IN-DEPTH

Insurance Disputes

EDITION 6

Contributing editor
Russell Butland
Allen & Overy LLP

LEXOLOGY

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LEXOLOGY

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Preface

Russell Butland

I am delighted that this is now the sixth edition of *The Insurance Disputes Law Review*. It is a privilege to be the editor of this excellent and succinct overview of recent developments in insurance disputes across 17 important insurance jurisdictions. I am particularly pleased in this edition to welcome chapters from China and Mexico.

Insurance is a vital part of the world's economy and critical to risk management in both the commercial and the private worlds. The law that has developed to govern the rights and obligations of those using this essential product can often be complex and challenging, with the legal system of each jurisdiction seeking to strike the right balance between the interests of insurer and insured and also the regulator who seeks to police the market. Perhaps more than any other area of law, insurance law can represent a fusion of traditional concepts (that are almost unique to this area of law) together with constant entrepreneurial development, as insurers strive to create new products to adapt to our changing world. This makes for a fast-developing area, with many traps for the unwary. Further, as this indispensable book shows, even where the concepts are similar in most jurisdictions, they can be implemented and interpreted with very important differences in different jurisdictions.

To be as user-friendly as possible, each chapter follows the same format – first providing an overview of the key framework for dealing with disputes – and then giving an update of recent developments in disputes.

As the editor, I have been impressed by the erudition of all authors and the enthusiasm shown for this fascinating area. It has also been particularly interesting to note the trends that are developing in each jurisdiction.

An evolving theme in almost every jurisdiction is the increase in protections for policyholders. Much of the special nature of insurance law has developed from an imbalance in knowledge between the policyholder (who had historically been blessed with much greater knowledge of the risk to be insured) and the insurer (who knew less and therefore had to rely on the duties of disclosure of the policyholder). With the proliferation of data, the increasing use of artificial intelligence to assess that data and provide more detailed scope for analysis across risk portfolios, the balance of knowledge has shifted; it will often now be the insurer who is better placed to assess the risk. This shift has manifested itself in tighter rules requiring insurers to be specific in the questions to be answered by policyholders when they place insurance, and in remedies more targeted at the insurer if full information is not provided. Coupled with these trends, however, is the increasing desire by some jurisdictions to set limits on the questions that can be asked so that, for example in relation to healthcare insurance, policyholders are not denied insurance for historical matters.

We can expect that this tussle between the commercial imperative for insurers to price risk realistically and the need to balance consumer protection, government policy and privacy will increasingly be at the heart of insurance disputes.

The past year has been tumultuous. The conflict being fought in Ukraine, and its effect on energy security and global supply chains, comes as a further shock on top of climate events and the legacy of the disruption from covid-19. The effect of the Ukraine conflict is having a substantial effect on the aviation insurance market, with previously lightly litigated policy forms now at the front and centre of major litigation in the US, the UK and Ireland. Business

interruption issues from the covid-19 pandemic meanwhile continue to be worked through across the legal systems; key areas of coverage have been addressed but now there are more bespoke issues, for example relating to the application of policy limits.

There has in the past year been particular focus on directors and officers policies. These are under increasing pressure as directors are in the spotlight as a result of strategic climate change litigation (particularly relating to greenwashing and transparency of transition to net zero). Similarly, cyber risks are ever increasing, as the scope of cover and capacity provided by the insurance market retreats.

No matter how carefully formulated, no legal system functions without effective mechanisms to hear and resolve disputes. Each chapter, therefore, also usefully considers the mechanisms for dispute resolution in each jurisdiction. Courts appear to remain the principal mechanism, but arbitration and less formal mechanisms (such as the Financial Ombudsman in the United Kingdom) can be a significant force for efficiency and change when functioning properly. The increasing development of class action mechanisms, particularly among consumer bodies (e.g., in France and Germany), is likely to be an important factor.

I would like to express my gratitude to all the contributing practitioners represented in *The Insurance Disputes Law Review*. Their biographies are to be found in the first appendix and highlight the wealth of experience and learning that the contributors bring to this volume. On a personal note I must also thank Rebecca Daramola at my firm, who has done much of the hard work in this edition. I would also like to thank the whole team at Law Business Research, who have excelled at bringing the project to fruition and in adding a professional look and more coherent finish to the contributions.

Last, but not least, I would to like thank Joanna Page, who co-edited the first five editions of this book. Joanna's leadership and intellect were instrumental in bringing the original concept for this book to fruition, and ensuring that it has gone from strength to strength with each edition. In following Joanna as editor I have big shoes to fill.

Russell Butland
Allen & Overy LLP
London
October 2023

Chapter 1

Austria

Ralph Hofmann-Credner[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
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I INTRODUCTION

This chapter provides insight into the legal sources that Austrian courts apply in cases of insurance litigation, the legal framework of the law applicable to insurance agreements and recently published insurance litigation rulings of the Austrian Supreme Court that may add value to specialists involved in drafting wordings, brokerage, claims management, underwriting and taking out insurance coverage. We consider it to be interesting that association proceedings seem to be on the rise.

II YEAR IN REVIEW

In the fifth edition of *The Insurance Disputes Law Review*, we described insurance dispute cases dealing with a policyholder's right to information and disclosure of an expert opinion obtained by an insurer; a clause in general insurance terms and conditions requiring a policyholder to issue all notices and declarations to an insurer in writing to be binding; and decisions regarding a policyholder's right of withdrawal.

In this edition, we present disputes that were initiated by the Association for Consumer Information[2] against the insurer (1) contesting the use of a data processing notice, (2) concerning the interpretation of clauses in general terms and conditions of insurance in the 'most anti-customer' sense, and (3) relating to the legal validity of 19 clauses used by a travel insurer in its general terms and conditions.

The first of these cases was published in January 2023 and reveals new case law for the use of an insurer's data protection notice. The defendant insurer in question drafted and used a document called data protection notice in relation to its consumers, who had to confirm in the insurance application to have taken note of that notice. The Supreme Court considered the fact that the data protection notice was not part of the general terms and conditions of insurance, but a separate form, and concluded that this fact does not speak against its contractual declaration character; rather, it depends on the concrete form of the contract. The further fact that the consumer did not have to agree to it but only confirm to have 'taken note' of the data protection notice was also considered by the Supreme Court and it was determined not to be a relevant difference, because taking note implies agreement to its content. Consequently, the insurer's data protection notice was not to be qualified as a mere information document without legal consequences.

Finally, the court examined the clauses criticised by the Association for Consumer Information as plaintiff in an association proceeding[3] before concluding further that the clauses in the data protection notice were non-transparent or grossly disadvantageous.[4]

A further recent insurance dispute that was initiated by the Association for Consumer Information as an association proceeding concerned the test of the Supreme Court on the interpretation of clauses in general terms and conditions of insurance pursuant to Section 28 of the Consumer Protection Act[5] in the 'most anti-customer' sense. In December 2022, the Supreme Court published a ruling that once again dealt with the legal validity of clauses used by an insurer in its general terms and conditions.[6] The association authorised to sue brought an action against an insurer for injunctive relief and publication of a judgment. A clause that was considered to be not grossly disadvantageous in the sense of Section 879(3) of the General Civil Code[7] in earlier proceedings between two entrepreneurs had to be examined as to its sufficient transparency for a consumer.

The Supreme Court confirmed the decision of the Court of Appeals that qualified the clause in this case as unclear and non-transparent within the meaning of Section 6(3) of the Consumer Protection Act due to the vague, undefined term 'exceptional situation'. This is because in general usage there are no clear criteria that allow a doubtless classification of every possible situation either as a rule or as an exception. According to the Supreme Court, the term is open to numerous interpretations, ranging from the merely unusual situation to the uncontrollable extraordinary coincidence in the sense of Section 1104 of the General Civil Code. Since a consumer cannot reliably assess the scope of the risk exclusion in question, there is a risk that they may not assert a justified claim against the insurer. Furthermore,

no consideration could be given by the Supreme Court to the possible partial admissibility of a disputed clause, because a reduction that preserves the validity of the clause – as in individual proceedings – is not allowed in association proceedings.

The final case that is presented within this chapter concerns an association proceeding that started with a lawsuit filed by the Federal Chamber of Labour[8] as an association entitled under Section 29(1) of the Consumer Protection Act against an operator of insurance business. The Supreme Court had to examine – after splitting a clause – the legal validity of 19 clauses used by an Austrian travel insurer in its general terms and conditions, of which the Supreme Court declared eight clauses to be inadmissible.

In association proceedings all clauses are governed by the principle that the validity control according to Section 864a of the General Civil Code takes precedence over the content control according to Section 879 of the Code: whereas 'objectively unusual' within the meaning of Section 864a of the Code is a clause that clearly deviates from the expectations of the contractual partner (i.e., which the partner does not need to reasonably expect according to the circumstances (the clause must have an inherent 'surprise effect')), pursuant to Section 879(3) of the General Civil Code, a contractual provision contained in general terms and conditions or contract forms that does not specify one of the main services to be provided by both parties shall be null and void if, taking into account all the circumstances of the case, it grossly disadvantages one party (the moving system thus created takes into account, on the one hand, the objective equivalence disruption and, on the other hand, the 'diluted freedom of will').

In the latter and in insurance contract law, the controlling standard for the description of services outside the core area are the legitimate coverage expectations of the policyholder. Gross disadvantage within the meaning of Section 879(3) of the Code does not only exist if the purpose of the contract is virtually thwarted or undermined, but already if the clause under review brings about a substantial restriction compared to the standard that the policyholder can expect from an insurance of this kind. Moreover, and according to Section 6(3) of the Consumer Protection Act, a contractual provision contained in general terms and conditions or contract forms shall be invalid if it is unclear or incomprehensible.

One of the disputed clauses, which goes beyond the scope of travel insurance products only, states that 'an act or omission for which the occurrence of damage must be expected with probability, but is accepted, shall be deemed equivalent to intent.' Contrary to the plaintiff's view, however, the Supreme Court concluded that the clause does not extend the exclusion of risk to cases where there is no intent. Rather, the clause presupposes intentional conduct on the part of the policyholder. Incidentally, and in contrast to general liability insurance wordings, gross negligence in bringing about the insured event also leads to the insurer being exempt from paying benefits. The clause is therefore neither unusual nor grossly disadvantageous nor non-transparent.

The lesson to be learned from these rulings is that general terms and conditions of insurance that are subject to Austrian law, or are to be adapted to it, should always be checked also on the basis of the criteria laid down by the Supreme Court for terms that are not defined but are used in common language in such a variety of ways that a definition for the insurance contract is necessary in order to make the meaning sufficiently clear for a consumer and thus make the clause effective. Moreover, as can be seen from the aforementioned, associations entitled under the Consumer Protection Act file lawsuits incriminating a larger number of provisions in general terms and conditions of insurance and therefore insurers should observe that their wordings are verified according to the validity control (Section 864a of the General Civil Code) and the content control (Section 879 of the Code).

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The three main sources of law are legislation, broadly acknowledged templates of general terms and conditions, and precedents.

The substantive insurance law is primarily governed by the Insurance Contract Act.[9] In addition, certain advice and information obligations of insurers towards insureds are stipulated in the Insurance Supervision Act 2016.[10] For certain types of insurance (e.g., motor liability insurance), special statutes exist. Where the insurance statutes do not provide for any special rules, general civil law provisions of the Civil Code apply.

The Insurance Contract Act is, in general, applicable to both consumer and non-consumer contracts without distinction, and also to large risks. It aims at protection of the insured (considered the weaker party to an insurance agreement compared with the professional insurer), mainly by means of various coercive provisions that cannot be deviated from to the detriment of the insured. However, specific types of insurance either do not fall within the scope of the Insurance Contract Act at all (reinsurance and marine insurance)[11] or are not subject to its restrictions (transport insurance of goods, credit risk insurance, insurance against exchange loss and continuous insurance, which is defined as an indemnity insurance taken out in such a way that the insured interests at the time of the conclusion of the contract are designated only in terms of class and are not given up to the insurer individually until after they have arisen).[12]

In addition, general insurance terms and conditions play a key role. Model terms are developed and published by the Austrian Insurance Association (VVO),[13] and although these are not binding, they are regularly adopted by Austrian insurance companies and incorporated into insurance contracts with minor changes. Whereas the most recent non-life model terms developed by the VVO, published in January 2019, cover cyber risks, the most recent life insurance model terms were published in September 2019.

For these reasons, Austrian case law on insurance agreements predominantly deals with legal questions related to the model insurance terms, while case law related to wordings that have an international background, such as warranty and indemnity, tax liability, cyber risk, directors' and officers' (D&O) liability, clinical trial insurance or prospectus liability insurance,[14] rarely exists.[15] Although court judgments in Austria are, in general, only binding on the parties involved in the specific civil proceeding, case law plays an important role and has a knock-on effect because the courts of lower instance have to observe and apply the jurisprudence of courts of higher instance, such as the courts of appeal and the Supreme Court of Justice, which is the highest instance in civil and criminal matters. Within the Supreme Court of Justice, as a specialist senate, the seventh senate handles disputed private insurance contract cases.[16]

As far as insurance regulation is concerned, the Insurance Supervision Act 2016 is the primary source of law, and conducting insurance business in Austria requires the holding of a licence. Depending on whether the applicant is a domestic company or a third-country insurer, the Austrian Financial Market Authority (FMA)[17] grants a licence upon application and fulfilment of preconditions. A European Economic Area (EEA) insurance company holding a licence and situated outside Austria does not require a further or domestic insurance licence. The EEA insurer may, upon notification of its home state regulator, conduct insurance business in Austria on a freedom-of-services basis or freedom-of-establishment basis, the latter through a local branch. The ongoing supervision of the insurance market in Austria is also carried out by the FMA.

The relevant sources of law for insurance intermediaries (agents and broker) are the Austrian Commercial Code[18] and the Rules of Professional Conduct for Insurance Mediation,[19] which have been amended following the transposition of the final part of the Insurance Distribution Directive in Austria.[20]

ii Insurable risk

Austrian law does not define the term 'insurable risk', but international legislative developments such as the Foreign Account Tax Compliance Act and the General Data Protection Regulation have posed again the question of whether insurance can be taken out against a specific (e.g., administrative) fine. The unchanged answer under Austrian law, which dates back to a ruling of the Supreme Court of Justice of 23 January 1917,[21] is that such fines are deemed to be

uninsurable because any agreement between a tortfeasor and a third party concluded before an infringement, whereby the third party shall be obliged to compensate the tortfeasor for any future penalty, is an immoral contract; however, it is different if such an agreement is made after the offence has been committed.[22]

Furthermore, Section 68 of the Insurance Contract Act contains a provision that deals with cases the facts of which are that either no insured interest existed from the beginning, or that an insurable interest ceased to exist during the term of an insurance agreement. The relationship between the insured and the insured asset is such an interest. An insured interest does not exist if either no insured who carries such an interest exists; or the insured asset or the relationship to this asset does not exist at the outset of the insurance agreement, or it certainly will not exist in the future.[23] As at 16 September 2023, between the years 1938 and 2013, the database of the Legal Information System of the Republic of Austria[24] recorded nine judgments of the Supreme Court of Justice and one judgment of the highest appellate court in Germany for civil and criminal cases in relation to Section 68 of the Insurance Contract Act, and this reflects that this statutory provision is not highly disputed in the courts.

iii Fora and dispute resolution mechanisms

Insurance disputes (i.e., disputes over the content or scope of a private insurance agreement) are typically heard by the state courts. Although arbitration proceedings in Austria, and particularly with Vienna as a seat of arbitration, are well-recognised, arbitration does not play a key role in Austrian insurance dispute practice. The same is true for mediation proceedings, which are recognised by Austrian courts, but it is not mandatory for a party to go through mediation before filing a lawsuit in a contested insurance matter.[25] Moreover, inter alia, in the event of a denial of coverage by an insurer, the broker can apply on behalf of its client (the policyholder) to a specific commission consisting of four experts to issue a legal recommendation, which is legally non-binding but has factual weight in out-of-court negotiations because of the professional standing of the commissions' members.[26] In any case, as stated in Section III.i, the highest state court instance in contested insurance matters is typically the seventh senate of the Supreme Court of Justice.

However, wordings can contain a stipulation that the parties must go through an expert procedure. The extent to which agreeing on an expert procedure in an insurance agreement may be admissible is stipulated in Section 64 of the Insurance Contract Act. In practice, the expert procedure is concluded by the parties within the framework of the general terms and conditions, and this is harmonised within the several types of insurance through the VVO model conditions. Examples of general insurance terms and conditions that contain provisions for an expert procedure are those applicable in property,[27] legal expenses[28] and accident insurance.[29]

The decision of an expert procedure shall be binding on the parties, unless the decision obviously deviates from actual facts.[30]

IV THE INTERNATIONAL ARENA

The local standard may be most accurately described as having three principal characteristics:

- an Austrian insured would expect the insurance wording to be in German or, in the case of bilingual special insurance wording, the German wording prevails;
- that no arbitration clause exists; and
- that Austrian law applies.

Nonetheless, international insurers serving the Austrian and German market sometimes apply German law to their insurance agreements with Austrian insureds. For insurance intermediaries and the Austrian courts, this does not cause any surprise or present complications in the application of the law because the Austrian Insurance Contract Act historically stems from the German Insurance Contract Act, with minor linguistic variation. However, a major recast of the German Insurance Contract Act in 2008 was not followed by a similar recast in Austria, and precedent and literature have since started to diverge.

If foreign law applies and Austrian courts have to decide a dispute under foreign law, then the judge would appoint a foreign law expert to gain an understanding of how the legal question would be answered under that foreign law.[31] This procedure is not necessary for German law as the official language is identical in both jurisdictions and both insurance contract acts are rather similar. However, if a foreign law cannot be determined within a reasonable period despite detailed efforts, Austrian law shall apply.[32] The determination of the foreign law by the lower courts has to be carried out *ex officio*, pursuant to Section 4 Paragraph 1 of the Private International Law. According to the Supreme Court of Justice, lack of determination of the foreign law by the lower courts constitutes a procedural deficiency of a special kind, constituting grounds for appeal on the basis of incorrect legal assessment, and leads to the revocation of the lower court decisions.[33]

Furthermore, lawsuits against foreign insurers are on occasion filed incorrectly against a party that is not the risk carrier (e.g., especially if the insurer had delegated underwriting authority or the policy was not issued by the insurer). These situations have resulted in confusion and the wrong person being named as the defendant. In fact, if the affected insurer gains knowledge of such a situation, it may, depending on its defence strategy, clarify the shortcoming and mutually agree with the parties to the litigation to change (the name of) the defendant, or it may let the wrong defendant defend the case with the argument that it is not the risk carrier and, therefore, the claim should be dismissed. If, however, the claimant only misspelled or wrongly named the correct insurer, the court is entitled to adjust the naming of the defendant, according to Section 235 Subsection 5 of the Code of Civil Procedure.

Since Austria is a member of the EU, jurisdiction in international insurance disputes is determined by the rules of Brussels I Regulation (recast).[34] As a general rule (see Articles 11 to 14), the Regulation stipulates that an insurer may bring proceedings only in the courts of the Member State in which the defendant (the policyholder, the insured or a beneficiary) is domiciled. However, the insurer may be sued in the courts of the Member State in which it is domiciled (including where it has a branch, agency or establishment); or in the Member State where the claimant (the policyholder, the insured or a beneficiary) is domiciled; or, if it is a co-insurer, in the courts of a Member State in which proceedings are brought against the lead insurer. For liability insurance, the insurer may, in addition, be sued in the courts of the place where the harmful event occurred and may, in general, be joined in proceedings that the injured party has brought against the insured.

Regarding international insurance litigation falling within the scope of the Rome I Regulation,[35] the choice of law is limited in particular by the restrictions listed in Article 7 Paragraph 3. For contracts covering risks (other than large risks) that are situated in a Member State, the choice of law is limited to:

- the law of the Member State where the risk is situated;
- the law of the country where the policyholder has their habitual residence;
- in the case of life insurance, the law of the Member State of which the policyholder is a national;
- for insurance contracts covering risks limited to events occurring in one Member State, the law of that Member State; or
- where the policyholder pursues a commercial or industrial activity or a liberal profession and the insurance contract covers two or more risks that relate to those activities and are situated in different Member States, the law of any of the Member States concerned or the law of the country of habitual residence of the policyholder.

For compulsory insurance, special provisions apply.

Article 7 of the Rome I Regulation provides that if the parties would be entitled to choose Austrian law and Austrian law allows greater freedom on choice of law in insurance contracts, then the parties are allowed to make use of this freedom. (This is the case in Austria, where, pursuant to Section 35a of the Private International Law, the parties may choose any law as the law applicable to the insurance contract.) However, if the insurer carries out its business or otherwise directs its activities to the state of residence of the insured, then by choice of

law the insured may not be deprived of the rights granted under mandatory provisions of the law that would be applicable in the absence of choice. In consumer contracts, further limitations exist.

For arbitration clauses, the general norms of the Code of Civil Procedure stipulate that an arbitration agreement may be concluded between parties for both existing and future civil claims that may arise out of or in connection with a defined legal relationship (insurance matters are not excluded). The arbitration agreement must be in writing and indicate the parties' will to submit to arbitration. In consumer contracts, however, stricter requirements exist.

V OUTLOOK AND CONCLUSIONS

In the previous edition of *The Insurance Disputes Law Review*, we indicated that insurers might see an increase in claim notifications resulting from environmental, social and governance violations as more came to light and anticipated that policyholders would take more tactical decisions as to which cases would be finally reported to an (e.g., D&O) insurer. From our practice in the past year, we can say that we are seeing more claims in Austria from D&O insurance, but also claims from the US, and clients are seeking advice related to balance sheet loss protection (BSLP) and financial interest cover (FINC) clauses. There are no Supreme Court rulings on the new BSLP and FINC clauses, but this may change in the near future if policyholders are dissatisfied with the settlement of claims under international programmes. International or global programmes seem to be more in demand also for financial lines products.

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Endnotes

1 Ralph Hofmann-Credner is the founder and owner of HOFMANN-CREDNER Rechtsanwalts GmbH.
2 Verein für Konsumenteninformation.
3 Verbandsverfahren.
4 Supreme Court of Justice 23 November 2022, 7 Ob 112/22d (ECLI:AT:OGH0002:2022:0070OB00112.22D.1123.000).
5 Konsumentenschutzgesetz.
6 Supreme Court of Justice 09 November 2022, 7 Ob 169/22m (ECLI:AT:OGH0002:2022:0070OB00169.22M.1109.000.
7 Allgemeines Bürgerliches Gesetzbuch (ABGB).
8 Bundesarbeitskammer.
9 Versicherungsvertragsgesetz (VersVG).
10 Versicherungsaufsichtsgesetz 2016 (VAG 2016). An English translation of the VAG 2016 is available online: www.fma.gv.at/download.php?d=825.
11 Section 186 of the Insurance Contract Act.
12 Section 187 Subsection 1 of the Insurance Contract Act.
13 Model insurance terms and conditions in German language are published on the website of the VVO: https://www.vvo.at/vvo/vvo.nsf/sysPages/Musterbedingungen_Sachsparten.html.
14 Usually called public offering of securities insurance, or POSI.
15 As at 16 September 2023, the Legal Information System of the Republic of Austria website (see footnote 24) had published six decisions of the Supreme Court of Justice dealing with D&O insurance between November 2015 and June 2021, and one ruling each on clinical trial insurance from November 2005 and on public offering of securities insurance from June 2021, but no decisions pertaining to warranty and indemnity, tax liability or cyber insurance.
16 The scope of the several senates within the Supreme Court of Justice can be accessed here: www.ogh.gv.at/der-oberste-gerichtshof/geschaeftsverteilung/.
17 The home page of the FMA is available in English. For a general overview on supervision of insurance undertakings, licensing and notification and other special topics, see www.fma.gv.at/en/insurance.
18 Gewerbeordnung (GewO).
19 Verordnung der Bundesministerin für Digitalisierung und Wirtschaftsstandort über Standes- und Ausübungsregeln für Gewerbetreibende, die die Tätigkeit der Versicherungsvermittlung ausüben (Standesregeln für Versicherungsvermittlung).
20 Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (recast).
21 ZBl 1918/348.
22 RIS – Justiz RS0016830.
23 Burtscher/Ertl in Fenyves/Perner/Riedler (Editor), VersVG (7. Lfg 2021) § 68 Rz 10.
24 The Legal Information System of the Republic of Austria is a platform and database providing information on Austrian law (https://ris.bka.gv.at/defaultEn.aspx).
25 According to information from 2014 on the website of the Austrian Federal Association for Mediation, a pilot project of court-based mediation proceedings was initiated at the Vienna Commercial Court. It was seen as a success because only a few of the 40 to 50 cases referred to mediation by the Commercial Court were returned to the Court (https://www.oebm.at/aktuelle-news-details/mediation-am-wiener-handelsgericht.html; last visited on 15 September 2023).
26 Further information regarding the Legal Service and Conciliation Board (RSS) can be found on the website of the Austrian chamber of commerce (https://www.wko.at/branchen/information-consulting/versicherungsmakler-berater-versicherungsangelegenheiten/rechtsservice-und-schlichtungsstelle-rss.html).
27 Article 8 of the General Conditions for Property Insurance (ABS 2012).
28 Article 9 of the General Conditions for Legal Expenses Insurance (ARB 2015).
29 Article 16 of the General Conditions for Accident Insurance (AUVB 2008, Version 06/2017).
30 Section 64 Subsection 2 and Section 184 Subsection 2 of the Insurance Contract Act.
31 Section 4 of the Private International Law (Internationales Privatrecht – IPR–Gesetz).
32 Section 4 Subsection 2 of the Private International Law.
33 RIS-Justiz RS0116580.
34 Regulation (EU) No. 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.
35 Regulation (EC) No. 593/2008 of the European Parliament and the Council of 17 June 2008 on the law applicable to contractual obligations (Rome I).

Chapter 2

Belgium

Merel van Dongen[1]

Summary

I INTRODUCTION
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I INTRODUCTION

In Belgium, insurance and insurance law has become a hot topic in the media. Increasingly, policyholders are dissatisfied with the cost of premiums, refusals by insurers to provide coverage, claims settlements and alleged violations of legal obligations such as information requirements.

The legislature and regulatory authorities are continuously working on legal solutions and trying to adapt existing legislation to fit contemporary practices and complaints. For example, insurance products covering multimedia devices at a variable premium are now prohibited on the Belgian market. It is not only legislation that is evolving but case law as well. For example, the obligation to limit damage only applies to the insured company that is entitled to compensation, and the insured company cannot be disadvantaged by an act of its appointee. Furthermore, the Supreme Court has ruled that the sanction consisting of an interest equal to twice the legal interest rate is only imposed on the fire insurer if the late payment of the insurance benefit is attributable to the insurer's fault or negligence and not when that late payment is caused by the deliberate and well-founded belief of the insurer that it should not provide coverage. Moreover, the time needed for administrative processing of data in an insurance company needs to be taken into account when assessing the timely notification to the policyholder or insured that the insurance company wishes to exercise a right of recourse. Last but not least, the limitation period for a direct claim against a lawyer's liability insurer for failure by the lawyer to bring legal action in due time starts to run when the limitation period for that legal action expires.

In this chapter, interesting recent case law on Belgian insurance disputes, the legal framework, international insurance disputes and emerging trends in insurance claims are discussed in detail.

II YEAR IN REVIEW

i Is the infringement by auxiliary persons-appointees of the obligation to limit damage attributable to the insured company?

An auxiliary person-appointee is regarded as the instrument through which a company carries out actions or legal acts. In principle, the actions of the auxiliary person-appointee coincide with the performance of the company, meaning that any infringement by that person has to be regarded as an infringement by the company itself. In insurance law, that principle cannot always be applied.

Pursuant to Article 75 of the Insurance Act, the insured subject of any non-life insurance policy has to take all reasonable measures to prevent and limit the consequences of a loss. If the insured infringes that obligation and this disadvantages the insurer, the insurer can claim a reduction of its insurance performance up to the amount of the disadvantage.[2] The insurer can refuse coverage if the insured has failed to fulfil this obligation with fraudulent intent.[3] The Supreme Court had to determine whether an insurer can invoke these provisions against an insured if the insured is a company and the infringement is committed by an auxiliary person-appointee of that company. To be more precise, the company concluded an all risk insurance for a motor vehicle. A natural person carried out transportation with that vehicle on behalf of and under the authority of the company; therefore, this natural person could be considered an auxiliary person-appointee of the company. This person caused damage to the vehicle but continued to drive, increasing the extent of the damage. The court of appeal had ruled that the auxiliary person-appointee did not take all reasonable measures to limit the consequences of the loss, and that this could be considered an infringement committed by the insured company itself of the obligation to limit damage. The court of appeal even stated that ruling otherwise would mean that a company, which can only act in legal transactions through its organs and auxiliary persons, could never be blamed for any contractual error.

However, the Supreme Court did not agree and ruled that the obligation to limit damage in accordance with Articles 75 and 76 of the Insurance Act only applies to the insured party that is entitled to compensation.[4] This means that the insurer cannot invoke an infringement of

this obligation against the insured company if the infringement was committed by an auxiliary person. The insurer can only invoke an infringement of this obligation against the insured company when the infringement is committed by the insured company itself (for example, if the company has not ensured that the motor vehicle meets all technical requirements).

ii Timely payment by the insurer

A common dispute between an insurer and an insured concerns the sanction of the insurer when it waits too long to pay out the insurance benefit. Strictly speaking, the late payment of claims is sanctioned by imposing interest on the insurer. No additional (punitive) damages apply. However, a few exceptions exist. One of those exceptions concerns fire insurance products for simple risks.

Article 121 Section 2 of the Insurance Act imposes upon the insurer certain time limits. For example, the insurer has to pay out the insurance benefit within 30 days following the date of the conclusion of the expert investigation or following the date of the estimate of the damage. The conclusion of the expert investigation or the estimate of the damage has to take place within 90 days following the date of the declaration of the claim. However, these time limits can be suspended, for example when the insurer has made clear in writing to the insured the reasons which, 'beyond its will and that of its agents', prevent the conclusion of the expert investigation or the estimate of the damage.

In case of non-compliance with these time limits, the insurer has to pay an interest equal to twice the legal interest rate from the day following the expiry of the time limit until the day of actual payment, 'unless the insurer proves that the delay is not attributable to itself or one of its agents'.

The Belgian Supreme Court had to interpret the two phrases between the quotation marks. The facts of the case can be summarised as follows. An insurer had refused coverage because its own expert had found that the insured had infringed a specific contractual obligation, resulting in a fire. Afterwards, a judge had ruled that the insurer had to provide coverage. The insured sued the insurer for an interest equal to twice the legal interest rate since the time limits mentioned above were not met. The insurer argued (1) that the time limits were suspended, and (2) that the delay could not be attributed to the insurer. Both arguments were based upon the insurer's assumption that it had initially refused coverage in good faith and that the late conclusion of the expert investigation on the one hand and the late payment of the insurance benefit on the other hand were not attributable to the insurer. The delay was attributable to the contractual provisions of the policy, or so the insurer argued.

The Supreme Court only partially agreed. First, regarding the suspension of the time limits, the Court held that the insurer's mere refusal to provide coverage was not a reason 'beyond its will' preventing the conclusion of the expert investigation or the estimate of the damage. Second, regarding the sanction of double interest, the Court held that this sanction only applies when the late payment by the insurer is attributable to its fault or negligence. Where the insurer had a deliberate and well-founded belief that it should not provide coverage, it is not committing a fault or negligence.[5]

iii Right of recourse: timely notification by the liability insurer

In accordance with Article 152 of the Insurance Act, the liability insurer can, if it could have refused or reduced the insurance performance under the law or the insurance contract, reserve a right of recourse against the policyholder or insured to the extent of the insured's personal share of liability. However, on penalty of forfeiting its right of recourse, the insurer has to notify the policyholder or insured of its intention to exercise recourse 'as soon as it becomes aware of the facts on which that decision is based'. It goes without saying that the quoted phrase stimulates debate.

In 2002 and 2009, the Supreme Court had already ruled that the insurer's obligation to notify the policyholder or insured arises at the time when the insurer learns of the precise circumstances of the insured event on the basis of which it can assess whether the insured

caused the damage and whether there are grounds for recourse.[6] The interpretation of this obligation belongs to the tribunal or court hearing the case. The Supreme Court only examines whether that tribunal or court could validly decide on the timeliness of the notification on the basis of its findings. In its judgment of 17 March 2023, the Supreme Court examined a judgment of the Court of Appeal of Ghent dated 10 March 2022.

The Court of Appeal had determined that the insurer had sent its notification on 12 January 2018 after it had learned the identity of the vehicle's main driver on 27 September 2017. Based on two arguments, the Court of Appeal had ruled that this notification was timely, namely (1) the time needed for administrative processing of data in an insurance company has to be taken into account, and (2) the claimant's interests were not violated by the three and a half months' lapse of time. The Supreme Court agreed.[7]

Note that the interpretation of this obligation remains a question of fact (for example, the Supreme Court previously ruled that 'the judgment could correctly conclude that the insurer's notification, four and a half months later, of its intention to bring an action does not satisfy the legal requirement of an immediate reaction').[8]

iv Starting point of limitation period

In Belgium, the injured party can file a direct claim against the liability insurer of the liable party (Article 150 of the Insurance Act). This direct claim is time-barred after five years following the date of the harmful event or, in case of a crime, from the day on which it was committed. However, if the injured party proves that they became aware of their right against the insurer at a later moment, the limitation period starts to run from that moment, but in any event it shall expire after 10 years following the date of the harmful event or from the day on which the crime was committed (Article 88 Section 2 of the Insurance Act).

The Supreme Court recently had to interpret the phrase 'harmful event'.

The facts of the case can be summarised as follows. On 20 May 2003, someone was injured in a traffic accident. The injured party contacted lawyer Mr B, who did not take any action. In 2013, the injured party decided to contact another lawyer, who initiated proceedings against the insurer of the liable person. However, on 19 May 2016 the tribunal ruled that this claim was time-barred, which was confirmed by a court of appeal in 2017. On 28 May 2019, the injured party summoned the liability insurer of lawyer Mr B, stating that Mr B had made a professional mistake resulting in his liability. Lawyer Mr B insisted that he did not make a professional mistake. The court of first instance and the court of appeal ruled in favour of the injured party.

The insurer of Mr B brought this case to the Supreme Court, stating that the court of appeal had violated Article 88 Section 2 of the Insurance Act. While the court of appeal had ruled that the five-year limitation period started on 19 May 2016 because the injured party only became aware of their right against Mr B's liability insurer at that moment, the latter did not agree. According to Mr B's liability insurer, the 'harmful event' is the event (or the last event) that is necessary for the occurrence of the damage. In this case, that would mean the date on which the limitation period against the liability insurer of the person who caused the traffic accident expired (i.e., 20 May 2008, five years after the traffic accident). That was the moment in which lawyer Mr B made his alleged professional mistake by not initiating proceedings in time.

The Supreme Court agreed with Mr B's liability insurer: in case of a direct claim by the injured party against the liability insurer of their lawyer for failure by the latter to bring legal action in due time, the harmful event is the time at which the limitation period for that action expired. The court of appeal that, notwithstanding its finding that the direct claim against the traffic accident insurer was already time-barred as of 20 May 2008, indicated that the harmful event occurred on 19 May 2016 does not justify as a matter of law its decision that Mr B's liability insurer was summoned well within the five-year limitation period on 28 May 2019.[9]

In other words, when a lawyer makes a professional mistake by failing to bring a legal action within the applicable limitation period, the limitation period against its liability insurer starts

to run on the date of expiry of that first limitation period. The client then has five years or, if they become aware of that professional mistake at a later date, at most 10 years to bring a direct claim against the lawyer's liability insurer.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

For Belgian law practitioners, the first point of reference regarding insurance law is the Act of 4 April 2014 concerning insurance (the Insurance Act), which contains, among others, provisions on the insurance contract, the obligations of the parties, limitation periods, insurance mediation and distribution, and supervision of insurance companies and insurance intermediaries.

In addition to the Insurance Act, Belgium has a number of relevant specific acts (e.g., for motor vehicle insurance, damage caused by terrorism, and the status and supervision of insurance companies) and countless royal decrees (e.g., for life insurance and fire insurance for simple risks).

Although the law changes constantly, there were no legislative changes regarding insurance disputes that are worth mentioning during the past 12 to 18 months (1 January 2022 to 31 July 2023).

Relevant for the permission of certain insurance products on the Belgian market is the prohibition by the Financial Services and Markets Authority (FSMA) of insurance contracts with variable premiums sold together with multimedia devices. Sellers of multimedia devices often offer insurance contracts covering damage, malfunction, loss or theft of the device. Sometimes, these insurance contracts provide free coverage in the first month or allow monthly premiums to gradually increase for the duration of the contract. To persuade consumers to sign such an insurance contract, sellers often highlight the free coverage in the first month and the possibility of cancelling the contract during that period. However, the FSMA uncovered serious problems with regard to these products and prohibits their commercialisation. The regulation of the FSMA entered into force on 13 November 2022.[10]

Relevant for supervision purposes is the Royal Decree of 18 April 2023 approving the regulation of the FSMA on reporting for the supervision of Insurance Distribution Directive (IDD) rules of conduct and validation of the IDD inventory. The IDD inventory is a periodic report to the FSMA by Belgian insurance companies and branches established in Belgium of foreign insurance companies. It is an instrument used for the supervision of compliance with the rules on insurance distribution. The obligation to file an IDD inventory applies as from 30 September 2023.[11]

Also of note, the Belgian legislature is rewriting the Civil Code. On 1 November 2020, new rules regarding evidence entered into force followed by new rules regarding property law on 1 September 2021. Book 2, Title 3 and Book 4 regarding family estate law and related subjects entered into force on 1 July 2022. Book 1 with general provisions and Book 5 regarding the law of obligations and contract law entered into force on 1 January 2023. On 8 March 2023, a legislative proposition concerning Book 6 on non-contractual liability law was presented, which might have an important impact in the insurance sector as well. For example, the legislative proposition abolishes the traditional exclusion of concurrence of contractual and non-contractual liability.

ii Insurable risk

As a rule, only the consequences of uncertain, future and possible events whose occurrence is beyond the control of the insured are insurable. One of the essential elements of an insurance contract is the insurable interest: the interest of the insured or beneficiary that the uncertain event does not occur.

In theory, almost every risk is insurable. However, a few exceptions exist.

First and foremost, fines and settlements in criminal matters are not insurable.[12] Nevertheless, the person who is legally liable for the perpetrator can conclude an insurance contract covering such fines and settlements unless the insurance relates to road traffic or road transport.

Second, no insurer can be obliged to provide coverage for intentional damage.[13] After all, when damage is induced intentionally, the parties to the insurance contract have not been confronted with any risk, which is one of the key components of insurance.

Third, some legal statutes or codes provide for general exclusions, such as Article 127 of the Insurance Act, which excludes harvest that has not been gathered, cattle living outside a building, soil, crops and forest plantations from natural disaster insurance coverage. However, the insurance contract can deviate from this provision.

Fourth, some insurers might refuse to insure a certain risk because, following a cost–benefit analysis, it proves to be too costly or too risky for the insurer. For example, a health insurer for pets often refuses to cover hereditary diseases. Generally, no insurer covers damage caused by war or similar circumstances.[14] The same applies to the life insurer who, in principle, does not cover suicide or death immediately and directly caused by a crime intentionally committed by the insured as perpetrator or co-perpetrator, if the consequences were foreseeable.[15]

Another distinction can be made between compulsory insurance and non-compulsory insurance. Belgium has introduced compulsory insurance for no fewer than 32 categories of risks.[16]

iii Fora and dispute resolution mechanisms

Insurance disputes are dealt with at various levels. Frequently, the general conditions of the insurance company advise the policyholder to file a complaint with the internal ombudsman service. If this step is unsuccessful, the policyholder often contacts the Insurance Ombudsman, established by the Federal Public Service Economy.[17] The Insurance Ombudsman tries to settle the dispute and to obtain a favourable solution for every party.

Increasingly, parties try to resolve their disputes amicably, not only through the Insurance Ombudsman but also through binding third-party decisions[18] and mediation.[19]

The parties to the insurance contract can also subpoena the other party before regular courts. Which court depends on the amount of the claim, the nature of the claim and the capacity of the parties. If the amount of the claim does not exceed €5,000, the claim can be brought before a justice of the peace.[20]

Generally, claims have to be brought before courts that have special or exclusive competence. For example, claims for damages resulting from a traffic accident have to be brought before a police court, unless the dispute has a purely civil nature.[21] The labour courts are competent for occupational accidents and group insurance (supplementary pensions).[22] If an insurer files a subrogation claim against a tenant, the claim has to be brought before a justice of the peace. In most cases, however, the parties refer insurance disputes to the court of first instance.

If the parties are both enterprises or if the defendant is an enterprise, the claim has to be brought before a commercial court.

The Belgian legislature is not very fond of arbitration in the insurance sector. According to Article 90 Section 1 of the Insurance Act, insurance contracts cannot include an arbitration clause. However, the Royal Decree of 24 December 1992 makes an exception for certain types of insurance.[23]

IV THE INTERNATIONAL ARENA

For matters concerning international and European areas, Belgium and other EU Member States often look to the European Court of Justice for guidance. For example, the Court of Justice ruled on the jurisdiction of Member States to hear a direct claim against an insurer. According to Article 11.1 of Regulation (EU) No. 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, the insurer domiciled in a Member State may be sued (1) in the courts of the Member State in which the insurer is domiciled, (2) in another Member State, in the case of actions brought by the policyholder, the insured or a beneficiary, in the courts of the place where the claimant is domiciled, or (3) if the insurer is a co-insurer, in the courts of the Member State in which proceedings are brought against the leading insurer. This Article also applies to direct actions brought by the injured party against a liability insurer.[24] The Court of Justice had to interpret point (2): does this provision determine not only the international jurisdiction of the courts of a Member State but also the territorial jurisdiction within that Member State?

Some language versions (such as the English version) use the plural 'in the courts'. However, other (and more) language versions (such as the Dutch, French and German versions) use the singular 'in the court'. According to the Court of Justice, the goal of this provision is to appoint a specific judge in a Member State. Therefore, this provision also determines the territorial jurisdiction within the Member State. By appointing the competent 'courts/court', this provision does not allocate jurisdiction to all courts of that Member State. In conclusion, this provision should be read as follows: in the case of actions brought by the policyholder, the insured or a beneficiary, the insurer domiciled in a Member State may be sued in another Member State in the court of the place where the claimant is domiciled.[25]

V OUTLOOK AND CONCLUSIONS

i Busiest areas of claims

It is very difficult to determine the busiest areas of insurance claims in Belgium. Belgium does not have an overview of all the claims referred to the different courts. However, one can investigate all insurance disputes of the highest courts of Belgium, since their judgments are always published. Here it becomes apparent that most disputes involve mandatory liability insurance for motor vehicles. This is very understandable since every person who owns or drives a motor vehicle is obliged to take out liability insurance.

In the past, the same conclusion could be drawn for all complaints filed with the Insurance Ombudsman. However, there has been a shift in the kind of insurance about which policyholders complain the most. Since 2021, the Ombudsman has received an increased amount of complaints linked to fire insurance.

In 2022, 1,611 complaints involved fire insurance (an increase of 21 per cent), 1,163 motor vehicle insurance, 947 life insurance, 821 health insurance, 654 legal expenses insurance and 619 all-risks insurance, such as for mobile phones. The remaining complaints were about various insurance contracts (transport, credit, and complaints not clearly defined (965)), cancellation (489, an increase of 50 per cent), other civil liability insurance (255), assistance insurance (212, an increase of 36 per cent), occupational accidents (81) and individual accidents (55). Compared with complaints in 2020, there has been a clear increase in complaints about fire insurance, especially regarding insurance for natural disasters.

