GLOBAL INSURANCE LAW CONNECT

ANNUAL REVIEW 2019

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IN THIS ISSUE

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Welcome

Insurers and reinsurers will always need legal advice that is specialist, international, and relevant to the markets in which they operate.

As a network built for insurers, the members of Global Insurance Law Connect are all specialist insurance law firms, capable of delivering the right advisers in the right places and in the right way to clients. Members provide global access to law and legal advice on a range of relevant issues across a wide variety of markets.

Whether you are in new or established markets, dealing with familiar or unusual issues, the advisors in our organisation will guide you through unfamiliar territories – delivering great outcomes as economically as possible while adding value through their commercialism and knowhow.

Our global reach means that we have up-to-date knowledge of key changes in all the major markets. Over the past year Global Insurance Law Connect have provided our clients with a variety of updates on global insurance changes, stretching from regulatory change in China, to the restructuring of the Norwegian Natural Perils Pool. If, in future, you'd like to receive these updates as they occur, follow us on LinkedIn at www.linkedin.com/company/global-insurance-law-connect. In the meantime, we have gathered together the most significant of this year's updates in our annual compendium of articles. We hope you find them useful – enjoy!

Jim Sherwood
Chairman, Global Insurance Law Connect

INDIA

INDIA'S JOURNEY TOWARDS MEETING THE GLOBAL IFSC BENCHMARK

The Indian Government and the regulators are making every attempt to showcase the country's first International Financial Services Centre – GIFT City IFSC as India's answer to global hubs for financial services like Dubai and Singapore.

In the first week of February, the Union cabinet cleared the draft law to create a super-regulator, a first of its kind, for IFSCs. The objective is to create a unified regulator to oversee dynamic financial services undertaken in GIFT City IFSC and ease inter-regulatory coordination. The news of the super-regulator follows a slew of measures announced by the Indian insurance regulator – Insurance Regulatory and Development Authority of India (IRDAI) in the last two months, including preferential treatment for reinsurers registered in GIFT City IFSC and creating a framework for registration and operation of insurance intermediaries in GIFT City IFSC.

For those who came in late, GIFT City IFSC is a 'smart' city with high-quality physical infrastructure and a special economic zone with a raft of tax and regulator advantages. Incentives include a 10 year tax holiday and foreign entities like insurers and reinsurers are permitted open shop (as branch offices) without the need of a joint venture partner, unlike mainland India that restricts foreign participation to 49% in direct insurance.

From the beginning of 2019, IRDAI notified the new reinsurance regulations that require Indian cedants to comply with 'order of preference' while making reinsurance placements. While the national reinsurer and reinsurers registered in India predictably got the top slots under the 'order of preference,' the units set up in IFSC were able to find themselves a notch above the cross border reinsurers (CBRs). It may be pointed out that over 300 CBRs seek reinsurance placements from India. Such treatment of GIFT City IFSC units was clear reflection of the importance accorded to GIFT City IFSC in regulatory policy.

The need for a coherent regulatory framework for India's first IFSC was recognized in the Union Budget 2018, when the Finance Minister of India proposed the idea of a unified regulator to play the key role of a catalyst and provide an integrated and undivided approach to the ease of doing business with a single window clearance. It was also advocated that one of the most important roles of a unified regulator would be to act as an enabler by creating a conducive regulatory framework that is benchmarked globally. It would not be helmed around domestic rules and regulations, and instead would try to create a level playing field for the IFSC to compete globally.

This development forms part of a series of steps that the government has taken recently to promote GIFT City IFSC. Over the last three years, the Regulators in India namely Reserve Bank of India (banking and exchange control), Securities & Exchange Board of India (capital markets), IRDAI (insurance, reinsurance and insurance intermediaries) have created the issued regulatory framework allowing Indian and foreign financial institutions to open their offices in GIFT City IFSC.

The framework for allowing foreign insurers and reinsurers to set up shop in GIFT City IFSC was already provided by insurance

regulator IRDAI in December 2017. Foreign insurers and reinsurers, subject to meeting eligibility criteria can set up units in GIFT City IFSC. While insurers can do direct insurance business in GIFT City IFSC and other SEZs across India, the reinsurers can seek placement from India subject to order of preference. There is no restriction on insurers and reinsurers on writing insurance/ reinsurance business outside India.

Recently in January, the framework to facilitate the entry and operations of domestic intermediaries in GIFT City was unveiled by IRDAI. Incentives in direct and indirect tax coupled with regulatory ease for setting up and operations have made the prospects of new business and growth brighter for insurance intermediaries.

It may be pointed out that Global Financial Centres Index, the world's most authoritative comparison of the competitiveness of the world's leading financial centres has recently featured GIFT City as one of the significant emerging IFSCs in the latest edition of 'Global Financial Centres Index 24 (GFCI)', released in London in September 2018. GIFT is ranked third in the list of the GFCI report, which has highlighted 15 centres that are likely to become more significant in the next few years.

The rank takes into consideration five major factors (business environment, human capital, reputation, infrastructure & financial sector development). This is a significant achievement for a centre entering for the first time in the main index. The GIFT City profile in the latest GFCI report also states that GIFT City is a gateway for inbound and outbound business from India and is fast emerging as a preferred destination for undertaking International Financial Services.

All in all, the situation for foreign insurers and reinsurers in India has at last taken a major step forward, and one which will be welcomed by many international companies.

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UK

THE POTENTIAL FOR AN INCREASE IN SUSPICIOUS CLAIMS FOLLOWING THE INTRODUCTION OF QOCS IN SCOTLAND

Qualified One-way Costs Shifting (QOCS) is coming to Scotland. That is most likely to happen from a date to be announced in the first half of 2020. The particular version of QOCS to be applied in Scotland is significantly different in detail to the version which has applied in England & Wales from 1 April 2013. Given that the Scottish judicial approach to issues of honesty in personal injury litigation is, in general, materially different to the English legislatively-governed approach on those matters, the introduction of QOCS to Scotland has the potential to increase the number of suspicious claims seen north of the border.

The rank takes into consideration five major factors (business enIn the past and at present in Scotland, the costs, or expenses, of a personal injury court case tend to be awarded in favour of the "winning" party against the "losing" party. The traditional mantra is "expenses follow success".

QOCS will complicate the traditional Scottish position on costs in personal injury cases. A successful defender in such a case will only be able to recover costs from an unsuccessful claimant if that claimant has acted or behaved "inappropriately" as defined in primary legislation and in rules of court to be made under that legislation.

