Global Insurance Industry

YEAR IN REVIEW 2017
Welcome to the 2017 edition of our Year in Review report, which is now in its sixth year. In this report, we discuss some of the more noteworthy developments and trends in insurance industry transactions over the past year in North America, Bermuda, Europe, Asia and Latin America, with particular focus on mergers and acquisitions, corporate finance, the insurance-linked securities and convergence markets, and pension risk transfers.

We also examine certain regulatory and tax developments that are impacting transactions in the industry.

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Overview

The number of announced M&A transactions involving North American property and casualty (P&C) insurance targets increased in 2017 to 61, compared to 50 in 2016, according to data compiled by S&P Global Market Intelligence. Overall deal value on announced transactions in 2017, however, was down to $7.5 billion compared to $12 billion in 2016. Similar to 2016, there were few P&C “megadeals” in 2017, with only five transactions having an announced deal value in excess of $500 million.

Warranty Business Elicits Interest

Transactions involving warranty coverage providers served as bookends to 2017, with significant transactions taking place both in the beginning and at the end of the year. January 2017 witnessed the closing of The Allstate Corporation’s $1.4 billion acquisition of privately-held SquareTrade, Inc. from Bain Capital and a number of other shareholders. SquareTrade’s main product offerings are protection plans for personal electronic devices and appliances.

In late October 2017, Assurant, Inc. announced that it had entered into an agreement with TPG Capital Management, L.P. to acquire a 77% stake in The Warranty Group, Inc., in a deal valued at $2.5 billion (including debt). The acquisition of The Warranty Group is expected to increase Assurant’s presence in the warranty market, expanding it to 35 countries. The resulting geographic footprint will provide, in particular, further resources to accelerate Assurant’s strategy in the Asia-Pacific region.

In November 2017, AmTrust Financial Services, Inc. announced its agreement to sell a majority interest in its US-based fee businesses, including warranty and services contracts for the automotive, consumer products and specialty equipment industries, to private equity firm Madison Dearborn Partners, LLC for $950 million. Madison Dearborn’s acquisition of the AmTrust US fee-based business gave Madison Dearborn a foothold in the warranty industry while also unlocking significant value for AmTrust.

Runoff

With a North American market estimated by PricewaterhouseCoopers to be around $350 billion, buyers’ appetite for deals involving legacy runoff operations continued throughout 2017. Enstar, R&Q, Berkshire Hathaway, Compre, Armour and Catalina remained active buyers in the US P&C runoff market. RenRe and Apollo announced the acquisition of a minority and majority stake, respectively, of Catalina. New capital entered the market in transactions sponsored by the likes of Premia (backed by Arch and private equity firm Kelso & Company) and Sunpoint Re (backed by Fosun). Examples of these deals include Catalina’s transaction to acquire a portfolio of legacy insurance liabilities from the US branch of Samsung Fire and Marine; Premia’s $400 million in loss development coverage for AmTrust and Armour’s reported acquisition of QBE’s US legacy commercial auto liabilities. While these transactions typically assume the form of a loss portfolio transfer, adverse development cover or the acquisition of a company in runoff, a new front in the US runoff market may be forming. ProTucket and R&Q took advantage of the recently enacted Insurance Business Transfer legislation in Rhode Island, as described in our 2016 Year in Review, to form stand-alone insurers with statutory authority to accept transfers of insurance risks and to insulate the transferors from future liability of those risks. The legislation has the potential to provide a new and important avenue for executing runoff transactions.

Specialty Insurance

Markel announced in July that it was acquiring State National Companies for $919 million. State National is one of the largest insurance fronting businesses in the US. In addition, at the end of September 2017, Intact Financial Corporation, a Toronto-based specialty insurance company, announced that it had completed its C$2.3 billion (US$1.7 billion) acquisition of US specialty insurer OneBeacon Insurance Group, Ltd. The acquisition purports to make the combined entity one of the leading providers of specialty insurance in North America with over C$2 billion in combined annual premiums focusing on small to midsize businesses. Tokio Marine HCC,
meanwhile, acquired AIG’s medical stop loss operations in October. While the financial terms of the transaction were not disclosed, the gross written premiums of medical acquired business were estimated to be $350 million.

While insurtech affords companies the opportunity to get closer to their customers through the potential disintermediation of distribution channels, the acquisition of the distribution channels themselves arguably allows for a more immediate means to achieve the same goal. 2017 saw a surge in deal activity involving MGA acquisitions, such as the acquisition of Cheechurch by Beazley (see Mergers & Acquisitions - Life Sector - UK and Europe), Alliant acquiring SES Insurance Brokerage Services, JenCap’s purchase of Special Risks Facilities and Specialty Program Group buying both the workers’ compensation MGA business of MarketScout and wholesaler Monarch E&S Insurance Services.

**AmTrust Proposes Going Private**

AmTrust Financial Services, Inc. found itself in the news over the last year. In March 2017, it announced that it would be restating its financial statements for the prior three years, causing it to delay the filing of its 2016 10-K to early April 2017. Then, as described above, it announced in November 2017 that it was divesting 51% of its US fee-based business. Finally, on January 9, 2018, AmTrust received a proposal from its founding family and private equity firm Stone Point Capital to take the company private. The proposal reflected a price of $12.25 per share, a 21% premium to the then-trading price of AmTrust. The board subsequently announced the formation of a special committee to consider the proposal. As of the date of publication of this Year in Review, the special committee had not yet announced its position on the proposal.

**M&A Outlook in North America/Bermuda for 2018**

Although P&C claims frequency and severity have continued to climb in the past year, capitalization levels remain relatively high. With this excess capital, more insurers see themselves as buyers rather than sellers, which has pushed the valuation levels of target companies higher. Rather than increasing market share via acquisitions of direct competitors and potentially paying more than the intrinsic value of a target, players in the P&C market appear more likely to allocate their excess capital to investments in technology and marketing. Consequently, it will likely be the more strategic deals that will be announced in 2018, such as the acquisition of Insurtech enterprises (see Technology and Innovation - Insurtech), that present disintermediation opportunities and the less commoditized specialty insurers. Indeed, the recently announced acquisition of Validus by AIG for $5.6 billion, which will allow AIG to access new markets and platforms, highlights the types of strategic acquisitions we may see more of in the coming year.

**UK and Europe**

Once again, it was a slow start to the year for deal activity in the UK and across Continental Europe but, as the year progressed, momentum returned and there were a few trends that emerged. As noted in previous reviews, private equity houses continued to be keen buyers of brokers and MGAs leading to strong valuations and returns for that sector of the market. Brexit planning and internal reorganizations may have distracted UK and European carriers from engaging in M&A activity. Certainly, 2017 saw most, if not all, groups finally choose or enhance an existing EU hub in order to be able to write EU business in a post-Brexit world. This time last year the speculation was that Dublin would be the principal beneficiary as the “go to” jurisdiction for continued access to EU markets. However, there were a number of unanticipated decisions such as Lloyd’s of London’s choice of Brussels for its EU platform with other established carriers picking Luxembourg. Both are jurisdictions without the kind of established presence in the industry that Dublin can claim. Nonetheless, Ireland can still point to the largest number of newly authorized entities established during the year.

The Lloyd’s market saw its fair share of activity as the number of remaining integrated listed groups fell from four to three with the sale of Novae plc to Axis. That leaves Lancashire, Beazley and Hiscox as the remaining publicly traded independent platforms. It is probably fair to say that Novae was the most available target for sale out of the four. Another restructuring of the business had led to an agreement to transfer its legacy book to Enstar. Once the Axis deal had completed, the value of the legacy deal with Enstar grew as Axis took immediate steps to rebrand and refocus the business going forward.
This clearly signalled a break with the past where other recent transactions in the Lloyd’s market have retained the target’s Lloyd’s branch and heritage, such as Hanover’s purchase of Chaucer, CNA Hardy, MS Amlin, and XL Catlin, to name but a few. Another interesting aspect to the transaction was Axis taking the step of increasing the offer to Novae shareholders to $640 million just prior to the shareholder vote. While there had been some speculation whether another potential buyer might emerge following the initial announcement of the deal, a competitive process in the UK-listed sector is rare, especially once the target board has recommended the original offer.

Elsewhere in the Lloyd’s market the auction of Argenta plc came to a conclusion early in the year with Hannover Re emerging as the winning bidder. As we mentioned in last year’s review, Argenta was an interesting if not unique target in that it brought to the table a combination of a Lloyd’s Members Agency and a Managing Agency platform. Interest in private Names Capital remains strong in the Lloyd’s market as the options for sourcing capital at the right price become ever more important in a continued soft cycle market, despite post event rate increases in certain classes.

Finally, in the Lloyd’s space Beazley entered the Canadian market with the purchase of the Creechurch Underwriting MGA from Ed Broking Group to create Beazley Canada. This transaction demonstrates the attractiveness to both sides that an MGA’s exit route has to an existing business partner, Beazley having provided Lloyd’s paper to Creechurch under the ownership of Ed.

In Continental Europe, German heavyweight Allianz had a busy year of M&A activity ranging from investing in Insuretech platform Lemonade to UK personal lines carrier LV=. The combined JV with LV= makes it the third largest general insurer in the UK market, valuing LV= at just over £1 billion and allows Allianz the option to buy out the remaining stake it does not yet own.

Allianz was also buying out the remainder of trade credit insurer Enler Hermes for approximately €1.3 billion in a deal announced just prior to the end of the year by way of tender offer. Euler Hermes is currently listed on Euronext Paris. On the other side of the ledger, Allianz entered into a deal with legacy operator Compre in respect of a portfolio of reinsurance liabilities from its German discontinued business book. Earlier in the year Compre struck a similar legacy deal with Swiss Re.

Once again, 2017 saw a number of large scale legacy deals come to market with the usual players – Enstar, Armour, Catalina, Compre and R&Q – all active across the UK and Continental Europe.

Large carriers such as Generali, Zurich, RSA, QBE and Axa turned to the legacy market to provide a capital efficient solution to deal with discontinued business units. As we reported last year, this style of actively managing out books of business to the legacy providers is becoming mainstream, and the legacy market now has a number of different tools to employ and a multi-platform approach which it can finally put to work. One area which has seen a number of transactions over the last couple of years is the UK employers liability market. Axa announced the transfer to Riverstone of a £600 million book via a court approved structure; Enstar entered into a similarly structured deal with RSA with £1 billion of reserves; and Catalina took on legacy liabilities from both the Hartford and Allianz.

Enstar was also busy in the Lloyd’s Reinsurance to Close (RITC) area of the market as both Neon and Novae look forward to exiting prior year business as part of a new strategy. Hamilton has also confirmed plans to offload its old Sportscover liabilities to the legacy providers. Prosight put its Lloyd’s syndicate into a run-off arrangement with R&Q. Meanwhile, R&Q was undergoing some changes of its own during the year, selling its Managing Agency to Coverys to refocus on its core legacy business. R&Q undertook related capital calls during the year to support such initiatives.

In the broker and intermediary sector, private equity houses continued with their interest in pursuing targets and in one particular example it’s easy to see why. Only in last year’s report did we mention Acquiline’s purchase of UK commercial lines broker, Simply Business. Travellers has now bought Simply Business from Acquiline for $440 million which represents a spectacular return for Acquiline over a short period of ownership and once again demonstrates the premium attaching to tech savvy business platforms in the distribution space. Another example of overseas interest in the UK distribution sector from North America was the Canadian Pension Plan Investment Board’s (CPPIB) purchase of a 30
percent stake in BGL Group for $900 million. BGL trades under the Comparethemarket.com website and life insurer Beaglestreet.com. BGL had begun preparations for a London-based IPO but, since CPPIB’s acquisition of a stake, BGL has shelved any such plans. CPPIB is no stranger to the insurance sector and is not the only Canadian pension fund investing with Caisse de dépôt et placement du Québec, confirming a $400m investment in London based Hyperion Group. Under David Howden’s leadership and with the backing of General Atlantic, the broker consolidator vehicle has surged in value in recent years as it pursued an aggressive expansion programme which shows no signs of slowing down.

On the M&A front, the hotly contested auction of London-based speciality MGA CFC Underwriting was won by private equity house Vitruvian at a reputed valuation of 15 x EBITDA. CFC had also attracted interest from seasoned US private equity funds keen to tap into the specialist MGA platforms on offer.

Elsewhere, JC Flowers purchased UK General MGA, a personal lines agency based in the north of England.

**Hong Kong**

Hong Kong’s non-life insurers are also being snapped up by mainland Chinese companies. MassMutual Asia, which mainly manages a general insurance business unit and a Mandatory Provident Fund business unit, sold 60% of its Hong Kong unit to Yunfeng Financial Group, a financial services firm founded by Chinese magnate, Jack Ma. Ant Financial Services, an affiliate company under Jack Ma’s Alibaba Group, which largely operates in the fintech industry, is amongst the investors who acquired the rest of the shares. This is another initiative from large Chinese companies to emerge as front runners in the insurtech sector.

**South Korea**

Samsung Fire & Marine Insurance, South Korea’s biggest top non-life insurance company, signed an agreement to buy a 20% stake in Vietnam’s non-life insurer PJICO, which is Vietnam’s fifth largest nonlife insurer with a 7% market share, further expanding its presence in the Southeast Asian region.

**Asia-Pacific**

**Japan**

To overcome challenges in the domestic market, non-life insurers are expanding their overseas revenues in the non-life sector. MS&AD Insurance Group acquired Singapore’s second-largest non-life insurance company, First Capital Insurance for US$1.6 billion, while Tokio Marine Holdings acquired the medical stop-loss insurance business of AIG for US$266 million, continuing its strategy in strengthening its overseas portfolio. Tokio Marine will buy the business through its subsidiary HCC Insurance Holdings, which will likely raise its share in the US market for such operations from fifth to third place.

On the other hand, after its notable purchase of Endurance Specialty Holdings, a Bermuda-based property and casualty insurer with a strong presence in the US, for US$6.3 billion, Sompo Holdings, Japan’s third largest property and casualty insurer, has sold its wholly-owned UK subsidiary, Sompo Canopius, in an effort to streamline business and boost brand unification.
**Life Sector**

**North America and Bermuda**

**Overview**

The number and size of announced life insurance M&A deals involving US targets were up in 2017 compared to 2016. According to S&P Global Market Intelligence, 2017 witnessed 32 deals, with an overall deal value of over $7.8 billion, with several large deals signed in the fourth quarter. Private equity-backed buyers showed a significant appetite for annuity businesses during 2017. Although most of the large annuity deals involved fixed annuities, the end of 2017 saw several large variable annuity business acquisitions.

**Regulatory Scrutiny of Chinese Buyers**

Chinese buyers faced some headwinds in completing transactions during 2017. China Oceanwide’s proposed acquisition of Genworth Financial, announced in October 2016, is still pending, reportedly in part because China Oceanwide has not yet obtained clearance from The Committee on Foreign Investment in the United States (CFIUS). CFIUS is an inter-agency committee authorized to review transactions that could result in control of a US business by a foreign person in order to determine the effect of such transactions on the national security of the United States.

Separately, in 2016, Anbang signed an agreement to acquire US insurer Fidelity & Guaranty Life for $1.6 billion. The parties twice extended the deadline to complete the transaction as Anbang sought regulatory approvals in Iowa and New York. In April 2017, the parties terminated their agreement, reportedly due to Anbang’s failure to obtain required insurance regulatory approvals.

Only weeks later, Fidelity & Guaranty announced a merger transaction with CF Corp. and certain other parties. The transaction was financed with $1.2 billion from CF Corp.’s IPO and forward purchase agreements, and more than $700 million in additional new common and preferred equity. Funds advised by Blackstone Tactical Opportunities, GSO Capital Partners LP (the credit division of Blackstone) and FNF provided a full backstop funding commitment. Following a model used by Athene and others, Fidelity & Guaranty Life entered into an investment management agreement with affiliates of Blackstone as part of the transaction.

**Appetite for Annuity Blocks Continues**

The continued low interest rate environment, combined with significant capital available for deployment into the life and annuity sector, led to a number of large annuity transactions during 2017. In May 2017, Reinsurance Group of America announced the completion of an asset-intensive transaction with Farmers New World Life, a subsidiary of Zurich Insurance Group, under which RGA reinsured a closed block of US annuity business. According to press reports, the transaction increased RGA’s invested asset base by approximately $2.3 billion. Also in May 2017, Wilton Re announced its acquisition of Transamerica’s payout annuity business and bank-owned/corporate-owned life insurance business. In total, Wilton Re assumed $1.2 billion of general account and separate account liabilities through administrative reinsurance agreements with Transamerica subsidiaries. As another example, in August 2017, Athene announced a flow reinsurance treaty transaction with Lincoln Financial, under which Athene will reinsure traditional fixed and fixed indexed annuities sold by Lincoln Financial.

On December 3, 2017, a group of investors led by Cornell Capital LLC, Atlas Merchant Capital LLC, TRB Advisors LP, Global Atlantic Financial Group, Pine Brook and J. Safra Group agreed to acquire The Hartford’s run-off life and annuity insurance business, Talcott Resolution. Total consideration for the sale is $2.05 billion. The transaction included significant blocks of fixed as well as variable annuities, which can be comparatively more difficult to divest than other kinds of annuity businesses. Also, as part of the transaction, Global Atlantic agreed to reinsure from the acquired business a $9 billion block of fixed and payout annuities.

In one of the last large deals announced in 2017, Voya Financial agreed to sell substantially all of its closed block variable annuity segment and its individual fixed and fixed indexed annuity business to a consortium of investors led by affiliates of Apollo Global Management, LLC, Crestview Partners and Reverence Capital Partners. In announcing the sale, Voya noted that, in addition to significantly reducing market and insurance risk, the agreement will enable it to focus on its higher-growth, higher-return, capital-light retirement, investment management and employee benefits businesses. In the transaction, Voya
will divest Voya Insurance and Annuity Company (VIAC), the insurance subsidiary that has primarily issued Voya’s variable, fixed and fixed indexed annuities. VIAC will be acquired by Venerable Holdings, Inc., a newly formed investment vehicle owned by a consortium of investors led by Apollo, Crestview and Reverence. Concurrent with the sale of VIAC, Voya will sell via reinsurance to Athene its individual fixed and fixed indexed annuity policies with approximately $19 billion of account value as of June 30, 2017, representing the significant majority of Voya’s fixed and fixed indexed annuities in force.

**The Hartford Acquires Group Business from Aetna**

In October 2017, The Hartford agreed to acquire Aetna’s US group life and disability business for cash consideration of $1.45 billion. The transaction was structured as reinsurance and the purchase of assets, including digital assets and an integrated absence management platform. Based on the balance sheet as of June 30, 2017, The Hartford received approximately $3.4 billion of investment assets at fair value and approximately $3.3 billion of corresponding reserves at fair value. The deal also included an exclusive, multi-year collaboration in which Aetna will be offering The Hartford’s group life and disability products through Aetna’s medical sales team. The transaction, which closed in November 2017, makes The Hartford the second largest group life and disability insurer in the United States, with approximately $5 billion in expected earned premium.

**AXA Opt for an IPO to Partially Divest Its Life and Annuity and Asset Management Businesses**

On November 13, 2017, AXA filed with the SEC to list shares of AXA Equitable Holdings, Inc., preliminary documents for an initial public offering of its US life-insurance operations, which offers variable annuities, group retirement products and investment management and research services. The listed company would include AXA’s ownership of AllianceBernstein Holding. According to the filing, AXA would retain the sale proceeds and retain control of the company. Following the planned IPO, the portion of the AllianceBernstein business not controlled by AXA would remain a separate publicly traded entity.

**Health Insurance Mergers**

The health insurance M&A space was dominated in 2017 by CVS Health’s landmark agreement to acquire Aetna for approximately $69 billion in a deal that would combine the drugstore giant with one of the largest health insurers in the United States. The merger came amid reports that Amazon is set to enter the pharmaceutical supply chain after knowledge surfaced that the online-retailer has obtained regulatory approvals in all 50 states. The vertical nature of the merger presents itself as currently the most viable form of M&A in the healthcare sector after the horizontal merger failures of Aetna-Humana and Anthem-Cigna at the beginning of 2017. Commentators also suggest that the vertical nature of the CVS-Aetna deal has the potential to reshape the nation’s healthcare industry by targeting unmet needs in the current system. Industry analysts speculate that it will redefine access to care at a lower cost by fostering an integrated community-centric health care experience that takes broader advantage of data and analytics.

**M&A Outlook for 2018**

Early signs indicate a robust market for life and annuity deals during 2018. As perhaps a harbinger of things to come, on January 18, 2018, Lincoln Financial announced an agreement to acquire Liberty Life Assurance Company of Boston from Liberty Mutual for $3.3 billion. Upon completion of the transaction, Lincoln Financial will retain Liberty’s Group Benefits business and reinsure Liberty’s Individual Life and Annuity business to Protective Life Insurance Company. Private equity, family offices and other alternative capital providers continue to show significant interest in the life and annuity sector. The prospect of rising interest rates will likely enhance valuations in this sector and thereby induce sellers to move forward. A question mark hovering over the market, however, is how tax reform will affect valuations.

