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In this week's Insurance Bulletin:

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1. REGULATION AND LEGISLATION

UK: Innovation in financial services – FCA sets out progress and next steps

The FCA's Executive Director for Strategy and Competition, Christopher Woolard, recently spoke in London on the impact of FCA Innovate, the FCA project which is aimed at promoting innovation in financial services in the interests of consumers. He also set out the FCA's next steps to ensure further progress.

Mr Woolard stated that firms completing the Innovate programme have come to market 40% faster than equivalent financial services firms, saving 3 months from testing to roll out. He explained that the entry into the market of smaller insurance firms has had a knock-on effect on incumbents, who have been forced to innovate their services, and in some cases have formed partnerships with these start-ups.

Overall, FCA Innovate has assisted nearly 700 firms in some capacity, and has received over 1,500 support requests since its launch in 2014, at which time it was staffed by just 2 employees.

Looking to the future, Mr Woolard referred to the Global Financial Innovation Network which the FCA launched at the start of 2019. This is an international network of regulators comprising 35 organisations that share knowledge and allows firms to trial cross-border initiatives. Mr Woolard said that projects aimed at solving cross-border issues such as trade and consumer access *"are not just tinkering around the edges of the status quo, but have the potential to fundamentally change how things are done"*.

While there are still significant challenges to face, Mr Woolard argued that innovations previously seen as "niche" are now operating en masse for the good of the public, including in areas which are currently in the public eye – for example, FCA Innovate has announced a list of 9 firms to work on its Green FinTech Challenge.

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EU: Big Data Analytics – EIOPA's findings following thematic review in July 2018

In July 2018 the European Insurance and Occupational Pensions Authority (EIOPA) undertook a thematic review into the risks and benefits of "big data analytics" in motor and health insurance. The purpose of the review was to understand the types and sources of data and the analytics tools used and to identify whether supervisory or regulatory actions were required at a time when data and security was at the forefront of regulatory development. EIOPA sought to gather evidence on the use of big data by insurance undertakings and intermediaries, whether in product development, sales/ marketing, pricing/underwriting or claims management.

Data collection and processing is integral to the business of insurance undertakings, as is data-led statistical analysis. Insurance undertakings gather and process data in order to inform underwriting decisions, set premiums, assess claims and prevent fraud. Big data is the act of gathering and storing large amounts of information from a variety of sources and in a variety of formats for eventual analysis. The aim of big data analytics is to reveal patterns, trends and associations, particularly relating to human behaviour.

Earlier this month EIOPA published the results of its thematic review. This covered a total of 222 insurance undertakings and intermediaries, representing over 60% gross written premiums of the motor and health insurance markets in each of the 28 member states and therefore

provides a good basis on which to draw conclusions from.

Broadly, EIOPA made the following interesting conclusions:

- there was a strong trend towards increasingly data-driven business models across the member states
- increased combination of traditional data sources (such as demographic data or exposure data) with new data sources (such as online and telematics)
- increased use of data outsourced from third-party data vendors
- prevalence of artificial intelligence (AI) and machine learning (ML). 31% of firms were already actively using them, with another 24% considering using them
- prevalence of cloud computing services. 33% of firms were already using them, with a further 32% intimating a move towards it over the next 3 years

EIOPA considers that there are many opportunities for the insurance industry and consumers arising from big data analytics, with stakeholders agreeing that, provided the key risks are addressed, it offers consumers a better quality of products and services. With the recent data protection regulations in mind, EIOPA was keen to stress the importance of developing sound data governance arrangements in light of the explosion of big data. Although firms will already have in place adequate measures, the advent of big data exacerbates the risks and implications arising from big data, particularly regarding accuracy, transparency and auditability. EIOPA would like to see more transparency towards customers and for firms to contribute towards public awareness, including in relation to consumer rights relating to the collection and use of big data by firms.

Following from the results, EIOPA and its InsurTech Taskforce will look into various other big data analytics initiatives, such as the supervision of algorithms relating to the AI and ML, the ethics and fairness in respect of the use of big data analytics by the market, guidelines on outsourcing of cloud computing services by insurers and cyber insurance and security.

