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Centre for Research in Corporate Law and Governance

CRCLG NEWSLETTER

In This Issue

ABOUT CRCLG:

Taking the legacy of standing distinct in the field of academic excellence in legal education, Army Institute of Law, Mohali, launched the Centre for Research in Corporate Law and Governance (CRCLG) in 2018 to provide to its scholars, a deep insight into the contours of corporate conundrums.

CRCLG, as a multi-faceted functional body, looks forward to conducting workshops, panel discussions, seminars, conferences, and guest lectures by the leading and eminent scholars from the legal field. It effectively deals with the discipline, balances, and imbalances of corporate law exhaustively to provide to the readers a holistic understanding of the subject and matters connected and incidental thereto. It shall work promptly to promote and provide:

• comprehensive research; preparing the students with analytical skills to critically evaluate legal provisions of corporate law & governance.

• in-depth study of corporate law and governance interwoven with its economic, business, and legal context with particular regard to how corporate law and governance mechanisms facilitate or inhibit economic activity.

• to provide a new way of thinking about the growing challenges in corporate law and how to respond to them. Dealing with the traditional issues and the contemporary ones, the newsletter shall give the reader an opportunity to fathom the corporate world.

RIPOSTING THE COVID-19 PANDEMIC: INSURANCE SECTOR RETORTS IN INDIA AND THE UNITED STATES

-Ajay Pal Singh (5th year)

PROLOGUE: COVID-19 AND INSURANCE SECTOR

The COVID-19 pandemic has resulted in the deaths of millions of people across the world, with disease-related illness affecting several more and contributing to widespread loss of businesses and livelihoods, as well as a major economic downturn in all sectors of the global economy. Consequently, the Insurance sector has attracted significant attention, as it is a fundamental part of the financial infrastructure and all other industries are supported by it thereby acting as a bedrock and safety net. Whereas for other sectors, the discussion surrounding COVID-19 was mostly limited to remote working and digitalization, insurance sector whilst providing coverage to the people (especially life and health insurance) has been in the direct line of fire, especially as legal and industry experts have predicted a jump in claims as the repercussions of the spread of COVID-19 has cut into human health. Ergo, the repercussions of COVID-19 on the insurance industry are significant, and the financial and liability exposures arising from a global crisis of this magnitude necessarily prompt an analysis of the myriad of complex insurance risks under a variety of products, extending coverage for first-party property and business interruption benefits, event cancellations, and liability claims. This article attempts to study the impact of COVID-19 on the insurance sector through a comparative analysis of the implication of the pandemic on the insurance sector, with respect to both India and the United States (the US) markets.

INSURANCE: LEGAL AND REGULATORY FRAMEWORK IN INDIA

The insurance sector in India is regulated at the Central level through the Insurance Act, 1938. Further, the insurance market is superintended by a Sectoral regulator in form of IRDAI i.e., the Insurance Regulatory Development Authority of India established by the IRDAI Act, 1999. Thus the Insurance Act, 1938 as well as the rules and regulations, and master circulars which are drafted by IRDAI form the basis of the insurance legislation in the country. In India the insurance products can be divided into 3 broad categories i.e., Life Insurance, Health Insurance and General Insurance (in addition to Reinsurance).

INSURANCE: LEGAL AND REGULATORY FRAMEWORK IN THE UNITED STATES

Although the US is the world's largest insurance market by premium volume, the Sectoral regulation is decentralized with no single federal legislation regulating insurance. Under the McCarran-Ferguson Act, 1945, the states alone shall have the power to regulate the business of insurance and reinsurance.

Consequently, the insurance sector in the US is regulated by different laws in all 50 states. Nonetheless, there an independent organization known as a National Association of Insurance Commissioners (NAIC) which plays a significant role in regulating the insurance sector indirectly. The NAIC works to present accurate summaries of state information and the regulated entities rely on official regulator communications. This organization is responsible for formulation of draft and model laws. These draft legislations, are then adopted by most state legislatures and therefore NAIC indirectly wields significant authority. So far as the Sectoral composition is concerned, the US insurance sector can be primarily divided into two different categories. On the one hand, is the Life and Health Insurance, which also includes annuities, whereas the, there is the Product and Casualty Insurance encapsulates all different types of General Insurance such as Fire, Marine, Home and Motor Vehicle/Auto insurance etc.