**UK and Europe**

The year began relatively slowly in terms of value of announced transactions but the trend was generally upwards as the year went on and then ended with a strong finish. We have seen a similar trend in prior years but it may be that the sluggish start to the year was more pronounced due to the uncertainties of Brexit and general elections in the major economies of the UK, France and Germany. It is no surprise to see muted deal activity against such a backdrop.
Two transactions in the bulk annuity market saw CVC Capital Partners take a minority stake for an undisclosed sum in the UK-based Pension Insurance Corporation (PIC). PIC currently has approximately £20 billion in financial assets covering more than 130,000 individuals. Later in the year, fellow private equity house Blackstone upped its stake in PIC competitor Rothesay Life. Rothesay had been set up by Goldman Sachs just prior to the financial crisis of 07/08 and this final sale tranche valued life insurer Rothesay at approximately £2 billion. Blackstone invested alongside Singapore sovereign wealth fund GIC and MassMutual. Both the PIC and Rothesay deals demonstrate private equity houses’ continued interest in the bulk annuity provider market in the UK.

Elsewhere in the life sector, private equity-backed International Financial Group (IFG) bought Friends Provident’s Asia and Middle East life business for £340 million from UK-listed Aviva plc. UK private equity house Vitruvian used Isle of Man domiciled IFG to execute the deal and is no stranger to the UK insurance sector also, backing the MBO of London-based MGA CFC Underwriting during the year.

Meanwhile, German carrier Allianz took full ownership of Allianz Irish Life buying out Canada Life’s minority stake for $172m cash.

Asia-Pacific

Japan

Insurers in Japan have been experiencing diminishing investment returns after the Bank of Japan launched aggressive monetary easing measures in 2013, which has driven down yields on Japanese government bonds – typically the main investments of the country’s insurers. Overseas investments have shown to be key to their initiatives to diversify risks.

MS&AD Insurance Group, a Japanese holding company for life and non-life insurers, is looking to explore the Australian and European markets. It has reached deals to acquire a 6.3% stake in Australia’s Challenger Limited (Challenger), the country’s largest annuity insurance provider, for approximately 44 billion yen (US$397.56 million) in a move to boost its annuity business, as well as a 5% stake in ReAssure Jersey One Ltd, a UK unit of Swiss Re, which deals largely in closed-book life business (i.e., where firms buy policy portfolios from other firms instead of underwriting new ones).

Nippon Life Insurance, Japan’s largest private sector life insurance company, announced the acquisition of the Japan subsidiary of US life insurer MassMutual Life, which will boost its bancassurance sales channels. This followed its major outbound acquisition of an 80% stake in Australia’s biggest life insurance operator, MLC Life Insurance, in 2016. The companies have entered into final negotiations with the sale price reporting at an estimated 100 billion yen to 200 billion yen, and are expected to sign the agreement by the end of the 2017 fiscal year ending in March 2018. The conclusion of the deal will make it the first consolidation in the Japanese life insurance market since 2015, when Nippon Life acquired Mitsui Life Insurance. The company is also seeking to diversify investment channels by investing in asset management firms. It has reached a deal to acquire 24.75% of TCW Group Inc. from Carlyle Group LP. More acquisitions of asset management firms are expected to follow, with Nippon Life’s president expressing an intention to seek potential partners in asset management companies with bond investment expertise.

China

Despite restrictions placed by Chinese insurance regulators on mainland residents’ purchase of Hong Kong insurance policies by credit card, there remains a strong demand for life insurance policies from mainland customers. This has attributed to the popularity of Hong Kong life insurers as attractive acquisition targets from overseas companies, especially from mainland China. Thomson Reuters reported that 9 of the 21 proposed takeovers of Hong Kong insurers worth at least US$4 billion in the past three years leading to July 2017 have been led by mainland companies.

A notable deal of the year was the sale of Hong Kong Life Insurance, one of the city’s last remaining independent life insurance business owned by five Hong Kong financial institutions. It was acquired by First Origin International, an investment firm owned by Beijing-based financial group UCF Capital Ltd in March 2017 for HK$7.1 billion.
Standard Life Asia, the Hong Kong unit of British insurer Standard Life, was acquired by its Chinese-British joint venture with Tianjin TEDA International Holding (Group).

The growing interest in Hong Kong licensed carriers contributed to announcements by several global players to exit the market. AXA agreed at year end to sell its Hong Kong wealth management unit to a local family office; MassMutual Asia sold a US$1.7 billion controlling stake to an entity controlled by tech billionaire Jack Ma; and MetLife is reported to be seeking the sale of its Hong Kong life business.

Non-insurance companies have also been showing interest in breaking into the Hong Kong life insurance market. Tencent, one of China’s and the world’s largest internet services companies acquired 20% of the Hong Kong life business of British insurer Aviva in February 2017 last year. They have ambitions to break into the insurtech industry, which has been quickly gaining traction recently, by integrating robo-advisory technology and advanced data analytics into the insurance business.

**Australia**

Australia is the second largest life protection market in the Asia-Pacific region after Japan, and Australian life insurers have also proven to be popular targets of acquisition in 2017. Australia and New Zealand Banking Group’s life insurance arm was acquired by Zurich Insurance for US$2.1 billion, which will be its biggest foray into Australia. This followed its purchase of Cover-More Group in April 2017 and Macquarie Group Ltd’s life insurance unit in 2016. This will give Zurich Insurance 19% share of the Australia’s retail life insurance market overall.

Hong Kong-based AIA also reached a deal to purchase CommInsure, the life and health insurance unit of Commonwealth Bank of Australia, for almost US$4 billion, which will make it the largest life insurance company in both Australia and New Zealand after the takeover. The deal is expected to be completed next year subject to regulatory approval.

**Bancassurance**

In December 2017, VPBank announced a 15-year exclusive bancassurance partnership with AIA Vietnam. As a result of the partnership, VPBank became the first bank in Vietnam to offer integrated wellness and insurance services to its clients through its extensive distribution network. We expect to see more activity in this sector in Vietnam in the next few years.

In May, DBS Bank India launched the first bancassurance platform in India with an open architecture model, allowing the bank’s customers to select life insurance products from three insurers (Tata AIA Life, Birla Sun life and Aviva Life) on a single platform.

Another notable partnership in bancassurance was the announcement by China Construction Bank (Asia) Corporation Limited and IBM of their development of the first blockchain-enabled bancassurance platform in Hong Kong in September. The implementation of a blockchain platform is expected to shorten transaction processing times and improve transparency.
Brazil

Despite the decrease of approximately 20% in M&A transactions during the last two years, in mid-2017 Brazil started emerging from its worst recession in history.

One of the most relevant transactions in the insurance arena, announced in late 2016, was approved by the Brazilian antitrust and insurance authorities in July 2017, and it involves the acquisition of Bradesco Seguros’ specialty risks portfolio by Swiss Re Brazil.

Although the exact value of the transaction has not been officially disclosed, it was estimated at USD 250 million in premiums. Swiss Re will benefit from the fact that Bradesco Seguros is part of Banco Bradesco’s conglomerate (one of the largest financial institutions in Latin America) and this is likely to help Swiss Re Brasil to access an impressive network of clients, potentially increasing the volume of risks underwritten by the Swiss insurer.

Another key transaction involves the acquisition of Itaú Unibanco’s life portfolio by Prudential Brasil, approved by the Brazilian authorities in April 2017.

The portfolio represents approximately USD 100 million in premiums, comprising approximately two million individuals (covered mostly under Group Life and Personal Accidents policies).

A joint venture between Santander and HDI Seguros has also been formed for the incorporation of a new insurer called Santander Auto. The new insurer will focus on 100% digital commercialization of auto insurance. The new “insurtech” venture will be equally controlled by Santander and HDI Seguros.
Equity Capital Markets

United States

The equity capital markets in 2017 remained slow as average capital and surplus levels in the P&C industry were at their highest levels in recent years. There were only 12 equity offerings in 2017 by North American and Bermuda insurers, raising approximately $4.5 billion, according to S&P Global Market Intelligence. This compares with 20 equity offerings completed in 2016, raising approximately $5.4 billion. The number of insurance companies going public in 2017 declined from 2016, with only one insurance company, Advantage Insurance Inc., a specialty private placement life insurer, going public in 2017 (raising $110 million), versus the two IPOs in 2016 (raising a total of $1.3 billion), which included the $1.2 billion Athene Holding IPO. The majority of the issuers were incorporated in Bermuda (eight), with four from the United States. All of the transactions in 2017 were for the sale of common equity. Nine of the offerings represented sales of securities by shareholders, with only three issuers raising capital for general corporate purposes.

Given the general over-capitalization of P&C insurers and the continuing growth of the insurance-linked securities and convergence markets as alternatives for investors seeking to invest in insurance risk, the low number of issuances is unlikely to change in 2018. In addition, notwithstanding the substantial number of North American catastrophe events in 2017, most property and casualty insurance companies remain well capitalized.

In August, MetLife announced the completion of its previously announced spin-off of Brighthouse Financial, Inc. through a distribution of shares of Brighthouse’s common stock, representing 80.8% of MetLife’s interest in Brighthouse, to holders of MetLife common stock. As a result, Brighthouse is now an independent, publicly traded company. The separation allows MetLife to separate its historically more volatile retail business and reduce its exposure to evolving fiduciary standards. It also solidifies MetLife’s position upheld by the district court that it is not a nonbank systemically important financial institution.

UK and Europe

By the end of the first quarter of the year the largest new company by market value to list on the AIM market was an insurance group, Global Benefits Group (GBG). GBG is a provider of international benefits insurance spanning health, life, disability and travel. The company’s market capitalization was just over £130 million and it raised £32 million of gross proceeds. Incorporated in Guernsey, GBG has a number of operating companies distributing products in partnership with other carriers, but also underwrites a portion of risks through its own insurance company, thereby creating a flexible, integrated business model and products tailored to its clients’ needs. Another private equity-backed insurer came to the London market at the tail end of the year, this time a motor insurer called Sabre. It managed to achieve a market capitalization of approximately £575 million. Having reportedly run a dual track process, its choice of going public can be seen as a vote of confidence in the equity markets following a generally lacklustre start to the year for new offerings. Its stock has since ticked up and follows a similar upward trajectory to the trend enjoyed by fellow motor insurer Hastings which came to market in late 2015. Hastings was backed by Goldman Sachs’ private equity arm, which this year sold down its remaining stake via an institutional placement in May. Goldman Sachs has seen a healthy return on its investment.

Another private equity house selling down its stake via a similar route was Cinven, placing approximately 10% of the issued share capital of retirement and annuity provider Just Group plc. The stock exchange announcement recorded strong investor demand, requiring the placement to be upsized, and was again an indicator of the health of the markets and broader investor appetite for the sector. Finally, as mentioned elsewhere in our report, R&Q conducted two separate institutional investor placings during the last year, one in February to raise £16 million and one later in October for £49 million, as it sought to refocus the group on its core legacy operations and exited certain areas, including the sale of its Lloyd’s managing agent.
Asia

Following the China Insurance Regulatory Commission’s release in the second half of 2016 of its policy to encourage insurance companies to list on China’s over-the-counter National Equities Exchange and Quotations (the “NEEQ”), 12 insurance companies listed their shares on the NEEQ in 2017. While individuals were previously limited to investing in insurance companies listed on stock exchanges, this policy also allows individuals to invest in insurance companies listed on the NEEQ. Listing on the NEEQ is expected to help insurance companies improve corporate governance practices while raising capital. However, the vast majority of the insurance companies currently listed on the NEEQ are insurance intermediaries instead of insurers.

Conversely, although the Insurance Regulatory and Development Authority of India has tabled its plans to mandate the listing of certain insurance companies, India experienced a boost in initial public offerings from its insurance sector. After ICICI Prudential Life Insurance Company Ltd. became the first publicly listed insurance company in India in 2016, five additional insurance companies in India listed their shares in 2017: SBI Life Insurance Company Limited, ICICI Lombard General Insurance Company Limited, General Insurance Corporation of India, HDFC Standard Life Insurance Company and The New India Assurance Co., Ltd.

Debt Capital Markets

United States

The insurance industry continued to take advantage of relatively low interest rates in 2017 to raise an aggregate amount of $37 billion (including twelve debt offerings by Canadian issuers with an aggregate value of $3.59 billion), although this represented a sharp decline from the $74 billion raised in the prior year. This decline was expected, as many issuers in 2016 took advantage of historically low interest rates, which began to rise at the end of 2016.

The most active issuers in 2017 were UnitedHealth Group Inc. (eight offerings with an aggregate value of $5.35 billion), Anthem (five offerings with an aggregate value of $5.5 billion) and Arthur J. Gallagher & Co. (five offerings with an aggregate value of $628 million). Anthem’s senior notes offerings of $1.4 billion and $1.6 billion dollars came in as the most sizable of 2017—one offering of 4.375% senior notes with a 30-year maturity and the other offering of 3.65% senior notes with a 10-year maturity.

Some insurers used proceeds from their debt offerings to finance acquisitions. In November 2017, Anthem used the proceeds of its debt offerings in part to fund the acquisitions of HealthSun and America’s 1st.

Four insurers issued Guaranteed Investment Contract (GIC)-backed notes in 2017, for an aggregate value of $7.25 billion. MetLife issued the most GIC-backed notes, closing on seven series of GIC-backed notes with an aggregate value of $2.1 billion. The maturities of all the GIC-backed notes issued over the last year ranged from one to ten years.

UK and Europe

2017 saw the diversification of the types of regulatory capital issued by European insurers. Although there were senior, unsecured bond offerings in the insurance space in 2017, such as the £800m senior secured offering by broker holding company Towergate, the attention of the insurance industry was principally focused on subordinated debt issues. Since the implementation of Solvency II in 2016, insurance companies have been issuing Tier 2 debt securities as part of the management of their solvency capital structure. However, 2017 saw
the first issuance of Solvency II-compliant restricted tier one securities (RT1s). RT1s are deeply subordinated notes that can count towards 20% of Tier 1 own funds under Solvency II. They are generally fully subordinated to policyholders and unsubordinated creditors. Typically, RT1s are converted into equity or written down upon (a) a breach of the solvency capital requirement for more than three months, (b) the solvency capital ratio falling below 75% or (c) a breach of the minimum capital requirement.

2016 had seen non-euro denominated RT1 issuances by Gjensidige Forsikring (NOK1 billion) and other non-euro RT1 issuances followed, including by RSA Insurance Group in March 2017 (DKK650 million). The first issuer of euro denominated RT1s by a European insurer was ASR Nederland, which in October 2017 issued a €300 million perpetual fixed rate resettable non-call 10-year contingent convertible RT1. The notes were priced with a fixed-rate coupon of 4.625% (resettable after 10 years). This issuance was followed by Direct Line Group’s issue of £350 million fixed rate reset perpetual RT1 contingent convertible notes. The proceeds were used to fund the tender of a portion of its outstanding Tier II debt. The notes were issued with a fixed-rate coupon of 4.750% (resettable after 10 years).

It remains to be seen whether these initial issues of RT1s will encourage other issuers to access this category of the subordinated debt capital markets. It is, in all probability, likely to remain a less commonly issued category of regulatory capital for a number of reasons. Firstly, insurers were permitted to grandfather pre-2015 capital instruments as Tier 1 capital for up to 10 years, so they may not need to issue fresh Tier 1 capital until those instruments are called. In addition, some insurers have indicated that they will prioritize Tier 2 issuances until they reach the 50% issuance limit for such category of subordinated debt, due to lower pricing levels. Indeed, Axa has stated that it will not issue any RT1s in the future. Furthermore, due to the write down provisions in contingent debt, investors typically expect greater transparency than for other securities, including frequent reporting on the issuer’s solvency position. Lastly, RT1s have tended to be rated by credit rating agencies at two or three notches below insurers’ counterparty ratings as a result of the deep subordination.

The range of Solvency II regulatory capital instruments being issued was also widened in February, when the UK insurer Phoenix Group issued £300 million Tier 3 notes due 2022, with a coupon of 4.125 per cent. Phoenix Group’s issuance was the first sterling-denominated Tier 3 issuance and only the third issuance in this category of capital in any currency (following Aviva’s C$450 million issuance in May 2016 and French group CNP Assurances’ €1 billion issuance in October 2016). Tier 3 notes cannot be used to cover insurers’ minimum capital requirements under Solvency II and can only form up to 15% of eligible own funds.
ILS and Convergence Markets

Property-Casualty Sector | Life Sector

Longevity and Pension De-Risking
Property-Casualty Sector

Introduction

In 2017, the convergence market, which includes insurance-linked securities, sidecars, dedicated funds and new collateralized reinsurance vehicles, solidified its importance as a critical component of the global reinsurance market, representing almost 20% of dedicated reinsurance capacity. There was a substantial increase in the volume of new catastrophe bond issuances in 2017, which witnessed the largest number of issuances in the history of the market. In addition, in 2017 several innovative new risks came to the market. As a result of a number of catastrophe events in 2017, several outstanding bonds are expected to suffer losses pending development of claims in the coming months. We review below the various segments of the convergence market.

Insurance-Linked Securities

In 2017, approximately $12.5 billion of new risk-linked securities were issued (compared to $7.1 billion in 2016), resulting in approximately $31.0 billion of total aggregate principal amount of risk-linked securities outstanding at year-end, almost 20% higher from the amount outstanding at the end of 2016. This represents the largest annual issuance in the history of the market. US catastrophe risks (particularly US wind) continue to dominate, representing approximately half of outstanding bonds at year-end. Japan risks (earthquake and typhoon) represented approximately 11% of outstanding bonds at year-end. European-only risks represented approximately 2% of outstanding bonds at year-end (a substantial decline since year-end 2016). However, multi-region bonds (typically covering the US and Western Europe, but also Japan and Australia) represented approximately 22% of outstanding bonds at year-end, showing an investor appetite for European risks when they are bundled with other regions. Sponsoring companies in 2017 included longtime annual participants (such as Everest Re, USAA and XL Catlin), primary insurer sponsors (such as Allstate, Generali, Heritage, Nationwide and SJNK) and new insurance sponsors (such as American Integrity via Hannover Re, Cincinnati Insurance Company, Covéa Group and ICAT Syndicate 4242).

State-sponsored insurance entities came back to the market in 2017, including offerings sponsored by the California Earthquake Authority, Florida Citizens, Louisiana Citizens and TWIA.

In July 2017, the Pandemic Emergency Financing Facility, a financing mechanism of the International Bank for Reconstruction and Development (IBRD) that provides funds to enable a rapid response to a large-scale disease outbreak, sponsored a catastrophe bond covering the peril of pandemics. The bonds were issued through the IBRD’s global debt facility, utilizing a parametric trigger based on World Health Organization reported deaths that hit the covered area.

In December 2017, the Covéa Group, the French mutual insurer, accessed the capital markets for the first time by sponsoring a catastrophe bond covering the peril of windstorm in France. The transaction utilizes an indemnity trigger, and is one of a limited number of transactions in 2017 exclusively covering European risks.

Ursa Re Ltd. issued two series of notes in 2017 to collateralize its obligations to the California Earthquake Authority (CEA). In May 2017, Ursa Re established a program structure, which included six classes of notes that were fully structured and modeled, but only chose to issue two classes. The program structure allows Ursa Re to rapidly engage in future issuances, thereby providing the CEA with efficient pre-modeled and structured reinsurance layers. Ursa Re took advantage of this structure again in November 2017 to issue two additional classes of notes.

Two noteworthy transactions in 2017 involved mortgage insurance risks: the Oaktown Re transaction (sponsored by National Mortgage Insurance Corporation) and the Bellemeade Re transaction (sponsored by Arch). Each of these transactions have scheduled maturity dates of 10 years from issuance, significantly longer than property catastrophe ILS deals.

Indemnity triggers (which calculate payouts based on the actual losses of the ceding company) continued to be used in the majority of 2017 transactions, representing almost 75% of all new issuances. Index transactions (using information from PCS and PERILS) represented most of the remaining transactions, relatively consistent with the rate in recent years.
Parametric triggers (which are based on measurable physical phenomena, such as wind speed or earthquake magnitude), while representing a minor part of the market, remained important for certain risks.

Aggregate triggers have continued to become increasingly common in catastrophe bonds, representing more than half of all transactions outstanding at year-end 2017 (although they represented slightly less than half of all new issuances in 2017). 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 2017, 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 2017 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.

2017 was notable for the occurrence of a number of catastrophe events, including Hurricanes Harvey and Irma, wildfires in California and earthquakes in Mexico, that are expected to cause losses for several outstanding catastrophe bonds. The availability of this reinsurance protection in a year with significant catastrophe losses illustrates the robust nature of the market and its critical importance in providing claims paying resources to sponsoring insurance companies when needed.