In July 2021, a large part of Belgium suffered from a natural disaster (flood). The Ombudsman was contacted almost daily but has confirmed that the insurance sector handled the claims resulting from the flood well. Of all the claims for damages (almost 75,000), only a few

hundred complaints were submitted to the Ombudsman. These complaints mostly related to the amount of the insurance benefit, refusals from an insurer to provide cover or a lack of either response or information from the insurer or expert investigations.

In 2022, the Ombudsman experienced a 29 per cent increase in the number of queries about the increasingly long management and response times at insurance companies and intermediaries as well as the difficulty or even impossibility of reaching them. Those complaints account for almost one in three queries. According to the Ombudsman, this problem is caused by a workforce shortage in the insurance sector. Furthermore, the digitalisation strengthens and supports the human aspect of the insurance sector, but does not replace it, meaning that not all problems are solved by digitalisation and that some customers still long for a personal touch.[26]

Furthermore, 772 complaints were made regarding the performance of insurance intermediaries, primarily because the customer is surprised by certain exclusions when loss occurs. The digitalisation of the conclusion of insurance contracts causes an increased amount of queries. According to the Ombudsman, some consumers conclude their insurance contract rather quickly, primarily focusing on the premium amount but not on the exclusions or extent of the cover. When the policy is subscribed to online, the analysis of the customer's wants and needs by the intermediary or direct insurer is not always conducted in an optimal way.

ii Areas that are likely to evolve and become more important in the future

First, new or changed legislation always results in new disputes and case law. Two noteworthy examples are the General Data Protection Regulation (GDPR) and the IDD.

Since the entry into force of the GDPR, insurers have had to change their privacy policy.[27] One of the most important changes is the protection against data breaches. Cyberattacks occur increasingly and, as a result, insurance against these is becoming more vital for businesses. One can see more and more insurers introducing these new kinds of policies. Since they are relatively new, they might become a hot topic in the near future. In 2022, the Ombudsman received the first queries regarding cyber insurance products or other insurance products that offer coverage for victims of phishing, spoofing or other digital scams. Apparently, consumers targeted by digital fraud often face exclusions or restrictions they did not expect.[28] The Ombudsman urgers consumers to be well informed about the scope of these types of insurance products.[29]

Furthermore, courts are often confronted with claims concerning life insurance policies without a guaranteed return (known as Branch 23 policies). In the years before the global financial crisis, these insurance policies were promoted by and concluded with the help of insurance intermediaries, which, at the time, were not extensively regulated. The clients for these policies are now starting proceedings because rather recently it became clear that all the money invested in these policies is now lost. The clients often claim in these proceedings that the insurance intermediaries or the insurer withheld information and had the clients received that information they would have invested in another product.

Obviously, the European and Belgian legislatures have now started to regulate the distribution activities of insurance companies and intermediaries, and clients are increasingly aware of the behaviour that the insurance companies and intermediaries have to adopt.

One of the most recent pieces of European legislation is the IDD. This instrument is relevant not only for compliance officers but also for clients, who can now expect certain behaviour on the part of their contracting parties. Recently, the FSMA published a ***vade mecum*** on product oversight and governance (POG) regarding insurance, containing various recommendations and expectations regarding POG requirements for the themes 'value for money' and 'exclusions'.[30] Furthermore, reference can be made to the inventory of IDD activities described above.[31] Moreover, on 7 December 2022, the FSMA published a newsletter on client demands and needs, explaining this requirement in a series of FAQs.[32]

In the context of evolving areas, a general awareness of global problems, such as climate change, can result in new insurance policies. Currently, the insurance sector is reluctant to provide coverage for weather disasters because of high costs and risks; for example, in the agricultural sector, the renewable energy sector, the transport sector or the tourism sector. However, these kinds of insurance policies are becoming more essential than ever. Reliance on the Belgian Agricultural Disaster Fund might not be sufficient. Therefore, the Belgian government has promoted insurance for weather disasters since the autumn of 2017 and together with several agricultural organisations continues to negotiate in favour of affordable premiums.[33] For example, the Decree of 5 April 2019 of the Flemish Region further simplifies administrative procedures, updates the reimbursement process and introduces an aid scheme for farmers who have concluded a comprehensive weather insurance contract.[34]

Following the massive flood in July 2021 and storms Eunice and Franklin in February 2022, it has become clear that the insurance sector, together with the government, is eager to help victims. Coverage for natural disasters will probably increase in the coming years because of the effects of climate change. Furthermore, the Ombudsman has received an increasing number of queries from consumers who live in areas with a high risk of flooding and fail to find a fire insurer. The Ombudsman refers to the Rating Office for risks that are difficult to insure and reiterates that nothing prevents an insurer from offering a general coverage with exclusions for certain risks. The professional association of insurance companies (Assuralia) has had frequent discussions with the Belgian government regarding a solution where every citizen can get insurance for natural disasters at an affordable price. According to Assuralia, the legal framework for fire insurance for simple risks should include a provision that victims will be compensated through a public-private partnership, referring to a partnership between insurers and local, national and European government. Assuralia also states that an effective prevention policy deserves the necessary attention.[35]

Probably in part related to climate change and sustainable commuting is the 40 per cent increase of bicycle insurance in 2022. A range of bicycle insurance products can be found on the Belgian market. The growing importance of these kinds of products cannot be ignored.[36]

In addition, technological and scientific progress sparks new insurance policies. As mentioned above, the first cyber insurance policy was concluded in 2010.[37] Vanbreda Risk & Benefits, a Belgian independent insurance broker and risk consultant, predicted that drone insurance would become common in 2020 and that the first insurance policy for robotics and automated guided vehicles will appear in 2030.[38]

Furthermore, the covid-19 pandemic has led to an increase in exclusions in life and non-life insurance contracts that did not already contain a general exclusion for pandemics, as well as an increase in claims. Some discussions might arise regarding the question whether an insurance policy covers pandemics, such as business interruption policies. The covid-19 pandemic might cause financial problems for the whole economy, resulting in many claims in trade credit insurance policies, covering businesses against debts that cannot be paid by their customers or suppliers.[39] This might eventually lead to increased premiums or financial difficulties for the whole economy, or both. The insurance sector has taken measures to combat the economic consequences of covid-19; for example, regarding fire insurance, outstanding-balance life insurance and group insurance of employers whose employees are temporarily unemployed.[40]

Insurance law is an ongoing process of trial and error and a constant interaction between the legislature, the judiciary and the executive. When new legislation is published, case law will evolve. When case law evolves, legislation has to be changed. When certain insurance problems receive media attention, both case law and legislation are to an extent forced into taking a certain direction. Therefore, it is fairly possible that new topics will arise in the future and we, as law practitioners, look forward to any evolution of insurance law.

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Chapter 3

Brazil

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Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

Considering its continental dimensions and its almost 212 million inhabitants, Brazil is the second-largest insurance market in Latin America and one of the largest in the world. The Brazilian insurance market includes 122 general insurers (life and non-life) and 133 reinsurers, which are responsible for 170,000 direct jobs in Brazil and hold risk guarantees in excess of 1.2 trillion reais.

In 2022, the sector saw growth of 16.2 per cent over the previous year, a result positively influenced by the low claims of that year. The annual revenue totalled 172.1 billion reais. The indemnities, benefits, redemptions and prize-draw sector totalled 450.5 billion reais, with an increase of 13.1 per cent over 2021, which is, therefore, higher than the premiums collected.

Local insurers are subject to specific legal requirements, which are defined based on aspects of the organisational structure of the project, the group and its operational qualifications. The National Council of Private Insurance (CNSP) and the Superintendence of Private Insurance (SUSEP) are the government agencies responsible for: (1) the adoption of rules for standardisation and control of the Brazilian market for products and agents; (2) ensuring that companies have liquidity and solvency in the market; (3) monitoring and conducting routine inspections and disciplinary procedures; and (4) ensuring balance in consumer relations, especially in the mass-marketing of products.

II YEAR IN REVIEW

In 2022, in a non-unanimous decision, the justices of the Third Chamber[2] of the Superior Court of Justice found that 'the statute of limitations only begins from the insured obtaining knowledge of the denial of insurance coverage'.

This finding conflicts with Precedent No. 229 of the Superior Court of Justice, issued by the Second Chamber[3] on 8 September 1999 to consolidate the findings from the 10 precedents issued by the Superior Court of Justice between 1991 and 1999 regarding the statute of limitations in cases of submission of claims to insurers. To reach this new conclusion, the Chamber established that:

> *for this conceptual evolution, it was necessary to take into account the new legal concept of statute of limitations, tied to the idea of extinction of the claim,[4] as well as the new criterion for the initial term of the statute of limitations of the insured, fixed according to the generating fact.[5]*

The Chamber reviewed the long-established position on the grounds that Precedent No. 229 of the Superior Court of Justice would have been established under the previous legislation (in this case, the Civil Code of 1916), which, contrary to the current legislation (the Civil Code of 2002) would not have contemplated 'the theory of ***actio nata***, according to which the statute of limitations begins at the exact moment of the onset of the claim'.

In view of this, on the basis of the supposed misunderstanding regarding the interpretation of the Civil Code of 2002, the Third Chamber agreed to alter the understanding prevalent in the 20 years of the legislation, concluding that 'with the occurrence of the claim, the insured is attributed the right to indemnity – the credit – but still devoid of chargeability', and also that:

> *Pursuant to Paragraph (b), Item II, Section 1, Article 206 of the Civil Code of 2002, as a rule, it is the insured's knowledge regarding the denial of insurance coverage by the insurer that represents the 'generating fact of the claim' and, therefore, the statute of limitations must begin from this moment on.*

The dissenting vote considered that (with the exception of optional civil liability insurance[6]) 'the rule to be addressed is that of Article 206, Section 1, II(b), of the Civil Code, which establishes the statute of limitations for other types of insurance (insurance in general)', a legal provision that 'provides for the date of the knowledge of the event that generates that claim as the initial milestone of the statute of limitations of the claim of the insured against the insurer'.

It also stated that 'if the [fact generating the] claim has occurred and the insured is aware of the claim, the insured may request payment of the insurance indemnity from the insurer', and that 'in this scenario, a claim already exists sufficient to require contractual compliance from the insured within the term, and the insured may choose to file an administrative request or file a legal action'. Furthermore, it was concluded that 'from the knowledge of the claim (the generating fact of the claim), the insured has one year to request the contractual compliance of the insurer, whether administratively or judicially', thus the insured cannot 'prolong the period of the claim notice, since it must observe the statute of limitations from the knowledge of the claim'.

To adapt the judicial findings to the reasonable scenario in which an extension of the submission period of the claim notice is avoided, the dissenting vote proposed that:

> *. . . in insurance in general, the insured has one year to file the claim against the insurer, requesting contractual compliance, administratively or judicially, from the date of knowledge of the claim. The denial of the insurer gives rise to a new claim and the insured has one year from the knowledge of that denial to file an action challenging the denial.*

However, as a dissenting vote, it was not accepted by the Court.

Finally, because the ruling in question altered the understanding of the Civil Code of 2002 that had been prevalent for the past 20 years, the winning vote proposed that the 'viability' of Precedent No. 229 of the Superior Court of Justice 'in light of the Civil Code of 2002' should be 'discussed, within the framework of the Second Chamber, in another concrete supervening case'.

In view of the legal uncertainty or gap that may remain until the issue is dealt with effectively by the Second Chamber, it is worth noting the definition of 'precedent' on the Superior Court of Justice website:

> *The precedents are the summary of consolidated findings from the Court's judgments and serve as guidance to the entire legal community on the case law of the Supreme Court, which has the constitutional mission of unifying the interpretation of federal laws.*[7]

As exemplified above, after consolidating the findings from several rulings, the Superior Court of Justice publishes precedents (as do the other Brazilian courts) by way of a summary and to provide guidance for the entire legal community.

Thus, precedents have the purpose of ensuring legal certainty and maintaining uniform, stable, intact and coherent case law, in accordance with Article 926 of the Brazilian Code of Civil Procedure:

> *Art. 926. The courts must standardise their case law and keep it stable, intact and consistent.*
>
> *§ 1 The courts shall publish precedents corresponding to their majority opinions, in the manner established and in accordance with the assumptions set out in the internal regulations.*
>
> *§ 2 When publishing case law, the courts must keep to the factual circumstances of the precedents that motivated their creation.*

In view of the need to guarantee legal certainty, the matter in the precedent should override isolated rulings until, as noted above, the issue of the viability of Precedent No. 229 is dealt with effectively by the Second Chamber of the Superior Court of Justice. Only the Supreme Federal Court has jurisdiction to revise binding precedents[8] and the idea that a ruling can be considered binding on other courts without express and specific legal provision to this effect would create widespread legal uncertainty, disrupting the system of precedents and violating the Brazilian Code of Civil Procedure of 2015.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The insurance sector in Brazil is a highly regulated environment, governed by the laws that make up the Brazilian legal system and regulate insurance contracts, and by regulations periodically issued by the CNSP and SUSEP in the form of resolutions and circulars respectively (and in addition to the aforementioned legal system).

In Brazil, there is no one specific law for insurance contracts and, therefore, they are governed by the Commercial Code[9] (for marine insurance), Decree-Law No. 73,[10] the Civil Code of 2002[11] and the Consumer Protection Code,[12] with the latter specifically governing products the marketing of which falls within the scope of consumer relations.

Decree-Law No. 73/1966 created the National Private Insurance System, composed of the CNSP, SUSEP, reinsurers, companies authorised to operate in private insurance, and duly qualified brokers. It also provided the basic rules for the development of the insurance market.

The Civil Code of 2002 has a chapter entirely dedicated to insurance contracts,[13] with well-defined provisions and principles for the relationships involving insurance law. Notable among these are the principle of good faith, which is provided for in Article 765 and must be observed by the parties during the execution of the insurance contract, and the principle of predetermination of risks, provided for in Article 757, which states that 'by means of the insurance contract, the insurer undertakes, upon payment of the premiums, to ensure the legitimate interest of the insured, related to the person or thing, against predetermined risks'. In addition, the insured has the duty to disclose to the insurer any and all relevant information during the negotiation phase of the insurance contract, for the correct pricing of the premiums and analysis of the risk; and the duty, throughout the term of the contract, to communicate to the insurer all the facts that aggravate – or have the potential to aggravate – the risk originally assumed, under penalty of loss of the right to the indemnity, in compliance with the rules and deadlines stipulated in the contract by the insurer and governing the termination of the contract.

In the context of mass-market insurance in particular, Brazilian courts understand that the technical, economic and legal vulnerability of the insured means that the latter does not have specific knowledge to determine what information is important during the contracting, or what can constitute an increase in the risk, so the courts tend to adopt a 'pro-insured' position in their decision-making.

In this regard, any dubious, obscure or contradictory provisions are normally interpreted in favour of the insured, thereby applying a pro-adherent interpretation to the insurance relationship (i.e., as the contractual provisions are, more often than not, drawn up unilaterally by the insurer, any dubiety, obscurities or contradictions must be resolved in favour of the insured in the event of dispute).[14]

These interventions by the judiciary result in constant updates of (1) the wording of the policies marketed in Brazil, and (2) the rules issued by the competent regulatory agencies, to clarify the issues most frequently discussed in the courts.

The tendency of the courts to favour pro-insured solutions can be mitigated by demonstrating that the insured is not a vulnerable party either in relation to the insurer (e.g., because of the size of the company or because expert advisers were used when contracting and executing the contract) or in relation to provisions inserted in the policy as a result of negotiations between the parties (commonly referred to as 'particular conditions').

ii Insurable risk

In Brazil, the contracting of certain lines of insurance, especially civil liability, is mandatory and the subject of express legal provision, as provided for in Article 20 of Decree-Law No. 73/1966. However, obligations of this kind need to be expressly provided for in legislation and a mandatory requirement for insurance is an exception.

As previously discussed, pursuant to Article 757 of the Civil Code of 2002, the subject matter of the insurance contract is the insured interest. As in other jurisdictions, insurable interest is defined in Brazil as 'the lawful relationship between the insured or beneficiary and an asset or a person who is subject to a risk determined in the insurance contract'.[15] In this regard, Brazilian law expressly states that the insurable interest must be lawful (i.e., it must be in accordance with the legal system) and it must be subject to a risk. Thus, if the contract is intended to cover a risk arising from an intentional act of the insured, the beneficiary or the insured's or beneficiary's representative, it will be null and void.[16]

Furthermore, in Brazil, the 'indemnity principle' is adopted, in the sense that the indemnification cannot exceed the amount of the insured interest at the time of the occurrence of the claim, and it cannot exceed the maximum limit of the guarantee fixed in the policy, except in cases of the insurer's late payment.[17] In contrast, the risk will include all the losses resulting or arising therefrom, such as the costs of any damage resulting from attempts to prevent the occurrence of the insured risk or to reduce the damage, or save the thing; however, sub-limits applicable to these expenses are permitted.[18]

With regard to the regulation of insurable risk, despite legislation prohibiting coverage for illicit purposes, SUSEP allows general civil liability insurance and allows coverage for civil and administrative penalties to which policyholders in general could be subject (such as directors, officers and employees with managerial functions – namely directors' and officers' liability insurance).

In Brazil, the risk should be a future risk, but the commercialisation of claims-made policies (with or without a notification clause) and the contracting of retroactive periods by the policyholders or insured are, in fact, permitted.

The Brazilian courts apply the maximum limits for deductibles and for liability (except when non-contractual losses arise, such as for a loss-adjustment procedure proven to have been conducted in bad faith by the insurer). In any case, Brazilian law does not allow punitive or exemplary damages.

iii Jurisdiction and dispute resolution mechanisms

Disputes regarding insurance in Brazil are heard by judicial or arbitral courts.

Judicial courts are divided into federal and state courts in accordance with the applicable jurisdiction. The federal courts have jurisdiction to settle cases involving the federal government, governmental companies or public entities, and the state courts hear all other cases that do not fall within the jurisdiction of the federal courts.

The Brazilian judicial system has, as a rule, two instances where the technical-probative issues of a dispute are examined: at first instance, disputes are examined by a single judge and, at second instance, appeals against decisions issued at first instance are analysed by collegiate bodies. Judges and collegiate bodies are obliged to provide grounds for their reasoning and to assess all the points raised in the dispute before them.

Appeals against second instance decisions may be brought before the Superior Court of Justice or the Supreme Federal Court, as defined by the Constitution. Thus, if the decision issued by the second instance violates a provision of federal law or is contrary to the decision given by another court (i.e., when there is a jurisprudential disagreement), it may be questioned by means of a special appeal to the Superior Court of Justice; violations of the Constitution may be the subject of an extraordinary appeal to the Supreme Federal Court.

In summary, therefore, the Superior Court of Justice is restricted to assessing questions of law in appeals against decisions of second instance courts that have violated federal law or have given the federal law a different interpretation from that of another second instance court. The Supreme Federal Court usually decides appeals against decisions of second instance courts that have violated the Constitution. The admissibility of these types of appeals is quite restricted for both higher courts.

In addition, arbitration has been adopted in Brazil and is increasingly seen as a feasible method of alternative dispute resolution in the context of insurance contracts. Recent decisions in the Brazilian courts have supported the binding nature of arbitral awards, offering a safe and favourable environment for their adoption. National arbitral awards are considered final and binding on the parties, and do not require recognition or confirmation by a court to be enforced immediately by the parties.

The Superior Court of Justice has established that the deadline for filing disputes is one year from the date the insured is informed of the denial of the claim, in whole or in part, by the insurer. The insured may obtain knowledge of this unfavourable decision through, for example, notification of the insurer's denial of coverage or through the insurer's payment of the indemnity in an amount lower than the amount claimed.[19] This limitation period may be interrupted by, among other things, a 'challenge that interrupts the statute of limitations'.

In Brazil, unlike in other jurisdictions, there is no stipulated deadline for the submission of a claim notice. Article 771 of the Civil Code of 2002 merely establishes that the insured must, under penalty of losing the right to indemnification, communicate the claim to the insurer, 'as soon as they become aware of the claim', and should take immediate steps to mitigate any consequences of the insured risk. When a delay in the notification of the claim is unjustified or in bad faith, or even when the delay results in a concrete loss to the insurer, the claim may be considered untimely – leading to the loss of the right to indemnification.

IV THE INTERNATIONAL ARENA

i Application of foreign law to insurance disputes in Brazil

Because IRB Brasil RE[20] had a monopoly in the Brazilian reinsurance market until 2007, the Brazilian legal and regulatory system is still very restricted and there are still numerous constraints on contracting insurance abroad, which ultimately reduces the chances of any disputes regarding the application of foreign law in insurance disputes that occur in Brazil, as insurance policies issued locally are governed by Brazilian law.

Pursuant to Article 19 of Complementary Law No. 126/2007, the following will generally be contracted exclusively in Brazil:[21] mandatory insurance; and non-mandatory insurance contracted by natural persons residing in the country or by legal entities domiciled in the national territory to guarantee risks in the country. Therefore, as a rule, mandatory and optional insurance for risks located in Brazil (contracted by people domiciled in the country) must be insured by local insurers.

There is a view that, in very exceptional situations, a global insurance contract could be subject to foreign law, even if the risk is located in Brazil, provided that the contracting party is not domiciled in the country. However, the most cautious approach assumes that, for insurance contracts in general, the place of risk determines the applicable rule of public order, and the fact that the rule of public order is so central to Brazil's legal system would prevent the application of foreign law in Brazil.

If Bill No. 29/2017[22] is enacted, the insurance market will be governed by a new law requiring the application of Brazilian law to all contracts (including, but not limited to, reinsurance contracts) and disputes (in the judicial system and arbitration tribunals) related to insurance contracted in Brazil. This Bill is currently pending in the National Congress.

ii Enforcement of foreign arbitral awards

Partial or provisional arbitral awards issued by arbitrators outside the Brazilian jurisdiction are enforceable in Brazilian courts.

In accordance with Article 35 of Law 9,307/96, to be recognised or executed in Brazil, a foreign arbitral award is subject only to approval by the Superior Court of Justice.

The ratification of the award should be requested by the interested party and the request must be submitted with the original arbitral award or a copy certified by the Brazilian consulate accompanied by a sworn translation, and with the original arbitration agreement or a certified copy accompanied by a sworn translation.[23]

The Superior Court of Justice may refuse to ratify the award only when the defendant demonstrates that: (1) the parties executing the award were incompetent; (2) the arbitration agreement was not valid in accordance with the law to which the parties submitted it or, in the absence of an indication of the applicable law, by virtue of the law of the country where the arbitral award was issued; (3) the appointment of the arbitrator or the arbitration procedure was not notified, or there was a contravention of the adversarial proceedings; (4) the arbitral award was issued outside the limits of the applicable arbitration agreement; (5) the commencement of the arbitration was not in accordance with the arbitration agreement or the arbitration clause; or (6) the arbitral award is not yet binding on the parties or has been annulled or suspended by a judicial body of the country where it was issued.

Furthermore, the ratification can also be refused if the Superior Court of Justice verifies that, according to Brazilian law, the subject matter of the dispute is not capable of being resolved by arbitration or the foreign arbitral award offends against Brazilian public order.[24]

In this regard, the summons carried out in the arbitration agreement or the procedural law of the country where the arbitration took place is not considered an offence against national public policy, provided that the Brazilian party is granted enough time to exercise its right to a defence. The Superior Court of Justice has already stated that it does not consider the fact that the arbitral award establishes the value of the conviction in foreign currency to be an offence against public order, and the appropriate conversion to the national currency should be carried out for the realisation of payment in Brazil.

Furthermore, if the ratification of the foreign arbitral award is refused because of formal defects, the interested party may renew the request when the defect in question has been resolved.[25]

Finally, in the process of ratification of a foreign ruling, there is no analysis of either the merits nor possible injustice of the decision and, therefore, the Superior Court of Justice will examine only the formal requirements provided for in Brazilian law.

V OUTLOOK AND CONCLUSIONS

i Public Procurement Law

Notable among innovations introduced by the new Public Procurement Law[26] is the change regarding contracts considered to be of great value (contracts with a value greater than 200 million reais), in which 'the provision of a guarantee may be required, as surety, with a resumption clause provided for in Article 102 of this Law, in a percentage equivalent to up to 30 per cent of the initial value of the contract'.

With the formal introduction of the resumption clause in this legislative reform, the insurer, in addition to appearing as a consenting intervening party in the guaranteed contract and having the power or duty to closely monitor the execution or supervision of the contract, should, in the event of occurrence of a claim, execute and complete the subject of the contract (i.e., 'step in') or pay the full insured amount indicated in the policy, if it does not intend to undertake the execution of the guaranteed contract.

Since this is a recent measure, the market is still adapting to this new step-in mechanism, given the need to update affected products and improve the insurers' teams to enable the monitoring, supervision or execution of the subject of the guaranteed contract.

ii Brazilian General Data Protection Law

With the entry into force of the Brazilian General Data Protection Law (LGPD)[27] after the ***vacatio legis*** period, coupled with the growing number of cyberattacks on companies in all sectors of the Brazilian economy, the interest in cyber risk insurance is growing exponentially. The LGPD establishes important and mandatory guidelines for the collection, processing and storage of personal data. It was inspired by the EU General Data Protection Regulation, which entered into force in 2018 with a significant impact for both businesses and consumers.

The legislation is based on several values and has as its main purposes: (1) to ensure the right to privacy and protection of users' personal data; (2) to provide clear rules on the processing of personal data; and (3) to strengthen the security of legal relations and the owners' trust in the processing of their personal data.

While still in the process of consolidation in the country, cyber insurance has seen an increase in demand of almost 22.8 per cent in 2022 compared with 2021, largely because of the LGPD and large data leaks, such as the one that occurred in January 2021, exposing Individual Taxpayer Registry-related data for almost the entire Brazilian population.

In 2022, premium collection amounted to 355.96 billion reais; however, the number of claims also increased, with indemnities accounting for 219.4 billion reais, 61 per cent of premium collection.

iii Regulatory efforts

Although the number of premiums in Brazil is significant, the number of insurance policies sold and the volume of premiums earned remain low, so SUSEP has taken active measures to increase acceptance and uptake in the sector, and facilitate the entry of new participants.

The economic and administrative reforms initiated by the government previously (the economic stabilisation plan, deregulation process, opening of markets to foreign insurers, and privatisation programmes) have had a significant impact on the insurance market and, in this context, SUSEP, the CVM and the Central Bank have also begun a programme of financial data sharing and the adoption of 'open insurance', linked to the establishment of rules for a regulatory sandbox (an experimental environment), and we are also seeing the relaxation of the rules for the preparation of contractual conditions for products aimed at major risks and non-vulnerable insureds.

iv Law Project 29/2017

In March 2023, the plenary of the Federal Senate shelved Bill 29/2017 (PL 29/2017), which aims to regulate the private insurance sector in the country through a General Insurance Law in Brazil, repealing the current provisions of the Civil Code that regulate the matter, in particular Articles 757 to 802, with effects for policyholders, brokers, insurers and regulatory bodies.

The continuation of this Bill, which has been in the National Congress since 2004, is the subject of special attention from the market as it deals with the regulation of the sector, its deadlines, time-bar limitation, specific conduct for individual and collective insurance, as well as the duties and responsibilities of policyholders and insurers.

As the Bill has already been approved in the Federal Chamber, if it is approved without amendments in the Federal Senate, it will go to the President of the Republic for direct sanction. If sanctioned, the law will come into force one year after its official publication.

Bill 29/2017 has been strongly criticised by the industry for being considered outdated and contradicting case law from the Superior Court of Justice, as well as resolutions and normative acts from SUSEP and CNSP, to the detriment of legal certainty and recent innovations introduced by the regulatory body, such as the regulatory sandbox.

Among the various criticisms of the Bill, it is possible to point out, for example, that Bill 29/2017 (1) does not differentiate between mass insurance and large risk insurance, contrary to the recent CNSP Resolution No. 407/2021; (2) requires the insured to share all

documents produced in the settlement of claims, contrary to the Superior Court of Justice's understanding on the subject and violating professional secrecy between regulators, lawyers and clients; and (3) provides that insurers will be bound in court to the same grounds set out in their administrative position, contrary to the constitutional principle of ample defence.

In short, there is a majority understanding in the sector that Bill 29/2017 is outdated, excessively interventionist and unbalanced, preventing the Brazilian market from keeping up with innovations in the international market, increasing regulatory costs and driving away new investors.

The sector is following the progress of this Bill with attention and concern.

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Endnotes

1 Bruno Melo, Dennys Zimmermann, Felipe Reis, Felipe Rosa and Nicole Priuli are partners and Fábio Tolmasquim is a senior associate at RPZ Advogados.
2 The chambers and panels of the Superior Court of Justice work in three fields of specialisation defined by subject. Within each specialisation, the chambers issue judgments on security warrants, complaints and conflicts of jurisdiction. They are also responsible for judging repeat appeals. Each chamber brings together justices from two panels, who are also specialists. The chambers are composed of 10 members, and the panels of five members each. Both are presided over by the oldest justice, for a period of two years, with no option for a return to office until all members have held office. (https://international.stj.jus.br/en/About-the-STJ/Structure-and-Judging-Organs).
3 See footnote 2.
4 Article 189 of the Civil Code of 2002.
5 Article 206, Section 1, II(b) of the Civil Code of 2002.
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17 Article 783 of the Civil Code of 2002.
18 Article 779 of the Civil Code of 2002.
19 Precedent No. 229 of the Superior Court of Justice re Article 206, Section 1, II(a) and (b) of the Civil Code of 2002.
20 Formerly the Reinsurance Institute of Brazil.
21 Exceptions are provided in Article 20 of Complementary Law No. 126/2007.
22 Bill No. 29/2017 provides for private insurance rules, revokes provisions of the Civil Code of 2002 and contains other provisions.
23 Law No. 9,307/96, Article 37.
24 Law No. 9,307/96, Article 39.
25 Law No. 9,307/96, Article 40.
26 Law No. 14,133/2021.
27 Law No. 13,709/18.

Chapter 4

China

Harrison (Hui) Jia, Fu Ranran and Zhang Youran[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

In recent years, China's insurance market has continued to develop and expand. Although the insurance industry suffered certain impacts and losses due to the covid-19 pandemic which began in 2020, the insurance industry has played an increasingly important role as a social stabiliser and economic shock absorber in the post-pandemic era. In 2022, China achieved growth in insurance premium income against the prevailing trend and ranked second in the world. However, with the rapid development of the insurance market in China, the number of insurance dispute cases is also on the rise. Insurance-related litigation cases have been one of the largest categories of civil and commercial cases heard by the courts at all levels in China, and the number of insurance arbitration cases accepted by the arbitration institutions has also been increasing year on year.

II YEAR IN REVIEW

The courts in China have recently dealt with many significant issues relating to insurance, including jurisdiction over liability insurance contracts, general average in marine insurance contracts and the recognition of the insured person in insurance subrogation, etc. Such cases are instructive for dealing with similar insurance disputes.

i Jurisdiction of liability insurance contract

In a number of employer's liability cases,[2] the Supreme People's Court of PRC (the Supreme Court) maintained its consistent opinions on whether the place of residence of the insured shall be regarded as the place of jurisdiction of the employer's liability insurance. The Supreme Court held that the subject matter of insurance refers to the subject matter of the insurance contract between the insured and the insurer, such as property, personal health, and life. The liability insurance contract involved in an employer's liability insurance case refers to the liability for property compensation in the event of death or injury of an employee of the insured. Although the liability for property compensation is intangible, the subject that assumes the liability for property compensation is specific, and the form in which the subject assumes the liability for property compensation and pays for compensation is specific as well. The domicile of the insured may be determined as the location of the subject matter of insurance. Meanwhile, if the domicile of the insured is considered as the location of the subject matter of insurance in the liability insurance contract, it will be convenient for the court to investigate the facts and for the parties to participate in the litigation.

ii The establishment or adjustment of the general average and the contribution to the general average

In a marine insurance contract dispute between a Shanghai marine transport company and a property insurance company,[3] the Supreme Court ruled on the calculation and contribution of the general average: the carrier and the insurance company entered into a marine insurance contract and agreed on the terms that the coverage scope is the apportioned part of the general average, salvage and salvage expenses, which is legitimate and valid. If the insured vessel, cargo, etc. encounter common danger during the carriage by sea, and the carrier employs other persons to render salvage services to the vessel, cargo, etc., for the common safety, the compensation shall be the general average, different from the contractual provisions on salvage and salvage expenses. Therefore, the insurance company shall pay for the ship's apportioned share of the salvage remuneration after adjustment for the general average.

iii If the affiliated companies of the insured do not constitute the members of the insured as provided in Article 62 of the Insurance Law, the insurer may exercise the subrogation right against the affiliated companies in accordance with the law

The interpretation of Article 62 of the Insurance Law, which states that 'the insurer may not exercise the subrogation right against the family members or employees of the insured' has always been controversial in legal theory and practice. The purpose this provision is to prevent the insured from being unable to actually obtain compensation due to the insurer's exercise of its right of subrogation. Therefore, the identity in terms of economic interests between the insured and the counterpart of the insurer's subrogation right shall be the basis for determining the specific scope of 'members of the insured'.

In a case involving a subrogation dispute between a Qingdao company and the insurer of a property insurance subsidiary,[4] the plaintiff and the defendant disputed the definition of 'member of the insured'. The court held that, as an affiliated company of the insured, the Qingdao company does not share the same economic interests with the insured, nor does it have any dependency in terms of legal personality with the insured. Therefore, the Qingdao company does not constitute the 'member of the insured' as stipulated in Article 62 of the Insurance Law, and the insurer may exercise the subrogation rights against the Qingdao company after indemnifying the insurance benefits to the insured in accordance with the law.

iv Whether the application for preservation is wrong cannot be judged simply by whether the claim of a petitioner for preservation was supported

In judging whether there is a mistake in an application for preservation, support for the litigation request of the applicant for preservation should not be taken as the sole standard. A comprehensive judgment should be based on the specific circumstances of the case; for example, whether the applicant has intent or is negligent, whether the object of preservation is wrong, or any other factors.

In *Yixing Building Engineering & Installation Co, Ltd v. Zhang Xin and Zhang Xueshan*, the Supreme People's Court held that, because the parties had different legal knowledge, different capability to prove the facts of the case, and different capability to analyse and judge legal relations – that is, they generally had no professional capacity as required for judicial adjudication – their judgement about the issues, rights and obligations might not be the same as the adjudicative results of the court. The due care of a party when petitioning for preservation should not be too harsh. If whether the claim of a petitioner for preservation was supported was the only basis on which to decide whether a petition for preservation was erroneous, the parties in good faith would inevitably be obstructed from defending their rights through the litigation preservation procedure according to the law. The functions of the litigation preservation system would therefore be adversely affected.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

In China, the substantive issues of insurance disputes are mainly governed by the following laws and rules: the Insurance Law of the People's Republic of China (as amended in 2015) (the Insurance Law) and its related Interpretations promulgated by the Supreme People's Court (the Interpretations of the Insurance Law); and the Civil Code of the People's Republic of China and its related Interpretations promulgated by the Supreme Court. Procedural issues are governed by the Civil Procedural Law of the People's Republic of China (as amended in 2017) and its related interpretations promulgated by the Supreme Court.

To support the implementation of the Insurance Law, the Supreme Court successively promulgated four judicial interpretations of the Insurance Law. The first interpretation is aimed at solving the issue of transition from the old Insurance Law to the new Insurance Law amended in 2009; the second interpretation is aimed at solving the problem of application of the rules on general provisions of insurance contracts; the third interpretation is aimed

at solving the issue of application of the rules on personal insurance contracts; and the fourth interpretation is aimed at solving the issues of application of the rules on property insurance contracts.

ii Insurable risks

Insurable risks versus uninsurable risks

In China, there is no clear legal definition of 'insurable risks' and 'uninsurable risks'. Generally, risks that are pure, contingent, unexpected, and have the potential for material loss for a large number of subjects and the loss can be measured, are insurable risks. On the other hand, risks that are speculative and certain, that result from intentional acts or failure to take reasonable precautions, or that will involve loss for only one or a small number of subject matters and the loss cannot be measured in monetary terms, are uninsurable risks.

However, the distinction between insurable risks and uninsurable risks is not absolute. In recent years, the scope of insurable risks has been expanding. For example, due to the impact of covid-19, some insurance companies have extended their existing insurance coverage for the coronavirus, and cancelled the waiting periods, deductibles, designated hospitals, and other restrictions, while introducing special types of insurance, such as isolation insurance, new coronavirus insurance, and resumption of work and production insurance. Similarly, with the growing capital of insurance companies, the continuous emergence of new insurance technology, and the expansion of reinsurance market, catastrophes such as earthquakes and floods, which were originally uninsurable, have been included in the insurance coverage of some insurance companies.

Insurable interests

'Insurable interests' refers to the legally recognised interests of an insurance applicant or the insured party in the subject matter of the insurance. Article 12 of the Insurance Law provides that an insurance applicant of a personal insurance shall have insurable interests in the insured party at the time of the conclusion of the insurance contract. An insured party in a property insurance contract shall, at the time of occurrence of an insured event, have insurance interests in the subject matter of insurance.

An overseas-based insurer or reinsurer that has not completed the registration process within China cannot write business directly in China. However, a foreign insurance company could write reinsurance of a Chinese domestic insurer. According to Article 19 and Article 21 of the Administrative Provisions on the Reinsurance Business (2021), except for aviation and spaceflight insurance, nuclear insurance, oil insurance and credit insurance, where a direct insurance company cedes out a direct insurance business for property insurance by means of proportional reinsurance, for each risk unit, the total proportion ceded by it to the same reinsurer shall not exceed 80 per cent of the insured amount or the limit of liability under the direct insurance contract undertaken by the cedant. In case of any disputes, the insured shall seek dispute resolution with the insurer in accordance with the insurance contract but not with the overseas-based insurer or reinsurer directly.

iii Fora and dispute resolution mechanisms

In China, the dispute resolution mechanisms for insurance disputes mainly include litigation, mediation, and arbitration.

In terms of the fora, according to Article 25 of the Civil Procedure Law of the People's Republic of China, a lawsuit brought on an insurance contract dispute shall be under the jurisdiction of the People's Court of the place where the defendant has their domicile or where the insurance object is located. According to Article 21 of the Interpretation of the Supreme People's Court on the Application of the Civil Procedure Law of the People's Republic of China (amended in 2022), for a lawsuit brought on a property insurance contract dispute, if the insurance object is a transport vehicle or goods in transit, the lawsuit may be under the jurisdiction of

the People's Court of the place where the transport vehicle is registered, the destination of transportation, or the place where the insurance accident occurs. For a lawsuit brought on a life insurance contract dispute, the lawsuit may be under the jurisdiction of the People's Court of the place where the insured is domiciled.

To facilitate the efficiency and the professionalism of the court, some provinces in China exercise a 'concentrated jurisdiction system', which designates all cases of a particular kind to be tried in a particular court. For instance, the Beijing Financial Court was established in March 2021. As declared by the Supreme People's Court, the Beijing Financial Court has jurisdiction over the first-instance trials of all financial civil and commercial cases related to insurance.

Arbitration is an important and popular form of insurance dispute resolution in China. In respect of arbitration cases, the applicable laws and rules include the Arbitration Law of the People's Republic of China (as amended in 2017) and the Interpretations of Supreme People's Court on the Application of the Arbitration Law of the People's Republic of China (as amended in 2008). Many cases concerning the validity of arbitration clauses in insurance-related disputes are about insurance subrogation claims, namely, whether an arbitration agreement reached between the insured and a third party before the insured event is binding on the insurer exercising the right of subrogation.

Alternative dispute resolution (ADR) is encouraged in China. According to the Civil Procedure Law (amended in 2017), there are generally two types of ADR: mediation and arbitration. ADR is highly encouraged and has developed rapidly in the field of insurance dispute resolution. Since 2012, the Supreme Court has been working with the China Banking and Insurance Regulatory Commission to explore the application of ADR in insurance dispute resolution. In 2016, the Supreme Court and the former China Insurance Regulatory Commission jointly issued the Opinions on Comprehensively Promoting the Interconnection System between Litigation and Mediation of Insurance Disputes to establish China's diversified dispute resolution mechanism for insurance disputes. Many ADR organisations, such as the International Commercial Mediation Center for the Belt & Road have emerged and developed rapidly. In practice, the diversified dispute resolution, which is a combination of arbitration and mediation, has become increasingly important.

In respect of the choice of law, according to Article 41 of the Law of the Application of Law for Foreign Related Civil Relations of the People's Republic of China, the parties concerned may choose the laws applicable to contracts by agreement. If the parties do not choose, the laws at the habitual residence of the party whose fulfilment of obligations can best reflect the characteristics of this contract or other laws that have the closest relation to such contract shall apply.

IV THE INTERNATIONAL ARENA

With the increase of foreign trade, economic cooperation and other foreign contacts in China, foreign-related insurance disputes are increasing continuously. In insurance disputes involving international parties, diversified rules on jurisdiction and complicated application of governing laws have become popular topics in foreign-related insurance disputes.

i Jurisdiction rules for foreign-related insurance disputes

The Civil Procedure Law governs the application of law in foreign-related civil litigations in China. However, Article 267 of the Civil Procedure Law also provides that, 'Where the provisions of international treaties concluded or acceded to by China are different from those of this Law, the provisions of such international treaties shall apply, except for those to which China has declared reservation.'

The jurisdiction rules for foreign insurance disputes also follow the principle of the autonomy of the parties' will. The parties to a contract may agree in writing to be subject to the jurisdiction of the courts of the places that have actual connections with such disputes, for example, the defendant's domicile, the place of performance of the contract, the place where

the contract is signed, the plaintiff's domicile, the place where the subject matter is located, etc. In practice, the principle of party autonomy of will prevails in the application, and the court shall respect the party autonomy of will when adjudicating the relevant cases.[5]

ii Application of governing laws for foreign-related insurance disputes

The parties to foreign-related insurance disputes may choose the laws applicable to their dispute in the insurance contract. If the parties fail to agree on any applicable law, the laws of the habitual residence of the party whose performance of the contract best reflects the characteristics of the contract, or other laws most closely connected with the contract may apply, namely, 'the most closely connected law'.[6] In the case of [2022] Hu 0118, Civil First Instance No. 15057, the parties agreed that the insurance contract should be governed by Korean laws. At trial, the court ruled that the case should be subject to the jurisdiction of and be interpreted according to Korean laws.

iii Enforcement of foreign judgments or awards by a Chinese insurance company

Foreign judgments may only be enforceable in China in accordance with the principle of reciprocity and the provisions of the international treaties concluded or acceded to by the foreign country and China. According to the Civil Procedure Law, if a final judgment or decree of a foreign court requires recognition and enforcement by a court of China, the party concerned may directly apply for recognition and enforcement to the intermediate people's court of China that has jurisdiction.

China joined the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the Convention) in 1986, and foreign arbitration awards could be recognised and enforced by a people's court of China. According to the Civil Procedure Law of the People's Republic of China, if an award made by a foreign arbitration agency requires the recognition and enforcement by a people's court of China, the party concerned shall directly apply to the intermediate people's court in the place where the party subject to execution has its domicile or where its property is located. The people's court shall deal with the matter in accordance with the relevant provisions of the international treaties concluded or acceded to by China or under the principle of reciprocity.