A known consequence of QOCS in Scotland will be that the risk of an adverse finding of costs against an unsuccessful claimant in Scottish personal injury litigation will be diminished. That is likely to lead to an increase in the number of litigated claims. Were that not so then there would be an argument that the underlying premise of the QOCS legislation, namely to increase "access to justice", would not have been fulfilled.

There is a school of thought that an increase in personal injury litigation generally is likely to give rise to an increase in the number of suspicious litigated claims. The contrary school of thought is that no claimant solicitor would ever wish to litigate a suspicious claim therefore any increase in personal injury litigation brought by represented parties may not give rise to a specific increase in suspicious claims.

Perhaps both of those schools of thought miss the real point. The real difference between Scotland and England and Wales in matters of honesty in personal injury litigation is that Scotland does not have any legislative equivalent to the "fundamental dishonesty" provisions of s.57 of the Criminal Justice and Courts Act 2015 for England & Wales. Legislatively-established fundamental dishonesty enables a court in England and Wales to dismiss a personal injury claim if it is satisfied, on the balance of probabilities, that the claimant has been fundamentally dishonest in relation to that claim or a related claim. Over the last four years, the courts in England and Wales have given meaning to these legislative provisions so that those courts are able to move swiftly and decisively to strike out claims which are spurious.

Regrettably, Scots Law is not nearly as sophisticated in directly tackling dishonesty in personal injury litigation. In Scotland, it is possible to seek dismissal (strike-out) of personal injury litigation as an abuse of process. The Scottish courts have, though, been very reluctant to define the situations in which that "draconian" power may be exercised. In Grubb v Finlay (2018), the highest Scottish civil appeal court permanently located in Scotland unanimously held that

"it is neither practical nor desirable to define the situations in which this power may be exercised, but the question of whether a fair trial remains possible is a factor of considerable, although not always determinative, weight." In short, "fundamental dishonesty" does not exist as a stand-alone legal concept in Scotland sufficient for a personal injury case to be struck out.

Legislative fundamental dishonesty is one of the qualifications to the one-way cost shift in England and Wales. The closest provision for QOCS in Scotland will be where a pursuer (claimant / plaintiff) or his or her legal representative "makes a fraudulent representation or otherwise acts fraudulently in connection with the claim or the proceedings." Proof by a defender of "a fraudulent representation", on the civil standard of balance of probabilities rather than on the criminal standard of beyond reasonable doubt, will suffice for the qualification to the one-way cost shift to apply.

However, "a fraudulent representation" is not defined in the 2018 Act which introduced the term. It is to be left to the courts to explain what may or may not count as such a thing. There is little, if any, binding Scottish authority on the definition of fraud in a personal injury case. Back in 1899, Professor Bell opined in his Principles of the Law of Scotland that "fraud is a machination or contrivance to deceive." Clearly, though, the Professor would not have had "a fraudulent representation" in a QOCS context in mind when he was writing those words 120 years ago.

So, it looks like the Scottish Courts will have to start grappling with more issues of honesty in personal injury claims in order to develop Scots Law on that. Meantime, we could see an increase in suspicious claims north of the border. A Scottish legislative equivalent to s.57 of the Criminal Justice and Courts Act 2015 would be most welcome to bring some definition and clarity to an uncertain and challenging area.

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ITALY

ITALIAN INSURERS FOCUS ON CENTRALISING RISK AND CAPITAL MANAGEMENT IN CHARGE OVERSEAS

The globalisation of Italian financial institutions has accelerated over the last two decades (albeit from a low base) and this has included insurers along with the banks.

For all insurers international business poses challenges in terms of maintaining oversight of their group's overall activities. It is much harder to keep track of, for example, the risks the group is exposed to, risk diversification, and the overall management of the group across a portfolio of different countries.

If take a step back and look across Europe, most European financial groups are more strongly internationally oriented than their American and Asian peers. This, of course, relates to the existence of an easily accessed homogenous internal European market for financial services; and in fact masks the true picture. When Europe is treated as one country, EU financial groups are as much focussed on foreign markets exactly as much as financial groups located in Japan, Hong Kong, Australia and the USA.

Diversifying business has led to appetite among Italian insurers expanding into other markets for more coherent policies and a central steering mechanism within the organisation. Such "enterprise risk management" has also led to the wider adoption of chief risk officers (CROs). However, insurance has traditionally been very much a local business, to a large extent influenced by country-specific factors, such as applicable rules and regulations, social security systems and fiscal treatment, which requires a more decentralised approach.

In particular, Italian insurance business still has a strong local focus. Most countries where Italian insurers became present differ with respect to applicable rules and regulations, language and culture; and firms have allowed local entities to remain almost entirely independent in process and management. This history has yet to be fully overcome.

If we look at comparable groups, it can been seen that European insurance groups are significantly more internationally oriented than the banks. Whereas European banks have a clear home bias (earning on average 61 percent of their revenues in their home country), insurance companies have a foreign bias (earning 65 percent of their revenues in host countries). However, this is not always the case for the Italian insurance companies expanding abroad.

In the last decades only Generali, with Allianz and AXA, whose GWP exceeded 50% of total European premium volume, could be defined as very internationally oriented.

Now, with change afoot, the organisational structure of Italian insurance firms is moving from the traditional country model to a business line model. This implies often an integration of key management functions.

One of the most notable advances in risk management is the growing emphasis on developing a firm-wide assessment of risk. Although costly to realise, once firms have a centralised risk management unit in place, they should expect to achieve economies of scale in risk management. Nevertheless, these centralised systems still rely on local branches and subsidiaries for local market data. The potential capital reductions that can be achieved by applying the approach offered by the Basel II framework encourage banking groups to organise their risk management more centrally. The same could also be true for the Solvency II framework for the European insurance industry.

The introduction of Solvency II regulatory framework in January 2016 has put the focus of insurers on capital management, reflected by a general improvement between 2016 and 2017 in the coverage of capital requirements across different lines of business. Overall, the Solvency II ratio reached in 2017 ca. 241%, with life and composite insurers showing higher coverage, in order to prevent fluctuations in the bond market (PwC source).

As Italian insurers consider how to implement new ways to measure and manage their business, they would do well to heed the lessons learned in the banking industry, which has been on a similar path for the last decade. Firms that implement a well-constructed risk and capital management framework can derive significant near-term business benefits, and substantially strengthen their medium-term competitive position. The emergence of CROs at the headquarters of large insurance groups confirms this trend towards centralisation.

It can therefore be concluded that the international presence of Italian insurers, led by Generali, in various jurisdictions has given rise to a shift to a more holistic approach towards risk and capital management, although local knowledge is still needed to properly operate within the national markets.

The dominant pattern is that the "rules of the game" are determined at the central level, while the actual implementation of these policies is left up to the local managers. This enables a coherent policy for managing risk and capital, while local management is given enough room to take account of local practices and developments.