COMPARATIVE ANALYSIS: RESPONSE IN INDIA AND THE US

Whilst attempting to undertake a comparative analysis, it is manifest that insurance sector participants especially the insurers and regulators in India and the US, have followed a very different approach in responding to the pandemic. As stated previously, Insurance is a highly regulated industry in India, subject to Central regulation by a Parliamentary legislation i.e., the Insurance Act, 1938 under the aegis of the IRDAI. In fact, the Life Insurance regime in India, till recently was a closed market and has only relatively transitioned into an open market and competition based industry. The Life Insurance Corporation of India (LIC) which acts as statutory insurance and Investment Corporation continues to remain a significant player in the industry. This coupled with the fact that large number of Indians are employed in unorganized sector, and healthcare facilities still being underdeveloped, state regulation and intervention has been deemed necessary. Nonetheless, insurance industry in India has grown by leaps and bounds, but the pandemic has once again warranted state intervention to protect the interests of the consumers and the people. Thus, it can be inferred that impact of Covid-19 in India has been the highest on life and health insurance, and this coupled with low insurance penetration rates has meant that the industrial and regulatory response has been especially oriented towards the individual policy holders. For instance in early 2020, the IRDAI issued norms on the standard covers, sum insured and policy wordings for a standard individual health insurance product i.e., the Arogya Sanjeevani Policy. Subsequently the health insurance providers were directed to launch the Corona Kavach and Rakshak indemnity and benefit plans. Whereas in the US, the industry stands at the opposite end of the regulation spectrum. Not only has the Insurance industry been subject of deregulation since the 1980's, the developed economy and significantly better (albeit flawed) healthcare system means that the governmental intervention has been limited during the pandemic.

As far as Health Insurance is concerned although, many insurers have launched new health COVID-19 plans and products, the same have been laid down by the insurers themselves and not generally at the insistence of insurance regulators. Thus the US insurance industry has traditionally worked on the principles of supply and demand (open competition), which has resulted in the launch of several new Covid-19 related health insurance policies. While the Patient Protection and Affordable Health Care Act, 2010 along with Medicare and Medicaid program reflects governmental intervention, the pandemic has seen limited response by State Government regulators (spurred by the NAIC), especially concerning business insurance, as harsher lockdowns in the US have contributed to business shutdowns and job losses (which in turn affects the people having insurance policies owing to them working in the organized sector). Still the US Federal Government and State Regulators have attempted to provide some relief (for instance through grace periods) to the individual policy holders under health and life insurance schemes. Therefore both the Indian and US model have their own merits and demerits but they definitely converge on certain points. It must be conceded though that the pandemic necessitates, the working of the Central/Federal and State Governments and presence of a single Central/Federal law and regulator is more beneficial to regulate the insurance sector's response to the pandemic, at least in a developing country such as India.

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ABSENCE OF INSURANCE FRAUD CONTROL ACT- A CHALLENGE

-Jaismeen Kaur (2nd Year)

INTRODUCTION

Insurance act of India does not even contain a definition of 'insurance fraud'. India has been struggling with insurance frauds for a long time now. In 2019, frauds burnt a Rs 45,000-crore hole in the Indian insurance industry's pocket but still we don't have any insurance fraud law. Indians appear to be really talented in cooking up false stories and deceiving insurance companies and ultimately they misuse the insurance law to their benefit . insurers bear a loss between 10%-15% across all lines of their business, whereas health insurance fraudulent claims touch 35%and about 90% of auto insurance frauds are the result of padding claims. The other 10% of insurance frauds consist of staged accidents.

LACK OF SPECIFIC PROVISIONS

No specific provision regarding insurance frauds is mentioned in the Indian Penal Code. There are few sections like-Section 205-false impersonation for the purpose of act or proceeding in suit or persecution; Section 420-cheating and dishonestly inducing delivery of property; Section 464-making a false document including signs, seals and forgery and Section 405-criminal breach of trust that have certain relevance. But these provisions are inadequate to prosecute a fraudster legally under the current scenario of organised insurance frauds.Backlog of pending judicial cases in courts poses a challenge in taking legal action against insurance frauds and frauds of small amounts are let go off to avoid the extensive investment of time and energy in pursuing the same.

As India's insurance industry is on a nascent stage and the elephant has woken up and has started walking now, fraud risk management is going to be a major issue for insurers and business leaders. Insurers will have to consistently reassess their processes and policies to alleviate the risk of frauds.

Both internal and external factors are responsible for frauds in insurance sector. Plethora of cases have depicted the collusion of employees with fraudsters and misuse of confedentialinformation. There is a requirement of stringent checks and balances to control these issues. "The false identity case" of Andhra Pradesh made headlines

In this case fraudsters colluded with employees of the insurance company and they used to use to create fake persons by using fake documents and information. The person used to take life insurance of 30 lakhs . the facts of the case are as follows: the person went for an evening walk and was bitten by snake. His friend took him to the

doctor and he was declared dead on arrival . How was this caught ? investigatorhad several doubts as 36 such cases were already reported that too from the same village and even the insurance agent was same in all these cases. When the investigator reached that village and enquired about the deceased persons, the people of the village amazed him by denying the existence of any such people ever.
In the Indian tobacco company case, every truck of ciggaretes was hijacked and the packages were stolen from trucks. The officials tried to change the routes and timings only to get the truck hijacked again. In the investigation it was found that the person of ITC was involved with the hijackers.External fraud risk has a potential to arise at severalstages: registration of clients, underwriting, reinsurance and the claims process. The insured create fake death cases, conceal other policies, hire people to murder themselves to get the insurance money etc
Sandeep Malik, a reputed Insurance & Risk Management Consultant , a specialist in insurance fraud opines that ,The government needs to frame provisions to enable the access to the insurance history and the claims record of the person who approaches the company so that the company is able to verify the details of the person just like banks can determine the creditworthiness of an individual by inquiring the Credit Information Bureau of India Ltd (CIBIL).