V OUTLOOK AND CONCLUSIONS

According to statistics from the Annual Report on Claims Settlement in the Insurance Industry 2022, insurers in China paid out more than 1.5 trillion yuan in 2022. Policy coverage disputes mainly arose from property and casualty insurance policies, among which motor vehicle insurance disputes accounted for the largest proportion. Among personal insurance-related disputes, the main types of insurance policies involved were illness insurance, accident insurance and medical insurance, and the claims were mainly due to the delayed settlement of claims, disputes over the claimed amount, and the burdensome materials that were required for the settlement.

In addition, as online insurance has been accelerated by the development of internet technology, online policy claim disputes mainly have related to the notification and exemption clauses. On 1 February 2021, the Measures for the Regulation of Internet Insurance Businesses were officially implemented, clarifying the essence of internet insurance businesses, and establishing a system of rules suitable for the development of internet insurance for various market players.

Climate change has a significant impact on the operations of insurance companies in China. In terms of underwriting and claims, drastic changes in the climate may lead to an increase in the probability of property loss claims, such as claims due to the rainstorm from the end of July to early August 2023 in Beijing and Hebei Province and an increase in underwriting costs.

The war in Ukraine may also be a major factor affecting China's insurance industry. Many countries have announced sanctions on some Russian personnel, companies and goods

since the war began. At the same time, many insurance companies refuse to cover goods and properties in Russia. As for cargo insurance, some insurance companies require an additional 'sanction' clause. Shipowners' P&I insurance has also been greatly impacted, since ships travelling back and forth from Russia rarely obtain international coverage. It is expected that property insurance companies might face huge losses, especially in fields such as aviation insurance and cybersecurity insurance. In addition, disputes in relation to marine insurance may occur since international trade and cross-border transportation related to Europe would be adversely affected by these circumstances.

Since 2020, the revision of the Insurance Law has been included in the legislative plan of the Standing Committee of the National People's Congress. During the two sessions of the National People's Congress and the Chinese People's Political Consultative Conference in 2022, some representatives put forward a proposal to revise the Insurance Law, suggesting that insurance business operation rules, risk prevention mechanisms and other aspects should be improved in order to adapt to industry development and regulatory needs. It is estimated that the mainstream opinions on revising the Insurance Law may gradually take shape in 2023, which may have new significant effects on the future insurance dispute resolution mechanisms and the regulation of the insurance industry.

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Endnotes

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2 [2023] Zui Gao Fa Min Xia No. 21; [2023] Zui Gao Fa Min Xia No. 23; [2023] Zui Gao Fa Min Xia No. 22.
3 [2021] Zui Gao Fa Min Shen No. 7578.
4 Number eight of the top 10 commercial cases issued by the Supreme Court in 2022.
5 Article 35 of the Judicial Interpretation of the Civil Procedure Law.
6 Article 41 of the Law of the People's Republic of China on Application of Laws for Foreign-related Civil Relations.

Chapter 5

Cyprus

Michael K Philippou[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

This chapter provides a brief overview of Cyprus insurance law, recent developments regarding insurance litigation and dispute resolutions in the Republic of Cyprus (Cyprus) as well as an analysis of different aspects of insurance law.

The first section of the chapter discusses the historical background of Cyprus and the milestones of the Cyprus legislation. The second section analyses recent case law on topics of general insurance interest as well as comparative comments where applicable. The third section includes a few remarks on the applicable insurance legislation, the relevant dispute resolution tribunals in Cyprus and the relevant recent updates in that respect as well as the new civil procedure rules that entered into force on 1 September 2023. The fourth section presents any international developments in the field of insurance law and their effect on the Cyprus insurance law. Finally, the fifth section deals with trends and upcoming key issues, which are briefly discussed.

Historical background

Cyprus became a protectorate of the British Empire in 1878, and in 1925 a British colony. On 16 August 1960, Cyprus was declared an independent state when the Constitution was signed.

The Constitution was the supreme law in Cyprus until the country's accession to the European Union in 2004. Following this, the Constitution was amended to give supremacy to the obligatory legislation of the European Union.[2]

In relation to Cyprus law and its connection to English law, judgments of the English Court of Appeal that were decided before 15 August 1960 and that interpreted the Laws of the House of Commons of the United Kingdom of Great Britain and Northern Ireland are applicable in Cyprus pursuant to Section 29(e) of the Courts of Justice Law No. 14/1960 provided that they do not conflict with the Constitution or the law of the state. Alternatively, those cases are binding on the courts of Cyprus to the same extent as the decisions of the Supreme Court of Cyprus. However, decisions of the English Court of Appeal and Privy Council that were decided after 15 August 1960 are not binding on the courts of Cyprus, but they are of great persuasive authority. It is important to underline that legislative provisions have superior effect compared to case law principles. In connection with insurance-related legislation, English case law and general common law influences can be seen in many Cyprus court judgments, although these influences seem to be reducing as Cyprus case law, as well as new legislation, are being implemented.

II YEAR IN REVIEW

This section summarises important cases decided recently by the Cyprus courts or having a significant influence on Cyprus jurisprudence in the field of insurance law and jurisdiction.

First, the case *Stait (Appellant) v. Cosmos Insurance Ltd of Cyprus (Respondent)*[3] discussed jurisdictional issues relevant to Cyprus and English courts. The claimant was a British national and a member of the Royal Air Force. At all relevant times, he was stationed at the Sovereign Base Area of Akrotiri (SBA). He had started living in Cyprus in 2016. The SBA is a British overseas territory in Cyprus. The areas, namely Akrotiri and Dhekelia, which include British military bases and installations, formerly part of the Crown colony of Cyprus, have been retained by the British under the 1960 treaty of independence of Cyprus signed by the United Kingdom, Greece, Turkey and representatives from the Greek and Turkish Cypriot communities. The claim involved a road traffic accident. More specifically, while the plaintiff was cycling, he was hit by the defendant's car on the main highway from Limassol to Paphos. The claimant turned against the defendant and subsequently against the defendant's insurance company in the court of England and Wales. The plaintiff suffered serious injuries. The defendant insurer is domiciled in Cyprus. Court proceedings were filed in England and Wales. However, the High Court of England dismissed the plaintiff's claim, due to lack of jurisdiction. Although the birthplace of the claimant was England, at all material times he

was living and working in Cyprus. The plaintiff then proceeded to appeal the judgment at first instance, claiming that the court of first instance had wrongly decided. Nevertheless, the High Court of England adopted the approach of the court of first instance, rejecting the appeal due to lack of jurisdiction. Interestingly, the High Court of England held that there was no evidence of any other place in England that the claimant would be entitled to live in or that could be classed as a base for any kind of settled pattern of life and that the claimant's life at and around the SBA was the place where he was living in accommodation with his family, where his children went to school, where he was working and where he was receiving his primary medical care. It follows that, through this case law analysis, there is an interesting illustration of the principles governing the jurisdiction of Cyprus courts in the context of the SBA's involvement.

Second, the case *Anthony Edgar v. Universal Life Insurance Public Company Ltd*[4] concerns a paramount judgment regarding interpretation of insurance contracts. The appellant/insured appealed to the Supreme Court, opposing the first instance judgment where the court rejected his claim against the insurer who had not paid the hospital fees alleging the application of an exception clause, that his treatment involved a pre-existing condition, something that as per the terms of his policy, the insured should have disclosed to the insurer. The Supreme Court in its judgment reaffirmed the traditional principle according to which every policyholder has the duty to disclose facts that they are aware of as well as any other material facts that should be known at the time of inception of the contract. However, as per the facts of the case the Supreme court dismissed the first instance court judgment. In its judgment it clarified once more the principle that the interpretation of any exemption clause is traditionally linked with the facts of each case. The Supreme Court continued to clarify that, because of the wording of the said clause, the *contra preferentum* rule applied and thus any ambiguity with regard to the interpretation of the said exemption clause operated against the insurer. Following these principles, the Supreme Court, overruling the first instance decision, decided that the insurance company/insurer should cover the appellant's medical expenses since the appellant was, as per the facts of the case, not aware of the congenital disease at the time of the inception of the contract.

Third, the case of *Savvas Ioannou v. Gan Direct Insurance Ltd, Kyriakou Thanasi*[5] carries significant weight within the field of insurance law. The case involved a road traffic accident where the defendant was the driver, and the plaintiff was a passenger who sustained injuries. Following the incident, the insurance company was required to cover the costs, but they claimed that they were not obliged to do so as the vehicle was sold prior to the accident (by the policyholder) and thus there was no insurable interest at the time of the accident. The policyholder had not informed the insurance company of the transfer of ownership nor the current owner. The insurer in its defence raised multiple arguments, the main one being that a contract of this kind was not assignable. The court, in adopting the principle set out in *Peters v. General Accident, Fire and Life Assurance Corporation Ltd*,[6] adopted the insurer's position and dismissed the claim.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Insurance law in Cyprus is governed by various pieces of legislation. We focus on three statutes that have undergone substantial amendments during recent years: the Motor Vehicles (Third Party Liability Insurance) Law of 2000;[7] the Law on Insurance and Reinsurance Businesses and Other Related Matters of 2016;[8] and the Statute of Limitations Act of 2012.[9] These Acts constitute substantial law at the core of insurance law in Cyprus and are considered the cornerstones of Cypriot insurance law.

It is worth reiterating the importance of the fact that cases decided by the Supreme Court of Cyprus are binding and, thus, create legal precedents. Hence, appellate court case law is a fundamental source of insurance law and must be read together with the relevant legislation so that the latter can be interpreted effectively.

Recent amendments to the Motor Vehicles (Third Party Liability Insurance) Law of 2000 were ratified in 2021, the most substantial of which are discussed below. The first two were incorporated into this legislation to align it with EU case law (discussed below), and specifically with the cases of *Churchill Insurance Company v. Tracy Evans*[10] and *Fidelidade-Companhia de Seguros SA* in mind.[11]

The third amendment allows the Motor Insurer's Fund of Cyprus (MIF) to intervene in civil proceedings. In summary, the MIF provides cover for claims arising out of uninsured or unidentified vehicles as well as third-party claims regarding insurance companies that are undergoing liquidation. An amendment to Article 28 of the Motor Vehicles (Third Party Liability Insurance) Law of 2000 was ratified to give to the MIF the right to intervene and become a party to proceedings if its legal rights are affected. The MIF has used this provision and became party to the *Demopoulos* action.[12] This action is still pending; however, since the application is uncontested, this provision of the Law has not yet been tested and decided.

The Law of Insurance and Reinsurance Business and Other Related Issues[13] underwent important amendments to bring it into line with the Directive on Insurance Distribution (IDD).[14] In summary, the amendments deal with the EU's policy on the prevention of money laundering, any Brexit implications, any platforms of cooperation provided by the IDD and reporting duties to the competent authorities. This initiative corresponds with the EU's Action Plan (see Section IV).

The final set of amendments concerned the ratification of the Statute of Limitations Law.[15] This act was amended so that, as of the date of amendment, the limitation period regarding a right of action for an act of negligence or a statutory right against a legal or physical person can be suspended for a further period of 24 months. This amendment is of major significance since, up until the amendment, the limitation period for such a right of action was limited to three years. This extension may give rise to uncertainty, as insurers would need to keep their records and potential claims open for this period. With this amendment, insurers will now be facing the threat of litigation for relevant claims for a period of two more years if a cause of action falls within the time frame of the amendment.[16] Undoubtedly, the previous regime had practical implications, notably during the covid-19 pandemic. Effectively, the amendment came to provide a 'cushion' to many future claimants affected by the pandemic.

ii Fora and dispute resolution mechanisms

Disputes in Cyprus have been traditionally resolved in Cyprus courts that exercise the relevant jurisdiction as well as through arbitration, although the latter is not preferred by most litigants.

It is worth mentioning that the judicial system of Cyprus is undergoing a restructuring process. The second instance jurisdiction has been reformed. Specifically, the establishment of a Court of Appeal, dealing with civil, criminal and administrative cases at second instance (16 judges) took place and the relevant legislation underwent the necessary amendments. Further, the pre-existing model of the Supreme Constitutional Court (composed of nine judges) has been reactivated. The operation of these courts started on 1 July 2023. It is also worth mentioning that a third instance jurisdiction has been introduced. To elaborate, the Supreme Court (composed of seven judges), granted additional third-degree jurisdiction to the Court of Appeal and the Supreme Constitutional Court.

The Cyprus judiciary reform is also marked by the establishment of a Judicial Advisory Council which acts consultatively to the President of the Republic for the appointment of judges to the Supreme Constitutional Court and to the Supreme Court, respectively.

Another important reform is the establishment of commercial and admiralty courts, to provide an appropriate forum for the determination of high-profile, high-value commercial cases and admiralty cases, respectively.

A Training School for Judges has been implemented by statute. This development will contribute to the ongoing training of judges, as it is now envisaged that judges will be obligated to go through lifelong training. The establishment of the Training School for Judges is of vital importance for safeguarding the high quality of the justice system.

While the submission of disputes to arbitration has not been a preferred vehicle for insurance dispute resolution in the past, the relevant legislation provides for arbitration according to the parties' preference. Accordingly, the Arbitration Law,[17] the origins of which are based on the English Arbitration Act of 1934, governs this type of dispute. International arbitration proceedings are governed by the International Commercial Arbitration Act,[18] which is identical to the UNCITRAL Model Law and deals with all procedural and substantive matters of international arbitration proceedings with the contracting parties as well as with the recognition and execution of the arbitral award.

The MIF executed an internal agreement between itself and contracting insurance companies, in force as of 7 July 2000, which provides that all disputes between the MIF and any of the contracting parties shall be referred to arbitration. Insurers and the MIF have traditionally implemented this provision for the resolution of disputes, and it has been found to be a very useful tool that provides a speedy and just procedure.

The Cyprus Arbitration and Mediation Centre (CAMC) was established in 2010 to offer an alternative method of dispute resolution. CAMC operates within the premises of the Cyprus Bar Association and aims to provide the efficient resolution of disputes both internationally and domestically.

More efficient and speedy dispute resolution has been developed. In detail, the introduction of the new Rules of Civil Procedure adopted by the Supreme Court in May 2021, for cases submitted as from September 2023, is also expected to have a significant impact on the efficiency of insurance claims. The new Rules include special provisions for insurance claims and the procedure that must be followed by the claimant and insurers before the filing of any action trial with a pretrial protocol.[19] Specifically, it provides for a step-by-step procedure, including actions that need to be followed by both claimants and insurers before the filing of any action. The failure of any of the parties to comply will render them answerable to the court in the litigation procedures that follow. This point is further analysed below.

iii New Civil Procedure Rules

As mentioned in last year's edition, the new Civil Procedure Rules (CPRs) came into force on 1 September 2023, following the publication of their final form by the Supreme Court on 7 July 2023. The new CPRs provide multiple radical changes. However, in this section we shall focus on two implementations relating to insurance law and which are expected to affect insurance claims. The first implementation is the introduction of a pre-action protocol in road traffic accident claims and personal injury claims, which provides a specific step-by-step procedure, with actions that need to be followed by both claimants and insurers before the filing of any action.[20] Failure by both or any of the parties to comply with the provisions will render them answerable to the court in the litigation procedure that will follow. The second implementation is the introduction of a more practical and detailed framework regarding the submission of proposal for settlement, from which stands out the fact that a written settlement proposal is now fully binding and is equivalent to depositing a payment into court, with the main difference being that in this procedure the amount of the proposal does not need to be actually deposited in the Court's Accounting Office.[21]

Before referring to the main provisions of these changes, it should be emphasised that they are in line with the overriding objective of the new CPRs, which is to enable the court to deal with cases fairly and at a proportionate cost.[22] This is achieved because these procedures have a threefold effect:

- to bring the parties, in a timely manner, to a better understanding of the claim and their position, in an attempt to avoid litigation, as the claim can be settled within the pre-action protocol procedure;

- to encourage the submission of settlement proposals without practical obstacles and with the incentive of avoiding additional costs in the future; and
- to have better case management proceedings in place before any filing of an action, that provide efficiency and certainty to litigants in future proceedings.

Pre-action protocol

The importance of the said protocol is that it provides a timetable with actions aimed at the substantive out-of-court discussion of the claim by the parties to settle the case, making the judicial process a last resort. It is specifically provided that as soon as there is sufficient evidence to establish a claim, the claimant is obliged to send two copies of the letter of claim to the insured, who is obliged to send the second copy to the insurer.[23] While if the claimant knows the insurer concerned, they can send the letter of claim directly to the insurer.[24]

The letter must be in accordance with the form provided in the new CPRs and must include the prescribed information.[25] Specifically, it must include a summary of the facts on which the claim is based, an indication of the nature of the claimant's injuries, the place of treatment and the attending physician, along with the date(s) of the treatment, the extent of the physical injuries at the time of the letter of claim, details of the material damages, an indication of the total amount of the claim with details and supporting documents (if any), an expert report of the claimant which exceptionally was not jointly secured with the proposed defendant (the defendant), and any other relevant information.[26] In addition, with their letter, the claimant may request from the defendant the disclosure of specific documents or categories of documents, which are relevant to the claim and which the court may have ordered to be disclosed either upon a request for pretrial disclosure or in the context of disclosure during the judicial proceedings.[27,28] Generally, the claimant must provide sufficient information for the defendant's insurer or lawyer to initiate an investigation and make a rough assessment of the claim, and in any case the claimant must warn the defendant and their insurers that failure to respond to their letter within 28 calendar days will allow the claimant to file an action without further notice and this may have adverse consequences for them as to the costs awarded.[29] Unless the parties agree to an extension of the response time,[30] within that time the defendant or their insurer must send a response letter to the claimant.

A specific form is provided in the new CPRs for the letter in response to the letter of claim and the information that must be included therein.[31] Specifically, there must be a statement admitting or denying responsibility for the accident. If there is a denial of liability or allegations of contributory negligence, supporting documents and allegations of facts that justify these arguments must be included in the letter.[32] As mentioned above, the defendant or the insurer must attach any documents in their possession which are material to the issues between the parties and which the court may have ordered to be disclosed either upon a request for pretrial disclosure or in the context of disclosure during the judicial proceedings.[33]

The above confirms that the new CPRs promote an out-of-court procedure of complete transparency in relation to the claim, where the parties negotiate with all cards on the table. This opinion is reinforced by the fact that the protocol makes the joint selection of experts, on medical or other matters, the rule.[34] While this view is also strengthened by the fact that even after the protocol procedure has been followed and letters have been exchanged without the claim being settled, the parties are required to engage without delay in appropriate negotiations to avoid litigation.[35]

Failure to comply with any provision of the protocol renders the defaulting party accountable to the court during case management and at the stage of directions.[36]

It is emphasised, of course, that in cases with urgent claims or where the claim is at risk of being time-barred or where there are other reasonable reasons that are sufficiently explained in the pleadings, compliance with the protocol is not required.[37]

Proposal for settlement

As mentioned above, the new procedure regarding the proposal for settlement is more thorough and more practical than the procedure of payment into court that was in force until now. This follows, first of all, from the fact that a specific form is provided,[38] in which the settlement proposal must be served to the recipient and which can be made both by the claimant and the defendant and may concern either the entire claim or part of it, while it may not include a proposal for the settlement of costs and interests, this must be explicitly stated.[39] The deadline for acceptance of a proposal cannot be less than 21 days and its acceptance must be served with a written notification to the proposer, while it is noted that any acceptance made after the start of the hearing process is not valid.[40] In the event that a proposal is made by the defendant and the court awards less than the total amount of the defendant's proposal, the plaintiff shall be required to pay any costs incurred by the defendant after the last date on which the proposal could be accepted. While in the event that a proposal was submitted by the plaintiff and the court awards an amount equal to or greater than the total amount of the plaintiff's proposal, the court may, in the exercise of its discretion regarding the issue of awarding interest, take into account the refusal of the defendant to accept the plaintiff's proposal.[41] It is noted that the procedure in question is also available during the pending appeal stage, with similar effects for the appeal procedure.[42]

Finally, it should be emphasised that the content of the proposal is never communicated to the court, except when the court's decision is issued, in order to influence at that stage its decision regarding the awarded costs and interest.[43]

IV THE INTERNATIONAL ARENA

As mentioned above, Cyprus is an EU Member State. For this reason, Regulation No. 864/2007 on the law applicable to non-contractual obligations (Rome II) applies to insurance disputes. Moreover, Regulation No. 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters is also relevant. These legislative instruments are of vital importance in every field of law. Accordingly, Cyprus courts could deal with these instruments in-depth as well as draw guidance from the principles established by the Court of Justice of the European Union in its judgments.

There have also been important updates regarding the IDD. Specifically, the European Commission announced its Action Plan: Financing Sustainable Growth. This initiative aims to incorporate sustainability when providing financial advice and to clarify the integration of sustainability into fiduciary duties. Thus, the IDD has undergone amendments for the purpose of specifying product oversight and governance requirements for insurance undertakings and insurance distributors. Hence, insurance intermediaries and insurance undertakings are now obliged to obtain necessary information about their customers' knowledge and experience in the investment field, their financial situation and their objectives, to enable the insurance intermediaries and insurance undertakings to undertake a suitability assessment. As a result, insurance intermediaries and insurance undertakings should give more appropriate consideration to sustainability factors.[44]

V OUTLOOK AND CONCLUSIONS

The introduction of new technologies in the justice system is worth mentioning. In this context, the digitalisation of the courts has been promoted, with the implementation of e-justice and the promotion of digital audio recording of minutes during trials. Specifically, the implementation of the electronic justice system has been tested successfully and it provides for digital filing and administration of courts' cases. The upcoming introduction of digital audio recording in courts will further enhance the efficiency and quality of operations. The installation and full operation of digital audio recording in court proceedings is expected by the first quarter of 2025.

To conclude, Cyprus' insurance legislation has come under the microscope of the legislature in recent years. The main cores of insurance legislation underwent amendments in an

attempt to provide certainty and effectiveness in a fast-moving industry. Apart from this, the judicial system is under reconstruction, in terms of both the tribunals' structure and the procedural rules. The result of these projects will inevitably affect the operation and substance of insurance law in Cyprus, as there is more to be done in the future. What can be concluded is that the Cyprus legislative and judicial systems have shown themselves to be adaptive to the new challenges of the past few years, and it remains to be seen how those initiatives and how upcoming trends will affect insurance law.

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Endnotes

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2 The Fifth Amendment of the Constitution Law of 2006 (127(I)/2006).
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8 Law No. 38(I)/2016.
9 Law 66(I)/2012.
10 C-442/10 Churchill Insurance Company Limited v. Benjamin Wilkinson and Tracy Evans v. Equity Claims Limited, reference for a preliminary ruling: Court of Appeal (England & Wales) (Civil Division). The Court of Justice of the European Union (CJEU) held that EU provisions must be interpreted as precluding national rules the effect of which is to omit automatically the requirement that the insurer shall compensate a passenger who is a victim of a road traffic accident when that accident was caused by a driver who was not insured under the insurance policy and when the victim, who was a passenger in the vehicle at the time of the accident, was insured to drive the vehicle himself but who had given permission to the driver to drive it. The CJEU also declared that the answer to that point is not different depending on whether the insured victim was aware that the person to whom he gave permission to drive the vehicle was not insured to do so, whether he believed that the driver was insured or whether he had turned his mind to that question.
11 C-287/16 Fidelidade-Companhia de Seguros SA v. Caisse Suisse de Compensation and Others, judgment of the Court (Sixth Chamber) of 20 July 2017. The CJEU held that, regarding limitations and the right of the insurer to declare as void the contract of insurance under specific circumstances, articles of the relevant directives must be interpreted as precluding national legislation to invoke against third-party claims, the nullity of a contract for motor vehicle insurance against civil liability arising because of the policyholder making false pretenses regarding the execution and conclusion of the contract.
12 Demopoulos v. Demopoulos, Action No. 189/2018.
13 Law No. 38(I) 2016.
14 Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution.
15 The Law on Limitation of Transferable Rights of 2012 (Law 66(I)/2012).
16 Article 27A of the Limitations Law.
17 Arbitration Law, Cap. 4.
18 Law No. 101/1987.
19 Article 12 of the Basic Agreement made by and concluded between the Republic of Cyprus through the Minister of Finance and the Motor Insurers' Fund
20 Section 3 of the CPRs, Type II, Protocol 2-RTA and Personal Injury Claims.
21 Section 35 of the CPRs – Settlement Proposal.
22 Section 1 of the CPRs – Primary Purpose.
23 Article 4(1) of Protocol 2. It is noted that unlike the English provision, from which it was inspired, the Cypriot provision does not provide for a specific time limit for the update.
24 Article 4(2) of Protocol 2
25 Form A of Type II – Letter of Claim and Article 4(4)(a)–(h) of Protocol 2.
26 ibid.
27 Article 4(7) of Protocol 2.
28 Article 31.5(7) of the CPRs provides the reasons why the disclosure of documents is excluded.
29 Articles 2(2), 4(3) and 4(7) of Protocol 2.
30 Articles 5(1) and 5(4) of Protocol 2.
31 Form B of Type II – Letter of Response and Article 5(2)(a)–(d) of Protocol 2.
32 ibid.
33 Article 5(2)(b)(iii).
34 Article 3(1) of Protocol 2.
35 Article 3 16) of the CPRs.
36 Article 3.10(4) of the CPRs. See also Section 39 of the CPRs.
37 Article 3.11(1) of the CPRs.
38 See Form 58 of the CPRs.
39 Articles 35.2–35.8 of the CPRs.
40 Articles 35.9–35.10 of the CPRs.
41 Article 31.13 of the CPRs.
42 Article 41.14(1)–(3) of the CPRs.
43 Articles 35.3(1) and 35.5(3) of the CPRs.
44 Commission Delegated Regulation (EU) 2021/1257 of 21 April 2021 amending Delegated Regulations (EU) 2017/2358 and (EU) 2017/2359 as regards the integration of sustainability factors, risks and preferences into the product oversight and governance requirements for insurance undertakings and insurance distributors and into the rules on conduct of business and investment advice for insurance-based investment products, Brussels, 21 April 2021 C (2021) 2614 final.

Chapter 6

England and Wales

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Summary

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III THE LEGAL FRAMEWORK
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I INTRODUCTION

English insurance law has traditionally been perceived as insurer-friendly and, as a result, England and Wales has been viewed as an insurer-friendly jurisdiction for insurance disputes. To a large extent this is the product of English legal history, with many of the most significant developments in English insurance law taking place in the context of marine insurance or similar overseas risks.[2] Until as recently as 2015, the leading statute in English insurance law remained the Marine Insurance Act 1906 (much of which also applied to non-marine insurance). For those risks, during that period of history, the informational asymmetry between the insured and the insurer was especially acute. To resolve that asymmetry, English insurance law placed onerous duties of disclosure and compliance with warranties on the insured, with potentially drastic consequences for failure, even if entirely innocent.

However, that historic imbalance has recently been partly redressed by the Insurance Act 2015, the most important development in English insurance law since the Marine Insurance Act 1906. The Insurance Act 2015 recasts the insured's duty of disclosure and the ability of insurers to convert pre-contractual representations into warranties, and sets out a new regime of proportionate remedies for insurers. At the time of writing, there have only been a limited number of disputes under the new law and so we are only beginning to see precisely how its provisions will be applied. There are also indications that insurers are seeking to contract out of many of the provisions of the Act where possible in commercial policies.

II YEAR IN REVIEW

The English courts have given judgment in insurance disputes covering a diverse range of issues since the previous edition. While insurance cases have not troubled the Supreme Court this year, the Court of Appeal has ruled in cases concerning the construction of policy provisions relating to causation, insurable interest, subrogation and jurisdiction. Covid-19 business interruption litigation has given rise to further High Court judgments on issues not resolved by the Supreme Court's judgment in January 2021. The High Court has also continued to see applications under the insurance business transfer regime in Part VII of the Financial Services and Markets Act 2000 (FSMA) which have been motivated by the consequences of Brexit. These and other significant recent cases are summarised below.

i Business interruption and covid-19

While business interruption cover is typically bought by policyholders as an extension to property damage policies, and primarily responds in cases of property damage, non-damage extensions to cover also exist in the market providing cover for losses caused by a range of risks, including disease or the response of public authorities to disease. There has been a deluge of claims against such policies as a result of covid-19 and the national lockdowns in the UK in 2020 and 2021, and considerable uncertainty as to whether such policies respond. The key coverage issues that arose on the most commonly used forms of policy were addressed by the Supreme Court in January 2021 in the first-ever case using the Financial Markets Test Case Scheme (the Test Case) under the Civil Procedure Rules (CPRs). The Test Case was brought by the regulator, the Financial Conduct Authority, on behalf of policyholders and with the consent and cooperation of eight insurers seeking to promote greater clarity on the legal issues.

We covered the outcome of both the Divisional Court and the Supreme Court judgments in the Test Case in the third and fourth editions of this book. We also covered the subsequent developments in this area in *Various Policyholders v. China Taiping Insurance (UK) Co Ltd*[3] and *Corbin and King Limited & Ors v. Axa Insurance UK PLC*[4] in the fifth edition. There have since been several further significant decisions in this area.

Arguably the most significant recent cases in this area relate to the application of the aggregation and policy limits provisions in the widely used Marsh Resilience wording. Three cases concerning policies written on the Marsh Resilience wording were heard in sequence

by the same judge: *Stonegate Pub Company v. MS Amlin*;[5] *Greggs PLC v. Zurich Insurance PLC*,[6] and *Various Eateries Trading Ltd v. Allianz*.[7] The cases also considered the treatment of furlough and business rates relief payments in the quantification of claims.

The Marsh Resilience wording includes a disease clause, a prevention of access clause, and an enforced closure clause. Each were subject to limits of liability that applied to 'any one Single Business Interruption Loss' (SBIL), which was defined as losses 'that arise from, are attributable to or are in connection with a single occurrence'. The court held that these words denoted 'a relatively loose causal link' but nevertheless required a causal link between the relevant losses and the single occurrence that was not too remote.

The court was required to consider and apply the Supreme Court's judgment in the FCA Test Case that each case of covid-19 was an equally efficient cause of the loss, and involved assessment of a significant number of alternative options for what might be the SBIL. This included in each case detailed virology evidence as to the origin and spread of the disease as well as up to 120 different government responses.

The court in each case concluded that the relevant single occurrence for aggregation purposes was the announcements/orders from the government applicable to the relevant business (which could be by reference to England, Wales, Scotland and Northern Ireland). Across the three judgments, the court also explicitly dismissed various other cases that the insurers argued constituted the single occurrence for the purposes of the aggregating provision in the SBIL, including any one case of covid-19 in the relevant vicinity of an insured premise; the initial outbreak of covid-19 in Wuhan; various virological developments that preceded the initial outbreak in Wuhan; the introduction of covid-19 into the UK or England; the first transmission of cases therein; the outbreak, continuation or spread of covid-19 within the UK or England; and various 'tipping points' when the expert evidence indicated that an epidemic or pandemic had become inevitable.

In *Stonegate* the court also dismissed the argument that the limits of liability applied on a per premises basis, holding that a single limit per SBIL applied to Stonegate and Various Eateries' businesses as a whole. It did so based on a close analysis of the wording of the specific limits and deductibles provisions in those policies.

On the question of whether claimants should give credit against their claims for furlough payments or other government support that they received, the court considered that the policy terms, rather than the general law of subrogation, were determinative. It held that the definition of 'Reduction in Turnover' in the Marsh Resilience wording was wide enough to capture the receipt of furlough payments as 'costs normally payable out of Turnover . . . as may cease or be reduced . . . as a consequence of a Covered Event'. However, the Court went on to consider the position under the general law of subrogation, and held that insurers are subrogated to furlough payments received by their insured, and therefore can take them into account on the quantification of claims. However, the Court also doubted whether, if the relevant policy terms were not wide enough to permit furlough payments to be taken into account, an insurer could nevertheless rely on the general law of subrogation to do so. It is notable that the English Court followed a similar approach to the Federal Court of Australia in *Swiss Re International v. LCA Marrickville Pty Limited (Second COVID-19 insurance test cases)*[8] in considering the issue to be primarily a question of policy wording rather than the law of subrogation (though the Federal Court arrived at the opposite conclusion to the High Court on the specific wording before it).

The main preliminary issue in *London International Exhibition Centre Plc v. Royal & Sun Alliance Insurance Plc & Ors*,[9] which addressed preliminary issues in six test cases, concerned clauses covering BI losses in consequence of the occurrence of notifiable disease 'at the Premises', rather than within a certain distance of the insured property (as had been considered in the Test Case). The court was required to determine whether such 'at the Premises' clauses should be construed as requiring some more direct causal relationship between those cases and the interruption of the insured's business than the wider 'disease' or 'radius' clauses considered in the Test Case. The High Court held that the concurrent proximate cause

approach in the Test Case should be read across into 'at the Premises' policies, primarily on the basis that 'at the Premises' clauses can be seen as radius clauses of narrow scope, and should therefore be subject to the same approach to causation.

An issue also arose in four of the cases as to whether occurrences of covid-19 prior to it becoming a notifiable disease on 5 March 2020 came within the scope of cover. It was held that only occurrences of notifiable diseases, rather than diseases which subsequently became notifiable, were covered.

In *PizzaExpress Group Limited & Ors v. Liberty Mutual Insurance Europe SE & another*,[10] the preliminary issue concerned the construction of provisions relating to policy limits. In particular, the question was whether the 'Sub-limits' of liability in the policy came within the wording 'all Limits of Liability apply any one Occurrence'. Rejecting the claimants' argument that there was a 'clear distinction' between 'Limits of Liability' and 'Sub-limits', the court held that the sub-limits relevant to the 'at the Premises' disease and prevention of access clauses in the policy were subject to the application of 'any one Occurrence'. Not only was this in accordance with the ordinary meaning of the wording and how a 'reasonable reader' would interpret it, but it also avoided a series of 'odd' conclusions arising from Pizza Express' construction.

It is worth noting that the above judgments cannot necessarily be treated as final determinations of the law on these issues. The claimants in *Stonegate* and *Various Eateries* have been granted permission to appeal in respect of points on aggregation and furlough, and those appeals will be heard in late November 2023. A trial on Liberty and Aon BI wordings is also scheduled for October 2023, in which the court will hear arguments on issues arising in at least six cases in which Liberty Mutual is the defendant insurer.

ii Part VII transfers and Brexit

Part VII of the FSMA provides a court-sanctioned procedure for the legal transfer of insurance policies between insurers. The court is required to consider a report on the viability of the transfer by an independent expert, along with submissions from the FCA and PRA and any objections made by policyholders (or any other person who alleges they are adversely affected by the proposed transfer).

A number of recent applications for sanction of a Part VII transfer have also had to consider issues raised by Brexit. Courts have frequently found themselves in the situation of having to balance:

> *the inevitable prejudice to a large body of EEA policyholders of their policies not being able to be serviced or paid after the end of 2020 if the scheme were not to be sanctioned, against any potential risk of prejudice to individual policyholders or reinsurers under the scheme's terms.*[11]

While the courts have still been careful to consider the interests of policyholders, they have shown that they are prepared to approve a scheme despite some elements of prejudice to policyholders where the transfer is in response to an external circumstance, such as Brexit.[12]

In *Phoenix Life Ltd, Re*,[13] the court sanctioned a scheme to transfer the insurance business of Phoenix Life Ltd and Reassure Life Ltd that had been written in the Republic of Ireland, Iceland, Germany, Norway and Sweden to a newly established Irish entity, to ensure that the relevant policyholders continued to obtain the full range of benefits under their policies following Brexit. The court held that loss of Financial Services Compensation Scheme protection for some transferring policyholders would not lead to a material adverse effect on the security of benefits as the likelihood of default was remote and the loss of protection was outweighed by the other benefits of the scheme.

In both *USAA Ltd, Re*[14] and *China Taiping Insurance (UK) Co Ltd, Re*,[15] the court sanctioned Part VII transfers of the insurance business of an English entity to an EEA entity, where the purpose of the transfer was to address the fact that as a result of Brexit, the transferor would no longer be able to passport its permissions under Part 4A of FSMA to carry out

insurance business in EEA states without having to be authorised in those states, meaning that it would not be able to issue new insurance policies across the EEA and might not be able to service existing EEA policyholders or administer claims.

iii Construction

There have been two recent cases in which the English courts have interpreted causation language in insurance policies. Both cases concerned an assessment of the 'proximate cause' of the insured's loss.

In *Allianz Insurance Plc v. University of Exeter*,[16] the High Court considered whether the damage suffered by the defendant to its property, caused by the controlled detonation of an unexploded World War II bomb, fell within the scope of the war exclusion clause in its property damage policy. The insurer declined the claim, on the basis that any loss or damage suffered by the defendant fell within the scope of the war exclusion clause, being loss and damage 'occasioned by war'. The defendant argued that, based on the language of the policy, the proximate cause of the loss was the deliberate act of the bomb disposal team in detonating the bomb and parties cannot have intended that the policy exemptions would apply to historic wars. The High Court held that the proximate cause of the loss was the dropping of the bomb, not the deliberate act of the bomb disposal team in detonating the bomb. Therefore, the war exclusion clause applied.

In *Brian Leighton (Garages) Ltd v. Allianz Insurance Plc*,[17] the Court of Appeal considered whether damage to the insured's garage caused by fuel leaking from a damaged fuel pipe constituted damage 'caused by pollution or contamination', and therefore was excluded from cover. The Court of Appeal held that the wording of the exclusion clause referred only to cases where pollution or contamination was the proximate cause of the loss, and the proximate cause of the damage to the garage was the penetration of the fuel pipe by the sharp object, and not subsequent leaking of fuel.

iv Insurable interest

The Court of Appeal considered the requirement for an insurable interest in ***Quadra Commodities SA v. XL Insurance Company SE and Others***.[18] The claimant had been the victim of a fraud whereby warehouse receipts for cargoes of grain had been issued to various buyers despite there being insufficient goods to fulfil them all. Payment had been made by the claimant for the grain recorded in its warehouse receipts but the grain had not all been received. The claimant sought an indemnity under its marine cargo insurance policy, which covered physical loss of goods through the acceptance of fraudulent documents or by misappropriation.

Insurers contended that the claimant had no insurable interest because the goods that were the subject of the claim did not form part of a bulk which was sufficiently identified. The Court of Appeal upheld the High Court's decision on this point, finding against insurers that the claimant had an insurable interest in the lost cargoes of grain. The characteristics of an insurable interest are set out in Section 5(2) of the Marine Insurance Act 1906, although this is not an exhaustive definition. The question of what is the subject matter of the insurance is to be ascertained from the terms of the contract of insurance, the nature of the insurable interest is to be discerned from all the surrounding circumstances and whether the contract of insurance embraces the insurable interest intended to be covered is a question of construction.

The Court of Appeal held that the contention that the goods had to form part of a sufficiently identifiable bulk was unsupported by authority and would, incorrectly, impose on the relationship of insured and insurer a requirement akin to that required between buyer and seller under Section 20A of the Sale of Goods Act 1979. An insurable interest is not the same as or dependent upon a proprietary interest.

v Unauthorised settlements

In ***Technip Saudi Arabia Limited v. The Mediterranean and Gulf Cooperative Insurance and Reinsurance Company***,[19] the insured (Technip) was a contractor for works in an offshore oil and gas field. A vessel chartered by Technip collided with and damaged a platform in the field. Following the defendant insurer's denial of cover and instruction for Technip to act as a 'prudent uninsured', Technip reached a settlement for US$25 million with the platform owner (KJO) without the consent of the insurer.

Technip's policy provided an indemnity for its 'Ultimate Net Loss', defined as the 'total sum the Insured is obligated to pay as Damages', and the definition of damages included the wording 'compensatory damages, monetary judgments, awards, and/or compromise settlements entered with Underwriters' consent'. The court accepted Technip's argument that the absence of the underwriters' consent did not preclude a claim under the policy, since Technip's settlement with KJO involved a payment of 'compensatory damages'. To Technip's alternative argument that, even if the settlement sum did not constitute 'compensatory damages', there was still no need for the underwriters' consent given their denial of cover, the court agreed that it 'would have little difficulty in concluding that the insurer had waived any requirement for the insured to seek its consent or was estopped from asserting that such consent should have been sought and insured'.

vi Subrogation

Subrogation enables an insurer to recoup all or some of the money from a third party that caused or contributed to a loss for which the insurer has indemnified the insured. Commercial insurance commonly involves multiple insurers underwriting part of the relevant risk, often across multiple excess layers, and, therefore, each having a partial, several and subrogated interest in any third-party recoveries. The High Court has recently given two key judgments in the context of a co-insurance policy and the limits of contractual prohibitions against assignment.

In *FM Conway Ltd v. Rugby Football Union*,[20] the Court of Appeal upheld the High Court's decision that the appellant could not rely on a co-insurance policy with the first respondent (Rugby Football Union) to avoid liability for its alleged defective work and a subrogated claim against the appellant. The appellant had argued that the first respondent could not claim against it in respect of the losses covered by the policy as it had the benefit of the policy on the same terms as Rugby Football Union; and that the insurer could not exercise subrogation rights because the loss and damage was covered under the terms of the policy. However, the Court of Appeal held that, as it was a composite insurance policy; each co-insured was to be treated as if they had their own policy. The mere fact that the appellant and first respondent were insured under the same policy was insufficient for the co-insurance defence to succeed. What mattered was authority and intention. A key consideration to determine authority and intention was the underlying contract between the appellant and respondent. The Court of Appeal also concluded that the appellant's insurance cover was limited with respect to the first respondent's losses.

In *Dassault Aviation SA v. Mitsui Sumitomo Insurance Co Ltd*,[21] a dispute arose because Mitsui Bussan Aerospace Co Ltd (MBA) had purported to transfer its rights under a sales contract with the claimant. The sales contract, governed by English law, contained an arbitration agreement providing for arbitration under the International Chamber of Commerce rules. It also prohibited either party from transferring or assigning the sales contract to a third party, without the consent of the other party. Subsequently, MBA entered into a contract of insurance (governed by Japanese law) with the defendant, without the claimant's consent. Article 25 of the Japanese Insurance Act, reproduced by the insurance policy, provides that if an insurer had made an insurance proceeds payment, it would, by operation of law, be subrogated with regard to any claim acquired by the insured due to the occurrence of any damages arising from an insured event. The insurer submitted a request for arbitration due to indemnity costs paid to MBA for its losses under the sale contract. The claimant challenged the arbitration tribunal's jurisdiction and argued that, as any transfer of rights from MBA to the insurer was precluded under the sales contract, the insurer was not permitted to enforce

the arbitration agreement and the tribunal had no jurisdiction. The insurer argued that the prohibition on assignment did not apply to an assignment by operation of law. The High Court held that, although previous case law did not establish an applicable principle, there was a distinction between voluntary and involuntary assignments. It held that the triggering of Article 25 of the Japanese Insurance Act was the consequence of voluntary acts by MBA and therefore the arbitral tribunal had no jurisdiction to determine the dispute.

vii Jurisdiction

Two recent decisions on jurisdiction turned on the precise drafting of the arbitration clauses in issue, demonstrating the importance of the careful drafting of jurisdiction and arbitration clauses.

In *Al Mana Lifestyle Trading LLC v. United Fidelity Insurance Co PSC*,[22] the High Court held that the 'Applicable Law and Jurisdiction' clause in a series of 'Multi-Risks' insurance policies issued by the insurers gave the English court jurisdiction over claims brought by the claimants under the policies. However, the Court of Appeal reached the opposite conclusion. The claims brought by the claimants related to indemnities for business interruption losses, said to arise from the covid-19 pandemic. The insurers argued that the clause provided for the exclusive jurisdiction of the court of the country where the policy was issued, with a fallback in favour of the English courts. In contrast, the claimants argued that the clause gives whichever party wishes to bring a claim a free choice between the local courts or those in England. The Court of Appeal agreed with insurers, deciding that the English court's jurisdiction applied only when the jurisdiction of the local court was not available, and it was common ground that each of the local courts would accept jurisdiction over the claimants' claims.

