable in connection with Centene’s acquisition of WellCare Health Plans, Inc (expected in the first half of 2020). Also in November, Nationwide Financial Services (“NFS”), the life insurance subsidiary of Nationwide Mutual, completed a 144A offering of $1 billion 30-year senior notes guaranteed by Nationwide Mutual. $600 million of the proceeds of the offering are to be applied to the repayment of NFS’s 5.375% senior notes due in March 2021.

UK and Europe

2019 saw significant innovation by European insurers in the debt capital markets space, fueled in part by the continued low-yield environment in the capital markets and a natural increase in demand amongst investors for innovative risk and pay-out profiles.

In the plain vanilla senior debt securities market, yield levels remained incredibly low. For example, Baloise Holding, one of the most active insurance issuers in 2019 in the European bond markets (5 offerings with an aggregate value of more than CHF750 million), successfully placed in September 2019 its first three-tranche senior bond transaction (comprised by three-, seven- and 10-year bonds) amounting to CHF425 million in principal amount, becoming the first ever insurance issuer to issue a three-tranche bond at a coupon of 0%.

In order to increase demand for senior bonds, insurance issuers targeted longer-dated paper that, given its longer duration, could attract investors with a higher yield. For example, this prompted Zurich Insurance, on June 11, to successfully issue the longest ever senior bond from a European insurance company—a €500 million 20-year deal.
The variety of insurers accessing the European senior debt markets was also a feature in 2019, with US insurers accessing the Euro-markets with reverse Yankees to diversify their inversions base. For example, Chubb took advantage of this demand for duration amongst investors when, on June 13, 2019, it included a 12-year tranche alongside an eight year in a €1.15 billion senior transaction in the Euro-markets.

In the regulatory capital space, insurers came to market with a number of Tier 2 and restricted Tier 1 issues which, given their more attractive yield, were significantly oversubscribed. For example, in January 2019, Generali issued a fixed-rate Tier 2 note with a maturity of 10 years and a target principal amount of €500 million. This issue ended up more than 13 times oversubscribed by investors. In April 2019, Ageas SA/NV came to market with its debut issue of fixed- to floating-rate subordinated bonds (Tier 2) in the principal amount of €500 million with a coupon rate of 3.25% per annum, followed up with an issue of a €750 million restricted Tier 1 Note with a fixed-rate coupon of 3.875% per annum payable annually in arrear and resettable in June 2030—which was more than 5 times oversubscribed. Following on from these offerings, Beazley Insurance dac elected to re-enter the subordinated debt market in September 2019 with a successful offering of US$300 million 5.500% Tier 2 notes due 2029.

On top of these developments in the senior and subordinated space, green bonds also hit the insurance scene. In September 2019, Generali issued the first green bond by a European insurer in the principal amount of €750 million. This green bond was followed by a Tier 2 issue of green bonds by CNP Assurances in a principal amount of €750 million and a senior green bond by Swiss Life Holding in the principal amount of CHF600 million, each in November 2019.
Introduction

In 2019, the convergence market, which includes insurance-linked securities, sidecars, dedicated funds and collateralized reinsurance vehicles, continued the growth trends of prior years, underscoring its establishment as a key component of the global insurance market. The volume of new risk-linked security issuances in 2019 was the third largest in the history of the market, although a noted decline from 2018. In addition, 2019 saw the introduction of several innovative new risks as well as the entry of significant new market actors. We review below the markets for catastrophe bonds, sidecars and dedicated funds.

Insurance-Linked Securities

2019 saw approximately $11.1 billion of new risk-linked securities issuances, compared to $13.9 billion in 2018. While this represented a decline in the aggregate amount of issuances compared to 2017 and 2018, it still is the third largest in the history of the ILS market, resulting in approximately $40.7 billion of total aggregate principal amount of risk-linked securities outstanding at year-end, more than 8% higher from the amount outstanding at the end of 2018. While the aggregate amount of issuances declined in 2019, an aggregate of $3.3 billion of catastrophe bonds were issued in the fourth quarter (significantly greater than fourth quarter activity in prior years), representing a strong resurgence of the market and a good indicator of increased activity in 2020.

US catastrophe risks (particularly US wind and US earthquake) continue to dominate, representing approximately 40% of outstanding bonds at year-end. Japan risks (earthquake and typhoon) represented approximately 8% of outstanding bonds at year-end, a decline from prior years. European-only risks represented approximately 1% of outstanding bonds at year-end. However, multi-region bonds (typically covering the US and Western Europe, but also Japan and Australia) represented approximately 19% of outstanding bonds at year-end, showing an investor appetite for European risks when they are bundled with other regions (thereby improving the pricing). Mortgage insurance risks represented approximately 20% of outstanding bonds at year-end, almost double that at the end of 2018. Additionally, risks from emerging markets, including Latin America, the Caribbean and the Philippines, represented approximately 4% of outstanding risks, largely issued through the World Bank’s note program.

Sponsoring companies in 2019 included longtime annual participants (such as Everest Re, State Farm, USAA and XL Bermuda), primary insurer sponsors (such as Allstate, American Integrity, Covéa, Safepoint Insurance Company, Security First Insurance Company and UnipolSai) and new
insurance sponsors (such as Bayview and Hamilton Re). State-sponsored insurance entities were significant participants in the market in 2019, including offerings sponsored by the California Earthquake Authority, FEMA, North Carolina Insurance Underwriting Association, Pool Re and Texas Windstorm Insurance Association.

Of particular interest in 2019 were breakthrough transactions, representing significant expansions in the use of ILS, including new types of risks and new types of sponsors.

Over the course of 2019, mortgage insurance-linked notes totaling more than $4.2 billion were issued by a number of sponsors, including Arch Capital Group Ltd., Essent Guaranty, Genworth Mortgage Insurance, MGIC Investment Corporation, National Mortgage Insurance Corporation and Radian Guaranty. These transactions represented over 40% of all issuances in 2019, illustrating the strong recent growth of this market (and offsetting the decline in new property catastrophe risks in 2019).

In February 2019, Pool Reinsurance Company, the UK government-sponsored mutual terrorism reinsurance facility, sponsored the Baltic PCC limited transaction, providing coverage for terrorism risk. This was the first terrorism risk catastrophe bond in the history of the market.

In February 2019, UnipolSiai sponsored the Atmos Re DAC transaction, which provided UnipolSiai with reinsurance protection for severe weather related perils affecting Italy. The transaction was notable in that it covered a broad range of perils over a specific geographic area.

In May 2019, Security First Insurance Company sponsored its third catastrophe bond offering (through Swiss Re), First Coast Re II Pte. Ltd. This transaction represented the first Rule 144A catastrophe bond offering to utilize a Singapore-domiciled special purpose reinsurance vehicle. Singapore saw its second catastrophe bond offering later the same month, with Safepoint Insurance Company sponsoring the Manatee Re III Pte. Ltd. transaction. Both of these transactions illustrate the viability of using Singapore-domiciled special purpose reinsurance vehicles for ILS transactions.

In June 2019, Swiss Re returned to the ILS market for the first time in several years through the Matterhorn Re Ltd. transaction, securing coverage for Northeast US named storms. As Swiss Re had not sought reinsurance protection from the catastrophe bond market in a number of years, it demonstrated the ability of the market to offer capacity as the market evolves.

In November 2019, the Republic of the Philippines accessed the ILS markets for the first time through the World Bank’s note program. The notes provided protection for earthquakes and tropical cyclones affecting the Philippines. This is the first ILS transaction to have exposure to the Philippines, and represents a notable expansion of the geographic coverage of the ILS market.

In late 2019, a fund managed by Bayview Asset Management, LLC sponsored the Sierra Ltd. catastrophe bond offering, providing protection for US earthquakes. The transaction was unusual as Bayview is not the typical insurance or reinsurance company sponsor. Instead, Bayview is a significant investor in mortgage-related securities, and pursued the transaction to mitigate its exposure to loan defaults arising following an earthquake. This was an important expansion of the use of ILS to meet risk mitigation needs outside of traditional insurance and reinsurance.

The PRC and Hong Kong governments have emphasized the importance of the insurance sector for Hong Kong’s development plan in upcoming years. On February 18, 2019, the State Council of the PRC announced the Outline Development Plan for the Guangdong-Hong Kong-Macao Greater Bay Area (the “Development Plan”). Under the Development Plan, the insurance sector has been identified as one of the pillar industries and the Development Plan seeks to explore the development of a trading platform for innovative insurance products and encourages Hong Kong to further strengthen its status as a risk management center. Consistent with the Development Plan, Hong Kong’s Chief Executive Carrie Lam commented at the Asian Insurance Forum held in Hong Kong on December 10, 2019 that it is the Hong Kong government’s goal to introduce relevant legislative amendments to its Legislative Council in early 2020 to enable the issuance of ILS, including cat bonds. We expect that there will be further developments in the use of Hong Kong-domiciled vehicles for ILS transactions in the coming years.
Indemnity triggers (which calculate payouts based on the actual losses of the ceding company) were used in a majority of transactions in 2019, representing approximately 67% of all outstanding issuances at year-end. Index transactions (using information from PCS and PERILS) were the next largest trigger-type, representing approximately 19.0% of outstanding transactions at year-end. Parametric triggers (which are based on measurable physical phenomena, such as wind speed or earthquake magnitude), at 4% of outstanding transactions, represented the third largest category of trigger type. The remainder consisted of multiple triggers or bespoke arrangements.

Aggregate triggers continued to dominate catastrophe bonds, representing more than half of all transactions outstanding at year-end 2019. With these triggers, losses from multiple events are aggregated (typically over a 12-month period) to determine whether the specified attachment level has been exceeded. This demonstrates one of the ways in which the catastrophe bond market has come closer to the traditional reinsurance market (where aggregate protection is more common).

In 2019, in line with previous years, most sponsors came to market without a rating on catastrophe bonds. This continues a trend over the past few years and reflects a perception that the time and expense of the ratings process outweigh the benefits to investors (and indirectly sponsors) to having the rating. The proceeds of insurance-linked securities continue to be invested in high-quality assets, such as money US treasury market funds. Many transactions in 2019 utilized putable notes issued by either the European Bank for Reconstruction and Development ("EBRD") or the International Bank for Reconstruction and Development ("World Bank"), thereby potentially providing an improved investment return on the underlying notes. In addition, the use of these putable notes helps to mitigate the risks of negative interest rates arising from holding money market funds denominated in currencies with negative interest rates. However, with the rise of interest rates (resulting in increases in the return for treasury money market funds), the use of putable notes has declined compared to prior years.

2019 saw the entry into the market of new sponsors, catastrophe bonds covering new perils and the availability of new jurisdictions for ILS issuances. Despite significant catastrophe losses in 2018 and prior years, the continued growth and evolution of the market demonstrates its importance in providing claims paying resources and flexible solutions to sponsoring insurance companies.

**Sidecars and Managed Funds**

In 2019, sidecars remained an important mechanism for providing additional collateralized capacity to the reinsurance market, while allowing sponsors to participate in a targeted fashion in the property casualty market. Several reinsurers extended their existing programs, including AXIS Capital, Brit, Liberty Mutual, Munich Re, Peak Re and Swiss Re. Reinsurers raised approximately $3.7 billion through sidecar issuances in 2019.

Sidecars are privately negotiated transactions that can be flexibly tailored to meet the sponsoring reinsurance company’s needs. They can be structured as market-facing vehicles (in which the sidecar directly enters into retrocession agreements with third-party reinsurers, with underwriting and management typically being performed by the sponsoring reinsurance company), and side-by-side vehicles (in which the sidecar enters into a retrocession agreement with the sponsoring reinsurance company, taking a quota share of a specified portfolio of risks of such company).

Sidecars typically have a risk period of one year. If loss events occur during that period, funds are held in the trust account established for the ceding company prior to being released to the sidecar investors. In order to protect the ceding company from adverse loss development, most transactions require that a buffer be established for the loss reserves, with such buffered amount held in the trust account. The buffered amount declines over time until the reinsurance agreement is commuted. As a result of significant losses in 2018, capital was “trapped” for much of 2019 (meaning that, while it would ultimately not be needed to pay claims, it was not immediately available to be reinvested in other transactions).
Large institutional investors, such as Canadian public pension funds, are continuing to allocate capital to ILS-dedicated funds, reflecting their acknowledgment that the asset class offers returns uncorrelated to the broader securities markets. This non-correlation began to attract institutional investors in the aftermath of the 2008 financial crisis, leading to significant growth in ILS fund assets under management since then, and investor interest appears to have been spurred on more recently by the anticipation of another end-of-cycle market downturn. In recognition of the growing importance to institutional investors of ILS funds, The Standards Board for Alternative Investments (“SBAI”), a standards setting body for the alternative investment industry, announced a series of projects relating to ILS funds, the first of which was a “Toolbox Memo” on valuation of ILS fund assets. In addition to standards of general applicability to hedge funds, the Toolbox Memo focused on the need to address the particular challenges posed by valuation in connection with a loss event pending receipt of claims data.

Until recently, the issues around valuations following a loss event had been addressed by means of conventional hedge fund technology used for illiquid or hard-to-value investments. Affected investments were placed in ‘side pockets,’ excluding them from the general net asset value pool on which investor redemption proceeds and performance-based sponsor compensation are calculated and excluding incoming investors from participating in profits and losses on these investments. This practice eliminated the need to value the side pocketed assets. The loss events of 2017 brought valuation following a loss event into sharp focus. Investors have particular concerns around the fact that investments were often not marked down before being side pocketed, and in response sponsors began to explore alternatives to side pockets, often establishing reserves in excess of GAAP reserves rather than removing the entire investment from the asset pool. This addresses investor concerns and also allows for a more precisely calibrated response to the loss event, which may not always affect the entire investment. The SBAI has announced that its next Toolbox Memo in the series on ILS funds will address side pockets.
2019 saw the highest ever levels of pension longevity risk transfer in the UK. The value of bulk annuity transactions is expected to exceed £40 billion, which is almost double the £24 billion market volume reached in 2018. This upward surge in the volume of de-risking transactions reflects a trend of increasing demand due to the natural maturing of schemes and the improvement of funding positions. As of October 2019, £70 billion of longevity deals had been completed by FTSE 100 companies, with 32 of the 100 companies having now taken steps to de-risk their schemes.

As was the case in 2018, individual deal sizes increased in 2019. 2019 saw two bulk annuity deals of over £4 billion, including a £4.7 billion buy-out with Rothesay Life for the Telent pension scheme, the largest ever bulk annuity policy entered into with a UK pension scheme. The dominance of these large deals means that insurer capacity is quickly consumed, so schemes need to be well prepared to appear more attractive to insurers so as to secure insurer capacity.

Pensioner buy-in pricing has been steady over the last few years, driven by the fact that, since the introduction of the Solvency II regulatory regime for European insurers, these insurers have been changing their investment strategies to take advantage of increased flexibility, moving away from corporate bonds to other assets with yields which better match deferred pension liabilities. In addition, as was the case in 2018, schemes have seen good asset performance which means that they are better placed to be able to afford to enter into a buy-in or buy-out.

Buy-out pricing has also become more affordable over the last few years due to a trend of reduction in life expectancy improvement rates. However, the first nine months of 2019 saw a relatively low number of deaths which, in turn, means that models may predict slightly longer life expectancies. That approach would mean that de-risking could become slightly more expensive, bucking the recent trend of year-on-year pricing improvement.

Increasing demand globally for longevity reinsurance could also raise bulk annuity prices as reinsurer capacity becomes more limited, although that capacity constraint is not expected to be felt for some time yet.

Back book transactions also form an important part of the bulk annuity market. 2018 saw Prudential sell £12 billion of its back-book to Rothesay Life. However, in 2019, the High Court did not sanction the transfer of the policies and liabilities of Prudential to Rothesay Life by way of a court-approved Part VII transfer. Despite the fact that the regulators and an independent expert approved the transfer, the Court agreed with policyholder objections and rejected the transfer, in
the light of the negative impact that changing the counterparty would have on policyholders. The Court focused on the fact that policyholders would have chosen Prudential as their annuity provider based on its length of time in the market and established reputation, as well as the fact that, in the event of financial distress, it is more likely that Prudential would have support from its wider group of companies, as compared to Rothesay Life. This decision will be appealed by Rothesay Life and Prudential in 2020; for the time being, however, the High Court’s ruling creates uncertainty for the economic viability of similar back-book deals between insurers.

The longevity swap and reinsurance market also remained strong in 2019 with longevity swap deals now in place covering over £77 billion of pension scheme liabilities. Significant transactions included a longevity swap entered into between HSBC and the Prudential Insurance Company of America (“PICA”) covering liabilities worth £7 billion. This is the second largest longevity swap entered into by a UK pension scheme to date and also is the first swap which uses a Bermuda-based captive company as the insurance intermediary. Reported deals also included a longevity swap entered into by the UK pension scheme of the French company Lafarge with Munich Re, covering an undisclosed amount of liabilities. High levels of reinsurance continued in 2019, with, for example, PICA alone having completed £2 billion of reinsurance contracts by the end of April 2019. Longevity swap activity is predicted to continue into 2020, as current life expectancy assumptions are the lowest that they have been in over a decade (reinsurers’ views on longevity tend to move more slowly than insurers’ views, so it may take time to change or not change at all, despite the first nine months of 2019 seeing a relatively low number of deaths as referred to above).

As in 2018, the number of active bulk annuity insurers in the UK market remained at eight, with no new entrants or leavers in 2019. Legal & General (“L&G”) and PIC continue to have the largest market share. L&G alone was expected to have transacted £12 billion in bulk annuities over the course of 2019, with final numbers still due to be released. Having joined the market in 2017 and completed its first external transaction in 2018, Phoenix Life completed almost £2 billion in bulk annuity transactions in 2019, demonstrating a persistent increase in market share.

In 2019, eight transactions all each worth over £1 billion insured more liabilities between them than insured in any year previously. Due to the increase in large deals over 2019, insurer capacity is increasingly being consumed rapidly. As a result, concerns are being raised in the industry about the level of market capacity and the ability of smaller schemes to buy-out. Going forward, insurers have indicated that schemes should be well prepared and plan carefully how they approach the insurance market. Insurers will prefer schemes who have well developed transaction plans, have carried out due diligence on their data and benefits and have experienced advisers in place. However, it is expected that 2020 will see a reduction in the number of large deals taking place, which presents an opportunity for smaller pension schemes to be able to secure competitive pricing and completed deals.

On the pensions legal front, in October 2018, the High Court held that pension schemes are required to equalize benefits for the effect of unequal guaranteed minimum pensions (“GMPs”). GMPs are a minimum benefit that schemes that were contracted-out of the state second pension on a salary-related basis between 1978 and 1997 are required to provide. The judgment set out a number of possible methods by which schemes can equalize GMPs. A survey of bulk annuity insurers carried out in 2019 indicated a unanimous preference for one method, which involves the conversion of the unequal pensions into a new benefit structure in order to achieve equalisation. The survey also indicated that schemes equalising using the conversion method could expect to receive more competitive pricing from bulk annuity insurers.

Following the UK government’s consultation on a proposed legal and regulatory framework for the authorization and supervision of defined benefit (“DB”) commercial consolidation vehicles or “superfunds”, it was hoped that the authorisation regime would be introduced in the most recent Pensions Bill to be published by the UK government.
However, the framework has not yet been put into place with no indication that it will be included in the forthcoming Bill. The government has indicated that legislation on this new framework would only be introduced after the government’s consultation response has been published. Commercial consolidation vehicles offer a complete risk transfer alternative to buy-outs as, essentially, they are occupational pension schemes into which other DB schemes can transfer their assets and liabilities. Two consolidation vehicles were set-up in 2018, the Pension SuperFund and Clara-Pensions, with 2019 seeing the Pension SuperFund entering into its second exclusivity agreement with a £300 million pension scheme. These deals cannot proceed without the proposed legal and regulatory framework having been implemented, although the reported exclusivity arrangements do indicate that schemes are interested in this alternative de-risking route.

The forthcoming Pensions Bill is also expected to introduce changes to the regime which governs the funding of DB pension schemes, so as to clarify funding requirements. The Bill is expected to include a requirement for schemes to have a long-term “funding and investment strategy” in place, based on a previous version of the Bill published before the UK’s recent general election at the end of 2019. A buy-in or buy-out is typically part of a scheme’s long-term strategy to reduce risk, so the introduction of this new funding regime could lead to an increase in demand in the de-risking market.

