Insurance Companies and Insolvency

- How does insolvency law apply to distressed insurance companies?
- APRA's prudential standards
- Issues specific to insurance companies during a winding-up

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Introduction

The collapse of general insurance and life assurance companies is not a new phenomenon. Such failures have occurred from time to time throughout the history of the industry\(^1\). However, the recent demise of insurers such as HIH, reinsurers such as New Cap Re and the financial difficulties experienced by the medical indemnity provider UMP, have in recent times focused renewed attention on the interaction between Australia's insolvency laws, insurance legislation and prudential standards as well as the workings of the industry itself. The application of the prevailing insolvency regime and the insurance legislation to distressed insurers is of considerable interest to various stakeholders, including insureds, insurers, directors of insurers, the regulators and insolvency practitioners as well as to the general public.

This paper\(^2\) discusses the impact of insolvency law on financially troubled insurance companies, how the Insurance Act 1973, accounting standards and actuarial calculations can be relevant in determining the solvency or insolvency of such companies and reviews the new APRA prudential standards which came into effect on 1 July 2002. It also explores some winding-up issues which are unique to the insurance industry.

When is an insurer "insolvent"?

APRA's powers over financially distressed insurers

The operation of insurance businesses carried on by corporations in Australia are governed generally by the Insurance Act 1973 (Cwth) (*the Act*). The Australian Prudential Regulation

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\(^1\) See eg *Re European Life Assurance Society* (1869) LR 9 Eq 122.

\(^2\) In preparing this paper we have relied on a number of sources, including papers prepared by Michael Quintan of AAR ("Corporations Act Insolvency Test – when is an insurance claim a debt" November 2001), Keiran Hutchinson of Ernst & Young ("Insurance Companies and Insolvency June 2002") and HIH Royal Commission Background Paper No 15, as well as research carried out by Kate Adams of AAR in relation to APRA's Prudential Standards.
Authority (APRA) is responsible for the general administration of the Act\(^3\). However, the Treasurer may give APRA directions about the performance or exercise of its functions or powers under the Act\(^4\).

In order to carry on an insurance business in Australia, a corporation must apply to APRA for an authority to carry on an insurance business\(^5\). APRA may grant an authority to a corporation to carry on an insurance business (a corporation who is so authorised becomes a *general insurer* under the Act) and in doing so, may impose conditions on the insurer's authorisation relating to prudential matters\(^6\). Those conditions may be expressed to have effect despite anything in the prudential standards which APRA may impose on all general insurers under s32 of the Act\(^7\).

APRA may revoke a general insurer's authorisation to carry on an insurance business where it is first satisfied the general insurer has no liabilities in respect of the insurance business carried on by it in Australia and one of a number of circumstances arise, one of which is where the insurer is "insolvent"\(^8\), a word which is not defined in the Act.

Up to 1 July 2002, an authority granted to a corporation to carry on an insurance business was subject to various conditions, including a condition that the value of its assets should at all times exceed the amount of its liabilities by not less than:

- (i) $2 million; or
- (ii) 20% of its premium income during its last preceding financial year, or
- (iii) 15% of its outstanding claims provision as at the end of its last preceding financial year; whichever is the greatest\(^9\).

Since 1 July 2002, the minimum financial requirements which must be complied with by general insurers are set out in Prudential Standards published by APRA relating to capital adequacy.

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\(^3\) See s8(1) of the Insurance Act.
\(^4\) Section 8(2) Insurance Act.
\(^5\) Section 12 Insurance Act.
\(^6\) Sections 11, 12, 13 Insurance Act.
\(^7\) Section 13(2) Insurance Act
\(^8\) Section 15(1)(d) Insurance Act
\(^9\) Former section 29(1)(b) of the pre 1 July 2002 Insurance Act.
Australian assets, valuation of liabilities, risk management and reinsurance, as discussed later in this paper.

Where it appears to APRA that an insurer is or is likely to become unable to meet its liabilities and that insurer is unable to show cause why it should not be investigated, APRA may appoint a person to carry out an investigation of that company's business and to report the results of that investigation to APRA\(^\text{10}\). Where such an investigation is being or has been carried out and it appears to APRA that the insurance company is or is about to become unable to meet its liabilities, APRA may, with the treasurer’s agreement, give a broad range of directions to the insurer with respect to the carrying on of its business, including prohibiting the insurer from issuing further policies, prohibiting it from disposing of assets, requiring it to make provisions in its accounts and requiring it to increase its paid-up capital\(^\text{11}\).

**Insurers and the test for insolvency**

Although the Insurance Act 1973 makes it an offence for a general insurer not to hold assets in Australia of a value that is equal to or greater than the total amount of its liabilities in Australia\(^\text{12}\), the definition of insolvency and the extensive procedures concerned with the winding-up of corporations in insolvency and otherwise set out in the Corporations Act, still apply to insurance companies in the same way as they apply to corporations which carry on businesses other than the business of an insurer.

Under the Corporations Act, APRA is just one of a number of interested persons who may apply to the court for an order that a company (including an insurance company) be wound up in insolvency\(^\text{13}\).

In order to determine whether an insurance company is insolvent and ought to be placed in liquidation, provisional liquidation or voluntary administration, the test set out in s95A of the Corporations Act must be applied.

\(^{10}\) Section 52 Insurance Act.

\(^{11}\) Section 62 Insurance Act.

\(^{12}\) Section 28 Insurance Act

\(^{13}\) Section 459P(1)(g) of the Corporations Act and Corporations Regulation 5.4.01
Section 95A provides:

(1) A person is solvent if, and only if, the person is able to pay all the person's debts, as and when they become due and payable.

(2) A person who is not solvent is insolvent.

As noted above, there is no definition of insolvency in the Insurance Act.

The definition of insolvency set out above is a cash flow test rather than a balance sheet test (although the state of a company's balance sheet can be highly relevant in determining whether a company is able to pay – in the immediate future – its debts, as they become due and payable).

It follows that an insurance company which has an excess of liabilities over assets in Australia (in breach of s28 of the Insurance Act) may be solvent under the Corporations Act if it has sufficient cash flow to pay its debts as and when they become due and payable. By the same token, even if the assets of an insurance company in Australia exceed its liabilities in Australia, in compliance with the Insurance Act, the company may still be insolvent if the nature of its assets are such that it has more than a mere short term liquidity problem and it is unable to pay its debts as and when they become due and payable. This can arise in particular where a company's working capital ratio is deficient, ie the ratio of its current assets to its current liabilities does not enable its debts to be paid as they fall due.

Although solvency and insolvency is assessed as at a particular date, the assessment is not limited to the question of whether the company can pay its debts which are due on that date. Section 95A makes it clear that in determining solvency on a particular date, an assessment needs to be made of the company's ability to pay its debts "as and when they become due" – a phrase which looks to the future.

Griffiths C J in Bank of Australia v Hall\textsuperscript{14} addresses the issue as follows:

The words "as they become due" require … that some consideration shall be given to the immediate future; and, if it appears that the debtor will not be able to pay a debt which will

\textsuperscript{14} (1907) 4CLR 1514 at 1528.
certainly become due in, say, a month (such as the wages payable … for the month of July) by reason of an obligation already existing, and which may before that day exhaust all his available resources, how can it be said that he is "able to pay his debts as they become due", out of his own monies?

Thus, in an assessment of insolvency either on a winding-up application or with the benefit of hindsight after a company has been placed in liquidation, a court may have regard to the company’s projected future financial position as at the date on which it is alleged that the company is insolvent.

