

REGULATION, INVESTIGATIONS AND PROFESSIONAL INDEMNITY INSURANCE FOR INSURANCE BROKERS

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THE IMPACT OF INVESTIGATIONS IN THE UK AND USA

Background

The investigations carried out by the New York Attorney General, Eliot Spitzer in respect of US insurance industry sales practices concentrated on the following issues:

- secret profits (contingent commissions agreements);
- channelling of business;
- bid-rigging and anti-competitive practices, and more recently,
- finite (re)insurance.

Mr Spitzer considered that major broking firms in the US had entered into contingent commission arrangements with insurance companies to increase their income by steering business to preferred insurance carriers in preference to the interests of their clients. Under the terms of these contingent commissions agreements (sometimes known as Placing Service Agreements or Market Service Agreements) brokers received payments from insurance companies based on the volume or profitability of the business placed with them or the number of policies that were renewed. These contingent commission payments, which were in addition to the fees received from insureds, were not disclosed to them. Mr Spitzer also considered that these contingent commission agreements placed higher costs on the insurance itself which resulted in consumers having to pay higher premiums.

The US civil complaint filed by Mr Spitzer against Marsh & McLennan Companies ("Marsh") in October 2004 alleged that Marsh had designed and executed a business plan under which insurance companies agreed to pay Marsh more than a billion dollars in contingent commissions in order to "steer them business and shield them from competition". According to the complaint, Marsh accepted payments from incumbent insurance companies to recommend their own renewals and fabricated bids to deceive clients into thinking they were getting the lowest-priced policies. It was alleged that in furtherance of this plan, Marsh and a number of insurance companies engaged in bid-rigging schemes.

On 30th January 2005, Marsh agreed to pay \$850m in order to settle the lawsuit. As part of the settlement, Marsh promised to adopt new reforms, including an agreement to limit its insurance brokerage compensation to a fee and/or commission at the time of placement, a ban on contingent commissions, and a requirement that all forms of compensation would be disclosed to their clients.

A lawsuit was also filed in the US against Aon Corp. alleging that they accepted contingent commissions from insurance companies for steering them business, and that acceptance of these secret payments created a direct conflict of interest with their

clients. Willis North America Inc. (the North American brokerage arm of London-based Willis) was also investigated regarding allegations of fraud and anti-competitive practices.

On 4th March 2005, Aon agreed to pay \$190m to compensate policyholders in order to resolve the lawsuit. It promised to adopt a new business model designed to avoid conflicts of interest whereby the company would accept only one payment for an insurance contract at the time of placement, and that these payment would be disclosed to and approved by Aon's customers. Willis agreed in April 2005 to pay \$50 million in compensation to policyholders and to adopt a new business model in order to resolve concerns raised about them. It promised to make full disclosure to clients regarding all compensation received for its services and to prohibit the acceptance of compensation and gifts.

Application of English law

The application of English law with regard to each of these types of conduct is explained below. It should however be clarified that there is no evidence to suggest that any such conduct has taken place in the London market.

Secret Profits

As a general rule, an insurance broker is the agent of the insured and the insured is the broker's principal. The broker will be entitled to receive as payment for his services either an amount agreed with the principal or the usual and ordinary commission payable for that transaction. If the broker is paid by the insured, then the broker should not receive any other payment or commission from the insurer without the client's informed consent. In other words, the broker must not breach the fiduciary duties that he owes to his principal to deal honestly with him, by making a secret profit. There does not need to be any dishonesty or fraud on the part of the broker in order to establish breach of this fiduciary duty, merely that he gained a financial advantage by virtue of his position.

If the broker accepts a secret profit then it must forfeit all rights against the insured and is also liable to the insured for all losses that arise from the breach of duty (*Mahesan v Malaysia Government Officers' Co-operative Housing Society Ltd [1979] AC 374*). It is therefore possible for the broker to receive payments from both the insured and insurer as long as the insured is aware that the broker will be remunerated by the insurer in addition to receiving a fee from the insured (*Lord Norreys v Hodgson (1897) 13 TLR 421*).

Under the common law rules, contingent commissions do not therefore amount to secret profits provided they are not excessive, are consistent with market custom and are disclosed to insureds.

An insurer may also be liable to the insured if it colludes with a broker to act in breach of its fiduciary duties, by agreeing a secret profit. The insured in such a situation can recover from the broker the amount of the secret profit (i.e. obtain an account of profits), and he may also recover from the insurer and the broker, jointly or severally, damages for any loss, which he may have suffered by reason of his having entered into the contract.

Channelling of Business

Mr Spitzer alleged in the complaints filed against Marsh and Aon that they were responsible for steering business to preferred insurers in return for the payment of contingent commissions. These payments acted as an incentive for the brokers to place business with preferred insurers even if they were not offering the best rates or terms. This meant that customers were not necessarily getting the best coverage for their needs. It was also alleged that brokers agreed to steer more retail insurance to an insurance carrier, if the carrier promised to use their reinsurance brokerage services.

A broker owes its principal a fiduciary duty to act in its best interests and not to place its own interests before that of the principal. If a broker places business with an insurer purely on the basis of the additional income they will receive as a result, this amounts to acting in breach of fiduciary duty.

