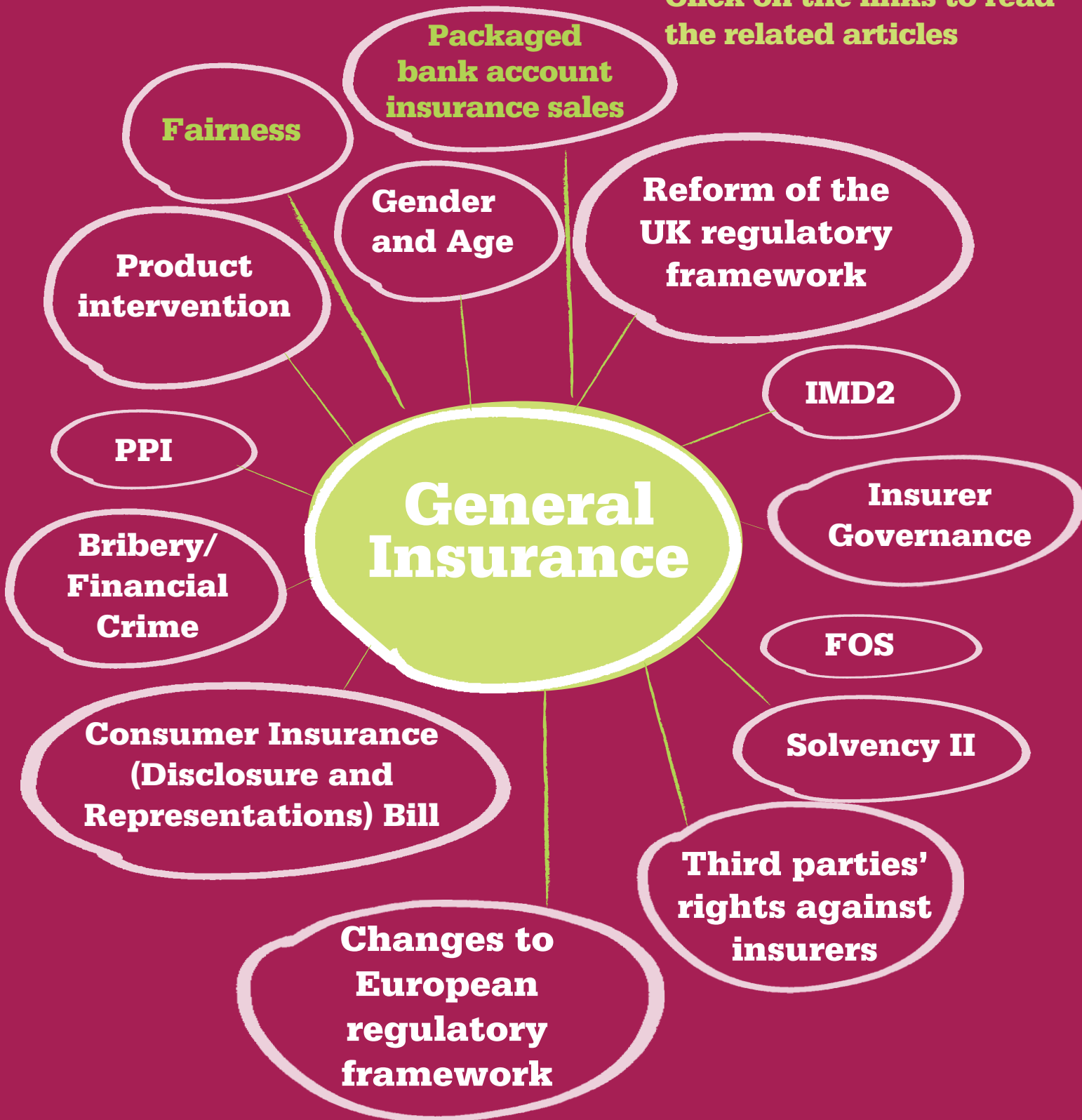


Financial Institutions Group

General insurance update on legal and regulatory developments

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This update has been prepared as a general overview mindmap for legal and regulatory issues on the horizon for general insurance clients. Information in this update is for information only and should not be relied on as advice.

The latest updates (January 2012) are indicated in green above

The Prudential Regulation Authority

Reform of the UK regulatory framework

In June 2010 the Government announced plans to abolish the current system of financial regulation, a tripartite system shared by the Treasury, the Bank of England and the Financial Services Authority (the FSA). This followed criticism of failures of the system during the recent/current financial crisis. The FSA in its current form will cease to exist and in its place the following three new regulatory bodies will be established:

- **The Prudential Regulation Authority (the PRA)**

The PRA will be a subsidiary of the Bank of England and will be responsible for the prudential supervision of insurers, deposit-takers and a small number of investment firms.

- **The Financial Conduct Authority (the FCA)**

The FSA will become the Financial Conduct Authority (the FCA) and will continue to be responsible for regulating the conduct of all firms, including those firms regulated by the PRA, as well as those that are not.

- **The Financial Policy Committee (the FPC)**

The FPC will sit within the Bank of England and will be responsible for macro-prudential regulation, effectively monitoring the combined effect of individual firms' actions.

On 16 June 2011 the Government published the draft legislation which will implement the changes. It is intended that the transfer of powers to the new regulatory bodies be completed by the end of 2012, with the new authorities becoming operational at the beginning of 2013.

The PRA's approach to supervision of insurers

The newly formed PRA will be responsible for the authorisation, prudential regulation and day-to-day supervision of all firms that are subject to significant prudential regulation, including banks, building societies, insurers and certain investment firms. As the FCA will act as the conduct regulator for these firms, they will be known as 'dual-regulated' firms.

The specific nature of insurance means that insurers are exposed to a different set of risks than banks, leading to a different impact on the stability of the financial system should an insurer fail. Recognising this and the fact that in practice it is difficult for policyholders to monitor the financial health of their insurer, the PRA's supervision of insurers is to be framed in a different way to that of banks.

On 20 June 2011, the FSA and Bank of England published a joint paper setting out how the PRA will approach the supervision of insurers. This briefing note will provide an overview of the PRA's approach and highlight a few of the issues that insurers may wish to consider.

The PRA's objectives

The PRA's general objective is to promote the safety and soundness of PRA authorised firms.

The PRA's insurance objective is twofold: to secure an appropriate degree of protection for policyholders whilst minimising the adverse impact that the failure of an insurer, or how it carries out its business, could have on the stability of the system. It should be noted, however, that the PRA is not required to ensure that no PRA authorised person fails and an express statement declaring this will be included in the new legislation that will implement the changes.

The PRA will treat UK subsidiaries of overseas firms in the same way as UK-headquartered firms, but will only have limited powers to supervise branches of EEA Insurers that have passported into the UK.

Scope of regulation of insurers

Dual-regulated firms include the following insurance entities:

- insurers (including retail mutual insurers and friendly societies)
- reinsurers and
- Lloyd's of London's Society of Lloyd's and Lloyd's managing agents (although please note Lloyd's members' agents and advisers, as well as Lloyd's brokers will be regulated solely by the FCA).

(for the purposes of this briefing, collectively known as **Insurers**)

The PRA will treat UK subsidiaries of overseas firms in the same way as UK-headquartered firms, but will only have limited powers to supervise branches of EEA Insurers that have passported into the UK.

Overview of the PRA's regulation of Insurers

Authorisations

Applications for authorisation to be a regulated firm will be made to the PRA, who will administer the application and be responsible for granting authorisation. However, the FCA will have to give its approval before granting the permission and it is intended that it will be fully involved in the authorisation process. This is in line with the overwhelming majority of those who responded to the February 2011 consultation and expressed a wish for applications to be made to a single regulator.

Permissions

An Insurer already authorised by the PRA would need to apply to the PRA in order to vary its permissions to undertake additional authorised activities.

Approved persons

It is intended that the PRA and FCA will have a dual role in approving individuals, although the PRA will have primary responsibility. The PRA will lead the process for roles that have a bearing on the safety and soundness of the firm, such as 'Significant Influence Functions' and its assessment will cover the competence of individuals applying to perform controlled functions, as well as their probity and integrity. The FCA will be responsible for approving individuals to conduct-focused controlled functions.

Change of control

The PRA will consider change of control applications, but will be under a statutory duty to consult with the FCA. Should the FCA object to an application on the grounds of the risks of money laundering or terrorist finance, the application must be refused or approved subject to specific requirements.

Where the target firm is regulated by the FCA, but is in a group which contains a dual-regulated firm, the PRA needs to be consulted. The PRA can then refuse an application on the grounds that following the change of control, either the firm will be unable to meet its prudential requirements or the regulator will be unable to supervise the firm.

Passporting

The PRA will be responsible for issuing relevant notices where an Insurer wishes to passport out of the UK by way of a branch office.

Rule waivers

If an application for a waiver or modification relates to an Insurer, both the PRA and FCA must consult the other before deciding on the application.

Part VII transfers

The PRA will be responsible for regulatory duties relating to applications under Part VII of the Financial Services and Markets Act 2000 (FSMA) for the transfer of insurance and banking business, although the FCA will need to satisfy itself that the transfer will not adversely affect customers of the firms involved in the transfer.

Each of the PRA and the FCA will be given powers equivalent to those available to the FSA under section 113 of FSMA, allowing them to apply to the court for an independent actuary's report after the transfer has been approved by the court.

Enforcement

The PRA, like the FCA, will be given a new power allowing it to publish the fact that it has issued a warning notice to a firm, together with a summary of that warning notice.

The PRA will not be obliged to publish this information, although it is to be expected. The PRA must consult the person to whom the notice will be given before any publication.

The PRA will not be permitted to publish a warning notice to Insurers if, in its opinion, it will be:

- unfair to the respective Insurer
- prejudicial to the safety and soundness of the Insurer or
- prejudicial to securing the appropriate degree of protection for policyholders.



Picture above courtesy of www.istockphoto.com

The PRA must also publish that it has issued a notice of discontinuance, if it later decides to take no further action.

The PRA's Power of Veto

Recognising that the PRA should be the best equipped regulator to make assessments of financial stability risks, it will be given a limited power of veto over the FCA's actions. The PRA will only be able to exercise its veto if it considers that the FCA's proposed action would:

- threaten the stability of the UK financial system and/or
- result in the failure of a dual-regulated firm in a way that would adversely affect the UK financial system.