A LOOK AT THE STEPS TAKEN BY USA TO FIGHT BACK INSURANCE FRAUDS
1. Establishment of fraud bureaus
State insurance fraud bureaus have been established in all the states. They are the state agencies that detect, investigate and avert insurance scams. The citizens are entitled to call at the respective bureaus and report the suspected scams. Scams can be reported through their respective websites as well.
2. National insurance crime bureau
It is a non profit organization that partners with insurance companies , consumers and law enforcement agencies to fight insurance fraud.
3. Coalition against insurance fraud
It is a national alliance of consumer groups, public interest organizations , government al agencies and insurers . The main objective is to prevent the insurance fraud.
4. National association of insurance commissioners is a regulatory support organization created and governed by the chief insurance regulators. They assist state insurance regulators individually and collectively to serve the public interest.
5. Federal investigative and intelligence agency
The complaint regarding insurance fraud can be reported at any local FBI office.

AN OVERVIEW OF THE ENFORCEMENT BRANCH OF THE DEPARTMENT OF INSURANCE OF CALIFORNIA
It is the investigative body for the department of insurance. It consists of 2 divisons namely fraud divison and investigation division. The mission of the enforcement branch is the protection of the public from economic loss and distress.

Their role is to investigate, arrest and refer the fraudsters for prosecution or adjudication. They take the initiative to curb insurance frauds and consumer abuse through anti-fraud outreach and training public, private and government sectors.

Fraud Division
1. It consists of detectives who are leading experts is the field of insurance fraud.
2. The strength of staff is 275. They are spread over 9 regional offices throughout the state.it is the largest law enforcement unit within enforcement branch
3. They are fully trained in criminal investigations and they also provide training to consumers, insurance companies, law enforcement agencies .
4. They have established a method for insurers and self-insureds to report the suspected insurance fraud.
5. The complaints of insurance frauds that are made anonymously are also considered.
6. They also employ a proactive approach by curbing the new emerging trends of insurance frauds.

Investigation Divison
1. It prosecutes offenders through both regulatory and criminal justice systems.
2. It employs 90 investigative and support staff and they are assigned to 7 regional offices of the state to handle the complaints. This makes the justice delivery very efficient.

CONCLUSION

The steps taken by USA are definitely worth following by India. The features of the agencies discussed above explicitly show the effective and efficient justice delivery in the matters of insurance fraud. These steps have helped USA in mitigating insurance frauds and promote the public interest. It is 2021 and still India lacks any of these types of initiatives to curb insurance frauds. alreadyoverburdened judiciary is unable to efficiently administer justice to the aggrieved, so it is critical to have the establishments like in USA. The further delay would definitely help people of India to suffer more economic losses.

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CHALLENGES AND ISSUES OF INSURANCE LAW AROUND THE WORLD

-Tarunveer Singh (4th year)

Introduction

Insurance is a complicated business as it involved a large number of tasks that has to be carried out by the entity which provides the insurance. These include formulation of new policies, marketing new policies, responding to the queries of the customers, processing of claims, responding to legal claims and complying with the statutory norms. With the advent of Covid-19, the insurance industry like any other was forced to digitize at a rapid pace. The legal systems of different countries often do not keep up with the changing times and gradually adapt to the change environment. The phase where the law lacks behind, is the one in which the insurers face their biggest challenge. This article explores the challenges and issues faced in the application of insurance law around the globe.

Challenges and Issues

Non-adequate disclosure by the client

In order to make insurance beneficial for both the entity and the person availing it, it is important that the client furnishes all the relevant information, so the risk and insurance premium can be fixed accordingly. In case such information is not submitted correctly, it could result in great losses for the insurance provider. The Indian Supreme Court held that, “untruth or inaccuracy in the statement in the proposal form will be considered as a breach of the duty of good faith and will render the policy voidable by the insurer.” This decision is significant as it puts some burden on the persons availing the insurance as people may disclose insufficient information to be eligible for greater benefits which puts a greater liability on the insurer. In the case of Bajaj General Insurance Company Ltd v. State of Madhya Pradeshthe Indian Supreme Court ruled that, “The principles of construction applicable to commercial contracts apply and the intention of the parties has to be upheld. The courts cannot form a new contract between parties or increase the exposure of the insurer.”

Statutory Embargoes

In India, there is a statutory embargo that states, “Policy shall not be called in question on the ground of misstatement after three years.” This prevents insurance companies from repudiating claims three years after policy has been issued and puts the burden on them to thoroughly verify everything in due time. Considering that the work is voluminous and there are a number of intricacies, there is always a possibility that the company might miss something. This led to the development of systematic fraud in order to prevent the companies from repudiating them since they are not allowed to anymore. Such embargoes are also present elsewhere and should be addressed in order to ensure that the fraudsters do not gain the upper hand.

Fraud Cases increasing

The pandemic of Covid-19 has resulted in several lockdowns and cancellations. However, there are instances where travel claims in particular have been filed relentlessly despite the travel being cancelled due to directions of the government and cost being refunded as well. Moreover, even the health conditions are being faked before insurers to get compensation. The economic impact of the pandemic has led to a further rise in such activities. Therefore, the law needs to be more stringent in order to ensure that people are dissuaded from doing such frauds.