If an insurer colludes with a broker to act in breach of its fiduciary duties to the insured, by entering an arrangement whereby insurance business is placed with the insurer for reasons other than that it is in the best interests of the insured, both the insurer and the broker may be liable to the insured. However if the broker acts in breach of its fiduciary duty to the insured without there being any collusion or involvement on the part of the insurer, then the insurer is not generally liable for the broker's acts. An insurer is not responsible for the fraud or breach of fiduciary duty of a broker who is not its agent, provided that the insurer takes no part in the fraud or breach of fiduciary duty.

Since insurance policies are contracts of good faith, it is an insurer's duty to disclose to an insured all material facts known to the insurer which are material to the nature of the risk sought to be covered and which a prudent insured would take into account in deciding whether or not to place the risk for which he seeks cover with that insurer (*Banque Keyser Ullman SA -v- Skandia (UK) Insurance Co. Limited 1989 2 All ER 95*). It follows from this that an insurer who is aware that a broker is acting in breach of fiduciary duty or fraudulently should disclose that fact to the insured.

Bid-rigging and Anti-competitive practices

The Spitzer investigations also focused on the alleged anti-competitive nature of some of the practices of major US insurance broking firms. Mr Spitzer found evidence of direct bid-rigging in excess casualty insurance markets, whereby Marsh allegedly arranged for the submission of fictitious or artificially inflated bids in order to create the illusion of a competitive bidding process among insurance carriers and to conceal the direct steering of insurance business to a favoured insurance carrier. He also found evidence that Marsh had allegedly arranged for insurance carriers to refrain from bidding on certain contracts in order to limit competition.

It was alleged that when a policy with an incumbent carrier was up for renewal, Marsh took steps to ensure that the incumbent carrier would win back the business. First Marsh provided the incumbent with a target premium and the policy terms for the quote. If the insurer agreed the quote, it kept the business regardless of whether it could have quoted a lower premium. Marsh then informed other carriers about the winning quote

and asked them to submit a so-called backup quote or “B quote” that was higher, thus putting them out of contention for the business.

It was also alleged that there was evidence of “no shopping” agreements between Marsh and insurance companies, whereby they would agree not to ‘shop’ policies when they came up for renewal, thereby guaranteeing that the business stayed with the incumbent insurer and with Marsh.

Mr Spitzer considered that this distorted competition in three ways. Firstly, the bid-rigging process itself denied insurers the opportunity to participate in a genuine competitive bidding process. Secondly, the additional income received by brokers from insurers through the use of PSA’s and MSA’s schemes permitted the discounting of quotes to insureds in order to enable Marsh and the favoured insurers to gain or retain business. Lastly, insurers who refused to enter into these arrangements found that they received less business as a result.

Two issues arise from these practices. First under the law of agency, the broker owes a fiduciary duty to the insured to act honestly (*Cook v Deeks [1916] 1 AC 654*). If a broker fails to inform the insured of the best available insurance quotation or otherwise fabricates an inflated quote, this clearly amounts to acting contrary to the best interests of its client and the broker may be liable to the insured for any loss suffered by the insured as a result.

If an insurer colludes with the broker in the bid-rigging scheme resulting in the broker breaching his fiduciary duty to the insured to act honestly and in the best interests of its client, the insurer may also be liable.

The second issue which arises is the statutory anti-competition laws. There is a dual system of competition law in the UK, with the provisions of the European competition rules and the UK Competition Act 1998 running alongside each other. Article 81 of the Treaty of Rome (“the EU Treaty”) and Chapter I of the Competition Act 1998 set out legal rules to encourage fair and effective competition between businesses. Art. 81 of the EU Treaty prohibits anti-competitive agreements and concerted practices between two or more undertakings, which “*prevent, restrict or distort competition within the EU*”. Chapter I of the Competition Act is concerned with the prevention, restriction or distortion of competition within the UK.

The Office of Fair Trading (“OFT”) has responsibility for investigating and enforcing alleged infringements of the Competition Act. Since 1st May 2004, it also has power to apply and enforce Art 81 of the EU Treaty in the UK. (This is the result of the Modernisation Regulation of the EU, which aims to use national authorities to form a network of competition authorities throughout the EU applying the EU Treaties).

Under Art. 81, the anti-competitive nature of the agreement is judged according to its effects or intended effects on consumers. The ‘agreements’ can be formal or informal, written or verbal. An informal understanding or telephone conversation will be caught by the provision in the same way as a formal agreement. ‘Concerted practices’ covers conduct, which falls short of an agreement or decision. Art. 81 is aimed at hardcore restrictions of competition law such as price-fixing or bid-rigging. The OFT considers bid-rigging agreements by their very nature restrict competition to an appreciable extent. A bid-rigging scheme entered into by a broker and insurers in the UK which relates

solely to the writing of UK risks, does not strictly breach Art. 81 since these activities do not distort trade between member states. However, since most of these practices were adopted in relation to large risks which were likely to have an international element this exception will probably be of limited affect and is unlikely to assist a broker or insurer where the relevant portfolio of risks includes international business.

Art. 82 of the EU treaty prohibits abuse by one or more undertakings of a dominant position within the EU, insofar as it may affect trade between member states. (A market share of 40% or more is considered to be a good indication that an undertaking is dominant in the market). Chapters II of the Competition Act mirrors this treaty provision except it specifically relates to trade within the UK.