However, the PRA will not be able to use the veto to prevent the FCA from doing something that it is legally required to do, such as an action that is required by EU or international law.

Issues for insurers to consider

Co-ordination between the PRA and FCA

A key concern for Insurers is the dual-regulation by both the PRA and the FCA. Not only is there a danger of confusion, where Insurers are unsure which regulator they need to deal with, but there is also a concern that the duties of the PRA and FCA might overlap. This could have a cost impact on Insurers, with the potential for extra compliance costs for dealing with two regulators in respect of the same matter. It is difficult to predict how well in practice co-ordination between the PRA and FCA will work, but for it to be a success there needs to be well thought out and effective systems in place. The Government is aware of this and whilst the draft legislation does not go into detail how the PRA and FCA will co-ordinate their activities, there will be a statutory duty to co-ordinate.

This issue is particularly prevalent in respect of with-profits insurance (policies which contain both a defined and a discretionary benefit), where the line between prudential and conduct regulation has always been a little cloudy. The PRA is to have sole responsibility for matters relating to the interests of policyholders, which could affect the financial position of the firm and in respect of material issues, the PRA will consult with the FCA.

The Treasury Select Committee is currently undertaking an enquiry into the accountability of the FCA including its interaction with other domestic regulators such as the PRA. Written evidence submitted to the enquiry was published in October 2011. We await further details of co-operation between the FCA and PRA.

The PRA's general objective is the safety and soundness of insurers and other regulated firms, with a view to promoting the stability of the UK's financial system.

Solvency II

The FSA has stated that much of the PRA's proposed approach to supervision will be achieved in practice through the application of Solvency II (the new European framework for insurance supervision). There is potential for some conflict here, however. The PRA's general objective is the safety and soundness of insurers and other regulated firms, with a view to promoting the stability of the UK's financial system, whereas its insurance objective is achieving appropriate protection for policyholders. The Government gives equal weight to both objectives, whereas compliance with Solvency II requires that the insurance objective has priority.

Enforcement

Enforcement is one of the most controversial elements of the proposed changes, because any publication of a warning notice would occur before an Insurer has had the opportunity to put its case to the relevant regulatory body. This could not only damage the Insurer's reputation, but also restrict its options when under investigation. For example, an Insurer may be more likely to contest proceedings if there has already been adverse publicity.

Relevant publications

- **26 July 2010**

HM Treasury's first consultation paper: 'A new approach to financial regulation: judgement focus and stability'. [Click here](#) to view.

- **24 November 2010**

HM Treasury's 'summary of consultation responses'. [Click here](#) to view.

- **17 February 2011**

HM Treasury's second consultation paper: 'A new approach to financial regulation: building a stronger system'. [Click here](#) to view.

- **16 June 2011**

HM Treasury's white paper on the reforms, which includes a draft version of the primary legislation which will bring the reforms into effect: 'a new approach to financial regulation: The blueprint for reform'. [Click here](#) to view.

- **20 June 2011**

The FSA and Bank of England published a joint paper on the PRA's prudential regulation of insurance companies: 'Our approach to insurance supervision'. [Click here](#) to view.

- **October 2011**

HMT publishes written submissions to enquiry into accountability of the FCA.

Insurer governance

Lessons learnt from the financial crisis

In May 2011, the OECD Council agreed on revised OECD Guidelines on Insurer Governance. The new Guidelines seek to reflect lessons learned from the financial crisis, including the need for a board with necessary leadership, expertise, and independent decision-making, effective risk management and internal control systems and integrated firm-wide reporting within an insurer, sound compensation arrangements, and well understood group structures. The new Guidelines recognise that the governance of financial institutions, including insurers, should be of a high standard and are a key component of the regulatory and supervisory framework.

The guidelines are divided into the following sections:

Governance structure

A governance structure should have an appropriate allocation of oversight and administrative responsibilities, stipulate and delineate clearly the duties, responsibilities and qualifications of persons having responsibilities, and protect the rights of shareholders (or member-policyholders) and the interests of policyholders.

Internal governance mechanisms

Insurers should have appropriate control, incentive and communication mechanisms and internal organisational structures that encourage sound and prudent internal decision-making and promote the efficiency and transparency of operations.

Groups and conglomerates

This covers transparency and knowledge of structure, having a comprehensive view of a group, establishing a governance system and having adequate group-flows of information.

Stakeholder protection

The governance framework for insurers should ensure an appropriate protection of the interests and rights of stakeholders (including policyholders, employees, creditors, supervisors and consumers) through proper disclosure and market conduct, effective governance and redress mechanisms, and respect for the rights and expectations of shareholders (or member-policyholders) and participating policyholders.

The guidelines apply to both life and non-life insurers.

Bribery/Financial Crime

What you need to know

New as at January 2012

MLD 4/Review of the EU and UK money laundering requirements

The European Commission has initiated a review of the 3rd Money Laundering Directive and will report on it in February or March 2012. The Commission will produce its proposal for a new Fourth Money Laundering Directive (MLD 4) in Autumn 2012. MLD 4 will take account of the Commission's own review of MLD 3 as well as new Financial Action Task Force AML standards. Negotiations on MLD 4 will take place throughout 2012 and the Commission aims for swift implementation in 2013. MLD 4 will involve amendments to the UK's Money Laundering Regulations 2007 in the course of 2013 or 2014.

A review of the UK regulations was initiated by the UK Government last year. The consultation closed on August 2011. A preliminary view is that none of the changes consulted on would require significant amendment to procedures. However we await the final outcome.

Bribery Act 2010

The Bribery Act 2010 (Act) came into force on 1 July 2011. The Act is intended to make Britain a leading player in stamping out corruption and reducing financial crimes. The Act applies to both individuals and companies in the UK; all foreign companies that do business in the UK are also affected by the Act.

Under the Act there are four main offences:

- **Bribing:** It is an offence for an individual to offer a financial or other advantage intending to induce or reward the improper performance of a function or activity;
- **Being bribed:** It is an offence for a person to request, agree to receive or accept a financial or other advantage to perform a function or activity improperly;
- It is an offence to bribe a foreign public official to influence their capacity as a foreign public official for the intention to gain advantages in business or in the conduct of business. This offence will not be committed where the act is permitted or required by local law; and
- A commercial organisation commits an offence where it fails to prevent bribery by associated persons, where the bribery was intended to obtain or retain business for that organisation (the Corporate Offence). The organisation need not be aware of the corrupt conduct. The penalties for this offence are an unlimited fine. Individuals can be found liable of all of these offences, save the Corporate Offence.

It is a defence to the Corporate Offence if the company has implemented adequate procedures to prevent those associated with it from committing bribery. There is no definition of adequate procedures, although draft guidance has been issued and recommends the adoption of six principles:

1. proportionate procedures: these should be clear, practical and accessible.
2. top-level commitment: the management should adopt a zero tolerance policy and regularly communicate their anti-bribery policy to staff and business partners.
3. risk assessment: regularly and comprehensively assessing the nature and extent of the risks relating to bribery in the relevant sector.
4. due diligence: companies should know who they do business with.
5. communication (including training)
6. monitoring and review: companies should identify the events that will trigger a review.

While firms do not have to employ external consultants or lawyers to help assess bribery risks, many are being advised to appoint an ethics officer. Hospitality is not prohibited by the act as it is recognised as a normal part of business, as reasonable hospitality improves client and business relationships.

Potential risks for firms

There is the potential for criminal liability for any offence on both individuals and the firm itself. Senior officers in particular could be liable (although not under the Corporate Offence).

There has been an increase in enforcement action being taken against firms in recent years, led largely by the USA.

If a company is convicted of a criminal offence, they will face mandatory debarment from public tenders under EU law. It is also likely that buyers will want to conduct anti-bribery due diligence on their suppliers, and if a firm has not taken adequate

measures, they could lose business. It has been speculated as to whether compliance with the Act will become a feature of tenders and winning work.

Warning signs

When doing business, you should watch out for the following, as they are likely to have a higher bribery risk:

- transactions which involve high risk jurisdictions or industry;
- transactions involving organisations with a high risk business nature (ie using agents);
- facilitation payments, gifts and donation; and
- government and political ties.

Willis Limited

On 21 July 2011 Willis Limited were fined £6,895,000 by the FSA for failings in its anti-bribery and corruption systems and controls.

Between January 2005 and December 2009, Willis Limited made payments of £27,000,000 to non-FSA authorised overseas third parties who assisted the firm in winning business from overseas clients. The FSA found that Willis Limited breached Principle 3 of the FSA's Principles for Businesses (PRIN) and the Senior Management Arrangements, Systems and Controls sourcebook (SYSC 3.2.6R) by failing to:

- establish and record an adequate commercial rationale to support its payments to overseas third parties;
- ensure that adequate due diligence was carried out on overseas third parties to evaluate the risk involved in doing business with them;
- regularly review its relationships with overseas third parties to confirm that it was still necessary and appropriate for the firm to continue with the relationship;

- adequately monitor staff to ensure that each time it engaged an overseas third party an adequate commercial rationale had been recorded and that sufficient due diligence had been carried out;
- ensure that policies and guidance aimed at mitigating bribery and corruption risks were adequately implemented by staff; and
- send sufficient management information to the board about the performance of anti-bribery and corruption policies to allow the board to assess whether risks were being mitigated effectively.

The FSA did not find evidence to suggest that Willis Limited's conduct was deliberate or reckless, but the firm's failings created an unacceptable risk that payments made to overseas third parties could be used for corrupt purposes.

The fine that the FSA would have imposed was reduced from £9,850,000 by 30% as Willis Limited agreed to settle at an early stage of the FSA's investigation and therefore qualified for a discount.

Financial Crime Guide

The FSA is currently consulting on its draft Financial Crime Guide, giving guidance to firms on how they can reduce their financial crime risk and gives examples of good and poor practice, as well as providing self-assessment questions, so that firms can evaluate their risks.

The consultation is open for responses until 21 September 2011.

As described in our last update, the FSA launched a consultation on its Financial Crime Guide, a document designed to give guidance to firms on how they can reduce their financial crime risk and giving examples of good and poor practice.

Following the end of the consultation period the FSA issued the final version of the guidance in December, along with a policy statement dealing with some of the concerns about the guidance:

- That firms may use the guide as a checklist to adopt a tick box approach;

- Lack of clarity around its status, especially in relation to the existing JMLSG guidance;
- How the guidance applies to different firms.