Data Protections Risks

Insurance companies have a large database containing sensitive and personal information about their customers which can be targeted by hackers. In this regards, the insurance law needs to develop in relation to data privacy law or allude to the data privacy law in order to tackle the issues bright forth by this. Moreover, the insurance companies must improve their security software and ensure that the data remains safe.

Rapid Increase of claims post the pandemic

The pandemic has upset the business and healthcare environment across the globe. There are an overwhelming number of people who suffered losses during this time and are seeking to claim insurance. In such times, the calculations of the insurance companies can also go haywire as their assets are not strategized in a way to deal with such a huge amount of claims. Moreover, considering that fraudsters will use the opportunity to sneak in and get some additional claims, there will be heavy litigation involved. The companies may go bankrupt as a result of the value of the claims and the legal fees in case, the matter is not resolved urgently. Therefore, there is a pressing need for the insurance law to evolve and provide a mechanism through which the companies can deal with the claims and the mountain of litigation that faces them.

Conclusion

The insurance industry remains one of the fastest growing industries and will continue to do so in the coming years. Covid-19 and digitization have increased the reach of the industry but also resulted in an increase in the challenges faced by it. One of the most significant challenge is to keep pace with the rapid digitization and allow the law to evolve in a manner that will aid in prevent any frauds or security mishaps. It also needs the support of the law to protect it from frivolous claims. The increased cases of litigation can be disposed of through creating dedicated courts with experts to handle the insurance matters so that the matter are wound up in a quick, just and fair manner which would reduce the costs on the party.

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CONSENT OF INSURERS FOR THIRD-PARTY LIABILITY

-Nishant Sharma (5th year)

Insurance policies are clearly defined contracts, the outcomes of which are based heavily on the terms and conditions the policy, The insurer's duty is only limited to the obligations specified under the insurance policy and the insured is bound by its terms and conditions.
The insured can invoke his rights under the policy only onfulfilling his liabilities under the policy. He gets the right to assert his rights under any insurance policy only if allobligations associated with the insurance contract arecomplied with. The insured is bound by the terms and conditions of the insurance contract and cannot go beyond them. These terms and conditions alone specify the obligations of the insured and the remedies which it can avail.
An important concept under insurance laws is the doctrine of uberimmae fidei i.e., utmost good faith, this common law doctrine requires that the parties to the contract shall honestly put forward any information required essentially for the insurance contract or fulfilling the obligations thereof. Even if the concealment on the part of the insured is innocent, the insurance contract may be annulled by the insurer. The insurer enjoys the power to revoke any insurance policy where the insured fraudulently The insurer's duty is only limited to the obligations specified under the insurance policy. Concealed the material facts.

Most insurance policies make it mandatory for the insured to make aware the insurer immediately about a claim/lawsuit. The insured can also be made responsible for providing the information to support the claim of the insurer. Not only this but the insured must also cooperate with the insured during the investigation and settlement of a suit or claim.
When the insured fails to comply with this provision of an insurance policy, it not only barges in on the rights of the insured but also comes in the way of the principle of natural justice. In Travellers Insurance Co. v. Maplehurst Farms, Inc., the court has observed that when an insurer's consent is not obtained while entering into a settlement agreement by the insured, it is a clear violation of the insured's obligation under the insurance contract and in such a case, the claim cannot be recovered from the insurer and prejudice is irrelevant.
Even if there is no explicit provision of consent-to-settle in the insurance policy, it is the duty of the insured to take insurer's consent before making a settlement with the third party for the sake of good faith and fair dealing. The insured must also allow the insurer to investigate and review the settlement and relevant documents. Most courts are of the view that there is an implied covenant of fair dealing and good faith in every contract which infers that the parties are bound not to commit any such act which would injure the right of the other party or refrain it from benefitting from the contract.

The objective to ask for the consent of the insurer is to allow the insurer to have a stake in the settlement negotiations with the third party and to prevent such a settlement from which the insured and the third party would benefit in an unjustified manner. Further, according to the principle of subrogation, the insurer is allowed to file a suit against the third party only in the name of the insured. In absence of the insurer's consent and no knowledge of claim to the insurer, no opportunity would be granted to the insurer to guide litigation or choose the attorney it preferred.

The consent-to-settle and voluntary payments clause also prevents the insured from taking additional risks and incur unnecessary costs, thereby guarding against the problem of moral hazard. In West Bend Mutual Insurance Co. v. Arbor Homes, LLC, the court made a significant observation that voluntary payment clause was not a notice provision per se, but a consent provision. It is essential that the insurer's consent must not be by implication, but must exist in fact. In case an insured demonstrates insurer's consent by way of implication and acquiescence, it would be legally insufficient. A notice of claim which is not responded to by the insurer would not be considered as consent of the insurer to proceed with the same.