A copy of the results of the thematic review can be accessed at https://eiopa.europa.eu/Publications/EIOPA_BigDataAnalytics_ThematicReview_April2019.pdf.

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2. COURT CASES AND ARBITRATION

England & Wales: Thoughts on Reinsurance Allocation – *Equitas v MMI*[1]

The correct allocation of EL mesothelioma losses to excess of loss reinsurances has been an issue in the market since at least as far back as the 1990s. Mesothelioma differs from other asbestos diseases in that it is "indivisible", namely injury can be caused by any material exposure rather than proportionately by reference to exposure.

Reinsurances written post 1984 often contain an ACOD/B clause, which was introduced in that year and which allocates loss on a "pro rata / pro rata" basis, namely the loss allocated by reference to the period of reinsurance versus exposure and with limits and retentions proportionately reduced. However, what is the correct legal position prior to 1984 or where ACOD/B was not included in the reinsurance?

Arguments historically from reinsureds have been that loss could be "spiked" (a word generated by one reinsured running this argument) 100% in any relevant reinsurance year with the application of one retention only. Reinsurers have argued for pro rata allocation across reinsurance years with a full retention each year. Most of the major EL players have

1. [2019] EWCA 718

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settled with their principal reinsurers over the years on an ACOB/B basis but with some discount on their claim.

MMI has not so settled. Rather, it has sought to pursue "spiking" against a reinsurance year written by Lloyd's (now Equitas) and with the effective application of one retention post contribution/recoupment. The Court of Appeal, in a decision handed down in April 2019, has found it is not able to do so, but has to spread its loss over years of exposure and with full reinsurance retentions each year.

Background

Before turning to the Court of Appeal decision, it is helpful to summarise briefly the mesothelioma position at employer and insurer level:

1. As a result of the House of Lords' decision in *Fairchild v Glenhaven*[2], a mesothelioma victim tortiously exposed by two or more employers, need only prove material contribution to the risk to be treated as having caused the disease – a far weaker test than the usual balance of probabilities.

2. Following the House of Lords' decision in *Barker v Corus*[3], the employer is only liable at common law on a several basis for the extent of its relative degree of contribution to the risk. This finding was expressed to be due to fairness to employers, given the significant relaxation of the law on causation in *Fairchild*.

3. The Compensation Act 2006 reversed *Barker*, providing that employers were to be liable for 100% of the loss.

4. In *Zurich v IEG*[4], the Supreme Court decided by a majority that an EL insurer in turn was liable to indemnify the employer for 100% of the loss each year (i.e. the employer could "spike"), but would gain contribution / recoupment rights as against insurers on different years and employers to the extent uninsured on other years. Such decision ensured the credit risk in respect of other insurers was borne by the insurer rather than the employer, thus protecting the victim.

Equitas v MMI

The central submission of Equitas was that the *Fairchild* and subsequent jurisprudence was innovative in order to ensure compensation for the victims of mesothelioma. However, that objective had been achieved and the same policy considerations did not apply at reinsurance level. Accordingly, the law should return to basic insurance principles of non-selection and coverage by risk, such that a Barker approach should be applied to ensure that liability was apportioned by reference to reinsurance time on risk.

Equitas put forward three ways in which this objective could be achieved: (1) by way of deemed allocation or implied term requiring MMI to allocate proportionately (it being accepted that MMI had not allocated itself due to its 100% liability each year to its insured employer); (2) by way of the duty of good faith or good faith principles generally; and / or (3) by way of contribution / recoupment where the loss was treated as proportionately allocated to the reinsurance programme and from the ground up.

The Court of Appeal accepted that the law should "return in a principled way to a more orthodox approach" given victims had now been protected. As to the legal manner of producing such result:

1. Deemed Allocation / Implied Term

The Court of Appeal accepted in principle that as the employer was 100% liable, so was the reinsurer as reinsurance was a type of insurance of the underlying risk (a result which would still have followed on the alternative analysis of reinsurance as a type of liability insurance of the reinsured) – and reflecting the *IEG* finding that the insurer was 100% liable each year. Accordingly, any deemed allocation or implied term would be inappropriate as inconsistent with the legal effect of the reinsurance terms.