The question of how far into the future such an assessment may go will depend very much on the nature of the business of the company, its assets and its liabilities and will include questions such as the nature of the liabilities which have been incurred, the quantum of those liabilities and the dates on which they will fall due for payment.

For most ordinary trading companies, a court is not likely to take into account liabilities which will fall due more than some weeks or perhaps some months into the future. The courts are reluctant to make a determination of insolvency based on the prediction of far-off future events in the life of a company which may be commercially uncertain.

In the case of an insurance company however, an assessment of its insolvency will involve consideration of its contingent and prospective liabilities which may or will arise many years into the future, by reason of insurance policies already written, and future assets in the form of insurance premiums and investment earnings yet to be received or earned. The High Court has been prepared to take into account liabilities of an insurance company falling due as late as 7 years after the date of alleged insolvency.\(^\text{15}\).

\(^{15}\) Insurance Commissioner v Associated Dominions Assurance Society Pty Limited (1953) 89CLR 78.
Persons with an interest in ascertaining the date of insolvency

APRA

As mentioned above, APRA administers the Insurance Act 1973 and regulates the operations of insurance companies. As well as the powers granted to APRA under the Insurance Act - in circumstances where it appears to APRA that an insurer is or is likely to become unable to meet its liabilities - to call for information from that insurer, to investigate its affairs and to give directions in respect of its business, APRA also has power to take steps to wind up an insurance company under the Corporations Act.

By s462(3) of the Corporations Act, APRA has power to apply for an order to wind up a company on a ground other than insolvency (in particular where the court is of the opinion that it is in the interests of the public or the members or the creditors that the company ought to be wound up) if APRA has already appointed an inspector to investigate the company (s52 Insurance Act) and the company's liabilities exceed the company's assets for the purpose of APRA's prudential standards.

Thus there are limits of APRA's power to wind up an insurance company on a ground other than insolvency.

However, if APRA can demonstrate that the insurer is insolvent within the meaning of s95A of the Corporations Act, the above pre-conditions are not required to be satisfied, ie if APRA can demonstrate that the insurer is unable to pay all its debts as and when they become due, even if the insurer's assets exceed its liabilities and even if no inspector has been appointed by APRA, it may obtain an order that the insurer be wound-up in insolvency.

ASIC

ASIC may also make an application under s459P of the Corporations Act (in ASIC's case only with the leave of the court) for an order that an insurer be wound up in insolvency. On any such application, ASIC is required to show a prime facie case of insolvency.\(^\text{16}\)

\(^{16}\) Section 459P(3) Corporations Act.
Liquidators

Assessing the date on which an insurer becomes insolvent is highly relevant to any liquidator appointed to that company for the purpose of investigating whether conduct of the directors of the insurer prior to liquidation would give rise to a claim of insolvent trading in breach of s588G of the Corporations Act. The date of insolvency is also relevant to a liquidator in investigating if any transactions engaged in prior to liquidation amount to unfair preferences or uncommercial transactions within the meaning of ss588FA and 588FB of the Corporations Act.

Creditors of the insurance company

A creditor of an insurance company may issue a statutory demand against the insurer requiring payment of the debt due within 21 days\(^\text{17}\). If the debt is not paid within 21 days of service of the demand, a presumption of insolvency arises\(^\text{18}\) which may be relied on in any subsequent application by the creditor for a winding-up order.

However, a contingent or prospective creditor (eg an insured seeking indemnity under an insurance policy in circumstances where payment under the policy has not yet fallen due) is generally unable to rely on a failure of an insurance company to comply with a statutory demand on an application for an order to wind up the insurer\(^\text{19}\).

A contingent creditor can, however, with leave of the court, make an application for an order that an insurer be wound up in insolvency\(^\text{20}\) and may obtain an order that the insurer be wound up where the creditor can establish that the insurer is in fact insolvent, ie that the insurer is not able to pay future or contingent debts when those debts become, in the future, due and payable.

Directors and the company itself

An insurance company or a director of that company may also apply under s459P of the Corporations Act for an order that the insurer be wound up, although a director requires leave of

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\(^{17}\) Section 459E of the Corporations Act.

\(^{18}\) Section 459C of the Corporations Act.

\(^{19}\) See Reinsurance Australia Corporation Limited v Odyssey Re (Bermuda) Limited[2001] NSWSC unreported 12 April 2001

\(^{20}\) Section 459P(2)(a) of the Corporations Act.
the court to do so. Directors of insurers are, along with directors of all other corporations, vitally concerned to ensure that their company does not trade while insolvent, having regard to the potential personal liability of directors to pay compensation to the company in respect of any losses incurred by creditors as a result of any such insolvent trading\textsuperscript{21}.

Where directors form the opinion that their company is insolvent or is likely to become insolvent at some future time, the board of that company may by resolution appoint a voluntary administrator over the company\textsuperscript{22}. Such action, if taken in a timely manner, will protect the directors from personal liability for insolvent trading.

At any time after the filing of a winding-up application (including an application filed by the company or its directors) the court may appoint an official liquidator on a provisional basis – in other words it may place the company in provisional liquidation\textsuperscript{23}, as occurred in the case of the HIH group of companies and in the case of United Medical Protection Limited.

The question of the solvency or otherwise of public companies and large proprietary companies also becomes relevant on an annual basis for the directors of those companies by reason of the declaration required of the directors in the company's annual financial report. The directors of such companies are required to state whether, in their opinion, there are reasonable grounds to believe that the company will be able to pay its debts as and when they become due and payable\textsuperscript{24}.

**Auditors**

The date on which an insurance company becomes insolvent is also highly relevant to the auditors of that company. If the company is insolvent and its directors fail to prevent the company from trading and incurring debts in breach of s588G of the Corporations Act, the auditors have an obligation to notify ASIC in writing if they have reasonable grounds to suspect that such a contravention of the Act has occurred\textsuperscript{25}.

\textsuperscript{21} Section 588J of the Corporations Act.
\textsuperscript{22} Section 436A of the Corporations Act.
\textsuperscript{23} Section 472(2) of the Corporations Act.
\textsuperscript{24} Section 295(4)(c) of the Corporations Act.
\textsuperscript{25} Section 311 of the Corporations Act.
Assessment of contingent or future liabilities of an insurer in determining solvency

The 'forward-looking' aspect to s95A

As mentioned above, in determining whether an insurance company is solvent on a particular date, regard must be had to whether the insurer will, in the future, be able to pay its debts as and when they become due and payable.

In particular, a court may take into account a "contingent" or "prospective" liability of the company in determining solvency on an application to wind up the company.\(^\text{26}\)

A "contingent" creditor is said to be a person towards whom the company owes an existing obligation out of which a liability on the part of the company concerned to pay a sum of money will arise in a future event, whether it be an event that must happen or only an event that may happen.\(^\text{27}\)

A "prospective creditor" is said to refer to a person who is owed a sum of money not immediately payable but which will become due in the future, either on some date which has already been determined or on some date determinable by reference to future events.\(^\text{28}\)

Even though contingent debts and prospective (or future) debts are not referred to expressly in s95A of the Corporations Act and are referred to in s459D as "liabilities", it is generally accepted that these items may be taken into account in assessing a company's solvency on a particular date.

Of particular relevance to insurance companies is the question of whether a particular future item is in fact a debt which has been incurred by the company – if not, it is not a debt which, as at the date on which solvency is being assessed, it is known will become due and payable.

Many of an insurer's debts are arguably incurred as at the date that a policy of insurance is entered into with the insured – there is then an existing obligation to indemnify the insured and a liability to

\(^{26}\) Section 459D(1) of the Corporations Act.

\(^{27}\) Re International Harvester Australia (1983) 1 ACLC 700 at 703.