The UK’s Risk Transformation Regulations 2017

Is Lloyd’s about to reclaim its lunch?

First hinted at in the UK Government’s Autumn Statement of 2014 and formally announced by the then-Chancellor George Osborne in March 2015, new laws were finally approved by the UK Parliament with the stated aim of facilitating onshore UK ILS transactions: The Risk Transformation Regulations 2017. The process was repeatedly delayed during consultation and legislative phases but, of course, since the original announcement, the UK has managed to hold two general elections on either side of the Brexit Referendum which may in part explain why attention and resources have been diverted elsewhere.

Although the UK already had existing regulations allowing for (re)insurance special purpose vehicles, the authorization and approval process, particularly the timeline, did not match the realities of the ILS market and what could be and was being offered elsewhere. The stand-out leader in terms of transactions launched to date across this section of the market is Bermuda. The British Overseas Territory has long been the jurisdiction of choice since the introduction of Special Purpose Insurer (SPI) legislation in 2009 which coincided with a rapid expansion of the ILS and wider convergence markets. One of the key factors in Bermuda’s success in attracting the lion’s share of ILS business has been its well-documented flexible and globally recognized regulatory process that understands that speed to market and predictable standards are crucial for this sector of the global (re)insurance market. So dominant was it that the London and Lloyd’s market in particular began to publicly question why such business was not being undertaken within the UK. Lloyd’s of London CEO, Inga Beale, remarked that Bermuda had stolen Lloyd’s lunch when it came to ILS business. Some might say the entry into force of the UK Risk Transformation Regulations is the first step of a coordinated
effort to challenge Bermuda’s status as the go-to jurisdiction. It is clearly early days but what can certainly be said is that the reinsurance market is truly global and so additional choice is never a bad thing when it comes to structuring transactions and choosing a jurisdiction to domicile the risk transformer entity.

While the new UK Regulations have sought to replicate many of the features that the industry requires in order to consider locating the transformer vehicle onshore UK – including the introduction for the first time in the UK of a protected cell regime – there is one aspect that may well be the deciding factor in a sponsor cedant’s decision on which jurisdiction to chose. That is the efficiency of and timetable surrounding the process to having regulatory approval of the vehicle. Not only does the Bermudian regulator, the BMA, have a wealth of experience with these ILS structures, but its timetable is, generally speaking, much shorter than the UK regulator’s stated aim of having a determination within six to eight weeks of submission of a complete application. Further, this estimate is for relatively straightforward applications. Moreover, in the UK, there are two regulators having dual competency and oversight of the process. While the PRA will lead the authorization process, it will require the FCA’s consent before granting approvals. In practice there has to be a question mark on the efficiency of a coordinated approach with two separate regulators involved from pre-application discussions through to final approval when both are under pressure on resources. Please see FCA and PRA guidance.

There is no doubt that the London and Lloyd’s markets have a depth of available talent, a history of innovation, and levels of expertise across the wider (re)insurance market which count in its favour, but some commentary and indeed legislators’ questions during the process seemed to reveal a lack of understanding of the vibrant market which already exists in London (and indeed other global insurance centres such as New York) when it comes to ILS and attracting third-party capital to insurance risk. For instance, some questioned whether this initiative would result in more jobs being created or more tax revenues for the UK Exchequer. This displayed some level of misunderstanding as to what such risk transformer vehicles look like, their purpose, and, perhaps more importantly, it fails to recognize the fact that many ILS Funds were conceived, and indeed continue to operate, in London and there is a good track record of (re)insurance professionals and their advisers structuring ILS transactions in the UK and other jurisdictions (principally New York) without requiring the SPV’s domicile to be in the same place.

A final point worth mentioning is the availability of and process governing a listing of an ISPV’s securities in the UK. The guidance doesn’t seek to address in any detail an aspect that is important to many ILS transactions marketed to a wider investor base. This is not just for liquidity reasons even though secondary trading of bonds may become more developed beyond event driven spikes as the market grows and matures. What is clear is that jurisdictions such as Bermuda may continue to attract listings of ISPV securities domiciled in the UK and that process is likely to be more efficient and proportionate.

Broadly, the market seems to have reacted positively to the new regulations and the simple fact is that another choice of jurisdiction in which to domicile the risk transformer vehicle is not a bad thing. While there may be continuing uncertainty surrounding the terms of a future EU trade agreement post-Brexit, that potential headwind is certainly not unique to the insurance sector.
Sidecars and Managed Funds

In 2017, sidecars remained an important mechanism for providing additional collateralized capacity to the reinsurance market, while allowing investors to participate in a targeted fashion in the property casualty market. Also, in 2017, several reinsurers accessed the capital markets through existing or new sidecar programs, including Brit (Versutus), Chaucer (Thopas Re), Everest Re (Mt. Logan Re), Munich Re (Eden Re) and Swiss Re (Sector Re), raising more than $3 billion.

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).

In addition to sidecars, dedicated insurance-linked securities funds continue to represent a critical component of the growth of the alternative capital market, providing an important source of capital in the reinsurance markets. At the end of 2017, there were over $80 billion of assets under management in ILS funds, an approximately 60% increase over 2014. Many newly formed funds give the investment manager broad discretion to deploy capital as reinsurance opportunities arise, whether through the purchase of catastrophe bonds, the funding of collateralized reinsurance for third-parties, or the entering into of quota share agreements with the sponsor or its affiliates.

In January 2018, Neon Underwriting announced the completion of the first insurance-linked securities transaction in the United Kingdom. Using the new UK ILS regulations, Neon’s UK ILS vehicle entered into a $72 million quota share reinsurance agreement with Neon Syndicate 2468, underwriting a portion of its property treaty reinsurance and direct and facultative insurance portfolios. Please see The UK’s Risk Transformation Regulations 2017 for a discussion on the new UK ILS regulations.

Singapore

Currently, catastrophe bonds are issued using special purpose vehicles domiciled in Bermuda, the Cayman Islands and Ireland. In late 2017, representatives of the Singapore government announced that they are seeking to develop an ILS market in Singapore and are actively looking for sponsors interested in using a Singapore-domiciled special purpose vehicle. While Singapore has implemented special purpose reinsurance vehicle legislation (which could be used to facilitate a catastrophe bond transaction), no such vehicles have yet been launched. Recognizing that potential sponsors may be hesitant to issue a bond in a jurisdiction that does not have a track record, the government is offering a grant that will cover 100% of the upfront costs incurred in issuing a catastrophe bond in Singapore. Covering such costs provides a strong incentive for sponsors to consider Singapore, notwithstanding its relative lack of experience. It will be interesting to see whether any transactions in 2018 are launched in this jurisdiction.
Life Sector

Regulation XXX/AXXX Update

During 2017, life insurers continued to take advantage of the low financing costs prevailing in the market by refinancing their XXX/AXXX reinsurance transactions or expanding their existing deals to cover new vintages of business. The newer business does not benefit from the “grandfathering” financing rules (i.e., business that was both issued and financed before 2015 and would not be exempt under AG48). However, during 2017 a number of insurers amended their existing financing facilities to include non-grandfathered business, generally using the same transaction structure.

The life insurers continue to search for cost-effective financing structures that can be applied to non-grandfathered business and under the emerging principles-based reserves regime (PBR). (The excess reserve requirements are expected to be lower under PBR but nevertheless material enough to compel insurers to consider a financing solution, particularly for universal life business.) Regulators generally have interpreted the requirements of AG48 stringently, particularly with regard to the kinds of collateral that can be used to support a portion of reserves equal to what would be required under a principles-based reserving methodology. This portion of the collateral, referred to as “primary security,” can consist only of cash, securities listed by the NAIC’s Securities Valuation Office (other than synthetic and credit-linked securities and securities issued by the ceding insurer or its affiliates) and specified other assets if the reinsurance uses a funds withheld or modified coinsurance structure (high quality commercial loans, policy loans and derivatives acquired for hedging purposes). In December 2017, the NAIC’s Reinsurance Investment Security (E) Subgroup issued a paper to clarify the kinds of investment securities that can qualify as primary security. The paper noted that the concept of primary security is a higher threshold than what is generally allowed as reinsurance collateral or as an admitted asset and that the asset cannot resemble financing or circular transactions. A number of life reinsurers and other risk takers are stepping up their efforts to develop products that comply with these requirements, both under AG48 and under PBR.

While these efforts are underway, we expect that the market for new financing transactions will remain somewhat stagnant. The industry will in the interim have to self-finance the redundant regulatory reserves on new business.
Longevity and Pension De-Risking

United States

“Risk transfer is visibly on the rise with no signs of slowing down.” (PBGC Participant and Plan Sponsor Advocate 2017 Annual Report)

Continuing a trend witnessed over the past several years, 2017 saw a growing number of transactions intended to extinguish pension plan liabilities through large-scale group annuity purchases, as well as the distribution of lump sums. LIMRA Secure Retirement Institute reported pension buy-out activity in the third quarter of 2017 of $6.4 billion, a 7 percent increase compared with the prior year’s third quarter (and buy-out activity in excess of $1 billion for the tenth straight quarter). According to LIMRA, as of the end of the third quarter of 2017, “[y]ear-to-date, single premium buy-out product sales were $11.9 billion, 47 percent higher than the same period in 2016.” Sales for all of 2017 are expected to be over $19 billion and LIMRA predicts sales in 2018 to top $20 billion. Companies in the US that engaged in pension risk transfer transactions that included annuity purchases in 2017 include: Hartford Financial Services Group ($1.6 billion), Accenture ($1 billion), Sears Holdings Corp. ($1 billion, over two transactions), MillerCoors LLC ($900 million), and International Paper Co. ($1.3 billion), and the New York Times ($225 million).

Another observed phenomenon in the market has been accelerated contributions to defined benefit plans for 2017, apparently fueled by both the desire to reduce PBGC variable premiums by reducing underfunded liabilities and to take advantage of the limited window for deductions against a 35% corporate tax bracket. In some cases, employers have borrowed to do this as the cost of borrowing has been outweighed by the tax benefits and reduced premiums associated with the contributions. Companies that borrowed to fund discretionary contributions in 2017 included: Verizon, E.I. du Pont de Nemours &Co., Kroger Co., FedEx Corp., and Delta Air Lines Inc. As one Goldman Sachs commentator notes, “Increased contribution activity leads to higher funded ratios which may be a catalyst for more de-risking activities. …[B]etter funded plans make it easier for the sponsor to transfer liabilities to a third party insurance company.” In other words, it appears that for many companies voluntary contributions to reduce underfunding are part of a long-term pension risk transfer plan. As we have discussed in our prior year reports, plan sponsor motivations for engaging in pension risk transfer transactions include volatility in pension obligations, accounting and funding rule changes, volatile capital markets, a low-interest rate environment, longevity risk issues, and escalating PBGC premiums. The following is a brief roundup of legal developments in this area in 2017. Significantly, as discussed below, in October 2017, the IRS finalized regulations that include a new mortality table and mortality improvement scale for defined benefit plans that apply for purposes of minimum funding, as well as PBGC premiums, and issued Notice 2017-60 with new tables for purposes of calculating lump sum distributions to participants. The new tables are generally effective for plan years beginning on and after January 1, 2018, subject to certain transition rules. Below, we also discuss the PBGC Participant and Plan Sponsor Advocate 2017 Annual Report, which identifies past and scheduled-future rapid increases in PBGC premiums as a primary driver of de-risking activity, and conclude our report with a discussion of the denouement of the Lee v. Verizon litigation.

IRS Developments

In 2015, as discussed in our 2015 Year in Review and below, the IRS issued preliminary guidance announcing that it will issue regulations, with an effective date retroactive to the date of the 2015 announcement, that will bar distributions of lump sums for de-risking purposes in certain circumstances. The IRS did not issue such regulations in 2016 or 2017.

In 2017, the IRS finalized regulations that include a new mortality table and mortality improvement scale (to be effective in 2018) that reflect the longevity gains of RP-2014 and MP-2014 (discussed below).

Offers of Lump Sums to Participants in Pay Status

In the past there had been some uncertainty about whether a plan sponsor may, consistent with the requirements applicable to qualified plans, offer a participant who has already commenced receiving benefits in the form of an annuity the right to cancel the annuity and receive a lump-sum distribution. In both 2012 and 2014, the IRS issued private letter rulings...
holding that, under the facts described in the rulings, offering a one-time lump-sum option for participants in pay status is not inconsistent with certain technical qualification requirements referred to as the “minimum distribution rules.”

In a somewhat abrupt about-face, on July 10, 2015, the IRS issued Notice 2015-49, which “informs taxpayers that the Treasury Department and the IRS intend to amend” certain regulations to provide that qualified defined benefit plans are generally not permitted to replace any annuity currently being paid from the plan with a lump-sum or other accelerated form of distribution. The amendment to the regulations will be retroactive to the date of the Notice. As we have noted in prior years, it appears that the IRS intends for the prohibition to apply to ongoing, but not terminated, plans, but the Notice is not entirely clear, leaving the issue somewhat uncertain until regulations are issued, and creating a dampening effect on offering lump sum distributions to retirees in pay status even in the context of a plan termination. Although an IRS official was reported to have stated in early 2016 that the regulations are in a “fairly advanced stage of development,” the promised regulations that we would hope would clarify a number of aspects of the IRS’s new position were not issued in 2016 or 2017.

**Mortality Tables**

In October 2017, the IRS issued final regulations that include new mortality tables for purposes of the minimum funding rules applicable to defined benefit plans. The regulations take effect for plan years beginning on and after January 1, 2018. (The new regulations are based on tables issued by the Society of Actuaries in the RP-2014 Mortality Tables Report and the improvement rates in the MP-2016 mortality improvement scale, which reflect current and projected gains in longevity, and apply for corporate financial accounting purposes.) Under the new IRS tables, plan liabilities can generally be expected to be larger, resulting in increased employer contributions. The actual increases in liabilities will vary by plan and depend on the demographics of the plan’s population. The increase in liabilities can be expected to result in lower funding ratios and, if that ratio is low enough, restrictions on lump-sum distributions to participants as well as special reporting requirements. Because the amount of PBGC premiums payable by a plan sponsor are in part a function of unfunded liabilities, PBGC premiums will generally be higher with the adoption of the new table. It should be noted that the final regulations also permit a plan sponsor to substitute a plan specific mortality table for funding purposes, but such tables can be complex to develop and would (as under prior law) require IRS approval, which is not a given. In addition, under limited circumstances, plan sponsors may use a one year transition rule to apply the prior mortality tables for 2018 funding.

In addition, the IRS issued Notice 2017-60, which provides a new mortality table for calculating the minimum present value (under Internal Revenue Code section 417(e)) of lump sum distributions with annuity starting dates that occur during stability periods beginning in 2018. The table is a modified unisex version of the tables published for funding purposes. (The Notice also includes updated static mortality tables determined under the prior regulation methodology for distributions that are made in plan years beginning in 2017 with respect to valuation dates in 2018.) Lump-sum distributions to participants calculated under the new tables can generally be expected to be larger, holding other variables, e.g., interest rates, constant. (Plan specific tables are not permitted for lump sum distributions.)

Finally, the IRS has also issued Notice 2018-02, which provides updated static mortality tables and mortality improvement rates for purposes of applying the minimum funding rules for 2019, and a modified unisex version of the tables for purposes of calculating lump sums with annuity starting dates occurring during stability periods beginning in 2019. The tables reflect the mortality improvement rates in the Mortality Improvement Scale MP-2017 Report (issued by the Society of Actuaries).

**Pension Benefit Guaranty Corporation (PBGC)**

*PBGC Participant and Plan Sponsor Advocate 2017 Annual Report.* The PBGC publishes the “Annual Report of the Participant and Plan Sponsor Advocate” (the Advocate Report). This year the Advocate Report included an appendix with a full pension de-risking study commissioned by the Office of the Advocate. The Advocate Report found a strong link between PBGC single-employer premium levels and pension risk transfer activity.
The report was commissioned to analyze the underlying causes and drivers of de-risking activity, focusing mostly on risk transfers, which according to the report have the most significant effect on the viability of the voluntary defined benefit system. The goals of the study were to “identify the key causes of de-risking activity as well as potential changes that could slow the growth of de-risking activity.” Not unsurprisingly, the study found that decision-makers within most organizations with defined benefit plans were considering, or were in the process of, de-risking, with over 86% of plan sponsors having taken some steps to de-risk their plans (whether via in-plan investment strategies or risk transfers). The PBGC in its summary of the study noted that “while plan sponsors understand the value that defined benefit plans bring to an organization, these benefits are outweighed by financial volatility and the increasing costs of PBGC premiums, leading sponsors to consider de-risking.”

The study notes that increasing risk transfer activity poses “an anti-selection problem where healthier sponsors reduce or eliminate their obligation and risk, leaving larger shares of the less healthy sponsors with more poorly funded plans in the defined benefit system, which increases the overall risk and exposure to PBGC.”

The study identified the most significant PBGC-related factor driving de-risking as PBGC premiums; flat rate premiums have doubled since 2012 and variable rates have quadrupled since 2013. The study indicates that for some sponsors, the present value of future PBGC premiums outweighs the cost of pension risk transfer activities, and concludes that reducing PBGC premiums or “stemming their growth” would likely have “the positive effect of slowing de-risking activity.” The results of this study may provide the impetus for Congressional action to reduce PBGC premiums.

**Litigation Developments**

As generally anticipated, the Supreme Court issued, in 2017, what appears to be the final death knell for the plaintiffs’ cause of action in *Lee v. Verizon*.

In June 2013, the District Court for the Northern District of Texas dismissed plaintiffs’ ERISA claims, but granted the participants leave to refile an amended complaint. Plaintiffs refiled, but in April 2014 the court again dismissed plaintiffs’ claims, including fiduciary breach claims. Plaintiffs appealed this decision to the Fifth Circuit, and, in a decision issued by the court on August 17, 2015, the court rejected all of the claims by the retirees with annuitized pension benefits. (The retiree class’s specific claims and the court’s dispositions were discussed in some detail in our 2015 *Year in Review*.) In the case of the class of plaintiffs whose benefits were not transferred to Prudential (i.e., those who remained covered by the plan), the court ruled that those non-transferee plaintiffs failed to allege an “injury in fact” sufficient to establish constitutional standing to sue, and in September 2015, the court rejected those plaintiffs’ subsequent petition for rehearing. In December 2015, the plaintiffs petitioned the Supreme Court for a writ of certiorari. The Supreme Court granted certiorari, and in May 2016 vacated the Fifth Circuit’s previous dismissal of the non-transferee plaintiffs’ claims and instructed the court to reevaluate its decision using the standing standard set forth in *Spokeo, Inc. v. Robins*, where the Supreme Court held that a plaintiff must assert a concrete and particularized injury to obtain Article III standing. On remand, the Fifth Circuit panel determined that *Spokeo* did not change the outcome on standing and dismissed plaintiffs’ claims. In December of 2017, plaintiffs, along with the Pension Rights Center, again petitioned the Supreme Court for a writ of certiorari on the ground that the Fifth Circuit had misapplied the *Spokeo* standard.

In March 2017, the Supreme Court denied the petition of a writ of certiorari. Plaintiffs interviewed by *Plan Sponsor* magazine have admitted that to date the pension risk transfer transaction has had no effect on their benefits, but remain concerned with the effect of pension risk transfer activity on the long term health of the PBGC.

**UK and Europe**

Bulk annuity activity levels were expected to be significantly higher in 2017 than in 2016 as insurers moved their attention from compliance with the Solvency II regime to new business. The first half of the year appeared to bear out this expectation, with a total deal volume of around £5.1 billion—the highest level for the first half of the year since 2014, and compared to around £2.6 billion in the first half of 2016. The second half of 2017 was less busy than expected, but the total deal volume in 2017 is still expected to exceed £10 billion for the fourth year running.
Individual deal sizes were comparatively low, however, with just one reported transaction over £1 billion (a £1.2 billion buy-in for the Pearson Pension Plan in October).

As was the case in 2016 (and previous years), there were far more buy-ins than buy-outs. This is likely due to the additional employer funding that is generally required for a buy-out – many employers currently prefer to prioritize business investment and a buy-in often offers a means of de-risking liabilities without the need for additional funding. However, most buy-in policies include provision for the policy’s conversion to buy-out in the future.

The longevity swap market saw a significant increase in business, with transactions hedging longevity risk association with over £6 billion of liabilities compared to transactions hedging risk associated with around just £1.6 billion in liabilities in 2016. Legal & General completed the first transaction using its new UK-based “pass through” structure to transfer longevity risk to the end reinsurer with a £800m longevity swap for the Scottish-Hydro Electric Pension Scheme. The swap was transacted at the same time as a £250 million buy-in for the same scheme and a £100 million buy-in for a second scheme sponsored by the same employer. This marked the first transaction in the UK where buy-ins have been carried out simultaneously with a longevity swap.