In Dreaded, Inc. v. St. Paul Guardian Inc. Co., the Supreme Court of Indiana held that if the insurer has no knowledge of a claim, it cannot defend the same. The duty of the insurer would not arise till the time it receives the foundational and basic information of a claim or suit. The insurer cannot be held accountable without the receipt of such enabling information. Moreover, any settlement done voluntarily on the part of the insured without involving the insurer would preclude the insured from recovering the claim amount from the insurer.

In order to verify if the provisions of the insurance policy are invoked in good faith and without any malafide intent, the courts have developed certain tests to verify the same. One of such tests is two-pronged test or the two-part Anderson test developed by the Wisconsin Supreme Court in the matter of Anderson v. Continental Insurance Co. According to this test, the burden is placed on the insured to show that there was no reasonable ground for rejection of the claim by the insurer and the insurer had the knowledge of such a lack. The reasonability of the insurer's decisions must be determined as per the terms of the insurance policy.

In India, the pre and post contractual duty of good faith is equally strict. However, in England, the scenario changed completely after the Star Sea case, wherein the courts emphasised on the continuity of the duty of good faith in the insurance contract, but also observed that the post contractual duty of good faith was less strict. The Indian courts are still far from adopting this approach. Thus, the insured in India has a heavy burden to inform the insurer about any claim or suit immediately.

Most courts also emphasise that the obligation of good faith and fair dealing shall be expressly embedded in the insurance policy. The US courts have also developed a test of "fairly debatable" standard to determine if the insurer has acted in bad faith. An insurer can deny claim coverage if it has reasonable basis for the same, otherwise the insured would be entitled to recover the claim.

Conclusion

Obtaining insurer's consent is quite significant when it comes to settlement of claims in cases of third-party liability. Non-compliance of consent-to-settle and voluntary payment provision by the insured can even lead to discharge of the insurer's liabilities under an insurance contract. However, it is necessary that denial of claim coverage is done in good faith and without any ulterior motives. Several rules and tests have been developed by the courts to keep a check on false and unfair insurance claims. The burden of proof to show that the insurer's denial was unreasonable is on the insured, otherwise there would be presumption of prejudice to the insurer.

INSURANCE LAWS: CHALLENGES AND ISSUES

-Gaurang Takkar (1st year)

"You don't buy Life Insurance because you are going to die, but because those you love are going to live"
-Anonymous

Insurance is a means of protection from financial loss. It is a form of risk management that immunizes an individual against any uncertain loss. It is not a new concept in the world and, is as old as human existence. In ancient times, there were friendly societies organized for the purpose of extending aid to their unfortunate members from funds made up by contributions from all. The studies show that insurance as a concept was well known to Romans, Rhodians although it was not highly developed. Let us discuss a little about Indian Insurance history.

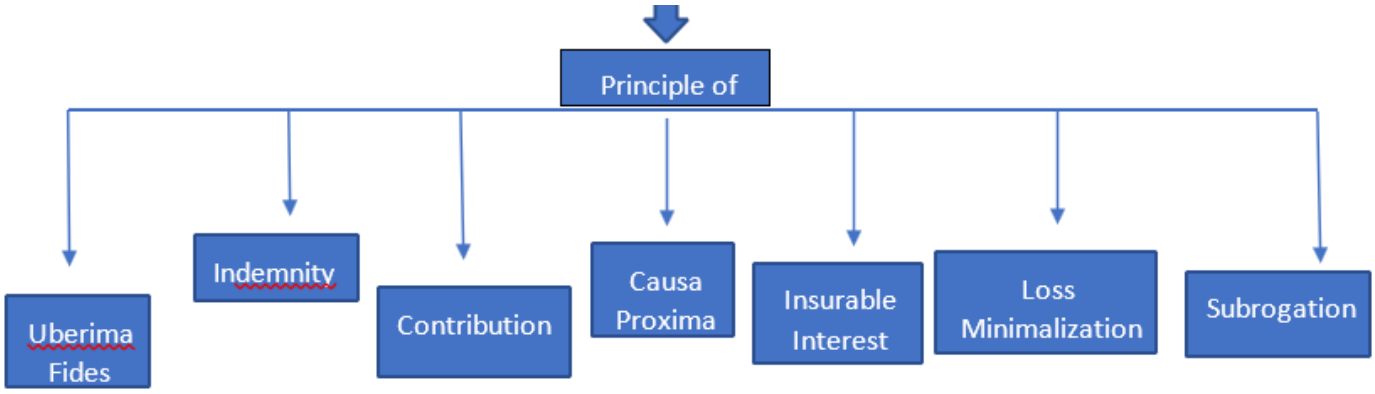
The Earliest traces of insurance in Indian History was in the form of Trade loans in the marine sector or carrier's contracts which can be found in Kautilya's Arthashastra, Manu Smriti's etc. In the 19th Century, Insurance without regulations started in India during British period but it was discriminatory in nature and somewhat unaffordable too. Bombay mutual life insurance society indicated the birth of 1st life insurance in India in 1870s and was pocket friendly. In 1912, Life Insurance Companies Act and the Provident Fund Act were passed to regulate the insurance businesses which were later nationalised in 1956 and thus LIC (Life Insurance Corporation) came into existence.