\(^{28}\) Commissioner of Taxation v Simionato Holdings Pty Ltd (1997) 15 ACLC 477.
make a payment to the insured will arise on the happening of an insured event, whether that is an event which must happen or only an event which may happen. In practice, an insurer will have many thousands of individual insurance contracts and the assessment of contingent and prospective debts of that insurer will be a matter of expert accounting and, importantly, actuarial advice.

Although an insurer (and ultimately the court) needs to have regard to its contingent and prospective liabilities in assessing insolvency, it is not required to speculate about what liabilities it may incur in the future and whether it will be able in the future to meet those liabilities which have not yet been incurred. In other words, it needs to have regard to existing obligations which may or will require payments to be made in the future but does not need to have regard to possible obligations which do not yet exist. As Keay states:29

"[Given] the relative accuracy of modern accounting methods and actuarial predictions [and] given a reliable balance sheet and the assistance of expert evidence, there seems to be no reason why it should be beyond the court's powers to arrive at a conclusion that the company is insolvent … without becoming involved in speculation about its future business prospects."

An assessment of solvency is a forward-looking exercise supported by the language of s95A, which refers to an ability to pay "all" debts – in other words not just debts payable as at the date of the assessment but also debts which become due and payable in the future. Thus if the company is able to pay all of the debts which have fallen due as at the date of the assessment, that is not sufficient of itself to satisfy the test of solvency. The company as at that date may still not be able to pay debts which will become payable in the future as and when those debts become due and payable. An ability to pay debts due now but not debts due in the future in effect prefers creditors whose debts are immediately payable over those creditors whose debts will fall due for payment later.

This phenomenon may be of particular relevance to insurance companies, where the insurer may have large cash reserves which enable it to pay claims falling due as at the date on which solvency

is being assessed, but by reason of the number and type of policies written may be insolvent because it is clear that it will not be able to pay claims on those policies which will fall due for payment perhaps several years in the future.

It is important however to bear in mind that although there is a forward-looking element to assessing solvency under the s95A test, the assessment is not whether the company is likely to become insolvent on a future date, but rather whether it is actually insolvent.

Thus a company that is likely to become insolvent at some time in the future is not presently insolvent.

Assessing the quantum of an insurer’s contingent liabilities to its insureds

As at the date that its solvency is being assessed, many if not most of the liabilities of an insurer will be payable at some time in the future, namely the obligation to make payments to insureds who the insurer is required to indemnify under a policy of insurance, when an insured event occurs.

This will include contingent liabilities for insured events which have yet to occur, incurred but not reported (IBNR), claims and reported claims which are unresolved (such as where the insured is a defendant to court proceedings and liability and/or quantum are yet to be determined).

An insurer is likely to have many thousands of contingent liabilities of this kind. Quantification of these liabilities requires expert actuarial assessment which has regard to statistical data and often records of patterns of insurance claims over many years. These assessments take into account the possibility and probability of events which are insured occurring in the future eg the prevailing rate of motor vehicle accidents.

Such assessments are ultimately estimates which are open to argument, particularly where the contingent claims may not fall due for payment for many years ("long tail" liabilities).

Where an insurance contract is entered into, in legal terms a contingent liability on the part of the insurer arises at that point, under the law of contract, to pay money to the insured in the future if an event which is insured under that contract of insurance, occurs in the future.

However, from an actuarial point of view, that contingent liability is not recognised in calculating the liabilities of the insurer as it is not then known whether a claim event under that insurance policy
has occurred or will occur. If a claim event occurs under that insurance policy (e.g., the insured commits an act of negligence which is covered under his insurance policy, or damage occurs to the insured's property or he suffers personal injury), that claim event will convert into a prospective liability payable at some time in the future, following quantification of the claim.

Under the relevant accounting standard\(^{30}\) the quantification of liabilities for claims payable by an insurer in the future is assessed on the basis of the present value of the expected future payments. This amount is the amount which, if set aside as at the financial reporting date, would accumulate so as to enable the insurer to pay the amounts of claims as they fall due in the future. The rate at which that amount, it is assumed, will accumulate is ordinarily the risk-free rate of return which the insurer anticipates it could earn from investing those funds in such a way that they are available to meet the contingent liabilities as they fall due.

Thus, to satisfy the solvency test in s95A, an insurer needs to have or be able to obtain sufficient assets (including assets equivalent to its claims reserves) which will enable it to meet both its immediate debts and its contingent debts, having regard to the insurance which it has written, as they become due and payable. In assessing its ability to pay insurance claims in the future, an insurer can take into account assets in the form of reinsurance which it has arranged with a reinsurer to pay contingent liabilities which will crystallise in the future.

If the present value of the insurer's reserves, its reinsurance protection and all its other assets which it expects will be available to pay insurance claims, is inadequate to allow the insurer to meet all of its liabilities as and when they become due and payable, the insurer is presently insolvent.

However, current reserves do not need to be maintained at a level such that they could pay all liabilities if those liabilities fell due immediately:

> There is no insurance company in the kingdom in which there would be assets sufficient to answer the liabilities, if those liabilities, instead of being contingent, were immediate.\(^{31}\)

Reliable actuarial evidence should disclose whether an insurer's present reserves are adequate to pay all claims which will become due and payable in the future. That evidence will take into

\(^{30}\) AASB1023 Financial Reporting of General Insurance Activities.

\(^{31}\)
account such matters as claims patterns, statistics, investment rates of return and reinsurance arrangements.

In assessing the solvency of an insurer, the court will look as far forward in the future as is necessary, having regard to the lines of insurance written by the insurer and in particular if those lines of insurance will give rise to long tail claims. Needless to say, the evidence regarding contingent liabilities becomes inherently more uncertain and liable to challenge the longer the period of time involved.

**Insurance Act requirements and insolvency**

There is no provision in the Insurance Act or the prudential standards determined by APRA pursuant to s32 of the Act which declares that a breach of the minimum financial standards in s28 or in the prudential standards, without more gives rise to a state of insolvency which would enable an insurer to be wound up under the Corporations Act.

If, however, directions are given to an insurer by APRA under s62 of the Insurance Act to cease writing new business and, in effect, to cease trading, that may have the effect of reducing the value of the insurer’s assets since those assets can no longer be valued on a "going concern" basis. That reduction in value may in turn result in an assessment (by the directors, the regulators or the court) that the insurer will not be able to pay its contingent and prospective liabilities as they become due and payable and accordingly is insolvent.

**Associated Dominions case – an assessment of the insolvency of an insurer**

In *Insurance Commissioner v Associated Dominions Assurance Society Pty Limited* the High Court ordered that a life insurance company be wound up and a liquidator appointed to it.

Fullagar J took the approach that an ability to pay contingent and future claims must be taken into account along with an ability to pay present claims, in assessing the solvency of an insurer. His Honour noted the peculiar features of an insurer’s liabilities, being both substantial and often largely contingent. He noted that the task of assessing a life insurance company's financial

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32. (1953) 18CLR 78.
position is more difficult than in the case of an ordinary commercial concern, because of these peculiar features. He noted:

While the immediate liabilities may be quite small, those which are payable in the future upon death, or in the case of endowment assurances upon survival, are likely to be very substantial\(^{33}\).

Fullagar J observed that it was therefore necessary to begin by estimating the cost of future claims and future receipts from premiums as well as income from investments.

Fullagar J also sounded a note of caution, observing that solvency is:

not such a clear-cut question as it normally is in the case of an ordinary commercial undertaking\(^{34}\).