2017 also saw two longevity swap transactions using a Guernsey captive insurance cell structure – a £1.6 billion transaction for the Airways Pension Scheme in August and a £3.4 billion transaction for the MMC UK Pension Fund in September. This structure, which borrows from technology found in the capital markets and collateralized insurance sectors, where incorporated cells are widely used, was first used in the pension scheme longevity swap context in 2014 and was used in a number of transactions in 2015, but appeared to lose popularity in 2016. Captive cell structures are still currently only being used for transactions over £500 million, but sub-£500 million longevity swap transactions are becoming increasingly frequent. In particular, Zurich has been focussing on this end of the market, offering a streamlined, uncollateralized approach using a panel of reinsurers, and has completed six deals hedging risk associated with liabilities between £50 million and £500 million since December 2015, including two £300 million deals in 2017 (both 75%-80% reinsured with SCOR).

The high levels of insurer reinsurance seen in 2016 have also continued, with Rothesay Life, Pension Insurance Corporation, and Legal & General entering into transactions totalling around £2.5 billion to reinsure parts of their back-books. Please see Longevity Swap Structures for a description of the different types of longevity swap structures.

The number of active market participants increased to eight in 2017 with Phoenix Life’s July announcement that it was joining the market after transacting its first buy-in in December 2016 (with its own pension scheme). Rothesay Life also began writing new business in 2017, having focussed in 2016 on its purchase of £6 billion of AEGON’s back-book, and Canada Life completed its biggest transaction to date – a £250 million buy-in with the Cancer Research UK Pension Scheme. Although the various participants target different sectors of the market, the current number of active participants creates increased capacity and competition, and this could create pricing opportunities for schemes. Market commentators expect at least one other participant to join the bulk annuity market in 2018 and that other reinsurers may enter the longevity swap/reinsurance market.

Insurer capacity and scheme demand is expected to remain high for both bulk annuities and longevity swaps in 2018; market commentators report that insurers expect the deal volume in 2018 to exceed £30 billion. Good equity returns, increased gilt yields, higher than expected mortality rates, and an increase in long-term interest rates have resulted in improved scheme funding, which has in turn meant that many schemes have hit de-risking triggers in their funding and investment strategies. The mid-range of the bulk annuity market (£100 million – £500 million) is likely to be particularly busy as all the currently active insurers operate in that space which maximises competition and therefore pricing opportunities.

However, a potential restriction on capacity is the level of insurer resources – insufficient IT and staff resources may mean that insurers have to be selective in which transactions they quote for. If this is the case, schemes that are able to present a well-prepared proposition with properly cleansed data will be more likely to attract insurer interest.
Capacity for reinsurance also remains high, although it may be affected by the increasing global demand for reinsurance. Potential demand for reinsurance is also likely to be high, thanks to the ongoing capital requirements of the Solvency II regime which make reinsurance attractive, and the substantial annuity back-books that some insurers now hold. Market commentators also expect to see the sale of annuity back-books by insurers that have exited the market, such as Prudential with an estimated £30 billion back-book and Standard Life with an estimated £16 billion back-book.

Although insurers have now largely adapted to the Solvency II regime, it continues to have an impact on the market. Bulk annuities covering deferred liabilities remain more expensive than transactions covering pensioners due to the cost for the insurer of obtaining the matching assets required under Solvency II. Pricing in general remains sensitive to the type of assets that are available to the insurer to back the transaction. Insurers have, however, been successful over 2017 in sourcing suitable matching assets from across a range of asset classes, in particular more illiquid assets such as social housing, equity release mortgages, infrastructure and transportation, which offer good yields over a long term.

Life expectancy improvement rates in the UK have fallen from 3.1% per annum in 2011 to 1% per annum in 2016. Recent data from the Office for National Statistics suggests that this trend will continue for 2017. It is not clear whether this recent mortality experience is a blip or a long-term trend. Either way, insurers and reinsurers now seem to be reflecting the increase in mortality rates in their pricing, which has contributed to the favourable current pricing for both bulk annuities and longevity swaps.

Tranched – sometimes known as ‘phased’ – transactions are making up an increasing percentage of the bulk annuity buy-in market, a development that has been reflected in the higher number of mid-range transactions and the lower number of £1 billion plus transactions; for example, the TI Group Pension Scheme entered into a £130 million buy-in in February 2017, its fifth such transaction. Schemes often used a tranched buy-in strategy as part of a journey plan to full buy-out, and splitting a larger scheme’s liabilities into tranches can make a buy-in of those liabilities more attractive to a wider range of insurers, resulting in increased competition and improved pricing. Insurers are traditionally less interested in smaller transactions as the transaction cost is the same as for a larger transaction, but with a lower potential return. However, the potential for multiple tranched transactions can make an initial smaller size transaction attractive to an insurer as there is the ‘promise’ of further deal flow from the Scheme; and policy terms from the first tranche can often be reused in subsequent tranches, reducing transaction costs. Indeed, umbrella contracts, which expressly provide for subsequent tranches to be completed on equivalent (updated) contractual terms as the first tranche, are increasingly common.

The use of medical underwriting has declined in popularity over the last 18 months, possibly because competition in this area has reduced with the 2016 merger of the two main participants, Just Retirement and Partnership to form Just, while the appetite of other market participants such as Legal & General remains low, driving schemes towards traditional, non-underwritten deals. Just is now offering the option of “post-deal underwriting” for some transactions with a price adjustment after the underwriting process has been carried out.

Pricing remains the main driver for trustees, and pricing for bulk annuities and longevity swaps improved throughout the course of 2017 – it is now at its lowest level in nearly a decade. Buy-ins are now cheaper than the gilts required to match the same scheme liabilities, with the effect that a buy-in therefore now generally improves scheme funding and is a better match for the liabilities as it addresses risks that gilts do not, especially longevity.

Other pricing-related trends in 2017 have included:

- an increase in price monitoring whereby the transaction documents are agreed and the price is then monitored until an opportunity arises at which point the transaction can be completed in a matter of days or even hours; and

- an increase in requests for collateral to be provided by insurers with bulk annuities – insurers are generally pushing back on such requests as providing collateral requires more assets to back the transaction which means the insurer’s assets are working less efficiently and capacity is reduced.
However, an increasing focus by schemes on contract terms at the insurer selection stage – insurers are being asked to comment on the likely contract terms that they will seek to include if selected – suggests that price is not the only driving factor for schemes.

On the legal front, the UK government’s green paper on the DB pensions sector, published in February 2017, suggested that the creation of consolidating superfunds targeted at delivering an alternative to buy-out for small schemes that cannot access the buy-out market would be helpful. The UK government would need to provide a suitable legislative framework for such superfunds. A white paper setting out more detailed proposals in relation to reform of the DB pensions sector is due to be published in early 2018 – it remains to be seen whether this carries forward the superfund proposal.

In addition, legislation came into force in the UK in December 2017 that introduces a regulatory and tax framework for insurance-linked securities in the UK, in recognition of the fact that London is the largest global market for commercial insurance and reinsurance. This will give insurers and reinsurers operating in the pensions and longevity de-risking market a further means of de-risking their liabilities which could increase capacity.

May 2018 will also see the EU General Data Protection Regulation (GDPR) come into force throughout the EU. The GDPR will replace existing data protection laws and introduce significant changes and additional obligations that will have a wide ranging impact on UK pension schemes. These changes are likely to require amendments to be made to the terms of existing bulk annuity policies and longevity swap contracts.

There is continuing uncertainty surrounding the impact and outcome of the Brexit negotiations, both in terms of the financial impact (i.e. investment returns and asset values) and the legal impact (i.e. what regulatory regime (if any) is agreed regarding the financial services sector). This uncertainty could affect capacity and demand, but equally market volatility can create pricing opportunities for schemes that are ready to transact in a short time span.

Longevity Swap Structures

Traditional Intermediary Structure

Under this structure, the scheme makes fixed payments to the insurer based on the scheme’s estimated mortality assumptions as advised by the scheme actuary (the “fixed leg”). The insurer makes floating payments to the scheme based on the scheme’s actual mortality experience (the “floating leg”). Typically, the insurer will then reinsure some or all of the longevity risk that it is assuming under the swap. Under this structure, the intermediary insurer is responsible for administering the swap payments and bears the credit risk of the reinsurer. This is the structure that has traditionally been used for longevity swaps involving pension schemes.
Captive insurance cell structure

Under this structure, the pension scheme sets up its own insurance company (the “captive insurance cell”) and enters into a longevity swap with that company. The captive cell then reinsures the longevity risk with one or more reinsurers. The structure enables the scheme to access the reinsurance market without paying fees to an intermediary insurer – under current UK legislation, pension schemes are not permitted to transact directly with reinsurers. However, under this structure, the scheme (via the captive cell) is responsible for administering the swap payments and bears the credit risk of the reinsurer.

“Pass through” structure

This structure is similar to the traditional intermediary structure, but with a direct “pass through” of the longevity risk from the pension scheme to the reinsurer via the intermediary insurer. This structure is a recent development, having been used for the first time in 2017.
US/ NAIC

US-EU Covered Agreement Introduces New Framework for Reinsurance Collateral

On September 22, 2017, nearly two years after negotiations began, the US Department of the Treasury, the US Trade Representative and the European Union (EU) executed the “Bilateral Agreement between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (commonly referred to as the “Covered Agreement”). The Covered Agreement finalizes the approach agreed upon in January 2017 between the US and the EU regarding several areas of insurance regulation that have long been a source of controversy, including reinsurance collateral requirements, group supervision, the exchange of information between regulators and local presence requirements in the EU.

Historically, state insurance laws governing the ability of ceding insurers to take credit for reinsurance have generally required reinsurers that were not authorized or accredited in the ceding insurer’s state of domicile to post 100 percent collateral for the liability being assumed. This was a big sore point for non-US reinsurers, including some of the largest reinsurers in the world, which were burdened with these collateral requirements solely because of their non-US status. In 2011, the National Association of Insurance Commissioners (NAIC) amended its Credit for Reinsurance Model Law and Credit for Reinsurance Model Regulation to allow unauthorized reinsurers that are domiciled in a “qualified jurisdiction” and have been certified by a ceding insurer’s domiciliary regulator to post a reduced amount of collateral (determined on a sliding scale) based on their financial strength and business practices. A majority of US states – though not all – have adopted the NAIC model law provisions for certified reinsurers. However, the collateral reduction provisions in the Covered Agreement are broader than the NAIC’s certified reinsurer provisions because they will completely eliminate the collateral requirement – as opposed to merely reducing it – and because the financial strength requirements are less stringent. At the same time, the Covered Agreement only applies to US and EU reinsurers, in contrast to the NAIC’s certified insurer provisions, which apply to qualified jurisdictions – currently Bermuda, France, Germany, Ireland, Japan, Switzerland and the United Kingdom.

With the execution of the Covered Agreement, the clock begins ticking for US state legislators and regulators to change their credit for reinsurance laws and regulations to eliminate requirements that EU reinsurers post collateral against the US risks they have reinsured. In fact, the Covered Agreement calls for the US states to reduce collateral requirements for EU reinsurers by 20 percent each year over the next five years. Accordingly, the policy statement by the Trump Administration that was released upon the signing of the Covered Agreement encouraged each US state to promptly adopt relevant credit for reinsurance laws and regulations consistent with the Covered Agreement’s provisions on reinsurance collateral and to phase out the amount of collateral required to allow full credit for reinsurance cessions to EU reinsurers.

For the states that have recently adopted laws allowing for collateral reduction by certified reinsurers, those states may not need to make significant changes to their laws in order to be compliant with the Covered Agreement (and presumably the existing certified reinsurer provisions would continue to apply to non-EU reinsurers). However, the states that have not adopted the certified reinsurer provisions will need to undertake significant revisions to their laws in order to conform with the Covered Agreement’s requirements. The Covered Agreement calls for the US government to begin deliberations on the federal preemption of state insurance laws that are inconsistent with the Covered Agreement by July 2020, which determination must be completed within eighteen months after deliberations begin.

On December 21, 2017, the NAIC’s Reinsurance Task Force announced a public hearing to be held in New York on February 20, 2018 to address the following topics:

- Amending the NAIC’s Credit for Reinsurance Model Law and Credit for Reinsurance Model Regulation to eliminate reinsurance collateral requirements for EU-based reinsurers meeting the conditions of the Covered Agreement;
- Extending similar treatment to reinsurers from other jurisdictions covered by potential future covered agreements that might be negotiated pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank);
• Providing reinsurers domiciled in Non-EU NAIC qualified jurisdictions with similar reinsurance collateral requirements;

• Considering changes to the criteria for evaluating whether a jurisdiction should be a qualified jurisdiction; and

• Considering additional “guardrails” relative to US ceding companies, such as changes to the risk-based capital formula or new regulatory approaches to help address the increased financial solvency risks caused by the elimination of reinsurance collateral.

As indicated by some of the topics for discussion at the February 20th hearing, the Covered Agreement will have ripple effects beyond US-EU reinsurance. Reinsurers in commercial centers outside of the EU have urged the NAIC to make any proposed changes to the Credit for Reinsurance Model Law and Regulation apply to not only the EU reinsurers that benefit from the Covered Agreement, but also to certified reinsurers domiciled in jurisdictions deemed to be a qualified jurisdiction by the NAIC. Currently, the qualified jurisdictions outside the EU are Bermuda, Japan and Switzerland. Depending on the final results of the Brexit negotiations, the list will likely expand to include the United Kingdom.

It is important to note that the required changes in state laws may take up to five years to implement, and, once implemented, those changes will only apply to prospective transactions. As a consequence, reinsurers with collateral arrangements already in force will need to maintain those arrangements going forward. Moreover, the Covered Agreement specifically contemplates that reinsurers and ceding insurers will have the ability to privately negotiate the collateral requirements that the parties deem appropriate, in keeping with the increased use of “comfort trusts” and similar arrangements in the wake of the financial crisis to mitigate credit exposure to reinsurers. So, while credit for reinsurance trusts and letters of credit may no longer be required by law in many circumstances once the provisions of the Covered Agreement are fully implemented, ceding insurers will still be able to request that EU reinsurers provide collateral protection, though such requests will need to be resolved through commercial negotiations, rather than through adherence to regulatory requirements.

For a detailed discussion of the provisions of the Covered Agreement relating to credit for reinsurance, please see our January 20, 2017 Legal Update.

Changing Approaches to Assessing Systemic Risk in the Insurance Industry

Under the purview of the Financial Stability Board (FSB) and the G20, the International Association of Insurance Supervisors (IAIS) – along with other standard setters, central banks and financial sector supervisors – is participating in a global initiative to assess systemic risk in the global insurance industry. As part of this initiative, IAIS has adopted a framework of policy measures that apply to insurers “whose distress or disorderly failure would potentially cause significant disruption to the global financial system and economic activity,” i.e., global systemically important insurers (G-SIIs). In consultation with the IAIS, the FSB publishes an annual list of G-SIIs.

In the United States, the Financial Stability Oversight Council (FSOC), which was established in 2010 by Dodd-Frank, is charged with designating nonbank financial companies for enhanced prudential standards and Federal Reserve supervision as systemically important financial institution (SIFIs). FSOC designations can be made only pursuant to the standards and processes set forth in US federal law and are published annually.

While decisions reached by the FSB with respect to G-SIIs are not required by Dodd-Frank to be considered by FSOC, FSO has previously followed the designations made by the FSB when determining the entities to be designated as SIFIs. In particular, in July 2013, the FSB identified an initial list of nine multinational insurance groups it considered to be G-SIIs, including three based in the United States (AIG, MetLife and Prudential), and FSOC similarly designated those three insurers as SIFIs in 2014. In March 2016, however, the U.S. District Court for the District of Columbia rescinded MetLife’s designation as a SIFI, and in September 2017 FSOC rescinded AIG’s designation as a SIFI. Both MetLife and AIG remain designated as S-IIIIs by the FSB.

In April 2017, President Trump issued a Presidential Memorandum directing the Secretary of the Treasury to conduct a review of the SIFI designation processes of FSOC.
In October and November 2017, the US Treasury issued its reports, which, among other things, concluded that entity-based systemic risk evaluations of insurance companies are generally not the best approach for mitigating risks arising from the insurance industry. Instead, the November 2017 Treasury report recommended that FSOC shift to an activities-based or industry-wide approach. Specifically, the report recommended that FSOC implement a three-step process for assessing and addressing potential risks to financial stability: (1) review potential risks to financial stability arising from insurance activities and products; (2) if a potential risk to financial stability is identified, work with relevant state regulators to address the risk; (3) if it is determined, after such broader consultation, that a particular entity could pose a risk to financial stability, consider making a SIFI designation only after consultation with the state regulators.

The October 2017 Treasury report also recommended that the US members of the IAIS advocate for the IAIS to adopt an activities-based approach to systemic risk as well. In December 2017, the IAIS published an interim public consultation paper on adopting an activities-based approach to evaluating and mitigating systemic risk in the insurance sector. The consultation paper is currently open for comment through February 15, 2018. The IAIS plans to launch a second public consultation on its final proposals by the end of 2018 with a view to adopting policy measures conforming with an activities-based approach in 2019. This ongoing consultation follows the decision by the FSB not to publish a new list of G-SIIs for 2017. In so doing, the FSB explained that it welcomed and encouraged the work being undertaken by the IAIS to develop an activities-based approach to systemic risk in the insurance sector and noted that an activities-based approach, once developed, is likely to have significant implications for the assessment of systemic risk in the insurance sector and hence for the identification of G-SIIs and for G-SII policy measures. While the FSB has indicated that the IAIS will continue to collect data for the G-SII identification process, it is generally anticipated that this process will remain on hold until at least November 2018, when the FSB indicated that it will next review the progress made by the IAIS in developing an activities-based approach in November 2018.

### Latest Developments Regarding Insurer Capital Standards

As discussed in our 2016 Year in Review, the Board of Governors of the Federal Reserve System issued an advance notice of proposed rulemaking (ANPR) in June 2016 – effectively, a preliminary proposal – to solicit feedback on a conceptual proposal that would impose capital standards on insurers designated as SIFIs by FSOC, as well as on insurers subject to the Federal Reserve’s supervision as a result of affiliation with an insured bank or thrift. Concurrently, the Federal Reserve Board proposed enhanced prudential standards for SIFIs in the areas of corporate governance, risk management, and liquidity management and planning. The ANPR stated that the proposed capital standards were intended to complement the state-based insurance regulatory system, which tends to focus on policyholder protection. To date, the Federal Reserve Board has neither issued a formal proposal based on feedback received to the ANPR nor has it promulgated final enhanced prudential standards for SIFIs. Given that the framework that the ANPR proposed was principally predicated upon the SIFI designation regime, it is likely that the Federal Reserve Board will not take any further action in respect of the ANPR, or capital standards generally, pending next steps, both domestically and internationally, in respect of the regulatory approach to systemic risk (see Changing Approaches to Assessing Systemic Risk in the Insurance Industry).

In the meantime, bipartisan bills restricting the ability of the federal government to agree to or adopt any international capital insurance standards are advancing through the legislative process. The International Insurance Capital Standards Accountability (S.1360) was introduced in the Senate by Senators Dean Heller (R-NV) and Jonathan Tester (D-MT), and the International Insurance Standards Act (H.R. 4537) was introduced in the House of Representatives by Representatives Sean Duffy (R-WI) and Denny Heck (D-WA). The Senate bill is now included in a larger bipartisan banking reform bill, the “Economic Growth, Regulatory Relief, and Consumer Protection Act” (S. 2155), which was approved by the Senate Banking Committee on December 5, 2017 and is awaiting action by the full Senate. The House bill was adopted by the House Financial Services Committee and is now pending final approval from the House. Both the House Bill and the Senate Bill are likely to be consolidated (or one will simply be discarded) before becoming law.
That said, no vote is currently scheduled in respect of either bill. Both bills seek to create a specific process for Congressional review of international agreements and were introduced in response to criticisms of the IAIS by the NAIC, state insurance regulators and various US industry groups. Critics have pointed to the IAIS’s alleged lack of accountability and transparency, the incompatibility of its approach with the US state-based system of insurance regulation and concerns about the IAIS’s entity-based approach taken with respect to systemic risk. (see Changing Approaches to Assessing Systemic Risk in the Insurance Industry).

Both the House and Senate bills would impose new restrictions on insurance-related international agreements and reinforce the primacy of the US state-based insurance regulatory framework. For example, the House bill requires the rejection of any international agreement that is not “consistent with and reflective of existing federal and state laws, regulations, and policies on regulation of insurance, including the primacy of policyholder protection in solvency regulation.” Under both bills, US federal entities participating in negotiations with international bodies would be required to coordinate and consult with state insurance commissioners. In addition, Congress would need to be consulted prior to any international negotiations taking place, as well as during and prior to entering into any agreement. Congress would also have the final say on the approval of any international agreement. The Senate bill would also establish a federal advisory committee on capital standards.