2. [2002] UKHL 22
3. [2006] UKHL 20
4. [2015] UKSC 33

2. Duty of Good Faith

The Court of Appeal noted that the duty of good faith was limited in principle to a duty of disclosure on inception and not to act fraudulently on a claim, and thus it had no part to play in the current context.

However, the Court considered a line of cases involving the implication of a term to the effect that a party to a contract shall act in good faith i.e. not irrationally in exercising a contractual power – most notably *Gan v Tai Ping*[5] where such term was imposed to fetter a reinsurer's ability to decline to consent to a settlement.

The Court of Appeal found the authorities concerned the proper construction of the contract. Here, there were "powerful reasons" to imply such a term to the effect that MMI could only present reinsurance claims by reference to each year's contribution to the risk. This was because the concept of spiking was inconsistent with the presumed intentions and reasonable expectations of the parties at the time of conclusion of the reinsurance contracts. *Fairchild* and its progeny could not then have been predicted and produced a result inconsistent with fundamental principles of liability insurance law – such principles being an inability to select cover against insurers, coverage by reference to risk during the policy period, and loss falling into one rather than into a series of separate periods. The position was materially different at insurance level due to the need to ensure victim compensation.

3. Contribution and Recoupment

Assuming 100% liability each year and an ability to spike, the Court of appeal found the "just" solution to eliminate anomalies flowing from the *Fairchild* jurisprudence was to adopt the approach proposed by Equitas, namely to treat the loss as spread across the years with a full retention in each, and then to operate contribution / recoupment accordingly. The full retention each year reflected the fact that MMI agreed to such in years victims were exposed, and such approach ensured higher layer reinsurers were not exposed until full exhaustion of retention and underlying reinsurances – all no doubt, it was said, reflecting the lower premium charged by such higher layer reinsurer.

The net effect of the above, given the level of retentions and increasing over the years, will be very significantly to reduce any MMI reinsurance recovery.

Comment

One of the results of reinsurance disputes usually being resolved by way of arbitration is that there is a dearth of authority on allocation. Indeed, prior to *Equitas* there were only two cases directly addressing the issue – *MMI v Sea Insurance*[6] and *IRB v CX Re*[7]. The latter is a difficult decision from which to draw any general principles. The position generally on reinsurance allocation seems to be as follows:

1. Where the reinsured has allocated to particular years by settlement, the reinsured cannot recover more than such allocation due to the operation of the indemnity principle.

2. The reinsurer is able to open up the settlement to ascertain the "real basis" of the settlement to ensure no breach of the indemnity principle. The Court of Appeal appears to have proceeded on this basis in *Equitas* by analogy with authorities addressing the ability of an insured to demonstrate quantum of a loss when claiming under a liability insurance and a reinsured's ability to establish loss fell within the terms of a reinsurance when relying on a follow clause.

3. Leaving to one side the indemnity principle, the reinsured's own allocation is legally irrelevant to reinsurance coverage. That is dictated by the terms of the reinsurance itself and the underlying factual position (MMI v Sea).

4. The reinsured is obliged to allocate and claim EL mesothelioma losses on a proportionate allocation basis. In *Equitas*, the Court of Appeal was at pains to stress this position is applicable only to such losses due to the manner in which the law on mesothelioma has developed.

As regards the *Equitas* decision itself, a number of questions arise:

1. Is it right that "spiking" offends basic principles of English insurance law? The reinsurance was written on the basis of loss due to occurrences during the reinsurance period, not relative risk of indivisible loss. It might be said that all that has happened is that the causal test for loss has been weakened to both insurers' and reinsurers' detriment given indivisible loss but which still falls within the reinsuring clause.

2. Is it right in any event that parties contracting, in say, the 1960s would objectively have decided that if the causal test for the insured's liability was weakened, the insurer alone must bear the consequences of such decision? The general principle is that parties to a contract must bear the consequences of a change of law.

3. One can see in principle that allocation spread across the years for the purposes of contribution / recoupment should be effected from the ground up to reflect the reinsurance market's relative participation in the risk. Can it be said the risk has been realised due to 100% liability in principle in each year?

The Court of Appeal has granted leave to appeal to the Supreme Court, a Court which presently contains no Justices experienced in insurance or reinsurance law. The market will await with interest the final say on this subject.