On the insurance legal front, at the time of writing it is expected that, following the UK’s departure from the European Union, the insurance regulatory regime will continue to be based on Solvency II, with any EU legislation having been transposed into UK law. However, the extent to which the legislation implementing the Solvency II framework will be amended remains unclear. The UK Treasury Select Committee opened an enquiry into the operation of Solvency II following the Brexit vote, looking at the possibility of making changes to improve the UK regime. Any changes to the Solvency II regime could have an impact on insurer pricing. More generally, the financial impact of Brexit remains uncertain, with the possibility of pricing volatility and changes to both market capacity and scheme funding levels.
Showing no sign of slowing down, pension risk transfer transactions continued in 2019 with a number of group annuity contract purchases. In 2019, $25 billion in US pension liabilities were transferred. This total falls just below the amount transferred in 2018. Even though there was a decrease in volume, the number of pension risk transfer transactions exceeded the total of 2018. According to the LIMRA Secure Retirement Institute, 301 group annuity contracts had been sold by the end of the third quarter. This is an increase from 281 over the same period in 2018.

2019 did not have an exceptionally large number of jumbo transactions in comparison to 2018, with the market comprised mainly of smaller and mid-sized pension risk transfers. Companies in the US that engaged in large pension risk transfer transactions that included annuity purchases in 2019 include: Baxter International, Lockheed Martin, Weyerhaeuser Co., Bristol-Myers Squibb Company, Avery Dennison, Rollins, Inc., Owens Corning and McKesson Corp. The Baxter International transaction with Prudential Financial was the largest pension risk transfer transaction in the US in 2019.

Notably, in October 2019, the Bristol-Myers Squibb Company transferred $3.8 billion of its US pension obligations through a full termination of the company’s US Retirement Income Plan. This transaction was the largest full plan termination that primarily included terminated vested and active participants, and included a first-of-its-kind plan termination solution, whereby the Athene Annuity and Life Company, a wholly-owned insurance subsidiary of Athene Holding, Ltd, agreed in advance to provide an annuity contract covering all obligations not paid through lump sums. The obligations were distributed through a combination of lump sums to Plan participants who elected such payments and the purchase of a group annuity contract from Athene. The Plan included approximately 4,800 active employees, 1,400 retirees and their beneficiaries receiving benefits, and 18,000 prior company employees who had not yet initiated their benefits.

Athene was busy in 2019. In addition to the Bristol-Myers Squibb transaction, Athene announced transactions with Weyerhaeuser Co. and Lockheed Martin in 2019. The Weyerhaeuser transaction saw a transfer of $1.5 billion of US pension liabilities to Athene following a lump sum offering to approximately 20,000 former Weyerhaeuser employees and the Lockheed Martin transaction included a buy-in transaction under which Lockheed Martin purchased an $800 million group annuity contract covering pension liabilities for approximately 9,000 retirees while retaining responsibility for plan administration. Further, AIG successfully followed through on their intention to grow their presence in the pension risk transfer market with the execution of a buy-out transaction with Avery Dennison.
Corporation where it assumed $750 million in pension obligations covering approximately 8,500 retirees, beneficiaries and deferred and active members. AIG also executed a transaction with Rollins, Inc., transferring $198.3 million of US pension obligations to AIG. Other notable transactions included: the transfer by Owens Corning of approximately $89 million in pension liabilities to an undisclosed insurer; McKesson Corp’s purchase of a $280 million group annuity contract from an undisclosed insurer following the distribution of approximately $49 million in lump sums to about 1,300 participants; Rogers Corp’s termination of its US non-union pension plan following a lump sum distribution of about $39 million and the transfer of approximately $124 million in liabilities through the purchase of a group annuity contract from an undisclosed insurer; and Lennox International’s purchase of a group annuity contract covering approximately $78 million in pension liabilities.

Looking Forward:
Factors Driving De-risking

The market’s performance in 2019 is indicative of the continued interest among plan sponsors in de-risking activities and, more specifically, pension risk transfers. MetLife’s 2019 Pension Risk Transfer poll reported that 76% of all plan sponsors with de-risking goals plan to completely divest their company’s defined benefit plan liabilities at some point in the future. Further, the 2019, biennial Mercer/CFO Research study reported that “76% of the executives polled said it was likely their organizations would take some form of lump-sum-based risk-transfer action in 2019 or 2020, in which at least some plan participants would be offered a lump-sum buyout of their pension benefit.” As we have discussed in our prior updates, plan sponsor motivations for engaging in pension risk transfer transactions include volatility in pension obligations, accounting and funding rule changes, volatile capital markets, rising interest rates, longevity risk issues, and escalating premiums paid to the Pension Benefit Guaranty Corporation (“PBGC”), the federal agency that insures private sector pension benefits. For example, the PBGC has previously identified past and scheduled future rapid increases in PBGC premiums as one of the primary drivers of de-risking activity. The MetLife poll further indicated that 55% of those surveyed cite “actions” by the PBGC as the primary catalyst for plan sponsors to initiate a pension risk transfer to an insurer. This apparently includes PBGC premium increases as well as the PBGC’s risk-based premium structure, which varies with plan underfunding. While some believe that the pension risk transfer market may cool in subsequent years since the pension plans that are ideally suited to execute pension risk transfer transactions will have already done so, interest among plan sponsors continues to be high. We expect such interest to continue.
INSURANCE REGULATORY
US/NAIC

Impetus from Insurtech May Lead to Changes in Anti-Rebating Law

NAIC Investment-Related Initiatives

Major New Developments Related to Credit for Reinsurance

Update on US Insurance Business Transfer and Division Legislation

New York DFS “Best Interest” Standard for All Life Insurance Products Goes Into Effect While the SEC and NAIC Adopt Rules Addressing Specific Segments of the Market

SECURE Act Signed Into Law

Finding Common Ground – Recent Developments in International Group Supervision

NAIC Begins to Address Cannabis

NAIC Pet Insurance White Paper Released and Pet Insurance Model Act Under Development

Breaking Down Blockchain Implications of Blockchain Technology for the Insurance Industry

UK/BREXIT

ASIA
For over a century, most state insurance codes have included broad prohibitions on the payment of “rebates” and “inducements” in connection with the purchase of insurance. Anti-rebating provisions are also included in the Unfair Trade Practices Act (“NAIC Model 880”), a model law of the National Association of Insurance Commissioners (“NAIC”), which is the support and standard-setting organization for the insurance regulators from all 50 states, the District of Columbia and the US territories.

In 2019, however, the NAIC’s Innovation and Technology (EX) Task Force indicated its willingness to consider recommending the relaxation of anti-rebating laws. In addition, the National Council of Insurance Legislators (“NCOIL”), an organization comprised mainly of members of state legislative committees that oversee insurance legislation, is also working on insurance modernization model legislation, including a model act addressing anti-rebating laws. Such initiatives, if implemented by individual state insurance regulatory authorities and legislatures, could have wide ranging effects.

Background

Rebates of insurance premiums would not be illegal in the absence of specific statutes prohibiting them. In the state of California, for example, where the anti-rebating statute for most lines of insurance was repealed in 1988 by popular vote through Proposition 103, rebates are not illegal for those lines of insurance. However, most states have laws on the books, many of which date back to the 1800s, that prohibit insurance companies, agents and brokers (or others acting on their behalf) from paying or even offering to pay a rebate of premium—or any other valuable consideration that is not specified in the policy—as an inducement to the purchase of insurance.

People from outside of the insurance industry often find the prohibition on rebates hard to understand, because it seems to run counter to consumer interests, but it has been a fixture of insurance regulation for a long time. The precise rationale for the prohibition is shrouded in the mists of history but most often cited are a desire to protect the solvency of insurance companies and the integrity of the rate regulation system, and to prevent unfair discrimination among insureds of the same class. It has been suggested that the durability of the prohibition may be related to a desire by independent agents and brokers (and their allies in state legislatures) to protect against price competition from large brokerage firms and, in recent years, insurtech startup firms. In any case, state insurance regulatory authorities have generally enforced anti-rebating laws quite vigorously.
To complicate matters further, anti-rebating laws and the interpretation of those laws by regulatory authorities are not uniform across the states. Some state statutes permit gifts to customers if they are under a specified value, such as $25 or $100, but many do not. The Illinois anti-rebating statute allows an insurance company to offer a child passenger restraint system for free or at a discount—a remarkable provision in that it suggests that, in the absence of this express exception, doing so might otherwise have been deemed illegal.

In addition to differences among the states with regard to statutory wording, there are differences among state regulatory authorities in the interpretation of the statutes. For example, most state insurance regulators take the view that if a valuable benefit is provided to prospective customers regardless of whether they actually purchase an insurance product, then it does not violate the anti-rebating statutes. Perhaps tongue in cheek, the New York State Insurance Department1 published an opinion in 2001 explaining that providing free refreshments at a seminar on life and long-term care insurance would not violate the anti-rebating statutes, but only if attendees were allowed to partake of the refreshments regardless of whether they purchased an insurance product. However, not all states follow this rule. A few years ago, the Office of the Insurance Commissioner of the State of Washington made headlines by ruling that offering any valuable consideration as an inducement to insurance violates the Washington anti-rebating law if the valuable consideration is not specified in the policy, even if the benefit is provided to all prospective customers without regard to whether they actually purchase an insurance product.

In a number of states, the state regulatory authorities have been applying a “rule of reason” to determine that certain “value-added” services will not be deemed to constitute a prohibited rebate. For example, the New York State Insurance Department2 issued a circular letter in 2009 stating that an insurer or insurance producer may provide a service not specified in the insurance policy to an insured or potential insured without violating the anti-rebating statutes if two conditions are satisfied: (a) the service directly relates to the sale or servicing of the policy or provides general information about insurance or risk reduction, and (b) the insurer or insurance producer provides the service in a fair and nondiscriminatory manner to like insureds or potential insureds. In several states, the insurance regulatory authorities have expressly adopted this approach, and it is generally considered to be a reasonable approach in states where the regulators have not published guidance on the subject—but some states expressly reject this approach and insist that any valuable consideration not specified in the policy is prohibited, except where there is a specific statutory carve-out.

Actions by the NAIC in 2019

As durable and unyielding as state anti-rebating laws have historically been, there is a rising groundswell of innovation and technology in the insurance sector that may well bring about some changes—in the statutes, the regulatory interpretations of the statutes or both. The notion that bringing the benefits of a technology platform to insurance customers could be deemed an illegal rebate has led to a rethinking of the whole anti-rebating system.

At the NAIC Spring National Meeting in April 2019, the Innovation and Technology (EX) Task Force announced that a session at the NAIC/NIPR Insurance Summit in June 2019 would specifically focus on the purpose of anti-rebating laws and whether such laws are still needed. The decision to hold this meeting, according to the Task Force staff, arose in the context of discussing potential obstacles to innovation. At the June meeting of the Task Force at the NAIC/NIPR Insurance Summit, various stakeholders presented a wide range of suggestions on anti-rebating laws, ranging from leaving the current regime untouched, drafting changes to NAIC Model 880, and proposing to repeal such laws entirely for commercial lines of insurance.

After evaluating the various proposals offered at the June meeting, the Task Force considered a number of potential approaches at the NAIC Summer National Meeting in August 2019. The Task Force Chair, Commissioner Jon Godfread of the North Dakota Insurance Department, acknowledged the need for an update to the anti-rebating provisions of NAIC Model 880. He observed that these

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1 In October 2011, the functions of the New York State Insurance Department were transferred to the newly formed New York Department of Financial Services.
2 Supra.
provisions were introduced more than 100 years ago in response to the threat posed by rebates to insurance company solvency and consumer protection against unfair discriminatory practices. Commissioner Godfread pointed out that in today’s insurance industry, both startups and incumbent insurers operating in the insurtech space face significant challenges in complying with anti-rebating laws, the regulatory interpretations of those laws and the inconsistencies in those laws and interpretations across the states. Commissioner Godfread also stressed that underlying the various presentations made at the June summit was a shared view that a consistent approach to and interpretation of statutes related to anti-rebating would constitute a major improvement over the current state of affairs.

Accordingly, Commissioner Godfread presented a draft North Dakota Anti-Rebating Guideline, which had been prepared based on feedback from the presentations at the NAIC/NIPR Insurance Summit, and which he offered as a starting point for discussion by the Task Force. The draft North Dakota Guideline provides that insurers may offer value-added products, services or programs at no additional cost as long as they are (a) specified in the insurance policy, (b) aligned with the type of insurance offered and (c) either (i) mitigate loss or provide loss control that aligns with the risks of the policy or (ii) assess risk, identify sources of risk or develop strategies for eliminating or reducing those risks that aligns with the risks of the policy. The draft North Dakota Guideline expressly requires that value-added products, services or programs must comply with all other provisions of North Dakota law and, further, stresses that an application of North Dakota’s laws to each situation would require a fact-specific evaluation.

Regulators and other interested parties had varying responses to the draft North Dakota Guideline at the NAIC Summer National Meeting. While a representative of the Center for Economic Justice opposed revisions to NAIC Model 880 as not being necessary, most regulators and other participants at least in principle appeared to support the idea of reforming anti-rebating statutes. A representative of the American Property Casualty Insurance Association, while supportive of reform, expressed preference for the approach taken by the Ohio Insurance Department in Bulletin 2019-14, which interprets the anti-rebating laws to allow value-added products or services at no or reduced cost using the concepts similar to those in the draft North Dakota Guideline, but which does not include a requirement that it be specified in the policy.

In addition, the Task Force discussed current proposals under consideration by NCOIL to review anti-rebating laws as part of an effort to develop model “insurance modernization” legislation aimed at helping the insurance industry move past what some view as antiquated processes. Representatives from NCOIL stated that many legislators shared the view that there was a need for a balance between modernization and preservation to allow for updating and selective repeal of old anti-rebating statutes on the one hand, while safeguarding against wholesale repeal of anti-rebating laws on the other hand. They also confirmed that legislators would continue their modernization efforts at the NCOIL meeting in December (see further discussion below).

At the conclusion of its meeting in August, the Task Force determined that it should continue work on drafting an NAIC anti-rebating guideline, using the draft North Dakota Guideline as a base, while simultaneously pursuing amendments to NAIC Model 880. Following the meeting, the draft North Dakota Guideline was exposed for comment until September 6, 2019.

However, at the NAIC Fall National Meeting in December 2019, the Task Force decided to take a different approach. Rather than drafting a separate NAIC anti-rebating guideline, the Task Force decided to focus solely on drafting amendments to NAIC Model 880, specifically to clarify what would be considered a “rebate” or an “inducement” in light of the new technologies that are being deployed to add value to existing insurance products and services. That decision was primarily motivated by concerns expressed by insurance regulatory authorities and other interested parties that current anti-rebating language in NAIC Model 880—and inconsistent interpretations of such language—could hamper innovations that are designed to minimize the risk of loss for consumers. The NAIC Executive (EX)
Committee subsequently voted to approve the Task Force’s request for approval to draft amendments to NAIC Model 880, so that process is now underway.

**Actions by the NCOIL in 2019**

In parallel to the NAIC Task Force’s activities, the Financial Services & Multi-Lines Issues Committee of NCOIL is engaged in ongoing discussions on the development of an [NCOIL Rebate Reform Model Act](#). The draft NCOIL Model Act clarifies when the provisions of value added services, certain gifts and prizes and free or below-market-value services would be considered an impermissible rebate under state insurance laws and regulations. NCOIL continued to discuss the draft Model Act at its 2019 Fall Meeting in December 2019 and discussions are expected to continue well into 2020. If NCOIL adopts the Model Act, that adoption should give additional impetus to the NAIC’s efforts and may encourage more states to amend their anti-rebating statutes.

**Going Forward**

As 2020 progresses, proposed amendments to NAIC Model 880 and the draft NCOIL Model Act will be discussed in greater detail by both the NAIC and NCOIL. Further revisions and input from stakeholders is expected. One thing is certain however—change is in the air.
A fundamental element of US insurance regulation is monitoring the safety and soundness of insurers, and a big part of that task involves regulating the types of investments made by insurers. Like most aspects of US insurance regulation, the regulation of insurers’ investments is a function of state law, although the NAIC has developed a framework for how insurer investments are treated for statutory accounting, financing reporting and risk-based capital (“RBC”) purposes that the states generally follow.

The NAIC committee that addresses financial regulation is the Financial Condition (E) Committee, often called the “E” Committee. Like all NAIC committees, it is composed of state insurance commissioners or their designated staff members. The “E” committee currently has 38 subgroups that focus on different aspects of the financial regulatory landscape. In this article, we will discuss some 2019 initiatives of two of those subgroups – the Valuation of Securities (E) Task Force (“VOS Task Force”) and the Statutory Accounting Principles (E) Working Group (“SAP WG”)—that could significantly affect the regulatory treatment of certain insurance company investments.

NAIC Bond Designations Becoming More Granular

The VOS Task Force oversees the NAIC’s Securities Valuation Office (“SVO”), which is responsible for assessing the credit quality of securities owned by insurers. The SVO’s operations are governed by the Purposes and Procedures Manual of the NAIC Investment Analysis Office (the “P&P Manual”). One of the key elements of the P&P Manual is a procedure for insurers to file information about their bond and preferred stock investments with the SVO, so that the SVO can perform a credit quality assessment and assign a “designation” (essentially equivalent to a rating) between NAIC-1 and NAIC-6, with NAIC-1 indicating the lowest credit risk and NAIC-6 the highest credit risk.

In 2004, the P&P Manual was amended to include a filing exempt (“FE”) rule, granting an exemption from filing with the SVO for certain bonds and preferred stock that have been assigned a current, monitored rating by an NAIC-recognized credit rating provider (“CRP”). Under the FE rule, the CRP rating is converted to the equivalent NAIC designation for statutory reporting and RBC purposes. The vast majority of fixed-income investments of insurers benefit from this filing exemption.

Beginning with the statutory statements for 2020, the historical six NAIC designations will be replaced with a more granular system of 20 designation categories. For example, all FE bonds rated between Aaa and A3 are currently assigned a designation of NAIC-1 and accordingly receive
the same RBC charge. Under the new system, the NAIC-1 designation will be subdivided into seven categories ranging from 1.A (equivalent to Aaa) to 1.G (equivalent to A3). Although the more granular designation categories will be in effect for 2020 statutory reporting, the NAIC has not yet adopted a parallel set of granular RBC charges to go along with the designation categories.

**Non-Principal Protected Structured Notes No Longer Have Admitted Status**

The SAP WG has responsibility for the NAIC’s Accounting Practices and Procedures Manual, which is the official codification of statements of statutory accounting principles (“SSAPs”). Statutory accounting is generally more conservative than GAAP accounting because it is not geared to helping investors assess an insurer’s value or performance, but instead focuses on solvency – that is, an insurer’s ability to keep its promises to policyholders. For example, assets that may have economic value but cannot be readily liquidated to fulfill obligations to policyholders are generally deemed “nonadmitted.” Nonadmitted assets do not count toward an insurer’s surplus, which is one of the key measures of an insurer’s financial strength in statutory accounting.

On April 6, 2019, the SAP WG amended SSAP No. 26R – Bonds to define a “structured note” as “an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due.” Due to those amendments, effective on December 31, 2019, such non-principal-protected structured notes are excluded from the scope of SSAP No. 26R and (unless they are “mortgage referenced securities”) are also excluded from the scope of SSAP No. 43R – Loan-Backed and Structured Securities. That means they are no longer treated as bonds, but instead are within the scope of SSAP No. 86 – Derivatives and, moreover, are a type of derivative that is generally nonadmitted, unless a special exception is granted by the insurer’s domiciliary state insurance department.

**Principal Protected Notes May Lose Filing-Exempt Status**

In July 2019, the SVO issued a memo to the VOS Task Force that proposed a new definition of “principal protected securities” that would be removed from the FE category and would need to be filed with the SVO for analysis and the assignment of a bespoke NAIC designation, rather than automatically receiving a designation based on a CRP rating. The assumption, of course, is that the NAIC designation that the SVO would assign to such filed securities as a result of its analysis would be lower than the CRP-equivalent designation the securities would have received under the FE system.

As described in the July 2019 SVO memo, principal protected securities are a type of structured security where a portion of the underlying assets are dedicated to ensure the repayment of principal at maturity or a third party may guarantee the repayment of principal at maturity. The remaining assets in the structure (the “performance assets”) are intended to generate additional returns and may be of a type (e.g., derivatives, equities, commodities, non-rated debt, loans, funds, private equity, real estate, affiliated or undisclosed investments) that would not be eligible for reporting as bonds on Schedule D of an insurer’s statutory financial statements if they were owned directly, but are indirectly included on Schedule D by being embedded within the note and benefit from the overall credit rating received by these notes.