It may be argued that the “effect” of PSA’s or MSA’s is to restrict or distort trade. However, if these agreements relate to the writing of UK risks, they will not breach Art. 82, since these activities do not distort trade between member states. It is also arguable whether any individual insurer or broker can be said to be dominant in the market, given the high level of market share that the law requires, although it is a possibility that the Office of Fair Trading will define markets according to the market for specific narrowly-defined insurance products e.g. professional indemnity insurance.

There was an exclusion under Chapter 1 of the Competition Act regarding “vertical agreements” i.e. agreements between businesses that operate at different levels of the supply chain (which would arguably include a bid-rigging scheme between a broker and insurer(s)). However, this exception does not apply to any vertical agreement, which has price-fixing as its object or effect and therefore would not exempt a bid-rigging scheme. This exclusion has now been repealed (with effect from 1st May 2005).

The OFT has a wide range of powers to investigate businesses suspected of breaching these laws and can order offending conduct to be stopped. It may request information informally or formally. Non-co-operation is punishable by a fine. Fines for infringements of EU Competition Law may be up to €1m, or a greater sum of up to 10% of an undertaking's annual worldwide turnover (Regulation 17/62, Article 15 (2)). The amount of the fine will depend on the seriousness of the abuse, the parties' position in the market, the size of the business and any mitigating factors.

Businesses which infringe Chapter I of the UK Act are liable to financial penalties of up to 10% of an undertaking's turnover in the UK during the proceeding year (s.36 (8) Competition Act). (The amount of the fine depends on the same factors listed above). If there is any over lap between European penalties and those which the OFT seeks to impose, the OFT must consider the European penalties so there is no “double jeopardy”.

Any bid-rigging scheme which infringes Article 81 or Chapter I of the Act are void and cannot be enforced. Any third parties (including customers or injured competitors) who have sustained loss as a result of anti-competitive agreements, are entitled to seek compensation.

Finite (re)insurance

Mr Spitzer and the Securities and Exchange Commission (SEC) have investigated a number of insurers in the US regarding their use of finite (re)insurance.

Finite (re)insurance is a reinsurance contract by which risk is transferred to a reinsurer but the risk transfer is limited in some way. It is typically purchased by insurers and insureds looking for protection against the financial impact of future liabilities when traditional reinsurance cover is not available. Finite (re)insurance differs from other reinsurance products in terms of pricing and structure. Unlike a reinsurance contract which is usually renewed annually, finite (re)insurance policies tend to cover 3-5 years. There is also an element of “dynamic” pricing, as the amount of premium payable is adjusted during the life of the policy in line with the claims record.

Finite (re)insurance can be legitimately used to strengthen an insurer’s solvency. However, there are concerns that if there is inadequate risk transfer under finite (re)insurances and that these contracts should be accounted as loans and not as an insurance contracts. Finite (re)insurances are generally treated as insurance contracts for accounting purposes. One of the key accounting issues is whether the contract meets the tests on risk transfer that allow treatment as an insurance contract. The rule of thumb developed from the US standard accounting principles is that there needs to be at least a 10% possibility that the reinsurer will suffer at least a 10% economic loss (i.e. a ratio of losses divided by premiums at least 110% which is known as the “10-10 rule”). In the event that there is not sufficient risk transfer under the transaction intended as a (re)insurance then the contract would need to be treated as a financial arrangement and the (re)insurance premiums would be accounted for as assets that the reinsured has deposited with the reinsurer.

Regulators in the US (and the UK) are concerned that insurers are using finite reinsurance as a method of concealing their true financial position from shareholders, policyholders, auditors and regulators. Their investigations have suggested that in some cases, contracts have been entered into which provide for genuine risk transfer, but side letters have also been agreed (that were not disclosed to regulators and possibly auditors) which have the effect of removing the element of risk transfer.

The FSA Regime

Brokers and insurers based in the UK, must ensure that their business practices do not fall foul of the FSA regime. The FSA rules are in addition to the common law principles set out above.

The FSA’s role is to set prudential and conduct of business standards for regulated firms and to monitor and enforce compliance. Following the implementation of the European Insurance Mediation Directive which required member states to regulate insurance sales, the FSA is also from 14th January 2005 the statutory regulator in respect of general insurance business. The Insurance Code of Business Sourcebook (“ICOB”) came into effect on the same date. The ICOB rules relate to the conduct of general insurance business and apply to both insurers and intermediaries.

The FSA is a risk based regulator. It focuses its resources on the mitigation of risks. The approach to risk assessment is based on the extent to which firms pose risks to the four (regulatory) objectives of the FSA. These are:

1. Maintaining market confidence;
2. Promoting public understanding of the financial system;
3. Securing the appropriate degree of protection for consumers;

4. Reducing financial crime.

The Principles for Businesses

The following 11 Principles are a general statement of the fundamental obligations of firms under the regulatory system. They derive their authority from the FSA's rule-making powers (as set out in the Financial Services and Markets Act 2000) and reflect the FSA's regulatory objectives.