The FSA have indicated that the guide will be a living document and will be updated from time to time with new examples of best (and worst) practice.

FOS consultation on complaints handling

What changes are being proposed

The FSA has published a consultation paper which contains its final policy on consumer complaint handling rules. The following changes have been made.

Increase to the award limit

The award limit of FOS has been increased from £100,000 to £150,000. This limit (contained within the Dispute Resolution: Complaints sourcebook (DISP)) took effect from 1 January 2012, and has been designed to prevent a decline in consumer protection in real terms (given the increased rate of inflation).

Changes to complaints-handling rules

The current two stage complaints process will be abolished from 1 July 2012 and require firms to identify a senior individual who is responsible for handling complaints from 1 September 2011.

Additional guidance as to how firms can meet the requirements will take effect on the same date.



Solvency II

Impact and implementation of the new regime

What is Solvency II?

The Solvency II Directive (2009/138/EC) (Solvency II) fundamentally reforms the capital requirements for Insurers and Reinsurers, taking into account developments in insurance, corporate governance, risk management, reporting and prudential standards. The new regime is designed to establish a more sophisticated and harmonised risk-based set of solvency requirements, taking into account all risks that Insurers and Reinsurers face, not just insurance risks.

Solvency II applies to almost all Insurers and Reinsurers, including those in run-off. Small firms may be excluded from the requirements if, amongst other criteria, their annual gross premium income is less than 5 million Euros. Pension funds covered by the Occupational Pension Fund Directive are not covered by Solvency II. In addition, the provisions of Solvency II can be applied proportionally, with regard to the nature, scale and complexity of each firm's risks.

Solvency II structure

Solvency II is made up of a three pillar structure.

Pillar 1 Capital Requirements

Pillar 1 sets out the capital requirements expected of the Insurers and Reinsurers to whom the regime applies. It requires firms to demonstrate adequate financial resources to satisfy the capital requirements of the regime. Firms are required to

hold sufficient capital reserves to cover all of their expected future insurance or reinsurance contractual liabilities. In addition, they are also required to have sufficient own funds to cover minimum capital requirements (the level below which a firm becomes insolvent) and solvency capital requirements (the level of capital required to absorb significant losses and give reasonable assurance to policyholders that payments can be made as they fall due).

Pillar 2 Governance and risk management requirements

Pillar 2 requires firms to develop and embed systems to identify, measure and pro-actively manage their risks. Firms must have an effective system of governance to provide for sound and prudent management of their business. The Pillar 2 requirements include having an adequate and transparent organisational structure; having a clear allocation and appropriate segregation of responsibilities and effective reporting lines; and establishing roles with responsibility for risk management, compliance and internal audit issues. Firms are able to decide for themselves how to organise and staff these roles.

In addition, firms must regularly assess their overall solvency needs and ensure that they are compliant with the Solvency II requirements.

Pillar 3 Disclosure and Transparency Requirements

Pillar 3 requires firms to publish an annual report containing details of their solvency and financial conditions. The report should contain details of the firms business and performance, governance system, risks, capital requirements and any material breaches of the Solvency II capital requirements. The obligation to publish this report may be removed if it would result in an unfair advantage to competitors.

Omnibus II

On 19 January 2011, the Commission published the Omnibus II Directive proposal. The Omnibus II Directive is designed to amend Solvency II to reflect the revised EU supervisory framework.

Solvency II is a Lamfalassy directive which means that the Commission will set detailed level 2 implementing measures on advice from EIOPA for those parts of the regime brought in by Solvency II.

The key amendments are:

- Extension of the Solvency II implementation date to 31 December 2012.
- New transitional requirements to enable smooth transition and avoid market disruption.
- Further level 2 implementing measures.
- Changes to ensure that the European Insurance and Occupational Pensions Authority can work effectively.

The Omnibus II Directive is expected to be implemented in January 2012, after which the level 2 implementing measures of Solvency II can be adopted.

Level 2 implementing measures

On 5 May 2011, the European Commission published a summary of responses to its consultation on the level 2 implementing measures for Solvency II.

The consultation invited feedback on the impacts, costs and benefits to support the policy decision-making process for the level 2 measures.

According to the summary, the majority of respondents were concerned with the following key issues:

1. The impact on long term products, given the validity of the value of assets and liabilities under a market consistent valuation framework and the measurement of specific risks that these products are often exposed to. A working party has been established to analyse the issues relating to long-term products. The commission has stated that necessary steps will be taken to ensure the characteristics of these products are adequately reflected in the level 2 measures.
2. Pro-cyclicality, including the need to ensure that mechanisms are designed to address pro-cyclicality, work effectively and do not create artificial volatility.
3. Limiting the reporting burden, in particular the need for proportionality. Respondents highlighted the need to exempt certain undertakings from the quarterly reporting based on the size, nature and complexity of the risks in their business.
4. The need for transitional measures to avoid market distraction, in particular in the areas of own funds, reporting requirements and third country equivalents.

The Commission has stated that it will now focus its impact assessment on the implementing measures on the policy issues relating to these issues. The level 2 measures were expected to be published by the end of 2011, but are now awaited early in 2012 with publication cued to follow adoption of the Omnibus II proposal.

Level 3 guidelines

EIOPA, the Pan European insurance and pensions regulatory authority, will be working on level 3 guidelines implementing Solvency II during the course of 2012 (likely mid 2012) although these cannot be finalised until the level 2 measures for solvency and the Omnibus II Directive is settled (maybe in April).

Consultation papers were issued by EIOPA in November on reporting and disclosure matters (i.e. the technical templates and other requirements for reporting). Comments can be made on the consultation papers and the impact assessment until 20 January 2012 and EIOPA plans to finalise its package of level 3 measures by Summer 2012.

The FSA has published a guide on reporting under the Solvency II directive in response to EIOPA's consultation on the proposed level 3 guidelines on reporting and disclosure. The guide sets out all the issues which the FSA has identified from the paper that are of interest to UK insurers. The guide includes a list of questions senior management of insurers and reinsurers should be asking themselves as part of their preparation for Solvency II implementation. The FSA urges firms to engage with the consultation thoughtful and constructively as it will inform the specification for their Solvency II implementation programmes.

UK Government implementation consultation

In November 2011 the Government published its consultation on changes to UK law to implement Solvency II and has published the draft statutory instrument to effect the changes. The approach taken by the Government is 'intelligent copy out' without any gold plating additional changes. The consultation does not cover the level 2 measures under solvency as these will be implemented by way of a European regulation and will have direct effect in the UK from the date of implementation.

The changes provided for in the draft implementing law relate to the role of the PRA (the Prudential Regulation Authority) which will be the regulator responsible for solvency II compliance, replacing the FSA as described in this briefing on the PRA.

The PRA will have the power to withdraw authorisation from insurance and reinsurance undertakings it regulates if they fail to comply with the minimum capital requirement and will be mandated to work with the European regulatory body EIOPA, the European insurance supervisor. The changes also relate to the PRA's powers to allow insurers to calculate their capital requirements on a Solvency II basis and for the PRA to perform other supervisory functions.

The consultation, 'The Solvency II Consultation Document', Statutory Instrument and Impact Assessment can be found on HM Treasury's website. The consultation closes on 15 February 2012.

FSA consultation on implementation in FSA Handbook

The FSA published CP 11/22 on the transposition of Solvency II in November 2011. The CP, referred to as "CP1" by the FSA, is the first of the FSA's planned consultations on this topic. A further consultation, "CP2" will follow once the Omnibus II directive and Level 2 measures have been finalised. This is currently scheduled for publication in Q2/3 2012. CP2 will cover application rules, reporting templates and COBS 20 with profits rules. Other issues such as permitted links and information to policy holders will be the subject of further consultation outside the CP1/2 process.



Picture above courtesy of www.istockphoto.com

The document describes the “intelligent copy out” approach to be used by the FSA in implementing the directive and confirms the FSA’s approach to the split commencement of the directive, that is that Member States will have transposed the directive by January 2013 but the rules will only become applicable to firms from January 2014. The exception to this is for any so called non-directive firms (mainly friendly societies) which fall outside the scope of the directive. These will apply the current solvency rules (to be reviewed by the FSA after Solvency II has been implemented) or can opt into the Solvency II rules.

CP11/22 (CP1) sets out the new draft rules to be included in SOLPRU, the new Handbook which will implement much of the directive, accompanied by smaller changes in other Handbooks.

FSA consultation on unit linked/index linked business

In November 2011 the FSA published its consultation on Solvency II and linked long term business, CP 11/23, including the amendments required to COBS 21 to reflect the removal of the specific permitted links list and the implementation of the new requirements under Solvency II which will be set out in SOLPRU, replacing INSPRU.

The FSA has confirmed that it will use its power under article 133 of the directive to restrict the assets that can be used to determine benefits under policies taken out by retail policy holders. In a statement, the FSA said that the proposed new rules would largely continue the existing FSA requirements, but would expand them to permit investment in some indices-based investments and bonds. “The FSA will implement high-level requirements from Solvency II that strengthen the current rules saying insurers should only invest in assets that they can properly value and monitor.”

The FSA also said it is waiting on European supervisor EIOPA to clarify its guidance for systems of governance before it further consults on governance arrangements for unit-linked and index-linked business. The current consultation closes on February 15, 2012. The FSA then intend to publish a feedback statement in Q2 2012.

Impact upon the insurance industry

The FSA have indicated that they expect the areas of greatest impact of Solvency II to be:

- Pillar I requirements on the level and quality of capital and valuation of technical provisions
- Pillar II enhanced governance and risk management
- Pillar III increased transparency requirements.

The FSA also reports seeing evidence of many firms recognising the need for significant changes to their business strategies, e.g. firms closing to new business, restricting the range of products they manufacture, limiting the range of distribution channels they use, and altering their distribution mix by, for example, building up a direct sales channel, selling off blocks of existing business portfolios, or merging brands and operational infrastructures.

Solvency II could also act as a significant influence on the consolidation of the industry, according to the FSA with some insurers benefiting from Solvency II leading to a gain in their market share, while other firms may exit the market or sell their ‘back books’ of discontinued business, in each case depending on their capital position.

Although Solvency II was initially reported to have caused a slow down in corporate and mergers and acquisitions business in the insurance sector, as there was an uncertainty over the value of insurance firms, it is clear from recent press releases that due to the increased reporting and compliance burden which will be expected when Solvency II comes into force, M&A activity is increasing. Recent examples are Royal London takeover of Royal Liver, Friends Provident’s acquisition of Axa Life, National Friendly closing some of its existing book to new business, and Foresters Life’s acquisition of the Communication Workers Friendly’s book on 1 August 2011.