In the ensuing months the VOS Task Force received considerable formal and informal comments on the proposal. At its October 31, 2019 meeting, the VOS Task Force directed NAIC staff to work with industry to refine the proposal, and following a series of meetings with industry representatives in November and December, the SVO released an updated proposal on January 27, 2020, which the VOS Task Force discussed on February 4, 2020 and exposed for a 30-day comment period ending March 5, 2020.

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3 SSAP No. 43R defines “mortgage referenced securities” as “credit risk transfer” securities issued by a government sponsored enterprise, where payments on the securities are linked to the credit and principal payment risk of a referenced pool of mortgages.
The updated proposal defines Principal Protected Notes ("PPNs") as "a type of security that repackages one or more underlying investments and for which contractually promised payments according to a fixed schedule are satisfied by proceeds from an underlying bond(s) (including principal and, if applicable, interest, make whole payments and fees thereon) that if purchased by an insurance company on a stand-alone basis would be eligible for Filing Exemption," but for which two additional conditions are satisfied:

1. The insurer would obtain a more favorable RBC charge or regulatory treatment for the PPN through filing exemption than it would if it were to separately file the underlying investments in accordance with the P&P Manual; and

2. Either:
   a. The repackaged security structure enables potential returns from the underlying investments in addition to the contractually promised cash flows paid to such repackaged security according to a fixed schedule; or
   b. The contractual interest rate paid by the PPN is zero, below market or, in any case, equal to or below the comparable risk-free rate.

The updated proposal provides three illustrative examples of transactions that would fall within the definition of a PPN—one of which is a repackaging of collateralized loan obligations ("CLOs") into a CLO combination note (or "combo note").

The updated proposal also includes the following exclusions from the definition of PPN:

- defeased or pre-refunded securities which have separate instructions in the P&P Manual;
- broadly syndicated securitizations, such as CLOs (including middle market CLOs) and asset-backed securities ("ABS")—but excluding the examples listed in the updated proposal (e.g., CLO combo notes); and
- CLO or ABS issuances held for purposes of risk retention as required by a governing law or regulation.

At the February 4, 2020 telephonic meeting of the VOS Task Force, NAIC staff expressed the view that the updated proposal had addressed the issues appropriately and arrived at the correct scope for the PPN definition.

Some industry participants agreed with that view, though one participant expressed a desire for more input on the methodology that the SVO would use to analyze filed securities and suggested that a weighted average rating factor approach would be unduly punitive. In response, SVO staff stated that they could not be confined to a single prescribed methodology, but needed the discretion to tailor their methodology to the variety of structures and the nature of the risks. Another industry participant on the call suggested that the PPN treatment being recommended for CLO combo notes, was based on an inaccurate assessment of the risks of CLO investments (see further discussion on this topic below).

A topic that was not discussed on the February 4, 2020 call, but was discussed on the October 31, 2019 call is whether the new filing requirements for PPNs, if adopted, would be effective only for PPNs that insurers acquire after the effective date. The SVO staff has been consistent in its view that while it is appropriate to provide a transition period for insurers to adjust their portfolios, once the new requirements are in effect, they should apply to all portfolio investments, regardless of when they were acquired. The SVO is opposed to any "grandfathering" of already-owned securities because it believes it has identified a risk to insurers that needs to be addressed with respect to insurers’ entire portfolios of these types of securities.

As noted above, the comment period for the current PPN proposal ends on March 5, 2020. The goal of the NAIC staff is to review the comments received and potentially have the current proposal, or a revised version of it, ready for adoption by the VOS Task Force at the NAIC Spring National Meeting on March 22, 2020.

**Collateralized Fund Obligations May Lose Eligibility for Bond Treatment**

SSAP No. 43R – Loan Backed and Structured Securities defines certain types of debt obligations as "loan backed and structured securities" ("LBASS"), which are treated similarly to bonds for statutory accounting purposes, are reported on Schedule D of an insurance company’s...
statutory statements and receive bond-type RBC charges based on their NAIC SVO designation (which is automatically assigned based on the CRP rating in the case of rated LBASS).

At the NAIC Summer National Meeting in August 2019, the SAP Working Group exposed for comment proposed revisions to SSAP No. 43R that, if adopted, would exclude collateralized fund obligations (“CFOs”) from LBASS status, which means they would no longer be treated as bonds for statutory accounting, reporting or RBC purposes, even if they were rated by a CRP. The original proposal stated flatly that SSAP No. 43R is intended to capture investments with bond-like cash flows and “does not include equity instruments, investments with underlying assets that include equity instruments or any structures representing an equity interest (e.g., joint ventures, limited liability companies, partnerships) in which the cash flow payments (return of principle [sic] or interest) are partially or fully contingent on the equity performance of an underlying asset.” The proposal added that the “scope of SSAP No. 43R shall not include any securitization of assets that were previously reported as standalone assets by the insurance reporting entity. In other words, an insurance reporting entity is not permitted to repackage existing assets as “securitizations” to move the reporting of the existing assets within scope of SSAP No. 43R.” The NAIC staff initially classified the proposed change as “nonsubstantive” because in their view it was merely clarifying what they understood to be the original intent of SSAP No. 43R.

During the comment period, which ended on October 11, 2019, there was a strong reaction from the insurance industry, with commenters asserting that the proposal was too “broad brush,” would impact billions of dollars of industry assets and could have major unintended consequences. In response, the SAP Working Group deferred action on the proposals until 2020, in order to give the staff time to analyze the comment letters. Doubtless as a result of the comments, the materials released by the NAIC staff in advance of the January 8, 2020 telephonic meeting of the SAP Working Group took a more measured approach. The staff now recommended that the Working Group classify the project as “substantive,” meaning that staff would prepare an issue paper on the subject, in consultation with industry representatives, and would make their revised proposal for changes to SSAP No. 43R in the context of that issue paper. As a preview of the direction in which they were leaning, the NAIC staff suggested the following:

- The guidance should distinguish between investments that satisfy the SEC definition of ABS and those that do not.
- Different treatment might be warranted for CLO combo notes and for ABS that are not broadly syndicated.
- Investments where the amount of principal or interest is calculated solely with reference to an external market index should be excluded from the scope of SSAP No. 43R.
- Detailed guidance is needed to clearly identify and assess “insurer-sponsored securitizations.”
- Separate treatment was needed for equipment trust certificates, credit tenant loans and lease-backed securities that is tailored to those securities.

Industry participants in the January 8, 2020 meeting of the SAP Working Group suggested that the staff working on the new SSAP No. 43R issue paper should coordinate their efforts with the SVO staff working on the PPN definition. Other participants expressed concerns about using the SEC definition of ABS as a controlling criterion and about what the consequences would be for ABS not meeting that definition. At the conclusion of the meeting, the SAP Working Group approved the staff’s recommendation for the preparation of an issue paper. With respect to timing, the staff stated at the meeting that its goal was to have the issue paper available in time to be exposed for comment at the Spring National Meeting on March 21, 2020.

Differing Views of CLO Risks and Investment Risks

A point of disagreement that was briefly discussed at the February 4, 2020 meeting of the VOS Task Force was how to assess the risks of CLO investments for insurers. On December 6, 2019, the NAIC Capital Markets Bureau released a report entitled “Collateralized Loan...
Obligations – Stress Testing US Insurers’ Year-End 2018 Exposure. “That report described stress-testing that the NAIC staff had performed to assess the impact on CLO investments of a potential market downturn. The results of the stress tests showed that (a) losses on “normal” CLO tranches (i.e., CLOs with regular promises of principal and interest) only reached BBB-rated tranches, even under the worst-case scenario and (b) for “atypical” CLO tranches (i.e., CLOs that have unusual payment promises, such as equity tranches and combo notes), losses reached AA-rated securities. On the February 4, 2020 VOS Task Force call, one of the industry representatives expressed concerns about the methodology of the NAIC CLO report, suggesting that default assumptions were too high (among other things, by failing to take account of structural changes in loan documentation following the financial crisis) and that stressed recovery rate assumptions were too low. That individual urged the VOS Task Force to engage an independent expert to advise the Task Force on this issue. In response, a representative of the NAIC Capital Markets Bureau stated that he disagreed with the criticisms of the NAIC report and was planning to respond to them with a written rebuttal.

This debate is important, because it is likely that the NAIC staff’s view of the risks associated with CLO combo notes has influenced the inclusion of CLO combo notes in the PPN definition that is currently under consideration by the VOS Task Force. Having said that, the debate may actually reflect a fundamental difference in orientation between the investment world and the regulatory world. Insurance regulators, with their focus on protection of policyholders above all else, generally have a more risk-averse orientation than investment analysts do. An investment structure that offers statistically attractive returns may be problematic in the eyes of regulators if they perceive that it has the capacity to cause even one insurance company to become insolvent. And the recent experience of a group of life insurers that are now in delinquency proceedings after having invested heavily in PPNs that involved underlying affiliate investments has led many regulators to conclude that the PPN structure is facilitating RBC arbitrage that undermines the integrity of the RBC system—although the proposed PPN definition goes far beyond just targeting affiliate underlying investments. Yet another perspective to consider is that for many years prior to the financial crisis, life insurers made long-term promises to policyholders based on assumptions of higher returns than they can now obtain from traditional classes of fixed-income investments – meaning that newer structures by which life insurers can obtain higher returns in a capital-efficient manner may be one ingredient in enabling them to fulfill their promises to their policyholders. Accordingly, it is important that the views and concerns of insurance companies continue to be heard as the NAIC deliberates on these potentially consequential initiatives.”
One of the most important regulatory developments of the year was the adoption of amendments to the NAIC Credit for Reinsurance Model Law and Regulation (the “NAIC Models”) on August 6, 2019. The amendments were designed to satisfy the requirements of (i) the bilateral agreement on insurance and reinsurance between the United States and the European Union and (ii) a substantially similar bilateral agreement between the United States and the United Kingdom (together, the “Covered Agreements”). The amendments have laid the foundation for state legislatures to amend their credit for reinsurance laws to become compliant with the Covered Agreements to avoid potential federal preemption.

Background of the Covered Agreements

In contrast to primary insurance, where an insurer generally needs to be licensed in a state in order to do business in the state, a reinsurer does not need to be licensed in a state in order to provide reinsurance to insurers in the state. However, if the reinsurer is not licensed in the state, then it has generally needed to collateralize its reinsurance obligations in order for the insurer purchasing the reinsurance (the “ceding insurer”) to take credit for the reinsurance on its balance sheet. Because reinsurers provide the financial support that enables primary insurers to meet their obligations to policyholders, requiring unlicensed reinsurers to maintain collateral in the United States is intended to ensure that claims-paying resources are available and accessible to US ceding insurers and regulators should they be needed, particularly in the wake of a natural disaster.

Originally, reinsurers that were not licensed in the state of domicile of the ceding insurer were required to post collateral for 100% of their reinsurance obligations. In 2011, however, the NAIC Models were amended to modify that requirement for some reinsurers. In states that have amended their laws and regulations to adopt the 2011 amendments, reinsurers that have completed a prescribed process to become “certified” reinsurers can post significantly less than 100% collateral to secure their US reinsurance obligations. Under the 2011 amendments, individual reinsurers are certified based on criteria that include, but are not limited to, financial strength, timely claims payment history and the requirement that a reinsurer be domiciled and licensed in a “qualified jurisdiction.” The NAIC has established a process to evaluate jurisdictions’ oversight of reinsurers, under which it has designated seven non-US jurisdictions as “qualified jurisdictions” for this purpose (Bermuda, France, Germany, Ireland, Japan, Switzerland and the United Kingdom). The NAIC has also established a peer review system to oversee the certification of non-US reinsurers by states, which enables non-US reinsurers that become certified in one state to “passport” that certification throughout the United States.
The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank") established the legal framework for the United States to enter into bilateral or multilateral “covered agreements” with foreign jurisdictions that address regulatory measures with respect to the business of insurance or reinsurance. If state laws are inconsistent with a covered agreement and provide less favorable treatment to non-US insurers or reinsurers than US companies, then the covered agreement will preempt state law. A covered agreement can serve as a basis for preemption of state law only if the agreement relates to measures substantially equivalent to the protections afforded consumers under state law.

The Covered Agreements

The US-EU covered agreement, signed on September 22, 2017 by the US Department of the Treasury ("Treasury"), the Office of the US Trade Representative ("USTR") and the EU, requires US states to eliminate reinsurance collateral requirements for EU reinsurers that satisfy certain stipulated qualifications within five years or else the Dodd-Frank preemption provisions will come into effect. In exchange, the EU will not impose local presence requirements on US insurers and reinsurers operating in the EU and, in effect, must defer to US group capital regulation for US entities of EU-based insurers and reinsurers.

On December 19, 2018, in anticipation of Brexit, the Treasury, the USTR and the UK signed a UK-specific Covered Agreement. The motivation for the US-UK Covered Agreement was to ensure that the arrangements embodied in the US-EU Covered Agreement would apply to the US-UK relationship after the UK ceased to be a member of the EU. The US-UK Covered Agreement effectively replicates the terms of the US-EU Covered Agreement.

The Covered Agreements eliminate local presence and collateral requirements for qualified US reinsurers operating in the UK and EU insurance markets. The Covered Agreements also eliminate the requirement for collateral for qualified UK and EU reinsurers operating in the US insurance market as a condition for their US ceding insurers to take credit for reinsurance. In addition, if US states implement appropriate group capital standards, the Covered Agreements provide that US insurance groups operating in the UK and EU will be supervised, at the worldwide group level, only by their relevant US insurance supervisors. Conversely, UK and EU insurers operating in the US will be supervised at the worldwide group level only by their relevant UK and EU insurance supervisors.

Broadly speaking, the Covered Agreements: (i) eliminate, as a requirement for reinsurance placement or as a condition for receiving financial statement credit for reinsurance, requirements for reinsurers based in the other jurisdiction to have a local presence or to post collateral; (ii) provide that an insurance or reinsurance group will be subjected to worldwide group supervision only in its “home” jurisdiction—not in its “host” jurisdictions where it operates; and (iii) establish regulatory best practices to be encouraged for cooperative exchanges of information among regulators across jurisdictions.

In order to obtain the benefits of the Covered Agreements, a non-US reinsurer must meet a number of requirements, including, among other things, maintaining a minimum capital and surplus of at least $250 million, meeting certain minimum solvency or capital ratios, adhering to prompt claim payment standards and furnishing certain financial information to the ceding insurer’s domiciliary regulator upon request.

2019 Amendments to the NAIC Models

The NAIC quickly recognized that it would need to amend the NAIC Models to dovetail with the Covered Agreements. Originally, those amendments were expected to be adopted in December of 2018, but adoption was delayed because Treasury had expressed concerns about certain provisions that granted state insurance regulators discretion that could result in reinsurance collateral requirements that were inconsistent with the Covered Agreements. Accordingly, in early 2019, the NAIC Reinsurance (E) Task Force made revisions to the proposed amendments to address Treasury’s concerns, and the revised text of the amendments was adopted in June 2019.

One of the most important features of the 2019 amendments to the NAIC Models is the concept of a “reciprocal
Reciprocal jurisdictions include: (i) jurisdictions with which the United States has entered into a covered agreement, (ii) US jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program and (iii) qualified non-US jurisdictions that have agreed to mutual recognition and reciprocity conditions that mirror those in the Covered Agreement (this category currently includes Bermuda, Japan and Switzerland). Under the 2019 amendments, the benefits of the Covered Agreements are extended to all reinsurers domiciled in a reciprocal jurisdiction—not just to EU and UK reinsurers—provided that the reinsurers meet the capital and other standards required by the Covered Agreements and the NAIC Models.

The NAIC is now tasked with ensuring that the individual US states amend their laws and regulations to conform to the amended NAIC Models in order to avoid federal preemption. Under the Covered Agreement, the Director of the Federal Insurance Office (“FIO”) will begin evaluating US state insurance laws and regulations for possible federal preemption by March 1, 2021, making those states with the highest volume of gross ceded reinsurance a priority. The FIO Director will complete any necessary preemption determinations by September 1, 2022. With that in mind, at the 2019 NAIC Fall National Meeting, the amended NAIC Models were designated as NAIC state accreditation standards effective September 1, 2022. As a result, states that fail to amend their laws and regulations by January 1, 2023 to comport with the amended NAIC Models will risk losing their NAIC accreditation. That prospect, together with the possibility of federal preemption, will doubtless motivate states to take the necessary steps to adopt the amended NAIC Models, but crowded state legislative agendas may make actually achieving that goal a challenge.
The past two years have seen a significant upswing in the adoption of legislation by US jurisdictions to allow for the voluntary restructuring of solvent insurers. As reported in previous client alerts, an increasing number of US jurisdictions are establishing legal frameworks that would allow for such restructuring, which in turn may signal growing acceptance of such procedures in the United States generally.

Since 2000, the UK Financial Services and Markets Act ("FSMA") has provided a statutory mechanism permitting certain voluntary restructuring activities by solvent insurers, including allowing such insurers to transfer a portfolio of insurance business to another entity. Governed by sections 104-116 of Part VII of FSMA, such transfers (commonly referred to as “Part VII Transfers”) allow an insurer (or reinsurer) to transfer blocks of insurance business from one legal entity to another, subject to court approval. This procedure has been used in a variety of contexts, including to give effect to group reorganizations.

However, while popular in the UK for nearly two decades, the use of an insurance business transfer by a solvent insurer has historically been resisted in the United States. Indeed, with certain exceptions, the concept has only begun to gain ground in the US insurance sector in the past five years. In the United States, legislation in this area has taken two related but distinct forms:

1. Insurance business transfer legislation, which is more closely related to Part VII Transfers and allows insurers to transfer blocks of insurance business to another legal entity; and
2. Insurance division legislation, which allows for an insurer to divide itself into two or more companies, with assets and liabilities (including insurance policies) being divided among the resulting companies.

There has been considerable variation in how legislation in this area has been adopted. While approval by the insurance regulatory authority in the insurer’s domiciliary jurisdiction is invariably required, different approaches have been taken as to whether policyholder or court approval is also required.

In 2018, the NAIC began to consider how to evaluate and monitor the growing adoption of this type of legislation and, at its Fall National Meeting in 2018, the NAIC’s Financial Condition (E) Committee initiated the process to form a new working group to specifically review adoption of this type of legislation by US states. The creation of such a working group was well-timed, as, over the course of 2018 and 2019, six jurisdictions enacted legislation with respect to insurance business transfer statutes or insurance division statutes. We discuss each of those initiatives below as well as current developments at the NAIC level.
Developments in Insurance Business Transfer Legislation

Two states which have taken significant steps with respect to insurance business transfer legislation were Rhode Island, which amended its longstanding insurance business transfer statute and regulation, and Oklahoma, which enacted its own insurance business transfer legislation.

RHODE ISLAND
Rhode Island was the first US state to adopt legislation allowing for the voluntary restructuring of solvent insurers, as a result of its enactment of Chapter 14.5 of the Rhode Island Insurance Code in 2002. The implementing regulation (called “Regulation 68”) was issued by the Rhode Island Department of Business Regulation (the “Rhode Island Department”) in 2004. The statute and Regulation 68 originally provided a process for extinguishing the outstanding liabilities of a commercial property and casualty insurer in runoff pursuant to a commutation plan that was approved by the Rhode Island Department, a requisite percentage of creditors (including policyholders) and the Superior Court of Providence County. This process was patterned on the “solvent scheme of arrangement” permitted under UK law and the laws of other countries that follow English law. To date, no such commutation plan has ever been implemented in Rhode Island.

In 2015, the Rhode Island Department amended Regulation 68 to add procedures for insurance business transfer plans—the complete transfer of closed blocks of property and casualty business from any commercial insurers (regardless of domicile) to a Rhode Island domiciled assuming insurer. In order to consummate such a transfer, the transferring insurer must submit a plan outlining the transfer to the Rhode Island Department for approval. Additionally, this plan must be approved by the domiciliary regulator of the transferring insurer. The Rhode Island Department may only approve such plan if it determines that the plan would not have a material adverse impact on policyholders, reinsureds or claimants. Following the receipt of the required approvals, the Rhode Island Department will allow the assuming company to apply to the Superior Court of Providence County for approval of the plan. No policyholder approvals or opt-out provisions are included in the Rhode Island insurance business transfer process, although policyholders must receive advance notice and the Superior Court of Providence County must hold a public hearing with respect to approval of the plan.