1	Integrity	A firm must conduct its business with integrity.
2	Skill, care and diligence	A firm must conduct its business with due skill, care and diligence.
3	Management and control	A firm must take reasonable care to organise and control its affairs responsibly and effectively, with adequate risk management systems.
4	Financial prudence	A firm must maintain adequate financial resources.
5	Market conduct	A firm must observe proper standards of market conduct.
6	Customers' interests	A firm must pay due regard to the interests of its customers and treat them fairly.
7	Communications with clients	A firm must pay due regard to the information needs of its clients, and communicate information to them in a way which is clear, fair and not misleading.
8	Conflicts of interest	A firm must manage conflicts of interest fairly, both between itself and its customers and between a customer and another client.
9	Customers: relationships of trust	A firm must take reasonable care to ensure the suitability of its advice and discretionary decisions for any customer who is entitled to rely upon its judgment.
10	Clients' assets	A firm must arrange adequate protection for clients' assets when it is responsible for them.
11	Relations with regulators	A firm must deal with its regulators in an open and cooperative way, and must disclose to the FSA appropriately anything relating to the firm of which the FSA would reasonably expect notice.

The Principles have been in force since 1st December 2001 though they did not apply to general insurance intermediaries until 14th January 2005. They are of universal application. The FSA has made it clear that regulated entities must have regard to the Principles as well as complying with the detailed requirements of the rules.

Therefore, even if the ICOB rules do not apply, these Principles remain applicable. For example, any act by an insurer or intermediary which involves breaching any of the fiduciary duties which it owes its client, are likely to breach these Principles. Breaching one of these high-level Principles makes a firm liable to disciplinary sanction.

The ICOB rules

These rules govern a firm's relationship with its customers before, during and after the sale of a non-investment insurance contract. They aim to ensure that all firms treat customers fairly. The ICOB rules are not all-encompassing. All reinsurance contracts and contracts with commercial customers that are defined as "*large risks*" are exempt from these rules.

ICOB 4.2.8(6) states that brokers and other intermediaries must inform the customer in relation to the non-investment insurance contract provided, whether it has provided, or will provide, advice or information:

- (a) on the basis of a fair analysis of the market; or
- (b) from a limited number of insurance undertakings; or
- (c) from a single insurance undertaking.

A broker/intermediary cannot hold itself out as giving information or advice to customers on the basis of a fair analysis of the market in accordance with ICOB 4.2.8 (6)(a) unless:

- (1) It has considered a sufficiently large number of non-investment insurance contracts available in the relevant sector or sectors of the market; and
- (2) The consideration in (1) is based on criteria which reflect adequate knowledge of non-investment insurance contracts in the relevant sector or sectors of the market (ICOB 4.2.11).

The ICOB guidance states that one way in which the requirement above may be satisfied is in using panels of insurance undertakings which enable the broker/intermediary to give advice on a fair analysis basis and which are reviewed on a regular basis. The guidance provides that insurance panels should be selected on the basis of product features, premiums and services offered and not solely on the basis of benefits offered by the insurance undertaking to the intermediary. Although this guidance is not binding, it is the clearest statement of the FSA's position.

The ICOB rules regarding product disclosure require information to be provided to insureds setting out the basis of the services provided to them to enable them to make an informed decision regarding a policy. Broadly speaking the insurer is responsible for the content and production of documents and information to be provided to the customer. Where a broker is involved in the transaction, the insurer must provide the broker with the documents and information. The broker is then responsible for providing this information to the customer.

A customer must initially be provided with an Initial Disclosure Document ("IDD") which provides details of the insurance services provided by the intermediary or the broker, the basis on which any advice will be provided and the charges which may be incurred (ICOB 4.2). (It is not required in the case of a commercial customer dealing directly with

an insurer). The firm must state the basis on which it selects contracts that it has recommended (e.g a fair analysis of the market or one insurer only). The provision of the IDD is an essential pre-requisite to the conclusion of the contract and must be provided in a durable medium (hardcopy or printable electronic format).

There is also a requirement before the conclusion of the contract to provide a statement that sets out the customer's demands and needs and confirms whether the insurer has personally recommended the contract (ICOB 4.4.1). There is no need in the case of commercial customers dealing directly with an insurer unless the insurer makes a personal recommendation to the customer (ICOB 4.4.2). If a personal recommendation has been provided and the customer buys the insurance contract, a copy of the demands and needs statement must be kept for three years (ICOB 4.4.7).

The FSA rules also provide that a policy summary must be provided to the customer before conclusion of the contract, which sets out the significant features and benefits of the policy and the principal exclusions (ICOB 5.5.1). The insurer is responsible for the content of the summary. In addition (commercial) customers must be "promptly" provided with a policy document (ICOB 5.5).

The FSA's reforms regarding prudential regulation which relate to professional indemnity insurance have been aimed at achieving its statutory objectives relating to promoting public confidence and securing an appropriate degree of protection for consumers.

Intermediaries must maintain professional indemnity insurance ("PII") to provide cover to third parties in respect of negligent acts or omissions by the firm's employees (Integrated Prudential Sourcebook: PRU 9.2). Firms must inform the FSA, if PII cover is refused or cancelled. Failure to do so amounts to a breach of high level Principle 11 regarding the need for a firm to co-operate with its regulators (Supervision Sourcebook: SUP 15.3.8).

The PII cover must cover all activities of the firm not just arising out of general insurance or activities regulated by the FSA. The prudential requirements regarding PII cover under PRU are more stringent than required under EU legislation. Article 4.3 of the Insurance Mediation Directive requires intermediaries to provide a minimum limit of indemnity amounting to EUR 1m for any one claim and in the aggregate EUR 1.5m annually. Under PRU 9.2, the minimum limit is as above or "if higher, 10% of annual income up to £30m" (PRU 9.2). This is to meet the FSA's regulatory objectives of maintaining market confidence by ensuring that firms have the ability to meet their liabilities to customers.