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5. 2001] Lloyd's IR 667
6. [1998] Lloyd's Rep IR 421
7. [2010] Lloyd's Rep

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"Whilst the Court of Appeal's decision offered some limited relief to entertainment venues, the case emphasises the liability of music venues where sufficient steps are not taken to reduce noise levels at source. "

England & Wales: The Court of Appeal makes some noise in *Christopher Goldscheider v ROH Covent Garden Foundation*[1]

In a recent case of interest to entertainment venues and their insurers, the Court of Appeal considered the potential liability of employers in respect of excessive levels of noise in the workplace.

Background

The Claimant, Christopher Goldscheider, was a viola-player employed under a full-time, non-exclusive contract with the Royal Opera House ('ROH'). During rehearsals, Mr Goldscheider was placed immediately in front of the brass section in the orchestra pit. Rehearsals were very loud and although he tried using ear plugs provided, he experienced pain and hearing difficulties. The ROH investigated Mr Goldscheider's complaints, and found that other orchestra members had similar concerns. The pit's layout was rearranged to create wider gaps between musicians, and noise levels were monitored to ensure a decrease.

Following the incident, Mr Goldscheider attempted to return to work several times but found it impossible due to his ongoing symptoms. His employment at the ROH ended in July 2014 and he is no longer able to play in an orchestra. He therefore sought to claim against the ROH for personal injury caused by "acoustic shock".

At first instance, Her Honour Judge Davies determined that the Claimant had suffered from "acoustic shock", caused by the failure of the ROH to reduce noise exposure to as low a level as reasonably practicable, as well as other breaches of statutory duties under the Control of Noise at Work Regulations 2005 (the 'Regulations'). In particular, it was noted that mandatory wearing of ear protection in the orchestra pit had not been enforced.

The ROH sought to appeal the decision, and the Association of British Orchestras, Society of London Theatre and UK Theatre association intervened on its behalf.

Court of Appeal decision

The Court of Appeal agreed with the decision that the ROH had been in breach of duties imposed by Regulation 6. Whilst it was accepted that the ROH had taken several steps (such as the use of hearing screens) in an attempt to reduce noise levels, the Defendant failed to show that it reduced the noise exposure to as low a level as was reasonably practicable, and that it took all reasonably practicable steps in doing so.

However, the Court of Appeal did acknowledge that it is not practicable for orchestra players to wear ear protection at all times. It therefore set aside the High Court's finding that, in failing to enforce the wearing mandatory wearing of earplugs by orchestra players, the ROH had breached Regulations 7 and 10. This decision will be welcomed by music venues and their insurers, as venues will not now face the arduous task of enforcing the wearing of ear protection by employees at all times.

In respect of factual and medical causation, the Court of Appeal found that Her Honour Judge Davies was entitled to reach the conclusions that she did on the evidence provided, suggesting that "acoustic shock" is now a generally accepted concept. The appeal was dismissed.

Conclusion

Whilst the Court of Appeal's decision offered some limited relief to entertainment venues, the case emphasises the liability of music venues where sufficient steps are not taken to reduce noise levels at source. The ROH is considering an appeal of the decision, so further discussion on this potential liability is likely in the near future.

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1. [2019] EWCA Civ 711

England & Wales: Litigation Funding – Money (and ors) in the Money

In a decision which could have a significant impact on the litigation funding and ATE insurance markets, the court in *Davey v Money & Ors*[1] held that litigation funders could be liable for the full amount of an adverse costs order against their funded client.

The costs judgment in *Davey v Money* arose from a claim brought by Ms Davey against the administrators appointed to her company (the first and second defendants) and the company which appointed the administrators (the third defendant). In order to pursue the claim, Ms Davey required very substantial funding, which she obtained from ChapelGate.

When Mr Justice Snowden found against Ms Davey in the Chancery Court, he ordered that she pay the defendants' costs, which they claimed were approximately £7.5m. She was unable to do so and the defendants applied for a non-party costs order against ChapelGate pursuant to section 51 of the Senior Courts Act 1981.