Tax reform will be necessary to bring UK tax legislation in line with the reporting and accounting requirements in Solvency II.

The Government has been consulting on these changes since mid 2009 and its consultations and technical notes setting out decisions affecting both life and general insurance companies are provided on the HMRC website. Legislation on the new post Solvency II insurance tax regime will be introduced in the Finance Bill 2012. The HMRC's latest note on the new regime and a technical note on transitionals was published in December 2011.

FSA resources

On 26 July 2011, the FSA updated its webpage on its internal model approval process (IMAP) under Solvency II.

The webpage now refers to the two-tier approach the FSA will adopt to review and assess firms' internal models in the pre-application phase of the FSA's IMAP. The FSA has announced that it intends to focus its resources on firms which represent a significant market share and have the highest potential impact on the FSA's statutory objectives (major life and non-life firms, Lloyd's market firms, and firms which are subsidiaries of major European groups where the FSA will be obliged to participate in a college of supervisors). All other firms will be subject to a reduced level of engagement.

Two new web pages have also been created:

Quantitative tools and techniques- The FSA is working on various quantitative techniques and tools applicable to life and general insurance IMAP firms. These are detailed on the webpage. The FSA will carry out pilot studies with some firms in order to gain insight into the technical details of firms' internal models and to assist discussions during the pre-application IMAP phase.

External review- The FSA has developed a tool to assess whether a firm's data management complies with the standards set out under Solvency II for IMAP purposes. It informs firms on what they might do in order to satisfy the standards set out in Solvency II and is also based on what the FSA expects the delegated acts (formerly referred to as the Level 2 implementing measures) will require.

Update on other Solvency II developments

EU Commission letter on third country equivalence
On 5 December the Commission published a letter to EIOPA confirming the work done by EIOPA in assessing third countries, Switzerland, Bermuda, Japan and Switzerland and confirmed that the decision on their equivalence will be taken by the Commission in the first half of 2013, once level 2 measures for Solvency II are finalised.

Insurance tax reforms

In the Budget of 23 March 2011, the government announced the outline of the new insurance tax regime which will take effect from 1 January 2013. The new regime is outlined in an HMRC technical note on Solvency II and the taxation of insurance companies. Legislation on the new post-Solvency II insurance tax regime will be introduced in the Finance Bill 2012. In December 2011, HMRC published a note on the new regime, together with a technical note on transitional arrangements.

Changes to ICOBS

In December 2011 the FSA issued its quarterly Handbook development briefing CP11/27 which contains proposals relevant to ICOBS, the insurance conduct of business sourcebook. The changes are to implement Solvency II.

The changes are broadly speaking updates to the Handbook to make it clear that information disclosure requirements that derive from directives predating Solvency II will no longer apply. The changes include:

- Confirmation that the rules on disclosure of head office do not apply in relation to contracts of large risk;
- Specification of certain information that has to be disclosed before conclusion of a pure protection contract, including a reference to the Solvency and Financial Condition report under Solvency II where there is one.
- A new rule in ICOBS 6 requiring notification of mid term changes to a pure protection contract.
- Changes to the contracts of large risk definition

ABI guide to catastrophe modelling

On 7 December 2011, the Association of British Insurers (ABI) published a guide to managing catastrophe models as part of an internal model under the Solvency II Directive.

Implementation

Currently firms will have to comply with Solvency II from December 2012, although it is expected that this date will move back to January 2013 because of Omnibus II. However on 27th July 2011, the Economic and Monetary Affairs Committee of the European Parliament proposed in a draft report on the Omnibus II directive that the Solvency II regime be introduced through a process of “phasing in”, with reinsurance and insurance undertakings not being required to comply in full until 1 January 2014.

Changes to European regulatory framework

Moves towards a single EU rule book

The former European insurance body CEIOPS has been replaced effective 1 January 2011 by the European Insurance and Occupational Pensions Authority (EIOPA), along side the other new European Supervisory Authorities (ESA), ESMA (the European Securities and Markets Agency) and the EBA (the European Banking Authority). EIOPA will oversee the regulation of insurance and pensions across Europe working with the other ESAs and the newly established European Systemic Risk Board (ESRB) which oversees financial stability and is tasked with strengthening and enhancing the EU supervisory framework.

The move to the new ESAs will hugely increase the importance to insurers of monitoring developments at European level as rules will apply as made in Europe with less room for interpretation by the UK regulatory bodies. This is because the ESAs will be working towards the creation of a single EU rule book. They will do this by developing draft technical standards, which will then be adopted by the European Commission as EU law. The ESAs will also issue guidance and recommendations with which national supervisors and firms must make every effort to comply. Where the ESAs believe that a national supervisory authority is failing to apply EU law, or is doing so in a way which appears to be in breach of EU law, they have the power to investigate. Their investigation may lead to the Authority issuing a recommendation to the national supervisor, followed by a formal opinion from the Commission (if the recommendation is not acted upon). If the supervisor does not comply with the Commission's formal opinion, the ESA may then

take decisions binding on firms or market participants to ensure they are complying with EU law. The ESAs will also be able to temporarily ban certain financial activities in emergency situations.

EIOPA's current/recent consultations of relevance to life/long term insurers include:

- A consultation analysing good disclosure and selling practices for variable annuities. The consultation does not set out any guidelines or recommendations but provides a review of the kinds of information customers should be given in order to make decisions on variable annuities. The consultation considers what product specific and general disclosures are advisable. It also indicates that good selling practice is to always sell variable annuities on an advised basis, even when being sold direct by the insurer and that firms should focus on the customer's objectives when assessing their demands and needs. The ABI announced last year that it plans to introduce a compulsory code of practice for insurers in relation to annuities.
- A consultation paper on proposed guidelines on complaints-handling by insurers under the Solvency II Directive. It is expected that the standards required are already largely implemented in practice.

- A proposed report on best practices by insurers in handling complaints. This lists best practices in some of the areas covered by the proposed guidelines. EIOPA has explained that, although the draft report complements the proposed guidelines, the best practices are not legally binding on supervisors or firms.

As noted in the section on Solvency above, EIOPA is also taking a critical role in the development of level 3 guidelines to Solvency II.

The Consumer Insurance (Disclosure and Representations) Bill

Reduced disclosure standard for consumers seeking insurance.

The Consumer Insurance (Disclosure and Representations) Bill (Bill) has been introduced into Parliament and dramatically reforms insurance law. The Bill reduces the obligation on consumers to disclose all relevant information to a prospective insurer. If brought into law (which is expected to happen in 2013), consumers would merely be obliged to take reasonable care not to make a misrepresentation.

Currently, a person seeking insurance must disclose to his prospective insurer all material information that a prudent insurer would consider relevant to its decision as to whether, or the terms on which, it might offer insurance. The criticism of this principle is that it treats consumers harshly and places an unfair burden on them.

Consumers may either innocently fail to anticipate the relevance of a particular fact or their insurer may refuse a claim that is unrelated to an undisclosed fact. The Bill's main feature is to replace the previous disclosure obligation with one that merely obliges the customer to take reasonable care not to make a misrepresentation. Various factors are to be taken into account when assessing whether a consumer has taken reasonable care, including:

- The type of insurance in the target market;
- Any relevant explanatory material provided by an insurer;
- How clear and specific the insurer's questions were; and
- Whether or not an agent was acting for the consumer

The test of reasonable care is an objective one, subject only to taking into account any

characteristics of the individual consumer of which the insurer was aware or ought to have been aware. A dishonest misrepresentation will always be in breach.

In order to successfully refuse paying out under an insurance contract for misrepresentation, an insurer must show that without the misrepresentation it would not have entered into the contract on the same terms. If the misrepresentation was deliberate or reckless, the insurer may treat the contract as if it never existed while retaining all premiums paid, unless such retention would be unfair to the consumer. If careless, the insurer may, where it would otherwise not have entered into the contract, refuse all claims and return all premiums paid. Where it would have entered into the contract under different terms, the contract would be deemed to include those terms. The Bill only applies to consumer insurance contracts.

On 1 December 2011, the House of Lords special public bill committee for the Consumer Insurance (Disclosure and Representations) Bill 2010-11 published its report on the Bill. The report consists of transcripts of oral and written evidence received by the committee, including memoranda from the FSA, the Financial Ombudsman Service (FOS) and the Association of British Insurers (ABI). In its memorandum, the FSA notes that the definition of "consumer" in the Bill differs from the definition used in the FSA Handbook. However, it does not believe that the difference creates a practical difficulty as the two definitions have different aims. A revised text of the Bill, incorporating amendments made by the committee, was published on 14 November 2011 and will move to its third reading in the House of Lords.

Payment Protection Insurance

The Competition Commission's Payment Protection Insurance Market Investigation Order 2011

The Order

On 24 March 2011 the Competition Commission published the final Payment Protection Insurance Market Investigation Order 2011 (Order). The Order implements the remedies required following the Competition Commission's market investigation into payment protection insurance (PPI) and imposes a prohibition on selling PPI at the point of sale of credit for all PPI (except for store card PPI). In addition, the Order sets out requirements in relation to the provision of personal PPI quotes and information that has to be included in marketing material and provided to third parties such as the OFT.

Requirements are also set out as to the prohibition and the sale of single premium policies and finally as to providing customers with an annual review.

The Order requires PPI to be unbundled from insurance cover. It came into force on 6 April 2011 with the obligations arising under the Order being implemented in two phases (some information requirements came into force on 1 October 2011 with the remaining measures (including the prohibition at point of sale requirement) coming into force on 6 April 2012).