Brexit is commonly quoted as an opportunity for insurers in other jurisdictions, including Italy. However, Brexit might not offer special opportunities to Italian insurers' expanding internationally. On one hand English insurers moved ahead of time to reorganize their business in Europe in order to avoid losing significant market shares. On the other side expansion in UK will be likely to face regulator constraints particularly in case of no deal Brexit.

A question for future research is to what extent geographic expansion of Italian insurance groups will lead to diversification benefits and to a higher valuation of such insurance groups. While the answer to the first question is very likely to be positive, the answer to the second question is still unclear. This remains an area of significant change, and one to be watched with interest.

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BRAZIL

REGULATOR'S MUDDLED RULING OVER SANCTIONS BRINGS CRISIS FOR BRAZILIAN INSURERS

In July 2019, the Brazilian insurance regulator, SUSEP, issued an update on the embargoes and sanctions clauses for Brazilian insurance contracts which has caused a major stir among Brazilian insurers.

The initial trigger was a specific case involving the Cuban beneficiary of a travel insurance policy. As a result of the ruling, which is applicable to all insurance policies issued in Brazil, Brazilian insurers may be held widely responsible for sanctions violations. Notwithstanding market efforts to get the regulator to truly understand the issue, the regulator SUSEP's July Circular Letter revealed a real lack of knowledge of the consequences of non-adoption of, and disrespect for, the embargoes and sanctions clause in insurance contracts. Instead SUSEP made a grave error in choosing to understand that sanctions imposed by countries on other countries are contrary to Brazilian law, and the consequences for insurers are serious.

Regulator holds insurers responsible for sanctions violations…

In the Circular Letter, SUSEP also confirms that it is the responsibility of the insurer to undertake research and to determine, at the time of underwriting the risk, if there are sanctions-related limitations on the coverage to be granted. Should the insurer find that there are limitations, they must refuse to underwrite the risk.

However, it is not always possible for the insurer to determine when underwriting the risk if there are likely to be sanctions violations. Clearly, some limitations may emerge during the time period of the policy or may be identified only if a loss occurs… but does not admit that new international sanctions rulings are valid within the lifetime of an insurance policy Added to this, SUSEP confirmed that the later loss of rights, or exclusions from coverage arising from embargoes or economic or commercial sanctions can only occur in a case of intentional fraud committed by the insured. However, for sanctions to be applied, it should be the case that the application of embargoes or economic or commercial sanctions can be based on objective external criteria, not only on the intentional acts or omissions of any specific person and/or the insured.

A further issue with SUSEP's stance is that the embargoes and sanctions clause is not a new contractual rule that is changed or revealed during the life of the insurance contract. Rather, it is a contractual rule that refers to a set of embargoes and sanctions that is regularly updated. The stance taken by SUSEP means that it becomes impossible for a Brazilian insurer to update their position regarding current insurance and reinsurance contracts should a new international sanction be issued by the UN.

The actions of the regulator have set Brazil's insurers legally apart from the rest of the world, requiring that insurers operating in Brazil should follow costly and unusual practices that have no legal basis and are divorced from the logic and practices that govern the global markets. In fact, it is the case that the entire ruling by SUSEP appears to be based on a misconception of how sanctions are applied internationally. This, in addition to the evident mismatch between the insurance and reinsurance coverages, may make some Brazilian insurance and reinsurance contracts unviable.

Further confusion in Brazil's new asset-freezing law

Meanwhile, the contradictions are beginning to pile up. For example, insurers also need to consider Brazilian Law no. 13810, published on 8 March, 2019, which, among several other issues, provides for compliance with sanctions imposed by resolutions passed by the United Nations Security Council. When this law comes into force, SUSEP, among other financial services supervisory bodies in Brazil, will be responsible for setting rules for compliance with the new law and will be required to supervise measures taken to freeze the assets of sanctioned individuals and legal entities.

According to the new law, assets must immediately be frozen in compliance with either the resolutions of the United States Security Council or its sanctions committees; or at the request of any foreign central authority (provided that their request is in accordance with the applicable legal principles and is based on objective grounds that meet the criteria set by the UN Resolutions.) This is a rule which has a dynamic similar to embargoes and sanctions, in that the rule itself does not change, however, the list of bodies affected by it can be updated. In this case the Brazilian legal system recognizes that an international decision may cause an immediate impact on contracts without violating the Brazilian constitution and the contracts themselves. In spite of this highly comparable example the Brazilian insurance regulator SUSEP has chosen not to recognize the same likelihood when discussing embargoes and sanctions clauses.

In other words, according to SUSEP Circular Letter, the sanctions law, but not the contractual rules that go alongside it, must be observed; which, given the constitutional nature of the protection of contracts, does not make sense, not to mention the major disturbances that this will cause Brazilian insurers.

Courts will need to untangle the 'jabuticaba'

In Brazil, a homegrown legal confusion is known as a 'jabuticaba' (after a grape-like fruit that lives only in Brazil). SUSEP has made a grave error in choosing to understand that the clauses on sanctions that refer to sanctions imposed by countries on other countries are contrary to Brazilian law and the consequences for insurers are serious. It now remains for insurers to develop procedures to deal with cases that arise. In an extreme case, it may be necessary not to perform the insurance contract and wait for a court order for its enforcement, which will reduce the risk of the insurer being held liable for noncompliance with embargoes and sanctions. All in all, this is a true Brazilian "jabuticaba".

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AUSTRALIA

AUSTRALIAN FINANCIAL SERVICES ROYAL COMMISSION – SPOTLIGHT ON SPECIALIST CLAIMS HANDLING

"There can be no basis in principle or in practice to say that obliging an insurer to handle claims efficiently, honestly and fairly is to impose on the individual insurer, or the industry more generally, a burden it should not bear" – Commissioner Hayne 2019.

Insurance claims handling has been under scrutiny in recent months in two high profile public reports:

- the Royal Commission (RC), and
- Treasury Consultation Paper: Disclosure in General Insurance: Improving Consumer Understanding.

Due to a specific exemption in the Corporations Act 2001 (Cth), there are presently no regulatory or licensing obligations imposed on companies providing claims handling services for general and life insurance claims. This exemption has meant that the Australian Securities and Investments Commission (ASIC) has no direct authority over specialist claims handling companies.

Specific activities considered to be exempt claims-related activities include:

- negotiations on settlement amounts
- interpretation of relevant policy provisions
- estimates of loss or damage
- estimate of value or appropriate repair
- recommendations on mitigation of loss
- recommendations, in the course of handling or settling a claim, made on increases in limits or different cover options to protect against the same loss in the future, and
- claims strategy, such as the making of claims under alternate policies.