Having regard to the company's contingent and prospective liabilities, Fullagar J was satisfied that this life insurance company was insolvent. He found as follows:

The central and outstanding fact in the whole case appears to me to be that the company is insolvent. I regard this as quite clearly established. The company is insolvent not merely in a technical sense but in a practical and commercial sense, not merely in slight degree but in very serious and substantial degree. This does not mean that it is unable at the moment to pay its debts as they fall due. It could so far as the evidence goes, discharge its current liabilities tomorrow, and it will for some time to come be able to pay its policy holders in full as and when their claims mature. But it is highly probable – practically certain, I think, as matters stand – that it will in the not very distant future be unable to discharge in full claims under maturing policies. When that event will occur cannot in the nature of things be precisely stated. I did not understand it to be suggested that it was likely to occur before 1960 [ie 7 years after the date of the decision].

It should be noted that Fullagar J found that the company was insolvent in 1953 – this was not merely a case where the company was likely to become insolvent at some future time.

\(^{33}\) (1953) 89CLR 78 at 97-98.

\(^{34}\) At p110.
Fullagar J also acknowledged that it would be possible for an insurer to lead evidence before a court pointing to facts which would establish a reasonable prospect that the insurer’s finances would improve in the future and its reserves would increase, such that it would be able to pay contingent and prospective liabilities as they fell due for payment. In the case before him, His Honour found that those facts were not present. Nevertheless, *Associated Dominions* suggests that courts will be cautious in making a determination that an insurer is insolvent having regard to its contingent and prospective liabilities, in view of the inherent uncertainties involved in assessing those liabilities and the ability of the insurer to pay them as they become due and payable.

**APRA prudential standards**

The *Insurance Act 1973* (Cth) (the *Act*) was amended in 2001 following the collapse of HIH. Solvency requirements imposed on insurance companies were replaced by a general provision giving the Australian Prudential Regulatory Authority (*APRA*) power to determine prudential standards which must be complied with by all, or by a specified class of, general insurers, authorised non-operating holding companies and their subsidiaries: s32. Under the Act, APRA is given power to give directions to require compliance with prudential standards and a failure to comply with a direction is an offence: s36.

That is, APRA is empowered to make, modify and enforce prudential standards. APRA’s authorisation is also still required to carry on general insurance business.

The prudential standards are accompanied by guidance notes and, together with the Act make up a three tiered prudential supervision framework. APRA have made prudential standards which apply to authorised deposit-taking institutions (banks, building societies and credit unions), general insurance companies, life insurance companies and friendly societies.

If the insurer is carrying on insurance business in Australia, it will be classified as a *general insurer*. This memorandum is limited to discussing prudential standards and guidance notes that impact on general insurers and what these insurers must do to comply. These comprise:

- capital adequacy;
• liability valuation;
• risk management;
• reinsurance arrangements;
• transfer and amalgamation of insurance business; and
• approvals of auditors and actuaries.

1. Capital Adequacy for General Insurers (GPS 110)

APRA requires each insurer to maintain sufficient capital to enable insurance obligations to be met under a wide range of circumstances. This required level of capital for regulatory purposes is referred to as the Minimum Capital Requirement (MCR).

An insurer may choose one of two methods for determining its MCR:

(a) an internal model developed by the company – Internal Model Based (IMB) method;

(b) a standardised approach – the prescribed method; or

(c) a combination of (a) and (b).

Regardless of which method is used, an insurer’s MCR is determined having regard to a range of risk factors that may threaten the ability of the insurer to meet policyholder obligations and it cannot be less than $5 million.

1.1 MB Method

Insurers with sufficient resources are encouraged to develop an in-house capital measurement model to calculate the MCR. Use of the IMB is conditional on APRA’s prior approval and will require insurers to satisfy a range of criteria, both qualitative and quantitative.

Qualitative criteria:

(b) the insurer should have an independent risk management unit that is responsible for the design and implementation of the insurer’s capital measurement model;
(c) the insurer’s board and senior management should be actively involved in the risk control process and must regard risk control as an essential aspect of the business to which significant resources need to be devoted;

(d) the capital measurement model must be closely integrated into the day-to-day risk management process of the insurer; and

(e) an independent review of the capital measurement model should be carried out periodically as part of the insurer’s own internal audit process.

Quantitative criteria:

(a) the model should calculate an amount of capital sufficient to reduce the insurer’s probability of default over a 1 year time horizon to 0.5% or below.

1.2 The Prescribed Method

Insurers that do not use the IMB method must use the prescribed method, where the MCR is determined by the sum of the capital charges of:

(a) **Insurance risk**: the risk that the true value of net insurance liabilities could be greater than the value determined under GPS 210 Liability Valuation for General Insurers. The methodology for determining the insurance risk capital charge is set out in GGN 110.3 Insurance Risk Capital Charge.

(b) **Investment risk**: the risk of an adverse movement in the value of an insurer’s assets and/or off-sheet exposures. The methodology for determining the investment risk capital charge is set out in GGN 110.4 Investment Risk Capital Charge.

(c) **Concentration risk**: the risk associated with an accumulation of exposures to a single catastrophic event. The methodology for determining the capital charge is set out in GGN 110.5 Concentration Risk Capital Charge.

1.3 Measurement of Capital Base

An insurer must, at all times, have eligible capital in excess of its MCR. Eligible capital is comprised of Tier 1 and Tier 2 capital which is described in GGN 110.1 Measurement of
**Capital Base.** Broadly, Tier 1 capital is permanent, and does not impose on-going servicing costs on the insurer, while Tier 2 instruments may be of limited life and/or have on-going servicing obligations. Within an insurer's eligible capital, Tier 2 capital cannot exceed Tier 1 capital. An insurer may be required by APRA to maintain a specified level of eligible capital in excess of that calculated using 1 of the methods discussed above in 1(a) and (b).

### 1.4 Foreign Insurers

Foreign-incorporated insurers authorised to operate in Australia as branches (foreign insurers) have slightly different requirements than those applied to locally-incorporated insurers. Specifically, foreign insurers are required to maintain assets in Australia in excess of their liabilities in Australia, of an amount at least equal to their MCR. Further detail regarding treatment of foreign insurers can be found in GPS 120 *Assets in Australia.* This standard specifies certain assets that will not be counted as "assets in Australia" for the purposes of s28 of the Act and GPS 110 *Capital Adequacy.*

### 1.5 Disclosure

Disclosure and transparency are allies of the supervisory process. To improve policyholder and market understanding of its capital adequacy position, an insurer should disclose, in its published annual accounts, details of its eligible capital and MCR. See paragraph 27 of GPS 110 *Capital Adequacy* for more detail.

### 2. Liability Valuation for General Insurers (GPS 210)

This prudential standard establishes a set of principles for the measurement and reporting of the insurance liabilities of all general insurers. The key requirements are:

(a) An insurer must seek the written advice of an approved valuation actuary in valuing insurance liabilities where the total insurance liabilities exceed $20 million or long tail business forms a substantial part of the total insurance liabilities.

(b) The board of an insurer that is required to have an actuary must obtain written advice from the actuary on the valuation of its insurance liabilities. This
requirement is designed to aid boards to perform their duties by ensuring they are adequately informed.

(c) To determine its insurance liabilities, the insurer must:

(i) determine the value of its outstanding claims liabilities (all claims incurred prior to the calculation date), and its premium liabilities (future claim payments) for each class of business, including the central estimates and risk margins for each; and

(ii) determine the risk margin on a basis such that the insurance liabilities will have a 75% probability of sufficiency.

(d) Insurance liabilities are to be valued on a discounted basis.

(e) It is ultimately for the board of the insurer to determine the appropriate valuation of insurance liabilities. Where the board decides not to accept the actuary’s advice, this must be disclosed to APRA.