ChapelGate admitted that it was liable for the adverse costs order against Ms Davey but argued that its liability should be capped at the level of the funding provided to Ms Davey. In doing so, it relied on what was known as the Arkin cap, a principle arising from the decision of the Court of Appeal in *Arkin v Borchard Lines Ltd* (Nos 2 and 3) [2005] 1 WLR 3055. The defendants argued that the Arkin cap was not, in fact, a rule to be applied to all cases where an unsuccessful party was funded, but a decision based on the specific facts of the Arkin case.

The Arkin cap has been the subject of criticism since the decision was made, including from Sir Rupert Jackson, whose views were cited in the judgment. Sir Rupert's views, expressed in 2009, were that "the criticisms of Arkin are sound. There is no evidence that full liability for adverse costs would stifle third party funding or inhibit access to justice. No evidence to this effect is mentioned in the judgment. Experience in Australia is to the opposite effect… It is perfectly possible for litigation funders to have business models which encompass full liability for adverse costs. This will remain the case, even if ATE insurance premiums (in those cases where ATE insurance is taken out) cease to be recoverable under costs orders…". He went on to recommend that the rule ought to be changed but no such change was adopted by the courts or enacted in legislation.

In considering whether or not to apply the Arkin cap to the application against ChapelGate, the judge was not in a position to overrule the decision in Arkin, which had been given by a higher court. Instead, he relied on the significant differences in the funding arrangements between Arkin and the instant case. In so doing, he held that ChapelGate was liable for the entirety of the costs order against Ms Davey.

It remains to be seen whether the decision will be appealed on the grounds that the judge ought to have been bound by the decision in Arkin. However at this stage, it appears that the Arkin cap should no longer be regarded as a general rule, but an approach that was suitable on the facts of the Arkin case. The apparent increase in the exposure of funders and their ATE insurers to adverse costs orders could give rise to an increase in the costs of funding and/or ATE premiums, although the market is much more mature now than when the Arkin decision was made.

For further information on the impact of the decision in *Davey v Money*, please see our earlier article at http://www.hfw.com/Are-we-seeing-the-end-of-the-Arkin-Cap-May-19, written by Nicola Gare, a member of the HFW Funding Committee, for details of which please see our Funding and Financing page at http://www.hfw.com/Disputes-Funding-and-Financing.

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1. [2019] EWHC 997(Ch)

Brazil: Subrogated Insurers bound by arbitration clause in underlying contract

A decision issued by the Brazilian Superior Court of Justice (STJ) on 15 May 2019 represents a shift in the Court's approach as to whether a subrogated insurer is bound by an arbitration clause in the contract between the insured and a third party.

Previously, where the contract between the insured and the third party contained an arbitration clause, subrogated insurers had the option of pursuing the recovery in arbitration or in court. This was on the basis that subrogated insurers were not bound by the arbitration clause. If the other side contested this, i.e. pushed for the case to be heard in arbitration, courts tended to rule in favour of their own jurisdiction. However, the recent judgment handed down on 15 May 2019 confirms that an insurer is bound by the arbitration clause.

The decision, which has not yet been published in full by the STJ, was issued in a case brought before the Court for the validation of a foreign arbitral award issued by the ICC in New York.

Under Brazilian law, the subrogation rights of the insurer stem from article 786 of the Brazilian Civil Code. Article 786 states that "Once the insurance indemnity is paid, the insurer is subrogated, within the limits of the respective value paid, in all the rights and actions the insured has against the party who caused the damage." Before the recent decision of the STJ, the prevailing interpretation of this article was that it offered the subrogated insurer the option of resorting to arbitration, at its own discretion, while still leaving open the possibility of seeking recovery in Court.

On the basis of the recent decision, if the underlying contract provides that disputes should be resolved through arbitration, an insurer cannot deviate from this provision and resort to the Courts to pursue recovery. The Court held that since the arbitration clause is binding on the insured, it also binds the insurer in any subrogated claim against a party who caused the damage.

The decision was not unanimous and the judgment transcripts have not yet been made public. While STJ decisions do not have binding precedent value, they are persuasive in forming future case law in Brazil. The clarification provided by this recent judgment needs to be considered by underwriters when assessing the merits of pursuing subrogated actions against third parties.

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