What are the potential impacts on specialist claims handling?

In response to evidence in and submissions to the RC raising inconsistent policy interpretations and out-of-date medical definitions and refusal of claims for reasons considered generally by community standards as unfair, the Commissioner has recommended that the handling and settlement of insurance claims, or potential insurance claims, lose the exclusion from the definition of a financial service. The RC noted the failure by insurers to process claims in a timely manner, to collect and use evidence, to adequately communicate the refusal of claims and to inform consumers of their rights to dispute resolution.

If RC Recommendation 4.8 is accepted and the exemption removed, claims specialists will become financial service providers subject to the Corporations Act and subject to the "financial services laws", which is a very broadly defined and specific term and includes the Insurance Contracts Act 1984 (Cth). Claims related to insurance products sold to retail clients involve additional service obligations, such internal and external dispute resolution processes, as well as compliance with industry codes of conduct, such as the General Insurance Code of Practice.

While there is no suggestion that the clerical–administration exemption be removed, there is a fine line separating some of these services and that of advice and dealing in relation to conduct considered to be insurance claims handling.

Both sides of Australian politics have committed to the introduction of the reforms and while the Federal election will delay implementation, the removal of the claims exemption can be done relatively quickly. This means the issue of Australian Financial Services (AFS) licensing or appointment as authorised representatives (if possible) are very real prospects for the claims management industry. Entities with their own AFS licence will have a competitive advantage over those without, given that there is presently a 6-9 month delay in AFS licence processing with ASIC. The claims industry is likely to experience change over the next 12 months with the Treasury Proposals calling for standardised definitions and exclusion clauses in insurance contracts as well as additional disclosures, such as component pricing.

As an indicator of things to come, on 19 February 2019 ASIC issued its planned timetable for the implementation of the RC recommendations, noting it had advocated for (and supported the extension of) ASIC's role to cover insurance claims handling and the application of unfair contract terms laws to insurance. This ASIC response coincided with the passage of the Treasury Laws Amendment (Strengthening Corporate and Financial Sector Penalties) Bill 2018, which increases maximum prison penalties and significantly increases civil penalties for companies – now to be capped at $525 million, with maximum civil penalties for individuals increasing to $1.05 million. Significantly, for the first time the Bill also introduces a civil penalty (capped at $525 million) for breaches of the primary obligation that banks and other financial services (and credit licensees) owe to all of their customers, that is "to do all things necessary to ensure the financial services covered by the licence are provided efficiently, honestly and fairly". This new obligation will track through to third party outsourcing service providers as financial services and credit providers seek to include these obligations in the terms of the outsourcing contracts.

What next for specialist claims handling?

While there is no suggestion that the RC specifically considered the role of specialist claims handling entities when looking at claims-related conduct, there is no carve out for this industry sector in the recommendations under consideration. This means the reforms will impact specialist in-house claims units operating within the insurance companies and also significantly impact the external claims handling specialists providing claims and settlement support for a number of the major insurers. Combined with the Australian Government's commitment to claims reforms – evidenced by the Consultation Paper released by Department of Treasury on 1 March, and which raises the potential of extending Australian Financial Services licensing requirements to a range of third party representatives of insurers referred to as "claims handling service providers" – there is a real possibility that significant change is going to occur in this industry.

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TAIWAN

TAIWAN REGULATORS RESPOND TO MARKET CHANGES

According to government statistics, in 2018, insurance penetration reached 20.88 percent in Taiwan (Swiss Re). It is also highly concentrated with 10 leading companies accounting for nearly three quarters of written premium in 2017. As of 2018, the recorded aggregate DWP for life and non-life insurance is US$121.9, making it the 10th largest market in the world, and the life insurance industry in the same year recorded a total of US$102 billion, ranking it as number seven in the world (Sigma).

Major reform of the Insurance Act

In response to this thriving market environment, the Financial Supervisory Commission of Taiwan recently proposed a major reform of the Insurance Act. The major thrust of which is towards greater consumer protection, such as extending the insureds' rescission period, requiring the delivery of policies and extending insurers' obligation to inform. The proposed reform also intends to build a more technology-friendly business environment for insurance enterprises, such as permitting multiple ways to deliver policies and allowing the appointment of third party service providers to provide data processing and exchange services to insurance enterprises.

Some of the proposed draft is yet to be passed. Below are the amendments that have taken effect as of today:

Insurtech sandbox

A regulatory test environment has been enabled for insurtech start-ups or technology firms who can apply to develop technology-based innovative financial products or services pursuant to the Financial Technology Development and Innovative Experimentation Act.

E-commerce for brokers

While the insurers have been long permitted to conduct on-line insurance business, the Insurance agents and insurance brokers are now permitted to conduct e-commerce to allow insurance contracts to be form electronically.

Reform of insurance trust

Pursuant to the terms and conditions of the trust contract, the trustee of the insurance trust can now require that the life insurance payout be remitted directly to the trust account. Before the regulatory reform, the insurance payout is not automatically paid into the trust.

Penalties raised

The penalty for unlicensed operation of insurance business and insurance agency/brokerage/surveyor business has been doubled.

Other market developments

In addition to these amendments to the Insurance Act, there are a number of other market trends that are developing in response to the changes in the regulatory environment.

D&O liability insurance

As of January 1, 2019, all the companies listed on the stock exchanges

in Taiwan were required to purchase D&O liability insurance. This has grown the size of the market and opened up some material business opportunities.

Cyber insurance

Cyber insurance is not mandatory for listed companies. However, the Financial Supervisory Commission has announced that the cyber insurance status of a listed company will be included as one of the grading criteria for the corporate governance evaluation they conduct. In response to this change, it is expected that there will be an increase in the demand for the product.

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SWITZERLAND / UK

SWISS / UK INSURANCE TRADE AGREEMENTS – A TEMPLATE FOR A NEW INSURANCE PASSPORTING REGIME?

Swiss and UK government officials signed a new bilateral agreement on direct insurance earlier this year, designed to ensure continuity after Brexit This is the first such deal in any industry or country, and it is therefore significant for many other partner nations. Insurers and other financial services companies are looking ahead to see if this is a template that could be used after the likely loss of UK access to the EU's passporting regime, and could this deal potentially be replicated elsewhere?

We've asked two lawyers to look at this possibly significant trade event, one from the UK perspective, and one from the Swiss perspective. Both our contributors are insurance specialists, members of the Global Insurance Law Connect network.