3. Risk management for general insurers (GPS 220)

This prudential standard aims to ensure that an insurer is well managed, has access to appropriate independent expertise and has systems for identifying, managing and monitoring risks that may reduce the ability of the insurer to meet its obligations to policyholders. The principles and risk areas underlying the standard (and the subject of the guidance notes) are:

(a) Governance: including fitness of directors, roles and duties, advice from experts, etc.

(b) Risk management systems: including a risk management strategy and policies, procedures and defined managerial responsibilities and controls.

(c) Balance sheet and market risk: including insurance, investment, concentration, underwriting, claims management, product design, pricing and liquidity management risks.

(d) Credit risk: including limits by counterparty, intra group, industry, geographic, region, etc.
(e) Operational risk: including technology, reputational, legal, outsourcing, business continuity planning and key person risks.

4. **Reinsurance arrangements for general insurers (GPS 230)**

GPS 230 aims to ensure that a general insurer has in place prudent reinsurance arrangements, contributing to a high likelihood that the insurer is able to meet its obligations to policyholders. The prudential standard requires the following:

(a) The board and senior management of an insurer must develop, implement and maintain a Reinsurance Management Strategy (REM), appropriate for the operations of that insurer, to ensure that the insurer has sufficient capacity to meet obligations as they fall due. The REM must be approved by the board of the insurer, and by APRA.

(b) An insurer must adhere to its REM at all times and must advise APRA if it intends to undertake activities in a manner that represent a material deviation from its REM. Any such activities must be first approved by the board.

(c) An insurer must inform APRA immediately if there is a likelihood of a problem arising with its reinsurance arrangements that is likely to materially detract from its current or future capacity to meet its obligations, and discuss with APRA its plans to redress this situation.

5. **Transfer and Amalgamation of Insurance Business (GPS 410)**

This prudential standard deals with the transfer or amalgamation of insurance business. Insurers transferring or amalgamating insurance business in accordance with the Act are subject to procedural requirements set out in the Act and this Standard. The key requirements are:

(a) An insurer cannot make an application to the Court for confirmation of a scheme of transfer or amalgamation unless, amongst other things, an insurer provides a copy of the scheme and any actuarial reports on which the scheme is based to APRA.
(b) Prior to making an application to the Court, and with APRA’s approval, the insurer must also publish a notice of intention to make the application in the Government Gazette and relevant newspapers.

(c) An application to the Court for confirmation of a scheme cannot be made unless, amongst other things, a summary of the scheme, approved by APRA has been given to every affected policyholder. A copy of the scheme must also be available for public inspection.

(d) An insurer to which insurance business is transferred or amalgamated must give APRA a range of documents after the courts have approved the scheme, including a statement of the nature and terms of the transfer or amalgamation, and the court order confirming the scheme.

6. Early Approvals of Auditors and Actuaries (GPS 900)

This transitional prudential standard states that appointments and approvals of auditors and actuaries were able to be made before 1 July 2002, to facilitate a smooth administrative transfer to the regime under the Act. However, such appointments and approvals did not come into effect until a day to be specified by APRA in relation to each proposed general insurer, which was 1 July 2002 or a later day. To facilitate the approval process this standard specifies criteria in relation to eligibility and fitness and propriety for persons wishing to hold the position of approved auditor and approved actuary of a general insurer.

Section 562A Corporations Law

1. Introduction

Section 555 of the Corporations Act 2001 (Cth) (Act) provides:

Except as otherwise provided by this Act, all debts and claims proved in a winding up rank equally and, if the property of the company is insufficient to meet them in full, they must be paid proportionately.
Section 555 is the legislative embodiment of the pari passu (meaning equally or without preference) principle. This constitutes a fundamental principle of Australia’s insolvency regime.

In the context of the insolvency of an insurance company, there are two important qualifications to this principle, namely:

(a) section 562A of the Act regarding reinsurance moneys; and

(b) section 116 of the Insurance Act 1973 (Cth) (Insurance Act).

Each of these provisions is considered in turn.

2. History

Section 562 provides that, where a company is insured against liability to third parties, an amount in respect of that liability has been or is received by the company or the liquidator from the insurer, the amount will effectively be paid by the liquidator to the third party in priority to the debts provided for in section 556. In a number of cases [Re Dominion Insurance Company of Australia Limited [1980] 1 NSWLR 271 and Re National Employers Mutual General Insurance Association Limited (in liquidation) (1995) 15 ACSR 624 at 625-626] a reference to “insurance” was held capable as of referring to “reinsurance”. In 1992, effective 23 June 1993, the old section 447 became section 562 and was amended to include the expression “not being a contract of reinsurance” after the expression “a contract of insurance” and section 562A was inserted to deal specifically with reinsurance contracts.

3. What Section 562A says

Section 562A is expressed to apply where:

“(a) a company is insured, under a contract of reinsurance entered into before the relevant date, against liability to pay amounts in respect of a relevant contract of insurance or relevant contracts of insurance; and

(b) an amount in respect of that liability has been or is received by the company or the liquidator under the contract of reinsurance.”

(Section 562A(1)).
“relevant contract of insurance” means a contract of insurance entered into by the company, as insurer, before the relevant date (section 562A(8)).

“relevant date” in relation to a winding up means the day on which the winding up is taken because of Division 1A of Part 5.62 to have begun (section 9 and see section 513A which provides that, except in the circumstances set out in sub-sections (a) to (d) (which are not presently relevant), the winding up is taken to have begun or commenced on the day when the order was made winding the company up).

Section 562A(2) provides that:

“Subject to subsection (4), if the amount received, after deducting expenses of or incidental to getting in that amount, equals or exceeds the total of all the amounts that are payable by the company under relevant contracts of insurance the liquidator must, out of the amount received and in priority to all payments in respect of the debts mentioned in section 556, pay the amounts that are so payable under those contracts of insurance.”

A question that arises is whether any emphasis should be placed on the word “relevant” and the word “those”. The expression “relevant contracts of insurance” where it appears in section 562A(2) suggests that the contracts of insurance must be relevant to the amount received ie contracts of insurance relevant to the contracts of reinsurance from which the amount is received. The reference in the last line of section 562A(2) to “those” contracts of insurance also suggests that there is an intention to refer to specific contracts of insurance. However, the fact that the expression “relevant contract of insurance” is itself defined in section 562A(8) suggests that under normal construction principles the definition of that expression could simply, in effect, be inserted into the section in place of the defined term so that section 562A(2) would read as follows:

“Subject to subsection (4), if the amount received, after deducting expenses of or incidental to getting in that amount, equals or exceeds the total of all the amounts that are payable by the company under contracts of insurance entered into by the company, as insurer, before the relevant date, the liquidator must, out of the amount received and in priority to all payments and in respect of the debts mentioned in section 556, pay the amounts that are so payable under those contracts of insurance.”
This language would suggest that the expression “relevant”, when used in section 562A(2) and in the definition in section 562A(8), was used by the draftsperson as a reference to contracts entered into “before the relevant date” rather than necessarily as a means of linking the contracts of insurance to the contracts of reinsurance to which they relate.

4. **When are payments “received” by the liquidator?**

Section 562A only applies when and if the insurance company in question goes into liquidation. The section only applies in relation to amounts payable under a reinsurance contract which have been or are “received” by the insurance company or its liquidator following his appointment. What then if you have an agreement which does not provide for any payment to ever physically be made to the insurance company or to the liquidator but it provides for all payments to be made directly to the insureds or to suppliers to the insureds eg panel beaters or retailers to replace goods stolen, lost or damaged.