THE EFFECT OF REGULATION BY THE FSA

The following is a review of the FSA rules as they may apply to the issues raised by Mr Spitzer.

1. Commissions

The FSA has closely monitored the Spitzer investigations and has reviewed the issues of secret commissions and the distortion of competition. Despite significant lobbying from certain market organisations, the FSA refused to mandate the disclosure of commissions. It decided that the existing rules for insurers and intermediaries provide

adequate protection. However there has been further recent lobbying by a variety of industry groups (including AIRMIC) and it appears that there may be a revision of the FSA's position, but nothing has been put in writing as yet.

"Commission" is widely defined by the FSA as "*any form of commission, including a benefit of any kind, offered or given in connection with designated investment business.*" An insurance intermediary must, if asked by a commercial customer, promptly disclose the commission that he and any associate receives in respect of the contract in question. (ICOB 4.6.1). If the precise amount of the commission value is unclear, an intermediary must estimate the commission (ICOB 4.6.5). The ICOB guidance states that this is in addition to the broker's normal fiduciary duties.

There is no requirement for intermediaries to disclose the amount of commission they have received to retail customers. However, it is a principle of agency law that an intermediary must disclose the amount of commission he has received to the insured, if he is specifically requested to do so (*Great Western Insurance Co. v Cunliffe (1874) 9 Ch App 525*).

If a broker accepts a secret commission from an insurer, this conduct will amount to a breach of high level Principles no. 1, 5, 6, 7, 8 and 9 (which are set out above). These duties include the need to act with integrity, observe high standards of market conduct, treat customers fairly, communicate information to clients in a way which is clear, fair and not misleading, manage conflicts of interest and to take care to ensure the suitability of advice provided to customers. An insurer who colludes with a broker to act in breach of its fiduciary duties to the insured by agreeing to pay him a secret commission, will breach high level Principles 1 and 5.

2. Channelling of Business

The FSA requires firms to take 'reasonable steps' to ensure that they do not "*offer, give, solicit or accept*" an inducement or direct business to another firm if it is likely to "*materially conflict with the duty the firm owes to its clients... or any duty which such recipient firm owes to its customers*" (ICOB 2.3.2). The definition of "inducement" in the informal guidance is very broad, being "a benefit offered to a firm, or any person acting on its behalf, with a view to that firm, or that person, adopting a particular course of action. This can include, but is not limited to, cash, cash equivalents, commission, goods, hospitality, or training programmes"

For the purposes of this definition, an inducement will be unfair if the result is contrary to or detrimental to the interests of the insured. If the FSA suggests that where there has been an inducement, then the burden will be placed upon the broker to prove that the inducement is not unfair. The FSA have left it to regulated firms, both insurers and intermediaries, and their senior management as to what constitutes an inducement in particular circumstances.

The key difference between the common law rules and the FSA rule on unfair inducements is that under the common law commission payments are generally permissible provided that they do not exceed a usual or ordinary amount of commission. Under the FSA rules, by contrast, the emphasis is upon the result of the inducement being detrimental to the interests of the insured. It follows that whilst at common law, evidence that a particular type of payment is widespread in the market may help to show

that it is a usual or ordinary payment; whereas, under the FSA rules, such a payment may be classed as an unfair inducement if the result is detrimental to the interests of the insured even though the inducement is a standard market practice.

The FSA has stressed in informal guidance that firms must not structure arrangements in a way which would breach ICOB 2.3. It has also describes conduct which will amount to a breach of these rules. This includes situations where an intermediary promises the best deal for the insured but has received an inducement which influences placement of the risk, an intermediary settles claims but has received the benefit of a profit commission or where insurers attach conditions to the placement of a risk (e.g. expectation of renewal of the policy). Furthermore, the inducement need not be purely financial. A scheme, which provides that the broker who produces the most new business to an insurer over the course of a year will receive a prize, may breach the rules. Something as simple as offering a broker tickets to a sporting event may be sufficient for an unfair inducement to have arisen, if as a result of that marketing activity the broker places business with an insurer to the disadvantage of the Insured. Although this informal guidance is not binding, it should be viewed as the clearest possible statement of the FSA's position

If a broker steers business to a particular insurer on the basis of the remuneration that they will receive and not because the policy provides the best coverage for their client's needs, this conduct will potentially breach the unfair inducement rules. This conduct will also breach high level Principles 1, 5, 6, 7, 8 and 9, in particular the need for a firm to conduct its business with integrity and pay due regard to the interests of its customers and treat them fairly.

An insurer who colludes with a broker to act in breach of its fiduciary duties to the insured by entering into an arrangement whereby business is placed with them solely on the basis of the additional income that the broker will receive, is at risk of breaching the unfair inducement rules. This conduct may also breach high level Principles 1 and 5 regarding the need act with integrity and observe proper standards of market conduct.

3. Bid-rigging and Anti-competitive practices

Bid-rigging schemes and related anti-competitive practices breach the unfair inducement rules insofar as they involve brokers receiving payment from insurers in order to predetermine the business that will be directed to them.