The view from Switzerland

The UK and Switzerland signed a bilateral Agreement on Direct Insurance (other than Life Insurance) on 25 January 2019. The deal replicates the effects of the existing EU-Swiss Agreement on Direct Insurance other than Life Insurance. While the EU-Swiss Agreement does not provide for full freedom of services (e.g. passporting rights), it is nevertheless very useful and has facilitated business in Switzerland, not least because it allows the home state supervisor to continue supervising solvency (i.e. Swiss branches of UK insurers are not subject to solvency-supervision by the Swiss Financial Market Supervisory Authority, FINMA). It has also ensured that the Solvency II risk location principles apply, which is of paramount importance when structuring international programs. By mirroring the EU-Swiss Agreement, the UK and Switzerland have ensured much needed planning certainty and continuity for the currently 14 UK insurers accessing the Swiss market (and vice versa). The UK-Swiss Agreement will immediately enter into force in case of a No Deal scenario and, in the alternative, after a transition period.

But why remain in the past by merely adhering to the status quo pre-Brexit? Since Switzerland is known to be a reliable partner ready to enter into pragmatic and solution-oriented negotiations, it should be expected that both the UK and Switzerland will work on further developing their relationship by using the Agreement on Direct Insurance other than Life Insurance as a platform for improvements in the reciprocal market access for insurers.

The mere possibility of not being required to deposit tied assets in the other jurisdiction would already offer a perceptible simplification for insurers, and could be further developed into a significant facilitation of market access and exit, provided that both the UK and Switzerland will ascertain that the rights of policyholders in run-off and insolvency scenarios will remain protected. Also, while it is not realistic that the UK and Switzerland will in the near future enter into an agreement similar to the Direct Insurance Agreement between Liechtenstein and Switzerland which provides for full freedom of services, it is quite possible that future relations will see considerable facilitations for insurers that insure professional policyholders only. Any improvements leading to a competitive and healthy insurance market should be welcomed by both parties.

The development of the UK-Swiss relationship in insurance matters should therefore be closely monitored, as it may serve as test case and template for future agreements of the UK with other insurance markets.

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The UK perspective

One of the unfortunate side-effects of Brexit has been the potential disruption within and between the European (re)insurance markets and the United Kingdom. Companies have for the last decade and more operated seamlessly across borders and within Europe due to mutual regulatory recognition and freedom of service. The financial powerhouse of Switzerland remains a key player within the UK's non-life market. Crucially, however, this is recognised by the UK and Swiss governments, and on 25th January both countries entered into the UK-Swiss Direct Insurance Agreement. Whilst not exactly "bed-time reading," the Agreement is good news for the London Market.

In replicating the provisions of the existing EU-Swiss Direct Insurance Agreement, coming into force once the existing EU – Swiss Agreement ceases to have effect, it will ensure that trading for non-life (re)insurers between the two jurisdictions will continue uninterrupted, enabling the continued and easy branching into either jurisdiction due to the mutual recognition of solvency requirements. As with the UK-US Covered Agreement, which replicated the US-EU Covered Agreement, this is a positive development for both markets. However, it does raise the further question of whether replication of existing Agreements should be the final target for the London Market and the Government, or should such arrangements be viewed as temporary placeholders?

The London Market has always been innovative in taking advantage of, or creating, a changing landscape. Rather than being content to simply maintain "normality," should the London Market be lobbying for more innovative Agreements with other third countries, such as Switzerland? This will enable the UK to have a real differentiator, and hence competitive attraction, to our soon to be former EU bedfellows and other overseas markets. Indeed, this is entirely in line with the London Market Group's recently published comment s of "seeking new trading opportunities."

BLM in the UK

ITALY

HOW WILL THE INSURANCE MARKET BE AFFECTED BY ITALY'S NEW LAW ON CLASS ACTIONS?

On 18 April 2019 the Italian Parliament approved new laws to govern class action lawsuits in Italy. The new law will come into force in April 2020. The new rules see substantial widening of the types of class actions that can be brought, as well as changes to their defensibility. The impacts for insurers are substantial, and need urgent consideration, as well as clarification by the courts.

Who can claim?

In Italy, class actions previously had to be brought by industry bodies or non-profit associations.

However, under the new Bill an individual may initiate a class action. Class actions may now also be brought against public service providers, or bodies who manage services in the public interest, in relation to any breach committed in the performance of such service.

Under the Bill, a class action now has three stages: the first and second stages, respectively concerning admissibility and merits, are heard before the Court's Business Division (the Tribunale delle Imprese). The final stage, where damages are assessed, is assigned to a judge who rules definitively and finally.

Opt-in system

Under the older system individuals had to join a class action at the start in order to benefit from it.

Under the Bill, however, individuals can decide whether to join in the class action even after liability has been established, a provision which plainly creates great uncertainty as to the scope of corporate liability. In theory, a wholly unknown number of individuals could decide to "back the winner" without having taken part in the liability stage.

Procedure

Class action case procedure has also been modified by adopting a "summary proceeding". This highlights the case-management role of the judge and should make proceedings move more quickly.

Class actions will be assigned to the Court Chamber specialising in business matters in the region where the defending entity is registered and need preliminary authorisation by the court.

Once the action is declared admissible the second stage begins, for determining liability. Here the judge has a wide discretion as to the form of the proceedings, and the rules of evidence are more relaxed.

The Bill appears to reflect government encouragement of the use of class actions, in particular via provisions permitting participation by multiple holders of similar rights. The first "opportunity" for others to join the actions is at the admissibility stage, but the most significant (and also the most debatable) change is the option for claimants to join in after a decision on liability i.e. at the stage where compensation is about to be set for damages in favour of the applicants.

Injunctive relief in a class action.

Under the new rules, as well as any organisation and association involved, an individual with a valid interest may ask the judge to order the relevant body to stop any detrimental conduct against multiple individuals or entities, or not to repeat it.

Impact on the insurance market

The new Italian opt-in system makes it difficult to identify in advance what might prove to be a large number of participants. It differs greatly from the US opt-out system, where class actions automatically include a large number i.e. the whole class, except those who opt out. This might offer leverage as regards the defendant business entity, but at least the scope of the claim is known, and the defendant and its insurers can plan and make provision accordingly.

On the flip side, there is no possibility of punitive damages in Italy, another factor making class actions less appealing. While the opt-in system means that the court's decision will bind those who do, the new provisions will allow people to opt in late on. This will create major uncertainty, as many claimants might decide to opt in only if the action succeeds at the first stage, setting up a critical chain reaction. This will obviously make it very difficult to set a suitable contingency in a company's balance sheet.

The likely future framework of class actions prompts reflection on the possible effects of the changes on businesses and the management of such actions, from a preventive and also a defensive standpoint.