April 2011 Articles in force	October 2011 Articles in force	April 2012 Articles in force
Article 1 Article 2 (interpretation) Article 12 (obligations to submit a compliance report) Article 14 (obligation to report on clarity of marketing communication) Article 15 (obligation to appoint a compliance officer) Article 16 (directions from the Competition Commission as to compliance)	Article 3 (obligations to provide information as to PPI) Article 5 (obligations to provide information to the Consumer Finance Education Body) Article 6 (obligation to disclose claims ratio)	Article 4 (Obligation to provide an Annual Review or Annual Reminder) Article 7 (Obligation to provide a Personal PPI Quote) Article 8 (Prohibition on the sale of PPI after the start of a Credit Sale) Article 9 (Prohibition on the sale of PPI before the start of a Credit Sale) Article 10 (Prohibition of payment by Single Premium and requirement to pay a rebate) Article 11 (Obligation to provide Retail PPI separately when sold in a package of insurance)

British Bankers' Association's challenge to DISP

In September 2009 and March 2010, the FSA consulted on changes to its rules as to how PPI complaints were handled. As a result of these consultations, PS10/12 was published in August 2010, including amendments to the Dispute Resolution: Complaints (DISP) section of the FSA's handbook and guidance as to how PPI complaints should be handled and the basis upon which they should be decided.

The British Bankers' Association (BBA) brought a claim challenging the legality of new complaint handling measures implemented in DISP.

The BBA argued that the policy statement on the assessment and address of PPI complaints and the online resources provided by the Financial Ombudsman Service (FOS) were unlawful on three grounds:

1. An amendment to the FSA's Principles of Business (Principles) had the effect that a contravention of the Principles would not be actionable by a private person as a breach of statutory duty under s150 FSMA 2000. The BBA argued that s150 went further than this, and also had the effect that a breach of the Principles would not result in any obligations arising from a firm to its consumers.
The court found against the BBA's argument on the grounds that whilst a private person would not have a cause of action for a breach of the Principles under s150, the section did not go as far as the BBA had construed it.
2. The second limb of the BBA's argument was that in some cases, the effect of the Principles would be to contradict other specific regulatory rules. As a result, firms would be required to compensate customers for misselling, even though it felt the PPI complied with specific rules that had been in force at the time of sale. The court rejected this argument. It was held that the Principles were an overarching groundwork for legislation and must always be complied with. Specific regulatory rules were merely applications of the Principles.

3. The third challenge was that PS10/12 required firms, through DISP, to compensate customers on the basis of 'root cause analysis', rather than adopting a specific statutory procedure which was, at the time, contained within s404 FSMA (note that the procedure is no longer in force).

This ground was also rejected, given that the court found that s404 did not expressly or impliedly exclude the course of action that the FSA had set out in the Principles and that there was similarity between the two procedures.

This Judgment has had the effect of reinforcing the importance of the Principles.

New Guidance from FSA and OFT

The FSA announced in November 2011 that it is working with the OFT to help prevent the problems associated with payment protection insurance (PPI) recurring in a new generation of products. The regulators issued a consultation on proposed guidance to firms in relation to PPI products which fall within the jurisdiction of either regulator. PPI products involving insurance are regulated by the FSA, whereas other kinds of products such as debt waiver relevant to a regulated credit agreement are regulated by the OFT.

The FSA's guidance stresses that firms should ensure that product features reflect the needs of the consumers they are targeting. There are four key areas of concern that providers should think about carefully:

- firms not properly identifying the target market for the protection product
- the protection not reflecting the needs of the intended consumers
- the benefit of a successful claim not matching the needs of the claimant, and
- product features or pricing structures creating barriers to comparing products, exiting a policy or switching cover.

The FSA are concerned that the risks associated with PPI and with new forms of PPI are tackled upfront in the design and preparation for distribution of the products. It is the first time guidance has been issued on the design of a specific product.

Both regulators have declared an intention to monitor developments in this area and to use their regulatory enforcement powers if necessary.

Gender and Age - 'Test-Achats'

A decision by the European Court of Justice's (ECJ) decision in the test case brought by a Belgian consumer group makes it clear that insurers will no longer be able to use gender related factors in determining premiums and benefits under an insurance policy.

Since 21 December 2007, the Gender Directive has meant that insurers have had to make sure that the use of gender as a factor in the calculation of premiums and benefits for the purposes of insurance and related financial services does not result in differences in the individual's premiums and benefits. However, there is a derogation from this in article 5(2), allowing member states to decide, before 21 December 2007, to permit proportionate differences in individual's premiums and benefits. The use of gender must be a determining factor and the assessment of risk must be based on relevant and accurate actuarial and statistical data. If member states rely upon this derogation, they must compile, publish and regularly update the relevant data and review their decisions after five years.

The ECJ have now ruled that this derogation is invalid with effect from 21 December 2012. In particular, the ECJ commented that although any decision to adopt the derogation was to be reviewed after five years, there was no requirements as to the length of time during which gender differences could be taken into account. This gave rise to the risk that the article would permit the derogation from the equal treatment of men and women to persist indefinitely. This is

incompatible with the charter and, therefore, the ECJ found that the derogation must be considered to be invalid upon the expiry of the appropriate transitional period.

The effect of Test-Achats Gender rules

The equal treatment of men and women is a fundamental right of EU law according to article 6 of the treaty. The Gender Directive was introduced to legislate the principle of equal treatment of women and men in the access to and supply of goods and services. However article 5(2) provides an exemption to this principle for insurance contracts which allows insurance companies in EU member states to continue to use gender-related factors when setting prices for certain products.

Following Test-Achats, insurance providers will need to adjust their pricing policies so that, from 21 December 2012, men and women will pay the same premiums for car insurance. Car insurers will need to place greater emphasis on other questions in the policy applications (eg focus on driving history). The general view seems to be that car insurance policies which are taken out up to and renewals made before 21 December 2012 will not be affected. Policies and relating documents may need to be updated to allow for the change to the pricing premium.

Annuities

The cost of insurance is likely to rise for women and the cost of annuities to rise for men or, alternatively, benefits may fall.

Bulk annuities

Bulk annuities should not be affected by the decision because the benefits are pre-determined and gender neutral. Annuity providers should be wary of taking into account gender-specific factors when pricing group contracts, as the contracts may result in gender differences as regards another group.

The Gender Directive only applies to insurance that is private, voluntary and separate from the employment relationship and therefore bulk annuity contracts issued to pension trustees as part of a buy in or buy out process should not be affected by the decision. These contracts may continue to be priced on the basis of gender specific facts.

Pension schemes

The impact on pension schemes is unclear. Occupational pension schemes are not directly affected by the ruling in Test-Achats, as they are not governed by the Gender Directive. However, changes may need to be made to benefits that may be calculated using gender related actuarial factors (eg pensions exchanged for the lump sum payments, money purchase benefits and transfer credits). Pension trustees should seek advice on what may need to be changed.

Age discrimination

The Equality Act 2010 contains provisions which ban age discrimination in the provision of services and the exercise of public functions. These provisions are expected to come into affect in April 2012. The Government is currently awaiting responses to the consultation published on 3 March 2011 as to the specific exceptions to the age discrimination ban.

The Government is planning to make a specific exception available for providers of financial services.

This means that providers of financial services, including insurers, will still be allowed to use age when assessing risk and deciding on product prices. The use of age banding and age limits will still be permitted however, any use of age will have to be based on relevant information from a source on which it is reasonable to rely.

Developments

On 8 December 2011, HM Treasury published a document setting out the UK government's proposed response to the Test Achats judgement. The document follows the statement made by the Government immediately following the judgement expressing disappointment with it. According to the response the UK recognises the right not to be treated unfairly because of gender but also considers that financial services providers should be allowed to make sensible decisions based on sound analysis of relevant risk factors- something which will be restricted due to Test Achats.

The response includes a consultation on amendments to the Equality Act 2010 to implement the judgment. It also includes comments on the areas which the proposed European Commission guidance on the issue should cover. Specifically the regulations would repeal paragraph 22 of Schedule 3 to the act making it clear that providers of insurance and related financial services may not discriminate on the grounds of sex in the prices and benefits offered to consumers.



The government consultation requests input on the scope of indirect discrimination, any impact on data collection and its use for assessing overall risk and on group insurance schemes and the definition of a “new contract” in the context of Test Achats:

- Indirect discrimination is prohibited under the 2010 act where an apparently neutral practice puts people sharing a protected characteristic at a particular disadvantage compared to those who do not share it and the practice cannot be objectively justified. According to the consultation, risk factors used by the insurance industry might be indirect discrimination if they have a disproportionate effect on one gender but could be lawful if they have a legitimate aim and are proportionate.
- The Gender Directive does not stop the use of sex as an actuarial factor but says this must not result in individual differences in premiums and benefits. This allows for the fact that insurers will need to collect data on gender and use it for the purposes of assessing the overall risk presented by a particular pool or pool of risks. For example, according to the consultation if a motor insurer insures a pool of people comprising 70% men and 30% women, the insurer might be able to take the relative proportions of men and women into account for the purposes of assessing the overall risk presented by the pool, and use that risk for the purposes of calculating the unisex premium applicable to men and women in that pool.
- The Gender directive derogation cannot be used for a “new contract” after 21 December 2012 and as such the question is what falls within this expression. Renewals will clearly create a new contract but a review of a contract under its terms is less likely to do so. The question of the continuity of insurance in a corporate restructuring or merger scenario is also relevant.
- The Government does not believe there is any requirement to amend the Equality Act in relation to the existing exemption for group schemes.

The consultation closes on 29 February 2012. HM Treasury will publish a summary of the result of the consultation within three months of the end of the consultation period. The government intends to legislate to implement Test-Achats “early in 2012”, with the necessary legislation coming into force from 21 December 2012.

A study of the impact of the Test Achats changes was released in December by the European Insurance and Reinsurance Federation and consistent with the Governments’ views, suggests that the impact will largely be on the consumer, through the resulting cross subsidization between men’s and women’s insurance premiums.

Product Intervention

FSA proposes more intrusive supervision of product design

On 14 June 2011, the FSA published a feedback statement (FS11/3) summarising responses it has received to its 'Product Intervention discussion paper', explaining how product intervention relates to other relevant products, outlining action already been taken by the FSA and setting out its proposed next steps.

The feedback statement confirms the FSA's intention to pursue a new product intervention approach. This will involve a move away from their previous approach which actively regulates all aspects of the product, lifecycle and places particular focus on the early stages (eg design, development and management products) and not just at the point of sale.

The FSA has said it will continue its work on the later stages of the value chain but has concluded that it must do more to consider product governance so that the entire chain is subject to appropriate regulatory attention.

The intention is to move towards a single set of rules and guidance on product governance, building on what is already in place (the Treating Customers Fairly, guidance on the responsibilities of product providers and distributors for the fair treatment of customers).