In *DC Bars Ltd and another v. QIC Europe Ltd*,[23] the claim turned on the construction of the arbitration clause, which applied to disputes as to quantum between the parties, 'liability being otherwise admitted'. The insurer argued that the quantum of claims for further losses caused by further occurrences of disease within the specified radius during the policy period but after the expiry of the maximum indemnity period was zero. Disagreeing, the court held that quantum disputes are concerned purely with calculation of sums owing on the basis that there is liability, rather than whether there is liability.

viii Professional indemnity insurance

In ***Royal Sun Alliance Insurance Ltd v. Tughans (A Firm)***,[24] a firm was found to be entitled under its professional indemnity insurance policy to an indemnity for a damages claim for a success fee, where the success fee was said to have been obtained through fraudulent misrepresentation.

Tughans had been instructed under the terms of an engagement letter which provided that a success fee was payable if certain conditions were met. The conditions – which included providing certain representations and warranties – were met and the success fee was paid, but it was subsequently alleged that there had been fraudulent misrepresentation on the part of the Tughans partner handling the deal. Insurers asserted that Tughans could not suffer a loss should it be required to repay the success fee because the fee had only been obtained through the partner's fraudulent misrepresentation and was money to which the firm would not have been entitled had the partner acted honestly.

An arbitrator had held that the insurer was obliged to indemnify the firm in respect of its liability for the amount of the success fee. The High Court agreed, ruling that a claim for damages against the firm in the amount of a success fee to which it had acquired a contractual right constituted a loss to the firm for which it was entitled to be indemnified by its professional indemnity insurer (if the other prerequisites to cover were established). It did not matter for these purposes whether there had been fraudulent misrepresentation, since the truth of the warranties and representations to be provided by Tughans was not a precondition to payment of the success fee under the engagement letter, which had not been rescinded.

ix Third Parties (Rights against Insurers) Act 2010

Rashid v. Direct Savings Ltd[25] was the first formally reported judgment to consider the issue of limitation periods under the Third Parties (Rights Against Insurers) Act 2010 (the 2010 Act). Each of the claimants made a claim for the negligent installation of a cavity wall insulation, most of which were brought against Direct Savings Limited (DSE). However, the defendants claimed that an associated company (Direct Savings (Scotland) Limited (DSS)) had carried out the installations, and had since become insolvent. Aviva Insurance Limited (Aviva) insured DSE and DSS during the period the installations took place. Some claimants made joinder applications to substitute either Aviva alone or Aviva and DSS for DSE, on the basis that DSS was the installer and the claimants were entitled to pursue Aviva under the 2010 Act. In response, Aviva and DSS made applications to disallow the amendments.

The court considered the provisions under the Third Parties (Rights against Insurers) Act 1930 (the 1930 Act) and the 2010 Act, and how they affect the limitation period under the Limitation Act 1980 (the Limitation Act) in cases where the defendant is insolvent. A key issue was whether, following the changes in the 2010 Act, the limitation period continued to run after the winding up order for DSS was made. The court ruled that the limitation period continued to run, despite the winding up of DSS. It concluded that the benefit of the policy issued by Aviva is not an asset in the insolvency of DSS. Under the 2010 Act, the right to bring a claim against Aviva is not inchoate, as it arises as soon as the insolvency event takes place. The normal reason for suspending the limitation period on insolvency, to enable the liquidator to collect in the company's assets and distribute them fairly without having to deal with litigation from the company's creditors, does not apply where the claimant made a direct claim against Aviva under the 2010 Act.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

English insurance law is a mixture of common law (drawn from cases before the courts) and statute. Many of the principles developed during early insurance disputes, including the duty of 'utmost good faith', were codified in the Marine Insurance Act 1906 (the 1906 Act), which continues to influence insurance law in the UK, US and Commonwealth jurisdictions. Although the 1906 Act expressly governs marine insurance, many of its sections and principles are also applicable to non-marine insurance contracts; it was the most significant statute in English insurance law until the Insurance Act 2015 came into force on 12 August 2016.

Other key statutes regulate risk-specific insurance contracts. For example, the development of life and fire insurance contracts led to the Life Assurance Act 1774 and Fire Insurance Duty Act 1782, key parts of which remain in force today. General consumer legislation, such as the Consumer Rights Act 2015, also applies to consumer insurance contracts.

Firms providing insurance, reinsurance services or insurance intermediation must be authorised to do so under the Financial Services and Markets Act 2000 (FSMA). The Prudential Regulation Authority (PRA) is responsible for the authorisation of such firms. The Financial Conduct Authority (FCA) regulates the conduct of authorised firms and the FCA's Insurance Conduct of Business Sourcebook applies to the sale of general and protection insurance products, outlining expected standards for insurers such as the maintenance of suitable customer information, appropriate product disclosure and fair claims handling. Commercial parties are not required to take out insurance with local providers, although any entities wishing to sell insurance products in England and Wales must be FCA-authorised.

We have covered the recent developments in the common law in Section II, but English insurance law has also seen substantial statutory revision (or restatement) in recent years. The four significant recent statutes are:

- the Enterprise Act 2016, which for the first time provides policyholders with a potential right to claim damages in the event of a late payment of a claim by an insurer. Prior to the Enterprise Act 2016, policyholders could not recover any additional losses they suffered as a result of undue delay in payment of a claim by an insurer;

- the Third Party (Rights against Insurers) Act 2010 (updating the 1930 legislation with the same name) updated and strengthened the regime whereby a third party with a claim against an insolvent insured can, following the insolvency, pursue that claim directly against the insolvent insured's insurers. The insurer continues to have any defences available to the insured in the third party's claim and any defences that the insurers may itself have under the terms of the relevant policy;
- the Consumer Insurance (Disclosure and Representations) Act 2012, which applies only to consumer insurance contracts, limits the consumer's duty of disclosure, establishing that an insurer must ask appropriate questions to which the consumer must answer honestly and carefully; and
- the Insurance Act 2015 applies to both consumer and business insurance contracts entered into from 12 August 2016. The most significant developments to English insurance law now codified in the Insurance Act 2015 are as follows:
    - The Insurance Act 2015 alters the policyholder's duty of disclosure in non-consumer insurance. Prior to the Insurance Act 2015, the insured was under an onerous duty to disclose all known material facts about the risk to be insured. A failure to disclose any material fact would entitle the insurer to avoid the policy (and so avoid paying any claims), if the insurer could show that, if that fact had been disclosed, it would not have written the policy on the terms it in fact did (or it would not have written it at all). The ability to avoid arose whether the non-disclosure was fraudulent, negligent or, indeed, innocent. As a result, insurance disputes in England were often characterised by searches for, and arguments over, alleged non-disclosures. The Insurance Act 2015 replaces that duty with a new duty on the insured to make a fair presentation of the risk to be insured. The insured must now disclose all material circumstances that it knows or ought to know, or provide sufficient information to place a prudent insurer on notice to make further enquiries. Thus the burden is shifted in part onto the insurer. For policies entered into after 12 August 2016, it will be enough for an insured to disclose sufficient information to place a prudent insurer on notice to make further enquiries. If the prudent insurer's enquiries would have revealed a material circumstance that was not disclosed, but the actual insurer made no such enquiries, the insurer may no longer be able to avoid the policy for non-disclosure. Further, if the insurer can establish a breach of the duty to make a fair presentation of the risk that induced it to write the policy, it will no longer be automatically entitled to avoid the policy. To do so, the insurer will now need to show either that the breach was deliberate or reckless, or that it would not have insured the risk at all if a fair presentation had been made. If the breach is not deliberate or reckless and the insurer can only show that it would have insured the risk on different terms (e.g., for a higher premium), the insurer's remedy is to treat the policy as though it were written on those different terms.
    - The Insurance Act 2015 includes new provisions relevant to breach of warranties in insurance policies. Whereas a breach of warranty previously discharged an insurer from liability under a policy from the date of breach, the Insurance Act 2015 introduces proportionate remedies, abolishing any rule of law that causes a breach of an express or implied warranty to result in automatic discharge of the insurer's liability. For example, if the breach is neither deliberate nor reckless and the insurer would still have entered the contract, the insurer is only able to reduce cover on a proportionate basis; if the breach is neither deliberate nor reckless but the insurer would not have contracted, the insurer is able to avoid the contract but must return the premiums to the insured. Any policy terms purporting to convert pre-contractual representations made by the insured into a warranty (known as 'basis of contract' clauses) will no longer have effect.
    - The Insurance Act 2015 clarifies the remedies available to an insurer in the event an insured makes a fraudulent claim. If a fraudulent claim is made, the insurer is not liable for any part of that claim and can terminate the policy from the date of the fraud. However, the insurer cannot avoid the policy altogether and remains liable for genuine pre-fraud claims.

ii Insurable interest

English law has historically maintained that, for an insurance contract to be valid, the insured must have an insurable interest in the subject matter of the policy. An insurable interest is a legal or equitable interest in the subject matter of the insurance, or some interest short of a legal or equitable interest that means the insured would suffer disadvantage or be deprived of an advantage should the risk manifest.

The historic centrality of insurable interest to the concept of insurance in English law means that certain types of derivative contracts, such as credit default swaps, which in many ways economically mirror an insurance arrangement, are not considered (or regulated) as insurance contracts in English law.

Following recent legislative reform, there is uncertainty as to whether an insurable interest is a common law requirement or an indirect statutory requirement. Prior to the Gambling Act 2005, there was a clear statutory basis for insurable interest. The 1906 Act codified the general rule of law (for marine insurance) into a statutory requirement; the Life Assurance Act 1774 rendered life and contingent insurance contracts void without an insurable interest; and the Gaming Act 1845 created an indirect requirement for an insurable interest in all other contracts of insurance.

The Gambling Act 2005, which was intended to regulate new types of gambling activities, removed the 1845 Act's indirect requirement for insurable interest. As the Act did not intend to affect insurance, the impact of the 2005 Act on insurable interest may be limited. However, uncertainty now exists as to the exact legal basis of insurable interest and proposals by the Law Commission of England and Wales to include a statutory definition of insurable interest in the Insurance Act 2015 were rejected. Nevertheless, the English and Welsh and Scottish Law Commissions are consulting on a draft Insurable Interest Bill, confined to life and life-related insurance, to introduce a statutory definition of insurable interest. Although an updated draft Insurable Interest Bill was published in June 2018, limited progress has been made since.

iii Fora and dispute resolution mechanisms

Insurance disputes with a value greater than £100,000 will generally be heard at first instance in the High Court. The Commercial Court, a specialist court within the Business and Property division of the High Court, has specialist judges with insurance experience and will be the most common forum for large insurance disputes. If a claim is greater than £50 million and raises issues of general importance to financial markets, it may be heard on the 'Financial List', a specialist cross-jurisdictional list established to handle claims related to the financial markets. At first instance the dispute will be heard by a single judge.

The procedural rules of the Financial List also provide a specialist expedited procedure known as the Financial Markets Test Case Scheme for claims that raise issues of general importance in relation to which immediately relevant authoritative English law guidance is needed. Business interruption insurance claims arising out of the covid-19 pandemic were the first (and so far only) use of this specialist procedure.

Appeals from the High Court are heard in the Court of Appeal, usually by a panel of three Lord Justices of Appeal. To appeal to the Court of Appeal, the appellant will need to obtain the court's permission and to obtain this will need to show that, where the appeal is a first appeal (i.e., the decision being appealed is not itself an appeal from a lower court), the appeal would have a real prospect of success or there is some other compelling reason for it to be heard. Where the appeal to the Court of Appeal is a second appeal (i.e., the decision being appealed is itself an appeal from a lower court), the appellant will need to show that the appeal would have a real prospect of success and either it raises an important point of principle or practice, or there is some other compelling reason for it to be heard.

Appeals from decisions of the Court of Appeal are heard in the UK Supreme Court (the UK's highest court), usually by a panel of five justices of the Supreme Court. Again, the appellant

will need to obtain permission to appeal, which will only be granted if it can be shown that the appeal raises an arguable point of law of general public importance that ought to be considered by the Supreme Court.

Claims with a value less than £100,000 will be heard in the relevant county court (which is usually the local county court of the defendant). The Financial Ombudsman Service (FOS) can also independently review and settle non-contentious complaints between an insured and insurer. The FOS is primarily designed to deal with complaints by individual consumers, but complaints can also be brought by, or on behalf of, small businesses who, as customers, use financial services. To qualify, the business making the complaint must have an annual turnover of less than £6.5 million and fewer than 50 employees or a balance sheet total of less than £5 million. Decisions of the FOS are binding on insurers and can only be challenged by judicial review.

The English courts encourage alternative dispute resolution (such as mediation) both before and during arbitral or litigation proceedings. An unreasonable failure to engage in alternative dispute resolution may lead to the refusing party being required by the court to pay more of the other party's legal and other costs of pursuing the claim (or receiving less of their own costs if successful). Mediation is the most widely used form of alternative dispute resolution in insurance disputes, but other alternatives include expert determination, adjudication and early neutral evaluation.

It is common for English law-governed insurance contracts to contain a London-seated arbitration clause. The QMUL 2021 International Arbitration Survey identified London as the most popular choice of seat for arbitration and the London Court of International Arbitration as one of the five most preferred arbitral institutions. London also remains a popular choice of seat for arbitrations arising out of Bermuda Form excess liability insurance policies. Bermuda Form policies often achieve a transatlantic balance between the perceived insurer-friendly laws of England and the perceived insured-friendly laws of New York by providing for the policy to be governed by New York law but for disputes to be resolved in London-seated arbitration (and, thus, in accordance with English procedural law).

Under the Arbitration Act 1996, an arbitral award issued by a London-seated tribunal can only be challenged in the English courts on the basis:

- that the arbitral tribunal did not have substantive jurisdiction;[26]
- of a serious irregularity affecting the tribunal, the proceedings or the award and that has caused or will cause substantial injustice.[27] The types of serious irregularity are set out in Section 68(2) and range from the tribunal exceeding its powers to the failure of the tribunal to deal with the issues that were put to it; and
- of a question of law.[28] To challenge an award on this basis requires leave to appeal from the court (which is not required for a challenge under Section 67 or Section 68), which will only be given if the decision of the tribunal on the question of law is obviously wrong or the question is one of general public importance and the decision of the tribunal is at least open to serious doubt.

While it is common for London-seated arbitral agreements to exclude appeals on the grounds of a question of law, it is not possible to exclude appeals regarding substantive jurisdiction or serious irregularity.

IV THE INTERNATIONAL ARENA

The rules that will be applied by the English courts to determine where insurance disputes between international parties are heard depend on where the insurer and the insured are domiciled. Prior to Brexit, if both were domiciled in EU Member States, jurisdiction was determined in accordance with the Recast Brussels Regulation. If one party was domiciled in an EU Member State and another in an EEA Member State, then jurisdiction was determined in accordance with the Lugano Convention. After 31 December 2020 (Brexit Transition Day), the Recast Brussels Regulation and the Lugano Convention no longer apply where English courts have been selected in commercial contracts, unless the claim form in the dispute was

issued before Brexit Transition Day, in which case, and in any case where the defendant is domiciled outside the EEA, the jurisdiction of the English courts is determined by Part 6 of the CPRs. Domicile is determined as at the date of issue of the proceedings.

In 2021, the EU refused the UK permission to accede to the Lugano Convention, which in relation to insurance disputes is materially the same as the Recast Brussels Regulation.

However, the UK is party to the Hague Convention on Choice of Court Agreements 2005 (the Hague Convention). The Hague Convention requires contracting state courts (including all EU Member State courts) to respect exclusive jurisdiction clauses in favour of other contracting state courts and to enforce related judgments. The Hague Convention is more limited in scope than the Recast Brussels Regulation and the Lugano Convention as it applies only where parties have chosen an exclusive jurisdiction agreement. It is unclear whether asymmetric clauses fall within the scope of the Hague Convention, and so parties may increasingly move away from asymmetric jurisdiction clauses to ensure they fall within the Hague regime.

The Ministry of Justice has consulted on whether the UK should join the 2019 Hague Convention on the Recognition and Enforcement of Foreign Judgments (the Hague Judgments Convention). The objective of the Hague Judgments Convention 2019 set out in its recitals is to create a 'uniform set of core rules on recognition and enforcement of foreign judgments in civil and commercial matters'. Although the Hague Judgments Convention does not apply to judgments covered by the Hague Convention, it is wider in scope as it applies to judgments where there is a non-exclusive jurisdiction clause (including asymmetric jurisdiction clauses), and applies to a wider range of disputes. If the UK does ratify the Hague Judgments Convention, there is a required period of 12 months between the ratification and the convention taking effect. The jurisdiction of the English courts for proceedings commenced after Brexit Transition Day is now largely determined under the common law rules. Where the defendant (which in insurance disputes is usually, although not always, the insurer) is domiciled outside the EEA (or is domiciled within the EEA but proceedings are commenced after Brexit Transition Day), Part 6 of the CPRs provides that the English court will have jurisdiction over a dispute if the claimant has the right to serve the claim form on the defendant and the English court is satisfied that it is appropriate for the case to be heard in England. A claimant will have the right to serve the claim form on a defendant without the court's permission if the defendant is present in England (even if only temporarily and habitually resident overseas) or has nominated a solicitor or process agent in England who is authorised to receive service. Often in insurance policies with an English jurisdiction clause, the broker will be nominated as the process agent for service for all the insurers and so service issues are relatively uncommon in insurance disputes.

Immediately after Brexit Transition Day, changes were made to CPR6.33 to make it easier to serve out of the jurisdiction (largely by the Civil Procedure Rules 1998 (Amendment) (EU Exit) Regulations 2019/521). A claimant is no longer required to apply to the court for permission to serve a document other than a claim form outside the jurisdiction in certain circumstances. If permission is required, the claimant needs to satisfy the court that: (1) it has a good arguable case that one of the jurisdictional 'gateways' in CPRs Practice Direction 6B apply; (2) there is a serious issue to be tried; and (3) England is the forum where the case should properly be tried. The jurisdictional gateways of most relevance to insurance disputes are the gateway for a claim for an injunction (which is the relevant gateway for commencing proceedings for an anti-suit injunction if one party is threatening or commences proceedings in breach of the policy's jurisdiction or arbitration clause) and the gateway for a claim made in respect of a contract that is governed by English law or contains a jurisdiction clause in favour of the English courts. Recent amendments to Paragraph 3.1 of PD6B to the CPR, which came into effect on 1 October 2022, expanded the jurisdictional 'gateways', including amending the gateway for a claim made in respect of a contract to include contracts concluded by the acceptance of an offer that was made within the jurisdiction.

In practice, where an insurance policy contains an English court jurisdiction clause, the English courts are highly likely to assert jurisdiction. Conversely, if an insurance policy contains a jurisdiction clause in favour of another jurisdiction, the English courts are likely to respect that choice and decline jurisdiction.

The English courts will also respect the parties' choice of arbitration as their chosen dispute resolution mechanism and decline jurisdiction where there is a validly incorporated arbitration clause in a policy. It is not uncommon for an insurance policy to contain both an English court jurisdiction clause and a London-seated arbitration clause. Although those clauses are on their face inconsistent, the settled approach of the English courts is to interpret the clauses as providing for disputes to be resolved by arbitration, subject only to the supervisory jurisdiction of the English court.

For all insurance policies entered into after 17 December 2009, the English courts will continue to determine the applicable law in accordance with European Parliament and Council Regulation 593/2008, as it forms part of English law by virtue of the European Union (Withdrawal) Act (2018) (the UK Rome I Regulation).

In addition to where the dispute will be heard, and under what law, one further issue of importance for the arbitration of international insurance disputes is which arbitrators will hear the dispute. This is a matter of choice for the parties, with a mechanism usually provided by either the arbitration clause or a set of institutional rules to appoint a sole or third arbitrator in the event of disagreement. In *Halliburton v. Chubb*,[29] the Supreme Court considered whether an arbitrator may accept appointment in multiple arbitration proceedings in relation to the same subject matter but with only one common party, or whether doing so gave rise to an appearance of bias. Both Halliburton Company and Transocean Holdings LLC commenced separate arbitration proceedings against Chubb Bermuda Insurance Limited to recover losses arising out of the explosion on the Deepwater Horizon oil rig in the Gulf of Mexico. The same arbitrator was appointed to both tribunals, but the appointment in the Transocean arbitration was not disclosed to Halliburton. Under the Arbitration Act 1996, an arbitrator can be removed by the court for a lack of independence if it gives rise to justifiable doubts of impartiality. The test for whether justifiable doubts of impartiality are present is the same as the test for apparent bias in a judge in the English courts, namely whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility of bias. The Supreme Court held that the courts should apply that objective test to the facts of the particular case and with regard to the particular characteristics of international arbitration, including its (typically) private nature and any customs and practice in the relevant field of arbitration. Arbitrators have a legal duty under English law to disclose matters that might reasonably give rise to justifiable doubts about the arbitrator's impartiality and a failure to disclose relevant matters is a factor to be taken into account in considering apparent bias. The Supreme Court concluded that the arbitrators had breached their duty of disclosure in failing to disclose their appointment in the Transocean arbitration. However, on the facts of this case, non-disclosure would not have led the fair-minded and informed observer to conclude that there was a real possibility of bias.

In applying *Halliburton v. Chubb*, the recent case of *Africa Sourcing Cameroun Ltd v. LMBS Societe Par Actions Simplifiee* emphasised that, although the test is the same for judges and arbitrators, it is important to bear in mind that arbitration is generally conducted in private with limited public oversight and powers of review, so there is a 'premium on frank disclosure by arbitrators of circumstances which may give rise to doubts as to their impartiality'.[30]

V OUTLOOK AND CONCLUSIONS

As in the past two editions of this book, covid-19 and the challenges deriving from the pandemic have been a dominant theme in insurance disputes this year. England and Wales was one of the first jurisdictions to examine, at speed, the issues of recovery of losses for business interruption as a result of the covid-19 pandemic. The first use of the Financial Markets Test Case Scheme by the regulator, the Financial Conduct Authority, for this purpose has meant that precedential clarity was obtained swiftly from the UK's highest court on the most common forms of policy in the market, meaning that in 2023 (as in 2022) insurers have continued to focus on resolving the large volume of claims against such policies resulting from covid-19 and the national lockdowns in the UK. As discussed in Section II, this year the

courts considered a range of issues, including the aggregation of claims for the purpose of policy limits provisions and the treatment of furlough payments and Business Rates Relief in the quantification of claims.

The effects of the conflict in Ukraine have also continued to be felt in the insurance market in 2023. In England and Wales, a number of actions have been brought in the Commercial Court involving claims by lessors of aircraft (and/or aircraft equipment, such as engines) against the insurers of their contingent and possessed policies in respect of the alleged loss of assets leased to Russian airlines since the Russian invasion of Ukraine. The Commercial Court has adopted a proactive approach to the case management of these proceedings: a joint case management conference for five of the cases took place in March 2023 and directions were given for a concurrent trial in late 2024.[31] A number of claims in the Commercial Court have also been commenced by lessors against the international reinsurers of the Russian insurers of policies of the taken out by the Russian lessees ('Operator Policies'). The reinsurers have disputed the jurisdiction of the English courts to hear those claims, and there is four-day jurisdiction hearing listed in February 2024 across all such claims filed to date.

A new 'consumer duty' introduced by the FCA came into force on 31 July 2023 for new and existing products and services that are open for sale or renewal. It will be introduced on 31 July next year for closed products or services. The duty requires regulated firms, including regulated insurers, to deliver good outcomes for retail customers. Firms are required, under the duty to act in good faith towards customers, to avoid causing foreseeable harm and to enable and support customers to pursue their financial objectives. While it may take some time for cases arising out of the consumer duty to reach the courts in England and Wales, it is to be expected that the correct interpretation and implementation of the new rules will be a focus for insurers and the FOS in the coming year.

Although the Insurance Act 2015 has now been in force for some years, it remains to be seen precisely how certain provisions of the Act will be applied. The Act potentially represents a major rebalancing of rights and obligations between insureds and insurers (in favour of insureds), but indications are that insurers are seeking to contract out of many of the provisions of the Act where possible in commercial policies.

Warranty and indemnity insurance and cyber insurance are two of the fastest-developing policy markets in England and the terms of both types of policy are becoming increasingly standardised. There have only been a limited number of significant disputes in relation to these types of policies, although we anticipate that will change in the next few years, especially with the increasing importance of private capital in global mergers and acquisitions markets, and as cyberattacks are becoming an increasingly common experience for businesses.

The coming into force of the General Data Protection Regulation has also generated interest in the extent to which the risks of failing to comply with the Regulation are insurable. The position is likely to be that insurance will not be available for any fines imposed under the Regulation or under the related Data Protection Act 2018 (either because English law prohibits the insurance of fines or because policies will specifically exclude them). However, insurance may be available for the costs of participating in an investigation by the Information Commissioner's Office and defending any subsequent proceedings. Insurance disputes arising out of data protection breaches may also be a developing area in the coming years. Disputes relating to a failure to appreciate the effect of artificial intelligence also look likely to be a developing area.

The use of after the event insurance to cover costs risks in English litigation has also increased significantly in recent years, both as a result of reduction in availability of legal aid at one end of the scale and the increased importance of litigation funding in English disputes at the other end.

In addition to these areas of potential development, climate change remains an area where claims must surely begin to rise. There appear to be no insurance claims before the English courts in this area as yet, but all eyes are on that space. Individual directors or officers that find themselves targeted by third-party claims or by regulators may also have cover under directors' and officers' insurance policies.

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Endnotes

1 Russell Butland is a partner, India Jordan is a senior associate and Abigail Witts is an associate at Allen & Overy LLP.
2 Lord Mansfield's celebrated judgment in Carter v. Boehm (1746) 3 Burr 1905, 96 ER 342, which established the concept of utmost good faith in English insurance law, concerned an insurance policy taken out on a fort in what is now Indonesia.
3 Ad hoc arbitration under the Arbitration Act 1996 (10 September 2021).
4 [2022] EWHC 409 (Comm).
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31 The cases are Aercap Ireland Ltd v. AIG Europe SA and Anor, Dubai Aerospace Enterprise and Others v. Lloyd's Insurance Co. SA and Others, Falcon 2019 v. Lloyd's Insurance Co. SA and Others, KDAC v. Chubb European Group and Others and Merx Aviation Servicing v. Chubb European Group.

Chapter 7

Finland

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Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

In Finland, an insurance-related dispute typically concerns the coverage of an insurance policy, and, hence, whether a damaging event reported to the insurer by the insured is covered by the insurance. Additionally, insurance-related disputes often concern insurance compensation, the amount of which the insured is unsatisfied.

In the majority of cases, the dispute does not end up in the Supreme Court but is finally settled by a district court, court of appeal or, most commonly, through arbitration in the case of business to business (B2B) insurance. Therefore, the publicly available case law of the Finnish Supreme Court on insurance is rather limited. Hence, some relevant case law regarding consumer insurances might also be relevant in the case of B2B insurance.

In addition to general courts, the Finnish Financial Ombudsman Bureau (FINE) handles insurance disputes and gives the parties solution recommendations. These recommendations are not binding by nature and do not obligate the parties to comply with them. However, in practice, insurance companies tend to follow the recommendations in their compensation decisions, which makes recommendations of FINE also relevant to all insurers.

Recent publicly available Finnish insurance law-related disputes have concerned mainly natural persons and the applicable insurance policies. The recent recommendations of FINE also include mainly disputes regarding natural persons insurance.

II YEAR IN REVIEW

In Finland, insurance-related disputes in which the policyholder or insured is a legal person are often resolved by arbitration and, thus, there is very little case law publicly available. Accordingly, most of the publicly available cases from recent years have involved natural persons (including entrepreneurs) and insurance policies relating to the daily insurance of natural persons. Such cases have been handled by the general courts, the Insurance Court and FINE.

For this reason, publicly available business-related cases include rather old Supreme Court precedents dating back as far as the 1990s and 1980s. However, the following presents the most relevant insurance case law in Finland over the years, which has been given weight, for example, in Finnish legal literature and, further, is still influencing the interpretation of insurance disputes today. Supreme Court precedents are given strong value in the assessment of similar cases in general courts, and general courts often refer to the precedents of the Supreme Court, if applicable, in their judgments.[2]

One of the most fundamental precedents of relevance relates to the 'claims made' principle. In Supreme Court judgment KKO 1997:134, the Supreme Court assessed the notification obligation of a policyholder or insured regarding changing circumstances during the policy period compared to the circumstances notified to the insurer when concluding the insurance contract. The parties had agreed under the insurance policy that the policyholder must notify the insurer immediately in writing of any information received that a claim is to be made against the insured. However, the insured had not complied with the notification obligation and failed to inform the insurer of the claim made.

In principle, failure to comply with such an obligation could be considered to constitute a breach of contract and a valid reason for the insurer at least to reduce the amount of insurance compensation. However, in this case, the Supreme Court considered that even though the insured did not notify the insurer of the claim, the insurer was not relieved of its liability under the insurance policy as the Supreme Court considered the insurer to have become aware of the claim against the insured based on an article published in a daily newspaper. The Supreme Court further considered the fact that the information of the claim had not come from the insured, had not caused the insurer any loss or damage, and the insurer was not relieved of its liability under the insurance contract.

The Supreme Court's judgment underlined the interests of the insured to such an extent that the insurer could not be released from its obligation even in case of the insured's breach

of contract. It can, therefore, be considered that, in principle, the interests of the insured are strongly protected and the refusal to pay compensation in full may require more than a formal breach of contract on the part of the insured, on a case-by-case basis.

In another precedent, in Supreme Court judgment KKO 2002:65, the Supreme Court assessed the relevance of the answers given by the policyholder when applying for insurance to the questions asked by the insurer in order to assess the granting of insurance. According to Finnish insurance law, the policyholder or the insured does not have to provide information on their own initiative.[3] In other words, the insurer should ask all the relevant questions relating to the said insurance contract, and the policyholder or insured only has a duty to answer the insurer's questions truthfully.[4]

The relevant question was whether the question of an alcohol problem in the medical declaration attached to the application for personal insurance was open to interpretation in such a way that the insured had the right not to declare an alcohol problem. In principle, under the Finnish Insurance Contracts Act (ICA), the insured has only an obligation to answer truthfully the insurer's questions but has no obligation to provide information other than that requested by the insurer. However, it is worth noting that in this case the insured was a natural person.

The Supreme Court assessed the insured's obligation to provide information under the ICA based on the insurer's need to obtain information about the insured that is necessary to assess its own risk and the insurability of the insured person. The key issue was whether the insured's failure to disclose such relevant information entitled the insurer to refuse compensation. The Supreme Court concluded that the ambiguity of the insurer's questions could not be resolved merely on the basis that the wording of the question might be interpreted in different ways. Instead, 'the whole content and purpose of the question and how the question can be naturally understood in general' must be taken into account. Thus, the Supreme Court considered that it was the insurer's clear intention to obtain such relevant medical information and the insured had failed to provide this information because of negligence. The Supreme Court found that the insurer had proper grounds to refuse compensation.

Although the judgment considered a natural person as insured, the judgment set a statement on insureds' obligation to provide relevant information and that this obligation could not be circumvented on the basis of mere formalities. As natural persons or consumers are often more strongly protected by law, the precedent sets even stricter requirements for legal persons as insured when answering insurers' questions, protecting insurers' rights to obtain the information necessary for the risk assessment when granting insurance.

In Supreme Court judgment KKO 2017:44, the Supreme Court considered whether a contractual obligation and failure to comply with this obligation by the insured, and the resulting damage, constituted an insured event under the insurance policy. The insurer refused to compensate the damage because, under the terms of the liability insurance, the policy did not cover the damage to the extent that liability was based on a contract, guarantee or other commitment, unless such liability would have existed in the absence of such a commitment. The Supreme Court considered that since the insured's obligation was based solely on an agreement, the damage caused by the failure to comply with the obligation was not covered by the liability insurance.

The Supreme Court considered that as the insured's liability was clearly contractual, the question under the contractual obligation exclusion clause was to assess whether there would have been liability in the absence of the agreement.[5] The precedent sets a rather clear rule that an explicit exclusion of the insured's contractual obligations results in a limitation of the insurer's liability when the obligation would not arise in the absence of the agreement.[6] Thus, the insurer is not liable to cover the damage caused by a contractual obligation when an explicit exclusion is included in the policy.

A more recent insurance disputes case concerned the interpretation of an insurance policy and was considered in the Supreme Court judgment KKO 2022:62. During the covid-19

pandemic, the serving and opening hours of restaurants and the number of customers were restricted by government decrees. A restaurant company claimed compensation from epidemic interruption insurance for damage caused by these restrictions.

The insurance in question covered damage caused by business interruption, which was a direct result of a binding order issued by the Finnish authority during the insurance period based on, for instance, the Communicable Diseases Act to resist infectious diseases. As the policy did not specify in more detail what was meant by 'binding order issued by the authority', the Supreme Court was to decide whether the government decrees should be regarded as binding orders issued by an authority based on the aforementioned Act within the meaning of the insurance policy.

The Supreme Court noted that, for the sake of uniform application of standard insurance conditions, it was justified to interpret the condition objectively. The achievement of said objective is facilitated by the fact that the legal concepts and terms used in insurance policies are understood, in principle, as their meaning in the relevant field of law. The Supreme Court held that the government decrees were not to be regarded as an order issued by an authority under said Act within the meaning of the insurance policy. Therefore, the Supreme Court considered that the damage caused to the restaurant by the restrictions was not a compensable insured event.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

In Finland, most of the regulation concerning life and non-life insurance companies is based on directives of the European Union.

The ICA, applicable to all forms of insurance other than statutory insurance and reinsurance, forms the most relevant piece of insurance related legislation in Finnish law. The ICA entered into force in 1995 and contains provisions on, inter alia:

- the information to be disclosed in insurance contracts;
- the validity of insurance contracts and amendments thereto;
- the liability of the policyholder and the insured;
- any exclusions from cover;
- the insurance premium; and
- the claims settlement.

The ICA does not contain provisions on the specific terms and conditions of the insurance policies or the interpretation thereof. Thus, the principles of interpretation of the insurance policies are left to the common claims-handling practice, legal doctrine and case law.

The ICA is, as a rule, of a mandatory nature. Any terms or conditions of an insurance contract that deviate from the provisions of the ICA to the detriment of (1) an insured person or a person entitled to compensation or benefits other than the policyholder, or (2) a policyholder that is a consumer or a legal person that can be compared to a consumer based on the nature and scope of its business or other circumstances, shall be null and void. However, the mandatory nature of the ICA is not applicable to credit and suretyship insurance, marine or cargo insurance, or aircraft insurance.

Additionally, relevant legislation related to insurance consists of, inter alia:

- the Insurance Companies Act stipulating the establishment, administration and operations of an insurance company registered under Finnish law;
- the Act on Foreign Insurance Companies applicable to insurance companies in European Economic Area (EEA) states and third countries, and stipulating foreign insurance companies' right to undertake insurance business in Finland and the requirements thereof; and
- the Act on the Provision of Insurances, which concerns insurers, full-time and part-time insurance agents and insurance brokers who:
  - prepare insurance contracts;

- provide personal recommendations and other information concerning insurance contracts;
- conclude insurance contracts; and
- assist in the management and completion of insurance contracts.

The Act on Earnings-Related Pension Insurance Companies contains special provisions that apply only to earnings-related pension insurance companies ensuring that such insurance companies are independent of the other insurance companies in the same group, the company's owners and financial institutions. Further, the provisions of the Finnish Tort Liability Act shall be applied when determining the compensation for personal injuries. Currently, no relevant or material amendments to the legislation mentioned above have been made.

In addition to legislation, the general principles of insurance and tort law, which play a central role in Finnish insurance law, are applicable to insurance contracts and policies, and to compliance with them. The principles set obligations on both the insurer and the policyholder or insured. These include, inter alia, the principle of non-enrichment according to which compensation cannot place the injured party in a better financial position than before the damage occurred. Therefore, the insured cannot benefit from the damage caused by the insured event and cannot, for example, claim the same compensation for the same event from the insurer multiple times or several insurers.[7] In addition, the insured has an obligation to mitigate the damage by acting in a way to minimise the amount of damage and, thus, the compensation to be covered by the insurance.

The insured must follow the instructions of the insurer in the case of an insured event to limit the damage. For example, in the Supreme Court's judgment KKO 1995:40, the Court dismissed the insured's claim for compensation on the grounds of failure to comply with the insurer's instructions. The insured had claimed compensation for the loss of the tax advantage from the insurer that had provided the liability insurance. The insurer gave instructions to the insured to avoid further damage, but the insured decided to avoid the loss by an alternative tax arrangement than the one proposed by the insurer, which failed. By acting contrary to the insurer's instructions, the Court found that the insured had taken a conscious risk by choosing prevention means that had failed.

Further, the general contractual principles apply to insurance contracts when the policyholder or insured is not a natural person. These include, inter alia, obligations relating to the duty of loyalty and duty of care on fulfilling the contractual obligations of the parties. These contractual principles are generally applicable and can be used in insurance disputes as supporting arguments.[8] Further, if the wording of a clause in the insurance contract or policy is considered ambiguous, the general rules and principles of contract and insurance law shall be applied to the interpretation of the clause in addition to the exact wording of the clause.[9] In addition, if the contract or policy includes an ambiguous clause, it shall be interpreted to the detriment of the insurer (i.e., the drafter of the contract). For these reasons, careful consideration should be paid when drafting insurance contracts and policies.

The insurer must also follow good insurance practice. However, the definition of 'good practice' has not been covered by law and is left to FINE and the courts to define in Finnish case law. According to FINE, good insurance practice refers to well-established good habits and practices in the insurance industry that guide the way the industry operates. Good practice imposes an obligation on the insurer to act professionally and with due care and attention to the interests of the policyholder. Further, good insurance practice affects the insurance contract relationship and relates to the principle of loyalty in contract law, as mentioned above. This means that good insurance practice includes the requirement of cooperation between the parties to the contract and consideration of the other party's interests. However, the duty to act in accordance with good insurance practice applies only to the insurer, not to the policyholder or insured. More generally, good insurance practice determines how insurers should organise their business and conduct their relations with the world around them.[10]

ii Insurable risk

In Finland, there is no particular legislation stipulating the issue of which risk can or cannot be insured; nor is there a clear definition of insurable risk. Instead, it is left to the common practice and the product development of the insurance companies to define the scope of the insurance and the restrictions thereof, including insurable risks and insured events under the policy.[11]

In Finnish legal literature, the definition of insurable risk has been classified into dynamic and static risks. Static risks refer to risks that are relatively unchanging and, in practice, usually insurable, such as a risk of fire. Dynamic risks, in turn, refer to risks that change according to circumstances, and may also be called business risks. Such risks have generally not been considered insurable risks.[12] Also, the insurability of a risk consists of certain conditions that shall be met:

- the risk must be foreseeable;
- the risk must be independent of the insured or beneficiary;[13]
- the risk must be stable over time (i.e., the risk must not change unpredictably over time to a great extent); and
- the occurrence of the risk must be rare.[14]

Therefore, general business risks cannot, as a rule, be insured. Insurance is mainly aimed at protecting against risks arising from unexpected and sudden events.

An insurance contract cannot be concluded for a known claim or an insured event that has already occurred in the past. If the insured event has already occurred before the conclusion of the insurance contract, even a clause on retroactive commencement of the insurer's liability cannot cover the event. In cases of this kind, the contract would not be considered an insurance contract but, rather, a contract on compensating the damage.[15]

Although it is left for the insurer to define the insurable risks or insured events covered by the insurance policy, there are certain restrictions under law. As a rule, only legal interests can be insured. Thus, insurance cannot cover any damage, loss or other interest that has arisen illegally by the insured. Additionally, criminal and administrative sanctions, such as fines, are not covered by insurance. Further, only interests that are in accordance with good practice can be covered by insurance.

iii Fora and dispute resolution mechanisms

If an insured is not satisfied with the insurer's decision, the insured may contact the insurer and request a reconsideration of the decision. This mechanism is often used if there is a clear technical or other error in the insurer's decision that can easily be rectified, or if the insurer considers the insured's request for rectification to be otherwise justified.

The matter may also be referred to an alternative dispute resolution body such as the Insurance Complaints Board operating under FINE or, if the insured is a consumer, to the Consumer Disputes Board. The resolutions issued by these bodies are not binding on the insurer but are rather of a recommendatory nature. However, insurance companies have, in practice, followed the recommendations issued by these bodies to a great extent.

As an actual dispute resolution mechanism, the insured may refer the matter to a competent district court (i.e., the court of first instance). Under the ICA, any statement of claim based on either a decision made by the insurer on a claim or another decision that affects the position of the policyholder, the insured or another party entitled to compensation or benefits, shall be filed within three years from the date on which the party concerned received the insurer's written notice of the decision and the time limit. The statement of claim shall be filed within the three-year time limit under penalty of forfeiture of the underlying right.

The procedural rules, including the rules for determining jurisdiction, set out in the Finnish Code of Judicial Procedure, apply to insurance-related disputes. The dispute is, as a rule,

considered by the district court with jurisdiction over the place where the defendant has its domicile (***forum domicilii***). However, in practice, a choice of court agreement is often applicable for corporate customers.

The procedural rules on appealing a court decision apply to insurance-related cases in the same way as to other civil cases. A judgment of a district court may be appealed to the competent court of appeal. In a civil case, an appeal is subject to leave for continued consideration granted by a court of appeal. Leave for continued consideration shall be granted if:

- there is cause to suspect the correctness of the final result of the decision of the district court;
- it is not possible to assess the correctness of the final result of the decision of the district court without granting leave for continued consideration;
- in view of the application of the law in other, similar cases, it is important to grant leave for continued consideration on the matter; or
- there is another important reason for granting leave.

An appeal of a judgment of a court of appeal lies to the Supreme Court. However, to appeal a decision of the court of appeal, leave to appeal shall be requested from the Supreme Court. Leave to appeal may be granted only if it is important to bring a case before the Supreme Court:

- for a decision with regard to the application of the law in other, similar cases or because of the uniformity of legal practice;
- if there is a special reason for this because of a procedural or other error that has been made in the case on the basis of which the judgment is to be reversed or annulled; or
- if there is another important reason for granting leave to appeal.

The requirements for leave to apply are restricted and high. Thus, in practice, it is extremely rare that the Supreme Court would grant leave to appeal. Therefore, the majority of cases are finally settled by the court of appeal.

Insurance-related disputes may also be resolved by arbitration. If the relevant insurance policy provides for an agreement to arbitrate, the dispute shall be resolved by arbitration. Finnish insurance policies applicable to large corporate customers commonly include a clause on dispute resolution referring to arbitration instead of general courts. The more valuable the insurance at hand is, the more often the policy refers to arbitration. Arbitration is common also in insurance cases involving international aspects. Arbitration under the Arbitration Rules of the Finland Chamber of Commerce is often used in insurance policies governed by Finnish law.

The Insurance Court is an independent and impartial special court dealing with income security matters in Finland. The Insurance Court has jurisdiction in matters concerning, inter alia, a person's right to an earnings-related pension, a national pension, unemployment benefits, wage security, housing allowance, financial aid for students and disability benefits paid by the Social Insurance Institution of Finland. The Insurance Court also deals with matters related to benefits under the Health Insurance Act, rehabilitation, right to compensation for occupational accidents and diseases, criminally caused injuries, military injuries and military accidents.

The Insurance Court's jurisdiction does not, however, include vehicle or household insurance matters or matters concerning any other private insurances.