There is no definition of “received” in the Law so that it is not certain that it would catch a payment which is never actually made to the company or the liquidator.

The Macquarie Dictionary defines “received” as “to take into one’s possession”. In such a scenario it is arguable that neither the company nor the liquidator ever does take those payments into possession.

However it could be argued “received” would catch reinsurance payments which the company or the liquidator had an entitlement to receive even if they are in fact never received. In saying that the fact that the draftsperson has used the word “received” rather than the words “entitled to” must be taken into account.

Section 562A(7), which provides that section 562A has effect despite any agreement to the contrary, may indicate that “received” should not be limited to actual receipt.

5. **The Formula for Payment**

Section 562A(3) provides that:
“Subject to subsection (4), if subsection (2) does not apply, the liquidator must, out of the amount received and in priority to all payments in respect of the debts mentioned in section 556, pay to each person to whom an amount is payable by the company under a relevant contract of insurance an amount calculated in accordance with the formula:

\[
\frac{\text{Particular Amount owed}}{\text{Total Amount owed}} \times \text{Reinsurance Payment}
\]

where

“Particular Amount owed” means the amount payable to the person under the relevant contract of insurance;

“Total Amount owed” means the total of all the amounts payable by the company under relevant contracts of insurance;

“Reinsurance Payment” means the amount received under the contract of reinsurance, less any expenses of or incidental to getting in that amount.”

Replacing the expression “relevant contract of insurance” with its meaning under section 562A(8), section 562A(a)(3) reads as follows:

“Subject to subsection (4), if subsection (2) does not apply, the liquidator must, out of the amount received and in priority to all payments in respect of the debts mentioned in section 556, pay to each person to whom an amount is payable by the company under a contract of insurance entered into by the company, as insurer, before the relevant date, an amount calculated in accordance with the formula:

\[
\frac{\text{Particular Amount owed}}{\text{Total Amount owed}} \times \text{Reinsurance Payment}
\]
Total Amount owed

where

“Particular Amount owed” means the amount payable to the person under the contract of insurance entered into by the company, as insurer, before the relevant date;

“Total Amount owed” means the total of all the amounts payable by the company under contracts of insurance entered into by the company as insurer before the relevant date;

“Reinsurance Payment” means the amount received under the contract of reinsurance less any expenses of or incidental to getting in that amount.”

The circumstances in which section 562A(3) appears to be designed to operate are circumstances in which the amount received from the reinsurer after deducting expenses or incidental to getting in that amount does not equal or exceed the total of all the amounts that are payable by the company under relevant contracts of insurance. If the expression “relevant contracts of insurance” means all contracts of insurance entered into by the company as insurer before the relevant date and the word “relevant” should not be given any additional meaning or emphasis, it seems very unlikely that the amount received from the reinsurer would ever equal or exceed the total of the amounts that are payable by the company under relevant contracts of insurance so that the formula provided by section 562A(3) would be the formula most likely to apply in the absence of an order of the Court to the contrary.

The fact that one of the elements the Court can consider in exercising the discretion to vary the operation of subsections (2) and (3) includes the answer to the question whether it is possible to identify particular relevant contracts of insurance as being the contracts in respect of which the contract of reinsurance was entered into does suggest that section 562A(2) is not intended to have the effect of automatically providing for the proceeds of the contract of reinsurance to be directed to the insureds under contracts of insurance reinsured by that contract. It is noteworthy that section
562A(5)(a) adds the word “particular” when it intends to refer to contracts of insurance relevant to the particular reinsurance policy rather than simply using the expression “relevant contracts of insurance”. That word “particular” is also used in that manner in section 562A(5)(b) and section 562A(5)(c).

6. The Court’s Discretion

Importantly, section 562A(4) gives the Court the power to vary the result which would apply under section 562A(2) or 562A(3) and provides as follows:

“The Court may, on application by a person to whom an amount is payable under a relevant contract of insurance [a contract of insurance entered into by the company as insurer before the relevant date] make an order to the effect that subsections (2) and (3) do not apply to the amount received under the contract of reinsurance and that that amount must, instead, be applied by the liquidator in the manner specified in the order, being a manner that the Court considers just and equitable in the circumstances.”

Section 562A(5) sets out some of the factors which the Court might take into account in exercising its discretion under section 562A(4) and provides as follows:

“The matters that the Court may take into account in considering whether to make an order under subsection (4) include, but are not limited to:

(a) whether it is possible to identify particular relevant contracts of insurance [contracts of insurance entered into by the company as insurer before the relevant date] as being the contracts in respect of which the contract of reinsurance was being entered into; and

(b) whether it is possible to identify persons who can be said to have paid extra in order to have particular relevant contracts of insurance [contracts of insurance entered into by the company as insurer before the relevant date] are protected by reinsurance; and
(c) whether the particular relevant contracts of insurance [contracts of insurance entered into by the company as insurer before the relevant date] include statements to the effect that the contracts are to be protected by reinsurance; and

(d) whether a person to whom an amount is payable under a relevant contract of insurance [a contract of insurance entered into by the company as insurer before the relevant date] would be severely prejudiced if subsections (2) and (3) applied to the amount received under the contract of reinsurance.

Section 562A(6) provides that:

“If receipt of a payment under this section only partially discharges a liability of the company to a person, nothing in this section affects the rights of the person in respect of the balance of the liability.”

Section 562A(7) provides that section 562A has effect despite any agreement to the contrary.

7. The Harmer Report

Section 562 was amended and section 562A was introduced following recommendations made by the Law Reform Commission in the Harmer Report (at pages 309-311; para 759-764).

The Commission appears to have been swayed by a submission made by Phillips Fox on behalf of 15 reinsurers to the effect that reinsurance is for the most part fundamentally different to contracts of insurance and that the application of section 447 (as it then was) to reinsurance contracts may lead to inequities. They submitted that the inclusion of contracts of reinsurance in section 447 may lead to problems if the company being wound up was an insurance company including:

“(at 760)

• the difficulty of identifying third party claimants who are entitled to the benefit of “reinsurance”

• where third parties are both creditors and debtors, the applicability of the law of set off in relation to the proceeds of an insurance policy
the possibility that surplus money will result from the failure of third parties to lodge claims (or there may be rejected claims or withdrawal of claims) which were reinsured

the inequity of those persons whose contracts of insurance are backed by reinsurance only being able to benefit.”

At 763 the Report stated:

“It appears unfair to allow an insured a special priority if the particular insurance policy is backed in some way by reinsurance whereas an insured with a policy not backed by reinsurance ranks with other unsecured creditors. There may however be situations where reinsurance is specifically taken out at the request of an insured even though this might not be a condition of the insurance contract. In such situations it is appropriate for the insured to get the benefit of the application of section 447. Generally, however, the Commission is of the view that section 447 should not apply to contracts of reinsurance.”

(at 764)

“The Commission recommends that, unless the Court otherwise orders, section 447 should not apply to a contract of reinsurance. The matters that the Court should take into account in deciding whether to make an order include the circumstances under which the contract of reinsurance was entered into, including any contract arrangement or understanding between the insured and the company that the company reinsure the risk and any prejudice likely to be suffered by the insured if an order is not made.”