Meanwhile, the US Treasury report issued in October 2017 recommended that the group capital initiatives by the NAIC, the states and the Federal Reserve be harmonized, to the extent possible, to mitigate duplicative and unnecessary regulatory burdens for US insurers. The report also stated that the Secretary of the Treasury would direct the Federal Insurance Office (FIO) to coordinate this work and to advocate for the US approach to group capital in international forums.

The NAIC has indicated that it is working collaboratively with the Federal Reserve to develop capital standards. The NAIC Group Capital Calculation (E) Working Group continues to develop a risk-based capital (RBC) aggregation methodology that includes (i) creating an inventory of the group’s insurance and non-insurance members, (ii) determining whether an entity should be included in the group capital calculation, and (iii) if so, determining the appropriate method for calculating the entity’s capital. The NAIC has been consistent in assuring the insurance industry that it does not intend for the final methodology to be incorporated into law or used prescriptively by regulators; instead, the calculation is merely intended as a tool to help understand a group’s aggregate available capital. The NAIC is still developing the boundaries of the model and is testing it with information voluntarily submitted by insurers. An initial version of the tool is scheduled to be available by late March or early April 2018.

DOL Fiduciary Rule Update – Where Are We Now?

In April 2016, the U.S. Department of Labor (DOL) replaced its 1975 regulation that set the parameters for determining when a person should be treated as a fiduciary under ERISA when providing advice with respect to investment matters (the “Fiduciary Rule”). The new regulation treats persons who provide investment advice or recommendations for a fee or other compensation with respect to assets of a plan or IRA as fiduciaries in a much wider array of relationships than was true under the 1975 regulation. In connection with the publication of the new Fiduciary Rule, the DOL also published two new administrative class exemptions from the prohibited transaction provisions of ERISA and the Internal Revenue Code—the Best-Interest Contract (BIC) Exemption and the Principal Transactions Exemption—as well as amendments to Prohibited Transaction Exemption (PTE) 84-24, commonly relied on for the sale of insurance contracts to ERISA plans. Just as the insurance industry geared up for these major changes, the DOL began to backpedal as a result of the change in administration and new leadership at the DOL. So where are we now?

- On November 27, 2017, DOL further extended its previously-announced “transition period” for the BIC Exemption and Principal Transaction Exemption (PTE 2016-01 and 2016-02, respectively) for 18 months until July 1, 2019, and further delayed the applicability date of certain amendments to PTE 84-24 (relating to the sale of insurance contracts) for the same period.

- DOL announced in Field Assistance Bulletin (FAB) 2017-03, dated August 30, 2017, that it will not pursue a claim against any fiduciary based on failure to satisfy the BIC Exemption or the Principal Transactions Exemption, or treat any fiduciary as being in of either of
these exemptions, if the sole failure of the fiduciary to comply with the contract requirement under either exemption is the inclusion of an arbitration agreement preventing investors from participating in class-action litigation. DOL noted that the US Government is no longer challenging such arbitration agreements. FAB 2017-03 states that this policy will continue to apply as long as the exemptions would be unavailable upon the inclusion of such an arbitration agreement.

- To date, nothing further has been published by the DOL with respect to its general non-enforcement policy set forth in Field Assistance Bulletin 2017-02, dated May 22, 2017. As a review, in FAB 2017-02, DOL announced that during the phased implementation period ending on January 1, 2018, the DOL will not pursue claims against affected parties who are working diligently and in good faith to comply with the fiduciary rule and exemptions and will not treat those parties as being in violation of the fiduciary rule and exemptions; and further noted that to the extent that circumstances surrounding the applicability date of the fiduciary rule and exemptions give rise to the need for other temporary relief, the DOL will consider taking such additional steps as necessary.

- The comment period for the DOL’s request for information on the Fiduciary Rule published on June 29, 2017 closed on August 7, 2017. Hundreds of comments were submitted and are currently under review by DOL.

- At the end of December 2017 Preston Rutledge was approved to head the Employee Benefits Security Administration – the division of the DOL directly responsible for the Fiduciary Rule. This development should help move forward the DOL’s efforts to reshape the rule.

- SEC Chairman Jay Clayton testified on fiduciary standards of conduct for financial professionals before the Senate Committee on Banking, Housing and Urban Affairs. In his testimony Clayton assured the Committee that the SEC is engaging expeditiously and constructively with the DOL regarding the changes being considered to the Fiduciary Rule. Clayton also stated that the SEC is seeking to develop standards for financial professionals that are consistent across retirement and non-retirement assets and coordinated with other regulatory entities. Labor Secretary Acosta has echoed the need for uniform standards of conduct in various informal statements attributable to him. The imposition of divergent standards for dealings by financial professionals with retail customers has been a major source of confusion and criticism.

The take away for the insurance industry is that the landscape for the Fiduciary Rule is likely to change significantly, but not in the near future. The DOL’s non-enforcement policy provides some relief during this transition period but still requires affected parties to make diligent, good faith efforts to comply. Insurance providers should also be aware that the DOL’s policy will not protect them from private claims.

**New York’s Proposed “Best Interest Rule”**

On December 27, 2017, New York Department of Financial Services (NY DFS) proposed a revision to the New York annuity suitability rule that would apply a “best interest” standard to all annuity and life insurance recommendations in New York (the NY Best Interest Rule).

The NY DFS press release announcing the NY Best Interest Rule frames it as a response to the recently delay of the DOL’s Fiduciary Rule, which is now scheduled to go into effect July 1, 2019, but may be delayed further or abandoned altogether by the Trump Administration. However, unlike the Fiduciary Rule, the NY Best Interest Rule applies to recommendations outside of retirement accounts but not to those to buy or sell mutual funds or other securities (except to the extent a recommendation would be tied to the purchase of annuity or life insurance product).

In extending its scope to include sales of life insurance as well as annuity products, the NY Best Interest Rule goes further than the NAIC Annuity Suitability (A) Working Group’s December 2017 draft revision to the NAIC’s Suitability in Annuity Transactions Model Regulation (the Draft NAIC Model). The NY Best Interest Rule and Draft NAIC Model also define best interest differently. The Draft 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.” The NY Best Interest Rule additionally requires the producer or insurer to act “without regard to the financial or other interests of the producer, insurer,
or any other party” and specifies that producers may not state or imply that the recommendation to purchase an annuity or a life insurance product is part of financial planning, financial advice, investment management or related services unless the producer has a specific certification or professional designation in that area. New York DFS Superintendent Maria Vullo has urged the NAIC to expand the scope of the Draft NAIC Model to also cover life insurance recommendations, in the same manner as the NY Best Interest Rule.

The NY Best Interest Rule is subject to a 60-day notice and public comment period that ends on February 26, 2018, with its final issuance expected soon after. Comments on the Draft NAIC Model were due by January 22, 2018 and are currently being considered NAIC Annuity Suitability (A) Working Group. It is anticipated that the NY Best Interest Rule will be issued prior to the finalizing of the Draft NAIC Model.

**New York Adopts a Comprehensive Cybersecurity Regulation**

On February 16, 2017, the NY DFS adopted a cybersecurity regulation – the first of its kind in the nation – that mandates cybersecurity standards for all institutions authorized by NY DFS to operate in New York, including many banks, insurance entities and insurance professionals. Significant portions of the cybersecurity regulation became effective in 2017, and other provisions will be phased in during 2018 and 2019.

The regulation applies to “Covered Entities,” defined as any person operating under or required to operate under a license, registration, charter, certificate, permit, accreditation or similar authorization under the New York Banking, Insurance or Financial Services Laws. Covered Entities include insurance companies that are licensed to do business in New York, as well as New York-licensed insurance agencies, brokers and claim-adjusting firms/TPAs. However, accredited reinsurers, certified reinsurers, non-New York risk retention groups and charitable annuity societies are excluded from the definition of Covered Entities, and NY DFS staff have also confirmed informally that excess and surplus line insurers are not Covered Entities.

Individual insurance agents and brokers can also be Covered Entities, although employees, agents, representatives or designees of a Covered Entity do not need to develop their own cybersecurity program to the extent they are covered by the Covered Entity’s cybersecurity program. There are also partial exemptions for entities that, together with their affiliates, have (i) fewer than 10 employees in New York (including independent contractors), (ii) less than $5 million in gross revenue in New York, or (iii) less than $10 million in assets. Those exemptions, however, are not self-executing. Exempt entities and individuals need to file a notice of exemption using an online NY DFS web portal in order to avail themselves of the exemption.

The regulation is largely keyed to the protection of nonpublic information, which is defined to include three categories of data: (1) business-related information, the unauthorized disclosure or destruction of which would cause a material adverse impact on the Covered Entity (e.g., trade secrets); (2) certain personally-identifiable information; and (3) certain health-related information.

Under the regulation, a Covered Entity is required to maintain a cybersecurity program that is based on its risk assessment and designed to accomplish six basic functions:

- identify and assess cybersecurity risks;
- protect information systems and nonpublic information;
- detect cybersecurity events;
- respond to identified or detected cybersecurity events and mitigate any negative effects;
- recover from cybersecurity events; and
- fulfill applicable regulatory reporting obligations.

A Covered Entity is required to implement its cybersecurity program through written policies and procedures that are based on its own risk assessment and approved by a senior officer or the board of directors. To the extent applicable, a Covered Entity’s cybersecurity policies and procedures must address the following extensive list of topics:

- information security;
- data governance and classification;
• asset inventory and device management;
• access controls and identity management;
• business continuity and disaster recovery planning and resources;
• systems operations and availability concerns;
• systems and network security;
• systems and network monitoring;
• systems and application development and quality assurance;
• physical security and environmental controls;
• customer data privacy;
• vendor and third party service provider management;
• risk assessment; and
• incident response.

One of the requirements of the regulation that has rightly garnered a lot of attention is the requirement for each Covered Entity to designate a Chief Information Security Officer (CISO). The CISO’s duties include:

• overseeing and implementing the Covered Entity’s cybersecurity program and enforcing its cybersecurity policies;
• providing an annual report to the board, assessing material cybersecurity risks, compliance with the cybersecurity program, cybersecurity events and the overall effectiveness of the cybersecurity program;
• approving and periodically reviewing the application security policy;
• approving any non-use of multi-factor authentication on external networks; and
• annually reviewing the approved use of compensating controls in place of encryption.

Beginning in 2018, the chairman of the board of directors or a senior officer of the Covered Entity is required to submit an annual certification to the NY DFS by February 15 of each year. The certification form is a fixed text (set forth in an appendix to the regulation) that states that to the best of the certifying individual’s knowledge, the Covered Entity’s cybersecurity program complies with the regulation. The NY DFS has indicated in its FAQs that if a Covered Entity is not in compliance with all applicable requirements of the regulation, then it is not permitted to submit a certification. And to the extent that a Covered Entity that is in compliance identifies areas of needed improvement, it is required to document those issues and the plan for remediating them.

A Covered Entity is required to put in place a written incident response plan designed to enable it to promptly respond to and recover from a cybersecurity event that materially affects the confidentiality, integrity or availability of its systems. Additionally, Covered Entities must notify the NY DFS within 72 hours after becoming aware of any cybersecurity event that has a reasonable likelihood of materially harming any material part of the normal operations of the Covered Entity, or for which notice is required to be provided to any government body, self regulatory agency or other supervisory body.

Significant attention has been focused on the provisions of the regulation relating to third party service providers (TSPs). Third party vendor risk management has been a “hot button” issue with federal banking regulators for many years and its importance to cybersecurity was made clear by a number of high-profile data breaches where vendors were identified as the weak link. The NY DFS regulation addresses this concern by requiring Covered Entities to take specific steps to ensure that their TSPs have adequate cybersecurity policies. The regulation defines a TSP as a person that (i) is not an affiliate of the Covered Entity, (ii) provides services to the Covered Entity, and (iii) maintains, processes or otherwise is permitted access to nonpublic Information through its provision of services to the Covered Entity. By March 1, 2019, Covered Entities will need to implement policies and procedures to address: (1) the identification and risk assessment of their TSPs; (2) minimum cybersecurity practices required to be met by TSPs in order for them to do business with the Covered Entity; (3) due diligence processes used to evaluate the adequacy of cybersecurity practices of TSPs; and (4) periodic assessment of TSPs based on the risk they present and the continued adequacy of their cybersecurity practices.
Mayer Brown has discussed the NY DFS cybersecurity regulation in a number of articles, Legal Updates and seminars, including The New York State DFS Cybersecurity Regulation: Preparing for Compliance published in The Review of Securities & Commodities Regulation.

NAIC Adopts an Insurance Data Security Model Law

On October 24, 2017, the NAIC adopted an Insurance Data Security Model Law. The model law builds on existing data privacy and consumer breach notification requirements by requiring insurance licensees to comply with detailed requirements regarding its information security program and responding to and giving notification of cybersecurity events. The NAIC model law is similar in many respects to the NY DFS cybersecurity regulation. However, the model law text is more limited in scope and less prescriptive in its requirements than the NY DFS regulation. One of the benefits of a less prescriptive law is more flexibility for licensees. A corresponding downside is that each licensee will need to make its own judgments based on its risk appetite with respect to its compliance with the law. This will likely raise interpretive questions as states adopt the model law or statutes based on it.

The NAIC model law defines “licensee” as any person operating under or required to operate under a license or registration issued pursuant to a state’s insurance laws. Licensees include not only insurance companies, but also other types of business entities and individual professionals who are licensed under a state’s insurance laws (i.e., insurance agents and brokers). The model law expressly excludes from the definition of licensee: (i) purchasing groups or risk retention groups that are chartered and licensed in another state and (ii) assuming reinsurers domiciled in another state or jurisdiction.

The NAIC model law defines “nonpublic information” as any information that is not otherwise publicly available and that is (i) business-related information, the unauthorized disclosure or use of which would cause a material adverse impact on the licensee (e.g., trade secrets); (ii) information concerning an individual that could be combined with specified data elements to identify the individual (e.g., traditional personally identifiable information); or (iii) derived from an individual or health care provider and related to certain health care information (except for age and gender). Like the NY DFS cybersecurity regulation, the model law broadly defines nonpublic information to include business-related information rather than just customer information.

The NAIC model law sets limitations on what qualifies as a “cybersecurity event” that materially diverge from the NY DFS cybersecurity regulation. Specifically, the NAIC model law does not cover unsuccessful attempts to access nonpublic information and covers unauthorized acquisitions of encrypted nonpublic information only if the decoding key is also acquired. While diverging from the NY DFS approach, the NAIC model law is generally consistent with many state data breach notification laws that exclude unauthorized access to encrypted information from notification requirements.

Under the NAIC model law, each insurer is required to submit an annual certification to the insurance regulator of its state of domicile, affirming its compliance with the “information security program” provisions of the model law. The certification must be submitted by February 15 for the preceding calendar year. In contrast to the NY DFS regulation, this annual certification requirement only applies to insurers, and not to insurance agents or brokers.

Employees and agents of a licensee who are themselves licensees are not required to develop their own information security programs as long as they are covered by their organization’s program. However, they remain subject to the other requirements of the model law, namely, the cybersecurity event investigation and notification requirements. A licensee that has fewer than 10 employees, including independent contractors, is exempt from the information security program requirements of the NAIC model law, and a licensee subject to the Health Insurance Portability and Accountability Act (HIPAA) may simply certify its compliance with HIPAA’s information security program requirements in order to satisfy the model law’s information security program requirements. The NAIC model law’s exemptions are somewhat narrower than those provided under the NY DFS regulation in that the model law does not provide a partial exemption for licensees with less than $5 million in gross revenue in a state or less than $10 million in assets.
Because the NAIC model law is only a model law, it will only apply to licensees in any given state if it is enacted into law by that state. Moreover, each state will have the freedom to modify the wording of the model law as it sees fit, so the actual adopted versions of the law may vary from state to state. Therefore, licensees need to carefully monitor when and how the model law is enacted into law in their states. Significant deviations among the states could make compliance more difficult.

Finally, while a drafting note indicates that the NAIC model law drafters intend compliance with the NY DFS cybersecurity regulation to satisfy a licensee’s obligations under the model law, the text of the model law does not contain an express exemption for licensees already subject to the NY DFS regulation, and it is unclear whether states will require additional documentation, or even a certification, to demonstrate that a licensee is in compliance with the NY DFS cybersecurity regulation.


New York Information Request on Life Insurers’ Use of Big Data

On June 29, 2017, the NY DFS issued a Section 308 information request to all life insurers and fraternal benefit societies licensed in New York regarding their use of Big Data. Section 308 of the New York Insurance Law authorizes the NY DFS to require New York-licensed insurers to submit written special reports on any topics specified in its information request.

The Section 308 request stated that the NY DFS had become aware of insurers’ use of external data or information sources (i.e., not provided by the consumer) in the underwriting of life insurance policies. Examples of such external information provided by the NY DFS included credit scores, purchasing habits, affiliations, home ownership records and educational attainment. The NY DFS letter noted that such data or information may be used to supplement traditional underwriting guidelines or as an alternative to physically invasive underwriting (e.g., paramedic examinations) as part of an accelerated or algorithmic underwriting program.

Companies that do not offer an accelerated or algorithmic underwriting program and limit their use of external consumer data sources for supplemental medical underwriting to attending physician statements, prescription drug databases and the MIB database, motor vehicle and inspection reports only needed to indicate that fact in their responses. However, for companies utilizing accelerated/algorithimic underwriting programs or non-traditional sources of external consumer data, they were required to answer a series of detailed questions. These questions ranged from technical (providing the policy form numbers that are impacted) to operational (disclosing the “specific” external data and explaining “exactly” how it is used, including software input and weights assigned to the data) to the more consumer-focused (describing the disclosures provided to the applicant, recourse available to the applicant for adverse underwriting decisions and use of the data following the underwriting process). For more on this topic, please see our July 2017 Legal Update.

NAIC Continues to Provide a Forum for Discussion of Insurers’ Use of Big Data and Innovation

The Fall National Meeting of the NAIC in December 2017 provided a lively forum for the discussion of insurer’s use of Big Data. At the meeting of the Big Data (EX) Working Group, there was extensive discussion of insurers’ use of consumer data. Birny Birnbaum of the Center for Economic Justice raised a number of questions, including the following:

- Are algorithms used for permissible and appropriate purposes or are they used for price optimization and claims optimization?
- Do algorithms promote risk-based pricing or encourage deviations from risk-based pricing?
- Do algorithms encourage or discourage loss mitigation?
- Is the data being used reliable?
- Is the data being used biased against certain groups of consumers?
- What type of notification should consumers receive if an adverse action occurs as a result of data not subject to the federal Fair Credit Reporting Act (FCRA)?
What rights do consumers have over consumer-generated data such as telematics data?

Should consumers be able to take their data from one insurer to another insurer, similar to how credit information and claims information is available to all insurers?

At the December meeting of the Innovation and Technology (EX) Task Force, Michael O’Malley from the American Insurance Association (AIA) gave a presentation on ways that state insurance regulators could operationalize the concept of the “regulatory sandbox.” He presented a draft of a proposed model law that would authorize state insurance regulators to grant targeted relief from specific insurance laws and regulations to allow the pilot testing of innovative insurance technologies, products and services, while also ensuring the preservation of consumer protections and providing protection for trade secrets.

The coming years will be important ones to see how the NAIC and individual state insurance regulators go about striking a balance between their mandate for consumer protection and openness to fostering technological innovation that has the potential to bring new benefits to consumers.

National Registry for Insurance Agents and Brokers Still Awaits Implementation

More than three years after the passage of the National Association of Registered Agents and Brokers Reform Act of 2015 (often called “NARAB II”), enacted as part of the Terrorism Risk Insurance Program Reauthorization Act of 2015, implementation of a streamlined process for nonresident insurance producer licensing remains elusive.

A provision in the federal Gramm-Leach-Bliley Act of 1999 (“GLBA”) provided for the creation of a National Association of Registered Agents and Brokers (“NARAB”), a nonprofit organization, to administer the nonresident licensing on a nationwide basis of insurance agents and brokers (referred to generically as “insurance producers”). However, the GLBA provided that NARAB would come into existence only if 29 US states failed to enact legislation providing for uniformity or reciprocity of multi-state producer licensing within five years. That prompted the NAIC to develop its Producer Licensing Model Act (PLMA) to streamline the nonresident licensing process for insurance producers, and a sufficient number of states adopted new licensing statutes based on the PLMA to prevent the creation of NARAB. Despite the adoption of PLMA by most states, however, the desired uniformity in the producer licensing process remained unfulfilled, as several large states continued to impose different requirements. This led to renewed calls for the implementation of NARAB, culminating in the enactment of NARAB II on January 12, 2015.

NARAB is to be governed by a Board of Directors, composed of eight state insurance commissioners (one of whom will serve as the chair person) and five industry representatives (three of whom must have expertise and experience with property and casualty insurance producer licensing and two of whom must have expertise and experience with life or health insurance producer licensing). Each of the Board members must be appointed by the President with the advice and consent of the U.S. Senate.