The most difficult issues are (a) the wider range of subject-matter and rights presented by the new rules (b) the evidential rules favouring claimants - including what may amount to reversal of the burden of proof, to the obvious disadvantage of a defendant, who may also be subject to a very strict time limit for filing a defence (c) problems with assessing the risks, in terms of claim size and timescale, as claimants progressively decide whether or not to join in, with (in many cases) no obligation to waive their rights at, or by, a particular time and (d) possible abuse of interim injunctions, perhaps especially in view of wider rights and more possible claimants.

Insurers, risk managers and their advisers are studying the potential impact and are trying to plan the liability insurance market's response.

It is very likely that higher limits on liability will be needed, at obviously increased cost, in response to what will be a broader and larger risk. Currently, in our view, the new provisions lack the clear guidance that is necessary for transparency and predictability, and present a number of flaws, so that it is currently far from clear whether they are effective provision for consumers or a disincentive for business.

Clarification, either from lawmakers or the courts, is urgently needed in order to avoid negative effect on relevant businesses, and to cut down the possible duration of proceedings, which (even with no kind of appeal) might take between two and four years.

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FRANCE

FRANCE ABANDONS NAPOLEON AT LAST

'My real glory is not to have won forty battles… What nothing will erase, what will live eternally, is my Civil Code.' Napoleon Bonaparte

The French Civil code was drawn up in 1804, and for more than two centuries, Napoleon Bonaparte's system underpinned the entire legal system in France. It became the basis for legal systems in a number of other countries too, including the Benelux countries, Italy, Romania, Spain and the former colonies of all these countries.

But now, modernisation is underway. The section of the Code that deals with the law of contract was amended and restructured in its entirety in October 2016 (followed by a comprehensive rewrite of French employment laws in 2017). This marked the beginning of a new era through the abrogation and/or amendment of many articles of the Civil Code familiar to generations of legal practitioners and scholars as well as the codification of some new principles established by French case law. The reforms put into law a much more comprehensive statement of the French law of contract.

The new law has been a major event in France. The codified articles on contract law had remained almost completely untouched since 1804, making this the first overhaul of French contract law in over 200 years. It is also the culmination of several attempts at reform that began more than a hundred years ago and have been in the planning stage for the last 15 years. The importance of the changes extends far beyond France's borders. Many international insurers with commercial interests in France will need to consider how the changes impact their existing and future contracts, and ongoing claims and reserving requirements. It is also significant for insurers in the many countries that have used the Code as a model or a source of inspiration to amend their own statues or forge new laws.

The impacts have taken time to work through, and the impact on insurance contracts is still being questioned by insurance professionals. In this field particularly, there are likely to be numerous case law interpretations in the coming months as the French higher courts begin to render their rulings on contract issues under the new regime. The main points which are likely to pose interpretation issues in the context of insurance contracts are the following:

Pre-contractual information

The new Article 1112-1 of the French Civil Code provides that any party to a contract who has information which would be a determining factor in obtaining the agreement of the other party must be disclosed to the other party. Whilst the French Insurance Code also contains a number of disclosure obligations with sanctions (e.g. the nullity of the insurance contract in case of bad faith non-disclosure) this new contractual obligation may be applied by the courts to reinforce the obligations under the Insurance Code. For example, article L 113-2, paragraph 2, of the French Insurance Code provides that " the insured is obliged to answer exactly the questions asked by the insurer, in particular in the risk declaration form by which the insurer questions the insured at the time of conclusion of the contract, regarding the circumstances which allow the insurer to access the risks to be covered".

The French courts have interpreted this provision as limiting the insured's duty to inform the insurer at the time of conclusion of the contract to answering the questions asked by the insurer, in particular in the declaration form (see e.g. Cour de Cass., Civ 1, 17 March 1993, n° 91-10-041). The courts have accordingly ruled on many occasions that the insured cannot be sanctioned for non-disclosure of risk unless the insured failed to correctly answer a specific question asked by the insurer. Under the revised Civil Code, there may now be grounds for the courts to require spontaneous full disclosure at the time of conclusion of the insurance contract.

Validity of the insurance contract

Under the reform, the traditional requirement for the validity of a contract based on the object of the contract and adequate consideration (cause), has been replaced by a new criteria that the content of the contract must be «certain and lawful». Under the former rule, the validity of insurance contracts could be contested on the ground of lack of consideration (cause) or hazard (aléa). Under the new regime the basic criteria of the requirement of an uncertain event or hazard still remains but may be interpreted differently by the courts.

Abusive clauses

The new regime provides that a clause is abusive where it creates a «material imbalance» (déséquilibre significatif) between the rights of the parties under the contract (Article 1171, Civil Code).

Whilst the French Insurance Code already contains a number of provisions concerning abusive clauses, it remains to be seen how the courts will interpret the new notion in the context of insurance contacts.

Unforeseen circumstances

The new regime specifically provides that «if a change in circumstances which was unforeseeable at the time of the conclusion of the contract renders the performance of the contract excessively costly for a party who had not accepted to assume the risk, this party has the right to re-negotiate the contract» (Article 1195, Civil Code). It is clear that in insurance-related disputes, this Article may be invoked in a number of situations, in particular concerning issues of aggravation of risk, which the French courts will have to deal with.

Subrogation

The new regime maintains the distinction between «conventional» subrogation and legal subrogation (Article 1346, Civil Code) but the new wording will again have to be interpreted by the courts. One significant issue in insurance matters is to what extent the legal subrogation is quasi-automatic upon payment of the indemnity to the insured, i.e. whether or not the insurer in addition to showing payment must also show it had an obligation under the insurance contract to indemnify the insured. As regards the «conventional» subrogation, the new Article 1346-1 specifically allows for the parties to agree on the transfer of subrogation rights before the payment is made (as previously allowed by case law).

In conclusion, although the reform of French contract law is in itself likely to be beneficial, it has, in the short term, created much uncertainty for corporates operating in France. The ripple effects also need to be closely watched. In Belgium, similar reforms are currently being passed through parliament, and other countries are likely to follow suit in the coming years.

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INDIA

GROWTH CROSSING THE $100 BILLION (USD) THRESHOLD

It was recently reported that India's insurance industry has become worth more than $100bn US dollars. While numbers certainly reveal something, in this case they do not show the complete story. India has crossed a significant milestone, but there is still immense potential for this market to grow.

The insurance industry has been at the forefront of economic development in India and has driven the growth of our gross domestic product (GDP) in the last decade. Gross premium in the Indian insurance industry has reached approximately USD 100 billion with approx. USD 71.1 billion from life insurance and USD 23.38 billion from non-life insurance, pushing the country's sector into the league of larger insurance economies globally. In life insurance business, India is ranked 10th among the 88 countries, for which data is published by Swiss Re and 15th in global non-life insurance markets.