8. The Explanatory Memorandum

In the Explanatory Memorandum to the Corporate Law Reform Act 1992 it was noted (at 494) that section 562 then provided:

“that where a company has entered into an insurance contract before the relevant date to provide against liability to third parties, and such liabilities are incurred by the company, the benefit of the insurance contract will be paid to the third party rather than to the creditors of the company as a whole.”
At 952 the Explanatory Memorandum states as follows:

“Proposed subsection 562A(2) establishes the general rule that the proceeds of contracts of reinsurance are to be applied to all relevant insurance contracts. It provides that, again subject to proposed subsection 562A(4), the amount received is to be used in the satisfaction of amounts payable under the contracts of insurance in priority to debts mentioned in section 556. Where the amount received under the contract of reinsurance is insufficient to pay such claims in full, then, again subject to proposed subsection 562A(4), the liquidator must pay out the amount received proportionately, to all the persons to whom the company is liable under such contracts of insurance…”

The Explanatory Memorandum explains the reasoning behind including section 562A(4) and the factors set out in section 562A(5) at 955 as follows:

“These factors are intended to bring out possible situations where a strictly proportional distribution would not be appropriate, either because some policy holders took particular action to secure reinsurance cover while others did not, or because some policy holders might be particularly and severely prejudiced (compared with other policy holders) if a strictly proportional distribution was implemented…”

9. Butterell v Douglas

The only case thus far to focus on the proper meaning of section 562A is Butterell v The Douglas Group Pty Ltd [2000] NSWSC 492 per Young J. This case concerned the Consulting Engineer Advancement Society of Australia Limited (CEASA) and involved an application by the liquidator of CEASA for directions. CEASA was a mutual insurance venture for engineers. The plan for CEASA was that it would bear claims up to a ceiling of $350,000 and reinsure thereafter. Declaratory relief was sought as to the proper application of section 562A and, in particular, whether the reinsurance payments:

“(a) form a pool of funds for the benefit of all insurance creditors of CEASA, irrespective of whether or not their claims against CEASA exceed $350,000;

(b) form a pool of funds for the benefit of only those insurance creditors of CEASA whose claims exceed $350,000;
(c) should be distributed only to the particular insurance creditor of CEASA whose claim exceeds $350,000 and in respect of which claim the liquidator has received a reinsurance payment; or

(d) form a separate pool of fund in respect of each policy year for the benefit of only those insurance creditors of CEASA whose claims exceed $350,000 and were notified within that policy year.”

CEASA entered into excess of loss reinsurance contracts in respect of the policy years covering the period 1 July 1989 to 30 June 1994. The reinsurance contracts were on a “losses occurring on risks attaching” basis and provided CEASA with certain reinsurance in various layers in excess of $350,000 in respect of each and every claim under contracts of insurance issued by CEASA to its members. At no stage was there any reinsurance in respect of claims of $350,000 or less.

Young J set out 5 possible ways in which the funds collected from the reinsurers could be administered in the winding up:

“(a) that the reinsurance payments form a pool of funds to be distributed to all insurance creditors of CEASA irrespective of whether or not their claims exceed $350,000. This possibility has been considered by all the learned counsel involved and none of them support it. Accordingly I can just put this to one side and in due course I’ll answer question 1(a) ‘No’ “.

Young J gives no reasoning behind his decision to reject this interpretation of the proper operation of section 562A other than the fact that the counsel for all the parties before him had agreed that it was so. It is important to recognise that he does not order that all of the proceeds of all reinsurance policies should be collected by the liquidator and distributed equally to all insureds irrespective of whether or not the insured is an insured under the relevant contract of insurance.

“(b) … that the reinsurance payments form a pool of funds to be distributed only to those insurance creditors of CEASA whose claims exceed $350,000.
(c) (i) that the reinsurance money should be distributed only to the particular insurance creditor of CEASA whose claims exceeds $350,000 and in respect of which claim the liquidator has received a reinsurance payment.

(c) (ii) that the reinsurance payments form a separate pool of funds in respect of each policy year to be distributed only to those insurance creditors whose claims exceed $350,000 and were notified within that policy year.

(e) … that the reinsurance payments received in respect of the Cohen claim should be paid directly to the Third Defendants and the balance of the reinsurance payments distributed either under (b) or (c) above.”

The basis of this argument related to an argument relying on section 6 of the Law Reform (Miscellaneous Provisions) Act 1946 which is not presently relevant.

Young J had this to say about section 562A:

“This section was introduced by The Corporate Law Reform Act 1992, effective as at 23 June 1993. Prior to that amendment, a contract of reinsurance was treated as a contract of insurance for the purpose of section 447 of the Companies Code, the predecessor of section 562A of the Law (see Re Dominion Insurance Co of Australia Ltd [1980] NSWLR 271; Re Saltergate Insurance Co Ltd (No 3) 1984 2 ACLC 740; Re Palmdale Insurance Ltd [1986] VR 439.

The Harmer Report, which was the basis of the Corporate Law Reform Act, examined the old section 447. The report took the view that reinsurance was fundamentally different from insurance and that unless there was a special provision it would lead to inequity. The report recommended that unless the Court ordered otherwise, section 447 should not apply to a contract of reinsurance. This was taken up in the explanatory memorandum to the Corporate Law Reform Bill, especially paragraph 952.”

In relation to the operation of section 562A(4), Young J made the following points:

“One of the reasons why the Court might make an order under section 562A(4) that some other regime apply to reinsurance moneys is if particular insureds insisted that their policy be the subject of reinsurance.”
“In making an order under … section 562A(4) the Court must direct the liquidator to distribute the reinsurance moneys in a way which the Court considers just and equitable in the circumstances. As the standard formula where there is a deficiency is that set out in subsection (3), one must work out why it is not just and equitable to follow the prescribed formula. The prescribed formula, as I read it, involves taking out of the reinsurance payment all just expenses. One then gives each eligible claimant a fraction of that pool found by taking as the numerator the amount of the claim and the denominator being the total amount of the claim.”

Young J then determined that the proper method of applying section 562A(3) and he concludes that that section must be applied on a yearly basis without really explaining why he reaches that view. He states that:

“To my mind, the intent of the section is that “reinsurance payment” in subsection (3) means a reinsurance payment for a particular claims year and what one does is to work out the net payments received from reinsurers in a particular year, and that each claimant in that year gets the fraction of that money as set out in subsection (3).”

Finally, his Honour considers the expression “expenses of or incidental to” in section 562A(3) and concludes that that involves both the direct expenses of obtaining payment of the reinsurance moneys and the fair proportion of overheads etc of the liquidator’s office in getting in the moneys.

The results in Butterell v The Douglas Group Pty Ltd was therefore that the proceeds of the various layers of reinsurance for each given year were made available to insureds under particularly relevant contracts of insurance in each year. This result was achieved without Young J attempting or purporting to apply section 562A(4). It appears to have been achieved merely because all of the learned counsel involved did not support a distribution of the proceeds of reinsurance amongst all insureds. Nevertheless, it is the leading case on the section and some commentors have suggested that it should be followed in future cases. For example, John Kernick’s recent paper Reinsurance recoveries on an insurer insolvency – who gets a share comments:

“It was conceded that only claims exceeding $350,000 should benefit from the recoveries and Young J held that the intent of the legislation was to apply net payments received from
a particular year proportionately to claimants in that year, taking account of the size of the claim according to the statutory formula. There is accordingly a strong argument for any reinsurance HIH has that is similarly structured to be dealt with a similarly comparable way.”

(at page 4)

10. Analysis

Commentators\(^{35}\) have criticised this decision as not giving effect to the policy objectives section 562A seeks to achieve. The decision favours those creditors of CEASA whose claims exceed $350,000. This is arbitrary. Arguably, the fundamental principles of insolvency law outlined in the Harmer Report would have been better served by requiring the pooling of reinsurance moneys for the benefit of all insurance creditors. In the absence of a specific request for reinsurance by an insurance creditor, it is unclear why some creditors should benefit from the pooling of reinsurance moneys received on an annual basis.