The feedback statement follows the FSA's product intervention discussion paper (DP11/1). HM Treasury have already consulted on the structure and powers of the future Financial Conduct

Authority (FCA) confirming that such product intervention will be integral to the delivery of the FCA's consumer protection strategy. The FCA are expected to have a lower risk tolerance than the FSA and will be more willing to act sooner and intervene more intensely at all points of the value chain.

The responses to DP11/1 have been mixed. Consumer organisers were supportive of the FSA's proposals, however many industry responses argue that the point of sale was the part of the product lifecycle where consumer detriment originates. It has been argued that the FSA's retail distribution review, which is already addressing this area, and the mortgage market review make product intervention unnecessary.

However the FSA's intention is :

1. to supervise product governance more intensely (this has already commenced);
2. to move towards a single set of rules and guidance on product covenants;
3. to make product interventions a part of the FSA's standard policy analysis;
4. to encourage changes at EU level that are consistent with the FSA's product intervention approach;

5. the FSA has agreed that the additional interventions in chapter 6 of DP11/1 (including product pre-approval, banning of products and price intervention) should not be used frequently or where other regulatory solutions or competitive prices would address the problem.

The FSA has confirmed that it is not considering pre-approval or pre-notification requirements at this time. The FSA continues to believe that banning or mandating product features and exclusions should be considered where products have potential to cause significant detriment or are causing detriment. Further, the FSA believes that it has available to it the option to prevent non-implied sales or limit sales to certain types of customers where the product is complicated or has a high risk of detriment. This power would only be used to where benefits outweigh the cost.

Implications

The proposed new regime threatens more and earlier regulatory interventions in product design and firms will need to keep developments under review because it is likely additional rules will be introduced by the FSA. These may include high level rules requiring identification and mitigation of inherent risks in products, sound governance and management around product design and strategies in relation to provider distribution to promote fair outcomes for customers. However the FSA's approach on the rules requirements remains unclear and it cannot be ruled out that there may be more detailed requirements covering a range of issues touching on each stage of the product life cycle, such as:

- product stress testing to ensure that likely risks are fully understood and assessed from a customer's point-of-view, enabling the product to be better targeted at relevant market segments and better designed to mitigate risks to the customer;
- analysis of the proposed charging structure to ensure that charges are reasonable;
- design of distribution strategies to guard against likely mis-sales (so, for example, providers could consider whether more complicated products should only be sold with advice);
- measures designed to increase the

quality of disclosure documents and communications directed to distributors, e.g. to analyse distributors' information requirements and ensure the communications are sufficient and accurate; ongoing requirements that provider firms must gather information to ensure that products are reaching the target market and consider what to do if they are being sold more widely than expected;

- ongoing requirements to consider if the product's risk profile has changed, because of external factors such as market conditions or changes to legislation, for example, or because the firm has made changes to the product's features over time, and to consider what to do if this has happened; and
- requiring staff responsible for signing-off products to have appropriate qualifications

The new rules will particularly focus on products which are complex, carry inherent risks of conflicts, are bundled, have secondary charges or teaser rates and barriers to exit. Insurance products would be those with

- Factors affecting eligibility to claim risk undermining the utility of the product or exclude large groups of customers.
- Circumstances in which the provider can withdraw cover risk undermining the utility of the product.
- Limited risk transfer to the insurer.
- Complex claims notification procedures that will deter claimants.

Third party rights against Insurers

New law quickens procedures

The third party rights against insurers legislation allows a claimant to make a claim against a defendant's insurers without having to issue court proceedings (and the term 'defendant' is used here to describe the party pursued by a claimant, whether or not proceedings have been issued). Furthermore, the rules apply as much where a defendant is an individual as with a defendant company.

At present the defendant must be insolvent, but new legislation will remove this requirement.

Current System

A regular frustration for claimants is not knowing whether a prospective defendant is worth pursuing. The claimant may have a winnable claim against the defendant, but if the defendant has no money or is about to go insolvent, then the game is not worth the candle. The claimant may establish its claim and even get a judgment in its favour, but may then be left with no way of recovering its damages.

It will also have to bear all its own costs, which could be considerable. The Third Parties (Rights Against Insurers) Act 1930 (the 1930 Act) provides a remedy. It allows the claimant to stand in the defendant's position in relation to its liability insurer. The right of a defendant to an indemnity from its insurer is transferred to a claimant when the defendant becomes insolvent. But the claimant is required to establish the claim against the insolvent defendant prior to obtaining any rights against the insurer. It does this by obtaining a

judgment, arbitration award or settlement of the claim in its favour.

However, the procedure a claimant must follow under the 1930 Act is cumbersome and expensive. The new legislation – Third Parties (Rights Against Insurers) Act 2010 (the 2010 Act) – introduces some important changes, as discussed in this article. The 2010 Act passed into law in March 2010, just before Parliament rose for the general election, and will come into force by ministerial order on a date yet to be announced.

How the current system works

Let's say that Fine & Dandy plc has a shop in the High Street selling its world-renowned tableware. One day Farmer Jones walks past with his prize Aberdeen Angus. Farmer Jones is careless and the animal breaks free. It heads towards Fine & Dandy's crockery emporium. The bull runs into the china shop, with predictable results.

Fine & Dandy spends several thousand pounds repairing the damage and it writes a letter to Farmer Jones asking for reimbursement.

It has a strong claim, and Farmer Jones holds his hands up and admits liability. But his farm is not doing well. He has no money to meet the claim and is about to be made bankrupt. There will be no dividend to go towards Fine & Dandy's losses.

However, Farmer Jones does have public liability insurance and when his bankruptcy order is made,

his right to an indemnity passes to Fine & Dandy. The mechanism of the 1930 Act passes that right automatically on the bankruptcy, because liability has been agreed. It would happen in the same way if a judgment (or arbitration award) had been obtained against Farmer Jones. Fine & Dandy can therefore stand in Farmer Jones's shoes and make a claim on his policy. Subject to any indemnity issues, it will be reimbursed for its losses.

Finding out if a defendant is insured

What should Fine & Dandy do to find out about Farmer Jones's liability insurance?

The 1930 Act provides some help: it states that if an insured defendant becomes insolvent, then it must provide a claimant with its insurance details. Therefore, when Farmer Jones becomes insolvent, Fine & Dandy should ask him for his insurance details.

If a claimant knows the identity of the insurer, it can also ask the insurer for more information about the policy. The 1930 Act imposes such a duty on the defendant's insurer if there are reasonable grounds for supposing that the mechanism of the 1930 Act has transferred the defendant's rights against it to the claimant. The obvious question any claimant would want to ask is whether the policy will respond to the claim and, if not, why not.



Unco-operative defendants

What about the common situation where a defendant goes bankrupt without admitting liability? The unfortunate truth is that a defendant company might be put into administration precisely because a claim has been made against it. Say that Fine & Dandy's letter of claim receives a less helpful response from Farmer Jones.

His reply is short but not particularly sweet and it suggests that he does not admit liability for the damage caused by the runaway animal. Then, while considering its options, Fine & Dandy discovers that Farmer Jones has already gone bankrupt. The 1930 Act does not apply to transfer any rights against Farmer Jones' insurers (if any), because there is no settlement, judgment or arbitration award.

Until the Court of Appeal decision in the First National Tricity Finance Ltd v OT Computers Ltd [2004], Fine & Dandy would have had a real dilemma. There was first instance case law holding that Fine & Dandy would have to obtain a judgment before being entitled to disclosure of the information it needed. Claimants had to proceed with a claim, and possibly issue court proceedings and pursue them to judgment, when all that time and expense might prove wasted if there was no insurance policy.

OT Computers concerned computers sold by OT Computers under the brand name 'Tiny'.

A finance company provided credit to purchasers, and under the consumer credit legislation it became jointly and severally liable with OT Computers to the purchasers. OT Computers went bust and so the finance company had to fulfil OT Computers' obligations under extended warranty schemes on the computers. OT Computers did have liability insurance, but its administrators and the insurers themselves refused to give the finance company any information about the insurance.

The finance company asked the court to order disclosure of the information. OT Computers argued that its liability had not been established and therefore the mechanism in the 1930 Act did not apply.

But the Court of Appeal held that there had been a transfer of 'inchoate' (contingent) rights on OT Computers' insolvency, which would crystallise when liability was ascertained.

Accordingly, it ordered disclosure of information about OT Computers' insurance arrangements. The finance company was entitled to know whether OT Computers was insured for a claim against it.

Therefore, when Farmer Jones goes bankrupt, Fine & Dandy can immediately ask for information about his insurance policy, ie whether he has liability insurance. Before it starts to pursue him, it will be able to find out if it is worth doing so.

Limits of the current system

Things do not always work out to the advantage of claimants under the 1930 Act. A real-life example of the expense and frustration involved in pursuing a claim came in the recent *Goldsmith Williams (a firm) v Travelers Insurance Company Ltd* [2010].

The claimant firm of solicitors was appointed by mortgage lenders in two separate transactions. Unknown to the claimant, these transactions were part of a mortgage fraud perpetrated by another solicitor. The claimant repaid the mortgages to the lenders and took assignments of the lenders' causes of action against the fraudulent solicitor.

The claimant jumped through all the hoops provided by the 1930 Act. First, it restored the solicitor's firm to the register. Next, it issued proceedings against

the firm. Then it entered judgment. Only then could it bring a claim against the solicitor's professional indemnity insurers, the defendant. It was at this point that the insurers revealed that they were relying on a fraud exclusion clause in the policy. The claimant challenged this, but lost at trial. The court held that the defendant insurer was entitled to reject the claim on these grounds.

All the claimant's time and expense in pursuing the claim went to waste. *Goldsmith Williams* illustrates another important aspect of the system. The claimant's rights against the insurer can only be as good as the defendant insured's claim to an indemnity. The claimant cannot have any better right against the insurer than the insured. If the insured's actions in causing the claimant's loss fall outside of the terms of the policy, or it acts contrary to policy conditions in some other way, then the claimant will walk away from the insurer empty-handed.

A further concern for claimants is the situation where a defendant company has been dissolved and the policy terms required the insurer to be given certain information by the defendant. The insured no longer exists and is therefore unable to give the information, so this condition can never be satisfied. The policy condition has not been met and, as a result, it does not respond to the claim. The claimant might then be left without a remedy.

2010 ACT: A new hope

The simple but important change implemented by the 2010 Act solves the claimant's problem in *Goldsmith Williams*. The 2010 Act gives a claimant the right to bring a claim against the defendant's insurer without first bringing a claim against the defendant. The right arises when the defendant is subject to an insolvency procedure. So if the defendant is a limited company that has been removed from the register, there is no need for a claimant to restore the company before proceeding.