Former President Obama had nominated 10 of the 13 members required for the Board, but the Senate Banking Committee did not act on the nominations prior to the end of the 114th Congress, despite the fact that NARAB II mandated the appointment of initial Board members within 90 days after the date of enactment. President Trump has yet to comment on NARAB II, and it remains to be seen when the Board seats will be filled, which is a prerequisite to NARAB becoming operational.

NARAB, which has the support of the NAIC, the FIO and most of the insurance industry, will “provide a mechanism through which licensing, continuing education, and other nonresident insurance producer qualification requirements and conditions may be adopted and applied on a multi-state basis;” but will preserve the existing authority of state insurance regulators with respect to the following:

- Licensing, continuing education and other qualification requirements of insurance producers who are not members of NARAB;
- Resident or nonresident insurance producer appointment requirements;
- Supervision and discipline of resident and nonresident insurance producers;
• Establishing licensing fees for resident and nonresident insurance producers so that there is no loss of insurance producers licensing revenue to the state; and

• Prescribing and enforcing laws and regulations regulating the conduct of resident and nonresident insurance producers.

Once NARAB has been established, any insurance producer licensed in its home state will be eligible to become a NARAB member, provided that its home state license has not been suspended or revoked and the producer undergoes a criminal background check.

Penn Treaty Liquidation and Its Impact on the Insurance Insolvency Regime

On March 1, 2017, Penn Treaty Network America Insurance Company and its subsidiary, American Network Insurance Company (collectively, “Penn Treaty”), were ordered into liquidation by the Commonwealth Court of Pennsylvania. At the time, Penn Treaty had been in rehabilitation for more than eight years.

Penn Treaty, once the second-largest U.S. long-term care insurer, became insolvent and was placed into rehabilitation in April 2009. The primary reason for its insolvency was that the actual cost of long-term care far exceeded the actuarial calculations that were made at the time the policies were issued, with the result that Penn Treaty had been charging insufficient premiums to cover the cost of claims. When it was placed into rehabilitation, Penn Treaty had more than 126,000 policyholders nationwide. Later in 2009, after an analysis indicated that Penn Treaty would need an additional $1.3 billion to cover future claims, the Pennsylvania Insurance Commissioner petitioned the court to place the companies in liquidation. The petition was opposed by Penn Treaty, and after the parties failed to reach a settlement, the matter went to trial in 2011. In May 2012, the court denied the petition, and ordered the Insurance Commissioner to develop a plan of rehabilitation.

On July 27, 2016, the Insurance Commissioner again filed a petition to liquidate the companies on the basis that the companies remained insolvent and that their liabilities continued to exceed their assets. At the time, the Penn Treaty companies had a combined deficit of more than $4.33 billion, and were projected to run out of assets in 2018. The court relented, as it became clear that policyholders could not be asked to pay premium increases of 300% to get the company out of insolvency, and ordered the companies to be liquidated. Policyholder claims will continue to be paid through state guaranty associations, subject to statutory limits.

The insolvency of Penn Treaty has, of course, raised questions about whether there could potentially be additional insolvencies of long-term care insurers in the future. But in addition, the Penn Treaty insolvency has posed significant challenges to the state guaranty association system. When a state guaranty association becomes obligated to pay claims for an insolvent insurer, the economic burden falls on all of the other insurers who are licensed in the state to write the same line of business, because they have to pay assessments to replenish the funds of the guaranty association. In the case of long-term care association, there turned out to be a mismatch in the assessment process. Because long-term care insurance was classified as a form of health insurance for state insurance regulatory purposes, the guaranty fund assessments resulting from the Penn Treaty insolvency fell mainly on health insurers (including those who had never written any long-term care insurance), even though most long-term care insurance had been written by life insurers. This was widely perceived as unfair.

To address this issue, the NAIC adopted amendments to its Life and Health Guaranty Association Model Act on December 21, 2017. The amendments were designed to broaden the assessment base for guaranty association assessments relating to long-term care insurance. One of the major changes to the model act is a requirement for HMOs to become members of the life and health guaranty associations in the states where they do business, which will both extend guaranty association coverage to HMO members and expand the assessment base to include HMO premiums. The other major change is to allocate 50% of guaranty fund assessments for long-term care insurance insolvencies to accident and health insurers and 50% to life and annuity insurers. Like any NAIC model act, however, these changes will come into effect in any particular state only to the extent that they are enacted into law by the legislature of that state.
Looking Ahead – NAIC Priorities for 2018

Each year following the Fall National Meeting, the NAIC adopts a series of charges to its various committees, working groups and task forces, and collectively those charges comprise the NAIC’s agenda for the coming year. Many of these charges involve ongoing reviews and surveillance of issues of interest to state regulators and remain relatively unchanged from year to year. However, the appearance of new task forces and working groups, as well as new charges to existing bodies, provide a preview of areas likely to see significant activity in the coming year. Highlights of the charges for 2018 include the following:

- **Innovation:** Innovation continues to be a focus of the NAIC, as evidenced by its formation in March 2017 of the Innovation and Technology (EX) Task Force (ITTF) and the realignment of certain innovation-focused NAIC task forces under the ITTF’s purview. The ITTF’s role, according to the NAIC, will be to provide a forum for regulator education and discussion of innovation and technology in the insurance sector, to monitor technology developments that impact the state insurance regulatory framework and to develop regulatory guidance, as appropriate. The ITTF reports directly to the NAIC’s Executive Committee, and will oversee the Big Data (EX) Working Group and the Speed-to-Market (EX) Working Group. The ITTF also oversaw the Cybersecurity (EX) Working Group prior to the disbanding of that working group on December 5, 2017 (following the completion of its task of developing the new Insurance Data Security Model Law that was adopted by the NAIC on October 24, 2017). For more on this topic, see Technology and Innovation—Insurtech and NAIC Continues to Provide a Forum for Discussion of Insurer’s Use of Big Data and Innovation.

- **Global Capital Calculation:** The Group Capital Calculation (E) Working Group had previously been tasked with constructing a US group capital calculation using an RBC aggregation methodology, and those efforts will continue in 2018. The working group is in the process of collecting and analyzing data from nine volunteer companies in order to help inform the group’s formulation of the standard, and it is expected that a field test of a beta version of the group capital calculation will be conducted in 2018. It is likely that the working group will circulate an exposure draft of the group calculation in the first half of 2018, which will likely take into account some of the work being performed by the ComFrame Development and Analysis (G) Working Group on international capital developments and the group capital developments by the Federal Reserve Board.

- **Pet Insurance:** In 2016, Nationwide Insurance presented a proposal to the Producer Licensing (D) Task Force to remove pet insurance as a form of limited lines insurance eligible for relaxed producer licensing requirements. While only a handful of states have classified pet insurance as limited lines insurance, Nationwide’s proposal garnered sufficient commentary from interested parties to lead the Producer Licensing Task Force to request the creation of a separate NAIC working group to better address the complexities of pet insurance before deciding on the Nationwide proposal. The Property and Casualty Insurance (C) Committee approved the request and created a new Pet Insurance (C) Working Group during the 2017 Fall Meeting. The new working group is charged with developing a white paper on pet insurance, which would cover a summary of coverage options, product approval, marketing, rating, and claims practices within the industry.

- **Variable Annuities Captives:** The NAIC is expecting to close out its work on the use of captives to reinsure variable annuities in 2018. The NAIC formed the Variable Annuities Issues Working Group in 2015 to identify changes to the statutory accounting framework in order to mitigate or remove the motivation for insurers to use captive reinsurance transactions for variable annuity business. In response, the working group proposed in 2017 certain revisions to Actuarial Guideline 43, the C3 Phase II component of the RBC formula for life insurers and the statutory accounting rules regarding variable annuity hedging programs. The working group’s 2018 charges set a deadline for their completion no later than the NAIC’s 2018 Fall National Meeting.

- **Long-Term Care Insurance Issues:** The impact of the Penn Treaty liquidation described above, as well as the possibility of additional long-term care insurer insolvencies, continue to reverberate throughout the NAIC with a clear sense of urgency, as each of the charges of the Long-Term Care Insurance (B/E) Task Force of the Health Insurance and Managed Care (B) Committee and Financial Condition (E) Committee are scheduled to be completed by the end of 2018. These charges include more rigorously assessing the financial solvency of insurers writing long-term care insurance.
insurance, evaluating the sufficiency of current financial reporting and actuarial valuation standards, assessing state activities regarding the regulatory considerations on rate increase requests on blocks and identifying common elements for achieving greater transparency and predictability, coordinating state actions aimed at revising state guaranty fund laws, monitoring the development of regulatory policy regarding short duration long-term care insurance policies and considering product innovations and the development of potential state and federal solutions for stabilizing the long-term care insurance market.

- **Principle-Based Reserving:** Principle-based reserving (PBR) became effective as of January 1, 2017 and life insurers must comply with PBR no later than January 1, 2020. While this has led to the disbanding of several PBR-related task forces and working groups in 2017, the Valuation Analysis (E) Working Group remains charged with responding to issues regarding PBR, including assisting the NAIC in developing a standard asset/liability model portfolio to be used to calibrate company PBR models. In addition, the Life Risk-Based Capital (E) Working Group is charged with evaluating RBC in light of PBR.

- **Accreditation:** The Financial Regulation Standards and Accreditation (F) Committee will be considering in 2018 whether to adopt as an accreditation standard the 2014 revisions to the Insurance Holding Company System Regulatory Act providing authority to a designated state to act as a group-wide supervisor for an internationally active insurance group.

**UK**

In our *2016 Year in Review*, we discussed the Insurance Act 2015, which came into force on August 12, 2016. All insurance policies incepted since that date – during late 2016, 2017 and going forward – will be subject to the provisions of this Act.

The Insurance Act (as amended by the Enterprise Act 2016) also now introduces an implied term into all policies incepting on or after May 4, 2017 which requires the insurer to pay any sums due in respect of a claim under the policy within a “reasonable time”. What is “reasonable” here will depend on all relevant circumstances, including the type of insurance, the size and complexity of the claim, and factors outside the insurer’s control. This, in turn, gives the insured a right to pursue a claim for damages against the insurer in the event of late payment following a claim under the policy. Any such claim has to be pursued within one year from the date of payment.
Hong Kong

On June 26, 2017, the independent Insurance Authority (IA), established by the Insurance Companies (Amendment) Ordinance (ICO) enacted in mid-2015 officially took over the statutory duties of regulating insurance companies from the then Office of the Commissioner of Insurance, which was a Government department that has since been disbanded. The Ordinance had enhanced the regulatory regime of insurance companies, raising corporate governance standards to keep insurers accountable.

The new provisions of the ICO have broadly defined insurance intermediary activity which will be under its scope of regulation as “regulated activity” and includes activities such as negotiating and arranging insurance, inviting or inducing a person to enter into a contract of insurance and giving any regulated advice.

The ICO has also notably expanded the scope of regulatory oversight to cover direct regulation of insurance intermediaries, which is scheduled to take place within two years from the changeover. Insurance intermediaries are currently self-regulated by three different professional bodies. The Insurance Agents Registration Board regulates insurance agents, whereas insurance brokers are under the purview of Hong Kong Confederation of Insurance Brokers and the Professional Insurance Brokers Association. With the new IA set to replace the three self-regulatory bodies, stricter enforcement and regulatory actions over insurance intermediaries is expected.

The new provisions of the ICO give the IA strong powers of inspection and investigation, including entry of premises and requiring production of documents, records and answering enquiries.

Under the new Section VA of the ICO, the IA will be vested with similar regulatory and investigative powers as other financial regulators in Hong Kong (such as the Securities and Futures Commission and Hong Kong Monetary Authority). Under the new Sections 41B and 64ZZF of the ICO, the IA may conduct inspection to ascertain whether an authorised insurer or a licensed insurance intermediary is complying with the ICO, a notice or requirement given under the ICO or a term or condition of their license. They will have very broad powers of inspection and may enter a premise for inspection without a warrant. For example, at any reasonable time, the inspector may enter any premises of an insurer or insurance intermediary, inspect, make copies or otherwise record details of business records, and make enquiries of the insurer or intermediary. The inspector may also require any answers to be verified by statutory declaration and the interviewee is not entitled to exercise his or her right to silence. It remains to be seen whether dawn raids will be conducted, but the industry has been advised to expect such a possibility.

The IA may conduct an investigation if it has reasonable cause to believe that the ICO has been contravened, a person may have been involved in defalcation, fraud, misfeasance or other misconduct in relation to carrying on insurance business or regulated activity, or that a person is conducting insurance business or regulated activity. The IA investigator may require a person to produce documents, give an explanation or further particulars on documents produced, attend an interview with the investigator and answer in writing any questions raised by the investigator. Any explanations provided may be required by the investigator to be verified by statutory declaration.

For any bancassurance, the IIA investigator must consult with the Hong Kong Monetary before investigating employees of banks.

Failing to comply with the IIA’s requirements comes with strong implications such as offences. The IIA may apply to the Court of First Instance for an inquiry. If the failure was without reasonable cause and the person was knowingly involved, such person may be punished as if he or she was guilty of contempt of Court. Severe sanctions are in place for failing to comply with the IIA, including personal criminal liability for obstructing investigations or providing misleading or false information. If a person fails to comply with a requirement specified by the IIA without reasonable cause, the person commits an offence. It will also be an offence for a person to give false or misleading documents, answers or explanations.
Brazil

In 2017, the Brazilian insurance regulator Superintendence of Private Insurance (SUSEP) has enacted some relevant regulations. In November 2016, SUSEP issued Regulation no. 560/2017, which sets forth rules for the operation of loss of profits and business interruption insurance in Brazil. The new regulation establishes that four basic coverages may be offered by insurers, being coverage for loss of net profit, gross profit, gross revenue and fixed expenses.

In November 2017, SUSEP also enacted Regulation no. 559/2017, which refers to the standard terms and conditions for commercialization of Hangarkeepers’ insurance policies by Brazilian insurers. The new regulation establishes that the Hangarkeepers’ policies should offer basic coverage for damage to the hangar premises, damage to third-parties’ aircraft, as well as civil liabilities arising from aeronautical products.

In addition, in December 2017, the National Council of Private Insurance (CNSP) - the federal agency which is responsible for establishing general directives for the Brazilian insurance market and to which SUSEP is subordinated - issued Regulation no. 335/2017 with rules for mandatory aviation insurance, also known as RETA.

The new regulation aims to clarify the methodology of the calculation of the amounts under each mandatory coverage to air operators and also consolidates sparse rules established by the Brazilian Aeronautical Code and Resolution no. 37 of the Brazilian Civil Aviation Agency (which had been the object of several class actions and public inquiries by the Brazilian Public Ministry, as well as consumer defense entities).

Finally, on 22 December 2017 CNSP enacted its Regulation no. 353/2017, which brings two significant changes to the Brazilian reinsurance market: (i) subject to the fulfillment of certain conditions, cedants are able to transfer 100% of the risks to reinsurers belonging to the same economic group and (ii) there is no longer a market reserve for local insurers.
Tax
Tax

Tax Cut and Jobs Act Impact Insurance in Unexpected Ways

The biggest news on the insurance industry tax front in 2017 was undoubtedly the so-called Tax Cut and Jobs Act (TCJA) which was enacted in late December. The reduction of the corporate tax rate from 35% to 21% will have a significant impact on the insurance industry. In the TCJA, Congress took back from the insurance industry much of the benefit of the rate reduction by changing tax treatment of life company tax reserves (with a $15.2 billion increase in tax revenues to the government), P&C company reserves ($13.2 billion in additional tax), the change in capitalization of deferred organization costs ($7.2 billion) and many other smaller changes which raised additional revenue from the insurance industry.

We thought we would use this space to inform you about some lesser known changes brought by the TCJA, focusing on some changes that were not in the section of the legislation labeled “Subpart B – Insurance Reforms,” but which we believe will have an impact on the insurance industry.

Base Erosion Anti-Avoidance Tax

The main feature of the House Republicans’ summer 2016 “Blueprint for Tax Reform” was a proposal called the “border adjustment tax” (BAT) to impose an excess tax on imports. We recall spending many hours on the phone with insurance industry clients trying to figure out how the BAT might apply to insurance. When the Senate Finance Committee version of the bill narrowed the BAT to a “Base Erosion Anti-Avoidance Tax” (BEAT), which abandoned the excess tax on imports for a minimum tax on US taxpayers’ tax deductible payments to the related foreign parties, we analyzed whether reinsurance payments made from a US insurer to a related foreign reinsurer might be the type of base-eroding payment subject to the BEAT. At this stage of the legislation some argued that, pursuant to Section 803(a)(1)(B) or Section 832(b)(4)(B), reinsurance payments are not “deductible payments,” but are offsets to gross premium income, functionally similar to “costs of good sold,” and that reinsurance payments were not subject to the BEAT. However, the final version of the bill included what is now Section 59A(d)(3) of the Code which explicitly states that reinsurance payments to a related foreign person are “base erosion payments” subject to the BEAT.

Change in Definition of “United States Shareholder” for Subpart F Purposes

Buried deep in the international provisions of the TCJA is a rule that was probably aimed at the offshore insurance industry. Many offshore insurers include a provision in their by-laws to limit the voting power of any one shareholder to less than 10% of the total voting power of the company. These by-laws were originally crafted to keep large US shareholders of the offshore insurance company from being treated as a “United States shareholder” of the company. Under prior law, a “United States person” was a “United States shareholder” for Subpart F purposes only if the US person held 10% or more of the voting power of the foreign corporation. If “United States shareholders” owned more than 25% of the stock of a foreign insurance company by vote or value, then the foreign insurance company would be a “controlled foreign corporation” (CFC). The “United States shareholders of that CFC were required to include in their current taxable income the “Subpart F income” of the CFC regardless of whether the CFC distributed that “Subpart F income” as a dividend to its shareholders or retained that income in the foreign insurance company. Since insurance income is a type of Subpart F income, avoiding CFC status was necessary for major US shareholders to have a chance to achieve deferral of taxation on their share of the offshore insurance company’s insurance income. If the company’s by-laws provided no shareholder could cast more than 9.9% of the votes in any shareholder vote, no “United States person” could be treated as a “United States shareholder,” no matter if the “United States person” owned 10% or more of the economic interest in the company. Without 10% voting “United States Shareholders,” the foreign insurance company could not be CFC, and no shareholder had to report currently his share of the company’s insurance income or other Subpart F income.

The TCJA changed the definition of “United States shareholder” by adding the words “or 10 percent or more of the total value of all shares” to the Section 951(b) definition of “United States shareholder.” Thus, the voting cutback provisions no longer accomplish the goal.
of keeping a large US shareholder from being a “United States shareholder” for CFC purposes.

This change is unlikely to affect existing large public corporations that probably already have diverse ownership. But the change will make it harder for new offshore insurance companies to be formed by small groups of U.S.-based private equity or other investors without being treated as CFC’s during at least the early part of their existence.

Anti-“Hedge Fund Re” Provision

In recent years many offshore insurance companies were formed to qualify for the exception to the PFIC afforded to insurance companies for income from the “active conduct” of an insurance business. Critics argued that some of these companies were functionally close to hedge funds, with just enough insurance activity to qualify for the “active insurance” exception, and thus turn hedge fund investment income (which would otherwise be passive income subject to current taxation in a U.S. shareholder’s hands pursuant to rules regarding “passive foreign investment companies,” (PFICs) into “active insurance” income the tax on which could be deferred.

The TCJA added a further requirement to the PFIC insurance company exception. Under the new rules, the issuer must not only satisfy the “active conduct of an insurance business” test, but also must be a “qualifying insurance corporation.” A “qualifying insurance corporation” is a foreign corporation which would qualify for taxation as an insurance company if it were a domestic corporation and its applicable insurance liabilities constitute more than 25% (or 10% in certain cases to be provided in Treasury regulations) of the corporation’s total assets.

This change will make it harder for the “hedge fund re” type companies to qualify for the PFIC exception.

Insurance-Linked Securities

Insurance “sidecars” and “catastrophe bonds” are two types of well-established insurance risk transfer transactions. The change in the definition of “United States shareholder” for CFC purposes and the revision of the insurance exception for PFIC purposes will have an impact on these two risk transfer techniques.

Both “sidecars” and cat bond issuers are likely to be classified as “insurance companies” for tax purposes and, therefore, the entities must be treated as corporations rather than pass-through entities under the regulations under section 7701. An insurance “sidecar” is usually structured as a segregated cell of a Bermuda or Cayman segregated cell company (SCC). The general account, or “core,” of the SCC is typically owned by an insurance company which cedes risks it has incurred to a cell of the SCC in a reinsurance transaction. Investors purchase non-voting preferred stock of the cell for an amount equal to the aggregate amount of the reinsurance transaction. The cell then uses the proceeds of the offering to collateralize its reinsurance obligation. The “core” exercises control over the cell, but it has no economic interest in the cell. The offering documents generally state that there is some uncertainty whether the segregated cell is treated as a separate entity from the core, and consequently it is unclear whether the stock purchased by the investor is stock of the core or stock of the cell, and then describe the tax consequences for both alternatives. But the change in definition of “United States shareholder” to be a 10% vote or value test will be relevant to either view of the issuer. If a US person acquires enough stock in the offering to equal or exceed 10% of the value of the issuer, that investor will be a “United States shareholder” of the issuer for purpose of the CFC rules.