Insurers who enter PSA's or MSA's may breach these rules unless they can prove that the payment of additional commissions under the terms of these agreements did not amount to an 'unfair' inducement. This will depend on the circumstances of the case and whether the insured was aware of the existence of the PSA/MSA and the fact that the broker would receive additional payment as a result.

This conduct may also breach the FSA requirement that a broker must inform the customer regarding the basis on which he recommends a policy, e.g. a fair analysis of the market or one insurer only (ICOB 4.2.8(6)). It may also breach the high level Principles 1, 5, 6, 7, 8 and 9.

4. Finite (re)insurance

The FSA has reviewed finite (re)insurance since 2002 but it has increased this review in light of the concerns raised in the US regarding the Spitzer investigations.

The FSA is undertaking specific supervisory work to establish the extent to which financial engineering is used by regulated firms. It stated in December 2004 that it *“would not hesitate to take enforcement action against any company suspected of using finite (re)insurance contracts...to conceal its true financial position”*. It also reminded firms of the need to have appropriate systems and controls for their businesses.

Since the beginning of 2005 insurers based in the UK have had to provide the FSA with Individual Capital Assessments (“ICA”) to satisfy the FSA that they have sufficient capital to maintain risks in their business (this requirement has been deferred in respect of Lloyd’s until January 2006). A firm’s ICA should explain the extent to which financial engineering has been used and for what purposes as well as assessing any capital required to mitigate risks arising from such contracts (Integrated Prudential Sourcebook: PRU 2.3).

The FSA sent a letter to the Chief Executive Officers of general insurance firms on 16th March 2005 asking them for *“specific information about financial arrangements they have entered into where the economic value of the transaction differs materially from the value placed on the transaction in their firm’s balance sheets”*. John Tiner (the Chief Executive of the FSA) has made it clear that the responses received to this letter would provide the basis of further targeted work. The firms were asked to provide the following details by end of April 2005:

- (a) the extent to which they engage (or have engaged since 1 December 2001) in transactions where the transaction’s economic value differs materially from the value placed on it in the balance sheet;
- (b) what systems and controls they have in place to subject those transactions to adequate scrutiny;
- (c) confirm that they do not engage in financial engineering or side agreements which obscure the firm’s financial position; and
- (d) confirm that the firm’s individual capital assessment (ICA) explains the extent to which financial engineering has been used, for what purpose and the impact on those assets and liabilities.

This letter highlighted the FSA’s concern that a firm could use financial engineering in order to obscure the financial condition of a firm, thereby misleading consumers and regulators. If it is used in this manner, this could amount to a breach of the FSA’s requirements under high level Principles 4 and 11, which require firms to hold adequate and suitable financial resources and to deal in an open and honest manner with their regulators.

In June 2004, the former chief executive of Equitable Life was banned from holding a management role at any company regulated by the FSA for six years. This followed his failure to disclose a side letter to Equitable’s reinsurers that could have reduced the value of a reinsurance contract that the company had taken out.

Although these high level Principles apply to all regulated firms, they are treated as of particular importance by the FSA when assessing an insurer's financial position and the accuracy of its regulatory reporting.

The FSA's approach to finite (re)insurance differs from Spitzer's and the US regulators. Instead of investigating individual insureds and insurers on a contract by contract basis, the FSA is looking at market reform as a whole. The FSA expects firms to have appropriate systems, controls and governance arrangements in place and for senior management to understand and mitigate against the risks arising from their business.

The risk for insurers who purchase finite (re)insurance products, is that by artificially increasing the capital resources of their company as presented on its balance sheets or obscuring their underlying financial position, they can mislead their company, directors or auditors. They may also be at risk of regulatory sanction. There is also the potential for claims to be made by shareholders against insurance companies regarding the misuse of finite (re)insurance, which may impact upon the company's D&O liability.

For the sellers of finite (re)insurance, exposure may exist if products have been sold on the basis of non-existent benefits. The seller may find that even where there has been no wrongdoing on their part, their reputation has been adversely affected. Reinsurers of companies who have purchased finite (re)insurance products will not be liable if their reinsureds have mis-stated their accounts, unless it can be proved that they knew that they were entering a sham transaction.

The Financial Ombudsman Service

Brokers and insurers may be the subject of a complaint regarding any of the above activities to the Financial Ombudsman Service ("FOS"). When a firm receives a complaint, it is under a duty to investigate it and inform the complainant of their right to refer the complaint to the FOS. Private individuals and small businesses (defined as having turnover/assets of less than £1m) are eligible to make complaints relating to the sale of insurance to the FOS.

The Ombudsman will initially investigate the merits of the case and will convene a hearing if necessary. It will determine the complaint by having regard to what is "fair and reasonable in all the circumstances of the case" but what is fair and reasonable is decided by the Ombudsman and can only be overruled by the court if the decision is irrational. However, in considering what is fair and reasonable, the Ombudsman must take into account *"the relevant law, regulations, regulators' rules and guidance and standards, relevant codes of practice and, where appropriate, what he considers to have been good industry practice at the relevant time"* (FSA Complaints Sourcebook: DISP 3.8.1(2)).

The FOS has a wide discretion regarding the type of evidence it will consider (which includes evidence that would not be admissible in court). It is entitled to demand information and documents from any party and failure to comply (without reasonable excuse) can be treated as contempt upon application to the court (under s. 231-232 and s.413 FSMA 2000).