The 2010 Act gives the claimant the right to obtain information about the defendant's insurance. The right arises if it can be shown that there is a contract of insurance that covers (or might be reasonably expected to cover) the defendant's supposed liability to the claimant. The information available is the identity of the insurer, the terms of insurance, and whether there are (or have been) proceedings between the insurer and the defendant in respect of the supposed liability.

However, the claimant can still receive no better right than the defendant insured. So in *Goldsmith Williams* the claimant would still not have been able to recover its outlay, but it would have discovered that fact without needing to go on an expensive and ultimately fruitless journey through the procedure provided by the 1930 Act.

To see how the 2010 Act works in practice, we'll go back to *Fine & Dandy* and the errant bull. Farmer Jones tells the company that although he does have liability insurance, he will not provide any details. *Fine & Dandy*, as the claimant, gives notice to Farmer Jones that it wants to know the identity of his insurer and the nature of the insurance. Farmer Jones then has 28 days to present as much of the information specified in the notice as he can. If he cannot provide it, he should state why and say who might be able to supply the information. Farmer Jones may therefore give *Fine & Dandy* the details of his broker. If he does not comply, *Fine & Dandy* can seek a court order obliging him to do so.

Restriction on insurer's defences

Another change brought in by the 2010 Act is a restriction to the defences available to the defendant's insurer under the 1930 Act. The first is the aforementioned 'loophole', whereby the insurer of a defendant company can say that the policy does not respond because a policy term requiring a defendant to give certain information to the insurer has not been satisfied. This occurs because the company has been dissolved. This restriction has now been abolished.

Another exception occurs if the claimant itself satisfies a requirement under the policy to meet a particular policy condition imposed on the defendant. If the defendant's rights against the insurer have been transferred to the claimant, then the insurer cannot rely on the non-performance of the policy condition by the defendant. The condition was satisfied, just not by the insured.

New system

The 2010 Act updates the existing legislation (which will be repealed when the 2010 Act comes into force), and introduces new elements to reflect the changes in both the insurance market and insolvency law since 1930. The procedure that claimants must follow under the 1930 Act is cumbersome and time-consuming, and the new system is intended to be quicker and cheaper, and will reduce litigation.

The new system is welcome for claimants seeking to pursue a claim against an insured defendant. They will be able to find out quickly and easily whether the insurance will meet the claim. It is good news too for insurers pursuing subrogated recovery claims.

NOTES

1) Section 2 Third Parties (Rights Against Insurers) Act 1930.

2) For previous case law see *Upchurch v Aldridge Estates* (1993) 1 Lloyd's Rep 535 and *Woolwich v Taylor* (1995) 1 BCLC 132

3) Schedule 1, Third Parties (Rights Against Insurers) Act 2010.

The Third Parties (Rights Against Insurers) Act 2010 updates the existing legislation, and introduces new elements to reflect the changes in both the insurance market and insolvency law since 1930.

For liability insurers, the 2010 Act is a mixed blessing. It is certain to mean that they face more claims and the claims will be brought directly against them, rather than against their insureds. Additionally, the 28-day deadline for responding to a notice requesting information means that insurers will need to have a procedure in place for processing the request as soon as they receive it. Otherwise the next thing they receive could be a court order and a costs award against them.

More positively, if the policy does not respond to the claim, then that issue is likely to be brought to the fore at an earlier stage. So, ultimately, the claim will be dealt with much more quickly.

Furthermore, if there is no policy defence, it will be possible to discuss and contest the merits of the claim (and quantum), rather than facing a judgment against the insured.

The 2010 Act (when it comes into force) should mean a quicker, easier and cheaper system, which will benefit both claimants and liability insurers.

First National Tricity Finance Ltd v OT Computers Ltd (2004) EWCA Civ 653

Goldsmith Williams (a firm) v Travelers Insurance Company Ltd (2010) EWHC 26 (QB)



IMD2

Review of the insurance mediation directive

The European Commission is currently consulting on proposed changes to the Insurance Mediation Directive (IMD) which came into force at the beginning of 2005. The IMD introduced a Europe wide regime for intermediaries involved in the promotion, sale and administration of insurance contracts.

The Commission has proposed a number of changes to the existing directive, including:

- extending the scope of the IMD to ensure that it covers all persons who have insurance market intermediation as part of their activities, including direct writers of insurance, banking and insurance companies and car rental firms;
- the exemptions from the IMD to relate to particular activities, rather than types of person- the scope of the IMD would also be extended to direct sales by insurers and to sales made by an insurer on behalf of another insurer;
- the extension of the current Articles 12 and 13 information requirements to insurers;
- the introduction of a definition of 'advice';
- conflicts of interest framework, using the current MiFID arrangements as a benchmark;
- measures to address transparency in relation to the remuneration of intermediaries;
- improvements to arrangements for cross border business, including changes to the passporting notification requirements and clarifying the treatment of intermediaries from outside the EU;
- high-level competence requirements on the knowledge and ability of persons selling insurance; and
- a chapter setting out the sales requirements for packaged retail investment products (PRIIPS), that is investments packaged as life insurance policies, in particular:
 - applying consistent conduct, inducement and conflicts rules to all persons selling PRIIPS regardless of whether they are an intermediary or product provider;
 - pre-contractual disclosure- those selling PRIIPS should be responsible for providing pre-contract disclosure to their clients.
 - client's best interests- requirement should apply to insurers or intermediaries selling or giving advice on PRIIPS
 - remuneration- Insurers and intermediaries should ensure that detail on seller's remuneration is provided to clients and remuneration should be designed to avoid conflicts, particularly with the client's best interests.

- suitability and appropriateness- insurers or intermediaries advising on insurance PRIPS should obtain sufficient information on the client to enable them to make suitable recommendations to the client. For non-advised sales the appropriateness of the service or product should be considered and a warning provided where necessary.
- conflicts- Conflicts of interests should be identified and disclosed to the client before undertaking business on their behalf where they cannot be managed or avoided.

These PRIPS selling rules will be aligned with the Mifid rules in order to ensure an equal level of protection.

The proposals were reviewed by CEIOPS and its advice to the Commission and the Commission's consultation published at the end of 2010. The responses to the consultation, including responses from the ABI and the FSA and HM Treasury were published in April 2011. The joint FSA and HMT response has, among other things, queried having common conflicts standards for both intermediaries and direct sales and have also objected to extending the existing information requirements applicable to intermediaries to direct sales.

The Commission originally indicated that a first draft of IMD2 would be published in December 2011; however, it has recently been announced that this has been pushed back to Q1 2012 (February) as a result of the system at the Commission being "clogged up with legislative proposals". One consequence of the delay is that the Commission now intends to publish its horizontal disclosure rules for packaged retail investment products (PRIPs) in February 2012.

[A report on the impact of IMD2 was published in November 2011 by the European Commission.](#)

See also the related update on PRIPS.

Fairness

CICA

At the end of last year the FSA announced the fine of £2.8 million imposed on ACE-owned Combined Insurance Company of America (CICA) for failing to ensure that its customers were treated fairly. CICA sold accident and sickness insurance products via a field force of self-employed sales agents.

During the period investigated by the FSA, 1 April 2008 to 26 October 2010, the company had 542,133 policyholders and received £47m in premiums for new policies sold. Its main customers were self-employed, small business owners and manual workers. In August 2010, due to its concerns about CICA's business, the FSA required the firm to undertake a section 166 report to examine the insurer's governance and controls framework, subsequent to which the firm stopped writing new business.

The FSA found that CICA had breached FSA Principle 3 (management and control) and Principle 6 (customers' interests) by failing to manage effectively its sales processes, claims handling and complaints handling to ensure the fair treatment of its customers. The FSA identified systemic failings across much of CICA's business. In particular:

- CICA had no minimum qualification requirements for its agents and employment references were not always obtained
- CICA lacked adequate systems and controls to ensure that its sales agents had the necessary skills and knowledge to provide suitable advice;
- CICA did not ensure that its sales agents recorded all relevant information when advising customers on the suitability of insurance products
- the remuneration structure for the sales force was high-risk with agents paid on a commission-only basis, based on sales volumes with insufficient emphasis on the quality of sales;
- CICA failed to take consistent and effective action against sales agents who were subject to customer complaints or who had breached company rules;
- CICA did not put in place adequate controls to monitor its claims handling process; and
- aspects of CICA's complaints handling procedure and the accompanying systems and controls were inadequate.

CICA has agreed to carry out a review of past business to identify any customer detriment and pay redress.

Although this case of CICA relates to a long term insurer, the issues raised in it are equally applicable to a general insurer.

FSA acting director of enforcement and financial crime Tracey McDermott said: “CICA’s widespread failures reflect a culture that did not recognise the importance of treating customers fairly. This created a significant risk that customers would not get a fair deal. “Firms must ensure that protecting the interests of their customers is at the heart of every aspect of their business.” CICA settled early with the FSA and received a 30% discount on its fine. The FSA also took into account that CICA had already taken steps to address some of the issues raised by the FSA.

FSA publishes undertaking by Legal & General Insurance regarding unfair contract terms

On 14 December 2011, the FSA published an undertaking given by Legal & General Insurance Ltd (L&G) under the Unfair Terms in Consumer Contracts Regulations 1999 (SI 1999/2083) (UTCCRs) in relation to an exclusion clause in its home insurance policy terms and conditions (and other policies with the same or similar terms).

The clause stated that L&G would not pay for loss or damage caused to the insured buildings by shrinkage, expansion, subsidence, heave, landslip or settlement. None of the terms “subsidence”, “heave”, “landslip” or “settlement” was defined in the policy. The FSA determined that the clause did not clearly define L&G’s liability and was not drafted in plain and intelligible language because the terms were very broad and there was considerable uncertainty when considering how this exclusion clause would be interpreted and applied. In the FSA’s view, the clause made it very difficult for the policyholder to determine whether he was or was not covered under the clause and to challenge any decision by L&G to exclude a claim. In addition, the FSA believed that, given the lack of clear definitions, the particular risk could not have been properly quantified and taken into account in the calculation of the premium.

Accordingly, the FSA deemed the clause to be unfair under Regulation 5(1) of the UTCCRs on the basis that the lack of clarity as to the terms used and the fact that the clause did not reflect what L&G does in practice:

- Creates a significant imbalance in the parties’ rights under the policy.
- Demonstrates a lack of openness that is contrary to the requirement of good faith.