In 2018, Rhode Island revisited its insurance business transfer regulation, in light of the fact that it had not been utilized since it was established in 2015. The concern was expressed that the provisions added to Regulation 68 in 2015 relating to insurance business transfers were not sufficiently well-grounded in the statute for insurers to feel comfortable relying on them. Accordingly, on July 2, 2018, the Rhode Island legislature amended the statute to clearly distinguish a commutation plan (where liabilities of the insurer are extinguished—and policyholders have a right to vote on the plan) from an insurance business transfer plan (where the liabilities are transferred to a new or existing Rhode Island-domiciled insurer – and policyholders do not have a right to vote on the plan) and to expressly authorize the Rhode Island Department regulations governing insurance business transfers. With those statutory revisions, a significant concern regarding the Rhode Island insurance business transfer process has been addressed.

The Rhode Island insurance business transfer process assumes an authority on the part of the Rhode Island statutory framework to bind non-Rhode Island policyholders of the transferring insurer. While the domiciliary regulator of the transferring insurer needs to approve the plan prepared by the transferring insurer, approvals are not required from the insurance regulatory authorities of each state where a transferred policy has been issued. To date, no insurance business transfer has taken place in Rhode Island.
OKLAHOMA

Oklahoma’s Insurance Business Transfer Act, which became effective on November 1, 2018, represents a more broadly applicable insurance business transfer regime than the process currently offered by Rhode Island. Under the provisions of the Oklahoma statute, any US insurer (whether domiciled in Oklahoma or not) or any non-US insurer may transfer and novate a block of business to an Oklahoma-domiciled, assuming insurer. The Oklahoma statute applies to both active and closed blocks of business, applies to both insurers and reinsurers and covers property, casualty, life, health and any other line of insurance that the Oklahoma Insurance Commissioner finds to be suitable.

Similar to the requirements in Rhode Island, a transferring insurer must submit a plan outlining the transfer to the Oklahoma Insurance Department for approval. In addition, the plan must receive either approval or non-objection from the domiciliary regulator of the transferring insurer. The Oklahoma Insurance Department may only approve such plan if it determines that the plan would not have a material adverse impact on policyholders or claimants, and a component of its review is required to include an opinion report on the transfer by a qualified independent expert. As with Rhode Island, no affirmative policyholder consent for the plan is required, nor is there a policyholder opt-out provision, though notice must be provided to the policyholders. Following the receipt of the required approvals, the Oklahoma Insurance Department will grant permission for the transferring insurer to apply to the District Court of Oklahoma County for approval of the plan, which then must hold a public hearing with respect to the plan. Similar to the Rhode Island statute, the Oklahoma statute provides broad authority to the Oklahoma Insurance Department, including with respect to non-US insurers.

On November 26, 2019, the Oklahoma Insurance Commissioner authorized Providence Washington Insurance Company (“PWIC”), a Rhode Island domiciled insurer, to submit its insurance business transfer plan to the District Court of Oklahoma County for approval. This authorization is the first insurance business transfer which has been successfully approved by a US insurance regulatory authority in the United States to date. If approved by the District Court of Oklahoma County, nearly all of the insurance and reinsurance business currently underwritten by PWIC would be transferred to Yosemite Insurance Company (an Oklahoma domiciled subsidiary of Enstar Group Limited) and would include the liabilities associated with this business as well as $38.5 million from PWIC as consideration for assuming those liabilities.

Developments in Insurance Division Legislation

In the latter half of 2018, Illinois and Michigan enacted legislation permitting divisions of domestic insurers. In 2019, Iowa and Georgia followed suit. Those four states join Arizona, Connecticut and Pennsylvania, which already had division statutes in place.

ILLINOIS

The Illinois Domestic Stock Company Division Law, which was enacted on November 27, 2018 and became effective on January 1, 2019, allows an Illinois-domiciled insurer to divide itself into two or more companies, with assets and liabilities, including insurance policies, being divided among the resulting companies pursuant to a plan of division that has been approved by the Illinois Department of Insurance. The Illinois statute applies to both active and closed blocks of business as well as to all lines of insurance. The law does not include a policyholder opt-out provision, but approval of the plan of division by the shareholders is required (with the same voting requirements as would be required to approve a plan of merger). In addition, although approval of the Illinois Department of Insurance is required, it need not take into account any review of the division by an independent expert. Furthermore, unlike the Rhode Island and Oklahoma statutes discussed above, no court approval is required as part of the Illinois division process. Though not required, the Illinois Department of Insurance may hold a public hearing on the division if it deems such a hearing to be in the public interest.

In addition to policyholders, certain affected state regulators and guaranty associations must receive notice of the insurance business transfer under the Oklahoma statute.

Additionally, under the terms of the Illinois statute, the Illinois domestic insurer which is requesting approval of the division may also request that a public hearing be held.
MICHIGAN

Chapter 55 of the Michigan Insurance Code of 1956, pertaining to the division of domestic stock insurers, became effective on December 20, 2018. In many ways, the Michigan statute is similar to the Illinois statute. The Michigan statute allows a Michigan-domiciled insurer to divide itself in an identical manner to that permitted by the Illinois statute pursuant to a plan of division that has been approved by the Michigan Department of Insurance and Financial Services (the “Michigan Department”). The Michigan statute also resembles the Illinois statute in the following respects: (i) applicability to both active and closed blocks of business as well as to all lines of insurance; (ii) requirement for the plan of division to be approved by a shareholder vote; (iii) lack of a policyholder opt-out provision; (iv) no requirement for review by an independent expert; and (v) no requirement for court approval.

The Michigan statute differs from the Illinois statute in two important respects. First, if one of the companies resulting from a division is to be sold to an acquirer, then the Michigan Department cannot approve the proposed division until the potential acquirer has received the required approvals for that acquisition. In addition, the approval standards in Michigan for a plan of division include certain standards with respect to such a potential acquisition that are not found in the Illinois statute. Second, while the Illinois statute sets out certain criteria for the approval of plans of division by the Iowa Division, the language of Section 521l.8(3) of the Iowa Insurance Code states, with reference to such criteria, that “[t]he commissioner may approve a plan of division if the commissioner finds that all of the following apply...” (emphasis added). When contrasted with similar language in the Illinois and Michigan statutes (which state that the commissioner shall approve a plan of division if certain statutory criteria are met), this language would appear to allow the Iowa Division to disapprove a plan of division even if all enumerated criteria for approval are met. Finally, unlike the Illinois statute, Chapter 521l of the Iowa Insurance Code requires the Iowa Division to hold a public hearing prior to the approval of a plan of division and requires the dividing insurer to mail written notice of the hearing to its policyholders.

IOWA

Chapter 521l of the Iowa Insurance Code became effective on July 1, 2019. Similar to Illinois and Michigan, the Iowa statute allows an Iowa domestic stock insurer to divide itself into two or more companies, with assets and liabilities, including insurance policies, being divided among the resulting companies pursuant to a plan of division that has been approved by the Iowa Division of Insurance (the “Iowa Division”). The Iowa statute closely resembles the Illinois and Michigan statutes, as its features include: (i) applicability to both active and closed blocks of business as well as to all lines of insurance; (ii) requirement for the plan of division to be approved by a shareholder vote (with the same voting requirements as would be required to approve a plan of merger); (iii) lack of a policyholder opt-out provision; and (iv) no requirement for court approval.

However, the Iowa statute differs from both the Illinois and Michigan statutes in several respects. First, Section 521l.8(2)(c) of the Iowa Insurance Code provides that the Iowa Division must select and retain an independent expert to review the plan of division in question and submit a report on the plan to the Iowa Division. Although both the Illinois and Michigan statutes allow the regulatory authorities in those states to hire experts as part of the approval process for plans of division, those statutes do not require plans of division to be evaluated by an independent expert. Second, while the Iowa statute sets out certain criteria for the approval of plans of division by the Iowa Division, the language of Section 521l.8(3) of the Iowa Insurance Code states, with reference to such criteria, that “[t]he commissioner may approve a plan of division if the commissioner finds that all of the following apply...” (emphasis added). When contrasted with similar language in the Illinois and Michigan statutes (which state that the commissioner shall approve a plan of division if certain statutory criteria are met), this language would appear to allow the Iowa Division to disapprove a plan of division even if all enumerated criteria for approval are met. Finally, unlike the Illinois statute, Chapter 521l of the Iowa Insurance Code requires the Iowa Division to hold a public hearing prior to the approval of a plan of division and requires the dividing insurer to mail written notice of the hearing to its policyholders.

GEORGIA

Article 6 of Chapter 14 of the Georgia Insurance Code (the “Georgia Division Statute”) also became effective on July 1, 2019. As with the laws discussed above, the Georgia Division Statute allows a Georgia domestic insurer to divide itself into two or more companies, with assets and liabilities, including insurance policies, being divided among the resulting companies pursuant to a plan of division that has been approved by the Georgia Office of Insurance and Fire Safety Commissioner (the “Georgia..."
Office”). Features which the Georgia Division Statute shares with the Illinois and Michigan statutes include (i) applicability to both active and closed blocks of business as well as to all lines of insurance; (ii) lack of a policyholder opt-out provision; (iii) no requirement for review by an independent expert; and (iv) no requirement for court approval. Shareholder approval of a plan of division is only required (i) if the articles of incorporation and bylaws of the dividing insurer require such approval, (ii) if the articles of incorporation or bylaws of such insurer are amended to require such an approval or (iii) if the dividing insurer will not survive the proposed division and has only one class of shares outstanding and the shares of each new insurer will not be distributed pro rata to the shareholders.

Additionally, the Georgia Division Statute mirrors the Michigan statute in two key respects. First, if the one of the companies resulting from a division is to be sold to an acquirer, then the Georgia Office cannot approve the proposed division until the potential acquirer has received the required approvals for that acquisition. Second, similar to Iowa, the Georgia Division Statute requires a public hearing to be held by the Georgia Office prior to the approval of a proposed division.

NAIC RESPONSE

In February 2019, the NAIC formed the Restructuring Mechanisms (E) Working Group to review and assess insurance business transfer and division legislation (which it collectively refers to as “restructuring mechanisms”). The working group has been charged with preparing a white paper that will: (i) address the perceived need for restructuring statutes and the issues those statutes are designed to remedy; (ii) consider alternatives that insurers are currently employing to achieve similar results; (iii) summarize the existing state restructuring statutes; (iv) address the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders in other states; and (v) consider the impact that a restructuring might have on state guaranty associations and policyholders that had guaranty fund protection prior to the restructuring. This white paper is currently in development, with the current goal for its release to be the NAIC 2020 Summer Meeting.
New York DFS “Best Interest” Standard for All Life Insurance Products Goes Into Effect While the SEC and NAIC Adopt Rules Addressing Specific Segments of the Market

As discussed in our 2018 Year in Review, on July 17, 2018, Superintendent Maria T. Vullo of the New York State Department of Financial Services (the “New York DFS”) promulgated a new “best interest” regulation as a replacement for New York’s preexisting annuity suitability regulation (Insurance Regulation 187, Part 224 of Title 11 of the New York Compilation of Codes, Rules and Regulations). Titled “Suitability and Best Interests in Life Insurance and Annuity Transactions,” the new regulation establishes a “best interest” standard for all sales of life insurance and annuity products. A transaction is considered in the best interest of a consumer when it is in furtherance of a consumer’s needs and objectives and only the interests of the consumer are considered in making the recommendation. The regulation also requires insurance companies to establish standards and procedures to supervise recommendations by agents and brokers to consumers with respect to life insurance policies and annuity contracts issued in New York.

The National Association of Insurance and Financial Advisors – New York State filed a lawsuit challenging the regulation in November 2018. That lawsuit was dismissed on August 1, 2019, clearing the way for the best interest standard to go into effect.

Insurers and producers were required to comply with the new rule beginning on August 1, 2019 for annuity sales and February 1, 2020 for life insurance sales.

Since it was first proposed in December 2017, the New York “best interest” regulation has been viewed as a way to fill the vacuum created by the delay and demise of the US Department of Labor “Fiduciary Rule” defining who is a “fiduciary” of an employee benefit plan under section 3(21)(A)(ii) of the Employee Retirement Income Security Act of 1974 as a result of giving investment advice. The Obama administration’s Fiduciary rule was scrapped through a combination of court challenges and Trump administration maneuvering in 2018. Unlike the Fiduciary Rule, the New York regulation applies to recommendations outside of retirement accounts and to the sale of all life insurance products (with limited exceptions) but not to mutual funds or other securities.

Meanwhile, on June 5, 2019, the US Securities and Exchange Commission (“SEC”) finalized its own Regulation Best Interest or “Regulation BI” with a compliance date of June 30, 2020. Regulation BI is only applicable to insurance products that are variable and therefore concurrently regulated by state insurance departments and the SEC. Under the new rule a broker-dealer is required to act in the best interest of a retail customer when making a recommendation of any securities transaction or investment strategy involving securities to a retail customer. Broker-dealers are currently
subject to suitability standards when recommending investment products to clients. Regulation Best Interest also reaffirmed and, in some cases, clarified the SEC’s views of the fiduciary duty that investment advisers owe to their clients. As a fiduciary, an investment adviser must act in the best interest of its client. This fiduciary obligation, which includes an affirmative duty of utmost good faith and full and fair disclosure of all material facts, is established under federal law, and the SEC believes that an adviser’s fiduciary duty serves as a key component to the SEC’s investor protection efforts.

On September 9, 2019, the states of New York, California, Connecticut, Delaware, Maine, New Mexico and Oregon and the District of Columbia filed a complaint for declaratory and injunctive relief against the SEC challenging Regulation BI. The lawsuit led by the New York State Attorney General alleges that the SEC failed to adopt the investor protections required by Dodd-Frank, instead promulgating a “watered down” rule that fails to address broker-dealer conflicts of interest and will increase investor confusion. On September 10, 2019, XY Planning Network, a coalition of fee-only financial planners, filed a similar suit against the SEC. The organization claimed that Regulation BI puts investment advisers at a competitive disadvantage to broker-dealers and makes it more difficult to differentiate an investment adviser’s fiduciary standard of conduct from the lower standard of conduct applicable to broker-dealers. Both lawsuits are still pending.

Finally, at the tail end of 2019, the NAIC Life Insurance and Annuities (A) Committee voted to approve its revised Suitability in Annuity Transactions Model Regulation (the “Revised NAIC Model”) during a conference call, and the full NAIC adopted the revision on February 13, 2020. New York DFS Superintendent Linda Lacewell (who took over from Maria Vullo in early 2019) voted against the revision. The new model requires insurance producers to “act in the best interest of the consumer when making a recommendation of an annuity.”

In extending its scope to include sales of life insurance as well as annuity products, the New York regulation goes farther than Regulation BI or the Revised NAIC Model. Moreover, each of the regulations defines “best interest” differently. The Revised NAIC Model defines “best interest” as “acting with reasonable diligence, care, skill and prudence in a manner that puts the interest of the consumer first and foremost.” Regulation BI does not specifically define “best interest” and instead takes what SEC Chair Jay Clayton has called a more “principles-based” approach (although the release adopting Regulation BI runs to 771 pages).

The New York definition of best interest is much more prescriptive:

The producer, or insurer where no producer is involved, acts in the best interest of the consumer when:

(1) the producer’s or insurer’s recommendation to the consumer is based on an evaluation of the relevant suitability information of the consumer and reflects the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use under the circumstances then prevailing. Only the interests of the consumer shall be considered in making the recommendation. The producer’s receipt of compensation or other incentives permitted by the Insurance Law and the Insurance Regulations is permitted by this requirement provided that the amount of the compensation or the receipt of an incentive does not influence the recommendation;

(2) the sales transaction is suitable; and

(3) there is a reasonable basis to believe:

(i) the consumer has been reasonably informed of various features of the policy and potential consequences of the sales transaction, both favorable and unfavorable, such as the potential surrender period and surrender charge, any secondary guarantee period, equity-index features, availability of cash value, potential tax implications if the consumer sells, modifies, surrenders, lapses or annuitizes the policy, death benefit, mortality and expense fees, cost of insurance charges, investment advisory fees, policy exclusions or restrictions, potential charges for and features of riders, limitations on interest returns,
guaranteed interest rates, insurance and investment components, market risk, any differences in features among fee-based and commission-based versions of the policy, and the manner in which the producer is compensated for the sale and servicing of the policy in accordance with Part 30 of this Title (Insurance Regulation 194) and Insurance Law section 2119;

(ii) the consumer would benefit from certain features of the policy, such as tax-deferred growth of any cash values, annuitization, or death or living benefit;

(iii) the particular policy as a whole, the underlying subaccounts to which funds are allocated at the time of the sales transaction, and riders and similar product enhancements, if any, are suitable for the particular consumer based on the consumer’s suitability information; and

(iv) in the case of a replacement of a policy, the replacement is suitable including taking into consideration whether:

   (a) the consumer will incur a surrender charge, increased premium or fees, decreased coverage duration, decreased death benefit or income amount, adverse change in health rating, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), be subject to tax implications if the consumer surrenders or borrows from the policy, or be subject to increased fees, investment advisory fees, premium loads or charges for riders and similar product enhancements;

   (b) the consumer would benefit from policy enhancements and improvements, such as a decreased premium or fees, increased coverage duration, increased death benefit or income amount; and

   (c) the consumer has had another policy replacement, in particular, a replacement within the preceding 36 months.6

The New York regulation also sets out specific disclosure requirements relating to situations where an insurer has different versions of a product for commission-based versus fee only sales and for captive agents, and the New York DFS issued granular guidance about those requirements on May 29, September 6 and September 11, 2019 and additional FAQs about the regulation as a whole as recently as February 12, 2020.

Regulation BI is divided into a series of “obligations” that the broker-dealer must meet: a General Obligation, a Disclosure Obligation, a Care Obligation, a Conflict of Interest Obligation and a Compliance Obligation (see our prior Legal Update). Broker-dealers and registered investment advisers also must provide a “relationship summary” dubbed Form CRS to every person to whom a recommendation is made. Form CRS is intended to be a plain language description of the relationship with the investor in a Q&A format that also includes information about any disciplinary actions against the broker-dealer or investment adviser.

Now that all three best interest standards are in place, insurers and producers are faced with the compliance challenge of harmonizing the varying requirements across different products (life versus annuities, variable versus non-variable) and distributions channels (broker-dealers versus investment advisers, captive agents versus brokers and independent producers). The Revised NAIC Model does include “safe harbor” provision stating that “Recommendations and sales of annuities made in compliance with comparable standards shall satisfy the requirements under this regulation.” Thus, compliance with Regulation BI or New York Regulation 187 should satisfy the requirements of the Revised NAIC Model in any state that adopts it. ▶

6 11 NYCRR 224.4(b).
As a part of the Further Consolidated Appropriations Act, 2020, the Setting Every Community Up for Retirement Enhancement Act of 2019 (the “SECURE Act”) was signed into law on December 20, 2019. The SECURE Act—the most significant legislation affecting retirement plans since the Pension Protection Act of 2006—made sweeping changes to the laws governing retirement plans and their administration, several of which will have a significant impact on the insurance industry. Those changes included:

**Annuity Safe Harbor.** Effective immediately, the SECURE Act provided a safe harbor that may make it easier for qualified retirement plan fiduciaries to include annuities within their plans. Specifically, the applicable fiduciary will be deemed to have satisfied ERISA’s prudence standard if, at a high level, the fiduciary:

- Undertakes an objective, thorough and analytical search to identify insurers.
- Considers the insurer’s financial capability and determines, at the time of selection, that the insurer is capable of satisfying its obligations under the annuity contract. Many of the financial capability requirements will be deemed satisfied if the fiduciary obtains specified written representations from the insurer.
- Considers the cost (including fees and commissions) of the annuity contract relative to its benefits, features, and services, and determines, at the time of selection, that it is reasonable. The fiduciary is not required to select the lowest cost annuity provider.

The SECURE Act further provides that a fiduciary who satisfies its annuity selection safe harbor requirements will not, following the distribution of a benefit or investment pursuant to an annuity, be held liable for losses due to an insurer’s inability to satisfy its financial obligations under the annuity contract.