IV THE INTERNATIONAL ARENA

The Act on the Law Applicable to Certain Insurance Contracts of an International Nature lays down the law applicable to an insurance contract where the risk covered by non-life insurance is situated in an EEA state or, where the habitual residence of a life policyholder (or, if the policyholder is a legal person, the establishment to which the contract relates) is situated in an EEA state. According to the Act, the contracting parties may, without limitation, agree on the applicable law in the insurance contracts covering large risks. Likewise, a reference to the

law of the state in which the policyholder is permanently resident can be agreed upon. If the risk is not located in the state where the policyholder is permanently resident, an insurance contract may be concluded for reference to the law of the state in which the risk is located.

If the parties have not agreed on the applicable law, the law of the country in which the policyholder is permanently resident or, if the policyholder is a legal person, where its central administration is located, shall be applied if the risk is also located in the same state. Otherwise, the law of the country with which the contract has its closest connection shall apply. Unless otherwise shown, the agreement is considered to have the closest connection with the country in which the risk is located.

Finland is a party to the Convention on the Law Applicable to Contractual Obligations concluded in Rome on 19 June 1980 (the Rome Convention). Therefore, insurance contracts shall also be governed by the provisions of the Rome Convention. Apart from a few restrictions applicable to insurance contracts, the main principle of the Rome Convention is that the contracting parties may choose and agree upon the applicable law.

In addition, Regulation (EC) No. 593/2003 on the law applicable to contractual obligations (Rome I) applies when assessing the applicable law on international contracts. The Rome I Regulation largely follows the rules of its predecessor, the Rome Convention. However, it contains some completely new provisions; for example, on insurance contracts, contracts of carriage and set-off. The Regulation applies to all conflict-of-law issues relating to contractual obligations in civil and commercial matters, with the exception of matters excluded by the Regulation.

As a rule, a civil judgment issued in a foreign country is recognised and enforced in Finland only if this has separately been agreed upon in an international treaty binding on Finland or provided for in the national or EU legislation. Among EU Member States, such as Finland, Regulation EU 1215/2012 of the European Parliament and of the Council on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (Brussels I) shall apply to a judgment issued in a case that has commenced on or after 10 January 2015. Brussels I provides rules on the jurisdiction of the courts and on the rapid and simple recognition and enforcement of judgments in civil and commercial matters given in the Member States. Judgments and court settlements falling within the scope of application of Brussels I are directly enforceable in another EU Member State. A judgment given in a Member State and enforceable in that state shall be enforced in another Member State without any declaration of enforceability being required. In Finland, Brussels I is nationally supplemented by the Act on the application of the Regulation of the European Parliament and of the Council on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

As for the enforcement of arbitral awards rendered in a foreign country, the Convention on the Recognition and Enforcement of Foreign Arbitral Awards, concluded in New York on 10 June 1958, shall apply. Apart from a few exceptions specified in the Finnish Arbitration Act, the main rule of the Arbitration Act is that an arbitral award that has been made in a foreign state by virtue of an arbitration agreement shall be recognised in Finland. However, a foreign arbitral award shall, inter alia, not be recognised in Finland to the extent it is contrary to the public policy of Finland.

The majority of insurance-related disputes involving international parties are referred to arbitration. Therefore, the case law that is publicly available is quite restricted.

V OUTLOOK AND CONCLUSIONS

During the past few years, an increasing trend within the claims sector has been the ever-greater complexity of underlying facts in insurance claims (e.g., professional liability in software development deliveries, cyber risks, pharmaceutical products). This often prolongs the handling times of claims to several years because of extensive document and information requests from insureds and the obligatory use of external experts in the claims-handling process, leading finally to dissatisfaction among insureds. This dissatisfaction then results in sometimes unnecessary, and exhausting, claims in litigation or arbitration.

Another trend has been a change in the distribution of insurance products. Because of ever longer distribution chains and technology platforms – and, further, the bundling of insurance products together with other products and services – claims have also become even more complicated.

On account of international sanctions against Russia, we are seeing some potential claims in respect of different insurances concerning deliveries and the import and export of products and services. We consider it likely that these claims cases will increase in number in the near future.

Further, fraud cases have become more frequent in the field of insurance than ever before. This development can be seen in particular in matters concerning credit loss insurance, and in cases where there are multiple parties from multiple countries involved. Our understanding is that these cases have become more frequent because of the pandemic – and travelling restrictions – making it difficult to assess the real situation of the claimed transactions in different jurisdictions.

Finally, in June 2023, the Financial Supervisory Authority (FIN-FSA) issued an extensive report on how the regulation concerning provision of insurance products (IDD) is complied with by the insurance companies. The goal of the report was to obtain an overview of compliance and application of the broad regulation of insurance provision in insurance companies, which came into force in 2018.

Although FIN-FSA considered that the insurance companies have comprehensive instructions and process descriptions required by law, FIN-FSA made many observations about shortcomings in provision of insurance products and issued several recommendations for the insurance companies concerning, for example, target marketing of the products, the product management procedure, product testing, use of agents and compliance with the delivery strategies. FIN-FSA's work will continue, and compliance with the recommendations made in the report will be evaluated later in the context of ongoing monitoring. These new recommendations and guidelines contain new rules that not all of the insurers currently comply with. Hence, we expect that the new recommendations and non-compliance will lead to an increasing number of claims cases and litigation in the future.

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Endnotes

1 Olli Kiuru is a partner, Antonina Paasikivi is a counsel and Janiela Valtonen is an associate at Waselius & Wist.
2 See Kari Kuusiniemi: 'Ylimpien tuomioistuinten asema ja prejudikaatit oikeusyhteisössä'. Lakimies 7-8/2021, pp. 1366–1374.
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4 Hoppu E and Hemmo M (2006) Vakuutusoikeus. Helsinki, p. 63.
5 KKO 2017:44, Section 26.
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7 Hoppu E and Hemmo M (2006) Vakuutusoikeus. Helsinki, p. 280. See also the Supreme Court's judgment KKO 2000:18.
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10 See FINE's guidelines on good insurance practice (available in Finnish): https://www.fine.fi/oppaat/julkaisu/hyva-vakuutustapa-ja-vakuutuslautakunta.html.
11 Hoppu E and Hemmo M (2006) Vakuutusoikeus. Helsinki, p. 28.
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13 For this reason, pure business risks and commercial risks are generally not insurable. See Rantala J and Pentikäinen T (2009) Vakuutusoppi. 11. uud. p. Helsinki, p. 68.
14 Rantala J and Kivisaari E (2014) Vakuutusoppi. 12. uud. p. Helsinki, pp. 79–80 and Rantala J and Pentikäinen T (2009) Vakuutusoppi. 11. uud. p. Helsinki, pp. 67–69.
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Chapter 8

France

Erwan Poisson and Julie Metois[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

New legal developments have not resulted in major changes this year. Most of the changes provide clarifications about well-established rules of insurance disputes in substantive and procedural terms that are helpful for practitioners. Nonetheless, the evolution of the insurance market and recent trends within insurance litigation raise many thorny issues that remain unresolved.

II YEAR IN REVIEW

i Significant cases in procedural terms

Bringing an action in insurance litigation

The special limitation period must be mentioned in some insurance policies pursuant to Article R112-1 of the Insurance Code.

In this respect, the Court of Cassation has held that an insurer who fails to fulfil this obligation cannot rely on either the special limitation period or the general limitation period (five years).[2] In 2022, the Court of Cassation specified that in such instance, the insurer can invoke neither the two-year limitation period specific to insurance matters nor the general time limitation of five years.[3] In addition, the burden of proof regarding the communication of the limitation period lies with the insurer.[4] Practitioners must also be aware that certain actions arising from the insurance relationship are not subject to the two-year limitation period.[5]

Conducting insurance litigation

Under French law, the insurer can conduct proceedings on behalf of the policyholder against a third party. By doing so, the insurer waives raising certain defences accruing from the insurance relationship in any concurrent or subsequent claims against the policyholder (except when specifically otherwise provided by the insurer).[6] It is, however, well established under case law that the waived defences are only related to the guarantee and do not concern the 'nature of the risk covered, nor the amount of compensation'.[7]

This distinction can be very hard to make in practice and frequently needs clarification by the courts. For instance, in *Perron company and others v. Allianz IARD*,[8] it was ruled that the clause that limited the guarantee to certain circumstances in which a risk occurred did not concern the nature of the risk covered.

Burden of proof in insurance litigation

Over the past few years, the Court of Cassation issued several interesting rulings with respect to the burden of proof. In a first case, the Court ruled that the insurer, who claims the guarantee should not apply given the policyholder's scope of business and specific terms applicable to that business, should demonstrate that it put the policyholder on notice of the specific terms and that the latter agreed to these terms.[9] In a second case, the Court recalled that if proceedings are initiated by the victim of the damage against the policyholder's insurer, the insurer has the burden to file as an exhibit a copy of the insurance policy, since the victim has no copy of such document.[10] In a third, even more recent, case the Court of Cassation ruled that the burden of proof for exclusion of cover lies with the insurer, not the policyholder. In this case, while the insurer invoked an exclusion clause, the Court of Cassation judged that a court of appeal could disregard such clause and condemn the insurer because the latter did not evidence that the clause had been known by and accepted by the policyholder.[11]

Similarly, in a preliminary ruling of April 2023, the European Court of Justice recalled that if a consumer could not become acquainted prior to the conclusion of an insurance contract with one of its terms that limits coverage, the national court is required, if this term is found to be unfair, to exclude the application of that clause in order that it may not produce binding effects with regard to that consumer.[12]

Settlements in insurance proceedings

In ***National Military Security Found and Benoit X v. Crédit Mutuel and Guillaume Y***,[13] the Court of Cassation held that the waiver of future claims contained in a settlement agreement prevents the victim from claiming further damages even if they were not covered by the settlement.

In this case, the victim suffered various losses then signed a settlement agreement with the insurer of the wrongdoer. Afterwards, the victim sued the wrongdoer and his insurer for further damages that were not covered by the settlement. Under French law, there are two contradictory theories to resolve this issue. First, the 'theory of the scope of settlements' states that the settler may claim for some losses that are not pointed out in the settlement. In contrast, the 'theory of abandonment' states that the settler waives all his or her rights to claim for damages related to the dispute regardless of the fact that the settlement does not deal with them.[14] In the matter at hand, the Court decided that the abandonment theory should prevail because the settlement agreement stated that 'the victim declares himself to be satisfied of all of his rights'. However, this does not mean that the same rule will apply in every case. It mainly depends on the way the settlement agreement is drafted.

In *CRAMA v. Mr X*,[15] it was found that the insurer cannot raise a settlement agreement concluded with the victim of the wrongdoing against the co-perpetrator of the damage.

In this case, the damage was caused by two wrongdoers. The insurer of the first wrongdoer concluded a settlement with the victim and compensated her. Then, the insurer of the first wrongdoer sought to reclaim half of the settlement sum from the second wrongdoer. However, the Court of Cassation found that the second wrongdoer was not bound by the settlement agreement concluded by the first wrongdoer. The fact that the second wrongdoer was aware of the settlement did not mean that it could be enforced against him.

ii Significant cases in substantive terms

Pre-contractual stage

Insurers usually require policyholders to issue a risk of statement before the conclusion of the insurance policy. In practice, it means the policyholder has to fill out an application form before entering the insurance policy. When the policyholder has made a false statement, it is usually raised by the insurer as a defence to deny the insurance claim.[16]

However, the insurer can invoke a false statement made by the policyholder in the insurance form only if the questions asked by the insurer were sufficiently precise.[17] The insurer has to prove it had asked clear questions to raise any defence based on the policyholder's false statement. Consequently, if the question is slightly unclear or stated in overly general terms,[18] the insurer loses any defence based on the imprecise answer given. Accuracy is particularly important as an insurer cannot invoke an omission or a false statement from the policyholder if the questions asked within the application form did not involve the disclosure of the relevant information. In *Mrs H and Mr V v. Macif*, the insurer could not blame the policyholder for not disclosing that her son was a secondary or occasional driver of the insured vehicle because the insurer had not asked questions about secondary or occasional drivers.[19]

To the opposite, the Court of Cassation recently upheld an appeal decision that declared null and void an insurance contract because of the voluntary omission made by the policyholder, who, therefore, had to reimburse the payments received from the insurance company.[20]

Defences of the insurer against the policyholder

Legal exclusion of intentional breaches

A risk brought about by intentional or wilful misconduct by the policyholder is not insurable. For the past decade, the second civil chamber of the Court of Cassation had approved reasoning of the Court of Appeal that distinguished intentional misconduct, characterised by the insured's willingness to create the damage as it happened,[21] from wilful misconduct,

characterised by the insured's awareness that their action has the effect of making the damage inevitable.[22] Very recently, the third civil chamber of the Court of Cassation adopted the same dualist approach between intentional and wilful misconduct.[23]

On this basis, the Court of Cassation recently denied the insurability of a barn destroyed as a result of the owner's failure to repair it. The Court held that the owner could not be unaware of the risk of collapse. Thus, by making the risk certain, the insuree had committed wilful misconduct, thereby excluding the insurer's liability.[24]

As an example, in *Axa France IARD v. Generali IARD* it has been reaffirmed that damage resulting from intentional misconduct is excluded from insurance coverage whereas damage not resulting from such misconduct should be included.[25] In this case, the policyholder's son had committed arson by setting fire to furniture outside an establishment, but the fire had spread to the inside of the establishment as well. The Court of Cassation ruled that the policyholder's son, while he sought to cause damage to furniture outside the establishment (damage that was, therefore, excluded from insurance coverage), did not intend to cause damage inside the establishment. Consequently, insurance coverage was still due for the damage to the facility. In *Family'Immo v. Lloyd's*,[26] the Court of Cassation ruled that the serious negligence of the policyholder who knowingly put its clients at risk did not amount to the intentional misconduct required to exclude the risk's coverage by the insurer.

In this case, an estate agency, Family'Immo, knew that the property bought by its clients had several construction defects but made the sale anyway. Family'Immo was found liable for contractual breach and asked its insurer, Lloyd's, to compensate its client. The Court ruled that even if the negligence of Family'Immo was unacceptable for a professional since it acted in bad faith, it did not amount to an intentional breach within the meaning of the Insurance Code.

Contractual exclusion: recent application

In addition to the legal exclusions, insurers can exclude some risks from the insurance policy. Pursuant to Article L113-1 of the Insurance Code, those contractual exclusions have to be 'formal and limited'. The formal and limited criteria aim at providing the insured with certainty as to when and under what conditions he or she is not covered.[27] A significant part of the insurance litigation in France is related to this issue.

The exclusion clause is formal when it is clear and leaves no room for uncertainty as to the parties' intention to exclude coverage in a particular case. It is limited when its wording is sufficiently precise, not only to enable the insured to know exactly the area of the exclusion of coverage, but also to avoid emptying the coverage of its substance.[28]

In construction insurance, the activity declared to the insurer excludes risks from other undisclosed activities. In the important case of *M C v. Mutuelle du Mans IARD*, the insured builder had contracted an insurance policy hedging the risk concerning only its structural work.[29] The builder, Euroconstruction, entered into a contract for the entire construction of a single-family house. The Court of Cassation ruled that the damage caused on this site was not covered by the insurance as the activity of building a single-family house was not expressly included in the contract.

Upon the occurrence of the damage, the insured must put in a claim accurately and faithfully. The insurer may exclude coverage because of a false statement of claim. To benefit from this exclusion, it was held that it must be provided for in the insurance policy by the insurance company, which must demonstrate the insured's bad faith.[30]

Conditions of guarantee: the hard hurdle of policyholders

To limit the coverage, an insurer may also protect itself by setting out conditions precedent in the insurance policy. Usually, the policy imposes certain duties on the policyholder, especially the obligation to take preventive measures. If the policyholder does not comply,

the risk is not covered. Contrary to exclusions of guarantee that are easier to defeat, recent insurance litigation has shown that the conditions are very difficult to override, as illustrated in ***La Riviera v. Alpha Insurance***.[31]

In this case, a nightclub owned and operated by La Riviera was ravaged by a fire. It appeared that La Riviera, which had entered into a property and casualty insurance contract with Alpha Insurance, did not comply with precautionary measures listed in the contract. La Riviera raised plenty of defences to override the conditions precedent of the insurance policy. All of them failed.

First, La Riviera argued that the conditions were so numerous that they contradicted each other. According to La Riviera, the guarantee was, therefore, illusory. This head of claim referred to *Chronopost*,[32] in which the Court of Cassation decided that a contractor cannot limit his or her essential obligation to the point that the obligation is no longer effective. Nevertheless, the Court rejected the claim by stating merely that the guarantee was not illusory.

La Riviera also questioned the appropriateness of the conditions. According to La Riviera, the breached preventive measures would not have enabled it to avoid the fire even if they had been taken. The Court rejected the argument, standing by a strict application of the clause.

Finally, La Riviera discussed the nature of the conditions. It argued that the condition precedent in fact amounted to an indirect exclusion of guarantee that was to be treated under the aforesaid Article L113-1 of the Insurance Code. The claim was rejected on procedural grounds. Meanwhile, the substantive issue of qualification is left unresolved. As observed by some authors, it could be a valuable defence in future cases.[33]

In a recent decision, the Court of Cassation brought some clarifications on the nature of exclusion clauses. While a court of appeal had considered that lack of maintenance and repair could not be construed as an exclusion clause but as a type of event that was not insured under the insurance policy, the Court of Cassation overturned this reasoning by stating that such clause deprives the policyholder from the benefit of a guarantee under specific circumstances and is, therefore, an exclusion clause.[34]

Scope of the insurance policy: the Poly Implant Prostheses case

Another ongoing legal saga, the Poly Implant Prostheses (PIP) breast prostheses scandal, has lasted over 12 years in France. In 2010, PIP placed breast prostheses on the market that were produced without regard to certain public health regulations. The hazardous prostheses were implanted in thousands of patients, leading to disputes in several countries. In ***Electromedics Ltd and others v. Allianz IARD***,[35] the Court of Cassation made a ruling in an action brought by the foreign distributors of the defective prostheses against the insurer of PIP.

In the case at hand, distributors from Brazil, Italy and Bulgaria asked for compensation from Allianz IARD on the basis of a liability insurance policy that Allianz had entered into with PIP. The distributors raised multiple losses that were covered under the policy (e.g., losses of turnover, stocks, margins and provision made for the compensation of customers). However, the insurance policy defined its territorial scope as limited to the 'harmful events' that occurred in France. Thus, the issue was whether the damage had occurred in France. According to the foreign distributors, the harmful event occurred during the manufacturing of the prostheses by PIP (i.e., the harmful event would allegedly have occurred in PIP factories in France). The Court of Cassation rejected the argument and held that the harmful event was the breaking of the prostheses, which occurred outside France. Thus, the losses suffered did not fall within the material coverage of the insurance policy.

The ECJ stated that Article 18 of the Treaty on the Functioning of the European Union providing for the prohibition of discrimination on grounds of nationality was not applicable to the insurance policy clause limiting the territorial scope of the coverage to one Member State.[36]

Last year, developments regarding the *PIP* case mainly focused on the liability of the French state. Whereas the Besançon Administrative Court considered that the French Agency for

Health Safety of Health Products had failed to act with due diligence in the *PIP* case, the Council of State, the highest French administrative court, annulled this decision considering that there was no demonstration of the Agency's failure.[37]

Remedies: the situation of the insurer during natural disasters

Natural disasters have become a growing cause for concern in the insurance sector, especially because case law tends to deprive insurance companies of any recourse against third parties that could have contributed to the damage on the grounds of force majeure. This trend was illustrated in ***Swisslife Insurance v. SNCF and the State***.[38]

In 2003, major abnormal rainfalls occurred in the south east of France. This resulted in floods that particularly hit the town of Arles. Swisslife Insurance compensated a large number of inhabitants who suffered damage to their properties. The final bill amounted to more than €5 million, yet the town was surrounded by flood barriers connected to the railway line used by SNCF, the French national rail operator. These protections having been ineffective, Swisslife Insurance exercised recourse against SNCF and the state. However, the Council of State, which heard the claim, found no breaches by the defendants. The Court pointed out that the floods were provoked by one of strongest rainfalls on record. The Court concluded that the state and SNCF could not be held liable since their alleged breaches would be excused on the grounds of force majeure.

An ordinance was enacted this year, which will come into force by 1 January 2024 at the latest, to cover the consequences of damages caused by global warming.[39] The ordinance adds the phenomenon of 'soil drought-rehydration' to the list of damages that can be considered as the effects of natural disasters, whose regime is set out in Articles L125-1 to L125-6 of the Insurance Code.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

France has a specific code dedicated to insurance law. This code provides very precise rules that derogate from the law usually applicable in contractual matters. For instance, the limitation period is, as a matter of principle, two years for insurance claims, whereas it is five years for contractual claims.[40] In addition to the specific law applicable to the insurance contracts, different regimes are set out according to the nature of the insurance policy (car insurance, life insurance, liability insurance, etc.). As a result, numerous solutions under French law are specific to a particular kind of insurance and cannot be generalised to all insurance policies. The French Civil Code also comes into play in insurance disputes. It applies in all matters related to the insurance policy that are not governed by a specific provision under the French Insurance Code. Other specific provisions may also come into play, such as the French Consumer Code when the dispute is between a professional and a consumer.

Finally, European directives on insurance hold considerable sway over insurance law. As noted below, the European influence was again demonstrated as it resulted in rendering ineffective some provisions of the Insurance Code related to car insurance.

ii Insurable risk

Under French law, the subscriber does not have to show any interest to conclude an insurance policy. As a result, the subscriber can issue an insurance policy not only on his or her own behalf but also on behalf of a third-party beneficiary.

Under French law, insurability of the risk is determined with regard to the nature of the insurance contract. Insurance is considered a 'contingent contract' under the French classification of contracts.[41] It implies the risk must exist to be insurable. In this respect, the Court of Cassation recently quashed an appeal decision that did not assess the existence

of a risk prior to ruling upon the parties' alternative claims.[42] Thus, an event that has already occurred cannot be covered. Moreover, if the event occurred as a result of the policyholder's intentional conduct, the insurer can reject the claim.[43]

In addition, a risk cannot be underwritten by an insurer if it contradicts public policy. Notably, criminal offences are not insurable. Therefore, a company cannot ask its insurer to pay a fine for which the company is liable.

Finally, some risks are excluded by law, such as the risk of riots or civil war.[44]

iii Fora and dispute resolution mechanisms

French law does not provide for a specific court to deal with insurance-related claims. Depending on the nature of the parties, the claim can be brought before the civil courts, the commercial courts and even the administrative courts when it involves public entities.

IV THE INTERNATIONAL ARENA

i International jurisdiction: the measures of inquiry in futurum

The Regulation Brussels 1 ***bis***[45] provides rules of jurisdiction applicable to insurance matters within the European Union.

In *Ergo Versicherung AG v. EPMD*,[46] it was ruled that French courts could order measures of inquiry *in futurum* in France within an insurance dispute even if foreign courts had substantive jurisdiction to handle the case. This is because Article 35 of Regulation Brussels I *bis* provides that a party may apply for 'protective measures as may be available under the law of that Member State, even if the courts of another Member State have jurisdiction as to the substance of the matter'.

In this case, the policyholder applied for measures of inquiry *in futurum*. Under French law, measures of inquiry *in futurum* can be granted by the president of the court to allow a party to collect evidence before any legal proceedings.[47] Therefore, the issue was whether those measures of inquiry *in futurum* are protective measures within the meaning of Regulation Brussels I *bis*. The Court of Cassation found measures of inquiry *in futurum* consisted in protective measures and fell within the scope of Article 35 of Regulation Brussels I *bis*.

In two requests for a preliminary ruling, the ECJ outlined that Articles 10 to 16 of Regulation Brussels I *bis* for jurisdiction in relation to insurance matters must be strictly interpreted and cannot apply to a dispute implying a business that had acquired a claim originally held by an injured party.[48]

ii Applicable law: recent developments within transport insurance

The Court of Cassation had to interpret an exclusion clause raised by an insurer against a transporter under an insurance policy that covered the international carriage of goods in ***AIG Europe the Netherlands v. Miedzynarowy Transport Drogowy***.[49]

The dispute was about an exclusion of guarantee provided by a transport insurance policy. In this case, two conflicting sets of rules were potentially applicable: the UN Convention on the Contract for the International Carriage of Goods by Road (CMR)[50] and the conflict rules applicable for insurance matters. The Court stated that the CMR is a special convention applicable to transport that could not govern the law applicable to the insurance contract but only determine the insurable risk. Thus, the Court applied the rules of conflict applicable to insurance matters.

V OUTLOOK AND CONCLUSIONS

i Prospective outcomes of recent legal developments

Class actions

French law has developed to allow class actions in limited circumstances. Consumer class actions may only be brought by an association of consumers. The action must also be related to sales contracts or provision of services contracts concluded by consumers placed under the same or similar situations.[51]

The *CLCV (Consommation, Logement, Cadre de Vie) v. Axa/Agipi* case[52] was the first insurance-related class action in which the CLCV initiated action against two insurance companies because they did not pay to the policyholders the remuneration that should have been guaranteed under a life insurance contract. First instance and appeal courts judged that this class action was inadmissible because the life insurance contract was not a 'provision of services' contract within the meaning of the Consumer Code. Despite this first decision, another consumer association, UFC-Que Choisir initiated in November 2020 a class action against LCL (Le Crédit Lyonnais) for reimbursement of group insurance premiums that would have been unduly charged to clients and these proceedings are still pending.

Insurers may also intervene in class actions as the guarantor of the victims or the wrongdoer. The Healthcare System Modernisation Act[53] extended class actions to damages claims arising from healthcare products, which is a growing concern for insurers.

On 25 November 2020, the Directive on representative actions for the protection of the collective interests of consumers was adopted. While France had until 25 December 2022 to implement this Directive into its domestic legislation, as of 1 September 2023, the draft transposition bill is still currently being reviewed by the French Senate.[54]

Information due to the policyholder

The Insurance Distribution Act[55] has significantly developed the insurer's duty of information. The text provides some vague standards. For instance, it requires that 'distributors of insurance products act in an honest, impartial and professional way'. The insurer is also required to provide 'objective information about the offered insurance product in an understandable form'. Ever-growing litigation may arise from this text, which offers great leverage to policyholders to obtain remedies for breach of pre-contractual information.[56]

In 2022, the French regulator of the banking and insurance sectors, the Prudential Supervision and Resolution Authority (ACPR) issued a severe disciplinary sanction, seven-year ban from practice and a fine of €20,000 to an insurance broker company in relation to information due to the policyholder, notably for failure to provide pre-contractual information on a durable support in the context of distance selling, failure to provide pre-contractual information in advance of the signature of the contract, inaccuracy and insufficiency of pre-contractual information provided, and failure to comply with obligations under the duty of advice.[57]

ii Evolving sectors of insurance litigation

Climate change

In the course of 2020–2021, the ACPR conducted a climate pilot group aiming at assessing the risks associated with climate change for financial institutions, thus showing the growing role of the French authorities in the fight against climate change. Similarly, a law was enacted on 2 March 2022 allowing the government to sharpen the framework of climate insurance for farmers. This law aims at implementing a universal system, although not a compulsory regime, for climate multi-risk insurance that farmers can subscribe in the event of climate damage (drought periods, floods, etc.).

Terrorism

In France, damages arising from terrorism are submitted to two different regimes with regard to the nature of the damage. Corporal damages are covered by the Compensation Fund for Terrorist Acts (CFTA),[58] which is financed by a contribution on insurance premiums.[59] Material damages are left to the insurance sector. Certain insurance policies must mandatorily cover material damages arising from terrorism.[60] Thus, insurance disputes related to terrorism mainly concern material damages. However, indemnification disputes with the CFTA in relation to corporal damages tend to develop in France as illustrated by ***Mrs Y v. CFTA***,[61] in which the CFTA successfully challenged the status of victim of the claimant and denied indemnification.

Cyber risk

One of the main developments in 2022 was that insurance against cyberattacks became provided for in Article L12-10-1 of the Insurance Code. While this risk was already included in some insurance policies, this new provision states that, when the risk of a cyberattack is included in an insurance policy, compensation is only due if the victim files a police complaint within 72 hours following knowledge of the cyberattack.

In its 2021 annual report, the ACPR outlined the efforts put in place to ensure that insurance companies manage their own cyber activities, incidents and attacks and concluded that some of the insurance companies' security systems could still be improved.

Political risk

The same goes for political risk. Mirroring global trends, employees of French multinational companies face an increasing risk of kidnapping around the world.[62] Specific insurance policies cover all the losses incurred by the company in the event of an attack against its employees on foreign territory: care of the victims, medical care, loss of profits, ransom paid and even the fees of a professional negotiator. The same issues may arise as those discussed above in relation to cyberattack risks regarding the validity of these guarantees: the insurability of the risk and the scope of the coverage.

Covid-19 pandemic

In reaction to the covid-19 pandemic, the government imposed three national lockdowns in turn, starting in mid-March 2020. Many businesses were forced to close to the public and have incurred significant operating losses as a result. Many of these businesses now hope to recover some of their losses under their insurance policy.

This gave rise to a number of disputes between businesses and their lessors or insurers, or both. In 2022, the Court of Cassation considered that closing to the public during lockdowns does not entail the loss of the thing rented and, therefore, does not constitute a non-performance, by the lessor, of its undertakings. A tenant cannot, therefore, rely on this event to refuse to pay the rents owed during lockdowns.[63]

As to the operating losses resulting from closures of shops and restaurants, the Court of Cassation ruled, in December 2022 and January 2023, that the most common exclusion clause in the AXA insurance policy[64] validly excluded indemnification for operating losses resulting from closures of shops and restaurants as a result of the covid-19 pandemic. Indeed, the Court considered that this exclusion clause was formal and limited and therefore applicable in the case of an administrative closure resulting from the covid-19 pandemic.[65]

The Court of Cassation has therefore now closed the debate on indemnification of businesses as a result of the covid-19 pandemic in favour of lessors and insurers.

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Chapter 9

Germany

Marc Zimmerling and Angélique Pfeiffelmann[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

The German insurance market contributes substantially to Germany's prosperity and economic growth.[2] With over €224 billion in premium income in 2022, the insurance industry is one of the highest turnover sectors in Germany.[3] It is one of the 10 biggest insurance markets worldwide and the second-biggest reinsurance market after the US.[4] In 2022, 466 million insurance contracts were taken out.[5] However, in light of the current crisis and inflation, losses in turnover are projected, although the market situation in 2023 has so far been better than expected.[6]

In this context, the effective and cost-efficient settlement of insurance disputes remains an important driver for the industry's success. It ensures legal certainty and fosters trust in the sector. The following chapter highlights the current jurisprudence of German courts and gives an overview of the legal framework for insurance disputes in Germany.

II YEAR IN REVIEW

i Judgment of the Federal Court of Justice dated 25 January 2023, Case No. IV ZR 133/21, regarding the decisive point in time for the requirements of a direct claim against the liability insurer under Section 115 VVG

With judgment dated 25 January 2023, the Federal Court of Justice (BGH) ruled on the controversial question of the decisive point in time for the requirements of a direct claim against the liability insurer according to Section 115 of the Insurance Contract Act (VVG).[7]

Under German insurance law, a third party generally cannot make direct claims under the insurance contract against the insurer of the damaging party (see Section III.i, 'German Code of Civil Procedure'). An exception to this is set out in Section 115 VVG, which provides for a direct claim of the third party against the insurer under certain requirements, inter alia if the policyholder has become insolvent.

In the case at hand, the injured party had filed a liability claim against the insurer of the damaging party due to the fact that insolvency proceedings against the policyholder had been initiated at a certain point in time after the liability claim had arisen.[8] At the time the claim was filed, the insolvency proceedings had already been terminated. The parties were in dispute about whether the requirements for a direct claim under Section 115 VVG had been met under these circumstances.[9]

According to the previously prevailing opinion in case law and legal literature, the requirements of Section 115(1) VVG had to be met at the time the proceedings were initiated or at least in the course of the proceedings.[10] The minority opinion at this time asserted that it was sufficient if the requirements of Section 115(1) VVG had been fulfilled at any point in time before the conclusion of the oral hearing, regardless of whether the requirements had already ceased to exist at that time.[11] The BGH has now decided in favour of the latter opinion.[12]

According to the BGH, neither the wording nor the legislative history or the rationale of Section 115(1) VVG indicated a restriction of this regulation to such extent that the requirements for a direct claim against the insurer still had to be fulfilled in the course of the legal dispute.[13] The BGH further held that the interests of the insurer were also sufficiently protected under this interpretation as the liability claim was still subject to the statute of limitations.[14] The insurer was therefore not exposed to an infinite liability claim.

With this decision, the BGH grants the injured third party an unlimited direct claim against the insurer once the requirements of Section 115 VVG have been met. It remains to be seen whether this will lead to more direct claims against insurers in the future or if this will rather remain the exception (as has been the case up to now).

ii Judgment of BGH dated 15 February 2023, Case No. IV ZR 353/21, regarding the policyholder's right of objection according to Section 5a VVG in the event of a minor information error

With a decision of 15 February 2023, the BGH changed its jurisprudence regarding the right of the policyholder to rescind a life insurance contract due to incorrect information according to Section 5a(1) Sentence 1 VVG (old version of 2001) in light of a recent decision of the European Court of Justice (ECJ).

According to Section 5a(1) Sentence 1 VVG (old version of 2001), the policyholder could object to the conclusion of an insurance contract within 14 days if the insurer failed to provide the insurance conditions or certain consumer information at the time of the application. According to Section 5a(2) Sentence 1 VVG, the objection period began only if the policyholder had been informed in writing about the right to object as well as the start and duration of the objection period. However, Section 5a(2) Sentence 2 VVG stipulated that contrary to Sentence 1, the right to object expired one year after payment of the first premium. With a judgment of 2013, the ECJ decided that this was contrary to EU law.[15] On that basis, the BGH subsequently decided that policyholders had an unlimited right to object under Section 5a(1) VVG if they were not properly informed about their right of objection.[16]

In the case at hand, the policyholders declared to rescind their life and annuity insurance contracts according to Section 5a(1) VVG after years of carrying out the contract.[17] The policyholders argued that the contracts contained incorrect information regarding the right to object and, therefore, the objection period had not yet begun. The contracts contained the incorrect information that the objection must be made in written form (meaning with an individual signature) rather than the required text form (without an individual signature).[18]

Nonetheless, the court held that the policyholders' objection according to Section 5a(1) Sentence 1 VVG was invalid as it violated the principle of good faith pursuant to Section 242 BGB. As there had been only a minor information error (i.e., written form instead of text form), the policyholders had the possibility to exercise their right of objection under essentially the same conditions as if the information had been correct.[19]

The court asserted that the written form is a typical and regularly practised form of notification that could be carried out by anyone easily and without any particular effort, so that no obstacles to an effective objection were apparent.[20] As the policyholders did not suffer any disadvantages from the incorrect information, it would be disproportionate to enable them to withdraw from the contract in the case at hand.[21]

The BGH further concluded that this decision was also in line with the case law of the ECJ.[22] According to the ECJ, it is disproportionate to allow the policyholder to be released from its obligations arising from a contract concluded in good faith if the policyholder was not in fact prevented from properly exercising its right of objection.[23]

With this judgment, the BGH explicitly departed from its previous strict line regarding the policyholder's right of objection pursuant to Section 5a(1) VVG.[24] In a prior decision of 2015, the BGH had still come to the conclusion that the incorrect information of the policyholder regarding a written form requirement for an objection always constituted a significant error, granting the policyholder an infinite right of objection.[25] It remains to be seen how the courts will define 'significant' and 'minor' information errors in light of the BGH's recent judgment and whether a rather insurer-friendly jurisprudence will follow from this.

iii Judgment of OLG Frankfurt dated 8 February 2023, Case No. 7 U 66/21, regarding the interpretation of the place of residence in a jurisdiction clause

OLG Frankfurt ruled with judgment of 8 February 2023 on the interpretation of the place of residence in a jurisdiction clause of a life insurance contract between a policyholder resident in the EU and an insurance company seated in the UK.

The clause stipulated that the court in whose district the policyholder is resident or where a residence is established has jurisdiction to decide any disputes that may arise from the contract.[26] When the contract was concluded in 2000, the claimant lived in Frankfurt am Main,

Germany.[27] On that basis, the claimant filed his lawsuit with the Regional Court of Frankfurt am Main. However, at that time of the commencement of the proceedings, the policyholder was resident in Switzerland. The parties argued about whether the place of residence at the time of the conclusion of the contract was decisive for the question of jurisdiction or rather the place of residence at the time of the commencement of the proceedings.[28]

OLG Frankfurt confirmed the latter, dismissing the lawsuit as inadmissible for lack of international jurisdiction.[29] Due to the foreign nature of the dispute, the court reviewed the jurisdiction clause under Article 25 of the Recast Brussels Regulation.[30] According to principles of conflict of laws, the interpretation of the clause was to be measured against German law as the parties chose German law as the statute for the main contract.[31]

OLG Frankfurt held that the wording of the jurisdiction clause speaks against the interpretation of the claimant that his residence at the time of the conclusion of the contract was decisive.[32] The clause referred to the place of residence that the policyholder 'has' or where a residence 'is established' and thus, based on the wording in the present tense, related to a present state.[33] Such an understanding was also supported by the fact that the clause referred to 'any disputes', which are naturally not given at the time of the conclusion of the contract, but arise at a later point in time and must in any case be given at the time of filing the lawsuit.[34] In addition, the court held that it would be far-fetched and impracticable if the policyholder would understand the provision to mean that in the event of a dispute it would have to check where its residence was when the contract was concluded.[35]

Moreover, the court held that the purpose of the provision was that the policyholder is able to pursue its rights close to its place of residence.[36] The fact that the claimant in the specific case at hand wanted to bring a claim against the defendant before a German court was irrelevant, as the clause and the general terms and conditions had to be interpreted in a way an average policyholder would understand them.[37] Moreover, it could often be difficult to clarify where the policyholder was resident when the contract was concluded, especially in the case of long-term contracts such as life and annuity insurance contracts.[38]

The decision creates legal certainty and is in line with the general interpretation of insurance contracts based on the understanding of an objective policyholder.

iv Judgment of OLG Celle dated 17 March 2022, Case No. 8 U 260/21, regarding supplementary interpretation of an insurance contract in case of an ineffective inclusion of general insurance conditions

OLG Celle had to rule in a decision of March 2022 on the controversial question of how to determine the contents of an insurance contract if the General Insurance Conditions (GIC) of the insurer had not been effectively included in the contract. It is disputed in legal literature and case law whether the GIC generally used by the insurer should apply in such a case or whether the contractual provisions are to be determined individually by way of supplementary interpretation of the contract.[39] OLG Celle decided in favour of the latter.

In the case at hand, the policyholder claimed payment under its household insurance policy for allegedly stolen cash that had been stored in a safe.[40] The safe used by the policyholder deviated from the requirements of the GIC of the insurer.[41] It was disputed between the parties whether the GIC had been effectively included in the insurance contract or not. The court therefore had to interpret the term 'safe' as used in the insurance policy.[42]

OLG Celle held that it did not have to decide whether the GIC had been effectively included in the insurance contract or not. Even if this would not have been the case, the term 'safe' should be interpreted as used in the GIC. To come to this conclusion, the court applied Section 306(2) of the German Civil Code (BGB), which stipulates that the contents of a contract are determined by the statutory provisions if terms and conditions have not been effectively incorporated into the contract.[43] According to the court, this also includes a supplementary interpretation of the contract pursuant to Sections 133 and 157 BGB as the statutory provisions usually do not completely fill out the contents of the contract.[44] It further held that such a supplementary interpretation of the contract is based on an objective and generalising standard which is oriented towards the will and interest of typically involved parties.[45]

In application of these guidelines, OLG Celle came to the conclusion that the term 'safe' could neither be defined solely from the claimant's point of view nor could the understanding of an average policyholder be taken into account, as there was no general, sufficiently specific understanding of the term.[46] The term was rather to be understood as generally used in all standard household insurance policies based on the model terms and conditions of the German Insurance Association (GDV) – which were also used in the case at hand.[47] Hence, the term 'safe' would have to be interpreted as used in the disputed GIC, even if they had not been effectively incorporated in the contract. According to the court, this definition corresponded to the insurance risk of the insurer and did not unreasonably disadvantage the policyholder.[48]

With this decision, OLG Celle applied general principles of interpretation to deal with invalidly incorporated GIC of the insurer. In light of the ongoing debate in legal literature and case law, it remains to be seen whether this will find approval in legal literature and jurisprudence.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Insurance law

The Insurance Contract Act

The main source of insurance law in Germany is the Insurance Contract Act (VVG). It sets out the general rules for insurance contracts as well as the statutory provisions for specific insurance branches. The VVG applies to all types of insurance contracts, except for reinsurance and maritime insurance contracts.[49] It came into force in 1908 and remained largely unchanged until a major reform in 2008.[50] The objective of the reform was to modernise German insurance law and improve the position of the insured person.[51]

Important changes included:

- the introduction of a right to revoke the insurance contract by the policyholder within 14 days of the conclusion of the contract;[52]
- the introduction of certain advisory, documentation and information duties of the insurer;[53]
- the abolition of the 'all-or-nothing' principle in favour of the 'more-or-less' principle;[54]
- the abolition of insurance-specific limitation periods, rendering applicable the general limitation period of three years pursuant to Section 195 of the German Civil Code (BGB); and
- the introduction of a new place of jurisdiction at the place of the policyholder's residence.[55]

The overarching purpose of the reform was to provide greater protection to the insured person by setting out restrictions on the freedom of contract. However, these restrictions shall not apply to large risks and open policies.[56] Large risks insurance includes some transportation and liability insurance (such as insurance for railway vehicles, aircraft or the transportation of large goods); some credit and suretyship insurance; and some property, liability and other indemnity insurance where the policyholder has a balance sheet total in excess of €6.2 million, a net turnover of €12.8 million or an average of 250 employees per fiscal year.[57] These insurance policies are typically taken out by big companies that do not need protection by the VVG. All other risks are deemed 'mass risks', to which the freedom of contract restrictions apply without limitation.

The Civil Code

The BGB is another source of German insurance law and is applicable insofar as no specific provisions of the VVG apply. The area of most relevance for insurance contracts is its section on the use of standard business terms. Almost all insurance contracts contain standard business terms of the insurer, especially insurance contracts concluded with a consumer.

Section 305 et seq. of the BGB set out the rules for the incorporation of standard business terms into the contract, the assessment of their effectiveness and the interpretation of their content. These rules apply regardless of whether the other party is a consumer or not. However, stricter requirements apply where a consumer is concerned.

Other provisions applicable to insurance law are the rules on the statute of limitations. As the special limitation periods for insurance claims were abrogated with the VVG reform in 2008, the general rules in Section 195 et seq. of the BGB apply. The limitation period is three years,[58] commencing at the end of the year in which the claim arose and the insured party obtained knowledge of the circumstances giving rise to the claim (or would have obtained this knowledge if it had not shown gross negligence).[59] An exception applies if the limitation period is suspended. For insurance contracts, Section 15 of the VVG provides an insurance-specific suspension rule. Where a claim arising from an insurance contract has been registered with the insurer, the limitation period shall be suspended until such time as the applicant has received the insurer's decision in writing. All other rules for suspension are set out in Section 203 et seq. of the BGB.

German Code of Civil Procedure

A further source of German law that is especially relevant for insurance disputes is the German Code of Civil Procedure (ZPO). It sets out the general rules for litigation proceedings and is also applicable to insurance disputes as far as no specific rules are set out in the VVG.