Hon'ble Madras High Court in All India General Insurance Co. v. S.P. Maheswari very rightly stated that, the origin of insurance and insurance law in England, United States of America and India is interesting and deserves more than a passing mention.

Hon'ble Court also threw light upon the history of Insurance law. This history can be gathered from the leading American treatise, Richards on Insurance. The origin of insurance is obscure. Loans on bottomry are of ancient date, and from this maritime usage the earliest form of insurance may have developed. There is ample evidence of use of marine insurance in the middle ages. The word "policy" is of Italian derivation. At its initial stage, the contract of insurance was underwritten by individuals and was regulated by mercantile custom, which became the foundation of all the laws and codes subsequently enacted upon the subject.

Talking about the present-day scenario, the principal legislation regulating the insurance sector in India is the Insurance act of 1938. Some others include the LIC Act, 1956, the Marine Insurance Act , 1963 and Insurance Regulatory and Development Authority Act, 1999 (IRDA) etc. The Indian Contract Act, 1872 and Companies Act, 2013 are also applicable on the Insurance Industry. After the LPG reforms of 1991, Insurance sector was introduced with many changes as the economy became liberative and free from governmental control although not completely. But this also meant many new challenges as this would have resulted in a huge competition. In order to prevent misuse by insurers of shareholders and policyholder's funds and to ensure accountability, it was imperative to have in place an effective regulatory regime. Insurers being repositories of public trust, efficient regulation of their business became necessary to ensure that they remained worthy custodians of their trust.

Insurance works on some essential principles. These are:-



Any law which comes into existence has its challenges which are very important to be discussed and looked upon. There is a huge insurance gap in India and this leads to low insurance density in comparison with Global Levels which indicates the huge uninsured population. The Insurance sector has transitioned from being a state monopoly to a competitive market but public-sector insurers hold a greater share of insurance market. Life insurance dominates the market and other general (Non-life) insurance is neglected. Rural-Urban divide is also a mounting challenge in insurance industry. Usually life insurers get attracted towards Urban class of people because they can afford the insurance. The insurance sector in India is Capital starved as it lacks sufficient capital for its smooth perusal. Investment in this sector was itself not sufficient and it dwindled further due to crisis in Banks and NBFC's (Non-Banking Financial Companies).

Besides Challenges, Insurance laws have some improvement opportunities as well which if availed in a judicious way can work wonders and help the country overcome the challenges. The Insurance sector has already been liberalized for domestic and foreign companies and has also seen the arrival of many Global players. The platform is also open for professionals willing to serve the industry. The industry needs people with expertise and technical brilliance which is possessed by Chartered Accountants (CA). Some problems in the sector can be solved by a dedicated study of the problems and their origin. In order to increase penetration rates and density, the Uninsured public of majorly rural areas needs to be brought under the ambit of insurance coverage. Long term commitment needs to be shown to rural people to firm their confidence in the industry. The distribution mechanism needs to be thought upon and managed in a more efficient way. Insurance needs to be made pocket-friendly and should be formulated for all classes of people. Easement of the application procedure for the same can help a lot towards this. A simultaneous and complementary thrust should be given towards spreading awareness and improvement of Financial literacy.

The government has taken some steps towards it like unfolding schemes such as PM Jan Arogya Yojana, Jeevan Jyoti yojana, etc. to lower down the premium rates for insurance which will eventually attract more people towards this sector. The application of technology in this sector can help in the expansion of this sector by leaps and bounds. The implementation of these suggestions is a long shot and it's not going to be easy for the country. Although it's quite early to predict results, yet if these challenges are looked upon sincerely and ways are formulated judiciously, it can truly change the shape of insurance sector of the country and can make India an educational hub. These Pandemic times are challenging but should not be a hindrance in the effective developmental enhancement because: -

"The path to success is to take massive, determined action."
-Tony Robbins

CHALLENGES AND ISSUES OF INSURANCE LAW AROUND THE WORLD

-Kumar Om (1st year)

Amid the COVID-19 pandemic, while on the one hand, it has conveyed the importance of insurance to the masses inadvertently it has also compounded the challenges of the industry at large. Even before the COVID- 19 pandemic. It is becoming increasingly challenging for insurance companies to survive in their current form as the 21st Century is all about adapting to the changing demand trends. To understand how process automation, cloud computing, AI, and other innovations can revolutionize the insurance industry, it is important to understand some of the important disruptions and threats the industry is facing.

The untapped gig economy: The primary customary base of the insurance sector belongs to the professionals of the organized sector, but what about the employees who are not registered under the company but contributing to the economy. Various online portals and reputed workplaces like Fiverr, Amazon Mechanical Turk, and others have led to the surge in the 'freelancer' population who work without any formal company allegiance. Though this is a win-win situation for both parties as the companies don't have to provide employee benefits, the freelancer at his convenience of time and skip all the paperwork and a boss, but it's a major threat to the insurance sector. Now as these gig workers comprise the millennials and the Gen-Z who prefer this kind of work, the insurers are losing a majority mass of their prospecting customer base debilitating the insurance sector. The most suitable option to deal with the situation would be to develop personalized insurance products as well as simplify the process of understanding these policies.