**Lifetime Income Disclosure.** Plan administrators will be required to include a disclosure regarding lifetime income payment streams at least annually on defined contribution plan benefit statements. Specifically, the disclosure will need to provide the participant’s or beneficiary’s expected monthly payment stream calculated using a single life annuity and a qualified joint and survivor annuity, assuming that the participant’s or beneficiary’s total accrued benefits were used to procure such annuity. This disclosure requirement will not apply until at least 12 months after the Department of Labor issues guidance, including interim final rules, a model disclosure and a defined set of assumptions.
**Portability of Annuities.** For plan years beginning after December 31, 2019, defined contribution retirement plans may include provisions permitting participants permitted to take a distribution of a lifetime income investment if the plan eliminates lifetime income investments as an investment option under the plan, without regard to whether the participant would otherwise be eligible to receive a distribution under the plan. Such a distribution must be made in the form of an annuity or a direct rollover to an IRA or an employer sponsored qualified retirement plan, and may be made no earlier than 90 days before the date that lifetime income investments are eliminated as an investment option under the retirement plan.

**Required Minimum Distributions.** The SECURE Act raises the age for required minimum distributions from age 70 ½ to age 72. This change is effective for distributions required to be made after December 31, 2019, for individuals who reach age 70 ½ after December 31, 2019.

Of course, the SECURE Act made a number of other changes that impact qualified retirement plans, plan sponsors and employers, including increasing the cap for automatic enrollments and lowering minimum service requirements to allow for participation by long-term, part-time employees. We will be monitoring developments closely as the Internal Revenue Service and Department of Labor begin issuing regulations implementing the SECURE Act’s provisions.
As with many industries, the insurance sector has become more complex and internationally connected over the past decade. The International Association of Insurance Supervisors (“IAIS”), a voluntary membership organization of insurance regulators and supervisors from more than 200 jurisdictions, has worked in recent years to promulgate the Common Framework for the Supervision of Internationally Active Insurance Groups (“ComFrame”), as a set of international supervisory requirements which can provide a basis for the effective groupwide supervision of internationally active insurance groups (“IAIGs”).

Background to ComFrame
The IAIS began developing ComFrame in July 2010 in recognition of the specific need for an internationally coherent framework for the supervision of IAIGs. In 2011, the IAIS adopted a set of Insurance Core Principles (“ICPs”) to provide a high-level, globally accepted framework for the regulation and supervision of the insurance sector. The ICPs are intended to provide guidance for all jurisdictions and are routinely reviewed for necessary updates. One of the important aspects of the ICPs is an emphasis on group-wide supervision. With IAIGs exerting growing influence on the global insurance marketplace, ComFrame is intended to provide insights on how IAIGs function as well as generally improve efforts at group-wide supervision by insurance regulatory authorities.

What is an Internationally Active Insurance Group?
An IAIG is defined as an insurance group that meets two criteria:

- the group’s premiums are written in three or more jurisdictions and gross written premiums outside of the home jurisdiction are at least 10% of the group’s total gross written premiums; and
- total assets of the group are at least $50 billion or gross written premiums are at least $10 billion (on a rolling three year average basis).

One of the foundational principles of ComFrame is that insurance regulatory authorities in an IAIG’s home jurisdiction and insurance regulatory authorities in other jurisdictions where they do business are to supervise IAIGs in a collaborative fashion. Key to this collaboration is the designation of a “group-wide supervisor” who will exercise a coordinating role, in cooperation with other insurance regulatory authorities through a “supervisory college.” There is no single criterion for the designation of a group-wide supervisor, but the factors used include (i) the place of domicile of the insurers within the IAIG that hold the largest share of the group’s written premiums, assets
or liabilities, (ii) the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the IAIG; and (iii) the location of the executive offices or largest operational offices of the IAIG.

In general, the group-wide supervisor of an insurance group will determine if an entity meets the requirements for an IAIG in cooperation with other insurance regulatory authorities in the supervisory college. While the criteria for IAIGs as proposed by the IAIS focus on size and international activity, they are considered by the IAIS to have an amount of elasticity, and a significant degree of discretion is reserved to insurance regulatory authorities as to whether to consider an insurance group to be an IAIG, regardless of whether the criteria are technically met. Accordingly, the IAIS does not itself intend to develop a list of IAIGs, but rather seeks to provide the framework for insurance regulatory authorities to periodically assess whether ComFrame should be applied to a particular insurance group. Consistent with its desire to make the identification of IAIGs the responsibility of insurance regulatory authorities, the IAIS has refrained from producing substantial guidance to interpret the criteria. Though field-testing has identified a number of insurance groups which may meet the criteria and be considered IAIGs, it is unclear whether these interim results will be maintained once the actual application of ComFrame begins. Accordingly, there are a number of material operational questions with respect to the application of the criteria which may need to wait until the implementation of ComFrame begins in earnest to be resolved.

Structure of ComFrame

ComFrame seeks to provide specific guidance to IAIGs derived from the ICPs and is organized in two categories:

- ComFrame Standards, which provide outcome-focused, specific requirements for insurance regulatory authorities built on the ICPs; and
- ComFrame Guidance, which is intended to facilitate the understanding and application of specific ComFrame Standards and does not include or represent any requirements.

As part of ComFrame, the IAIS has also been developing a risk-based, global insurance capital standard (the “ICS”). The ICS is not intended to replace any existing capital standards for legal entity supervision in any jurisdiction, but aims to provide a comparable measure of capital across jurisdictions. The goal of the IAIS in developing the ICS is that establishing a comparable measure of capital across jurisdictions will facilitate a common understanding of IAIG capital adequacy and enhance cooperation and coordination among insurance regulatory authorities.

Adoption of ComFrame—2019 and 2020

In November 2019, the IAIS adopted ComFrame, following a lengthy public consultation process. Building on the materials it previously prepared as part of the public consultation process, the IAIS is now working to prepare materials to help its members to understand the expectations which ComFrame sets out.

Also in November 2019, the IAIS adopted ICS Version 2.0, which will be implemented in two phases. In the first phase, referred to as the “monitoring period,” which began in January 2020 and will last for five years, the ICS Version 2.0 will be used for confidential reporting to group-wide supervisors and discussion in supervisory colleges. The ICS will not be used as a prescribed capital requirement (“PCR”) in this phase. The second phase, which will begin at the end of the five-year monitoring phase, will involve the implementation of the ICS as a group-wide PCR.

Of particular concern is what will be the interrelationship between the ICS developed by the IAIS and the group capital calculation developed by the NAIC for use with groups that include one or more US insurers—which uses an aggregation method. The IAIS has issued an explanatory note that outlines a “comparability assessment” to be conducted between the ICS Version 2.0 and the NAIC’s aggregation methodology. This guidance defines “comparable outcomes” as an assessment of whether the NAIC’s aggregation method would produce similar, but not necessarily identical, results over time that trigger supervisory action on group capital adequacy grounds. If
the IAIS determines at the end of the monitoring period that the NAIC’s aggregation method provides comparable outcomes to the ICS, then the NAIC’s aggregation method will be considered an outcome-equivalent approach to the ICS for complying with the PCR. The IAIS currently plans to issue a consultation paper in early July 2020, which will address the high-level principles to be utilized in this comparability assessment.

At the NAIC level, the Group Solvency Issues (E) Working Group is currently preparing an assessment of ComFrame and potential recommendations for its implementation in a manner appropriate for the US insurance regulatory framework. The first major task that this working group has identified is to analyze gaps which may exist between ComFrame requirements and existing requirements under US insurance statutes and regulations. In addition, the Group Capital Calculation (E) Working Group has been tasked with liaising with the NAIC’s International Insurance Relations (G) Committee on international group capital developments and considering input from the US insurance regulatory authorities that participate in the ICS Version 2.0 monitoring period.

Accordingly, as implementation of ComFrame and the ICS begins, a shift is beginning in group supervision. Whether this regime lives up to the hopes of the IAIS will be a question for the next decade.
NAIC Begins to Address Cannabis

The cannabis industry is rapidly evolving and expanding as more states legalize medical and/or recreational cannabis. By 2018, cannabis had been legalized for medical use in 33 states and the District of Columbia, and for recreational use in 10 states and the District of Columbia. Nationally, at the end of 2018, the overall cannabis industry was valued at over $10 billion and is expected to be valued at over $20 billion by 2021. With innovative entrepreneurs, experienced investors, large public and private corporations and high profile executives entering the market, there is a new level of sophistication in the cannabis industry. Legal cannabis businesses, like any other business, are exposed to a variety of risks and seek access to insurance to cover those risks. However, there are many legal uncertainties, emerging risks and unique hazards involved in cannabis-related insurance activities.

NAIC Working Group and White Paper

To begin to address these uncertainties and risks, the NAIC Cannabis Insurance (C) Working Group was formed in 2018. In 2019, the working group drafted a white paper entitled “Regulatory Guide: Understanding the Market for Cannabis Insurance.” The white paper, which was adopted at the NAIC 2019 Summer Meeting, identifies insurance issues, gaps and opportunities facing the legal cannabis industry and identifies best regulatory practices to address those issues. The white paper provides information to state insurance regulators, insurers and consumers about the structure of the cannabis business supply chain, the types of insurance needed by companies in the cannabis industry, the availability of insurance for cannabis businesses in state insurance markets and the scope of insurance gaps. The white paper further identifies best practices that state insurance regulators can apply to encourage insurers to write insurance in the cannabis industry. The white paper does not address workers’ compensation or safety issues related to auto insurance.

Insurance Coverage Gaps

The white paper identifies substantial gaps in insurance coverage for the cannabis industry. While many of the risks facing the cannabis industry are no different from any other business in the same general area of business activity; a unique feature of the cannabis industry is the different treatment of cannabis under federal and state law (in states that have legalized cannabis). Conflicting state and federal laws, a paucity of data, emerging standardization of business practices and rapidly evolving regulations have largely discouraged insurers from participating in

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7 For example, outdoor cultivators of cannabis encounter similar risks to their crops as other cultivators in the agricultural industry.
this market. For example, while laws in many states have legalized cannabis, federal laws such as the Bank Secrecy Act and federal laws relating to anti-money laundering and unlicensed money transmission could expose insurers to liability. Insurers may face exposure in other areas as well, including, but not limited to, environmental and agricultural regulation and intellectual property. Although state law generally preempts federal law with respect to the regulation of “the business of insurance,” it is unclear whether this would apply to federal laws that could be deemed to be violated by activities of insurers in insuring cannabis-related exposures.

Moreover, issues of conflicting law have already proven problematic in dealing with such elementary concepts as whether one has an insurable interest and whether one can contractually insure for a substance that is federally defined as “illegal.” For example, there is conflicting case law surrounding whether a cannabis-related insurance policy would be enforceable as a matter of public policy, since cannabis is federally defined as an illegal substance. Thus, due to the fear of criminal and civil liability, many insurers are not willing to write cannabis-related insurance policies.

Best Practices for Regulators

In addition to identifying the insurance gaps facing the cannabis industry, the NAIC white paper also suggests best practices for state insurance regulators to follow to address coverage gaps and other cannabis insurance regulatory issues. These best practices include education, outreach and public communication; creating dedicated internal infrastructure and resources; and monitoring the market and conducting gap analyses. By way of example, California was the first state to approve admitted insurance carriers to offer coverage to cannabis-based businesses.

Going Forward

As more states legalize cannabis and the industry continues to innovate and grow, the need and demand for cannabis-related insurance will continue to increase. Although a few admitted insurers are issuing policies in the cannabis industry, the white paper makes clear that there are substantial gaps in insurance coverage for the cannabis industry—which put consumers, workers, vendors, owners and investors at risk. With the establishment of the NAIC Cannabis Insurance (C) Working Group and the development of the white paper as a starting point, the next decade may see an increased effort by state insurance regulators to further address the coverage gaps and encourage more insurers to participate in the cannabis industry.
NAIC Pet Insurance White Paper Released and Pet Insurance Model Act Under Development

Pet insurance is receiving increased attention from insurance regulators. As Americans increasingly purchase insurance to help cover their pets’ veterinary bills, the NAIC is taking a closer look at an insurance marketplace that until recently was treated sparsely and inconsistently by state insurance regulators. In 2019 the NAIC released a pet insurance white paper entitled, *A Regulator’s Guide to Pet Insurance* and also began the development of a pet insurance model law.

**Background**

Pet insurance provides accident and illness coverage for pets. Although pet insurance is similar in many ways to human health insurance, it is classified and regulated as property and casualty insurance. Unlike traditional property and casualty insurance, however, pet owners purchase pet insurance for reasons other than purely monetary reasons—to protect their pet’s health as well as to help manage the cost of veterinary bills. Coverage options vary by insurer. Most pet insurers write coverage for cats and dogs only, but at least one carrier offers coverage for exotic pets, such as reptiles and birds. Pet insurance coverage is concentrated in large urban areas, with New York and California being the largest markets.

The first pet insurance policy in the United States was issued in the early 1980s, and the market has grown significantly since that time. According to the NAIC white paper, there was a 23.2% increase in premium volume in 2017 from 2016, compared to only a 4.7% increase over the same time period for the property and casualty market as a whole. The direct written premium for pet insurance in the United States, was also approximately $640 billion in 2017.

State insurance laws and regulations that apply specifically to pet insurance are sparse and inconsistent. Currently, California is the only state with insurance laws that specifically govern pet insurance. As of this date, a pet insurance bill has been introduced in New York, but has not yet been enacted. Most states require a property and casualty insurance producer license to sell pet insurance policies, but a few states—Idaho, New Jersey, Rhode Island and Virginia—allow pet insurance to be sold under a limited lines license. By way of illustration, a limited-lines license is a license that a travel agent, for example, would need to sell travel insurance, while a full property and casualty license is required of producers selling homeowners or auto insurance.

The NAIC’s increased attention to the regulation of pet insurance is due, at least in part, to recent enforcement actions against a large pet insurer. In 2013 the Washington Office of Insurance Commissioner began monitoring a pet insurer for suspected use of unlicensed producers and
eventually initiated a targeted market examination of that insurer. Ultimately, the pet insurer and its affiliates were fined by regulators in Maine, Kansas, Missouri, Massachusetts and Washington. The alleged violations included using unlicensed and unappointed producers, issuing unfiled policies, charging unfiled rates and paying unlawful inducements. In light of the growing popularity of pet insurance, these recent enforcement actions have led state insurance regulators to consider whether additional initiatives are warranted to regulate pet insurance and protect consumers.

**NAIC White Paper**

The NAIC white paper provides a history of the pet insurance market, outlines different approaches states have used to regulate pet insurance, and identifies “a number of concerns that might be served by development of a model act.” Such concerns include:

1. **Marketing of pet insurance under brand names.** It is common for pet insurance policies to be marketed under a brand name rather than the legal name of the insurance company that is actually underwriting the policies. This practice creates confusion for consumers, insurance agency employees, TPAs, veterinary clinics, hospitals and for regulators. Such practices, including failing to prominently identify the underwriting insurer, are susceptible to violations under state insurance laws prohibiting unfair trade practices.

2. **Insufficient disclosure to consumers.** There is often insufficient disclosure with respect to key policy terms, such as annual and lifetime limits and exclusions for congenital conditions and pre-existing conditions.

3. **Using unlicensed producers to market and sell pet insurance.** Pet insurers often contract with licensed insurance producers, but those licensed producers may use unlicensed, unappointed call center employees in their business operations. Moreover, pet insurers frequently partner with unlicensed veterinary clinics and use them and their employees to market pet insurance. These activities may violate state producer licensing laws.

4. **Regulatory oversight of pet insurance rate and form filings.** Some of the pet insurers and their branding entities are using unfiled policy language and rates. There is further concern about the use of premium waivers, satisfaction guarantees, unfiled discounts and pre-dispute arbitration clauses.

5. **Lack of data related to pet insurance.** Pet insurance data is not reported separately from other types of insurance. For example, while pet insurance mostly provides accident and health coverage or accident-only coverage for pets, it is classified for regulatory purposes as property and casualty insurance. It is reported on line 9 of the NAIC property and casualty statutory financial statement, which is for inland marine insurance (a category that includes various other types of coverages). Because pet insurance premium is reported together with other inland marine insurance coverage, it is hard for state insurance regulators to determine the exact premium volume for pet insurance. In addition, pet insurance is not separately identified in most state complaint databases which makes it difficult to track trends in pet insurance consumer complaints. The inability to analyze data specific to the pet insurance industry presents an obstacle for state insurance regulators to understand the current state of the pet insurance industry.

6. **Difficulties posed for reciprocal producer licensing.** Most states require a full property and casualty producer license to sell pet insurance, but a handful of states permit pet insurance to be sold by producers holding a limited lines license. If a producer who holds only a limited lines license for pet insurance in its home state applies to become licensed in another state that does not have a limited lines license for pet insurance, that producer may, depending on the state’s reciprocity rules, be granted a property and casualty producer license, with the limitation that the producer’s authority is restricted to the authority granted by its resident state. For example, Idaho issues a resident limited lines producer license for pet insurance, but Washington does not. If Washington would issue a non-resident property and casualty producer license to the Idaho resident, this producer would be restricted to the authority granted in Idaho. However, it will not be visible on the face of the license that it is restricted to pet insurance, and licensing databases will only show that the non-resident license has been issued for the property and casualty line of authority.
NAIC Pet Insurance Model Act

At the NAIC Summer Meeting, the Property and Casualty Insurance (C) Committee formed a Pet Insurance (C) Working Group to draft a model law or guideline to establish appropriate regulatory standards for the pet insurance industry. The working group has been discussing a draft of a Pet Insurance Model Act, which is still undergoing review and revision. Comments on the draft have been submitted by both state insurance departments and interested parties from industry, such as the American Property and Casualty Insurance Association and the North American Pet Health Insurance Association. The model act drafting process is expected to extend well into 2020 and beyond.
As the decade comes to a close, new technologies are having a major impact on how insurance industry participants conduct their operations—especially how they collect, process, analyze, store and disseminate vast amounts of data—as well as how they interact with those with whom they do business. In recent years, blockchain technology has gained increased visibility as a type of innovative technology with the potential to transform the insurance industry. Although insurance industry participants have generally been eager to learn about the capabilities of blockchain technology, relatively few have begun the process of identifying ways to incorporate such technology into their business, preferring a more cautious “wait and see” approach instead. Similarly, insurance regulatory authorities, while generally curious about the nature of blockchain technology, have only started taking steps to ensure that the regulatory framework can keep pace with the potential changes accompanying this technology.

Yet change is on the horizon. In 2018, the Vermont legislature mandated the Vermont Department of Financial Regulation (the “Vermont DFR”) to review the potential application of blockchain technology to the provision of insurance and banking and to make recommendations for potential adoption of blockchain technology and any necessary regulatory changes. In January 2019, the Vermont DFR submitted its report and recommendations to the legislature: *Blockchain: Implications for the Banking and Insurance Industries, Michael S. Pieciak, Commissioner Vermont Department of Financial Regulation, January 15, 2019.* In addition, the Vermont DFR announced a pilot program to explore the use of blockchain technology in digital recordkeeping practices for captive insurers domiciled in Vermont.

This article sets out a brief overview of blockchain and related technologies, potential obstacles for the use of blockchain, potential applications of such technology in the insurance industry and Vermont’s novel approach to assessing the impact on the regulatory framework.

The Basics of Blockchain

Blockchain is a type of distributed ledger technology (“DLT”) and is a system of maintaining records utilizing advanced encryption methods over a decentralized network of computers. Generally, equal access rights are provided to all participants although certain data can only be accessed if a user has the proper encryption keys. Blockchain organizes data into “blocks” of data. Each block of data may contain information about a transaction and the parties involved in such transaction, although personally identifiable information is encrypted through a digital signature...
called a “public key”. A user can only unlock the person-
ally identifiable information in the block if the user also
has the corresponding private key which the user can
store offline or in a digital wallet. Once a block is created,
it then needs to be connected to the blockchain network.
This is done through attaching the block to another block
that is already part of the network “chain”. In order for a
block to be added to the chain, the content of the data in
the block must be verified by the network of computers
on the blockchain through a complex algorithmic
process. Once the information in the block is verified as
accurate, the block is added to the chain and given a
unique “hash” to identify the block from other blocks.