Post liberalisation and privatisation, the regulatory changes enabling growth in the domestic insurance industry started with the Insurance Law (Amendment) Act in 2015 which increased the foreign direct investment (FDI) limit from 26% to 49% to help attract foreign investments in the sector. Since then, insurers have been allowed to raise hybrid capital such as subordinated debt and/or preference shares from both onshore and offshore investors, divest equity through initial public offerings. The insurance regulator IRDAI (with support from the Government of India) has taken a multifaceted approach towards developing the local insurance market.

Creation of reinsurance hub

The Indian reinsurance sector has a good number of players (both domestic and cross border reinsurers) to promote a healthy and competitive market for reinsurance, and it is expected that the capacity will increase which will result in to the establishment of a reinsurance hub in India in near future. A number of factors including the recent regulatory changes, India's geographic advantage of being located in the heartland of South Asia with conducive relationships with the Chinese and Middle Eastern markets, the emerging economy and the exposure to increasing natural catastrophes allows India to become a regional reinsurance hub and expand aggressively and inclusively. The development and benefits of IFSC GIFT City in Gujarat (infrastructure, exchange control relaxations and tax benefits) has garnered interest of many insurers, reinsurers and intermediaries which demonstrates the potential of GIFT City to match up to global financial centres in Singapore, London, Tokyo and Dubai and further facilitate the creation of a regional reinsurance hub in India.

Risk based capital regime

The regulator is currently weighing the option of shifting calculation of capital of insurance companies to a risk based regimes from a solvency denominated regime. This will ensure light touch supervision for entities that manage their risk well and will allow them to maintain minimum capital to support its overall business operations in consideration of its size and risk profile. While there are predicted casualties along the way, in the coming years some form of price discipline may be implemented to create a balance and democratise the process of calculating capital requirements.

Innovation Sandbox

Indian insurance development has always been conventional and conservative in its approach, however, the rise of digital technologies are ushering in a more precise, data-driven era, creating huge opportunities for insurers to demonstrate their value and to reap the financial rewards of doing so. Parallely, today's customers have greater access to integrated information and their behaviour towards seeking and purchasing insurance products has immensely changed. The lack of brand loyalty and the need for exemplary customer satisfaction compounds the competition between insurance providers and the requirement to innovate and create seamless products further intensifies.

Insurance companies are now embracing InsurTech disruptors instead of combating them and are developing enterprise innovation models. IRDAI is granting access to start-ups and aggregators and is also enabling the innovation sandbox experiment. IRDAI has recently released the 'Report of the Committee on Regulatory Sandbox' which recommends that a regulatory test environment is needed to foster growth in the insurance value chain and increase the pace of the most innovative companies, in a way that provides InsurTech in particular and the Fintech sector as a whole with flexibility in dealing with regulatory requirements and at the same time focussing on policyholder protection and managing risks in a controlled environment.

Government Schemes

The Indian Government has launched various social insurance schemes in several insurance segments that have increased penetration and driven sectoral growth. In April 2016, the Government launched Pradhan Mantri Fasal Bima Yojana (PMFBY), the flagship government scheme for agricultural/ crop insurance in India. Enrolments under the Pradhan Mantri Suraksha Bima Yojana (PMSBY) reached 130.41 million in 2017-18.

Industry experts have also predicted that the government's ambitious national health protection scheme- Ayushman Bharat scheme covering 100 million poor and vulnerable families with a cover of Rs. 5 lakh (US$ 7,723) per family of tertiary care and hospitalisation will be transformative for the insurance industry as it would have a major multiplier effect on a host of allied sectors like pharmaceutical, medical devices, data management, insurance hospitality and human resource management.

While the insurance sector regulator is rapidly taking the insurance market into the next phase of growth, other financial services regulators and law makers of the country are looking to holistically incentivise insurance market players. For e.g., some insurance products are covered under the EEE method of taxation, which translates to an effective tax benefit of approximately 30% on select investments and exchange control regulator has opened the market for offshore borrowings etc.Having crossed a major milestone, the Indian insurance industry is expected to grow significantly by 2019-20, aided by the Centre's Ayushman Bharat health insurance scheme.

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NORWAY

THE MINNOWS TAKE ON THE GIANTS OVER NATURAL PERILS COSTS

Norway has suffered numerous natural disasters throughout its history and as a result has a longstanding pooled arrangement for natural perils risk.

The current pool covers damage caused by landslides, storms, storm surges, floods, earthquakes and (uncommon in Norway) volcanic eruptions: effectively almost all natural and weather-related disasters that occur. The compensation system is two-fold, being regulated both by private insurance and by public/government funds. This two-part system was adopted in 1979 and had a dual purpose. Partly, it was intended that those who suffer damage from a natural accident should be better covered than under previous regulations. On the other hand, the government also sought more privatisation of natural peril covers. The regulations introduced in 1979 are now enshrined in the Natural Perils Insurance Act of 1989 (no. 70).

Private natural perils cover

Currently private natural perils insurance is required by law and is a compulsory cover linked to fire insurance in Norway. Buildings and movable property covered against fire are therefore also automatically covered against natural damage. The insurance works on a communal cover principle. The premium is determined annually as a per capita rate of the total value of fire insurance cover and is the same regardless of location of the building and how risky an area may be. This works in contradiction to the normal insurance rule, where price reflects levels of risk, but the 1989 laws play an important role in helping to secure many Norwegians' security and financial stability, allowing them to live and operate throughout the country.

Under this system, the individual insurance company acts as the insurer, issues the insurance certificates, pays compensation and handles all direct contact with the policyholders. The Norwegian Natural Perils Pool maintains oversight of the overall arrangements for the pool.

Norwegian Natural Perils Pool

The Norwegian Natural Perils Pool itself serves as a link between the Norwegian insurance industry and the Directorate of Agriculture. Its activities are governed by the Natural Perils Insurance Act and the Rules for the Norwegian Natural Perils Pool. All insurers providing fire cover in Norway must be member of the Pool.

Each insurance company shares information about claims, payments and provisions to the Pool's claims reporting system. The Pool acts as a levelling mechanism whereby claims and costs are distributed between members in proportion to their share of the Pool, which corresponds to their share of the market for fire insurance in Norway. The premium rate is set by the Pool's board. If the premiums earned exceed the insurer`s relative share of claims payments made via the Pool and provisions for outstanding claims, the difference is allocated to a special natural perils reserve at the insurer. This provision has always historically belonged to the insurer and must be used exclusively to cover future natural peril claims.