Material non-disclosure of health: Though this is an issue primarily concerning the Life insurance sector but it has repercussions over the entire perception of the insurance industry as it's based on the principle of utmost good faith the life of a person is the most concerning theme for them. When a customer while completing the proposal form does not furnish his correct health condition or is suffering from any ailment and does not disclose it then it is considered under a material non-disclosure of health. This results in unworthy processing of claims impacting the pol funded by genuine policyholders and profitability of insurers. An ideal harmonious solution would be, if insurance companies can consider implementing additional stringent diligent checks while issuing policies, and pragmatic judgments are passed by courts.

The insurance in addition to these face a plethora of other challenges but gradual adaptation will Thi ease a lot of operational pressure on insurance companies which can then concentrate further on devising new path-breaking products, providing superior customer experience, increasing penetration of insurance products in the masses..

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RECENT UPDATE: AMENDMENTS OF SEBI TO THE RPT REGIME

-Rituparna Ray (4th year)

SEBI finally disclosed its far-reaching reforms to the regulatory regime for Related Party Transactions ("RPT") on November 9, 2021, after a long and tense wait. The SEBI (LODR) Regulations, 2015 ("LODR"), which update the RPT regulatory system, have its origins in the Report of the Working Group on RPTs ("WG Report"), which was issued by SEBI on January 27, 2020.

Despite the fact that the SEBI adjustments made several significant changes to the WG Report's proposals, the alterations have raised substantial concern among India Inc.

When the revisions take effect on April 1, 2022, India Inc. has already begun preparing for the 'new normal.' The authors will present a bird's eye view of the revisions and their practical ramifications in this essay.

Inclusion of “Promoter” within the definition of “Related Party”

A "promoter" [as defined in Section 2(69) of the Act] or a person or entity affiliated to the promoter/ promoter group is not included under the definition of "associated party" in Section 2(76) of the Companies Act, 2013 ("Act"), which is a fundamental inexplicable flaw.

SEBI is now proposing to close this critical loophole for listed businesses by defining "associated party" to include any person or entity related to the promoter or promoter group. This is a positive step toward ensuring that transactions between the listed firm and its promoters do not fall outside of the regulatory net.

Furthermore, the definition of "associated party" has been expanded to encompass any person or company that holds equity shares amounting to:

20% or more [w.e.f. April 1, 2022]

10% or more [w.e.f. April 1, 2023]

Because the limits are not limited to direct holdings, businesses will need to carefully examine the disclosures made under Section 89 of the Act to see if any person or entity meets the levels on a beneficial interest basis.

Broader Definition of ‘RPT’

SEBI has revised Regulation 2(1)(zc) of the LODR's definition of "RPT" to include transactions conducted at the subsidiary level, which were previously exempt from regulatory examination. Even transactions between two subsidiaries will henceforth be considered a "RPT" and must be approved by the listed corporation.

A transaction between the listed company or any of its subsidiaries on the one hand, and any other person or entity on the other hand, with the intention and effect of benefiting a related party of the listed entity or any of its subsidiaries, shall also constitute a 'RPT' as of April 1, 2023. SEBI has not established any test for examining the 'purpose and impact' of the transaction, despite the fact that this "catch-all" provision was derived from the UK Premium Listing Rules.

Given that the 'purpose and effect' test will only apply from April 1, 2023, SEBI should adequately clarify its scope and ambit so that compliance officers of listed companies have a better understanding of how to make this determination and do not face practical difficulties in identifying such transactions.

Audit Committee approval for transactions undertaken at subsidiary level

The requirement of seeking clearance from the listed entity's Audit Committee for transactions involving two or more subsidiaries of the listed business is perhaps the most contentious component of the revisions. SEBI's move follows a number of recent business scandals in which high-value harmful linked party transactions were carried out at a subsidiary level to avoid regulatory attention.

The value of the transaction (either individually or when combined with earlier transactions during a financial year) must now be approved by the Audit Committee if it exceeds 10% of the listed entity's annual consolidated turnover, as determined by its most recent audited financial statements.

A "subsidiary" will also include an overseas subsidiary incorporated under the laws of a foreign country, according to Section 2(87) of the Act.

As a result of the modifications, the Indian holding company's consent will be required for transactions involving two or more overseas subsidiaries of the listed corporation.

Let's look at a real-world scenario to see what this means.

Firm X [an Indian publicly traded holding company] has unlisted foreign subsidiaries in the United Kingdom ("UK Subsidiary") and France ("French Subsidiary"), respectively.

The UK Subsidiary and the French Subsidiary propose to enter into a transaction with a turnover of more than 10%. This transaction between two overseas subsidiaries will not be completed unless the Audit Committee of the listed entity, Company X, gives its prior approval.

The modifications may thus result in a 'conflict of laws' situation, in which the Audit Committee of an Indian listed business has veto power over transactions entered into by two international entities incorporated under the laws of a foreign jurisdiction and bound by their domestic law requirements. A foreign jurisdiction could impose legal duties that are incompatible with India's legal system.