This chain of blocks, or the blockchain, is stored on all
computers in that particular blockchain’s network. This
collection of information, therefore, is decentralized as the
data is not just stored in one location or by one user; the
data verification process is also done on a collective basis.
Once a block is added to the blockchain, the block and
the data on such block is technically permanent and
cannot be changed because it has its own unique hash
identifier and encryption keys. Many forms of blockchains
are public, permissionless systems which allow any
individual to participate, contribute data to the system,
and to receive identical copies of the records maintained
on the system. While some blockchains impose, as a
qualification for becoming a participant in the system,
possess of a specified threshold level of computing
power established by “proof of work” in solving a complex
mathematical puzzle, many blockchains do not include any
requirements for participation (beyond the minimum
amount of computing power required to support the
actual requirements of the system). A widely publicized
example of a public blockchain is the DLT underlying the
Bitcoin cryptocurrency. Because this type of public
blockchain is essentially a public database operated by
anonymous, unauthenticated individuals (as opposed to a
centralized database operated by known, trusted individu-
als), the participants in such a system must agree on
protocols for determining how data may be published to
or edited on the blockchain system. In addition to public
blockchains, there is a growing number of private block-
chains which require participants to have been granted
prior permission in order to gain access to the specific
distributed ledger system. The closed, restricted access
nature of private blockchains may make them potentially a
better fit for a highly regulated industry such as insurance.

Because blockchains are decentralized in nature, they rely
on consensus in order to operate. Indeed, a primary
purpose of a blockchain is to allow for potentially adverse
parties to collaborate on transactions without relying on
other actors to process or otherwise manage the transac-
tion. Proponents of blockchain assert that the technology
creates the potential to eliminate certain “intermediary”
parties to transactions, such as insurance brokers, and
thereby achieve increased efficiencies and reduced costs.
Additionally, as blockchains create permanent ledgers to
which information can only be added but not deleted, the
use of blockchains would create a complete audit trail,
which would potentially reduce the risk of fraud.

An additional technological development facilitated by the
use of blockchain technology has been the creation of
“smart contracts.” A smart contract is a programmable,
code-based contract, which is stored in the blockchain
system itself and which automatically executes upon the
occurrence of specified conditions that have been previ-
ously agreed upon by the parties—for example, upon the
payment of the consideration for a transaction. Use of smart
contracts, particularly in conjunction with distributed ledger
technology, would theoretically reduce the need for
intermediaries, lower costs and increase transparency. It
should be pointed out, however, that most of these smart
contracts rely on an impartial, arm’s-length third party (the
so-called “oracle”) to verify the occurrence of contractual
conditions. At this early stage, smart contracts are best
suited for simple, straightforward, standardized transac-
tions with clear, unambiguous parameters that can be
readily verifiable, rather than for complex, customized
transactions that are inherently ambiguous because a
number of variables may be involved.

Potential Stumbling Blocks for Blockchain

Blockchain will need to successfully address some
fundamental challenges if its potential for increased
accuracy, efficiency, security and privacy is to be realized
in the insurance industry. While there is always room for
improvement, currently insurance transactions are
generally conducted efficiently, securely and privately by established institutions which operate in a well-structured, professional manner within a clearly defined regulatory framework. Blockchain’s overarching challenge is to demonstrate that it is potentially a significantly better alternative in terms of cost savings, improvement in customer experience and prudential regulation of insurance companies for the protection of policyholders. Among the specific challenges that blockchain faces are technological constraints and regulatory uncertainty.

From a technological perspective, two key issues limit the growth of blockchain technology. First, in their current stage of development, blockchains are limited in their ability to grow. For many public blockchains, each party or “node” must process every single transaction (to affirm compliance with the protocols in place) and then maintain a copy of the entire revised ledger of records. As a consequence, a blockchain is constrained in the number of transactions it can process in a set period of time. Presently, for example, blockchains have a fraction of the transaction-processing capacity of established centralized transactions and data processing entities such as VISA. Second, the amount of storage space and computing power required for blockchain technologies to operate in a timely manner is quite high and results in massive energy consumption issues, which is neither cost-effective nor environmentally friendly from both enterprise and community perspectives. In this regard, the growth of blockchain technology may benefit from the ability of such systems to interact with one another. While hundreds of blockchain systems currently exist, each operates independently from the others. The ability to share information between blockchain systems as well as within such systems may allow participants to derive greater value from their use of such systems. Blockchain technology is still in the early stage and advances are currently being developed to improve the number of transactions that can be processed per second and interconnectivity of different blockchains.

From a regulatory perspective, blockchains largely remain unaddressed, with most regulators preferring to remain on the sidelines. As a practical matter, blockchain technology has yet to penetrate the insurance industry in a meaningful way, so at this stage there is simply not much for insurance regulatory authorities to regulate about blockchains. However, public blockchains would, in their current form, likely present major problems under the California Consumer Privacy Act and the European Union’s General Data Protection Regulation (see other articles in this publication), as concerns would be raised regarding the safeguarding of confidential information of individuals to protect their privacy, and the difficulties with correcting, compartmentalizing or deleting data once it is placed onto the blockchain system itself. While private blockchains have been developed that restrict viewing, publishing and editing privileges to a subset of participants—thereby facilitating compliance with data privacy regulations—it is not clear that such private blockchains are significantly better than existing centralized platforms in terms of security, efficiency, security and regulatory compliance.

In addition, data privacy laws and laws regarding enforceability of self-executing smart contracts on a blockchain network are not uniform across jurisdictions. The decentralized nature of the blockchain, where computers and data are potentially located across many jurisdictions, poses potential challenges to a consistent application of blockchain’s potential benefits to the insurance industry. Although digital signatures are recorded and stored in blocks on the blockchain, accessing personal user data attached to such data blocks may not be easily obtainable by insurance regulators. For example, an insurance regulator concerned about market conduct practices that may be harmful to certain vulnerable groups may not be able to obtain such information very easily under current pure form decentralized block chain structures.

Applications for Insurance

Blockchain technologies, speed bumps notwithstanding, could have major applications for insurance industry products that require accurate and secure recordkeeping, are self-executing and require a high volume of data to be shared and used by a large collective group. This potential cannot be ignored.

Several large insurance companies have formed consortia to study and further develop blockchain for the insurance industry such as B3i, R3 and the RiskBlock Alliance. The American Association of Insurance Services
has announced the use of a permissible blockchain to help insurers and regulators share information with each other in an efficient and secure manner. These collaborative efforts among insurance industry players show that the insurance industry is taking the potential benefits of blockchain seriously—even if it is just to ensure that the insurance industry does not lag too far behind such other industries as financial services, health care and general retail in the use of innovative technology.

In the near term, the marriage of smart contracts with private blockchain systems holds out the prospect of significant efficiency and an enhanced user-friendly interface for simple, well-defined insurance products with clear and objective parameters. Examples include crop insurance, hurricane insurance and flight delay insurance, where events and losses can be easily verified through reliable interconnected databases and other information. Closer cooperation with insurance regulators will encourage and foster innovation in this important market segment. For example, flight delay insurance is by its very nature short duration and time sensitive. This in turn means narrow windows for mandated notice periods with respect to insurance policy review and cancellation. Current regulatory requirements are geared to insurance products that are longer duration and therefore provide for notice periods that may not be realistic or practical—45 days for flight delay insurance when flights are usually booked very close to departure dates will simply not work. Proactive regulatory involvement can address such anomalies between the nature of the insurance product and the regulatory framework.

An interesting segment of the insurance industry where private blockchain technology could be useful is the potential market for customized and personalized insurance products that reflect different patterns of user behavior. For instance, how an individual operates a car can be monitored electronically in real time, and a customized driver’s insurance policy can be designed with appropriate pricing. Such policies may induce drivers to modify their driving habits to reduce the cost of their insurance—clearly a benefit for not only insurance users and providers, but also the community if translated into lower accident rates. Of course, privacy issues with respect to such personal data would need to be addressed—but this is an existing issue, not a new one. Another facet of customization involves the possibility that disruptive new entrants who share a mutual interest in a specific type of insurance coverage might group themselves together and form a blockchain system for such a purpose. Clearly, to the extent that such an initiative addresses an underserved insurance niche, this may be quite useful.

Over the longer term, the specter of significant disruption looms large over the title insurance industry. For example, land and vehicle title insurance is critically dependent upon concurrent entries of the same data by different parties to the same transaction. Currently, the recording of ownership title to land property (real estate in general) and for vehicles (moveable personal property in general) is highly fragmented; use disparate and incompatible electronic and manual systems, and are prone to error and fraud. In the United States, land and vehicle ownership titles typically are recorded at the local level using computer or paper-based documentation. The report on blockchain by the Vermont DFR indicates that nationally nearly 30% of title insurance losses related to real estate are attributable to fraud. Obviously, the current state of affairs is far from satisfactory. Blockchain technology has an opportunity to demonstrate that it offers a better alternative than the present system. Whether it can rise to this challenge remains to be seen.

The Vermont Example

The Vermont DFR has recognized the potential benefits of blockchain technology and has launched an initiative to gain a better understanding of the potential impact of this technology for the insurance industry. On January 9, 2019, the Commissioner of the Vermont DFR and the Vermont Secretary of State jointly entered into a memorandum of understanding to collectively examine the use of blockchain technology in the digital recordkeeping practices of the captive insurance industry in that state. The two officials have jointly issued a request for information to identify vendors to help the Secretary of State register captive insurers utilizing blockchain technology. Depending on the outcome of the pilot program, blockchain technology could be utilized in other state regulatory processes.
The “closed” nature of captive insurance within the structural framework of affiliated companies provides a built-in protection against fraud, minimizes the use of third-party intermediaries, and facilitates compliance with regulatory reporting and capital adequacy requirements. Electronically connecting insurance regulators to such private blockchain systems of captive insurers could enhance transparency and timeliness—a major “win-win” for captive insurers and their regulators.

As noted above, on January 15, 2019, the Vermont DFR submitted a report to the state legislature reviewing the strengths and weaknesses of blockchain technology generally. While the report expressed the view that blockchain-specific regulation or legislation is not currently needed for entities regulated by the Vermont DFR, it recommended a “regulatory sandbox-type approach” to evaluate platforms and products which may include blockchain technology. To support such innovation, the Vermont DFR requested that the state legislature specifically codify the regulatory agency’s ability to grant variances, waivers or no action letters to applicants who wish to test products or innovations that would not otherwise be permitted. In such instances, the Vermont DFR would grant waivers or variances on a case-by-case basis with respect to specific laws and regulations for limited periods of time. The Vermont DFR expressly stated that certain laws and regulations, including solvency and capitalization requirements, would not be subject to waiver. The Vermont DFR also committed to actively engage with each entity testing a new product to both ensure the protection of Vermont consumers and gain insight into how such products could affect existing regulatory frameworks. It is unlikely that the Vermont initiative will prove to be an evanescent, sui generis blip in the regulatory landscape. What is more likely is that the Vermont experiment will be replicated, albeit with variations, by other regulatory authorities in the United States. Accordingly, the insurance industry will have to remain alert and be prepared to shift to a more proactive mode.

Conclusion

Blockchain technology has the potential to improve customer experience and lower operational costs of data-intensive businesses. Other industries are beginning to develop blockchain technologies and applications, which are starting to change customer expectations of the marketing and delivery of products and services. If companies in the insurance industry want to participate in these new blockchain innovations, they will need to continue to advance the technology to tailor blockchain technology to insurance while concurrently addressing regulatory concerns about data management, data privacy, enforcement of smart contracts and market conduct compliance as new blockchain applications are rolled out to consumers.
Brexit

The UK has now left the EU and has entered into the implementation period provided for in the withdrawal agreement negotiated between UK and the EU, which means that relations between the UK and the EU will largely remain unchanged until December 31, 2020. After this date the implementation period ends and the terms of a future relationship, if agreed, will instead govern the relations between the UK and the EU. During 2019, the UK government and financial markets regulators were largely concerned with contingency planning for the possibility of the UK failing to conclude a trade agreement with the EU before exit day, i.e., a no-deal Brexit. One of the ways this would have impacted EEA insurance firms operating in the UK would have been the loss of their permission to use the “passporting” system, which enables insurance firms regulated in one EEA state to provide cross-border and branch services in the rest of the EEA (including the UK) on the basis of their home state authorizations. A no-deal Brexit in that sense remains a possibility if the UK and EU fail to agree the terms of their future relationship before the end of the implementation period on December 31, 2020.

EU INSURANCE FIRMS OPERATING IN THE UK AND THE TEMPORARY PERMISSIONS REGIME

Further to their no-deal Brexit planning, the UK government and financial regulators have sought to ensure that EEA insurance (and other financial services) firms currently operating in the UK could continue to do so in the event of a no-deal Brexit. This was addressed by the UK government’s announcement of a temporary permissions regime (“TPR”), which will enable EEA insurance firms to continue to operate in the UK for a three year transitional period after a no-deal Brexit, in which time they can seek direct UK authorization. The TPR will now take effect from January 1, 2021, if no alternative arrangements are agreed before that date.

UK INSURANCE FIRMS OPERATING IN THE EU

The EU has not offered the same hospitality to UK insurance firms relying on passporting to operate in the EEA. Upon a no-deal Brexit, such firms will instead need to comply with local laws to continue to operate, including, where applicable, by obtaining authorization in the relevant EEA states or transferring business to affiliates authorized in the EEA. Many UK firms have been progressing these alternatives in order to be ready for a no-deal Brexit. Where the authorization approach is taken, it may also be possible for the EEA entity to outsource certain activities from that entity back to the
UK, although the various European Supervisory Authorities have urged local regulators in their assessment of applications for authorization to be vigilant against the establishment of “empty shell” subsidiaries (i.e., those without substance) established purely to gain access to the Single Market. It may also be possible for certain services to be provided without the need for local authorization where “reverse solicitation” laws can be relied upon. Under certain circumstances reverse solicitation allows a firm to market and provide financial services to a client where approached by the client on its own initiative. However, the value of this approach will be limited given the requirement for a client to have initiated contact, as well as the varying interpretation across Member States of what constitutes reverse solicitation.

**Disclosure Regulation**

The Disclosure Regulation is one part of the European Commission’s package of reforms relating to sustainable finance. It was published on December 9, 2019, entered into force on December 29, 2019, and its main provisions will apply from March 10, 2021. The Disclosure Regulation contains transparency rules relating to financial products for financial market participants, such as insurance undertakings that offer insurance-based investment products (“IBIPs”), and financial advisers, including insurance intermediaries or insurance undertakings that provide insurance advice relating to IBIPs. The Disclosure Regulation requires that relevant firms disclose, for example, in pre-contractual documents, the manner in which sustainability risks are integrated into their insurance advice; and, on their website, information on their remuneration policies on how they integrate sustainability risk. Other various pre-contractual documents, such as marketing documents, annual reports will also need to be amended to comply with the Disclosure Regulation.

**FCA’s Evaluation of its Packaged Retail and Insurance-based Investment Products (“PRIIPs”) Review**

Since January 2018, the European PRIIPs Regulation has required firms, such as insurance companies or firms providing services in relation to insurance-based investments, to produce, publish and provide investors with a standardized key information document (“KID”) for PRIIPs, for example insurance contracts used for investment purposes, including unit-linked or with-profit policies. The purpose of the KID is to help investors make better and fully-informed decisions by being able to compare key features, risks and rewards. The FCA published its Feedback Statement in February 2019 following the publication of its Call for Input in July 2018, where the FCA sought input from firms and consumers about their initial experiences of the PRIIPs regime. Responses the FCA received included concerns in relation to uncertainty about scope and unintended effects of compliance with PRIIPs requirements. Since then, there have been developments at an EU level and the European Supervisory Authorities (“ESAs”) have consulted on a targeted review of PRIIPs, focusing in particular on performance scenarios. The ESAs also published a Supervisory Statement together with their Final Report, providing a further warning in the KID that the performance scenarios are only an indication of some of the possible outcomes that are based on recent returns. The ESAs’ consultation closed to responses in January 2020. In the meantime, the FCA has stated that it will continue to work with firms and trade associations on what it can do to resolve the issues identified in its Feedback Statement such as performance scenarios and the scope of the PRIIPs regime. It added that it was going to work closely with the ESAs and the European Commission through 2019, subject to the nature of the UK’s relationship with the EU. The FCA will also consider the extent to which domestic interpretive guidance could mitigate its concerns in relation to key issues raised in its Feedback Statement.

**Wholesale Insurance Broker Market Study**

On February 20, 2019, the FCA published its final report for its Wholesale Insurance Broker Market Study. The study was launched in November 2017 to assess how effectively competition was working within the sector. In reaching its findings, the FCA analyzed data including feedback to questions, responses to data requests, independently commissioned client research and undertook discussions with firms and stakeholders. At the end of its analysis, the FCA concluded that it could
not find evidence of significant levels of harm to competition that would have warranted the introduction of intrusive remedies. However while the market study was closed, the FCA did identify areas warranting further action, including conflicts of interest, information firms disclose to clients and certain contractual agreements between brokers and insurers. While the FCA stated these issues could be addressed within its usual supervisory processes, it acknowledged that the market is dynamic and therefore broker business models and the effectiveness of competition would be subject to its continued monitoring.

UK Developments Relating to Retail General Insurance and Pension Schemes

The FCA has been evolving its thinking in relation to general insurance and pension pricing and value for money. It undertook a number of initiatives in 2019 relating, among other things, to charge disclosure, excessive pricing and the cost and value of distribution chains. It has also undertaken initiatives relating to advice in the pensions market, in particular advice relating to the transfer of defined benefit pensions. The outcome of these initiatives remains uncertain but could significantly change the way retail insurance is sold in the UK and the way independent financial advisers operate. It may also have a wider impact in Europe, because its thinking addresses themes in EU legislation, in particular the Insurance Distribution Directive.
Hong Kong

2019 was a landmark year for the Insurance Authority ("IA") as it took from the three Self-Regulatory Organisations ("SROs") the responsibility for direct regulation of some 110,000 insurance intermediaries in Hong Kong. Although the IA took over the statutory functions of the Office of the Commissioner of Insurance to regulate insurers in June 2017, it did not regulate insurance intermediaries in Hong Kong until the handover on September 23, 2019.

The IA is now responsible for all aspects of regulation of intermediaries, including determining the minimum capital and net asset requirements of insurance brokers, academic requirements, CPD training, issuing codes of conduct, monitoring compliance, conducting investigations and taking enforcement action where breaches have occurred. Insurance intermediaries are now subject to a higher standards of compliance. Individuals in senior management and responsible officer roles of insurance intermediaries are subject to extensive requirements set out in the codes of conduct, and they will be held accountable for any breaches. After taking over regulation of insurance intermediaries, the IA has issued codes of conduct for insurance agents and brokers, which set out expected standards of conduct as well as new guidelines on insurance sales related activities and CPDs.

It is relevant to note that under the Insurance Ordinance Cap. 41, the IA (like other financial regulators, such as the Securities and Futures Commission) has broad powers of investigation and inspection available at its disposal, and it is expected the IA will be active in its scrutiny of insurance intermediaries. With a tougher stance taken by the Government on anti-money laundering ("AML"), it is expected AML may well be an area the IA will further focus on. In 2018, the IA conducted on-site inspections of insurers of their AML controls and some deficiencies were noted.

Insurance intermediaries are expected to put in place sufficient controls and policies to ensure compliance with all relevant requirements, as the IA is likely to adopt a proactive role in its investigation. There will be increased compliance and administrative costs for insurance intermediaries, coupled with greater accountability upon key persons, may result in consolidation of insurance brokers.

Completing the IA’s taking over of regulation of insurance intermediaries is the coming into effect of the new insurance licensing regime, which is activity-based. “Regulated activities” has been broadly defined under the Insurance Ordinance. Any person who invites or induces a person to enter into a contract of insurance or makes a material decision or gives regulated advice will be caught by the definition of “regulated activity” and must be licensed. The use of the word
“attempt” potentially has far-reaching implications, given any effort to induce a person—whether successful or not—is also caught. This also has implications for referrals of business by unlicensed individuals to insurance intermediaries for a fee.

Insurers will also face more onerous requirements in the coming years. The IA is developing its capital framework towards a risk-based capital regime consistent with the insurance core principles issued by the International Association of Insurance Supervisors (“IAIS”). The introduction of the risk-based capital (“RBC”) in 2021 will overhaul the current capital framework set out under the Insurance Ordinance. Similar to the insurance industry RBC requirements in other jurisdictions, RBC in Hong Kong is taking the three-pillar approach in its solvency assessment for insurers. The assessment covers quantitative aspects, qualitative aspects on enterprise risk management (“ERM”), own-risk and solvency assessment (“ORSA”), and disclosure. Under the Hong Kong RBC, insurers’ assets and liabilities are valued on a consistent and economic basis. Insurers have to work ahead in preparing for and implementing the ERM framework under the RBC regime to ensure continued effectiveness.