One of the main principles of German civil procedural law is that each party has to present the facts and prove the case upon which its claim or defence is based. Unlike in common law jurisdictions, there is no pretrial discovery or document production. In general, no party to litigation proceedings is, therefore, obligated to deliver to the other party the documents or evidence necessary for its case. However, there are exceptions to this principle. One example is Section 142 of the ZPO, which sets out that the court may direct one of the parties or a third party to produce records or documents, as well as any other material in its possession if one of the parties has made reference to it. Another example is Section 422 of the ZPO, which stipulates the obligation of a party to produce certain documents favourable for its opponent if its opponent is entitled to demand the surrender or production of the relevant documents pursuant to civil law stipulations.

With regard to insurance disputes, the VVG stipulates specific disclosure obligations of the insured person. According to Section 31(1), the insurer may, after the occurrence of an insured event, demand that the policyholder or the beneficiary shall disclose all the information necessary to establish the occurrence of the insured event or the extent of the insurer's liability. In addition, the insurer may demand supporting documents to the extent that the policyholder may be reasonably expected to obtain them. The policyholder is even obligated to disclose facts unfavourable to him or her. The VVG, therefore, sets out more extensive disclosure obligations of the insured person than it would have under the rules of the ZPO. However, Section 31 of the VVG does not set out any consequences for cases of non-compliance. Therefore, the insurer will usually incorporate the policyholder's disclosure duties in its general terms and conditions and stipulate contractual consequences for non-compliance.[60]

Another specific aspect of insurance disputes concerns direct claims by third parties against the insurer. This issue typically arises in relation to liability insurance that covers damage claims made by third parties against the policyholder. In general, a third party cannot make direct claims under the insurance contract against the insurer of the damaging party. Therefore, the third party may only enforce its damage claim against the policyholder (a liability claim), who may then raise a claim against his or her insurer (a coverage claim). However, there are exceptions to this rule. One is set out in Section 115(1) of the VVG, which provides for a direct claim by the third party against the insurer if third-party vehicle insurance is concerned; the policyholder has become insolvent; or the policyholder's whereabouts are unknown. If one of these requirements is fulfilled, the third party may claim payment directly from the insurer and initiate court proceedings against it without having to proceed against the policyholder first.

The ZPO also stipulates the place of jurisdiction for litigation proceedings regarding claims in connection with the insurance contract. Optional places of jurisdiction are the place of the insurer's registered seat,[61] the place of performance of the contract[62] or the place of the insurer's branch office.[63] In general, all these venues favour the insurer. With the introduction of Section 215 into the VVG in 2008, the legislature established a new place of jurisdiction that favours the insured person. The policyholder can now also choose to proceed against the insurer at the court in whose district he or she has his or her place of residence. For actions brought against the policyholder, only this court shall have jurisdiction. The parties can only deviate from this place of jurisdiction to the detriment of the policyholder after the dispute has arisen or if the policyholder moves his or her domicile to a different country after signing the contract or if his or her domicile is unknown at the time the action is filed.[64] The purpose of this change was to guarantee the policyholder access to a court near his or her domicile.[65] This was supposed to compensate for the subject-specific and economic advantages of the insurer.

Regulation

German Insurance Supervision Act

The main legal source for insurance regulation is the German Insurance Supervision Act (VAG), which implemented in 2015 the European Solvency II Directive.[66] It enables the supervision of insurance companies in their legal and financial operations[67] by the German Federal Financial Supervisory Authority (BaFin) and the supervisory authorities of the federal states. The BaFin is the competent supervisory authority for private insurance companies that operate in Germany and are of material economic significance as well as for public insurance companies that participate in free competition and operate across the borders of any federal state.[68] The supervisory authorities of the federal states are mainly responsible for overseeing public insurers whose activities are limited to the federal state in question and private insurance companies of lesser economic significance.[69]

Therefore, all private and public insurance companies, pension funds and reinsurers carrying out private insurance businesses within the scope of the VAG and that have their registered office in Germany are subject to supervision.[70] Social insurance institutions[71] are not supervised under the VAG but regulated by other government agencies.[72]

The primary objective of the VAG is the protection of policyholders and beneficiaries.[73] To ensure that only regulated companies offer insurance services, insurance companies registered in Germany must acquire a licence before commencing business operations.[74] To be granted authorisation to operate, the insurance company must fulfil a number of requirements. This includes, inter alia, that the company:

- operates in the legal form of a public limited company;[75]
- has its legal seat in Germany;[76]
- engages only in insurance businesses and directly related businesses and observes the principle of business segregation (e.g., a life insurance company may not at the same time provide health or property insurance);[77]
- submits a detailed business plan that contains the company's charter and sets out the insurance segments in which it will operate, as well as the risks that are intended to be covered;[78]
- demonstrates that it has a sufficient amount of own funds[79] as well as sufficient resources to develop the business and sales organisation;[80] and
- has at least two members of the management board that are fit and proper persons.[81]

In its ongoing supervision, the BaFin monitors, among other things, whether the insurance company complies with all statutory and regulatory requirements, whether it is capable of fulfilling its insurance contracts and whether it observes the principle of good business practice (e.g., keeping proper accounting records and rendering proper accounts).[82] In accordance with the Solvency II Directive, it also supervises the company's solvency, in particular the fulfilment of certain capital requirements.

In the event of any undesirable conduct by an insurance company, especially non-compliance with legal requirements, the BaFin may take any appropriate and necessary measures to prevent or eliminate this conduct.[83] For consumers, it is also possible to file a complaint against an insurance company with the BaFin.[84] The BaFin will review the complaint and issue a report with its legal opinion. If necessary, it may also take regulatory steps against the insurance company. However, it is not authorised to render a binding decision or give legal advice.

ii Insurable risk

German insurance law applies differently to two types of insurable risks: socially insured risks and privately insured risks. Socially insured risks are codified in the German Social Code (SGB), which distinguishes between health insurance, unemployment insurance, nursing care insurance, pension insurance and occupational accident insurance. These are statutory insurance contracts, which do not come into effect by agreement but are taken out by law when the insured person fulfils certain requirements.

The VVG only applies to privately insured risks. Because of the freedom of contract, the parties to an insurance contract may, in principle, insure any type of risk they choose to. They are only bound by the limitations applicable to any civil law contract (e.g., the prohibition of contracts that violate public policy or a statutory prohibition).[85] The VVG regulates the most common types of private insurance in Germany by stipulating the rules applicable to the different insurance segments. The most significant segment in Germany is that of liability insurance for third-party damage claims against the policyholder.[86] In 2018, about 83 per cent of German households had taken out private liability insurance and 81 per cent third-party vehicle insurance.[87] What is special about this area of insurance is that some liability insurance is taken out on a voluntary basis while others are compulsory insurance contracts. This is the case where the legislature has deemed it especially important to insure the risk of damage to a third party caused by the conduct of another party.[88] The most prominent example of compulsory liability insurance is third-party vehicle insurance, from which the other types of compulsory insurance evolved. Other insurance segments stipulated in the VVG are legal expenses insurance, transport insurance, fire insurance for buildings, life insurance, occupational disability insurance, accident insurance and private health insurance.

iii Fora and dispute resolution mechanisms

In general, arbitration and other alternative dispute resolution (ADR) mechanisms have experienced an expansion in recent years.[89] In Germany, however, the popularity of arbitration and ADR rather depends on the type of insurance contract concerned. A distinction can be drawn between reinsurance, insurance for commercial and industrial risks and insurance for mass risks.

Disputes regarding reinsurance are traditionally solved amicably between the parties.[90] The reason for this is a kind of 'gentlemen's agreement' to solve reinsurance disputes by negotiations for amicable settlement. However, arbitration proceedings have become more and more common in the past 30 years and most reinsurance contracts now also contain arbitration clauses. This may be attributed to an increased willingness in the Anglo-American reinsurance market to refer reinsurance disputes to arbitration, which also reflects on the German market. Another reason might be the increase of disputes regarding large risks that involve higher stakes for the parties. A third factor may be that more reinsurance companies withdraw from the reinsurance market, making it less necessary to solve disputes amicably to retain ongoing business relationships.

In insurance disputes concerning commercial and industrial risks there is a rather restrictive use of ADR mechanisms, especially arbitration.[91] This is a distinctive aspect of German insurance law in comparison to other jurisdictions. It might be owing to the still widely held perception by German insurers that German court proceedings are, when compared to other jurisdictions, more efficient, less time-consuming and less costly. Furthermore, German

courts regularly have specialised chambers that will hear insurance law-related disputes. This ensures a qualified legal judgment that otherwise only specialised arbitral tribunals might be able provide. Benefits of this kind in German court proceedings apparently still outweigh the general advantages of arbitration for many insurance companies. However, there is reason to believe that the use of arbitration clauses in commercial or industrial insurance contracts will increase in the future. For contracts that are related to international law or written in a foreign language, or for contracts that contain unusual clauses or concern risks of a highly technical nature, arbitration proceedings may, in principle, be deemed more favourable.[92]

In German insurance contracts concerning mass risks, arbitration clauses are basically non-existent.[93] This is owing to the fact that they are often concluded with 'consumers' under German consumer protection law, which significantly raises the bar for a valid arbitration agreement. Section 1031(5) of the ZPO states that arbitration clauses involving consumers are only valid if they are contained in a separate record or document signed by both parties that shall not contain agreements other than those making reference to the arbitration proceedings. If the arbitration agreement is included in a contract, it is only valid if it has been recorded by a notary. Both requirements are rather difficult to fulfil in practice. In addition, arbitration clauses in insurance contracts are usually part of the insurer's general terms and conditions and, therefore, have to fulfil the requirements set out in Section 305 et seq. of the BGB (see Section II.i, 'BGB'). This leads to a high risk that an arbitration clause contained in an insurance contract for mass risks could be deemed invalid by a court.

Because of these difficulties with arbitration proceedings against consumers, the German Insurance Association formed Versicherungsombudsmann eV, the Insurance Ombudsman Association, in 2001 to establish a mechanism for out-of-court dispute settlement of insurance disputes with consumers before an 'insurance ombudsman'.[94] Under this mechanism, consumers may file a complaint against an insurance company (or an insurance broker) with the ombudsman.[95] To be able to refer an insurance dispute to the ombudsman, the insurer needs to be a member of the Insurance Ombudsman Association,[96] which almost all insurance companies in Germany are.[97] The complaint is only admissible if the insured person has made a complaint with the insurance company first and if at least six weeks have passed since then.[98] The ombudsman cannot decide on complaints that:

- have a value of more than €100,000;
- concern healthcare or nursing care insurance;
- have already been filed with or decided by a court or another institution (unless the court has ordered, in accordance with Section 278a(2) of the ZPO, that court proceedings shall be stayed); or
- are obviously unfounded.[99]

The proceedings shall take no longer than 90 days.[100] The insured party may refer the dispute to an ordinary court at any time.[101] If the complaint is admissible and the value in dispute is no more than €10,000, the ombudsman can render a decision that is binding for the insurance company; otherwise, it can make a non-binding recommendation.[102] Dispute settlement before the insurance ombudsman has proven to be quite successful. In 2022, the Insurance Ombudsman Association received 15,907 complaints, of which 11,898 were admissible and 12,247 were settled.[103]

IV THE INTERNATIONAL ARENA

Cross-border insurance contracts have proliferated in recent years, putting insurance disputes increasingly into a more international context. Questions frequently arise in cross-border insurance disputes regarding the correct place of jurisdiction and the applicable law. For German courts, EU Regulation (EC) No. 593/2008 of 17 June 2008 on the law applicable to contractual obligations (Rome I) and EU Regulation (EC) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (recast) (Recast Brussels Regulation)[104] set out the relevant rules for these questions.

Rome I applies to insurance contracts concluded after 17 December 2009 and provides the rules to identify the applicable law to contractual obligations in civil and commercial matters involving a conflict of laws. Article 7 of Rome I sets out specific rules for insurance contracts covering large risks as well as insurance contracts covering mass risks situated inside the territory of the Member States. To all other insurance contracts, especially regarding mass risks situated outside the territory of a Member State as well as reinsurance contracts, the general rules of Articles 3–6 of Rome I apply.[105]

Regarding the question of jurisdiction, the Recast Brussels Regulation provides the relevant rules for legal proceedings instituted on or after 10 January 2010 against a defendant that has its domicile[106] in a Member State and concern a dispute that is not located solely in one Member State (e.g., one of the parties has its residence or place of business in one Member State and the other party in another Member State or a third state). It contains specific rules for insurance disputes in Articles 10–16. The rules are similar to those under German law (see Section II.i, 'German Code of Civil Procedure'). If the defendant has its residence in Switzerland, Norway or Iceland, the Lugano Convention (2007) applies with corresponding rules.

The Recast Brussels Regulation also applies to the enforcement of judgments rendered by a court of a different Member State. In general, such judgments shall be recognised and enforceable in the other Member State without any special procedure or declaration of enforceability being required.[107] However, the Recast Brussels Regulation does not apply to the enforcement of arbitral awards.[108] Regarding the recognition and enforcement of foreign awards by a German court, the rules of the Convention of 10 June 1958 on the Recognition and Enforcement of Foreign Arbitral Awards (New York Convention) apply.[109] Regarding the recognition and enforcement of domestic awards, the rules of the ZPO apply.

V OUTLOOK AND CONCLUSIONS

The current discussions on environmental, social and governance (ESG) factors have also reached the insurance sector. Companies face increasing accountability for ESG-related violations, raising the focus on ESG risks and their coverage. This not only creates a demand for new insurance solutions but also results in more insurance claims for ESG-related damages under existing policies.

In Germany, this is particularly relevant in light of the new Act on Corporate Due Diligence Obligations in Supply Chains (LkSG), which came into force at the beginning of 2023. The LkSG aims to ensure that German companies comply with basic human rights and environmental standards in global supply chains.[110] It sets out due diligence obligations for companies with more than 3,000 employees, including the conduct of a risk analysis and the implementation of a risk management system as well as prevention and remediation measures.[111] Companies that fail to comply may face fines, exclusion from public tenders and potential civil lawsuits.[112]

This raises the question of whether damages arising from LkSG violations are covered under existing insurance policies. One possible scenario is that companies seek recourse against their managers who are responsible for the violations.[113]

Coverage claims under D&O insurance policies will therefore gain further importance in relation to ESG-related risks[114] and will lead to various coverage issues and disputes. These may include the extent to which environmental or personal damages are covered under the D&O insurance (which generally only covers financial losses), the applicability of certain exclusions (such as an environmental damage exclusion), or the coverage of legal costs for defending against fines, contractual penalties and reputational damages.[115]

But ESG will not only have an impact on the insurance sector at the coverage level, but also with regard to underwriting.[116] For instance, some insurers already include ESG scores in their risk assessments.[117] A recent study commissioned by Allianz has confirmed this scientifically and found that 'ESG indicators have significant explanatory power to indicate whether a company has a higher probability for experiencing future harmful events.'[118] The study identified several parameters that have a high predictive ability for the occurrence of

future claims.[119] In view of this, it is likely that such ESG parameters will become even more relevant in the risk assessment of insurers in the future and provide an additional incentive for companies to comply with ESG-related requirements.

All this shows that ESG will continue to shape both insurance disputes and the insurance industry in general in the future.

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Endnotes

1 Marc Zimmerling is a partner and Angélique Pfeiffelmann is a senior associate at Allen & Overy LLP.
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41 ibid., [49].
42 ibid., [27, 41, 43].
43 ibid., [42 et seq.].
44 ibid., [42].
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49 Section 209 VVG.
50 It is, therefore, important to consider carefully whether decisions and publications on insurance law refer to the current or the old rules of the VVG.
51 Entwurf eines Gesetzes zur Reform des Versicherungsvertragsrechts of 20 December 2006, Bundestagsdrucksache 16/3945, p. 1.
52 Section 8 VVG.
53 Section 6 et seq. VVG.
54 The all-or-nothing principle allowed the insurer to refuse payment for the insured event if it was caused by the insured person, regardless of the degree of misconduct, whereas the more-or-less principle stipulates that the insurer may only refuse payment in full if the insured person caused the insured event intentionally; in cases of gross negligence, the insurer may refuse payment only partly depending on the degree of negligence; Sections 26(1), 28(2), 81(2) VVG.
55 Section 215(1) VVG.
56 Section 210(1) VVG; an open policy is a contract made in such a manner that, at the time when the contract is concluded, only the class of insured interest is designated and it is only specified to the insurer in detail once the contract has been concluded, Section 53 VVG.

57 Section 210(2) VVG enumerates all large risks conclusively.
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65 Klimke in Prölss/Martin, VVG, 31st edition 2021, Section 215[1].
66 Directive 2009/138/EC of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II) (recast).
67 Section 294(2) VAG.
68 Section 320 VAG.
69 www.bafin.de/dok/7859578.
70 www.bafin.de/dok/7859578.
71 i.e., statutory health insurance funds, statutory pension insurance funds, statutory accident insurance institutions and unemployment insurance institutions.
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73 Section 294(1) VAG.
74 Section 8(1) VAG.
75 This includes SEs, mutual societies or public law institutions, Section 8(2) VAG.
76 Section 8(3) VAG.
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91 ibid., [9]–[10].
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93 ibid., [15]–[17].
94 www.versicherungsombudsmann.de/welcome/.
95 Section 2(1) Code of Procedure of the Insurance Ombudsman (VomVO).
96 Section 1 VomVO.
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98 Section 2(3) VomVO.
99 Section 2(4) VomVO.
100 Section 7(6) VomVO.
101 Section 11(2) VomVO.
102 Sections 10(3), 11(1) VomVO.
103 Annual report of the Insurance Ombudsman Association, pp. 104–106, https://www.versicherungsombudsmann.de/wp-content/uploads/Jahresbericht_2021.pdf.
104 As well as its predecessor, Council Regulation (EC) No. 44/2001 of 22 December 2000 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, which still applies to legal proceedings instituted before 10 January 2015 as well as to judgments given or court settlements concluded before that date (Article 66 of the Recast Brussels Regulation).
105 Rome I, however, does not apply to insurance contracts providing benefits for employed or self-employed persons in the event of death or survival or of discontinuance or curtailment of activity, or of sickness related to work or accidents at work, excluding life assurance according to Article 9 No. 2 of the Solvency II Directive.
106 For a company, this would be the place where it has its statutory seat, central administration or principal place of business, Article 63 of the Recast Brussels Regulation.
107 Articles 36(1), 39 of the Recast Brussels Regulation.
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Chapter 10

Greece

Antonios D Tsavdaridis and Kosmas N Karanikolas[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

The volume of insurance disputes in Greece is rather limited compared to other countries with an equivalent population, since premium income remains poor in relation to the country's income per capita,[2] as social insurance takes up a major part of insurance normally covered by private insurers.[3] Due to private insurance's underdevelopment, insurance contracts are mainly concluded on international insurance terms and clauses, albeit the Greek law is usually stipulated as applicable.

The core legislation on contractual insurance law has remained mainly intact over the past 26 years, that is since the introduction of the Greek Insurance Contract Act (ICA),[4] in 1997. Despite its very succinct nature, the ICA is regarded as a pioneering law in Europe, its provisions resembling those of other contemporary European insurance contract laws. Rules applicable to insurance contracts are also found in the legislation on insurance supervision and distribution of insurance products, which, for the most part, comprise enacted EU legislation, as well as in special laws regulating other, individual issues. Rules on general contract law apply supplementarily. Recently, several compulsory liability insurances were introduced, including those of travel agents and travel service providers,[5] payment institutions,[6] investment service providers[7] and insolvency practitioners within the meaning of Law No. 4738/2020,[8] while the provisions on liability insurance of shipowners and operators of yachts and tourist dayboats were amended.[9] Finally, albeit the introduction of a new Code of Private Maritime Law (CPML)[10] could be of interest to insurance law as the latter encompasses a few provisions on marine insurance as well, insurance contracts covering maritime risks are mainly regulated by standardised insurance terms and English law is usually stipulated as applicable, so that the CPML's provisions on marine insurance are of rather limited utility.[11]

Some positive developments in insurance dispute resolution are also apparent. The application of a system enabling the electronic submission of lawsuits and other legal instruments, as well as the expansion of the scope of mediation in retail cases, can shrink the volume of insurance litigation. Brokers and experts play a major role in the resolution of commercial insurance disputes. Although, as a rule, insurance disputes in Greece are not resolved through arbitration, marine insurance disputes concerning ocean-going vessels are usually resolved through international arbitration, whereas disputes related to short sea-shipping and yacht issues are typically referred to state courts. The aforementioned developments have contributed to the acceleration of dispute resolution and the curtailment of trials.

The trends in the fundamental developments in insurance law in Greece can be traced in the jurisprudence of the Supreme Civil and Criminal Court of Greece (the Court of Cassation),[12] certain decisions of which were of particular interest. Notably, following the issuance of the controversial Court of Cassation decisions Nos. 18/2015 and 19/2015[13] (in plenary session) there remains uncertainty as to whether and to what extent a derogation from the provisions of the ICA can be validly agreed whereby the policyholder has concluded the insurance for professional or commercial reasons – rather than a derogation being permitted exclusively for large-risk commercial insurance contracts. Finally, the supervisory authority on insurance, the Bank of Greece (BoG) has adopted a quite formalistic approach on supervisory issues lately, thus giving rise to potential insurance disputes with the supervised insurance undertakings.

II YEAR IN REVIEW

Although case law is only a secondary source of law, so that judicial precedent is not binding for the courts, it constitutes a useful means of interpretation, given the brevity and non-exhaustiveness of the legislative provisions on insurance contract law.[14] In this regard, the following Court of Cassation decisions, which are irrevocable and represent a significant evolution in the jurisprudence, are noteworthy.[15]

Recently, the Court of Cassation[16] ruled that the provisions of Greek legislation on compulsory MTPL insurance, as in force until 2022,[17] were incompatible with the provisions of the respective (EU) Directives,[18] as they included in the concept of 'non-third parties'

whose damages are excluded from coverage, persons other than the driver of the damaging vehicle, thus limiting the protection afforded to injured third parties. Of particular interest is whether, given the said incompatibility of national rules with EU law, injured third parties can invoke the direct application of EU law provisions vis-à-vis insurance undertakings covering the liability of the damaging party. To date, the CJEU has accepted the direct application of provisions of Directives that have not been transposed – in whole or correctly – into national law, but only vis-à-vis the state and entities assimilated to the state, not against private undertakings licensed and supervised by the state, such as insurance undertakings. In view of its importance, the matter was referred to the Plenary Session of the Court of Cassation.

In another important decision,[19] the Court of Cassation clarified that the activity of 'management of group pension funds' carried out by insurance undertakings does not entail assumption of insurance risk but constitutes an asset management activity. In the case concerned, a bank staff association had concluded a contract for the management of group pension funds in favour of its members (i.e., the bank's employees), being obliged to render the contributions collected from the employees to the insurance undertaking, which would deposit the money in an account and profitably manage them, so that the employees could receive pension benefits upon retirement. According to the contract, the account was financed exclusively by the contributions collected by the said staff association and the insurance undertaking was obliged to pay benefits only to the extent that the account's balance sufficed thereto. When retired employees turned against the insurance undertaking claiming their pension benefits, the court held that the insurance undertaking was not liable to pay the benefits since the account's funds were inadequate due to sub-capitalisation by the employees' association, despite the insurance undertaking's notifications to the latter to top up the account.

A ruling of the Court of Cassation[20] relating to the protection conferred upon injured third parties by compulsory liability insurances is also of particular interest. Albeit there are more than 50 compulsory liability insurances in Greece, injured third parties do not always have a right of direct action against the liability insurer of the damaging party, since the ICA's provision,[21] stipulating that the prior designation of an authority empowered to receive notifications from insurers on the events leading to the insurance contract's termination as well as to monitor compliance with compulsory insurance is a condition precedent to the injured third party's right of direct action, has not been complied with. Thus, in a case of group liability insurance taken out by a hunting association in favour of its members, a citizen injured during woodcock hunting by a hunter who was a member of the association could not bring a lawsuit against the hunters' liability insurer.

Moreover, in a case concerning home insurance against the risks of flood, gale and storm, the Court of Cassation[22] confirmed the validity of a clearly formulated insurance term envisaging that the facilities located in the house's surrounding area, such as atriums, stone walls, and fences, were not included in coverage. In this case, due to heavy rainfall, there was a landslide of a retaining wall in the insured house's courtyard, thereby endangering the stability of the house's foundations. The court held that the risk incurred was not insured and its exclusion from coverage was not subject to assessment for its unfairness, since the term limiting coverage to damages occurring only within the insured house was part of the terms defining the relationship between the performance and the consideration due as well as the main subject matter of the contract which are not subject to assessment as to their unfairness, according to Article 4 Paragraph 2 of the (EU) Directive 93/13 on unfair terms in consumer contracts. The court held that this provision is directly applicable, albeit the Greek law enacting the Directive[23] has not transposed its content.

Judgments that are open to criticism are also apparent. For instance, in two similar decisions,[24] the Court of Cassation adjudicated that group insurance taken out by a lending bank against the risks of death and total permanent incapacity for work of its borrowers, in which the bank was designated as the beneficiary of the insurance money, constituted insurance on the bank's own account. Nevertheless, in personal insurance, the insured person is the person at risk (i.e., the person with the life events of whom the insurance risk is linked with); thus, in insurance against the risks of death or incapacity for work of the bank's borrowers, the capacity of the insured is not borne by the person who may suffer

financial loss due to the risk's materialisation (i.e., the bank that may not be able to recover the entire loan if the borrower dies or is incapacitated for work), but by the person on whose life the insurance is taken out (i.e., the borrower). Therefore, in the cases concerned, the lending bank did not conclude insurance on its own account, but insurance on the account of its borrowers – insureds, in which the bank was appointed as the sole beneficiary of the insurance money to secure the loans it had granted. It would have been an insurance on the bank's own account if the bank had insured the risk of non-repayment of the granted loans, which is a risk of pecuniary losses threatening the bank.

In another decision[25] on home insurance against damages including pipe breakage – rupture, the Court of Cassation rejected the insurance undertaking's objection on the exclusion of damages attributable to ageing or wear of the pipes from coverage, accepting that this exclusion entailed a derogation from the insured's application for insurance. Although the exclusion in question should have been appropriately indicated to the applicant for insurance, either in the application form or by way of a special warning included in the part of the policy containing its individual elements (type of insurance, covered risks, duration of insurance, etc.), the provision of Article 2 Paragraph 5 ICA, according to which derogations from the application for insurance that have not been communicated to the insured, thus depriving the insured of the right to object to them, are not binding on the insured, should concern only derogations from terms that are subject to the parties' negotiation, not derogations from terms that are predetermined or standardised, as applicable to mass insurance.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Insurance law comprises two interrelated segments: first, contractual insurance law and, second, the rules extensively harmonised at European Union level on supervision of reinsurance and insurance undertakings and on the distribution of reinsurance and insurance products.[26]

Contractual insurance law is mainly incorporated in the ICA, enacted in 1997, which replaced the obsolete provisions of the Commercial Code, which had in turn been transposed from the repealed Italian Code of Commerce of 1882.[27] The ICA's provisions are rather few and concise, and because of this succinctness insurance law is extensively supplemented by customary law and business usage in the insurance sector, as well as by standardised terms and conditions.[28] In particular, in commercial risks insurance, the industry commonly applies international standards to insurance terms and conditions, with only slight amendments (or none). However, Greek law is almost always stipulated as the applicable law in policies.

Insurance law is regarded as special contractual law, with its own methodology and concepts, which, albeit being literally identical to the civil law institutions, are sometimes interpreted differently from the understanding commonly applied in both civil and even commercial law.[29] Notwithstanding these different interpretations, the general provisions of the Civil Code also apply to insurance contracts in respect of, indicatively, contract formation, contracts voidable because of error, fraud or conclusion under duress, and interruptions of the limitation period.[30] Special legislation applies to marine insurance[31] and aviation insurance.[32] Furthermore, several dispersed provisions stipulate compulsory insurance, among which Law No. 489/1976 on motor vehicle third-party liability (MTPL) insurance stands out.

Legislation on supervision of insurance undertakings, namely on the taking-up and pursuit of insurance business, is structured in layers, as is the case in all EU countries, according to the Solvency II[33] system. Law No. 4364/2016 constitutes the first level, harmonising Greek legislation with Solvency II, followed by the European Commission's delegated regulations and decisions.[34] Applicable law also includes a number of decisions issued by the BoG, establishing strict legal provisions; most of the BoG decisions are issued in compliance with relevant European Insurance and Occupational Pensions Authority (EIOPA) Guidelines.[35] The provision of insurance services is subject to prior authorisation by the BoG upon fulfilment of certain conditions, with insurance undertakings licensed to carry out either life or non-life insurance business, according to the standing principle of business segregation.[36]

Despite the national legislature's omission of a special rule on the minimum share capital of insurance companies, it has been suggested that this should be differentiated from that of common *sociétés anonymes* (i.e., €25,000[37]) and should not fall short of the minimum capital requirement for insurance undertakings, which varies among insurance branches, ranging from €2.5 million to €9.8 million.[38]

As regards distribution of insurance products, the relevant national legislation was recently modified following the transposition of the Insurance Distribution Directive[39] by Law No. 4583/2018, which has been extensively supplemented by European Commission delegated regulations inserting special provisions on the distribution of insurance-based investment products, on product oversight and governance, and on packaged retail and insurance-based investment products; in addition, regulations on applicable key information documents and insurance product information documents are also enforceable. The novel legal framework establishes requirements for the provision of pre-contractual information to prospective insureds that are, in principle, equally applicable to insurance intermediaries and insurance undertakings engaging in direct sales of their products. Insurance intermediaries can provide their services subject to prior enrolment in the relevant registry under one of three designated categories (insurance agent, insurance broker or coordinator of insurance agents), although they cannot act in the capacities of both an insurance agent and an insurance broker concurrently. Notably, according to a national arrangement, banks, investment firms or agricultural cooperatives wishing to distribute insurance products are required to register in the category of insurance agent.

In response to the withdrawal of the licences of two large life insurance undertakings that led to losses for hundreds of thousands of long-term insureds[40] and resulted in the launching of numerous lawsuits, the Life Insurance Guarantee Fund was established,[41] entrusted with the duty to ensure the portfolio transfer of life insurance undertakings in liquidation and, should a transfer prove impossible, to provide coverage in place of the insolvent insurance company. Moreover, the liability of the Auxiliary Fund has been extended by national law[42] to cover insurance companies in bankruptcy or whose licence has been withdrawn or against which the execution of a judgment has proved fruitless.[43] The Auxiliary Fund is the body responsible for providing compensation for damage to property or personal injuries caused by unidentified vehicles or vehicles whose use fails to comply with the civil liability insurance requirement.

ii Insurable risk

Every risk capable of causing damage to a person or property, namely any risk that can harm tangible or intangible assets or generate liability, is deemed to be insurable.[44] There is a great deal of freedom in the formulation of insurance contracts, with the only condition to insurability being, in principle, the avoidance of fraud and collusion, without attachment to dogmatic positions given that the risk of fraud or collusion is not apparent.

In this regard, in view of public order considerations, non-insurable risks include liability for intentional damage caused to third parties and coverage for fines imposed for criminal offences, with the disputed exclusion of fines imposed in circumstances not constituting crimes punished by the Greek Penal Code. Although legal costs incurred for the defence of a claim regarding a fine are borne by the insurer, these have to be refunded if the final judgment of the criminal court goes against the insured. Moreover, intangible values are non-insurable because they cannot be damaged, therefore the specific risk does not actually exist and this is also the case for items without objective value and whose value is exclusively subjective for the policyholder. Furthermore, the risk of the death of a person is non-insurable without the written approval of the person at risk. Finally, an insurable risk must already be present at the time of effective commencement of the coverage but not necessarily at the time of conclusion of the insurance contract.

The ICA[45] contains certain risks that are, as a rule, excluded from coverage (acts of war, civil war, rebellion, civil commotion and natural deterioration of the insured items), in the sense that these risks are deemed not to be covered in the absence of an agreement to the contrary (the existence of which would be complemented by payment of an additional premium).[46] The

presence of these statutory exclusions in the ICA signifies that if for any reason whatsoever the policyholder is not bound by the terms and conditions of the policy that exclude coverage, the aforesaid statutory exclusions will still apply. However, these risks are not uninsurable and the insurer is entitled to cover them if so agreed, as is the established practice in, for instance, marine insurance. Finally, the provision requiring an insurance undertaking to be licensed to legitimately conclude insurance of the class specified by the licence does not render 'uninsurable' a risk covered in default of the appropriate licence; rather, covering a risk in default of the correct licence only exposes the insurance undertaking to the risk of an administrative fine.

All types of non-life insurance presuppose that the policyholder has, according to the ICA,[47] an 'insurable interest' that is 'a legal interest in the preservation of the property that is threatened by the risk against the materialisation of which coverage is sought'.[48] Greek insurance law doctrine distinguishes between insurable interest *lato sensu* and insurable interest *stricto sensu*; the existence of the former entitles the insurance applicant to conclude the insurance contract, while the latter means that as a result of the occurrence of the risk the policyholder shall suffer no less damage than the insurance money claimed. If neither the policyholder nor the insured have an insurable interest, the policy is null and void, irrespective of whether the insurer is seeking to benefit from avoiding the policy.[49]

iii Fora and dispute resolution mechanisms

The resolution of disputes arising between the insurer and the policyholder, insured or the loss payee (beneficiary) are resolved, as a rule, by referral to the competent state courts, while other methods include arbitration, mediation and expert adjudication.

Courts' jurisdiction is defined in accordance with the standing separation between civil, criminal and administrative courts. In this regard, civil and commercial disputes arising between the insurer and either the insured or the collaborating insurance intermediary are resolved by civil courts and the handling of criminal prosecutions is entrusted to criminal courts. Disputes arising between insurance undertakings and the regulator (the BoG) concerning, inter alia, the latter's refusal to grant a licence or the licence's definitive or temporary withdrawal, as well as sanctions imposed by the BoG, are subject to an 'application for annulment' before the Council of the State (i.e., the country's supreme administrative court).[50]

In principle, civil courts' material competence is dependent on the monetary value of the object of the dispute: if the value does not surpass €20,000, the case is brought before the magistrate's court; if it exceeds €20,000 but is less than €250,000, the single-member court of first instance is competent; and if the object exceeds €250,000 in value, the dispute is resolved by the multi-member court of first instance. However, as an exception, lawsuits concerning compensation for damage resulting from car accidents and disputes regarding the amount and the payment of insurance premiums are brought before the single-member court of first instance, even if the monetary value of the dispute's object exceeds €250,000,[51] as they are subject to the special procedural rules on the resolution of property disputes.[52] Nevertheless, if the value of the object of the dispute does is less than €20,000, the magistrates' court is competent. Shipping law disputes, including marine insurance claims, are heard by the Piraeus Court of First Instance Maritime Disputes Department. Given that the trial process in the country is lengthy (with issuance of an irrevocable decision by the Court of Cassation taking several years from the initiation of proceedings), to avoid the risk of failing to obtain satisfaction from the defendant because of the latter's potential insolvency, a request for precautionary or interim measures until the trial's conclusion constitutes common practice; the decision on such measures is executable within days or even hours (e.g., in the context of marine insurance, the liability insurer who paid the insurance money and was therefore subrogated to the right to the insured's claim against the liable third party could ask for the precautionary seizure, or arrest, of the third party's ship).[53]

Notably, with a view to expediting court trials, as well as imposing a duty on lawyers to inform their clients of the possibility of resolving a dispute by way of mediation, Law No. 4640/2019 introduced a requirement for a mandatory initial mediation session in civil and commercial

disputes falling within the competence of either the multi-member court or the single-member court of first instance (provided that the value of the dispute exceeds €30,000, in the latter case). Lawsuits launched in violation of this obligation will be deemed inadmissible. The new legal framework for mediation entered into force following advisory decision No. 34/2018 of the Court of Cassation (in plenary session), which declared as unconstitutional the pre-existing provisions of Law No. 4512/2018, providing for the compulsory submission of car accident compensation-related disputes to mediation (with the exception of bodily injury or death), insofar as the costs incurred in this process jeopardised the right to free and unimpeded access to justice.[54]

With the exception of marine insurance, resort to arbitration is rather limited. Legislation for domestic arbitration is found primarily in the Civil Procedure Code[55] and in Law No. 2735/1999 (adopting the UNCITRAL Model Law) for international arbitration, both providing, inter alia, that in the event of the parties failing to agree on the appointment, the presiding arbitrator will be appointed by the competent single-member court of first instance. Furthermore, the arbitration award cannot be challenged in the courts on the accepted facts and their legal assessment; it can only be annulled in cases of procedural rule violation (e.g., breach of fair trial principles) or if the award contravenes public policy.[56]

Alternative dispute resolution mechanisms encompass expert adjudication and amicable settlement: expert adjudication is commonly agreed upon in commercial property insurance cases (e.g., fire insurance) with a view to determining the extent (quantum) of the damage, excluding the issue of liability;[57] whereas the amicable settlement system (knock-for-knock contracts) is applicable in motor liability insurance cases, and the non-liable injured party's insurer pays the insurance money (for property damage) directly to the injured party then settles with the liable injuring party's insurer.[58]

A special ombudsman for disputes arising between consumer insureds and insurance undertakings does not exist. Out-of-court settlements are arrived at with the valuable assistance of insurance intermediaries, experts and loss adjusters, and with the Hellenic Consumers Ombudsman, which is a general ombudsman service covering several kinds of consumers, but it is not 'insurance-focused'.[59] In addition, pursuant to BoG Executive Committee Act No. 88/5.4.2016, implementing relevant EIOPA guidelines, insurance undertakings are required to adopt and implement a written policy on complaints handling and maintain a corresponding business function with a remit to address and investigate complaints thoroughly. Finally, an insured that lodges a complaint with an insurance undertaking but does not receive a timely response or receives an unsubstantiated answer, is entitled to file a complaint with the BoG, which will evaluate the matter albeit solely in the context of its supervisory competence as it lacks jurisdiction to settle disputes.

IV THE INTERNATIONAL ARENA

As far as insurance contracts with cross-border elements are concerned, the EU Rome I Regulation[60] determines the applicable law[61] and the Brussels IA Regulation[62] applies to court jurisdiction and the recognition and enforcement of judgments.[63]

As provided in Article 9 of the Rome I Regulation in respect of uniform rules, the applicable law (either chosen by the parties or determined in accordance with the special conflict rules set out in Article 7 of the Regulation) cannot override the rules of Greek insurance law, which prevail mandatorily if a dispute is heard before the Greek courts (Greek law being the *lex fori*).

Greek insurance law prevails optionally if a dispute is heard before other EU Member State courts provided that the obligations arising out of the insurance contract are to be or have been performed in Greece; for example, the 'over-insurance rule' stipulates that in property insurance if the declared value of the insured object exceeds its current value, the insurer shall not be liable for the excess should the risk occur. This rule is regarded as being in the nature of Greek public policy and is therefore mandatory.[64]

By way of derogation from the provisions of Solvency II regarding the determination of the 'Member State where the risk is situated' (which also operate as a connecting factor in determining the laws potentially applicable to the insurance contract under the Rome I

Regulation), Greek law (amongst only a few national laws of EU Member States) envisage the risk as being located in the country of 'registration where insurance concerns all means of transport', as opposed to the Solvency II provision that the risk is situated in the country of registration 'where insurance relates to vehicles of any type'.

The practical implication of this verbal imprecision is that Greece may be regarded as the country where the risk is located, including for vessel hull insurance, as long as the ship is entered in the Greek registry and even if it has never sailed in Greek waters – as is usually the case with large, ocean-going vessels.[65] Furthermore, the ICA provides that the insurer is obliged to pre-contractually inform the insurance applicant of the set law or the proposed applicable law and, if the contract is to be subject to a law other than Greek law, this should be marked on the first page of the policy containing the individual elements particular to that contract, rather than merely being included with the preformulated insurance terms.

As far as courts' jurisdiction regarding the settlement of insurance disputes is concerned, by way of derogation from the general rule that the courts of the defendant's place of residence have territorial jurisdiction, a lawsuit against the insurer may also be filed before the courts of the place where the policyholder, insured, beneficiary or injured third party (who has a right of direct action against the liability insurer of the injuring party) is domiciled.[66] Hence, the Court of Cassation[67] approved the jurisdiction of the Greek courts in respect of a car accident that occurred in Germany, for the launch of a lawsuit against the German liability insurer of the liable German driver by the injured third party, who was domiciled in Greece.[68] Notably, the procedural advantage in favour of the weaker claimant does not extend to disputes between insurance undertakings.[69] Moreover, although the validity of a clause in the insurance terms providing for the prorogation of courts' territorial jurisdiction presupposes the signing of the terms by the policyholder, jurisprudence has affirmed that such a clause can be validly contained in unsigned terms, provided that there is another signed document (i.e., the insurance contract) referring to the terms.[70] The Court of Cassation has accepted that the agreement on the prorogation of jurisdiction may also be oral,[71] on condition of a subsequent written confirmation; however, the Court also clarified that the letter of guarantee granted by the vessel's insurer cannot be regarded as the necessary verification.[72]

Apart from the location of the insurance company's head offices, the sites of its branches and agencies are also regarded as places in which it is domiciled. The mere existence of an office necessary for the exercise of insurance under the 'freedom to provide services' regime within the EU internal market does not suffice on its own to establish jurisdiction for the courts of the place where the office is situated (neither does it indicate that the undertaking operates under the 'freedom of establishment' regime[73]). Moreover, the appointment of a claims representative by undertakings providing MTPL insurance is not regarded as sufficient basis to establish court jurisdiction, although claims settlement business other than MTPL claims representation could in principle establish jurisdiction.[74]

The Brussels IA Regulation[75] provides that any co-insurer may be sued before the courts of the Member State where the case against the lead co-insurer has already been brought, without defining the concept of the 'lead' co-insurer. This term should be interpreted autonomously, in view of the fact that it is also used in other EU legislation.[76] Any other interpretation would lead to uncertainty. In a case of this kind, the admissibility of proceedings against a co-insurer before the courts of the country where the lead co-insurer has already been sued would depend on the meaning ascribed to the term 'lead' by the law applicable in the court before which the dispute has been brought (the *lex fori*). Under Greek law,[77] co-insurance presupposes that the insurance contract was concluded by joint agreement, with each of the co-insurers being proportionally liable for the insured amount. Thus, if the lead co-insurer was sued in Greece, the Greek courts could dismiss a lawsuit initiated against another co-insurer if they found that there was no joint agreement – a conclusion that could not be reached by the courts of a country where the existence of a joint agreement was not considered a *conditio sine qua non* for the establishment of co-insurance. To counter the possibility of uncertainty in this matter, the inclusion of a jurisdiction clause in the policy should be accompanied by a governing law clause.[78]

V OUTLOOK AND CONCLUSIONS

Over time, a considerable volume of insurance-related litigation has been focused on MTPL disputes. Notwithstanding the recent introduction of legislation regarding the circulation of e-scooters, the issue of whether the owner or driver of these vehicles should compulsorily conclude MTPL insurance remains unclear.[79] This issue may be resolved by the insertion of a provision thereto in the law enacting the (EU) Directive 2021/2118 that amends the legal framework for MTPL insurance which, inter alia, links the concept of 'vehicle' with the maximum speed it can achieve. This law must be enacted by the end of 2023.