The FOS has the power to make awards of up to £100,000 plus interest. It can award more than this sum by making a non-monetary award. The FOS has the power to direct

that firms take such steps as the Ombudsman considers to be "just and appropriate". This means that the Ombudsman may decide that an insurer was wrong to avoid a policy for material non-disclosure and direct that a claim be adjusted and paid, even if the adjusted claim is in excess of £100,000.

The FOS can therefore recommend awards which exceed the maximum enforceable limit. These recommendations are not enforceable by the complainant, but it may be difficult for a firm to ignore them. Recommendations are normally excluded from professional indemnity policies and Underwriters can therefore decline cover on this basis. However, they may have to indemnify if an Assured establishes that the loss was a true legal liability.

An authorised firm has no power to reject an FOS award, but the complainant may do, at which point neither party is bound by it and the matter may be referred to the courts. Non-compliance with a decision by the FOS will lead to disciplinary action by the FSA.

THE IMPACT OF REGULATION BY THE FSA

1. The effect on brokers

Marsh, Aon and Willis announced new business models in the wake of the Spitzer investigations. They agreed that as part of their new business models, they would only accept commission from insurers when it is disclosed to the client in dollar or percentage terms and the client consents in writing. Marsh and Aon also agreed not to use wholesale chains unless full disclosure is made to the client regarding their interest in or contractual agreement with the wholesaler, the amount of compensation received and whether there was an alternative to using a wholesaler.

Marsh, Aon and Willis control a large part of the worldwide insurance broking market. A market study conducted by Swiss Re found that in 2002, Marsh and Aon comprised 54% of the global brokerage market and Willis comprised an additional 7%. (They also dominate the reinsurance brokerage market). Since the insurance broking market is a global business, one can hope broking firms in London will follow their example by introducing similar business models regarding broker remuneration. Certainly, it must be the case, having regard to what we have outlined above that, if the settlement agreements with Spitzer reflect what is acceptable behaviour by the US regulators, and (while the UK rules are different) similar issues would result in similar regulatory breaches in the UK, it follows that the conduct approved by the US regulators is likely to be considered proper conduct in the UK. Our analysis is that if the Spitzer settlement agreements were applied to all business handled by brokers subject to the FSA rules, there should be few breaches of the rules here.

The Lloyd's Market Association (the "LMA") has recently been leading discussions between insurers and brokers in the London Market regarding the issue of broker remuneration. The LMA has clearly stated its opinion that full transparency is the right way forward. Bill Rendall (head of underwriting and claims at the association) has welcomed the commitment by these three US brokers to change their remuneration practices following the Spitzer inquiry. He points out that although the settlement agreements relate to US business, these brokers have "all undertaken to apply the

standards throughout their businesses. This can only be a good thing for the London market”.

The Association of Insurance and Risk Managers (AIRMIC) has recently undertaken a review regarding this issue. This study showed that there is virtual unanimous agreement between their members that brokers should inform their clients automatically about all aspects of their remuneration including commissions. Nearly two thirds of their membership believes that brokers should receive no payment at all from underwriters. It supports the FSA’s demand that brokers should adopt a system of automatic notification of their earnings by 2007. Jardine Lloyd Thompson (“JLT”) has followed the lead of AIRMIC by recently announcing its intention to adopt a policy of disclosing its insurance earnings in respect of UK domiciled risks.

The EU Commission announced its intention earlier this year to review the competitiveness of the EU insurance industry. This review will encompass the entire insurance sector, including brokers and intermediaries. The Commission has promised to use its powers to demand participation, threatening fines to companies or associations who provide “information that is misleading or incorrect” or responses that are “incomplete or absent”. If these inquiries confirm the existence of anti-competitive agreements or practices or abuses of a dominant position, the Commission is prepared to use its wide powers “to take appropriate measures to restore competition in the relevant market”.

Brokers are at risk of claims being made against them in respect of commission payments received from insurers, which they have not disclosed to their clients. Major broking firms may find that this impacts upon their D&O cover in respect of claims brought by their shareholders. To avoid the risk of breaching the FSA rules it would be advisable for brokers to disclose their commissions to their customers and any other benefits received e.g. gifts etc. They should also ensure that staff incentive schemes do not determine with whom business is placed.

2. Effect on managing agents/insurers

Insurers should review their internal operations to ensure compliance with the FSA regulatory regime and reduce potential liability. Insurers can protect their position by ensuring that the amount of commission paid to a broker is in line with the usual or ordinary amount according to market practice. This will reduce the risk that the insured has been treated unfairly or there has been a lack of integrity in the transaction.

It is important that the information which should be provided by the broker to the insured regarding the basis upon which the broker offers its services is confirmed in writing. This is to ensure compliance with the ICOB disclosure requirements. It will also reduce the possibility of any allegations being raised that the insured has been treated unfairly.

An insurer who enters into a PSA or MSA is at significant risk of breaching the unfair inducement rules. If an insurer wishes to enter into these arrangements, it should protect itself by requiring the broker to disclose the existence of the PSA or MSA to the insured and the amount of commission that the broker will receive.