Aside from RBC, the International Financial Reporting Standard 17 Insurance Contracts (“IFRS 17”) published by the International Accounting Standards Board (“IASB”) will come into effect in 2021. This is a major milestone, as the change has been the most significant since the implementation of the Insurance Contracts Project in 1997. The implementation of the IFRS 17 is to achieve consistency and comparability around the world, which poses some difficulties for insurers in Hong Kong. The implementation of IFRS 17 will change the current system, processes, calculations and data stored in Hong Kong. The first key change is the reporting of profit: IFRS 17 will categorize companies by a measurement of profit in line in terms of services provided, rather than in terms of revenue or cash-flow. The rationale is that profit represents what has been earned as a result of services provided in the contract. The second key change is insurance companies will draw up their contracts on a current measurement basis, meaning that companies can no longer use historic assumptions. The last key change is the measurement of risks. The risk of any shortfall of investment returns against pricing assumptions needs to be reflected in the valuation of the insurance contract. The IASB’s intent is to ensure companies quantify risks in the insurance contract to protect policy-holders.

In 2020, the Hong Kong Government plans to introduce an insurance-linked securities (“ILS”) regime. Hong Kong is a prime location for an ILS market due to its developed capital markets and its proximity to mainland China. According to the 2019-2020 budget speech the Government is prioritizing the ILS regime so that such securities can be issued in Hong Kong. It is hoped this regime will give reinsurance companies in mainland China an alternative option to manage and share their risks. Institutional investors will also gain an alternative investment method that is not correlated to economic cycles. As real estate and urban development in mainland China continues to grow, especially in the Great Bay Area, there is significant opportunities for the ILS market in Hong Kong. [See “ILS and Convergence Markets” chapter beginning on page 35].

Alongside ILS, the Hong Kong Government also wants to promote the use of captives. The Government has mentioned the development of captive insurance in Hong Kong is one of its priorities for the insurance industry, aiming to license five to ten captives per year. Hong Kong is attractive in its proximity to mainland China which has the size, scale, risk profile and growth plan to utilize captives. Along with China’s initiative to internationalize Chinese Renminbi, this combination of currency liberalization and development of captive insurance provides an opportunity for Hong Kong to increase its financial product offerings. Further, with the relaxing of financial restrictions in mainland China to foreign companies, Hong Kong has an unprecedented opportunity to host captives. The potential of insurance service expansion in Hong Kong also creates an opportunity for the development of insurtech within the sector. A local captive market potentially leads to an increase in tailored or bespoke risk management and captive management systems in aid of the operation of captives.
China

In recent years, the China Banking and Insurance Regulatory Commission (“CBIRC”) has made remarkable progress in opening up to foreign investors in the banking and insurance sectors, with 34 measures released to encourage liberalization in the past two years. Since the beginning of the year, the regulator has issued administrative approvals for several foreign-funded institutions to set up insurance agencies, including AXA and Allianz.

We highlight some of the significant regulatory developments throughout the course of 2019 which contributed to liberalization below:

- In July 2019, the CBIRC announced that the 51% foreign shareholding restriction in joint venture life insurance companies will be lifted in 2020, one year earlier than originally planned.
- On October 15, 2019, the amended “Regulations on Administration of Foreign-Funded Insurance Companies” came into force. The revised regulations removed existing requirements for foreign insurance companies to have at least 30 years of relevant experience and to have operated a representative office in China for at least two years before setting up business. In addition, overseas insurance groups are now permitted to establish foreign-funded insurers in China, and overseas financial institutions may hold stakes in foreign-funded insurers.
- In December 2019, the CBIRC announced that it will further reduce the number of items on its “negative list” in order to ease market access and ensure that liberalization policies are effectively implemented.

On October 1, 2019, new bancassurance regulations issued by the CBIRC came into force. The comprehensive set of regulations cover access to bancassurance channels, operating rules, exit from bancassurance operations, management and supervision of bancassurance. For the first time, the CBIRC set out quantitative requirements for protection products sold through bancassurance, such as the premium income generated from various types of life and health insurance, and annuities with a term of no less than ten years. Other provisions include:

- Banks are required to obtain an insurance agency licence in order to offer bancassurance services;
- Insurance sales personnel in banks should have at least one year of insurance sales experience and must have received a required amount of training and a favourable track record; and
- Restrictions on the type of products to be sold to low-income individuals and senior citizens.

Indonesia

In February 2019, the Directorate General of International Trade at the Indonesian Ministry of Trade (“DGIT”) finally issued the long-awaited implementing regulation for the mandatory procurement of insurance Regulation No. 02/DAGLU/PER/1/2019 (“DGIT 2/2019”) following the issuance of the Minister of Trade Regulation No. 82 of 2017 regarding Provision on Utilization of Sea Transportation and National Insurance for Export and Import of Certain Goods (“MR 82/2017”), which was first issued in October 2017, and subsequently amended.

Under Article 4 of the DGIT 2/2019, from February 1, 2019 onwards, exporter/importers of coal, crude palm oil, rice and goods for government procurement are required to procure insurance from an Indonesian insurance company and/or Indonesian insurance consortium.

Myanmar

Foreign insurance companies had been largely barred from operating in Myanmar (except the three foreign insurers that have already been licensed to operate in the Thilawa Special Economic Zone).

The government moves to attract foreign investment by introducing new Myanmar Companies Law on August 1, 2018, which permits foreign investors to take up 35% in local companies, including non-life joint ventures. In January 2019, the Ministry of Planning and Finance (“MOPF”) issued the announcement No. 1/2019 that the government would grant permission to foreign companies wishing to operate businesses offering life and non-life insurance in Myanmar.

As of November 2019, the Financial Regulatory Department, under MOPF, awarded licenses to five fully
foreign-owned life insurers and six joint venture companies for insurance services. It was the first time the government granted license to fully foreign-owned life insurers to issue life insurance policies in Myanmar. The Financial Regulatory Department, under the Ministry of Planning and Finance, has authored a proposed Insurance Business Law which is currently under public consultation. Following the liberalization of the insurance sector, insurance providers are preparing to introduce more options to the market where only 1% of the nation’s population currently has exposure to insurance.

Malaysia
Following its order that foreign insurers should reduce their shareholdings to a maximum of 70% to comply with the foreign ownership cap introduced in 2009, the Bank Negara Malaysia (“BNM”) (the country’s central bank and regulator for the insurance sector) confirms that all foreign insurers have submitted their proposals to address the minimum 30% Malaysian ownership requirement for their businesses by the deadline of April 30, 2019. BNM will assess the insurers’ proposals on a case-by-case basis and will engage in ongoing discussions with the foreign insurers. If approved, these foreign insurers will be exempted from having to pare down their holding to 70% by divesting the remainder to local institutions or via an initial public offering. The exemption scheme kicked off in 2019, when a Singapore-owned foreign insurer contributed MYR 2 billion (US$479 million) fund to a proposed national “B40 Health Insurance Fund”, which has allowed its exemption from the minimum 30% local shareholding threshold set by BNM.

Philippines
The Philippines Insurance Commission (“IC”) is seeking to amend the insurance law, which was last revamped in 2013, to cater to developments like takaful and catastrophe insurance. The IC will pitch the new amendments to the Philippines’s Congress by the middle or latter part of 2020. The proposed amendments are expected to, amongst other things, include a supervisory framework to enforce and monitor insurance companies’ compliance with antifraud regulation, public disclosure requirements for insurers, development of reinsurance regulations, and will introduce new rules on agri-insurance as well Islamic, catastrophe and parametric insurance.

Separately, the IC confirms that a majority of general insurers in the Philippine market could not meet increased capital requirements in the Philippines Insurance Code by the deadline of December 31, 2019. Several insurance companies are expected to merge in order to meet the new capital requirement, and announcements would be made by the relevant insurers. Early in the year of 2019, the IC deferred the implementation of new accounting rules (IFRS 17) to give life and non-life insurers more time to comply with the new insurance accounting regulation. This gives insurers an additional year from the initial January 1, 2022 deadline set out by the International Accounting Standards Board.

Thailand
In May 2019, Thailand’s Supreme Court overturned two lower court decisions and ordered six insurers (New Hampshire Insurance, Dhipaya Insurance, Fall Call Insurance, Bangkok Insurance, Deves Insurance, and Muang Thai Insurance) to pay THB 89 million to the Stock Exchange of Thailand, THB 57,500 to the Thailand Securities Depository, and THB 9 million to the Family Knowhow Company in compensation for losses incurred due to anti-government protests that led to rioting in 2010. The Supreme Court held that the torching of the building and valuables during a riot was not an act of terrorism (due to the numbers of persons causing the damage were very few), and so the damage caused by the rioters was covered under the insurance policy taken out by the claimants.

Amendments to the Non-life Insurance Act B.E. 2535 (1992) and Life Insurance Act B.E. 2535 (1992) became effective on November 21, 2019, introducing the modernization and improvement of Thailand’s insurance laws. These amendments mainly deal with insurance intermediaries, i.e., agents and brokers including (i) adopting electronic transactions; (ii) extension of the validity period of loss adjuster licenses from two years to five years; (iii)
new qualifications of loss adjusters, agents, individual brokers, or corporate brokers; (iv) introduction of corporate brokers’ obligations and liabilities; (v) conditions to terminate an agent or broker’s license and suspension procedure; (vi) use of advertisement materials by agent or broker without prior approval from the insurer; and (vii) penalties where breach of regulations including additional daily penalty rates. Three new offences (including fraudulent claim, offering or accepting bribes for the payment of claims, and encouraging a person to enter into an insurance contract by deceitfulness were also introduced). Penalties for these offences extend to the managing directors or other persons responsible for a corporate broker’s business operation.
INSURTECH
CYBERSECURITY
Insurance, Technology and Innovation at a Crossroads: Build or Buy?

In last year’s Year in Review, we noted that collaboration remained robust in 2018 between and among incumbent carriers, startups, venture capitalists and leading technology companies (among others) in the insurtech ecosystem. In 2019, collaboration continued and grew more mature as incumbent carriers increasingly implemented new technology and innovation to find ways to analyze data at a more efficient way while being cognizant of compliance with insurance and consumer protection regulations.

The strategy of investing in insurtechs through providing early stage funding or direct collaboration to develop data-driven digital platforms through smaller scale projects has proven to be a sound approach for many incumbents. Investing in technology and innovation at a smaller scale does not put significant stress on legacy systems, break the budget or create a potentially large loss that could dent an incumbent’s return on investment statistics. According to data compiled by CBInsights, in 2019 over $6 billion has been invested globally in insurtech funding rounds compared to over $4 billion in 2018 and approximately $2 billion in 2017. Most of this early stage insurtech funding still comes from traditional venture capital funds, but in the last several years, the amount of insurtech investment by incumbent carriers has rapidly grown. The number of deals by corporate venture entities is roughly 50% of the total insurtech fundraising deals per year. Compare this to years prior to 2014 when virtually only traditional venture capital funds invested in early stage insurance technology and innovation companies.

Direct collaboration deals have also increased in number and size of investment. Collaborations accelerate the pace of innovation by putting together the respective strengths of collaborators. This is in contrast to an early stage investment in an insurtech in which an incumbent carrier may not have the immediate opportunity to have direct access to the insurtech’s technology.

The results and long-term benefits of these investments and direct collaborations are still in too early of a stage to declare victory for the insurance industry. Certainly, there have been challenges to this portfolio building strategy as many insurtech startups and collaborations with insurtechs have not met expectations. Some incumbent carriers are rethinking their strategy on the best way to build a sustainable, but yet cutting-edge, digitized platform to attract customers. Prudential’s $2.35 billion acquisition of Assurance in 2019 could be an early indicator of a riskier but potentially more value-enhancing strategy of acquiring companies with larger scale technology and innovation. Such larger acquisitions could help an incumbent carrier to leapfrog its competition to become a modern
technology-enabled insurance carrier in a short period of time to gain access to cutting-edge distribution, efficient underwriting/claims capabilities and new products appropriate for customers’ lifestyles and risk profiles.

Is the Prudential-Assurance deal an early indicator of the start of a larger and more fierce technology arms race within the insurance industry? Or will financial, regulatory or other factors discussed elsewhere in this Year in Review put the brakes on larger scale technology acquisition and consolidation?

The Case for Building and Investing in Targeted Niches Through Investments and Collaboration

In the first three quarters of 2019, venture capital volume in insurtech actually declined compared to the same period in 2018. However, a flurry of deal activity in the fourth quarter resulted in insurtechs raising close to $2 billion in the last three months of 2019, which powered the insurtech venture capital volume to over $6 billion for the year. This is compared to $4.2 billion of insurtech venture capital funds raised in 2018.

In 2019, a greater proportion of venture capital cash flowed to a smaller number of insurtechs, many of which are full-stack with end-to-end capabilities to underwrite and distribute insurance products. Below are examples:

• Bright Health raise $635 million in a Series D round
• Collective Health raised $205 million in a Series E round
• Hippo raised $100 million in a Series D round
• Lemonade raised $300 million in a Series D round
• Next Insurance raised $250 million in a Series C round
• Policybazaar raised $152 million in’s Series F round
• Root raised $350 million in a Series E round

There were 38 deals that raised over $40 million, a 90% jump from 2018 in which only 20 deals raised over $40 million. In 2017, only 13 deals raised over $40 million. This could be further evidence that investors are starting to concentrate their bets on insurtech companies that are sufficiently mature to use capital for larger scale projects. In addition, out of the 10 or so insurtechs valued at over $1 billion, five of them were created in 2019. The newest additions to the insurtech “unicorn” club are: Bright Health, Hippo, Lemonade, Next Insurance and WeFox. This is in contrast to prior years where strategic and financial investors focused more on making smaller investments across a broader portfolio range.

Direct collaboration deals have also increased in number and size of investment. Some notable collaboration deals between incumbent carriers and insurtechs in 2019 include:

• Allianz’s strategic partnership with Dinghy. Dinghy offers flexible on-demand business insurance for freelancers where coverage is charged by the amount of time coverage is required. Cover levels may be flexed up or down, on or off, and payment is settled through a mobile app.
• Liberty Mutual entering into a strategic alliance with Intellect SEEC to harness the power of big data to more proactively identify target opportunities with individual brokers, and develop solutions for customers. Through the relationship, Liberty Mutual underwriters and risk managers gain automated access to thousands of third-party data sources including, court filings, industry data, government records, and social media content to assist in underwriting and to assist customers in managing their exposures.
• Société Générale and Roadzen formed a strategic alliance to jointly build a digital and contextual insurance player for Europe. Roadzen acquired a minority stake in Moonshot, an insurtech startup incubated by Société Générale. Moonshot develops usage-based insurance products and services to offer consumers affinity insurance solutions.
• Travelers’ strategic partnership with Groundspeed Analytics to simplify its new business and policy renewal processes through the use of artificial intelligence (“AI”). The two companies will also collaborate on the design of additional AI capabilities that can provide increased efficiencies through the automation of commercial insurance analytics.

1 Other insurtech unicorns include Clover Health, PolicyBazaar and Root Insurance.
Collaborations can increase the pace of implementation of technology and innovation while still managing enterprise risk at a reasonable level. Most insurtech related collaborations so far have been relatively small and contain risk sharing mechanisms among the collaborators to limit potential downside. There are other challenges with collaborations such as allocating ownership of jointly developed intellectual property and data and determining a clean exit once the joint enterprise has met its objectives or the collaboration no longer makes sense to continue for one or more of the parties to the collaboration.

The Case for Accelerated and Broad-based Growth through Majority Investments and M&A

When investing in an insurtech startup or entering into a technology collaboration with an early stage insurtech company does not accomplish the rate of change necessary to meet an insurance company’s goals, acquiring the technology and the people who know how to implement it, may be a viable option.

In 2019, there seem to be early signs that at least some players in the insurance industry are making the decision to buy entire technology-enabled platforms rather than slowly building up capabilities through minority investments or niche-focused collaborations with insurtechs. Incumbent carriers have seen over the last several years the challenges and rate of success (or lack thereof) of the strategy of making more passive investments and smaller, less ambitious collaborations that generally push technological progress forward but incrementally, especially compared to the lightning speed in which other industries are adopting technologies to improve their operations and interactions with consumers. In addition, incumbent insurance carriers are not alone in M&A activity in the insurtech space. Private equity, technology companies and full-stack insurtechs are potential acquirers. While the threat of disruption to incumbent insurers has been tempered somewhat, the threat of a full-stack insurtech with access to ample capital through private equity or elsewhere gaining traction with consumers is still real. The increasing number of insurtech unicorns underscores this potential threat.

We have already mentioned Prudential’s acquisition of Assurance for $2.35 billion plus an additional $1.15 billion in earnouts if certain targets are achieved. Assurance uses data science and machine learning to speed up the application process and purchasing of health, life, medigap, home, and auto policies and already has a sizeable customer base. The combination of the data analytics technology and customer affinity group developed by Assurance gives Prudential a ready-made platform for interacting more effectively with customers in the digital age—a platform which it presumably could not easily develop on its own in the short term. Also in 2019, Zurich acquired Sea Pine Technologies, an insurtech company specializing in digital applications for the marketing of auto financing and insurance products and Willis Towers Watson acquired TRANZACT for $1.2 billion. TRANZACT helps link consumers to insurance carriers. Similar to Prudential’s rationale for acquiring Assurance, Willis Towers Watson stated that one of the reasons for acquiring TRANZACT was TRANZACT’s comprehensive technology platform to enable a digital driven direct-to-consumer strategy.

Private equity funds and insurtechs are also competing for insurance consumers’ market share through M&A. In February 2019, Solera, a data analytics and SaaS company, acquired in4mo. In4mo is a property claims solution provider operating in the Nordic countries and provides an end-to-end property structural claims adjustment platform to insurance carriers through a mobile platform. In June 2019, GI Partners acquired Insurity with the rationale to improve innovation. Insurity provides policy administration, claims, billing, and data analytics software to more than 200 insurance clients and was established in 1985. Home insurance startup, Hippo, also acquired home protection startup, Shelti, in its first M&A transaction.

Whether or not these deals are early signs of an acceleration of the adoption of insurance technology and innovation through M&A is to be seen. The investment landscape is in flux as insurtech winners get stronger and funds continue to flow into the insurtech sector to fuel new startups. Also, we anticipate that some insurtechs are approaching their performance and funding limits operating on their own. This could create
some consolidation among insurtechs as the smaller, less well-funded companies become attractive acquisition targets. We expect that these forces at work, in addition to further technology advances and regulatory changes discussed elsewhere in this Annual Review, will help make insurtech deal activity an interesting area to watch in 2020.
A number of new data protection laws were passed in the US in 2019. These laws highlight a few growing trends, but what these trends have in common is the expansion of the requirement to have more stringent data security requirements in place. Outside of the US, a number of countries, including the Cayman Islands and Brazil, have adopted their own GDPR-like laws, furthering the influence of the EU General Data Protection Regulation (“GDPR”) outside of the EU.

In July 2019, New York passed the Stop Hacks and Improve Electronic Data Security Act (“SHIELD Act”). The SHIELD Act amends New York’s existing data breach notification law and adds a number of new requirements. The most significant change is the addition of new data security requirements. The SHIELD Act requires companies to adopt reasonable safeguards to protect the security, confidentiality and integrity of private personal information. Unlike most state data security laws, the SHIELD Act imposes more specific requirements, including the requirement to conduct risk assessments, test key controls, train employees, and dispose of information after it is no longer needed. These specific security requirements continue the trend of other recent US data security laws, such as the NY DFS Cybersecurity law, to impose more specific security requirements. The SHIELD Act also expands New York’s existing data breach notification obligations. Specifically, the definition of “private information” now includes additional elements, such as biometric information. The SHIELD Act also broadened the definition of “breach” and expanded the territorial scope of the law.

2019 also saw a trend of new data protection laws focused on data brokers. Vermont started this trend when its data broker law went into effect in January 2019. Vermont’s law requires businesses collecting and selling data about Vermont residents to annually register with the Secretary of State and provide certain information, and also imposes minimum security requirements for data brokers. California continued this trend with its recent passage of A.B. 1202, which also requires certain businesses that sell data about California consumers to annually register as data brokers with the California Attorney General. However, unlike the Vermont law, the California law does not have a specific data security component.