Despite the ever-growing risks associated with network hacking, malware infection, cyberattacks, etc., and the theoretical discussion on the necessity of compulsory cyber risk insurance (either on a stand-alone basis or as part of a directors and officers policy[80]), only a few undertakings have concluded such insurance. As far as losses related to the covid-19 pandemic are concerned, recently the concessionaires of two major Greek highways initiated proceedings claiming insurance money to recover their loss of revenue arising from the containment of vehicles' circulation owing to the curfew imposed in response to the pandemic, based on a special term of their policies extending coverage to business interruption resulting from notifiable human infectious or contagious diseases. Finally, the Greek government incentivised the conclusion of insurance of buildings against the risks of flood, fire and earthquake by providing for a reduction of 10 per cent on the property tax imposed on the landlords who will take out such insurance.[81]

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Endnotes

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74 A Tsavdaridis, 'Jurisdiction in Insurance Matters', op.cit., Article 11, at pp. 268–270.
75 Article 11 Paragraph 1, letter c.
76 See Article 190 Solvency II; A Tsavdaridis, 'Jurisdiction in Insurance Matters', op.cit., Article 11, p. 276, fn. 75.
77 Article 15 ICA.
78 See I Rokas, Contractual Insurance Law, op. cit., Section II 96-98.
79 A G Kritikos, Summary of new essential legislative regulations of recent Law No. 4784/2021, amending, inter alia, the Road Traffic Code, Transportation Law Review 2021, at pp. 93 ff.
80 I Rokas, Contractual Insurance Law, op. cit., Section III 210.
81 Article 44 of Law No. 5045/2023.

Chapter 11

India

Neeraj Tuli and Rajat Taimni[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

The Indian insurance industry has seen significant growth and development in recent years.

The government of India, following a comprehensive review of the legislative framework by the Finance Ministry and in consultation with the Insurance Regulatory and Development Authority (IRDAI) and other stakeholders in the industry, has issued a draft Bill titled 'The Insurance Laws (Amendment) Bill, 2022' of 29 November 2022. This Bill proposes several amendments to the Insurance Act 1938 and the Insurance Regulatory and Development Authority Act 1999 such as opening up registration to various classes, sub-classes and types of insurers with minimum capital requirements based on the form of business (as may be specified by the IRDAI), allowing insurance companies to additionally perform services that are incidental or related to insurance business as well as distribution of other financial products as may be specified by the IRDAI.

In addition, the IRDAI has undertaken various initiatives that include relaxations in relation to the launching of insurance products by insurers, relaxation in filing returns, lifting of commission limits payable to insurance agents or intermediaries by insurers and introduction of additional allowances for insurtech and insurance awareness expenses. By way of a press release of 27 June 2023, the IRDAI has stated that it has been working towards developing and implementing a risk-based supervision framework for the insurance sector in India with the objective of moving towards a principle-based regulatory regime rather than a rules or compliance-based approach and in order to foster the ease of doing business in India.

The IRDAI has also eased the product filing mechanisms and various reporting and compliance requirements for insurers who are planning to launch new life, general or health insurance products. These changes and modifications have been stated to have been brought about to enable the ease of doing business by insurance companies.

The IRDAI has also issued exposure drafts indicating that there may be changes on the horizon for a variety of subject matters, including the following:

- an exposure draft on the 'Bima Vahak Guidelines 2023' of 1 June 2023;
- an exposure draft on the 'IRDAI (Insurance Advertisements and Disclosure) (First Amendment) Regulations 2023' of 4 May 2023; and
- an exposure draft on the 'IRDAI (Re-insurance) (Amendment) Regulations 2022' of 25 November 2022.

In terms of insurance claims, over the past few years, there has been an upsurge in the frequency and severity of claims, specifically those made under professional indemnity (PI), directors' and officers' (D&O), employment practice liability (EPL) and cyber policies. We see this trend as only going upwards in the years to come as the awareness of risks associated with any business increases, and particularly as the legal and regulatory framework tightens. The government has undertaken initiatives to improve the business environment; for example, for the commercial courts and consumers, initiatives have helped set out some time-bound measures regarding the disposal of disputes. Consumer fora and commercial courts both cover insurance and reinsurance disputes. The strict timelines laid down by the Commercial Courts Act 2015 (the Commercial Courts Act) have helped set up a positive image in relation to the early resolution of disputes in India.

II YEAR IN REVIEW

i Disputes pertaining to interpretation of insurance policies

Disputes between the insured and the insurer usually arise when an insured's claim, which the insured believes is covered under the policy, is rejected in part or in full by the insurer. There can be disagreement between the insurer and the insured in relation to the scope of the insuring clauses or extensions, the applicability of exclusions or compliance with the policy terms and conditions, and the quantum payable under the policy if liability is admitted. Recently, the Supreme Court in the case of ***National Insurance Co Ltd v. Harsolia Motors and Ors***[2] adjudicated on whether an insured that obtains an insurance policy is a 'consumer' under Section 2(1)(d) of the Consumer Protection Act 1986.

The Court held that to decide whether anything is being done for a 'commercial purpose', what needs to be considered is whether the items or services are directly related to the activity that generates profit. The Supreme Court observed that availing of an insurance policy is an act of indemnifying a risk of loss or damages and there is no element of profit generation. The fact that the insured is a commercial enterprise is unrelated to the determination of whether the insurance policy shall be counted as a commercial purpose under Section 2(1)(d) of the Consumer Protection Act 1986.

In another landmark judgment of *United India Insurance Company Limited v. Levis Strauss (India) Private Limited*,[3] the Supreme Court discussed the concept of 'double insurance', which is when two or more insurance policies are taken by the insured for the same interest (or a part of such interest). The Supreme Court held that the contract of insurance is a contract of indemnity, where an insured in case of loss cannot make a profit and once an insured has been paid by one insurer it cannot claim for the same loss from another insurer.

In another case, *Haris Marine Products v. Export Credit Guarantee Corpn (ECGC) Ltd*,[4] the Supreme Court has reiterated the settled law of interpreting an ambiguous term in an insurance contract. The Supreme Court has held that the terms of the insurance contract must be read in their entirety and if such reading does not provide clarity to the ambiguous term, it must be interpreted against the insurer (i.e., the drafter) of the policy.

ii Recent case laws on computing limitation for insurance claims

The manner of computing the limitation period for insurance claims is provided under Article 44(b) of the Limitation Act 1963, which states that time is to be calculated from 'the date of the occurrence causing the loss, or where the claim on the policy is denied either partly or wholly, the date of such denial'. The prescribed limitation period for filing a claim in the civil court or an arbitration is three years, whereas the limitation period for filing a claim in the consumer court is two years.

iii Case laws pertaining to arbitration

In the absence of an arbitration clause in the policy, an insured can approach a commercial court or (if the dispute qualifies) a consumer court. An insurer can only approach a commercial court. The remedies available are either specific performance of the contract or claims for damages. Indian courts also award interest and costs to the winning party. Interest is usually awarded at a rate of 8 to 11 per cent from the date of the cause of action until the date of recovery. Costs remain at the discretion of the courts. If the policy contains an arbitration clause, the courts in India will direct the parties to arbitrate.

The Constitution Bench of the Supreme Court in its recent landmark decision in the case of *NN Global Mercantile Pvt Ltd v. Indo Unique Flame Ltd & Ors*[5] has held that an unstamped instrument containing an arbitration clause is not valid and is unenforceable in law.

iv Case laws on subrogation

Indian law recognises the concept of subrogation, under which the insurer is entitled to pursue recoveries in respect of losses suffered by the insured that the insurer has indemnified.

This right arises pursuant to both statute and case law. As for statute, the Marine Insurance Act 1963, specifically Section 79,[6] is relevant.

There are numerous pieces of case law dealing with subrogation, of which we consider the *Economic Transport Organization v. Charan Spinning Mills (P) Ltd*[7] decision to be the most prominent. This case was decided in 2010 by the Supreme Court. The Supreme Court explained that subrogation is inherent, incidental and collateral to a contract of indemnity, which occurs automatically when the insurer settles the claim under the policy by reimbursing the loss suffered by the insured.

We are not aware of any Indian statute or case law that prescribes or limits the types or rights or claims that can be pursued under a subrogation action, the only limitation being that the insurer cannot claim anything more than the amount indemnified to the insured. The insurer becomes subrogated as an indemnifier to all the rights and remedies that the insured has against any third parties. The insurer can exercise these rights either in the name of the insured or as a subrogee-cum-attorney holder on behalf of the insured.[8] While the right is inherent to an indemnity contract, nevertheless, in certain circumstances parties may execute a subrogation letter or subrogation-cum-assignment deed, which sets out the precise rights and obligations of the parties (e.g., the cost-sharing arrangement).

In the event that the insured fails to preserve its recovery rights, waives them or generally acts in breach of the subrogation clause, then the remedies available to insurers were explained in *EID Parry (India) Ltd v. Far Eastern Marine Transport Co Ltd and Ors*[9] in the following terms:

> *As is laid down in the policy of insurance, the insurer's liability is only to succeed to and not in any way supersede any claim which the insurer may be entitled to make on any carriers or their agents. It is also laid down therein that it is the duty of the assured and the agents in all cases to take such measures as may be reasonable for the purpose of averting or minimising a loss and to ensure that all the rights against the carriers, bailees or other third parties are properly observed and exercised. In particular, the assured or their agents are required to take these steps and failure to comply with this requirement may prejudice any claim under this policy. Under the law of Insurance, the right of the Insurer on payment of the loss to the assured is to be subrogated to the rights of the assured so as to enable the insurer to proceed against the third party and indemnify itself. It is therefore incumbent upon the assured to keep alive his remedies against the carrier or other third party and any default committed by the assured either by allowing the remedy to get time-barred or by abdicating or abandoning, his rights against the carriers or the third party will deprive the insurer of its remedies against the third party for indemnity. In such cases, it is open to the insurer to repudiate the liability under the policy, the loss is not paid to the assured or to lay a counter-claim against the assured for damages if it has paid the loss to the assured.*

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Insurers, reinsurers and insurance intermediaries in India are governed by the IRDAI. The primary legislation regulating the Indian insurance sector consists of the Insurance Act 1938 (the Insurance Act) and the Insurance Regulatory and Development Authority Act 1999. Pursuant to the powers granted to it under both of these statutes, the IRDAI has issued various regulations governing the licensing and functioning of insurers, reinsurers and insurance intermediaries. Appeals against orders issued and decisions made by the IRDAI may be referred to the Securities Appellate Tribunal, in accordance with the procedural rules notified in this regard.

The past year was significant for the insurance sector as several regulations and guidelines were issued by the IRDAI:

- The IRDAI has notified the IRDAI (Payment of Commission) Regulations 2023, in furtherance of the exposure draft with the same title issued on 23 November 2022 and repealed the IRDAI (Payment of Commission or Remuneration or Reward to Insurance Agents and Insurance Intermediaries) Regulations 2016. The new regulations stipulate that the total amount of commission payable to an insurance agent or intermediary should not exceed the expenses of management limits specified under the respective expenses of management regulations while removing the previous limits specified for each line of insurance business.
- The IRDAI has notified the IRDAI (Expenses of Management of Insurers Transacting General or Health Insurance Business) Regulations 2023 and the IRDAI (Expenses of Management of Insurers Transacting Life Insurance Business) Regulations 2023 of

28 March 2023, in furtherance of the respective exposure drafts with the same title and repeal the respective regulations of 2016. These regulations specify the overall limits on expenses of management for insurers.

- The IRDAI has notified the IRDAI (Registration of Indian Insurance Companies) Regulations 2022 and the 'Master Circular on Registration of Indian Insurance Company 2023' of 24 April 2023 which repealed the IRDAI (Registration of Indian Insurance Companies) 2000, the IRDAI (Transfer of Equity Shares of Insurance Companies) Regulations 2015 and the IRDAI (Investments by Private Equity Funds in India Insurance Companies) Guidelines 2017 of 5 December 2017. These guidelines set out various norms in relation to the registration of Indian insurance companies.
- The IRDAI has notified the IRDAI (Regulatory Sandbox) (Amendment) Regulations 2022, in furtherance of the exposure draft issued on 3 August 2022, to amend the IRDAI (Regulatory Sandbox) Regulations 2019.
- The IRDAI has notified the IRDAI (Other Forms of Capital) Regulations 2022 which set out norms in relation to issuance of other forms capital by Indian insurance companies.
- The IRDAI has notified the IRDAI (Insurance Intermediaries) (Amendment) Regulations 2022 which amend the regulations governing the registration of corporate agents and insurance marketing firms to increase the maximum number of tie ups that are permitted with insurance companies.
- The IRDAI has issued the 'Guidelines on Issuance of File Reference Numbers (FRN) to Cross Border Reinsurers' on 3 January 2023. The guidelines allow for auto renewal of the FRN and supersede the 'Guidelines on Cross Border Re-insurers' of 22 January 2021.
- The IRDAI has issued the 'Guidelines on Remuneration of Directors and Key Managerial Persons of Insurers' of 30 June 2023 which supersede the erstwhile guidelines of 2016. The guidelines now govern the remuneration of all key managerial persons and provide extended norms on age, tenure, and annual remuneration payable to non-executive directors and key managerial persons respectively.
- The IRDAI has issued the 'Information and Cyber Security Guidelines 2023' of 24 April 2023 which supersede the IRDAI's 'Guidelines on Information and Cyber Security for Insurers' of 7 April 2017 and various circulars issued on this subject.
- The IRDAI has also issued guidance on common directorships between insurance companies and insurance intermediaries and common directorship among insurance intermediaries.

ii Insurable risk

As is the case under English law, Indian law also requires a person entering into an insurance contract to have an insurable interest in the subject matter of the contract. The insurable interest must be present in all types of insurance, failing which it would be a wagering contract, which is void.

Neither the Insurance Act nor the IRDAI regulations set out precisely what constitutes insurable interest, nor an exhaustive list of risks that can and cannot be insured. However, there is guidance provided by way of other statutes, court judgments and IRDAI regulations.

Insurable interest has been defined under Section 7 of the Marine Insurance Act 1963 as follows:

> *7. Insurable interest defined. – (1) Subject to the provisions of this Act, every person has an insurable interest who is interested in a marine adventure.*
>
> *(2) In particular a person is interested in a marine adventure where he stands in any legal or equitable relation to the adventure or to any insurable property at risk therein, in consequence of which he may benefit by the safety or due arrival of insurable property, or may be prejudiced by its loss, or by damage thereto, or by the detention thereof, or may incur liability in respect thereof.*

To have an insurable interest in anything, there must be subject matter to insure, the insured should have some legally recognised relationship with the subject matter and the loss of the property should cause pecuniary damage to the insured.[10] If the insured suffers a loss

or derives benefit, he or she has an insurable interest in the subject matter of the insurance contract.[11] The courts have held that an insurable interest is not complete ownership. It need not necessarily even strictly be title and interest in the object insured.[12]

Further, Paragraph 6(b) of the 'Guidelines on Product Filing Procedures for General Insurance Products' of 18 February 2016[13] states: 'the product should be a genuine insurance product covering an insurable risk with a real risk transfer. Alternate risk transfer or financial guarantee business in any form shall not be accepted, including indirect insurance products such as insurance derivatives.'

There are specific requirements as far as trade credit policies are concerned; for instance, they cannot cover reverse factoring, loan defaults of sellers and other financial guarantees in any form; or any receivable arising from transactions made other than trade credit transactions.

Further, Indian law recognises the principle that the law will not help a criminal to recover any kind of benefit from or for his or her crime.[14] Accordingly, the results of a criminal act will typically not fall within cover under an insurance policy and no benefits will extend to the perpetrator.

Non-admitted insurers are not permitted to directly insure property situated in India, or any ship or other vessel or aircraft registered in India. However, a person resident in India is permitted to take or continue to hold a health insurance policy issued by an insurer outside India provided the aggregate remittance does not exceed the limits prescribed by the Reserve Bank of India (RBI). In this regard, a person resident in India may take or continue to hold a life insurance policy issued by an insurer outside India, subject to certain foreign exchange requirements stipulated in the Master Direction – Insurance of 1 January 2016 (as amended) issued by the RBI. Similarly, a person resident in India may take or continue to hold a general insurance policy issued by an insurer outside India, provided that the policy is held subject to the conditions provided under the Foreign Exchange Management (Insurance) Regulations 2015 (as amended).

In addition to the above, foreign reinsurers are allowed to access the Indian market and are permitted to set up branch offices in India or operate through branches set up in India under the IRDAI (Registration and Operations of Branch Offices of Foreign Reinsurers other than Lloyd's) Regulation 2015, service companies under the IRDAI (Lloyd's India) Regulations 2016, and international insurance offices under the International Financial Services Centres Authority (Registration of Insurance Business) Regulations 2021. Non-admitted insurers that are listed with the IRDAI as cross-border reinsurers can reinsure risks in India in accordance with the IRDAI's reinsurance regulations and subject to compliance with the order of preference for cessions. The restrictions on non-admitted insurers mean that cross-border insurance disputes involving insurers and insureds are scarce in this jurisdiction.

Further, even in the case of policies obtained by Indian residents from insurers residing abroad, the Insurance Act gives policyholders a right to override contrary policy terms in favour of Indian law and jurisdiction as long as the insurance business is transacted in India.

iii Fora and dispute resolution mechanisms

Disputes before a civil or commercial court

There are no exclusive procedures or judicial venues for resolution of insurance disputes. Insurance disputes, in the absence of an arbitration clause, can be litigated before the civil courts or consumer fora. The option to approach consumer fora, however, lies only with the insured in the event of a dispute. The civil and consumer courts have territorial and pecuniary jurisdiction to adjudicate disputes, which is decided based on the place where the insurer is located, where the dispute has arisen and the quantum of the dispute.

India has a three-tier hierarchy of courts to hear civil disputes. There are over 3,000 district courts at the lowest level, 25 High Courts at the middle level and the Supreme Court of India at the top level of the court pyramid. The High Courts of Delhi, Bombay, Madras, Calcutta and Himachal Pradesh have original jurisdiction to hear matters over a certain pecuniary value, so the civil courts and judges under them do not hear matters involving values higher than

that limit. In all other cases, district courts and the competent courts of first instance have unlimited pecuniary jurisdiction to hear any insurance dispute. There is no right to a hearing before a jury and cases are decided by judges.

In 2015 the Indian legislature enacted the Commercial Courts Act for fast-track resolution of commercial disputes. Special commercial courts were set up under the Act for exclusive adjudication of commercial disputes. The Act defines a commercial dispute to include insurance and reinsurance disputes over the value of 300,000 Indian rupees. The Act has mandated compulsory mediation for parties before filing a commercial suit, except where a party seeks urgent interim relief.

The Code of Civil Procedure 1908 (CPC) governs the method of instituting and trying civil suits. The Commercial Courts Act provides for summary judgment in a suit. A plaintiff can apply for summary judgment in a suit after summons have been served upon a defendant. If the court is convinced that the defendant has no real prospect of succeeding in a claim, it may grant a summary judgment. In other circumstances, the court may pass conditional orders allowing a defendant to defend the suit after payment of a deposit or on such other terms as the court may deem fit.

Disputes before a consumer forum

The consumer fora follow a three-tier hierarchy that comprises, in ascending order, the district consumer disputes redressal commissions (district commissions), the state consumer disputes redressal commissions (state commissions) and the National Consumer Disputes Redressal Commission (NCDRC).

The Consumer Protection Act 2019, which was brought into force on 20 July 2020, revised the pecuniary jurisdiction of the consumer courts. Subsequently, the central government introduced the Consumer Protection (Jurisdiction of the District Commission, the State Commission and the National Commission) Rules, 2021, which once again revised the jurisdiction of the consumer fora. In accordance with the revised jurisdiction, the district commissions now have jurisdiction to entertain complaints where the value of goods and services paid as consideration does not exceed 5 million rupees. The term 'value of goods and services paid as consideration' refers to the premiums paid by an insured to obtain a policy. The state commissions can entertain complaints where the premiums paid to obtain a policy are valued at over 5 million rupees and up to 20 million rupees, and where premiums of over 20 million rupees have been paid, the complaints will need to be filed with the NCDRC. An order passed by the NCDRC can be challenged before the Supreme Court of India.

As a mechanism of alternative dispute redressal in the case of all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises, the insured can also approach the Insurance Ombudsman for disputes that do not exceed 3 million rupees in value. The Insurance Ombudsman is a quasi-judicial authority and does not have the power to enforce its decisions against the insurer.

In addition, Section 89 of the CPC provides for the settlement of disputes outside court. Considering the time taken for legal proceedings and the limited number of judges available, alternative dispute resolution (ADR) is encouraged. This can take place in the form of courts encouraging parties to utilise the ADR mechanism, as stipulated under Section 89 of the CPC. The ADR mechanisms contemplated by Section 89 include arbitration, conciliation and judicial settlement, including settlement through a *Lok Adalat* (a mode of ADR) or mediation. There is usually a mediation cell associated with each court.

IV THE INTERNATIONAL ARENA

Overseas insurers are barred from writing direct insurance business in India; however, cross-border reinsurers can reinsure risks written by Indian insurance companies in compliance with the relevant IRDAI regulations. Therefore, international disputes in the insurance sector are disputes relating to or arising out of reinsurance policies.

Indian courts give prominence to party autonomy when it comes to choice of jurisdiction and the law governing contracts. If the contract is silent on the governing law and jurisdiction, then conflict of laws principles apply, and the Indian courts will examine the law and place where the dispute has its closest nexus to determine these questions. Given the restrictions on overseas insurers in writing business in India, these issues have not been considered by the courts in an insurance context.

The CPC lays down the procedure for enforcement of foreign judgments and decrees in India. To enforce a foreign judgment, a suit in terms of the foreign decree has to be filed. Prior to enforcement, the courts will examine whether:

- the judgment or decree was passed on the merits of the case by a competent court;
- the principles of natural justice were followed;
- any fraud was involved; and
- the judgment is not against the public policy of India.

If India has a reciprocal arrangement with a foreign country, then judgments pronounced by the courts of that country can be enforced as a decree passed by the Indian courts.

India is a signatory to both the New York Convention and the Hague Convention for the enforcement of foreign arbitration awards, and a foreign award obtained in a signatory country can be enforced in terms of these Conventions. Indian courts have increasingly followed a hands-off approach when it comes to arbitration and will enforce foreign arbitration awards. The courts in India have limited scope to refuse enforcement of a foreign award, and the usual grounds available under the New York Convention dealing with incapacity of a party's natural justice, suspension of an award, scope of the arbitration clause and public policy apply. In *Avitel Post Studioz Limited v. HSBC PI Holdings (Mauritius) Limited*,[15] while dealing with the issue regarding finality on the arbitrability issue of allegations of fraud, the Bombay High Court opined that the court should be mindful of the approach adopted in the New York Convention which is embodied in Section 48 of the Arbitration and Conciliation Act 1996. Further, the High Court also held that while examining allegations of bias, conflict of interest and duty of disclosure, the court is expected to adopt a pragmatic and commonsensical approach. Under Indian law, public policy has an expansive definition, but in the context of a foreign arbitration this has been watered down to mean the fundamental policy of Indian law, fraud, and interests of justice and morality.

V OUTLOOK AND CONCLUSIONS

While the focus used to be on more traditional lines of insurance, such as catastrophe, life, health and motor insurance, over the past decade or so, the Indian insurance market has evolved, and we have seen liability products such as PI, D&O, cyber policies and EPL come to the forefront. There is familiarity of and demand for these products and, consequently, significant claims activity. Among the liability products, in our experience over the past five years, there has been a steady upward trend in claims made under PI policies, and it remains the busiest claims area, followed closely by D&O. In fact, PI and D&O claims make up at least half of the total claims that we have seen being made under liability policies.

Not only has there been an upsurge in the frequency of claims, but there has also been a sharp increase in the quantum being claimed by the insured, which means that claim severity is also on the rise. The sorts of numbers in play can be gauged from the recent settlements entered into by Indian technology and pharmaceuticals companies in the United States, which have attracted media attention. Another reason for increased exposure is the high legal fees that have to be spent in the defence of claims, which may run for a number of years because of the delays inherent within the court system.

While PI and D&O claims are likely to continue to make up the largest share, we have recently seen a steep rise in cyber claims, and these will continue to grow at a fast pace in the coming years. The number of cyber incidents has increased, and these range from automated telling machine fraud and phishing attacks to ransomware attacks. We say this specifically in light of the enactment of the General Data Protection Regulation, the ramifications of which are evidenced by, inter alia, the terms of the penalties imposed and the notification costs arising

therefrom. Another area of interest is EPL, where previously claims were usually made in outside jurisdictions; however, recently we have seen such claims being made in India, with high-value settlements demanded.

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Endnotes

1 Neeraj Tuli is a senior partner and Rajat Taimni is a partner at Tuli & Co.
2 2023 SCC OnLine SC 409.
3 2022 SCC OnLine SC 537.
4 Haris Marine Products v. Export Credit Guarantee Corpn (ECGC) Ltd, 2022 SCC OnLine SC 509.
5 2023 SCC Online SC 495.
6 79. Right of subrogation. – *(1) Where the insurer pays for a total loss, either of the whole or, in the case of goods, of any apportionable part of the subject-matter insured, he thereupon becomes entitled to take over the interest of the assured in whatever may remain of the subject-matter so paid for, and he is thereby subrogated to all the rights and remedies of the assured in and in respect of that subject-matter as from the time of the casualty causing the loss.*

(2) Subject to the foregoing provisions, where the insurer pays for a partial loss, he acquires no title to the subject-matter insured, or such part of it as may remain, but he is thereupon subrogated to all rights and remedies of the assured in and in respect of the subject-matter insured as from the time of the casualty causing the loss, insofar as the assured has been indemnified, according to this Act, by such payment for the loss.
7 (2010) 4 SCC 114.
8 Fresenius Medical Care India (P) Ltd v. Kerry Indev Logistics (P) Ltd 2022 SCC OnLine Del 1946.
9 (1988) 1 Mad LJ 144.
10 The New India Assurance Co Ltd v. GN Sainani (1997) 6 SCC 383.
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Chapter 12

Italy

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Summary

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I INTRODUCTION

The field of insurance contracts is extensively regulated in Italy, especially as a result of provisions enacted at the EU level. The same complexity is reflected in litigation, with a large number of cases brought before Italian courts each year. Disputes cover not only traditional topics related to civil liability and damage compensation, but also claims for nullity of finance-related insurance products (such as unit-linked and index-linked policies) because of their alleged lack of compliance with the Italian Consolidated Financial Act, and claims for mis-selling and incorrect management of underlying assets and personal funds.

Contrary to other specific areas of dispute resolution – such as private enforcement, intellectual property and corporate litigation, which are subject to the jurisdiction of specialised courts or divisions – insurance disputes can be brought to the attention of any Italian court, provided that the general criteria on jurisdiction are fulfilled. Usually, the place where the insured is domiciled will determine the local court's jurisdiction, so virtually every court in Italy decides on insurance disputes. For this reason, and also taking into account that the ***stare decisis*** rule does not apply in Italy, court decisions over insurance claims may vary significantly, offering quite a diversified picture in Italian case law, especially in the absence of clear leading cases rendered by the Supreme Court.

II YEAR IN REVIEW

Insurance disputes can be classified into litigation focused on life insurance policies and litigation regarding third-party policies. The following insurance law issues have been hot topics in the Italian courts recently and they are grouped here into these two categories.

i Life insurance

With regard to life insurance policies, one of the main issues concerns the nature of unit-linked and index-linked policies and their qualification as insurance or financial products. Their potential qualification as financial products is particularly significant, as it results in the application of rules (the Consolidated Financial Act (TUF) provisions) other than those the insurance companies and intermediaries had in mind when these policies were sold (the Insurance Code provisions), thus exposing them to the risk of a negative outcome in the event of disputes. A law was passed with the aim of solving this problem, clarifying that the TUF also applied to unit-linked and index-linked products,[2] but the results were not satisfactory. The application of the TUF provisions to these products was only partial, and no clear provisions were passed in respect of the distribution of unit-linked and index-linked policies, which can be sold by either financial intermediaries or insurance brokers and agents, who have traditionally been subject to a different regulatory regime.

Because of this uncertainty and lack of clarity, the Italian courts have developed different approaches, which the Supreme Court has also failed to reconcile. In fact, according to the Supreme Court, unit-linked and index-linked policies could be classified as insurance products when the demographic risk undertaken by the insurer prevails over the financial risk borne by policyholders,[3] but this is to be assessed by the courts of first and second instance on a case-by-case basis. As a result, some courts have found that when any and all risks related to the investment are borne by the insured, the policy has a financial nature (with consequent application of the TUF rules);[4] some others have instead applied the ECJ's interpretation, whereby unit-linked and index-linked policies are qualified as insurance contracts (with the consequent application of the Insurance Code) when they provide for the payment of a premium by the policyholder in exchange for a service by the insurer upon the occurrence of an event linked to the insured party's life.[5]

Investors who have lost (or partially lost) premiums invested in unit-linked and index-linked policies have generally raised several different claims with the aim of being reimbursed for their losses.

A first set of claims is usually connected to an alleged breach of information and conduct duties in the intermediation stage, including lack of information on the features of the

policies and the underlying assets, and their lack of compliance with the policyholder's risk profile. The breach of these duties is to be attributed to the intermediary, not to the insurance company, which lacks any standing before the courts[6] (unless the policy is sold directly by the insurance company itself), and may only entail a claim for damage compensation.[7] It follows that policyholders cannot have the policy terminated or nullified based on breaches of information and conduct duties in the intermediation stage and cannot, therefore, ask for repayment of the invested premiums. However, although this position has been consolidated by Italian case law, the Court of Appeal of Turin adopted a different approach, whereby a lack of information on the features of a policy and its underlying assets, as well as inconsistency between the product and the policyholder's risk profile, may lead to the termination of the policy and the repayment of the invested premiums.[8]

Nonetheless, in a notable recent decision, the Court of Bergamo declared as inadmissible the termination claim brought by 33 policyholders in respect of unit-linked policies that had already been surrendered at the time when the litigation was launched. The judge argued that a surrender request is equivalent to a contractual withdrawal and it is not possible to terminate a contract that has already ceased to exist,[9] irrespective of whether the alleged breach of information duties has actually occurred. The Courts of Pordenone, Verona, Milan and, recently, of Gorizia have also recently ruled in line with this case law.[10]

Another common set of claims pertains to the alleged nullity of index-linked and unit-linked policies for lack of a framework agreement, which is a written contract between the intermediary and the investor reporting information on possible future investments and the provision of related services by the intermediary. Such a contract is required by Article 23 of the TUF (Article 23) prior to any investment in financial products, under penalty of nullity of the investment made in the absence of a contract.

By qualifying unit-linked and index-linked policies as financial products, some courts[11] have considered the lack of a framework agreement to lead to the nullity of the policy, for having been concluded in breach of Article 23. However, the topic is strongly debated, as other courts have ruled (more reasonably in our view) that the framework agreement is not required if the policy contains all the information required under Article 23,[12] or if the distribution of the policy is carried out by brokers or insurance intermediaries, as this would lead to the application of the Insurance Code provisions (which do not require a framework agreement to be concluded) (the double-track principle).[13] Some courts have also ruled that, in the case of unit-linked policies, the conclusion of a framework contract would be misleading and superfluous[14] since the framework agreement works as an umbrella for a number of future investments, while unit-linked policies are single contracts that comprehensively rule the entire and sole contractual relationship between the policyholder and the insurer. It is in any event undisputed that the framework agreement is stipulated – when due – with the intermediary, which is the reason why some courts that have required the conclusion of a framework agreement also in respect of unit-linked policies have also stated that the relevant repayment obligation lies with the intermediary rather than with the insurer[15] (unless, of course, the product has been directly distributed by the insurance company).

On 4 November 2019, in relation to the purchase of financial products other than unit-linked policies, the Joint Divisions of the Supreme Court[16] stated that when an investor claims the nullity of an investment for lack of a framework agreement, the judge is required to conduct a full investigation into the matter of the agreement, although clearly this cannot be done if the parties involved have not all been summoned before the court. As a result, claims for the declaration of nullity of unit-linked or index-linked policies sold in the alleged absence of a framework agreement, and through intermediaries that are not involved in the proceedings, should be dismissed on procedural grounds, without even entering into a consideration of the merits of the claim.

This decision by the Supreme Court is also important on another count, as it states that investors cannot abuse their exclusive right to claim the nullity of the framework contract by seeking a declaration of nullity in respect of selected parts of the investment instructions (i.e., those parts that have not led to successful results) if the investment as a whole has been beneficial to them. This argument was followed recently by the Court of Salerno, which on 5 March 2020 rejected an investor's request to declare the nullity of an investment made

in a financial product for lack of a framework agreement, as the nullity was claimed only when the investor realised his investment had performed badly. According to the Court, the constitutional principle of good faith in the conclusion and implementation of a contract prevents individuals from abusing their rights by requesting remedies that appear to be inconsistent with their own prior behaviour (e.g., a request of surrender cannot be followed by a claim for the nullity of the same contract, regardless of the overall financial result of the investment).

Claims of nullity are generally not subject to limitation. However, because of the particular character of the nullity provided under Article 23, which can only be invoked by the investor, some courts have applied the limitation period of five years provided by law for the annulment of contracts.[17]

Finally, the Court of Verona[18] has clarified that Article 1923 of the Italian Civil Code (ICC) (which excludes enforcement proceedings for the indemnification sum due by the insurer in the case of life insurance policies) should also apply to unit-linked policies of a financial nature.

ii Third-party insurance

With regard to claims related to third-party insurance, a recent decision of the Supreme Court finally settled one of the most debated issues, concerning claims-made clauses.

These clauses are contained in third-party insurance policies and generally establish that the policy will cover only those damages for which the third party raises a claim during the period of validity of the policy. However, these clauses can be formulated in different ways and, for example, may also provide that the policy will cover only those cases in which both the damage and the claim occur within the period of validity of the policy.

The validity of insurance contracts containing claims-made clauses was subject to extensive scrutiny by Italian courts, which in some cases declared them null and void as vexatious under Article 1341 of the ICC. The courts considered that those clauses limited the liability of insurance companies, with a consequent need for the explicit written consent of the insured for the contracts to be valid.

In some other cases, the validity of the whole contract was challenged, as it would have allegedly constituted an agreement that was outside the scope of lawful atypical insurance contracts, thus being unenforceable under Italian law.

The Joint Divisions of the Supreme Court were, therefore, requested to issue a decision on the topic. The judgment was rendered in September 2018 and, while it rejected the alleged grounds of invalidity reported above, it substantially declared that the validity of claims-made clauses shall be assessed on a case-by-case basis.[19]

In particular, the Court confirmed that insurance contracts containing claims-made clauses are not atypical, especially taking into consideration that recent laws expressly govern them. Moreover, such clauses cannot be considered vexatious, as they merely define the object of the contract and do not limit the liability of the insurance company. Accordingly, the potential invalidity of such clauses cannot generally be upheld and must be assessed depending on additional and specific elements, including the way they are formulated.

In line with this approach, a claims-made clause whereby the insurer undertakes to compensate the third party for damage only if the insurer or the policyholder receives the third party's claim within 12 months of the termination of the contract was recently declared to be vexatious by the Italian Supreme Court. According to the Supreme Court, in the absence of a specific request from the third party for compensation, it would have been nearly impossible for the insured to raise the claim within the requested time.[20]

Finally, legal costs are another topic of note. In particular, insurance companies are usually joined in the proceedings to indemnify the insured, and the issue of the awarding and attribution of legal costs is usually debated. The Supreme Court, in a decision of 4 May 2018,[21] held that the indemnification should cover not only the legal costs that the losing party pays

to the counterparty, but also the costs related to the legal assistance provided to the losing party, even if these exceed the agreed cap (by an amount within the limit of one-quarter of the cap, as provided under Article 1917 of the ICC).

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The following are the most significant sets of provisions governing insurance contracts in Italy:

- the Italian Civil Code (ICC),[22] which establishes under Article 1882 et seq. the general rules on contracts and obligations, as well as the specific rules governing insurance contracts;
- the Insurance Code,[23] which provides the general legal framework concerning insurance companies, intermediaries and brokers; and
- the Consolidated Financial Act (TUF)[24] and the regulations of the Italian securities market regulatory authority, CONSOB, which govern the pre-contractual requirements to be met by financial intermediaries' (such as banks) when selling insurance-based investment products (such as unit-linked and index-linked life insurance policies).

Additional relevant provisions derive from the regulations issued by the Italian Insurance Market Regulatory Authority (IVASS), which establishes:

- specific rules regarding each type of insurance contract or some of their specific aspects;
- transparency and disclosure requirements to be met in the pre-contractual phase of the conclusion of the insurance contract; and
- post-sale requirements.

The Consumer Code[25] is also part of the relevant legal framework if the policyholder qualifies as a consumer, and particularly in relation to contracts concluded at a distance or on unfair terms.

Finally, various EU provisions related to insurance undertakings have been integrated into the national legal framework:

- Legislative Decree No. 68/2018,[26] also amending the Insurance Code and the Consumer Code, IVASS Regulations Nos. 39, 40 and 41[27] of 2018 and CONSOB Regulation No. 20307/2018,[28] implementing the EU Insurance Distribution Directive (IDD).[29] These provisions establish additional rules for intermediaries with particular reference to pre-contractual disclosure requirements and conduct rules, aimed at safeguarding the interests of policyholders;
- Legislative Decree No. 187/2020, setting out Supplementary and Corrective Provisions to Legislative Decree No. 68/2018, implementing the IDD, introducing a number of amendments to the Insurance Code, with specific regard to the distribution of insurance products;
- Law No. 124/2017,[30] which provides, inter alia, new rules concerning competition in the insurance market and uniform criteria for determining the value of non-economic damage. In addition, it establishes that insurance companies will be compelled to offer discounts to customers in the field of motor insurance under certain conditions (vehicular third-party insurance is compulsory in Italy);
- Law No. 24/2017 (the Gelli-Bianco Law),[31] which introduces the obligation for healthcare facilities to conclude a third-party civil liability policy and establishes specific procedures related to damages claims (see Section V); and
- Legislative Decree No. 165 of 25 November 2019,[32] which introduces amendments to Legislative Decree 129/2017, which implemented the Markets in Financial Instruments (MiFID II) Directive[33] and the Markets in Financial Instruments Regulation (or MiFIR)[34] in Italy, through the TUF. In particular, the Decree, among other things, abolishes the obligation for notification of the key information document for insurance-based investment products and provides sanctions for entities authorised to carry out insurance distribution activity.

IVASS has also issued several notes providing rules for facilitating the activities of insurance companies and intermediaries following the covid-19 outbreak.[35]

ii Insurable risk

As a general rule, under Italian law, insurance contracts cannot cover risks connected to illicit or catastrophic events. For example, insurance contracts do not cover:

- events caused by fraud or gross negligence of the insured;
- the risk connected to the payment of a ransom in cases of kidnapping;
- administrative fines;
- the risk of temporary driving disqualification or suspension of a driving licence;
- damage caused to the public administration by public officials; and
- various catastrophic events, unless a specific clause is agreed.

All other risks are, in general terms, insurable, provided that there is an interest upon the contracting party to insure the specific asset or event.

In particular, with reference to the concept of insurable interest, Article 1904 of the ICC establishes that a non-life insurance agreement is invalid if the policyholder does not have an interest in the compensation of the damage. Moreover, if the interest never existed or if it ceased to exist before the conclusion of the contract, the latter is null and void. When the interest ceases to exist after the conclusion of the contract, then the policy is considered terminated. This provision is grounded on the fact that the existence of an interest is considered a fundamental element of the agreement under Italian contract law.

As a consequence, it is generally not possible to insure the assets of another subject against damage. However, interest is not necessarily connected to an ownership right, it being sufficient that a relevant relationship is in place between the insured person and the insured object (e.g., the Italian Supreme Court considers a house 'fire-insurable' by tenants, who bear the responsibility if the damaging event occurs).

Policyholders are free to insure their risks also with foreign companies, which must nevertheless comply with certain requirements. EU insurance companies can carry out their activities without having their registered office in Italy, under the approval of their home-country regulatory authority. Additional fulfilments might be required, depending on the type of insurance contract.

The nationality of the insurance company might impact the law applicable to some aspects concerning the merit of the dispute, as well as the enforcement of a possible negative judgment. With regard to finance-related products, for instance, the principle of home country control could lead to the application of the law of the country of the insurer for issues regarding the composition of the fund underlying the policy; moreover, if the insurer has no assets in Italy, the enforcement shall be started abroad, in accordance with the relevant rules of the selected forum.

The involvement of a foreign insurance company in an Italian litigation also implies some minor changes in terms of procedural rules, particularly aimed at granting a full right of defence to the party involved. The translation of the policyholders' writ of summons in a language known to the insurer might be requested under certain conditions, as well as the Italian translation of documents filed by the insurer in another language. In addition, foreign entities are granted with a longer minimum term of appearance.

iii Fora and dispute resolution mechanisms

In Italy, there is no specific court dealing with insurance disputes, which tend to be decided predominantly by civil courts. When a policy is entered into with a consumer, the competent court is the one of the place of residence or domicile of the insured (although alternative criteria for jurisdiction may apply at the plaintiff's discretion).

As regards international disputes, the jurisdiction of the Italian courts is established pursuant to the Brussels Regulation,[36] and, thus, Italian ordinary courts may have jurisdiction depending on the cross-border elements contained in the insurance contract (e.g., if the policyholder resides in Italy).

As to the procedural rules generally applicable to all insurance-related disputes (i.e., also for foreign insurance companies), the plaintiff shall start compulsory mediation proceedings before initiating full legal proceedings in court; this constitutes a prerequisite for action. A court claim could, therefore, be lodged only if the mediation proceedings proved to be unsuccessful, as may be the case if the defendant does not attend mediation or the parties do not reach an agreement.

Italian law also provides for some alternative dispute resolution mechanisms, which are summarised below.

For disputes regarding compliance by the insurer or its financial intermediaries (e.g., banks, investment companies and other financial intermediaries) with the provisions of the Consolidated Financial Act (and relevant implementing regulations on distribution of insurance investment policies), claimants may refer the matter to the Arbitrator for Financial Disputes (ACF), established by CONSOB.

Arbitration clauses, on the other hand, are not common in insurance contracts with consumers and must be specifically negotiated and approved in writing if proposed by the insurer. Furthermore, for certain types of coverage (e.g., accidents and health insurance), IVASS provides specific requirements as to the seat of the arbitration.

This scenario is likely to be subject to future developments, as a ministry decree setting up a further alternative dispute resolution mechanism (as established by the recently introduced Article 187.1 of the Insurance Code[37]) is expected soon, and this is likely to follow the ACF model of specialised arbitral tribunals.

This would represent a voluntary venue for dispute resolution and would, therefore, be more accessible, even for individuals and small companies.

IV THE INTERNATIONAL ARENA

i Jurisdiction

In the context of litigation involving international parties, the issue of jurisdiction is often raised. A recent case focused on this topic in the context of civil liability litigation and in particular on the possibility of a damaged party suing in his or her own country the foreign insurance company of the counterparty. The Italian court applied EU Regulation No. 44/2001,[38] which establishes different alternative criteria for identifying the court that has jurisdiction to decide the case. In its reasoning, the judgment found that, as a general rule, an insurance company may be sued before a court of the state in which the company has its registered office, in which the event occurred or, alternatively, in the place in which the litigation has been commenced by the subject who suffered the damage, provided that the insured and the insurer can be summoned in the same proceedings. In addition to those general criteria, the court clarified that under Article 9 of Regulation No. 44/2001, the insurer may also be sued before the court of the state in which the claimant is domiciled if litigation is commenced by the insured, the beneficiary of the policy or the person who concluded the insurance contract. Following an ECJ case law precedent, the court concluded that pursuant to Article 11 of Regulation No. 44/2001, all the above-mentioned criteria apply also to litigation commenced by the person who suffered the damage and who can therefore directly bring an action against the insurance company of the counterparty if that is possible under the domestic law of the person who suffered the damage (which it is in Italy).

ii Representatives of foreign insurance companies

With reference to third-party insurance, and specifically on the point of standing, a topic addressed by both EU and Italian courts concerned the possibility of suing directly the claims representative of a foreign company. Pursuant to Article 1 of Directive 2000/26/EC,[39] every insurance company that issues its policies in foreign states has to appoint a claims representative in each Member State other than the one in which it has its registered office. The claims representative shall be responsible for handling and settling claims arising from the events referred to in Article 1. However, the Directive does not specify whether it is possible for the insured to sue the claims representative directly. On this point, the ECJ ruled that the representative is entitled to receive judicial notices on behalf of the company, but cannot stand trial on behalf of the company, as established by Article 18 of the Rome II Regulation (which considers the insurer to be the only subject that can be sued directly).[40] On the other hand, the Italian Supreme Court later issued a decision that, according to some scholars, would be at odds with that of the ECJ as it held that the plaintiff would be entitled to bring an action before the damaged person's national court also against the representative of the company.[41]

iii Home country control

The topic of unit-linked policies is also often connected to the activity of international insurance companies in Italy. With particular reference to EU companies, one of the principles most often debated is that of 'home country control'.