An insurer can further seek to protect itself from allegations of unfair inducement by adopting a number of procedures. The first would be to establish market norms for

commissions for particular bands or types of insurance business. Once established it can adopt practices and procedures to ensure that, in the absence of justification for a higher commission, brokers are paid commission within these norms. Where higher commissions are to be paid the insurer should ensure that it has a procedure by which the broker provides confirmation that the insurer is not being selected solely on the basis of income to the broker alone. An insurer may wish to go further and require the broker to produce details as to the basis on which that insurer is being chosen. The insurer can also establish a procedure by which the underwriter records the basis on which the commission was agreed and/or by which the broker is required to disclose to the insured the commission which it is receiving.

Responsibilities on directors and officers are more onerous within the FSA's regulatory regime. For example, the misuse of finite (re)insurance may lead to claims on D&O cover. Substantial inaccuracies in published accounts for which directors have accepted responsibility may amount to a breach on the part of the firm of the high level Principles 1, 2 and 3 regarding the need to conduct business with integrity, care and diligence and by adopting adequate risk management systems.

D&O policies are designed to protect a company's directors and officers in respect of their liabilities and defence costs in relation to their activities arising out of their capacity as a director or officer (s. 310 of the Companies Act 1985). Until now a company could only indemnify its directors for their costs in defending legal proceedings if the directors were successful i.e. only after the event. From 6th April 2005, companies can indemnify its directors if an action is brought by a third party or a director makes an application for relief from liability (Companies (Audit Investigations and Community Enterprise) Act of 2004). These new provisions are intended to address directors' concerns about the increasing risk of them incurring personal liability which cannot be indemnified by the company. This is an increasing concern for insurers in light of the recent investigations by US regulators and the FSA regarding finite (re)insurance. This may mean that the terms and conditions of D&O policies will have to be revised to take account of the potential for misuse of finite (re)insurance. This could prove to be difficult in practice. US regulators have alleged that the misuse of financial reinsurance products may amount to fraud, however liability for fraud is expressly excluded from PII policies.

3. Effect on Professional Indemnity Insurers

Professional indemnity insurers may wish to place limits on their cover to reduce their likely exposure to D&O claims. Following the Spitzer investigations, insurers in the London market have inserted various exclusion clauses in their brokers E&O policies in order to exclude some of the issues raised by Spitzer. Many already exclude cover in respect a claim for an account of secret profits.

However, professional indemnity insurers may consider relying upon exclusion clauses in standard policies in order to decline cover. For example, a typical exclusion clause in an E&O brokers policy provides that *"Underwriters shall not indemnify the Assured against any claim or loss arising from...the failure to account for money"*. Insurers may also rely upon the standard exclusion clause which provides that they shall not indemnify in respect of *"dishonest or fraudulent acts or omissions committed by any person after the discovery in relation to that person of reasonable cause for suspicion of fraud or dishonesty."* Many dishonesty clauses are, in fact, wider than this and simply exclude all fraud.

DOES REGULATION MAKE PII BETTER FOR THE UNDERWRITER

In 2000 the General Insurance Standards Council ("GISC") became responsible for the regulation of insurers and intermediaries in respect of general insurance business. However, it was 'toothless' in terms of its powers and since its membership was voluntary, this attempt at self-regulation was ultimately doomed to fail.

The FSA's powers as a statutory regulator are far greater and wide ranging than that of GISC. This increase in regulation has positive and negative effects, it sets minimum standards for firms but also exposes them to regulatory risk. The impact of regulation on a business can have a sustained impact on its day-to-day management and long-term operation. This is especially the case if the result of disciplinary and enforcement action by the FSA is the imposition of large fines or the cancellation of a firm's permission to undertake regulated business. There is also the additional burden of the substantial cost of compliance with the FSA, in terms of undertaking Individual Capital Assessments, internal audits, staff training etc.

However, in the long-term, increased regulation, which is consistently applied, can benefit the insurance industry in terms of increasing standards and working practices as a result. It can also reduce a broker's potential liability. For example, although a broker must inform the customer regarding the basis on which he recommends a policy (ICOB 4.2.8) if he makes it clear that he is not providing this advice on the basis of a fair analysis of the market, this should significantly reduce his potential liability. Furthermore, since an insurer is responsible for producing a policy summary (ICOB 5.1) the broker cannot be liable if the description of the terms of cover are incorrect (unless it can be shown that the broker should have known this).

The increase in regulation combined with the duty on brokers and insurers to inform insureds about their right to complain to the FOS, may be expected at least in the short-term to lead to an increase in low level attritional complaints. The FSA's highest priority is the protection of customers. It is therefore more concerned with industry-wide issues, which affect consumers rather than single instances of contravention of the regulations by small broking firms. If breaches of the rules are suspected, the FSA strategy will be to pursue high profile disciplinary cases to send out a strong message to the industry that it will not tolerate breaches of a firm's duties to clients.

Enforcement action by the FSA is not necessarily a threat to insurers, as firms are not permitted to take out PII cover in respect of financial penalties imposed by the FSA. However, all policies must include cover for legal defence costs and awards from the Financial Ombudsman Service. Although enhanced regulation in terms of PII cover may lead to more claims and an increase in costs, it has the benefit of increasing standards within the industry. Underwriters may therefore take comfort in the long term from the fact that a firm is regulated. Like many things however, this will always be dependent on whether that firm is truly embracing the required cultural change, or merely paying it lip service.