Public cover

Beyond this, public natural perils compensation covers property damage that is not insurable and that is not covered under the above private arrangement. The public arrangement is application-based and the state agricultural administration makes decisions on whether to accept applications. This public arrangement is designed to to promote safeguarding measures against future natural damage and subsidies for this purpose.

The system under review

The current Norwegian natural perils arrangement has been increasingly criticised in recent decades.Sources for discontent have been two-fold – criticism has been raised against the natural coverage arrangement as a whole, and against the financial structure and management of the Pool in particular. Among other things, it has been pointed out that the principle of communal costs does not give Norway's insureds any incentive to invest in preventative measures, such as flood barriers, which are becoming more and more important in light of Norway's exposure to climate change.

Criticism has also been levelled at some insurers. High premium rate levels over time have led to a considerable natural perils surplus being accumulated by the large and established insurance companies – approximately NOK 8,5 billion (or £9bn) at the end of 2017. As the larger insurers claim ownership to this sum, they have been able draw on saved capital to pay claims, while newly established companies have to pay the ever-increasing natural damage claims charges from their equity. A number of smaller companies have spoken out against this in strong terms, branding the current scheme anti-competitive, and claiming it is distorting the market. As a result, in 2018 a new Natural Perils Insurance Committee was appointed to evaluate the effectiveness of current coverage arrangements and to consider alternatives. Their report, published in February 2019, proposed a raft of amendments to today's regulations.

Although the Committee concluded that basic principle of the system should be retained, their proposal involves:

1. Natural perils capital (surplus) should no longer be managed by the individual insurance companies. Future profits should be collected in a joint fund in the Pool.
2. Natural perils cover should still be financed as a fixed per capita rate based on the total fire insurance sum.
3. Insurance companies should continue to bear the risk that the fund is insufficient, but the already established natural perils capital of NOK 8,5 should be used if needed.
4. Insurance companies should continue to handle claims settlements.

The proposal has been largely praised by the smaller companies, but unsurprisingly, larger companies have disagreed, and suggested that the new solution will be bad for the market. This has led to a stalemate, and as of today, no legislation has been brought before the Norwegian parliament. Although the minnows have won in principle, it seems that the market giants still hold some significant cards. Watch this space in 2019 to see who wins, and how the story of natural perils cover in Norway evolves.

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AUSTRALIA

RIDING THE WAVE OF REGULATORY AND SOCIETAL SCRUTINY

Much can change in six months, and this is particularly true in the current Australian environment. Fundamentally, the Australian insurance market is in the midst of volatile times, a reflection of the hardening global market but also of the renewed focus on "doing the right thing" and restoring trust following the recent Financial Services Royal Commission. When this regulatory and societal scrutiny is combined with the fast pace of change around AI-related technologies, customer behaviours, cybercrime and data protection, the local industry is under unprecedented regulatory pressures and constraints.

Property

Property is a leading insurance 'hot topic' for courts and the regulator in Australia, partly because of the ripple effect of the construction boom on the insurance industry. There is also a rising incidence with building failure issues. In the property space there is continued litigation, whether class or individual action, in relation to the dominant problem of combustible cladding. With rectification costs at each impacted site usually running into seven figures, insurers are faced with challenges around managing the fall-out from both sides of the argument. Overlaid with that, there are highly publicised site-specific building quality problems, such as the movement and cracking which caused evacuation of residents from almost 400 new apartments in the recently opened Opal Building in Sydney and the apparent failure of the primary support structure and facade of another Sydney apartment building, Mascot Towers.

Further, and also not unrelated to the construction boom, Australia is seeing an upswing in silicosis claims, primarily coming out of Queensland, and to a lesser extent New South Wales and Victoria, with class actions also looming there. This is attracting a lot of media scrutiny.

Finally, there are significant other pain-points being experienced by property insurers around D&O insurance, with record numbers of class actions and "event-based" claims; and insurers are, of course, vulnerable to the increasing frequency of climate-driven disasters.

Royal Commissions – not one, but two – impact insurers

In the Directors & Officers and Financial Lines space Australia is seeing continued fallout from the Financial Services Royal Commission. There is of course litigation spinning out of the Commission's findings but the regulatory impact is also starting to bite in the form of some very interesting decisions coming out of the Australian Financial Complaints Authority, to the point, at the extreme end, where insurers are being told they ought to pay for claims under policies where there has never been a contract of insurance in existence because of alleged uncertainties or consumer misunderstanding.

Hard on the heels of the Financial Services Royal Commission has come the Aged Care Royal Commission, which, in October 2019 produced an interim report with some truly disturbing conclusions. The report found that found that a fundamental overhaul of the regulation and funding of aged care in Australia is required. Lawyers are tied up in that space as more issues come to light and hearings progress.

Cyber risk

The growth of cyber risk is significant in Australia as elsewhere, and insurers are struggling to keep pace as the nature and extent of cover evolves. Some of the reported cases particularly in North America involve huge numbers. Lawyers also need to keep pace – advising on pre-breach risk management and post-breach cyber claims, as well as developing data protection, privacy structures and breach response tools.

Climate change – the uninsurable risk?

Unsurprisingly, climate change is the biggest issue of them all. Reinsurers have been sounding the alarm for many years and anecdotally it is a standing agenda item for all major Australian insurance players. With climate-driven disasters impacting more of the population than ever before, there is intense debate about whether parts of Australia are becoming uninsurable – with some places already considered too disaster-prone to insure. Whether or not it is a function of the Financial Services Royal Commission fuelling public expectations around access to and affordability of cover, and the perceived past conduct of some insurers; insurers face a tough task in balancing what is often sometimes controversially referred to as a "social licence to operate" against the harsh realities of increased climate change-induced risk in the property and related cover space.

Looking ahead

What does the next twelve months look like? In the case of direct legislation impacting the industry, there will not be much if any change. But, what will have an impact is how insurers respond to the increasing impact of regulation on the Financial Services sector generally. The settlement of disputes through tribunals or government agencies rather than traditional adversarial or internal processes will continue to challenge insurers "social licence to operate" and appetite for some risks as they deal with their ability to price outcomes not contemplated before the Financial Services Royal Commission.

The insurance industry as a whole – whether it's the companies who provide the cover, intermediaries or the lawyers and other service providers – are all fighting for talent in a highly competitive space. The war for talent is not going away any time soon! To deal with the tidal wave of structural and regulatory change, firms have to continue to be very agile, have great technology and great people and have to be able to tap into the best and brightest of the younger generation; a democratisation or flattening of the traditional pyramid.

As a legal profession, our role is to support insurers during this change. We are expected to do more, and that forces us to focus on our process improvement and our investment in technology, leveraging data that we can apply to enhance our services and truly collaborate with our clients.

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