Another trend we saw emerge in 2019 was the emergence of laws relating to the security of internet of things (“IoT”) devices. California’s Internet of Things Security Law, which was signed into law in September 2019, requires all connected devices that are sold or offered for sale in California to have reasonable security measures in place. Specifically, the security measures must be appropriate to the nature and function of the device, appropriate to the information that the device may collect, and designed to protect the device from unauthorized access. Oregon followed shortly thereafter with its own IoT law, which has security requirements that are similar to California’s law. Both laws became effective on January 1, 2020.
A number of countries have also started passing GDPR-like laws, revealing the influence of the GDPR outside of the EU. The Cayman Islands’ Data Protection Law, 2017 ("DPL") came into force in September 2019. The DPL is modeled after the GDPR and contains many of the same requirements of the GDPR, such as providing a number of rights to data subjects to their personal data. However, there are key differences between the two laws, including consent requirements and the issuance of fines. Brazil has also passed a similar General Data Protection Law, the Lei Geral de Proteção de Dados Pessoais ("LGPD"), which takes effect in August 2020. Like the DPL, the LGPD was heavily inspired by the GDPR but contains a number of differences, including breach notification requirements and fines.
EUROPEAN CASE LAW
DEVELOPMENTS
UK AND EUROPE

UK
Germany
France
UK

YOUNG V ROYAL AND SUN ALLIANCE PLC [2019] CSOH 32

The Scottish Courts have considered the disclosure of material information by an insured under section 3 of the Insurance Act 2015 and, in particular, the circumstances in which an insurer might be taken to have waived its entitlement to information under section 3(5)(e) of the Act.

The insured owned a commercial premises in Glasgow, which caught fire. The property was insured by Royal & Sun Alliance ("RSA"). The Proposal Form for the insurance policy had asked the insured to identify whether any of its directors had, in any capacity, been made bankrupt or insolvent. The insured left this question unanswered. Subsequently, by way of an email sent prior to inception, RSA sought confirmation as to whether “the insured” had ever been declared bankrupt or insolvent, and the insured confirmed this to be correct.

It transpired that one of the insured’s directors had previously been a director of four companies which had entered into insolvent liquidation. RSA therefore sought to avoid the policy for material non-disclosure. The director, in response, alleged that RSA had waived the need for such information to be disclosed, pursuant to section 3(5)(e) of the Act, by way of its aforementioned email’s reference to “the insured” alone.

The Scottish Court of Session held that:

• Waiver of disclosure is not to be readily inferred. The question for the Court is: would a reasonable person, reading the Proposal Form, be justified in thinking that the insurer had restricted its right to receive all material information, and consented to omission of the particular information not disclosed?
• The burden of proof is upon the insured (as the party asserting the waiver).
• In this case, the insurer had not waived its right to disclosure of the information in question.

XYZ V TRAVELERS INSURANCE COMPANY [2019] UKSC 48

The Supreme Court has considered the circumstances in which a liability insurer can be subjected to a non-party costs order where it has funded the defence of an uninsured claim.

The insured was the defendant to a group litigation action brought by claimants alleging they had
been supplied with defective breast implants. The litigation included claims in relation to ruptured implants, as well as implants at risk of rupture. The insured’s liability policy (underwritten by Travelers) did not cover the latter category of claims, which were therefore uninsured. Notwithstanding this, Travelers agreed to fund the insured’s defence costs. The insured claims were settled. The uninsured claims were successful at trial, by which time the insured had entered into administration. Consequently, the claimants in such uninsured claims sought a non-party costs order against Travelers, pursuant to section 51 of the Senior Courts Act 1981.

The Supreme Court held that:

- There are two approaches to deciding whether a non-party insurer should pay costs. The first is to ask whether the insurer took control of the litigation and became the “real defendant”. However, this test only applies to claims which are insured—not to the defence of uninsured claims.
- With uninsured claims, the correct question to ask is whether the insurer engaged in “unjustified intermeddling” in the conduct of the defence, and thereby caused the claimants to incur costs.
- The claimants alleged that the insurer had “intermeddled” by advising the insured not to disclose its insurance arrangements. However, this was not intermeddling with any desire to dilute Travelers’ costs risk, and was not inappropriate.
- Further, Travelers’ involvement in settlement decisions in relation to uninsured claims which were closely related to live insured claims would not have justified the making of a third-party costs order.

This decision helps to clarify the tests that the Court will apply when considering whether an insurer, who funds an insured’s defence against related insured and uninsured claims, should be subjected to a costs order where the latter claims are successful. It affords comfort to insurers that funding the defence of partly-insured and partly-uninsured claims will not, of itself, lead to exposure to such an order.

**EURO POOLS PLC (IN ADMINISTRATION) v ROYAL & SUN ALLIANCE INSURANCE PLC [2019] EWCA CIV 808**

In this decision, the Court of Appeal considered the key principles relevant to the question of whether there has been a notification of circumstances to a claims-made liability insurance policy.

The insured, Euro Pools, installed swimming pools with moveable divisional walls, known as “booms”. In around February 2007, RSA notified as a circumstance to its liability insurance policy (the “First Policy”), underwritten by RSA, apparent problems with booms failing to rise and fall due to a faulty steel tank system operating the booms installed in swimming pools at two sites. Euro Pools informed RSA that it would attempt to fix such problems by installing inflatable bags in the booms. The First Policy expired on 29 June 2007.

In May 2008, Euro Pools notified to its subsequent year policy (the “Second Policy”), also underwritten by RSA, problems with the proposed inflatable bag system. In August 2008, Euro Pools advised RSA that the only solution was to install a hydraulic system, and sought an indemnity under the Second Policy for the costs of such installation.

RSA took the position that such costs attached back to the circumstance notified to the First Policy (which had a largely eroded aggregate limit of indemnity). Euro Pools sought cover under the Second Policy, contending that the circumstance notified to the First Policy had related only to the problems with the steel tanks, and not to issues with the inflatable bag system which had only been identified afterwards.

The Court of Appeal, overturning the decision at first instance, held that the costs of installing the hydraulic system properly attached back to the First Policy. In summary, this was on the following basis:

- The test that notified circumstances “may” give rise to claims (that being the wording of the First Policy) set a deliberately undemanding test. It required only a possibility of claims in the future.
• An insured is entitled to notify a problem that may give rise to a claim, even where the exact scale and consequences of that problem are not known. The insured does not need to know or appreciate the cause or all the causes of the problem which has arisen, or the consequences which may flow from it.

• For a subsequent claim to attach back for cover, there has to be some causal, as opposed to merely some coincidental, link between the notified circumstance and the later claim.

• The notification to the First Policy concerned a problem with booms failing to rise and fall. It is not necessary to dissect every potential cause of that problem as a different notifiable circumstance. Euro Pools properly notified a problem, and that it might face potential claims from third parties as a consequence. The fact that Euro Pools did not know the fundamental cause of the problem made no difference, and would not matter to potential third-party claimants.

• The connection between the circumstance notified, and the costs of installing a hydraulic system to solve the problem with the booms, was more than coincidental. Accordingly, such costs attached back for cover under the First Policy.

SARTEX QUILTS V ENDURANCE CORPORATE CAPITAL LTD [2019] EWHC 1103

In this case, the High Court addressed the basis upon which an insured was entitled to an indemnity under its property insurance policy following a fire at its premises. The insured sought an indemnity on a reinstatement basis, even though it had not reinstated the property some eight years after the fire. The insurer, on the other hand, argued that the insured was only entitled to an indemnity in respect of the market value of the buildings, plant and machinery.

The insurers relied upon the judgment of Lord Justice Clarke in Great Lakes Reinsurance v Western Trading [2006], in which he stated: “I doubt whether a claimant who has no intention of using the insurance money to reinstate, and whose property has increased in value on account of the fire, is entitled to claim the cost of reinstatement as the measure of indemnity unless the policy so provides”.

On the facts, the Judge held:

• Great Lakes is authority for the principle that, in assessing an insured’s entitlement to an indemnity on the reinstatement basis, “it is necessary to look at all the circumstances, which can include the position up to the date of trial”. “In some circumstances”, the lack of a continuing intention to reinstate on the part of the insured will indicate that the reinstatement basis is not appropriate, because it would over-compensate the insured.

• There is not, however, any general rule requiring the insured to show that it had, and continues to have at the date of trial, a genuine, fixed and settled intention to reinstate the property. Rather, the question for the court is what measure of indemnity fairly and fully indemnifies the insured for its loss.

• In the present case, in the light of all circumstances including events after the fire, the insured’s intention to reinstate its property was continuing (even though little progress had been made in that regard). Accordingly, the reinstatement basis applied.

• The burden of proof is upon the insurer to establish any appropriate reduction to an indemnity on the reinstatement basis in order to take account of “betterment”, where the insured is receiving a new property for old. This will depend upon the damage suffered and the nature and extent of repairs proposed.

AIRBUS SAS V GENERALI ITALIA [2019] EWCA CIV 805

The Court of Appeal has considered the application of an exclusive jurisdiction clause to a subrogated claim brought by insurers against a third party.

The insured, Alitalia, operated an aircraft sold by Airbus. Alitalia and Airbus entered into a Warranties Agreement, by which Airbus gave a number of warranties as to (for example) its delivery of the aircraft and post-delivery obligations. The Warranties Agreement was expressly subject to the exclusive jurisdiction of the Courts of England & Wales in connection with “[the warranties] or any non-contractual obligations connected with it”.
In September 2013, the aircraft was forced to make an emergency landing due to a defective landing gear, resulting in significant damage. Alitalia was indemnified by its Italian insurers, who then sought to pursue a subrogated claim against Airbus in Italy. In short, the insurers argued that Airbus had failed to take preventative action in the light of similar defects previously affecting the same model of aircraft.

Airbus argued that the insurers’ subrogated claim had been brought in breach of the exclusive jurisdiction clause under the Warranties Agreement, in circumstances where the claim was “connected with” the warranties set out therein. The insurers, on the other hand, argued that the jurisdiction clause was limited to disputes as to which party had the benefit of the warranties, or as to the validity of the Warranties Agreement.

The Court of Appeal, finding in favour of Airbus, held that:

- The jurisdiction clause under the Warranties Agreement was wide. To the extent Airbus had an obligation to take preventative action, that obligation was at least connected with the post-delivery obligations forming part of the warranties. Consequently, the insurers’ subrogated claim did fall within the scope of the jurisdiction clause.
- Even though the insurers were not parties to the Warranties Agreement, in the course of bringing their subrogated claim, the insurers were nevertheless bound by the exclusive jurisdiction clause to the same extent as the insured would have been. In commencing a claim in Italy, the insurers had not acted in breach of contract, but they had acted in breach of “an equivalent equitable obligation which the English court will protect”. Airbus was therefore entitled to enforce the exclusive jurisdiction clause against the insurers, and the English court was able to make a declaration to that effect.

Europe (Germany)

DIRECTORS AND OFFICERS INSURANCE AND MANAGEMENT LIABILITY

The Higher Regional Court of Cologne (case no. 18 U 34/18) issued a decision on the allocation of the burden of proof in cases in which the legal successor of a manager is held liable for an alleged breach of duties by the manager. As a general principle, the manager bears the burden of proving his lawful behaviour. In this case, the court had to decide whether or not this rule also applies to cases in which the manager’s legal successor is sued by the company. In this regard, the court held that the successor bears the burden of proof for the manager’s lawful behaviour if, in his defence, he relies on “negative” facts and circumstances. The company argued that there was no justification for the manager’s actions in connection with a joint venture agreement he had entered into and costs he had incurred, which resulted in a loss for the company. Without further justification for his actions, the manager had to be held liable. In such circumstances, the court decided that it was on the successor to present the grounds that justified the conclusion of the joint venture agreement and the costs that had been caused. This was because the successor was able to inspect the company’s records, in order to gain the required information: there was no basis for shifting the burden of proof to the company, as an exception to the general rule.

- The Regional Court of Wiesbaden denied a claim for coverage brought against a D&O insurer by an insolvency administrator, on the basis of Section 103 para. 2 of the German Insolvency Act (case no. 5 O 234/17). The court held that the claimant administrator had conclusively terminated the insurance agreement by electing not to perform obligations thereunder—in particular, by choosing to stop paying insurance premium, and declaring that the company’s obligations under the insurance agreement would not be fulfilled. The court held that the administrator had thereby waived a claim for coverage in respect of any claims subsequently made against the company’s managers. Furthermore, the court ruled that it is an intentional breach of duties (therefore excluded from cover under the insurance agreement) if the manager has granted unsecured or insufficiently secured loans, and has failed to ensure solvency of the debtor, at a time when the company is already in a financial crisis.
- A decision issued by the Higher Regional Court of Hamm (case no. 1-8 W 6/19) addressed whether or not the D&O insurer could be joined as a party to proceedings
between the insured and a third party, in order to support the insured. While the first instance court had denied the insurer’s ability to do so, the Higher Regional Court concluded that, because findings made in the liability proceedings would be binding upon the parties in separate coverage proceedings, the insurer had a legitimate interest in joining the liability proceedings to put forward its arguments. In reaching that decision, the court recognised that, in reality, the insurer often was the actual target of the suing party. Therefore, the insurer should not be prevented from putting forward its factual and legal arguments, so as to avoid subsequent expensive and time-consuming coverage proceedings.

PROFESSIONAL INDEMNITY INSURANCE

The Regional Court of Dusseldorf (case no. 9 O 188/14) considered a case in which the client of an attorney had directly sued the attorney’s liability insurer for damages, after insolvency proceedings had been initiated with regard to the attorney’s assets. The proceedings concerned the question of whether or not the insurer’s liability under the PI policy was excluded, due to the attorney’s intentional breach of duties. The court analysed the required elements of “intention” for an exclusion of liability, and held that it was sufficient for the insured to have had positive knowledge of the duties he owed (and breached). Further, the court decided that the subjective contractual exclusion of liability existing between the insurer and insured also applied to the third party who was bringing a direct claim against the insurer. The court held that the burden was upon the insurer to prove the requisite positive knowledge on the part of the insured—however, this burden was lessened in cases in which the insured party had breached fundamental professional duties of which every professional should be aware. In such circumstances, the existence of the required knowledge was already indicated.

WARRANTY & INDEMNITY INSURANCE / TAX ISSUES

- In a request for a preliminary ruling issued by the Supreme Administrative Court of Finland, the European Court of Justice (“ECJ”) (case C-74/18) had to decide on the interpretation of Articles 13 and 157 of the Directive 2009/138/EC of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance as subsequently amended (“Solvency II”).

The proceedings before the national court concerned the question of which Member State had the authority to impose tax on premiums for W&I cover in connection with a share purchase transaction. It was, in particular, in dispute whether taxes were due in the state of residence of the policyholder, or the target company’s place of business. According to Article 157 of Solvency II, insurance contracts are subject exclusively to the indirect taxes of the Member State in which the insured risk is situated. Article 13 of the Directive provides for a definition of the place at which different types of risks are situated.

- The ECJ answered the questions referred on the basis of the wording of Art 13(d)(ii) of Solvency II, by stating that when an insurer established in a Member State offers insurance covering the contractual risks associated with the value of the shares and the fairness of the purchase price paid by the purchaser in an acquisition, the insurance contract is subject to the indirect taxes on insurance premiums in the Member State in which the policyholder is established. According to the ECJ, there should be a concrete factor corresponding to each risk which would allow it to be localised in a specific Member State. If the insured risk was not linked to (say) a building or a vehicle, as set out in Art 13 Solvency II, then emphasis should be upon the place where the activity whose risk was covered is exercised. The Court concluded that, in the present case, the objective of the insurance was to protect exclusively the policyholder (irrespective of its position as seller or purchaser) against the risk associated with the seller’s breach of representations made in the sale and purchase agreement. Therefore, the insurance premiums shall be subject to taxes in the State in which the policyholder was established.
Europe (France)

LEGISLATIVE DEVELOPMENTS

- Law No. 2019-486 of 22 May 2019 relating to the growth and transformation of companies, known as the “PACTE Law”, amended the French Insurance Code in several areas.
- Life insurance (Art. L. 131-1 et L. 131-1-1 of the French Insurance Code): The “PACTE Law” authorises specialised professional funds offered as part of life insurance policies to invest in crypto-currencies. Decree No. 2019-117 of 14 November 2019 provides the list of financial instruments eligible to life insurance contracts and amends the limits applicable to the holding of certain private equity instruments.
- Decree No. 2019-1098 of 29 October 2019 amends the provisions of the Monetary and Financial Code relating to intermediaries in banking transactions and payment services. It is now possible for intermediaries in banking operations to be put in contact with operators such as intermediaries in equity financing, insurance companies in the context of their lending activities and management companies in the context of their FIA (“Alternative Investment Funds”) management activity.
- Law No. 2019-733 of 14 July 2019 relating to the cancellation of complementary health contracts without charge gives insured parties the option to cancel such contracts “at any time” (Art. L. 113-15-2 of the French Insurance Code). This extends the “Hamon Law” (Law No. 2014-344 of 17 March 2014), which only applied to cancelling home and private vehicle insurance contracts. It also relaxes the cancellation notification procedure to the extent that the insured may elect to cancel the contract by giving written notice of the termination by letter or on any other durable medium.
- Discussions on a reform of the natural disaster scheme are ongoing and a Bill (Text No. 154 of 27 November 2019) has been tabled in the Senate. The Bill aims to provide a rapid and concrete response to affected victims, municipalities and mayors by, among other things, reforming the functioning of the Fund for the prevention of major natural risks (known as the “Barnier Fund”) and by reassessing the rights of the insured persons and the amount of compensation that they receive.

CASE LAW

- Cass. com., 30 January 2019, n° 17-19.420: A failure to disclose, or a misrepresentation, to the insurer of circumstances prior to the conclusion of the contract (for instance, circumstances that would significantly diminish the insurer’s view of the risk) leads to the nullity of the contract. In this case, however, the Court decided that the failure to declare information subsequent to the conclusion of the contract (in this case, the financing method used for a particular acquisition) does not lead to the nullity of the contract.
- Cass. com., 7 February 2019, n° 17-27.223: The court held that the option of renunciation offered to any natural person subscribing to a life insurance policy under the conditions of Article L.132-5-1 of the French Insurance Code can constitute a right abuse. The assessment of such abuse falls within the discretion of the court.
- Cass. civ. 2e, 7 June 2019, n° 18-17.907: Prior to the conclusion of the life insurance contract, the insurer must provide the future insured (if a natural person) with a notice informing him/her of the terms and conditions for exercising his/her right of renunciation. If the insurer fails to comply with such obligation, the insured person shall benefit from an extension of the time limit in relation to exercising his/her right of renunciation. Notwithstanding this failure, the insured person could still be considered to be abusing his/her rights of renunciation.
- Cass. com., 7 March 2019, n° 18-13.347: Where the accidental nature of the loss is a condition of the cover, the burden of proof lies with the insured (or, in this case, his/her beneficiaries) to show that the loss is accidental, rather than intentional.
- Cass. 3e civ., 7 March 2019, n° 18-10.973: This case involved the sale of a building which suffered damage after the conclusion of the agreement to sell, but before the transfer of ownership (which had been delayed until the date of signature of the deed of sale as agreed). In such circumstances, it was held that the buyer was the beneficiary of the insurance indemnity providing cover for repair costs. This contrasts with previous case law where it was held that the insurance indemnity contract would not transfer from the seller to the buyer until ownership had been transferred.
• Cass. 3e civ., 19 September 2019, n° 18-19.616: The French Supreme Court (Cour de cassation) ruled that a clause in an insurance contract, which excluded cover for “the damage resulting from an intentional, deliberate or inexcusable disregard of the rules of art and technical standards applicable in the area of activity of the insured person”, did not allow the insured person to determine precisely the extent of the exclusion of guarantee. This was in the absence of any contractual definition of both “the rules of art and technical standards”, and the voluntary or inexcusable nature of their non-observance. This decision confirms the rigour shown by case law in assessing the validity of exclusion clauses, which must be formal and limited in accordance with Article L. 113-1 of the French Insurance Code.

• Cass. 2e civ., 29 August 2019, n° 18-14.768: Interpreted in the light of European Union law, the nullity of a contract of civil liability insurance (pursuant to Article L. 113-8 of the French Insurance Code) is not enforceable against the victims of a traffic accident or their heirs, when such nullity results from initial misrepresentations made by the policyholder regarding the identity of the owner and usual driver of the vehicle, or from the fact that the person for whom the insurance contract was concluded has no economic interest in the conclusion of such contract. This marks an absolute turnaround in French case law.

• The French National Commission for Information Technology and Civil Liberties ("CNIL"), decision n° SAN-2019-007, 18 July 2019: The CNIL sanctioned an insurer for failing to comply with data protection obligations under the GDPR (Art. 32), on the grounds that customer data was accessible online, without any prior authentication.
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