L&G have agreed to delete the clause and replace it with a revised clause, set out in the undertaking. It will also introduce new definitions for the terms used in the clause. Under the revised clause, L&G no longer has wide scope to determine what constitutes “damage caused by settlement, shrinkage or expansion” and therefore which claims to exclude. In turn, the consumer has clearer information as to what is or is not covered by the policy from the outset.

New customers will receive a revised policy with the new wording from 1 January 2012. Existing customers will be notified of the changes at their annual review falling due after that date. In the interim, L&G has confirmed it will treat all policyholders making claims under the clause as it currently stands as though the new terms already applied.

Motor insurance review

On 14 December 2011, the Office of Fair Trading (OFT) announced that it had decided to launch a market study into private motor insurance in the UK, specifically relating to features of the market for the supply of insurance and provision of third party vehicles and replacement vehicles which were suspected to be anti-competitive.

Although the OFT intended to complete its review by Spring 2012 it has since announced that it will not be continuing with the review, after accepting commitments from six insurance companies and two IT software and service providers to limit the data they exchange between them. The insurers in this case were Ageas Insurance Ltd (formally Fortis Insurance Ltd), Aviva Insurance UK Ltd, AXA Insurance UK plc, Liverpool Victoria Insurance Company Ltd, RBS Insurance Group Ltd, and Zurich Insurance plc - UK Branch; and IT software and service providers Experian Ltd and SSP Ltd.

The original investigation identified an increased risk of price coordination among motor insurers using a specialist market analysis tool provided by Experian called Whatif? Private Motor. The Experian tool allowed insurers to access not only the pricing information they themselves provided to brokers, but also pricing information supplied by other competing insurers. The OFT warned the firms that, because insurers were able to access information about their competitors' future pricing intentions, the information exchanged through WhatIf? Private Motor raised competition law concerns, in particular that it could potentially be used to coordinate on price.

The formal commitments given by those firms address these concerns by ensuring that the companies will exchange pricing information through the analysis tool only if that information meets certain principles agreed with the OFT. These principles require the information, if less than six months old, to be anonymised, aggregated across at least five insurers and already 'live' in broker-sold policies.

Having accepted the commitments, the OFT has ended its investigation and will not be proceeding to a decision on whether or not the Competition Act has been infringed.

Selling general insurance through price comparison websites

In October 2011 the FSA issued its guidance on selling insurance through price comparison websites. This followed a thematic review earlier in the year. The FSA identified a number of areas of breach in relation to selling general insurance this way, including lack of permissions and non-compliance with the FSA Handbook insurance selling rules as well as the high level systems and controls rules. It recommended carrying out a review of activities to ensure no unauthorised business or dealing with unauthorised third parties. It also recommended firms should review their disclosure and sales documentation and procedures and ensure these complied with all applicable law and regulation.

The FSA found that customers may be being misled by price comparison sites, particularly in relation to quotes which may appear based on their individual demands but are in reality merely illustrative. They may take out policies which then do not pay out, where there are material facts relevant to the insurance which were not disclosed.

Further the FSA found that depending on the model of business adopted, comparison sites may be arranging contracts of insurance, for which they would require authorisation or providing advice in the form of an explicit or implicit recommendation of a particular product.

Based on the regulatory pitfalls of potential arranging or advice, the FSA guidance emphasises the importance of checking the regulatory position, both for comparison firms and for general insurers whose products are featured on them. The FSA also found that terms and conditions for the price comparison sites contained too many exclusions and therefore might be contrary to the UCCTR regulations if the exclusion was inappropriate.

In so far as the customer's personal risks the FSA identified that checks on eligibility for a policy were not being handled properly. The firms involved both needed to ensure that customers would only buy a policy under which they were eligible to claim.

The FSA also had concerns about the clarity of the relationships and roles of the different parties involved in the comparisons and who to complain to. This did not comply with ICOBS requirements for disclosure to customers. Similarly there was poor disclosure of the service being provided, i.e. non-advised or advice based. The FSA thought that some of the comparison services could be viewed providing advice. If it was an information only sale this needed to be made clear. If advice based then this would trigger suitability requirements under ICOBS.

Under typical business models the FSA found that the price comparison service was acting as insurance intermediary and therefore was responsible for providing a demands and needs document. However in many cases this was being passed on to the actual insurer inappropriately. Customers were also not being made aware that the policies being offered were based wholly or largely on a generic set of demands and needs rather than their own personal ones.

Satellite warranties

In a recent case brought by the FSA against Digital Satellite Warranty Cover Limited, the court has confirmed that such warranties covering satellite television equipment are contracts of insurance. Selling these kinds of warranties is a regulated activity requiring a firm to have FSA authorisation.

The businesses involved in the legal action sold extended warranty contracts for satellite and other similar equipment. People targeted for sales were told that the warranty would cover not only equipment break down but also accidental damage. The companies offering the warranties were required to repair or replace faulty or damaged equipment but did not have to pay money.

The FSA claimed that the warranties were contracts of general insurance within UK financial services regulation. The defendants argued that since their policies did not provide for the payment of cash but only benefits in kind, this meant that they were not contracts of insurance within “miscellaneous financial loss”.

The court held that the contracts were capable of being general insurance, notwithstanding the quite narrowly drafted provisions of the UK legislation defining such insurance, because they would be contracts of insurance at common law, that is an agreement for the payment of a sum of money or corresponding benefit on the happening of an uncertain event that is generally adverse to the interests of the person taking out the insurance. The uncertain event was the equipment breakdown or malfunction, the repair and replacement service represented a corresponding benefit and the insured (as owner) clearly had an insurable interest.

The court found that the contracts were miscellaneous financial loss and that the wider cover for breakdown would also bring them within the head of fire/natural resources and accidental damage insurance.

The court of appeal decision went the same way as the original decision, finding that the risk covered by a contract which provides for repair and replacement of the equipment and a contract which provides an indemnity for the costs involved is essentially the same. In both cases, the risk is the breakdown of the equipment which will lead to expense on the part of the insured. So, although the cover provided for the risk of malfunction to be dealt with by repair or replacement, that risk was essentially a financial one attributable to the insured incurring unforeseen expense and thus within “miscellaneous financial loss”.

The court therefore made it clear that the UK statute should not be construed restrictively so as to prevent contracts amounting to insurance based solely on the narrow wording of the statute.

Firms will need to take this case into account when they offer warranties or service contracts on products such as televisions or other equipment.

Other Developments

Insurance Guarantee Schemes

The European Commission's work programme for 2012 includes considering a directive on insurance guarantee schemes, as considered in its July 2010 white paper on insurance guarantee schemes. The annex to the work programme states this is considered necessary in order to ensure that there are schemes in all Member States and that they comply with a minimum set of design features.

The European Insurance and Occupational Pensions Authority (EIOPA) issued a report last year which looked at existing arrangements, including mechanisms for cross-border co-operation between member states' insurance guarantee schemes (IGSs) and between IGSs' and national supervisory authorities. The reports findings suggested a need for:

- Clear co-operation procedures for consumer protection.
- Requiring IGSs to exchange information in order to ensure effective policyholder protection.
- Provision of legal certainty for the purpose of confidentiality.
- Provision of infrastructure for exchange of information.
- A mechanism to resolve disputes.

EU Insurance Contract Law

The EU Commission initiated industry discussions in September 2011 in relation to the proposed introduction of a European insurance contract law instrument. The proposal which is currently being prepared by the Commission is intended to facilitate cross border trade for SMEs and consumers buying insurance across borders. The proposal will be developed in 2012 and is planned for 2013. It is described as optional. It will be separate from other plans to introduce a European contract law more generally.

Financial Conglomerates Directive

The EU Commission's work programme for 2012 includes a fundamental review of (likely leading to a legislative proposal to amend) the Financial Conglomerates Directive (2002/87/EC) (FICOD). This is known as FICOD II. A legislative proposal effecting the review is expected to be published in the Summer of 2012.

Financial conglomerates are large financial groups or sub-groups, that operate in the insurance sector and in the banking and/or investment services sector. Because of their size and complexity, financial conglomerates are often of systemic importance to individual EU member states or the EU as a whole. FICOD introduced a prudential regime for these financial conglomerates in order to combat the risks associated with large cross sector businesses. This regime was in addition to sectoral directives applicable to different parts of the group, such as capital requirements for banks and investment firms and insurance directives applicable to insurance firms (now Solvency II).

The scheduled review (required by FICOD 1) requires a review of the scope of FICOD, including whether the directive should be extended to non-regulated entities, such as SPVs. The review will also consider:

- the identification criteria for financial conglomerates owned by wider non-financial groups, whose total activities in the banking sector, insurance sector and investment services sector are materially relevant in the internal market for financial services; and
- systemically important financial conglomerates.
- mandatory stress testing.

Crisis resolution for non bank financial institutions

The Commission's work programme for 2012 has indicated that it will be considering a possible framework for crisis management and resolution for financial institutions other than banks, (including insurers). The Commission intends to publish, by the end of 2011, a report examining the need for a crisis management regime for these financial institutions and may subsequently propose legislation to grant powers and tools to authorities to deal with their failure.

Packaged bank account insurance sales

In October 2011 the FSA launched a consultation (CP11/20) on the rules relating to selling non-investment insurance as part of a packaged bank account. A packaged bank account is a current account bundled with various insurance policies, access to preferential terms for other financial services (such as an overdraft, personal loan or mortgage) and, on occasion, non-financial products and services.

The FSA's proposed new rules are designed to make sure that consumers can make an informed choice about the kinds of accounts available and to make sure they get enough information at the point of sale. These rules will be implemented in new rules in the ICOBS Sourcebook.

The new rules require banks and building societies selling insurance policies as part of a packaged bank account to take reasonable steps to ascertain whether a customer is eligible to claim under each policy. They must also provide customers with an annual eligibility statement prompting them to check whether their circumstances have changed and whether the policies still meet their needs. When selling on an advised basis, firms must consider the suitability of each insurance policy and alert the customer should some not be suitable. A record of the suitability assessment and advice given must be kept for at least three years. The proposed new ICOBS rules are set out in Appendix 1 to CP11/20. The FSA will be collecting data during 2012 from firms which do provide packaged bank accounts.

The consultation closes late January.