Catastrophe bonds are nominally debt securities of a special purpose insurance company. Because the special purpose reinsurer that is the issuer of a “cat bond” typically has de minimis equity, the “cat bonds” are treated as equity for tax purposes. The tax disclosure typically advises that the “cat bonds” could be treated as voting stock for CFC purposes. The change in the definition of “United States shareholder” to adopt a 10% of vote or value test makes clear that a U.S. investor who owns 10% of an issuer’s “cat bond” will be treated as a “United States shareholder” for CFC purposes.

Although “cat bond” disclosures generally expressed skepticism that the “cat bond” income would qualify as income from the “active conduct” of an insurance business for the prior-law PFIC exception, the addition of the “qualifying insurance corporation” 25% test made it even less likely that a “cat bond” special purposes reinsurer would qualify for the PFIC exception.
Case Law Developments
United States

Developments in Interpretation of Representations and Warranties

**Ratajczak v. Beazley Solutions Ltd.** [Seventh Circuit 2017]: Beazley Solutions Limited (Beazley) was sued in federal court in Wisconsin by the Ratajczak family, sellers of Packerland Whey Products, Inc. (the Company), for indemnity under a representations and warranties insurance policy (the Policy). The Ratajczaks sought indemnity for the amounts they paid to settle a claim made against them by buyers. Beazley denied coverage on the grounds that the thrust of buyers’ claim was that the Ratajczaks had defrauded them by failing to disclose that the Company had for many years engaged in a scheme to sell adulterated animal feed, and that fraud was excluded from coverage under the Policy. In addition, Beazley denied coverage on the grounds that the Ratajczaks had settled the claim without Beazley’s consent. Finally, Beazley asserted that buyers had not alleged breach of a fundamental representation in the sales contract, and that the sales contract capped liability for breaches of non-fundamental representations at $1.5 million, which was within the insured’s retention. The District Court granted summary judgment to Beazley because the Ratajczaks had failed to obtain Beazley’s consent before settling the claim and because the draft complaint provided by buyers before the Ratajczaks settled did not allege a breach of a fundamental representation. In August 2017, the Seventh Circuit Court of Appeals affirmed the summary judgment on both grounds.

The most important aspect of the Seventh Circuit’s decision for insurers is that it holds Beazley’s consent to settlement clause is absolute, finding that under New York law (the choice of law in the Policy) the insurer need not show prejudice to enforce the consent to settlement provision. The Court’s decision is also helpful for insurers on commercial policies in that it upheld the insurer’s choice of law provision on the grounds the policy involved a multi-jurisdictional business transaction (between a UK insurer with a New York-based adjuster and a Wisconsin insured) and sophisticated insureds.

Data Breach Litigation

**Kuhns v. Equifax Inc., et al.** [2017]: Plaintiffs have tried a different approach to crafting data breach-related D&O suits by styling their claims as securities class actions. In the wake of Equifax’s September 7, 2017, announcement that it suffered a “cybersecurity incident” potentially impacting 143 million US customers, a securities class action was filed in the Northern District of Georgia against the company, its Chairman and CEO, Richard F. Smith, and its CFO, John W. Gamble, Jr., alleging that they issued materially false or misleading statements or failed to disclose that “(1) the Company failed to maintain adequate measures to protect its data system; (2) the Company failed to maintain adequate monitoring systems to detect security breaches; (3) the Company failed to maintain proper security systems, controls and monitoring systems in place; and (4) as a result of the foregoing the Company’s financial statements were materially false and misleading at all relevant times.” The complaint alleges that the company’s stock price fell nearly 17% on account of the news of the data breach, a feature that makes this suit especially attractive to plaintiffs’ lawyers who usually file shareholder derivative suits in the absence of a significant stock price drop. The complaint also alleges that executives traded in company stock following the data breach but before they went public with the news.

This action was consolidated with hundreds of data-breach actions against Equifax, many of which are proposed class actions, and assigned to U.S. District Chief Judge Thomas Thrash Jr. for the Northern District of Georgia by the US Judicial Panel on Multidistrict Litigation.

It is still an open question whether the allegations in the complaint are sufficient to pass the motion to dismiss stage. Whether this suit presages a trend of more data breach-related securities class actions is worth keeping in mind in the coming year. A successful outcome for the Equifax plaintiffs may usher in similar securities class actions in the future. Companies whose business is dependent on safeguarding sensitive, nonpublic data and their D&O insurers may need to increasingly take the possibility of such suits into account.
Securities Litigation

As to insureds, this year saw prominent developments in several areas of law that may impact the insureds’ prospect of avoiding liability under federal securities laws.

California Public Employees Retirement System v. ANZ Securities, Inc. [2017]: The Supreme Court of the United States held that the three-year statute of repose under Section 13 of the Securities Act is not tolled by the tolling doctrine announced by the Court in American Pipe, an earlier Supreme Court decision holding that equitable considerations require the tolling of the statute of limitations for individual claims during the pendency of a class action. This decision resolved a circuit split between the Tenth Circuit, which held that the statute of repose is tolled under American Pipe, and the Second, Sixth and Eleventh Circuits which came out on the other side of the issue concluding that the American Pipe rule did not toll the statute of repose.

In 2008, investors brought a putative class action alleging that Lehman Brothers Holdings Inc. violated Section 11 of the Securities Act by issuing a registration statement for certain securities offerings that purportedly contained material misstatements and omissions. California Public Employees Retirement System (CalPERS) subsequently opted out of a class settlement to settle these claims and filed an individual action in 2011 based on the same allegations. Lehman Brothers moved to dismiss the individual action as untimely under Section 13’s three-year statute of repose since the alleged misstatements were made in 2007 and 2008. CalPERS argued that the American Pipe precedent tolled the statute of repose. A five justice majority of the Supreme Court disagreed. While the Court noted that a statute of limitations “[is] designed to encourage plaintiffs ‘to pursue diligent prosecution of known claims,’” the Court reasoned that the “object of a statute of repose, to grant complete peace to defendants, supersedes the application of a tolling rule based in equity.” Thus, the Court concluded that because Section 13 is a statute of repose, it “displaces the traditional power of courts to modify statutory time limits in the name of equity.” This decision allows class action defendants in cases where statutes of repose apply to better gauge the potential for individual claims and provides a clear rule that defendants can use to avoid facing individual claims filed after the three-year time bar.

City of Dearborn Heights Act 345 Police & Fire Retirement System v. Align Technology, Inc. [Ninth Circuit 2017]: In Omnicare v. Laborers District Council Construction Industry Fund, a 2015 decision, the Supreme Court held that in order to plead a Section 11 claim under the Securities Act based on an allegedly false or misleading statement of opinion, a plaintiff is required to plead both that the statement was actually false and that the defendant subjectively did not believe the truth of the opinion. In City of Dearborn Heights Act 345 Police & Fire Retirement System v. Align Technology, Inc., the Ninth Circuit extended the Supreme Court’s Omnicare holding to claims brought under Section 10(b) of the Securities Act. The litigation arose from Align Technology, Inc.’s acquisition of Cadent Holdings, Inc. in which it acquired Cadent for $187.6 million and represented that $76.9 million of the value was attributable to goodwill associated with certain of Cadent’s business units. The plaintiffs alleged that the purchase price of Cadent was inflated due to Cadent’s channel stuffing activities and that Align must have known of this inflation from its own due diligence. The district court interpreted Align’s goodwill valuations of Cadent’s business units as opinion statements and applied Omnicare to dismiss the action on the basis that the plaintiffs failed to plead that Align subjectively believed its goodwill valuations of Cadent’s business were false.

The Ninth Circuit affirmed the trial court’s decision and concluded that the plaintiffs failed to include “allegations of subjective falsity” in the complaint. According to the panel, the plaintiffs’ pleadings were flawed because they did not “allege the actual assumptions that Defendants relied upon in conducting their goodwill analysis.” “Without this allegation,” according to the panel, “it cannot be plausibly inferred that Defendants intentionally disregarded the aforementioned events and circumstances when conducting their goodwill analysis, such that the goodwill valuations were knowingly false or misleading when made.” By this decision, the Ninth Circuit joins the Second Circuit’s 2016 Tongue v. Sanofi decision which was the first instance in which Omnicare’s requirement of pleading subjective falsity for opinion statements was applied to Section 10(b) claims. The Ninth Circuit’s decision helps issuers avoid liability when making statements of opinion about proposed or pending transactions, provided such opinions are honestly held.
In re Petrobras Securities Litigation [Second Circuit 2017]: The Second Circuit clarified the “predominance” requirement for certifying securities class actions under Federal Rule of Civil Procedure 23(b)(3). Under Rule 23(b)(3), before certifying a class, the court must find that questions common to the class predominate over any question affecting individual class members. In Petrobras, investors alleged violations of the Securities Act and Exchange Act due to a scheme in which Petróleo Basileiro S.A. allegedly engaged in money-laundering and kickbacks. The district court granted class certification and Petróleo Basileiro S.A. appealed arguing that individualized questions concerning whether class members purchased stock in US transactions or through foreign exchanges predominated over questions common to the class. Petróleo Basileiro S.A. argued that these individualized questions are raised pursuant to the Supreme Court’s 2010 decision in Morrison v. National Australia Bank in which the Court held that federal securities laws do not apply extraterritorially to foreign purchases and sales.

The Second Circuit found that the district court failed to meaningfully address whether the issue of domesticity, i.e., whether the transactions complained of have a sufficient connection to the United States, is “susceptible to generalized class-wide proof” and remanded to the district court for a factual determination as to whether common questions predominate over individual questions. The Second Circuit noted that the proposed class included investors who purchased securities on the secondary market for which plaintiffs would have to show both that they acquired such securities in a domestic market and trace the particular notes to one of the “U.S-registered [o]fferings.” “In this case,” the panel concluded, “the potential for variation across putative class members—who sold them the relevant securities, how those transactions were effectuated, and what forms of documentation might be offered in support of domesticity—appears to generate a set of individualized inquiries that must be considered within the framework of Rule 23(b)(3)’s predominance requirement.” The plaintiffs have petitioned for review of this decision from the Supreme Court. Should this decision remain the applicable law, it makes it more difficult for plaintiffs to gain class certification where the proposed class includes both domestic and foreign purchasers of securities.

Arkansas Teachers Ret. Sys. v. Goldman Sachs Grp., Inc. [Second Circuit 2018]: The Second Circuit recently articulated the standard of proof a defendant would have to meet to successfully rebut the presumption that a plaintiff relied on the defendant’s alleged misrepresentations. By way of background, this rebuttable presumption was first articulated by the Supreme Court in Basic v. Levinson which held that a plaintiff bringing a securities fraud claim can be presumed to having relied on the integrity of the market price of that security as long as the plaintiff made a threshold showing that the security traded in an efficient market. Later, in Halliburton Co. v. Erica P. John Fund Inc. (Halliburton II), the Supreme Court clarified that securities class action defendants may rebut the Basic presumption by showing that the defendant’s alleged misrepresentations had no impact on the stock price.

In 2015 plaintiffs filed a complaint against Goldman Sachs in the Southern District of New York, alleging the bank made several material misstatements about its conflict-of-interest policies and practices that were revealed by a subsequent government investigation to be false. In the district court, the plaintiff moved to certify a class by invoking the Basic presumption. The Defendant presented evidence that the there was no price impact when the alleged misstatements were made and evidence that the price was unaffected by the “corrective disclosure” that plaintiff alleged first revealed the truth to the marketplace. The district court certified the class and stated that it is the defendants’ burden to demonstrate a “complete absence of price impact” by making a showing with “conclusive evidence that no link exists between the price decline and the misrepresentation.”

On appeal, the Second Circuit held that the district court should have applied a preponderance of the evidence standard when assessing the defendant’s evidence rebutting price impact instead of requiring “conclusive evidence” of a “complete absence of price impact” and remanded to the district court to reconsider the defendant’s evidence in light of this standard. This decision clarifies which standard a judge is to use when assessing a defendant’s rebuttal of the Basic presumption using lack of price impact evidence. It is particularly useful for defendants because it instructs the district court to apply a preponderance of the evidence standard, a standard much less stringent than the “conclusive evidence” criterion that had been first applied by the district court in this action.
US Supreme Court Cases

There are three notable securities cases in which the United States Supreme Court granted certiorari in 2017 and these matters are on the Supreme Court’s calendar for the 2017-2018 term:

(i) Leidos Inc. v. Indiana Public Retirement System; (ii) Cyan Inc. v. Beaver County Employees’ Retirement Fund; and (iii) Digital Realty Trust, Inc. v. Somers. The Leidos cases presents the question of whether the failure to make disclosures required by Item 303 of Regulation S-K is actionable under Section 10(b) and Rule 10b-5. Cyan Inc. presents the question of whether courts have concurrent jurisdiction for Securities Act liability or whether this jurisdiction was eliminated by Congress’ passage of the Securities Litigation Uniform Standards Act of 1998 (SLUSA). And Digital Realty Trust presents the question of whether Dodd-Frank’s anti-retaliation provisions protect whistleblowers who report internally within their companies, and not just whistleblowers who make reports to the Securities and Exchange Commission. The Supreme Court’s decisions in these cases will be closely monitored by securities litigators, corporations and D&O carriers.

UK and Europe

UK

AIG Europe Limited v OC320301 LLP & Ors [2017]: The Supreme Court examined the aggregation wording in the SRA Minimum Terms and Conditions of solicitors’ professional indemnity insurance. In circumstances where cover under the Minimum Terms cannot be subject to an aggregate limit of indemnity, the aggregation wording plays a vital role in determining the level of an insurer’s exposure. The Supreme Court clarified the interpretation of the aggregation provision in circumstances where 214 individual property development investors brought separate claims against solicitors insured by AIG. AIG argued that such claims ought to be aggregated together as a single (or, at most, two) “claims” for policy purposes, because they arose out of “similar acts or omissions in a series of related matters or transactions.”

The Supreme Court, finding in favour of AIG, held that aggregation clauses are to be read neutrally, in recognition that they sometimes benefit the insurer and sometimes the insured. As to whether matters or transactions are “related” (that being the key issue in this case), the Supreme Court held that determining whether transactions are related is an acutely fact-sensitive exercise, involving an exercise of judgement. For these purposes, “related” requires a real connection; some identifiable substantive link, or connection, beyond mere similarity; and some inter-connection between the matters or transactions, or, in other words, they must in some way fit together.

The Supreme Court recognized the weighty public policy factors in play insofar as the aggregation wording is concerned. On the one hand, consumers of legal services have an interest in ensuring that, when mistakes are made, their potential losses will be covered. On the other hand, there needs to be a market of insurers willing to afford cover to solicitors on commercially attractive terms. Where this tension has produced an aggregation clause that does not precisely address every factual scenario, it is important to exercise judgement when applying the aggregation clause to any given case.
Gard Marine and Energy Ltd & Anor v China National Chartering Company Ltd & Anor [2017]: In this decision, the Supreme Court considered the ability of an insurer to bring a subrogated claim against a co-insured. A majority of the Supreme Court held that, where the contractual arrangements between co-insured parties were intended to create an insurance fund that would be the “sole avenue” for making good the relevant loss or damage, it follows that the co-insured parties cannot claim against each other in respect of that loss. Where the insurer indemnifies the loss, therefore, it cannot bring a subrogated claim in the name of one co-insured against the other, nor can it bring a subrogated claim against a third party that is contingent upon the existence of liability between the co-insureds. Consequently, in Gard, where the owners of a ship and its demise charterers had obtained co-insurance, and where the ship suffered a total loss, the co-insurance scheme meant that the demise charterers were not liable to the owners for such loss. This, in turn, meant that the insurers could not bring a subrogated claim against either the demise charterer as a co-insured or against the sub-charterers who caused the ship to sink. The demise charterers had no liability to the owners on which a back-to-back claim against the sub-charterers could be based.

Redman v Zurich Insurance Plc & Anor [2017]: In 2016, the Third Parties (Rights Against Insurers) Act 2010 finally came into force. The purpose of this 2010 Act, and that of the 1930 Act it replaced, is to enable claimants to bring claims for compensation directly against the insurers of insolvent defendants. The 2010 Act introduced changes which (among other things): (1) enable a claimant to bring a single set of proceedings against both the insured and insurer (there is no longer any need for the claimant first to establish liability on the part of the insolvent insured, and only then to pursue a separate, direct claim against the insurer); and (2) clarify the extent to which the claimant is entitled to obtain information about the insurer and the insurance policy as soon as the defendant becomes insolvent.

Against this backdrop, the Court in Redman clarified that the 1930 Act continues to apply in situations where both the insured became insolvent, and the insured’s liability to the claimant was incurred, before August 1, 2016. To this end, liability is incurred when damage is caused, not when liability is established by a Court judgment or otherwise. This is likely to mean that, going forward, the 1930 Act will continue to apply in a large number of situations.

(1) Timothy Crowden and (2) Carol Crowden v QBE Insurance (Europe) Limited [2017]: Crowden concerned a claim pursued directly against the insurer of an insolvent financial advisor, under the Third Parties (Rights Against Insurers) Act 1930. The insurer applied to strike out the claim on the grounds that (among other things) the claim against the financial advisor was excluded from cover by an insolvency exclusion in the policy, which excluded the insurer’s liability for claims “arising out of or relating directly or indirectly to the insolvency or bankruptcy of” various entities, including (on the facts of the case) the issuers of securities to the claimant.

The claimant argued that the exclusion clause ought to be construed narrowly, in line with the approach adopted towards exemption clauses in ordinary contracts. However, the Court disagreed, and found that the wording of the insolvency exclusion was relatively clear. The use of the words “arising out of or relating directly or indirectly to” meant that the insolvency of the security issuers could be more remote than a proximate cause of the claim, although it nevertheless had to stand out as a contributing factor. On the facts, this test was satisfied. The Court therefore summarily dismissed the claim.

This decision is the latest in a line of authorities where the Courts have resisted attempts by claimants to construe exclusion clauses under insurance policies in a narrow manner. The Court went so far as to make it clear that such exclusion clauses are “wholly distinguishable” from exclusion of liability clauses in other contracts, because they form part of the definition of the scope of cover being afforded under the policy, rather than an attempt to exclude primary legal liability.

Oldham v QBE Insurance (Europe) Limited [2017]: In refusing a challenge to an Arbitration award, the Court provided useful clarification of the meaning and effect of clause 10.2 of the Institute of Chartered Accountants of England and Wales’ minimum terms for professional indemnity insurance. Clause 10.2 states: “In the event of any dispute concerning liability to indemnify the Insured ... the Insured and the Insurers agree that Insurers will advance Defence Costs and indemnify the Insured ... pending resolution of any such dispute”.

A claim was brought against the insured accountant. Insurers disputed coverage of the claim, which they considered had been first made prior to inception of
the policy, but nevertheless advanced Defence Costs to the insured (in accordance with Clause 10.2) while the coverage dispute was determined by way of Arbitration. The Arbitrator held that the claim did not fall for cover. Furthermore, the Arbitrator held that Clause 10.2 entitled Insurers to claw back from the insured the amount of Defence Costs advanced, given that cover under the policy was not triggered. This interpretation of Clause 10.2 was upheld by the Court.

**Ted Baker v AXA Insurance** [2017]: The insured suffered losses arising from employee theft, and sought an indemnity in respect of the same from insurers. The insurers declined cover, on the basis that the insured failed to comply with a claims cooperation clause (a condition precedent) by failing to provide certain profit and loss and management accounts when requested.

Such accounts had been requested from the insured by a loss adjuster during a meeting, at which the insured had suggested disclosing such accounts once policy cover had been confirmed. The loss adjuster had agreed to take instructions from insurers, but nothing further was ever heard, and in future correspondence there was no indication given to the insured that any information was outstanding.

The insured argued that the insurers were estopped from avoiding cover on the grounds of the alleged breach of condition precedent. The Court of Appeal held that such an estoppel may arise if “in the light of the circumstances known to the parties, a reasonable person in the position of [the insured] would expect the other party [i.e. the insurers] acting honestly and reasonably to take steps to make his position plain”. The Court of Appeal described this as “a form of estoppel by acquiescence arising out of a failure to speak when under a duty to do so”. On the facts of the case, the Court of Appeal found that the insured could reasonably expected the insurers to say if they required the accounts, especially if the absence of such information was considered fatal to the claim. Accordingly, an estoppel arose. The Court of Appeal was keen to stress that this outcome was not a product of the good faith relationship between insured and insurers – rather, it was derived from general commercial law principles. Exactly how far such a “duty to speak” might go does, however, remain to be seen: the Court of Appeal also accepted that “an insurer is, generally speaking, under no duty to warn an insured as to the need to comply with policy conditions”.