Following the collapse of HIH, this issue may again fall for consideration by the courts.

11. Other cases

No different view appears from other cases, although they are not cases where much analysis has been done. See \(Ibbco\ v \ HIH\) [2001] NSWSC 346; \(Bateman\ v \ FAI\) [2001] NSWSC 348; \(Transfield\ Philippines\ v \ HIH\) [2001] NSWSC 347; \(NC\ Re\ Capital\ Ltd\) [1999] NSWSC 625.

Those cases concerned applications by claimants against HIH for leave to continue pre-existing proceedings against HIH even though it was now in liquidation. The significance of those cases is that they proceed on the assumption that the existence or otherwise of reinsurance for the particular contract of insurance will have a direct bearing on the funds available to pay the particular claim. In those cases it appears to have been accepted by the provisional liquidator that the reinsurance recoveries are paid to the relevant insureds in priority to other creditors and, whilst

the issue is not determined in those cases, the Court does not take issue with the provisional liquidator’s view. For example, in *Transfield* Hunter J makes the following points:

“26. On the question of reinsurance, whether there is a missing level of reinsurance I think is a matter of little significance. While it is true, as stated by the provisional liquidators, that the reinsurers have not indicated their attitude to the claim made in these proceedings, there is no reason to think that, if the policy responds to the claim, the reinsurance contracts will not respond: particularly having regard to the nature of a quota share contract.

27 In a press release by the provisional liquidators of 11 April 2001 they referred to the operation of 562A of the Corporations Law in the following terms:

‘Reinsurance priority

Section 562A of the Corporations Law only applies once an insurance company is in liquidation. The effect of the section is that reinsurance recoveries collected by a liquidator are allocated in priority to the claims of creditors or groups of creditors whose claims lead to the particular reinsurance recovery.

The HIH companies have extensive and varied reinsurance arrangements. Although the intention of the section is very clear, its application in practice is not straightforward, particularly for complex treaty reinsurances covering a number of companies. It is likely that allocation of reinsurance recoveries between different groups of creditors will need court direction. In some cases this will involve extensive delay, because the pool of sharing creditors will not be known until all claims of the particular type are known

*We as provisional liquidators will preserve the position until the companies are in liquidation or are subject to schemes of arrangement approved by the courts and creditors."

28 There may be some force in those statements as to the time it may take to finally sort out the reinsurance position in different classes of cover. In my view, that is not reason to defer the granting of leave.
29 A successful outcome for the plaintiff in these proceedings will be an important first step towards gaining access to funds made available under s562A: assuming the defendant is placed into liquidation."

Section 116 of the Insurance Act

1. Introduction

Section 116 of the Insurance Act limits the pari passu principle by requiring Australian assets of the insolvent insurer to be distributed in respect of Australian liabilities. That is, Australian assets are to be set aside as a fund for the satisfaction of what is described in section 116(3) as "liabilities in Australia".

2. Interpretation – what are "liabilities in Australia"?

Following amendments to the Insurance Act made in 2001, the definition of "liabilities in Australia" is contained in section 116A of the Insurance Act, which provides that a liability will be a "liability in Australia" if undertaken by the insurer under a contract of insurance (including reinsurance) made in Australia or in respect of which a proposal was accepted or a policy issued in Australia, other than contracts relating to contingent liabilities that can only arise outside Australia or a liability which the insurer has undertaken to satisfy outside Australia.

There are no cases considering the meaning of "liabilities in Australia". Commentators have suggested that the Courts may adopt one of two broad approaches to the interpretation of this phrase, being:

1. the Australian connection approach: which requires courts to construe individual contracts in accordance with the rules of offer and acceptance to determine the location in which the contract of insurance was made; or

2. the Australian operations approach: a liability will be an Australian liability if it relates to the insurer's Australian operations.

36 Op cit.
It is submitted that the Australian operations approach is to be preferred as it will avoid arbitrary results.

Resolution of the appropriate construction of section 116 of the Insurance Act will, in turn, define the scope of the exception to the pari passu principle.

3. **Relationship with Section 555 of the Act**

Section 116(3) of the Insurance Act was considered by McClelland CJ in *Re National Employers’ Mutual General Insurance Association Ltd (in liquidation)* (1995) 15 ACSR 624. National Employers’ Mutual was incorporated in England and registered as a foreign company in New South Wales and carried on business as an insurer in both the United Kingdom and Australia. Orders for its winding up were made in both New South Wales and England.

Section 518(13) of the Code required a liquidator of a registered foreign company to remit the net amount of moneys realised in Australia to the company’s liquidator in the place where it was formed or incorporated. This was inconsistent with section 116 of the Insurance Act.

McClelland CJ resolved the inconsistency by holding that section 116(3) of the Insurance Act prevailed over section 518(13) of the Code by virtue of section 109 of the Constitution, ie the Commonwealth Act prevailed over the State enacted companies legislation.

This finding undermined the English liquidator’s attempt to apply the “hotchpot” principle. This principle provides that where a special distribution has already been made, beneficiaries of the special share are required to add the special distribution to the fund for the purposes of calculating the distribution of each beneficiary. That is, dividends were not to be paid to section 116 preferred Australian creditors until English creditors received dividends equal to the benefits already received by those Australian creditors.

To achieve equity between all creditors, including those based in the United Kingdom, the liquidators sought court approval for the payment of differential dividends (as between creditors who had received a benefit from the reinsurance recovery cut through and those who had not).

McClelland CJ held that there was no rule of law which justified the proposed differential dividend. Indeed, the proposal contravened the pari passu principle, as set out in section 440 of the Code.

Section 116 of the Insurance Act required Australian assets to be retained and administered in
Australia in accordance with Australian law. Consequently, McClelland CJ was not prepared to authorise the contravention of that law.

This decision evidences the difficulty of implementing the pari passu principle in the context of cross border insolvencies.

4. Construction of the Act and Insurance Act

The predecessor to the Act, the Corporations Law, was a national co-operative scheme of legislation uniformly maintained in each State and Territory. In *National Employers’ Mutual*, McClelland CJ resolved inconsistencies between the Insurance Act and the Corporations Law via section 109 of the Constitution.

That solution is no longer workable due to the enactment of the Act as Commonwealth legislation. As such, the conflict between section 116 of the Insurance Act and the pari passu principle contained in section 555 of the Act may fall for judicial consideration.

How will the inconsistency be resolved? Possible solutions include:

* the doctrine that a general provision will not implicitly repeal a specific provision, that is, section 116 of the Insurance Act will operate, as a specific provision, in conjunction with and override to the extent necessary section 555 of the Act.

* the doctrine of implied repeal – under this doctrine, where a legislation is inconsistent, the earlier Act is repealed by implication. In this case, section 116 of the Insurance Act may be implicitly repealed by the pari passu principle set out in section 555 of the Act.

* the express wording of section 555 of the Act which provides: "accept as otherwise provided by this Act". As the legislature has specifically considered insurance and reinsurance issues, as evidenced by sections 562 and 562A of the Act, its failure to address the priorities to be conferred on Australian claimants implies that section 116 will not undermine the operation of the pari passu principle.

This issue remains to be considered by the courts.
5. International Implications

As can be seen from the decision of McClelland CJ in the *National Employers' Mutual*, Australian courts may be reluctant to authorise the transfer of Australian assets overseas in contravention of local laws, including section 116 of the Insurance Act, even where that transfer would assist in achieving equity as between all creditors of an insolvent insurance company.

Similarly, it is to be expected that other jurisdictions may act so as to give full force and effect to priorities favouring local creditors over other creditors, including Australian creditors.