The directors of the UK subsidiary, for example, will be required to exercise "independent judgement" and "due care, skill, and diligence" under Sections 173 and 174 of the English Companies Act, 2006. Given their fiduciary responsibilities to the UK subsidiary and their responsibilities under English Company Law, such directors may not be allowed to approve the transaction purely on the basis of the holding company's Audit Committee's consent. Furthermore, because France is a civil law country, the Board of Directors of the French subsidiary may be subject to rules that are incompatible with the Indian legal system.

It is also possible that the Board of the foreign subsidiary is in favour of entering into a transaction with another foreign company, but the deal is not approved by the Indian listed entity's Audit Committee.

Such circumstances may jeopardise the foreign subsidiary's board of directors' autonomy.

While it is true that the Indian listed firm owns and controls the overseas subsidiary, the essential idea of'separate legal existence' articulated in Salomon v. Salomon must not be overlooked. A subsidiary, according to the Salomon principle, has a separate legal existence from its parent, as well as an independent Board of Directors who have a fiduciary duty only to the subsidiary and not to the parent.

In this regard, the famous Supreme Court ("SC") ruling in the Vodafone case is instructive, where it was declared that "the legal situation of any company established overseas is that its rights, functions, and obligations are governed by the law of its incorporation." Furthermore, the fact that a parent company exerts shareholder influence over its subsidiaries does not negate the subsidiary's directors' decision-making power or authority, and the directors owe a responsibility to the subsidiary only, not to the parent.

The Audit Committee's veto power may have a significant impact on the autonomous decision-making authority of foreign subsidiary directors, and it may also be in conflict with the laws under which the foreign company was formed. When it comes to RPT approval, such an extraterritorial interpretation of Regulation 23 of the LODR would make the Boards of such overseas companies "functus officio."

The provisions of the LODR may also be subject to judicial scrutiny, based on the fact that Regulation 23's extraterritorial applicability lacks a real or substantial nexus with India, and thus violates Article 245 of the Constitution, according to the tests laid down by the Supreme Court in the GVK Industries case. It's also questionable if SEBI's delegated legislation can enable for such extraterritorial applicability.

“Material Modification” of RPTs

Prior approval of "significant adjustments" to an RPT is now required by the Audit Committee. The revisions, however, do not define what constitutes a "major alteration," instead stating that the Audit Committee shall define "material adjustments" and declare it in the listed entity's RPT Policy. Leaving this decision completely in the hands of the Audit Committee could be counterproductive, as the revisions do not include any clear-cut criteria for making this decision.

Materiality Threshold

The materiality threshold for getting shareholder approval has been amended by SEBI to cover transactions exceeding Rs. 1000 crore or 10% of annual consolidated turnover, whichever is lower. While the Rs. 1000 crore threshold could put many more transactions under shareholder approval, SEBI has made a significant adjustment to the WG Report's recommendations.

The materiality level should be changed to 5% of yearly total revenues, total assets, or net worth on a consolidated basis, or INR 1000 crore, whichever is smaller, according to the WG Report. A 5% criterion would have captured an even larger number of transactions within the shareholder approval net, increasing India Inc's worry.

In addition, under Regulation 23, SEBI has not included a "net worth" based criterion (1). SEBI may have adopted a similar criterion for specific RPTs, given that Section 188 of the Act stipulates a "net-worth" based materiality requirement for some RPTs.
In contrast to the Act, SEBI has chosen not to give any exemptions for transactions carried out in the ordinary course of business and at arm's length.

Conclusion

The revisions may disproportionately increase the burden of the Audit Committee of listed corporations, in addition to impacting the Board autonomy of foreign subsidiaries. From January 1, 2022, only the Audit Committee's independent directors will be able to approve RPTs.
Independent directors will now be required to investigate transactions involving two or more foreign subsidiaries that are subject to a separate company law regime. It may be unreasonable to expect independent directors to get conversant with the requirements of a slew of foreign laws before approving complex transactions involving overseas subsidiaries.
While some requirements may pose corporate governance issues and necessitate a carefully calibrated approach on the part of corporations, many revisions are in line with industry requests. Excluding preferential allotment, rights issues, and buybacks of securities, for example, from the scope of Regulation 23 of the LODR is a positive step, as such transactions are already governed by the SEBI (ICDR) Regulations, 2018. In addition, requiring periodic RPT disclosures is a positive step that would increase openness for minority owners whose interests must be protected.
Overall, the reforms bring about a paradigm shift in the RPT system, putting RPT regulation back at the forefront of India's fight for good governance. It has unquestionably increased the regulatory burden on publicly traded corporations.

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CHIEF ADVISOR

DR. TEJINDER KAUR,
PRINCIPAL, AIL

FACULTY COORDINATOR

DR. PUJA JAISWAL,
ASST. PROFESSOR OF LAW

STUDENT MEMBERS

CONVENER:

MARVIE MAGOTRA (5TH YEAR)

CONVENER:

NISHANT SHARMA (5TH YEAR)

CO-CONVENER:

MOROMI MUDGAL (4TH YEAR)

CO-CONVENER:

RITUPARNA RAY (4TH YEAR)

CO-CONVENER:

SRISHTI JHA (3RD YEAR)