**Germany**

On February 22, 2017, the German Supreme Court ruled on the scope of cooperation obligations according to Art. 31 of the German Insurance Act.

The claimant insured held an occupational disability benefit policy issued by the defendant insurer. The claimant sought pension payments under this policy, on the grounds that he was suffering with a case of occupational disability (burn-out syndrome).

The insurer sought disclosure of all of the claimant's medical records, both for the purposes of assessing the claim under the policy and the insurer’s obligation to pay, and also to enable suspected breaches by the insured of his pre-contractual notification obligations to be investigated.

The claimant, however, agreed only to provide a limited release of medical data insofar as it related to his capacity for work. The insurer therefore declined cover.

The German Supreme Court upheld the decisions of the Regional Court and Court of Appeal, finding that the claimant’s right to benefit under the policy did not arise until the insurer had completed its investigations into all the circumstances relevant to the case – which included ascertaining whether the alleged disability had occurred before the inception of the policy, and therefore whether the insurer might be entitled to avoid the policy for non-disclosure. To that end, the insured has a duty to disclose pre-inception information to the insurer.

In reaching this find, the German Supreme Court recognized that restrictions might apply to this “full disclosure” obligation upon the insured where there are no indications of potential pre-inception non-disclosure or fraud.
France

Apart from long-standing disputes on recurring issues, developments in French insurance law during 2017 are marked by the following:

**In loan insurance matters:** The establishment, by the law No. 2017-203 dated February 21, 2017, of the right for borrowers of property loans to terminate their insurance contracts at the end of each contract year, and therefore change the insurance securing the repayment of their loan on an annual basis. This legal development addresses the difficulties that previously affected borrowers who had taken out their loan, and therefore their insurance coverage, before the recognition by the laws of July 1, 2010 and of March 17, 2014 of an option to substitute, under certain conditions, the insurance provider proposed by the lender with an insurer of the borrower’s election within one year following the signature of the loan offer.

**In life insurance matters:** The publication of decree No. 2017-1104 of June 23, 2017, specifying the rules for the application of article L. 131-4 of the French Insurance Code (derived from law No. 2016-1691 of December 9, 2016), known as “Sapin 2 law on Transparency, Fight against Corruption and on the Modernization of Economic Life”. Sapin 2 allows the Haut Conseil de stabilité financière (HCSF) (Financial Stability Board) to adopt macro-prudential conservatory measures against insurance companies and, in particular, to temporarily limit the payment of the cash value of a life insurance policy. The new decree establishes the triggering threshold for such a potential restriction measure and recalls the information to be provided to subscribers, policyholders and beneficiaries of the contracts. In this regard, the insurance company must “describe the measures adopted and their planned or anticipated duration” and inform about the “conditions of postponement and revocability of the transaction request that would not be performed in all or in part” and of the “terms of payment of the transactions on the contract”. It must also justify to the Autorité de contrôle prudentiel et de résolution (ACPR) (French Prudential Control Authority) the reasons for its decision to suspend or restrict the transactions on the contract.

**In general insurance contract matters:** The continuation, by the case law, of two approaches regarding the validity of exclusion of liability clauses based on L.113-1 of the French Insurance Code, which provides that insurers are not liable for losses and damage resulting from a *faute dolosive* (fraudulent breach) or *faute intentionnelle* (intentional breach) on the part of the insured. The first approach has focused upon *faute dolosive*, interpreted as a fault committed by the agent with the knowledge that the damage was inevitable or, at the very least, very likely. This co-exists with the second approach, focusing upon *faute intentionnelle*, where case law has continued to insist upon an intention on the part of the insured to cause the damage the way it occurred.

**In civil liability insurance in respect of the use of motor vehicles:** A decision of the Court of Justice of the European Union of July 20, 2017 held that an insurer who entered into a contract based on the omissions or false statements made by the insured cannot invoke the legal provisions on the nullity of the contract either against third-party victims or on the basis of non-disclosure of the fact that the insured is not the usual driver. The immediate impact of this decision is to render article R. 421-5 of the French Insurance Code, which specifically provides for enforceability in matters of insurance against civil liability in respect of the use of motor vehicles, non-compliant. Consequently, by this decision, the case law which declares the nullity provided for by article L. 113-8 of the French Insurance enforceable against any beneficiary of the guarantee has been challenged. In addition, it could further be inferred that the Fonds de garantie des assurances obligatoires de dommages (FGAO) (Mandatory Third Party Liability Insurance Guarantee Fund) will see its charges reduced as they will be borne by the insurer providing coverage for the relevant vehicle.
The Court of First Instance quashed Payment Order made by the IARB

In February 2014, an insurance agent’s insurance registration was revoked for seven years and a payment order of HK$806,200.00 was made against his principal, AIA, by the Insurance Agents Registration Board of the Hong Kong Federation of Insurers who found that the agent fraudulently misappropriated funds he had received from his client and that he had created false documentation in an attempt to deceive clients and conceal his dishonest activities. AIA appealed against the IARB’s decision at the Appeals Tribunal of the Hong Kong Federation of Insurers but it was dismissed without hearing.

In May 2017, AIA sought a judicial review of the Appeals Tribunal’s decision before the Court of First Instance and the Court found for AIA. It concluded that while the IARB could require the principal to repay premiums resulting from the misconduct of its agents or reinstate the policy if the premiums were misappropriated by the agent and never received by the insurer, in this case, no actual insurance policy existed. As such, the payment order did not constitute a repayment of premium and the payment order should not have been made. Further, the Court opined the IARB’s order was made in breach of justice as no oral hearing was held and AIA had not been given any prior notice regarding the payment order. The matter has been remitted back to the Appeal Tribunal for rehearing where there will be submissions by AIA whether it ought to be held responsible for the agent’s misconduct.

The defendants were both convicted for driving with a blood alcohol level above the prescribed limit and using a motor vehicle without third party insurance. They appealed against their convictions under the Motor Vehicles Insurance (Third Party Risks) Ordinance (Cap. 272) (MVIO), arguing that the policies limiting insurers’ liabilities was contrary to section 12(1)(a), which stipulates that any restrictions placed on a drivers’ age, physical or mental condition in a certificate of insurance was of no effect. The Court agreed with the defendant’s arguments, stating that on both a literal and purposive construction of the Road Traffic Ordinance and the MVIO, a restriction based on the proportion of alcohol in a driver’s urine, blood or urine was “clearly a restriction by reference to the driver’s physical condition”. The defendants’ convictions were both set aside.

Hong Kong insurers should re-examine the wordings and the effect of their conduct exclusion clauses in light of this judgment.

Secondary Charge of not having Third Party Insurance in Drunk Driving Cases

Third Party Insurance Policies

In the recent Hong Kong judgment of HKSAR v Law Wing Fai [2017] 4 HKLRD 352, the court overruled the restriction commonly found in third party insurance policies stating that insurers would not be liable for any loss or damages arising from the insured’s negligence in a traffic accident where the amount of alcohol in the insured driver’s blood, breath or urine exceeded the legal limit.

The defendants were both convicted for driving with a blood alcohol level above the prescribed limit and using a motor vehicle without third party insurance. They appealed against their convictions under the Motor Vehicles Insurance (Third Party Risks) Ordinance (Cap. 272) (MVIO), arguing that the policies limiting insurers’ liabilities was contrary to section 12(1)(a), which stipulates that any restrictions placed on a drivers’ age, physical or mental condition in a certificate of insurance was of no effect. The Court agreed with the defendant’s arguments, stating that on both a literal and purposive construction of the Road Traffic Ordinance and the MVIO, a restriction based on the proportion of alcohol in a driver’s urine, blood or urine was “clearly a restriction by reference to the driver’s physical condition”. The defendants’ convictions were both set aside.

Hong Kong insurers should re-examine the wordings and the effect of their conduct exclusion clauses in light of this judgment.

The Judiciary’s Guide for Solicitors’ Hourly Rates to Increase Higher Costs Recoverable

Overview

The Law Society of Hong Kong (the Law Society) announced to its member in a circular on 11 December 2017 that the Solicitors’ Hourly Rates (SHR) on party and party taxation in civil proceedings will be increased effective from 1 January 2018 onwards. This will mean that the winning party of an action can recover a higher sum of legal costs for work done by their solicitors from the losing party. The existing rates will continue to apply for work done by solicitors up to 31 December 2017.

The SHR

Parties are required by Practice Direction 14.3 issued by the Judiciary to attempt to reach an agreement on the sum of costs payable to the party entitled to costs. Only if they are unable to do so should they proceed to “Taxation of costs” by a taxing master, whereby the court assesses the amount of costs payable at a sum it considers to be necessary or proper for the attainment of justice or for enforcing or defending the party’s rights.
The Revised Rates

The revised rates will apply in the taxation of solicitors’ costs starting from 1 January 2018 will have an impact on civil litigation.

The increase in SHR means that successful litigants will recover more costs and the increase is significant. Insurers would be well advised to monitor their reserves for legal costs in civil litigation. It is worthy to note that the Working Group recommended that the SHR be reviewed regularly every four years to take into account inflation which shall be measured according to the Composite Consumer Price Index (CCPI) and monitored by the Judiciary.

The SFC’s Manager in Charge Regime

Introduction

The Securities and Futures Commission (SFC) has focused on tackling market misconduct against senior executives this year by enforcement actions. The targeted scope is not limited to directors alone and will include responsible officers, shadow directors and Managers-In-Charge of Core Functions (MICs). MICs are determined by an individual’s seniority and authority within the corporation. They should hold a senior position with authority to manage and make decisions on an everyday basis. The SFC will take civil and criminal actions against those individuals where enough evidence is presented.

Enforcement Actions

Five notable enforcement actions tackling market misconduct were taken by the SFC against senior executives this year.

On February 20, 2017, the SFC obtained a 12 year disqualification order and an compensation order of HK$84,880,000.00 with compound interest in the Court of First Instance against Mr. Yeung Chung Lung, former chairman and executive director of First Natural Foods Holding Limited, for embezzlement and provision of false bank statements to auditors.

On February 28, 2017, the Market Misconduct Tribunal (the MMT) found Mr. Nagai Michio, the CEO and Mr. Ng Chi Ching, the Financial Controller of Yorkey Optical International (Cayman) Limited, guilty for Yorkey’s 13 week delay disclosure of its material loss in the second half of 2012. The MMT considered this as failure to disclose inside information as soon as reasonably practicable. Hence, Yorkey and Mr. Nagai were fined HK$1 million dollars each. Further, Mr. Nagai and Mr. Ng were disqualified for 18 and 15 months respectively.

In another case, the MMT fined Mayer Holdings Limited and nine of its previous and current senior executives HK$10.2 million dollars each for failure to disclose inside information as soon as reasonably practicable. Two former executive directors were additionally fined HK$1.5 million dollars each and disqualified from being a director for 20 months.

The MMT also took action against Greencool Technology Holdings Limited’s former chairman and CEO for disclosing false or misleading information and for inducing transactions by grossly overstating the corporation’s sales, profit, bank deposits, trade receivables and the company’s net asset value. The MMT imposed disqualification orders ranging from three to five years against the senior executives, a cold shoulder order against the CEO to prevent him from dealing in any securities, futures contract or leveraged foreign exchange contracts, or any interest in related products, and cease and desist orders against the senior executives to prevent them from engaging in any further misconduct.

Finally, in September 2017 the SFC obtained disqualification orders against the former chairman and four current independent non-executive directors of Hanergy Thin Film Power Group Limited due to their conflict of interests, their failure to exercise reasonable care and diligence in connection to an undisclosed loan, failure to make appropriate disclosure about the viability of the corporation’s business model, to properly assess the financial positions of connected parties, and to take proper steps to recover receivables. The trading shares of the corporation was also suspended.

MIC Regime

The SFC is beginning to take a more focused approach to enforcement and will be focusing on individual culpability from the inception of any investigation. At the SFC’s Keynote speech at 8th Pan Asian Regulatory Summit on October 11, 2017, Mr. Thomas Atkinson, the Executive
Director of the Enforcement Division, announced the implementation of the Manager-in-Charge regime, which requires firms to identify those individuals in charge of core functions and map out their responsibilities and reporting lines. This aims to help the enforcement team to identify individuals who should be regarded as senior management of a licensed corporation and assist them in identifying responsible individuals when issues arise. With the change in focus by the SFC, D&O carriers should take note that the risk of investigation or enforcement action is not limited to directors of the listed company but also senior managers. As such, they should anticipate the possibility of more enquiries and investigations at the senior manager level as well.
Technology & Innovation
Insurtech

Insurtech Deal Volume Continued to be Robust

According to data compiled by CB Insights and FT Partners, there was a record number of insurtech equity funding transactions in 2017. While 2017 also saw a record number of +$50 million deals, 2017 did not have the mid-to-high nine-figure deals that impacted the statistics in the prior two years (ZhongAn (+$900 million) and Zenefits ($500 million) in 2015; Oscar ($400 million) and Sedgwick ($500 million) in 2016). As a result, despite the increase in deal volume, 2017 saw a modest year-over-year decrease in the aggregate amount invested in this sector.

Strategic and Corporate Investors Continue as Drivers of Deal Volume

While traditional venture capitalists continue to supply the majority of funds to insurtech start-ups, strategic and corporate venture capitalists continued to be active investors in insurtech companies in 2017. According to FT Partners, corporate and strategic investors participated in 36% of all financings in 2017, up from just 12% in 2014.

Some of the largest and most active corporate investors in 2017 were AXA Strategic Ventures and MassMutual Ventures, each with seven publicly announced investments made in insurtech companies in 2017. According to FT Partners, corporate and strategic investors participated in 36% of all financings in 2017, up from just 12% in 2014.

Insurers Landed the Biggest Insurtech Financings of 2017

Some of the largest financing deals of 2017 were landed by companies that provide insurance, including two that raised significant amounts in 2016. For example, health insurance startup Clover raised $130 million in a round of financing that included Greenoaks Capital Management, Google Ventures, Sequoia Capital and Western Technology Investment. Clover is a full service health insurance provider that allows senior citizens who use private versions of Medicare to purchase insurance. Clover's model combines data analytics with preventative care in order to help customers stay healthy. Since last year, Clover has expanded from a selected number of counties in New Jersey to Georgia, Texas and Pennsylvania.

In addition, digital home insurer Lemonade returned to the market with a $120 million round of financing from an investor group that included Softbank, Thrive Capital, Google Ventures, General Catalyst, Allianz, Sequoia Capital and XL Innovate. Lemonade, an online provider of low-cost renters and homeowners insurance, previously raised $47 million in 2016 and is currently available in eight states, including New Jersey, New York, California, Illinois and Texas, and licensed in 17 additional counties. Lemonade works with reinsurance partners such as Everest Re, Lloyd's of London, XL Catlin and National Indemnity.

Moreover, the largest financing of 2017 came from consumer-driven health insurer Bright Health. BrightHealth raised $160 million in a financing round that included Greenspring Associates, NEA, Greycroft Partners, Cross Creek Advisors, Bessemer Venture Partners, Redpoint, e.Ventures and Flare Capital. According to BrightHealth, its model uses health systems economic rewards for practicing efficient, high-quality healthcare and creates exclusive partnerships with a single health system in each market to support the relationship between patients and providers.

Insurtech M&A Was Driven by Both Strategic and Private Equity Buyers

While some venture capitalists and investors sought to finance the growth of the insurtech companies, other strategic and financial investors continued to take insurtech companies off the market through acquisitions. According to data compiled by FT Partners, the largest insurtech M&A deal announced in 2017 was Assurant's $2.5 billion acquisition of The Warranty Group, a global provider of protection plans and related programs. The extended warranty offered by Amazon at its checkout on appliances such as washing machines, mobile phones, tablets, TVs, and kitchen appliances is created by the Warranty Group, which underwrites Amazon Protect policies. Other strategic investors that made headlines
with large acquisitions included Travelers, with its $490 million acquisition of Simply Business, a leading U.K. distributor of small business insurance policies; and Guidewire, with its $275 million acquisition of Cyence, a data science and risk analytics software company.

While private equity firms were the sellers of The Warranty Group and Simply Business, private equity also fueled acquisition activity during 2017. Notable deals with a private equity acquirer included New Mountain Capital’s $560 million acquisition of One Digital, the nation’s largest employee benefits-only company, and Verisk’s $151 million acquisition of LCI, a provider of risk insight, prediction, and management solutions.

**Collaboration Among New and Established Players – Inside and Outside the Insurance Industry – Continued to be a Driver of Innovation**

The past year saw continued collaboration between and among incumbent carriers, start-ups, venture capital and growth financing (for start-ups), alternative sources of funding (for insurers), and even established businesses in different industries seeking to expand into the insurance market. Due to the expansive and ever growing collaborative system within the insurance industry, below are just a few examples of the highest-profile collaborations that took place in 2017.

Early last year, American Family Insurance partnered with TrueMotion, a provider of usage-based insurance (UBI) technology, to create a new, app-based driver safety program called KnowYourDrive. Through this program, American Family customers who download and use the app can receive discounts on their premiums based on their actual driving.

In an effort to cater to millennials and others, Nationwide partnered with Sure—the first on-demand insurance mobile app in the United States. Sure allows iPhone and Android owners to receive an insurance quote, purchase a policy, and pay their Nationwide renters insurance premiums via a mobile app.

Lyft, the ride sharing app, partnered with CSAA Insurance Group to offer drivers who are going through the claims process an option to receive up to $200 in Lyft credit to get around while their car is out of commission, or they may choose to rent a car through their CSAA agent.

Generali partnered with Google Nest to provide its European home insurance customers with Nest Protect. Nest Protect detects both smoke and carbon monoxide levels in homes and sends alerts to customers’ phones. The partnership with Nest is intended to help Generali’s home insurance customers reduce the chance of harm to their families and homes.

Similarly, Aviva established a life insurance joint venture with Tencent and Hillhouse Capital in Hong Kong. The venture is intended to develop an online digital insurance company focused on mainland China.

**Insurtech Saw Its First IPO Since 2015**

Chinese online property and casualty insurer ZhongAn raised approximately $1.5 billion on the Stock Exchange of Hong Kong on September 28, 2017. The offering attracted key investors such as Japan’s Softbank. ZhongAn has sold over 7.2 billion insurance policies and served over 492 million customers, making the company China’s largest insurer. ZhongAn was launched as China’s first online-only insurer in 2013 with backing from Chinese conglomerates Tencent Holdings and Alibaba Group and Chinese insurer Ping An. ZhongAn offers a wide-range of insurance products such as health products, travel and auto coverage, and consumer finance protection, in addition to unusual specialty insurance products such as “binge drinking” insurance. The company utilizes advanced data mining, artificial intelligence, automatic underwriting, and data driven risk management to optimize product features and enhance customer experience. The proceeds of the IPO will go to strengthening the company’s capital base and supporting business growth.

**Regulators Continued to Grapple with Insurtech Innovations and the Pace of Change**

Due to the unique regulatory framework that governs the insurance industry, innovative technology can often run into distinct regulatory hurdles that have the potential to ultimately hinder the innovation process. Technology and innovations in insurance not only require new ideas
to be placed within existing regulatory frameworks; they also call for the industry and its regulators to define new standards and rules that apply to novel questions. In particular, the nature of digital insurance has brought forth a host of data privacy and security concerns from regulators. In an effort to address some of those concerns, two major events occurred during 2017. The New York Department of Financial Services (NY DFS) adopted a comprehensive cybersecurity regulation, and the National Association of Insurance Commissioners (NAIC) adopted an Insurance Data Security Model Law. Both the NY DFS cybersecurity regulation and the NAIC model law build on existing data privacy and consumer breach notification obligations by requiring insurance licensees to comply with detailed requirements regarding maintaining an information security program and responding to and giving notification of cybersecurity events. Both of these regulatory developments are discussed in more detail in Insurance Regulatory - US.

While some regulators have expressed concern about the pace of innovation in the existing regulatory framework, several have taken steps to adapt this framework to the evolving needs of the industry. In order to address these needs, this past year the NAIC formed the Innovation and Technology (EX) Task Force, which is meant to help insurance regulators, innovators and established insurance industry players stay informed on key developments and issues related to companies leveraging new technologies in the insurance sector. For example, during the December 4, 2017 meeting of the NAIC Innovation and Technology (EX) Task Force, a representative of the American Insurance Association (AIA) unveiled a proposal for an “Insurance Innovation Regulatory Variance or Waiver Act.” The AIA’s proposed legislation would create a formal process for insurance commissioners to grant variances or waivers from specific insurance regulatory requirements to “facilitate the introduction of new, innovative or more efficient insurance products, services or technologies.” Further discussion about the NAIC Innovation and Technology (EX) Task Force is included in Insurance Regulatory - US.
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