In decisions rendered in 2016 and 2015, the Courts of Turin and Milan rejected policyholders' requests for the declaration of nullity of unit-linked policies, as these were linked to hedge funds not allowed under Italian law.[42] The decisions were grounded on the principle of home country control, according to which the investments linked to the policy are governed by the rules of the law of the country in which the insurance company has its registered office. This holds true even if the policies are governed by Italian law. In this context, it is also worth noting that this principle has been applied recently by the Supreme Court.[43]

iv Punitive damages

Another issue that has been much debated among private insurance associations is the decision of the Supreme Court rendered in July 2017 concerning punitive damages.[44] The decision was rendered in the context of the enforcement of a US judgment in Italy and substantively introduced the possibility of recognising the award of punitive damages against an Italian company in a foreign judgment. However, this matter did not touch upon insurance and is unlikely to have an impact on existing Italian insurance contracts, as punitive damages are still not insurable under Italian law. Furthermore, the decision will not result in the possibility of Italian judges awarding punitive damages, as a specific law would be required for that purpose.

V OUTLOOK AND CONCLUSIONS

i Healthcare disputes

The recently introduced Gelli-Bianco Law regarding hospitals and other healthcare facilities' liability is likely to have a significant impact on insurance litigation, with preliminary data registering an increase in disputes in the medical field since the entry into force of the Law on 1 April 2017.

On the one hand, the Law establishes that healthcare facilities are responsible for any damage they (or the operators working therein) may cause to third parties. On the other hand, healthcare facilities are now obliged to conclude a policy that covers the risk related to damages claims that may stem from this liability. Subjects who have allegedly suffered damage can bring an action against the insurance company directly. Under certain conditions and within certain limits, the healthcare facilities have the option to reverse the

liability for the potential damages arising on to the healthcare operator responsible for the illicit event. Moreover, the Law establishes the nature of the liabilities of healthcare personnel and healthcare facilities with consequences for the burden of proof, which may impact the outcome of proceedings and then the insurance company. In particular, according to the Law, healthcare facilities have a contractual liability in relation to the damaged parties in cases of medical malpractice. Hence, the damaged parties have to allege the breach of the contractual obligation and prove the damage suffered, while the healthcare facility has to prove that the damage was not linked to its conduct. Furthermore, the Law establishes that the healthcare personnel have a non-contractual liability and, therefore, the major burden of proof lies upon the damaged parties, who have to prove the negligence and wilful misconduct of the healthcare personnel.

Before bringing an action to court on grounds of the aforementioned liability, any interested party must initiate a compulsory preliminary attempt at settlement with the other parties involved (including the insurance company), with the assistance of an expert appointed by the court for the calculation of the amount of the alleged damage (the proceedings are governed by Article 696 ***bis*** of the Code of Civil Procedure). Alternatively, it is possible to seek the assistance of a civil mediator.

This item is, therefore, likely to increase in importance in the future because of the complexity of the matters, the number of subjects potentially involved and the multiple steps that govern relevant claims. However, it is now six years since the enactment of the Gelli-Bianco Law, and the ministerial decrees necessary to implement and render effective the procedural tools outlined above (such as a direct actions against insurance companies) have not yet been issued. Nonetheless, in the meantime jurisprudence has been playing an important role as a 'regulatory substitute', offering interpretive solutions to implement the reasoning underlying the Law, in the absence of ministerial decrees. For example, the Court of Benevento[45] has also recently stated that the damaged party should bring the action against all the parties concerned (including the insurance company).

ii Unit-linked policies

As reported above, disputes related to unit-linked policies are widespread in Italy, with several pending proceedings throughout the country. These policies are, nonetheless, still one of the highest-selling products in the life insurance market, accounting for 30.7 per cent of the total premiums on 31 December 2022 as noted by IVASS.

iii Tampering policies

Another topic currently under the spotlight of the Italian insurance-related press is that of tampering policies, which were introduced to the insurance market to protect companies from the risk of accidental or intentional contamination of food-related products, which may occur if the systems of production, conservation and distribution of the products are not hygienically appropriate, or because of fraudulent acts of third parties. The withdrawal of a contaminated product from the market may have disruptive consequences: it may damage a company's reputation and usually results in high unexpected costs. Tampering policies prevent these consequences by providing reimbursement for the consultancy costs in the various phases of the crisis, the costs directly incurred for the withdrawal of defective products, the information to be provided to consumers and the redistribution of new products. The area of product liability disputes is currently very active in Italy, and tampering policies introduce a new relevant element to the scenario, whose developments shall be closely monitored in the future.

iv Insurtech

Insurtech (i.e., the application of new technologies to the insurance sector) is a growing field in Italy, even though its figures are low compared with those found in the Anglo-Saxon market. Some insurance companies are also carrying out research aimed at verifying the

applicability of blockchain technology to prevent disputes and, ultimately, litigation, especially in the medical and transport fields. Attention is also focused on aspects related to artificial intelligence, given the increased use of AI applications (e.g., ChatGPT). The widespread use of these applications is indeed giving rise to the need to adapt the regulatory framework to better face possible liabilities that may arise with the use of these applications. All in all, this sector is still in its infancy, but it is likely to increase. Specialist areas of competence will, therefore, be required to deal with potential disputes in the future.

v Covid-19

The spread of covid-19, as might be expected, has impacted insurance litigation.

Insurance coverage cases increased, with insurance companies trying to limit their coverage because of the unforeseeable nature of the event. Some insurers have also argued that covid-19 has increased insurance risk coverage and that, according to Article 1898 of the ICC, they are in principle entitled to withdraw from the contract, or that the pandemic is to be considered a catastrophic event, which cannot be insured as such, unless specific provisions are agreed between the parties.[46]

Medical malpractice cases resulting from the difficult situation caused by covid-19 have also increased. We are witnessing an increase in claims raised against both insurance companies and healthcare facilities for compensatory damages for medical liability regarding deaths caused by covid-19. However, case law is quite inclined to reject such claims[47] in view of the following:

- the difficulty in identifying the causal link between death caused by covid-19 and doctors' alleged negligent behaviour;
- the limited scientific knowledge about covid-19 and appropriate treatments at the time of the conduct;
- the limited material and human resources available to deal with the pandemic; and
- finally, the limited technical and empirical expertise of non-specialised personnel.

Furthermore, as a result of the covid-19 outbreak and the restrictions imposed by state authorities, there has been an increase in litigation for business interruption and compensation of relevant losses. The outcome of these disputes depends on the possibility of ascertaining, on a case-by-case basis, whether economic losses are the result of the interruption business caused by the government-imposed restrictions during the covid-19 period.

Finally, litigation is also emerging regarding the possibility of seeking compensation by invoking the accident insurance policy. According to the prevailing case law,[48] viral illnesses such as covid-19 cannot be covered by accident insurance policies because an accident is typically defined as an instantaneous and violent event, whereas covid-19 is a viral disease that persists over time. However, some courts[49] have ruled that injuries (and potentially death) caused by covid-19 could be qualified as accidents and may be covered by an accidents insurance policy, provided there are no exclusion clauses or pre-existing medical conditions that would exclude the existence of an accident.

vi Class actions

Although it is not directly linked to the insurance field, the Italian class action reform might have a significant impact on insurance litigation. The new class action legislation, Law No. 31 of 12 April 2019 (which finally entered into force on 19 May 2021 with no retroactive effects), introduced a large number of innovations. Under the previous legal framework, the class action procedure was expressly reserved to consumers and end users, whereas the provisions of the new Law have a broader scope. Claimants may seek compensation for any kind of damage and have access to a wider opt-in mechanism, which allows them to join the class action not only during the proceedings, within a prescribed time limit, but also after the court's favourable judgment on the merits: specifically, up to five months after the decision on the merits has been issued. Finally, another significant change concerns economic incentives: in the event of a successful outcome of an action, the common representative

and the lead claimant's counsel may obtain a monetary reward. As a consequence of these changes, the Italian litigation scenario is likely to witness a significant increase in collective actions, and all companies, including insurance companies, should be prepared to deal with such actions.

vii The war in Ukraine

The war in Ukraine is likely to increase insurance litigation, especially for business interruption. In general, insurance policies do not cover the risks of war: for instance, business interruption insurance policies tend to cover only losses resulting from physical damage to business premises or to production facilities, whereas they do not cover losses caused by the failure of a supplier to provide raw materials or energy necessary for the operation of a business. However, as was the case with the pandemic, careless wording of those clauses defining the insurable risks may lead to a potential litigation: claims may be filed to clarify whether insurers are required, for example, to compensate damage due to a business interruption in cases of war, and thus expose insurers to unexpected payments if the courts rule in favour of the claimants.

viii Insurance and climate change

Climate change is one of the most challenging risks that our era is facing. Insurance companies seem to recognise the impact of climate change, and the number of customers paying attention to the climate's impact on their lives is increasing. In this ever-changing market, insurance companies are, therefore, currently engaged in providing new coverage for risks related to climate change. However, this is still a developing area, so it will be necessary to wait and see how the litigation around policy issues of this kind will develop.

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Endnotes

1 Andrea Atteritano is a partner at Hogan Lovells Studio Legale. The author would like to thank his colleague Serenella Kaluthantrige for her support in the preparation of this chapter.
2 Law 28 December 2005 No. 262, which introduced Article 25 bis TUF to extend the application of Articles 21 and 23 TUF to insurance financial products. The provision only entered into force on 1 July 2007 following issuance of CONSOB's implementing regulation.
3 Supreme Court, 5 March 2019, No. 6,319. This evaluation should be made taking into consideration (1) the premium amount paid by the policyholder, (2) the duration of the policy and (3) the type of investment. The policy at issue provided death cover equal to 0.1 per cent of the counter value of the units of the fund linked to the policy, and the Supreme Court objected that this amount, compared to the premium amount paid by the policyholder, was not enough for the balance of the obligations of the parties under the contract. Moreover, the Supreme Court also declared that even if the financial purpose prevails, the life insurance purpose must in any event be compliant with the general principles set out by the Italian Civil Code, by the Insurance Code and by IVASS regulations.
4 Court of Appeal of Milan, 11 May 2016. Court of Florence, 30 March 2020. See also Court of Crotone, 13 January 2020.
5 European Court of Justice, 31 May 2018, C-542/16 in line with its previous decision of March 2012 (Supreme Court, 18 April 2012, No. 6,061). The ECJ has recently ruled again on the matter, affirming that to connect a given contract to the notion of the insurance contract, it is sufficient that 'the payment of a premium by the insured and, in return for that payment, the provision of a benefit by the insurer in the event of the death of the insured or the occurrence of another event referred to in the contract in question' (CJEU, Sec. III, 24 February 2022 - C-143/20 and C-213/20). In line with ECJ case law, see Court of Bergamo, 12 November 2019, 21 November 2019, 23 July 2021 and 6 December 2021, Court of Rome, 28 May 2021 and Regional Tax Commission of Lombardia, 17 May 2021, Court of Florence, 11 February 2020, Court of Viterbo, 16 September 2020, Court of Appeal of Milan, 30 September 2021, Court of Gorizia, 6 January 2022, Court of Vicenza, 25 March 2022, Court of Pisa, 7 February 2023 and Court of Appeal of Trieste, 14 June 2023.
6 Court of Reggio Emilia, 3 May 2019, Court of Bergamo, 12 November 2019, Court of Forlì, 11 December 2019. See also Court of Viterbo, 16 September 2020, Court of Milan, 30 September 2021, Court of Verona, 12 April 2022, Court of Pordenone, 28 April 2022, Court of Como, 1 June 2022 and Court of Gorizia, 6 January 2022.
7 Supreme Court, Joint Divisions, 19 December 2007, No. 26,724. Supreme Court, Joint Divisions, 19 December 2007, No. 26,725. See also Court of Appeal of Potenza, 22 June 2020, Court of Bergamo, 23 July 2021, 6 December 2021, Court of Milan, 30 September 2021 and 6 June 2023, and Court of Gorizia, 6 January 2022.
8 Court of Appeal of Turin, 1 June 2021. See also Supreme Court, 30 April 2018, No. 10,333.
9 Court of Bergamo, 23 July 2021.
10 Court of Pordenone, 28 April 2022, Court of Verona, 12 April 2022, Court of Milan, 30 September 2021 and Court of Gorizia, 6 January 2022.
11 Court of Rome, 7 October 2020, Court of Rome, 6 August 2020, Court of Verona, 6 April 2021. See also Court of Treviso, 20 October 2017.
12 Court of Pavia, 7 March 2021, Court of Parma, 13 February 2017, No. 233; Court of Mantova, 6 May 2016, No. 533; Court of Verona, 28 September 2016; Court of Rimini, 12 August 2016, No. 6,532; Court of Appeal of Turin, 4 March 2019, No. 402. See also Court of Verona, 12 April 2022, Court of Pordenone, 28 April 2022, Court of Como, 1 June 2022, Court of Milan, 30 September 2021 and 6 June 2023.
13 Court of Bergamo, 12 November 2019, 21 November 2019 and 23 July 2021. See also, Court of Rome, 28 May 2021, Court of Vicenza, 25 March and 18 May 2022, Court of Verona, 12 April 2022, Court of Pordenone, 28 April 2022, Court of Gorizia, 6 January 2022, Court of Appeal of Milan, 4 January 2017 and Court of Appeal of Trieste, 14 June 2023.
14 Court of Milan, 7 April 2020 and Court of Venice, 21 May 2021. See also Court of Arezzo, 12 December 2022, Court of Pisa, 7 February 2023 and Court of Milan, 6 June 2023.
15 Court of Salerno, 24 May 2016; Court of Bari, 3 March 2011, No. 801; Court of Pesaro, 22–23 October 2020, No. 1,132.
16 Decision No. 28,314.
17 Court of Ravenna, 12 October 2017 and Court of Prato, 8 August 2018.
18 Court of Verona, 17 April 2019. See also Supreme Court, Joint Divisions, 31 March 2008, No. 8,271.
19 Supreme Court, Joint Divisions, 24 September 2018, No. 22,437. In this context, see also more recently Court of Brescia, 2 May 2019, Court of Rome, 12 June 2022.
20 Supreme Court, 13 May 2020, No. 8,894.
21 Supreme Court, 4 May 2018, No. 10,595. See also Supreme Court, III Sec., 22 April 2022, No. 12,908.
22 Royal Decree No. 262 of 16 March 1942.
23 Legislative Decree No. 209 of 7 September 2005, published in the Official Gazette of the Italian Republic (OG) on 13 October 2005 (the Insurance Code).
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Chapter 13

Japan

Shinichiro Mori, Sho Tanaka, Ryo Otobe and Shun Tamazaki[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

In Japan, the insurance landscape is governed by a dynamic and evolving legal framework, with the Insurance Act at its core. Enacted in 2008, the Insurance Act modernised and enhanced insurance-related provisions that had previously existed within the Commercial Act. This act introduced new measures such as fixed-amount accident and health insurance and emphasised the protection of policyholders. It also brought amendments to damage insurance and life insurance-related provisions.

Further, the amended Companies Act, which came into effect in March 2021, expressly sets out the procedures for certain directors' and officers' (D&O) insurance and also expressly exempts them from conflicts of interest.

As explained in Section V, the rapid development and implementation of autonomous driving technology have spurred new legal considerations under the Act on Securing Compensation for Automobile Accidents. Further, the revised Road Traffic Act, which allows Level 4 autonomous driving under certain conditions, came into effect on 1 April 2023. This revision has significant implications for the future of both autonomous driving technology and insurance law in Japan.

Similarly, the outbreak of covid-19 raised novel issues as to how insurance claims related to covid-19 should be treated within the traditional insurance framework. In April 2020, upon a request of the Financial Services Agency (FSA), the insurance regulatory authority, insurance companies have started to apply a flexible interpretation and application of insurance policy provisions from the perspective of protecting policyholders by, for example, allowing covid-19 patients to be eligible for payment of hospitalisation benefits when treated in accommodation facilities (such as hotels) or at home. Yet, the evolving nature of the pandemic and subsequent changes in legislation mean that the landscape remains uncertain, and further issues may emerge.

This chapter aims to provide an overview of the Japanese insurance landscape by addressing the following areas:

- the year in review – highlighting recent noteworthy cases and judicial decisions;
- the legal framework of insurance disputes in Japan;
- the handling of international insurance disputes; and
- emerging trends in insurance practice in Japan.

II YEAR IN REVIEW

The following recent cases are notable for the reasons explained below.

i Tokyo High Court judgment dated 17 December 2020 affirming the application of the insurer's exemption clause in D&O insurance

An insurer had concluded a D&O insurance policy with a company, where the representative director was insured. In a shareholder suit, the representative director was ordered to compensate the company for damages arising from negligence related to his duty of care. An attorney representing the director filed a claim against the insurer, asserting entitlement to legal fees based on the subrogation right to the obligee, who was the representative director. However, after the director's subsequent bankruptcy, the bankruptcy trustee assumed responsibility for the lawsuit.

The D&O insurance policy in this particular instance contained a clause exempting the insurer from obligations to pay claims generated by actions conducted with the insured's conscious knowledge of legal violations (including where there were reasonable grounds to believe that the insured was cognisant of such). The central issue was whether the representative director's breach of duty of care constituted a breach of the law and whether the director was aware of the breach.

A concise summary of the Tokyo High Court judgment is as follows:

- Article 330 of the Companies Act provides that the relationship between a company and its directors is subject to the Civil Code's mandate provisions. Article 644 of the Civil Code provides that a mandatary has a duty of care to handle delegated matters with the care of a good manager in accordance with the essential purpose of the delegation. Thus, the duty of care that a director owes to the company is a statutory duty. Consequently, the term 'breach of the law' in this case's exemption clause encompasses a failure in the duty of care as a director.
- The High Court interpreted that the exemption clause released an insurer from making an insurance payout in relation to damages if the insured knowingly violated the duty of care or if there were reasonable grounds to believe that the insured had such knowledge.
- The High Court determined that the representative director had directed deceitful accounting practices and provided false explanations to the external auditor, fully cognisant that these actions violated the duty of care. The district court's decision, affirming the applicability of the exemption clause in this scenario, was upheld.

The judgment by the High Court is noteworthy, as there are relatively few legal precedents in Japan that have arrived at a decision concerning the application of an exemption clause to D&O insurance.

ii Yamaguchi District Court judgment dated 15 July 2021 affirming exemption of an insurer based on an increased risk outside the scope of insurance underwriting

The case was brought before the Yamaguchi District Court and involved a dispute between the plaintiff and the defendant, a property and casualty insurance company. The dispute centred around a comprehensive home insurance policy, including fire insurance, covering a building owned by the plaintiff.

The plaintiff insisted that the building was demolished by fire during the policy's coverage period and thus demanded that the defendant pay the insurance claim under the policy's terms.

In opposition, the defendant asserted that it had cancelled the policy by delivering written notice to the plaintiff, consistent with the policy's stipulations. The grounds for this cancellation were:

- the building's structure or utilisation was altered, resulting in an augmentation of risk; and
- the risk had veered outside the scope of insurance underwriting, as the building's use had changed, and it was no longer used for residential purposes.

A summary of Yamaguchi District Court's judgment is as follows:

- Condition of the building: the building had been abandoned for roughly four years after the family who resided there moved out, subsequent to the insurance policy being signed. At the time of the fire, the electrical wiring was found to be severed and stolen. The building was filled with dog feces, debris, and around 10 CRT televisions that had been illegally dumped.
- Change in purpose of use: given the building's state, the court found it implausible that an ordinary policyholder would perceive the building as a residence at the time of the fire. The court determined that the building's purpose had altered, and it was no longer utilised for residential functions.
- Cancellation affirmed: as a result, the court affirmed cancellation of the comprehensive home insurance policy and exemption of the insurer under the terms and conditions of the policy.

Article 29 of the Insurance Act provides for cancellation in the event of an increase in risk 'within' the insurance underwriting. However, Article 29 of the Insurance Act does not apply to this case, because the insurance policy was cancelled based on an increased risk 'outside' the scope of insurance underwriting. This is a rare case in which the insurer's exemption for increased risks outside of insurance underwriting has been challenged, and is instructive in practice.

iii Tokyo High Court judgment dated 27 February 2020 affirming exemption of an insurer based on an intentionally caused insured event

In this case, the appellant, who had purchased a fire insurance policy for a building with an insurance company (the appellee), claimed that part of the building was destroyed by arson committed by a third party. The appellee countered this by arguing that the appellant or his sister's common-law spouse had a deliberate hand in the arson. Given the circumstances leading to the fire, the appellee contended that it was not liable to cover the damages, citing the terms of the fire insurance policy. These terms mirrored Article 17, Paragraph 1 of the Insurance Act, which absolves the insurer of responsibility for damages stemming from intentional misconduct or gross negligence on the policyholder's part.

In summary, the High Court judgment is as follows:

- the court found that the arson was committed with the involvement of a person who was the beneficial owner of the building or who enjoyed an economic interest in the use or disposal of the building; and
- the arson in this case was equivalent to the deliberately caused insured event by the appellant. Therefore, the court affirmed exemption of the insurer under the terms and conditions of the fire insurance policy in this case.

In Japan, there have been court decisions equating a person who substantially owns the subject matter of the insurance, or has an economic interest in its use or disposition, with the policyholder or the insured. This High Court decision is another case that supports this concept. This case is instructive when insurance companies are engaged in determining whether the exemption clause for deliberately caused insured events is applicable.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The Insurance Act and other laws

In Japan, the Insurance Act primarily governs the formation and validity of insurance contracts.

The Insurance Act regulates three main types of insurance: damage insurance, life insurance and fixed-amount accident and health insurance. In addition, there are also other laws on specific types of private insurance, such as the Act on Securing Compensation for Automobile Accidents. Further, since insurance disputes are also one type of civil dispute, general private laws such as the Civil Code, the Commercial Act and the Code of Civil Procedure also apply to insurance disputes.

Regulation on insurance business

The Insurance Business Act regulates the insurance business. The primary aim of the Insurance Business Act is – given the public nature of the insurance business – to protect policyholders by ensuring the appropriate management of insurers and the fairness of solicitation for insurance. The FSA regularly issues supervisory guidance and provides responses to public comments.

Although it is not necessarily common for insurance disputes to revolve around the interpretation of the provisions of the Insurance Business Act, the regulations on solicitation of insurance set out in the Insurance Business Act are sometimes at issue in claims for damage caused by an insurer's breach of duty to explain a policy when soliciting insurance.

Major updates in recent years

The amended Companies Act (which came into effect in March 2021) now provides explicit provisions for D&O insurance. Specifically, the amended Companies Act expressly sets out the procedures for certain D&O insurance and also expressly exempts them from conflicts of interest.[2]

ii Insurable risk

Uninsurable risks

There are two types of insurance in Japan: (1) public insurance managed by the national government and other public organisations and (2) private insurance. With regard to private insurance, under the principle of freedom of contract, theoretically, any risk can be insured in principle; however, there are certain restrictions – for example, insurance contracts that violate public policy are not allowed.

Insurable interest

In Japan, an insurable interest is generally considered an economic interest that could be impaired by the occurrence of an insured event. The insurable interest is an essential element of damage insurance. Article 3 of the Insurance Act provides that only interests that can be assessed in monetary terms may be the subject matter of an insurance policy for damages.

iii Fora and dispute resolution mechanisms

Litigation

Litigation in court remains a primary avenue for resolving insurance disputes in Japan. Japanese civil litigation is governed by the Code of Civil Procedure. The litigation procedure normally starts when a party to an insurance dispute files a lawsuit with the district court. After the district court's judgment, a party dissatisfied with the judgment may appeal to the high court, and the high court's judgment may be appealed to the Supreme Court if certain requirements are met. Although it depends on the complexity of the case and other factors, according to statistics in 2022, approximately 90 per cent of cases are usually completed within one to two years in the case of ordinary civil litigation at district courts. More than 90 per cent of cases finish in one year in high court proceedings. Approximately 90 per cent of cases are completed within six months at the Supreme Court.

Japanese judges occasionally recommend settlements, and disputes naturally end more quickly when a settlement is reached in the middle of a legal proceeding. In fact, according to 2022 data, approximately 33 per cent of cases in the civil courts of first instance in Japan ended in settlement.

In addition to the above, the following briefly lists the features of civil litigation in Japan:

- First, in Japanese civil litigation, attorneys' fees are not normally borne by the losing party, and therefore, in principle, the court does not order the losing party to bear the winning party's attorneys' fees (except for up to 10 per cent of the amount of damages in a tort claim).
- Second, there is no extensive discovery system (such as that of the United States). While there are mechanisms in place to request the opposing party to unveil certain documents, these are conditional and restrict the range of documents that can be disclosed.
- Third, as discussed in Section IV, Japanese courts do not allow punitive damages.

Alternative dispute resolution

Aside from traditional litigation, insurance disputes in Japan can also be addressed through the alternative dispute resolution (ADR) system, which was introduced by the FSA in 2009. The designated dispute resolution institutions for insurance disputes are:

- the Life Insurance Association of Japan;
- the General Insurance Association of Japan;
- the Insurance Ombudsman; and
- the Small Amount & Short Term Insurance Association of Japan.

According to recent statistics, the number of cases received by these institutions between April 2022 and March 2023 were 345, 502, 18 and 11, respectively.

Most of the designated dispute institutions do not charge adjudication fees, and approximately 70 per cent of the cases in the dispute resolution process are completed within six months, which has the advantage of being less expensive and time-consuming compared to litigation.

However, although nearly half of dispute resolution procedures end in settlement or conciliation, more than half the cases do not reach resolution and, in such cases, the parties will have to resort to other measures such as litigation proceedings.

IV THE INTERNATIONAL ARENA

i International jurisdiction

When a Japanese court decides on the jurisdiction of an international dispute, the Code of Civil Procedure applies as follows:

Agreement on jurisdiction

If the parties to the insurance contract have agreed which country's court shall have jurisdiction, that agreement shall prevail.[3]

However, for the agreement to be valid, it must pertain to a particular legal relationship and be documented in writing.[4] In addition, an agreement that an action may be filed only in a foreign court may not be invoked if that court is unable to exercise jurisdiction by law or in fact.[5]

Furthermore, jurisdictional agreements between consumers and enterprises (consumer contracts) shall not be effective unless the agreement grants jurisdiction to the courts of the country in which the consumer was domiciled at the time the consumer contract was entered into; or the consumer has brought an action pursuant to the agreement on jurisdiction, or has invoked the agreement on jurisdiction.[6]

In 2020, the Tokyo High Court issued a judgment regarding an agreement between a Japanese small to medium-sized enterprise and a US tech giant in which the two parties agreed to submit to the exclusive jurisdiction of the US courts. The Court rejected the Japanese company's argument that the agreement was invalid as against public policy because the US tech giant had taken unfair advantage of its superior bargaining position.[7]

No agreement on jurisdiction

In the absence of an agreement on jurisdiction, if the defendant is domiciled in Japan, a Japanese court has jurisdiction.[8] In addition, the Code of Civil Procedure provides several types of cases in which Japanese courts have jurisdiction with respect to actions concerning contractual obligations.[9] Further, an action by a consumer against an enterprise with respect to consumer contracts may be brought in a Japanese court if the consumer is domiciled in Japan at the time of filing the action or at the time the consumer contract is concluded.[10]

Dismissal due to special circumstances

Except for cases where there is an agreement that grants jurisdiction only to a Japanese court,[11] even where a Japanese court has jurisdiction over the action, the court may dismiss the action in whole or in part without prejudice when it finds that there are special circumstances that would prejudice the equity between the parties or prevent a fair and speedy trial if a Japanese court were to hear and try the action.[12]

ii Governing law

When Japanese courts decide on the governing law of international insurance disputes, the Act on General Rules for Application of Laws applies as follows:

Agreement on governing law

If the parties to an insurance contract agree on governing law, that agreement shall prevail.[13] However, in consumer contracts, if the consumer indicates to the enterprise that a specific mandatory provision in the law of the consumer's habitual residence should apply, that mandatory provision also applies.[14]

No agreement on governing law

In the absence of an agreement on governing law, the law of the place most closely connected to the juridical act at the time of the act shall apply.[15] Further, if a characteristic performance in the juridical act is performed by only one of the parties, the law of the habitual residence of the party providing that performance is presumed to be the law of the place most closely connected.[16]

Thus, in insurance contracts, the law of the habitual residence of the insurer providing the characteristic performance is presumed to be the law of the place most closely connected. Yet, for consumer contracts, the law of the consumer's habitual residence is applied, superseding the law of the most related place.[17]

iii Recognition and enforcement of foreign judgments

Requirements for recognition of foreign judgments

To enforce a foreign final and binding judgment in a Japanese court, it is necessary to obtain recognition of the judgment and obtain an execution judgment. The requirements for recognition of a foreign judgment are as follows:[18]

- the jurisdiction of a foreign court is recognised by law, regulation or treaty;
- the losing defendant has received service of the summons or an order necessary to commence the litigation (other than service by publication or other similar service), or has appeared without being so served;
- the contents of the judgment and the court proceedings are not contrary to public order or morals in Japan; and
- a guaranty of reciprocity is in place.

Judicial precedents

Punitive damages

The Supreme Court of Japan refused to allow the enforcement of the part of the judgment of the Superior Court of California that allowed punitive damages. This decision was made on the grounds that punitive damages were incompatible with the basic principles of the Japanese damages system and violated public order.[19] In a subsequent case where a party made a payment based on the judgment of the Superior Court of California which ordered punitive damages, the Supreme Court of Japan held that punitive damages were not effective in Japan and the part of the monetary claim related to the punitive damages could not be deemed to exist. Thus, the payment made by the party was appropriated to the portion of the claim excluding the punitive damages, and only the remaining amount was allowed to be enforced.[20]

Attorneys' fees

In Japan, attorneys' fees are not generally borne by the losing party. In a case where the petitioner sought to enforce an order by the Hong Kong High Court that ordered the losing party to bear the attorneys' fees of the winning party, the Supreme Court of Japan held that it was not against public order if the fees were within the range of actual costs.[21]

Default judgments

In a case concerning a default judgment by the Superior Court of California, the Supreme Court of Japan held that, where a foreign judgment becomes final and binding without giving notice, or substantial opportunity to know, of the foreign judgment even though it was possible to notify the contents of the foreign judgment, recognising such a judgment is against public order under Article 118, Item 3 of the Code of Civil Procedure.[22] Reflecting this judgment, in a case where enforcement of a default judgment by the Superior Court of California was sought, the Tokyo District Court refused to allow enforcement on the grounds that the party subject to enforcement was not notified of, or given the substantial opportunity to know, of the foreign judgment, even though it was possible to provide notice of the contents of the foreign judgment.[23]

iv Recognition and enforcement of arbitral awards

The New York Convention

Japan is a Member State to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the New York Convention). An arbitral award, regardless of whether the place of arbitration is in Japan, has the same effect as a final and binding judgment if the party seeking enforcement obtains an enforcement order.[24] An enforcement order is granted unless there are grounds for refusal of recognition.[25] Grounds for refusal of recognition are substantially the same as those set out in Article 5 of the New York Convention.[26]

Amendment to the Arbitration Act

On 21 April 2023, the bill to amend the Arbitration Act to reflect the latest revision of the 2006 UNCITRAL Model Law on International Commercial Arbitration passed the Diet. The amended Arbitration Act will take effect in or before April 2024.

The amended Arbitration Act introduces the following measures:

- Interim or provisional measures: Japanese courts may recognise and enforce certain interim or provisional measures ordered by arbitral tribunals.[27] A party may file a petition with the court for the enforcement of interim or provisional measures. The grounds for refusal of enforcement are narrowly limited in line with the 2006 UNCITRAL Model Law.[28]
- Submission of translations: the current Arbitration Act requires the petitioner seeking to enforce an arbitral award to submit a complete Japanese translation of the award. The amendment will allow the court to decide not to require the submission of the translation if the court considers it appropriate after hearing the respondent's opinion.[29] The same will apply to a petition for an enforcement order of interim or provisional measures.[30]
- Jurisdiction over arbitration-related cases: with respect to arbitration-related court cases, the Tokyo District Court or the Osaka District Court will have concurrent jurisdiction regardless of the locations of the parties or the competent court agreed on by the parties.[31]

v Recognition and enforcement of international settlement agreements

On 21 April 2023, the Act for Implementation of the Singapore Convention on Mediation (the Implementation Act) passed the Diet. The Act will come into force on the day the Convention enters into force with respect to Japan.[32] On 9 June 2023, the Diet approved Japan's accession to the Convention.

The Implementation Act will allow Japanese courts to enforce commercial international settlement agreements resulting from mediation.[33] For international settlement agreements to be enforceable, the parties must expressly agree that the agreement can be enforced under the Convention.[34] The party seeking enforcement must file a petition with the court, and the court will grant the enforcement unless there are grounds for refusal.[35] The Implementation

Act is novel in the Japanese legal system in that it grants enforceability to a settlement agreement between private parties entered into without the supervision of a court or other government institution.

V OUTLOOK AND CONCLUSIONS

i Insurance for autonomous driving and bodily injury

The development and implementation of AI-driven autonomous driving technology are accelerating in Japan, posing some challenges to the traditional landscape of motor vehicle insurance.

Historically, motor vehicle accidents have been primarily caused by human error, with personal injury risk covered by mandatory insurance under the Act on Securing Compensation for Automobile Accidents. However, the advancement of autonomous driving technology is shifting the nature of risk. As human negligence decreases, malfunctions and defects in autonomous systems could become more common sources of accidents.

This shift presents legal challenges in defining liability. In cases of accidents caused by autonomous system malfunctions, the vehicle owner may still be considered an automobile operator under the Act on Securing Compensation for Automobile Accidents.[36] In such a case, while the manufacturer of the autonomous car should be responsible for the malfunction or defect of the car, the liability insurance may be paid for by liability insurance, which is financed by the insurance premium paid by the car owner. As a result, there may be a discrepancy between the location of the risk and the legal 'person' who bears the cost for covering that risk.

With regard to the issue of liability and insurance in autonomous driving, one proposal involves applying a mechanism that ensures insurance companies' right to reimbursement from automobile manufacturers. This would shift some of the financial responsibility for accidents caused by system malfunctions or defects from vehicle owners to the entities responsible for those malfunctions. This represents a complex and evolving area of insurance law, and stakeholders must pay careful attention to further developments that could affect both the industry and consumers.

Further, a significant milestone in this field was reached on 1 April 2023, when revisions to the Road Traffic Act went into effect in Japan. The revised law allows Level 4 autonomous driving, which allows vehicles to operate without a human driver present under certain conditions.

The revised law is expected to further advance the implementation of the autonomous driving system in the future, and is also expected to stimulate discussions on insurance for autonomous driving.

ii Aftereffect of the covid-19 pandemic

Issues

The covid-19 pandemic has posed significant challenges to the insurance industry, leading to a re-evaluation of traditional frameworks and practices. In the beginning of the pandemic, the outbreak of covid-19 led to insurance claims being made by people infected with covid-19. At that time, it was not clear how these claims would be positioned within the traditional insurance framework. For example, some people infected with covid-19 were required to be hospitalised, while others were required to stay in certain accommodation or remain at home (instead of hospitals) because of hospitals' limited capacity. In the case of people staying in an accommodation or at home in lieu of hospitalisation, a problem arose as to whether they would be eligible for payment of hospitalisation benefits. As explained below, insurance companies' handling of this issue has changed with the evolution of the infection situation and the changing position of covid-19 under the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases (the Infectious Diseases Act).

FSA's requests to insurance companies and changes in insurance companies' practice

Since March 2020, the FSA has issued requests to insurance associations for the flexible handling of covid-19-related matters. In accordance with such requests, insurance companies took flexible measures in providing insurance benefits, etc.

More specifically, on 10 April 2020, the FSA requested insurance companies to consider applying a flexible interpretation and application of insurance policy provisions as well as taking necessary measures in their insurance products from the perspective of protecting their customers. In response, insurance companies have treated covid-19 as a disease that is eligible for payment of hospitalisation benefits, and have treated all infected patients who are treated in accommodation facilities (such as hotels) or at home as being eligible for payment of hospitalisation benefits.

As the infection situation has changed and the position of covid-19 in the Infectious Diseases Act has also changed, the insurance industry in Japan has had to continually adapt its approach as follows.

First, on 25 August 2022, the Ministry of Health, Labour and Welfare (MHLW) limited the scope of reporting of outbreaks when a doctor diagnoses a patient with covid-19 from all cases to only those at high risk of serious illness, such as those 65 years of age or older. In response, insurance companies have limited the individuals eligible for payment of hospitalisation benefits when treated in an accommodation facility or at home to those who are at high risk of serious illness.

Next, on 8 May 2023, the status of covid-19 under the Infectious Diseases Act was downgraded from 'new influenza and other infectious diseases' (so-called category 2 equivalent) to 'category 5 infectious diseases'.

In response to this change, insurance companies terminated the payment of hospitalisation benefits for treatment in an accommodation facility or at home.

MHLW expresses its views on workers' accident compensation insurance

Under the workers' accident compensation insurance system, which is covered by the insurance premiums paid by employers in principle, insurance benefits are provided to workers who sustain an injury or illness because of work-related reasons or commuting. The MHLW expressed its view that workers' accident compensation insurance benefits will be provided if covid-19 infections are caused by work or if symptoms of covid-19 persist and absence from work is necessary. Further, the MHLW has also indicated that it would make judgements on the work-relatedness for workers' accident compensation on an individual basis, even if the route of infection is not necessarily clear, in cases where the employee was engaged in work that is considered to have a high risk of infection, after investigating the work engagement status and general living conditions during the incubation period.

The MHLW's view on the matter remains unchanged even after the reclassification of covid-19 as a 'category 5 infectious disease' under the Infectious Diseases Act, as of August 2023.

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Endnotes

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2 Companies Act, Article 430-3.
3 Code of Civil Procedure, Article 3-7, Paragraph 1.
4 id. at Paragraph 2.
5 id. at Paragraph 4.
6 id. at Paragraph 5.
7 The Tokyo High Court Judgment dated 22 July 2020, Hanrei Jiho No. 2491, p. 10.
8 Code of Civil Procedure, Article 3-2, Paragraph 1.
9 id. at Article 3-3.
10 id. at Article 3-4, Paragraph 1.
11 In consumer contracts, an agreement that an action may be filed only with a court of the country where the consumer is domiciled is deemed not to preclude the filing of an action with a court of any other country (Code of Civil Procedure, Article 3-7, Paragraph 5, Item 1).
12 Code of Civil Procedure, Article 3-9.
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15 id. at Article 8, Paragraph 1.
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27 Amended Arbitration Act, Article 24, Paragraph 1, Article 47.
28 id. at Article 47, Paragraph 7.
29 id. at Article 46, Paragraph 2.
30 id. at Article 46, Paragraph 2.
31 id. at Articles 5, 8, 35, 46 and 47.
32 Implementation Act, Supplementary Article 1.
33 id. at Article 2, Paragraph 3, Article 5.
34 id. at Article 3, Singapore Convention on Mediation, Article 8, Paragraph 1, Item (b).
35 Implementation Act at Article 5.
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Chapter 14

Mexico

Miguel Ángel De la Fuente Estrada and Eduardo J Sánchez Laurent[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV OUTLOOK AND CONCLUSIONS

I INTRODUCTION

Every society, which can be understood as a group of individuals pursuing a common goal, must be governed by a system of rules to regulate coexistence among themselves. As a consequence of the latter, failure of individuals to comply with the rules established for their coexistence brings a consequence that they are responsible for their actions before society, depending on the seriousness of their infringement or non-compliance.

In the Mexican legal system we can identify different types of liability, such as (1) criminal liability derived from the commission of a crime typified by the Criminal Code of one of the states of Mexico and the Federal Criminal Code applicable to crimes committed in a federal jurisdiction; (2) administrative liability arising from damages that may be caused by Mexican authorities in the performance of their employment, position or commission, or in the exercise of their duties under Mexican law; and (3) civil liability arising from damages caused to other individuals, which is the subject of this chapter.

Each of the types of liability indicated has a specific consequence; for example, criminal liability results in a custodial sentence (i.e., imprisonment for a certain period of time); administrative liability results in a public or private reprimand, suspension from employment, position or commission, removal from office, the imposition of economic sanctions and/or disqualification of the public servant; and finally, civil liability results in the payment of damages caused to the affected party.

In the first part of this chapter, civil liability will be studied, explaining the different types of consequences that derive from it, according to Mexican law. Subsequently, a brief summary will be made of some transcendental cases on the subject in order to continue with the criteria that judges in Mexico have issued. Finally, we will deal with the regulation of the liability insurance policies that exist in the market and their importance, as well as the proposal of some solutions and recommendations on the same topic.

Regulation of civil liability in Mexico

Before starting with the study of the regulation of civil liability in Mexico, it is important to mention that the United Mexican States Political Constitution currently empowers the local state congresses to legislate on civil matters in each of the states of the Mexican Republic, therefore, we have 32 state civil codes and a Federal Civil Code in Mexico. For purposes of clarity, all references will be to the Federal Civil Code and its correlatives in the states of the Mexican Republic (collectively referred to as 'the Civil Code').

Going into the subject, Article 1910 of the Civil Code establishes the following: 'Whoever acting unlawfully or against good customs causes damage to another, is obligated to repair it, unless he proves that the damage was caused as a consequence of fault or inexcusable negligence of the victim.' Therefore, we can understand that civil liability is the consequence that originates from an unlawful act that causes damage to another individual.

In this sense, for civil liability to exist, three elements must be fulfilled. The first of them is the fact that originates the civil liability, the second is the damage caused, and the third is the causal relationship between the first and the second of the aforementioned.

The event that gives rise to liability

Regarding the first element, and in order to better understand the definition proposed by the Civil Code, we must understand what is meant by a 'wrongful act'. According to the doctrine, a wrongful act is 'any culpable human conduct, by intention or negligence, which is in conflict with a legal duty ***stricto sensu***, with a unilateral manifestation of will or with what was agreed by the parties in an agreement'.

From the latter, we may conclude that the wrongful act is the generating cause of obligations that are liable for compensation. Analysing Articles 1910 to 1934 of the Civil Code, we can conclude that civil liability can be classified in two ways: subjective civil liability and objective civil liability.

Subjective civil liability is generated by a wrongful act committed by a person who must comply with a legal duty or obligation, because it results from fault (which is always subjective), intentional or negligent. Objective civil liability is generated by a lawful act but which has as a consequence a patrimonial detriment and has its origin in the determination of the legislator. In summary, we can conclude that subjective civil liability may arise from the breach of a legal duty or obligation, while objective civil liability arises from a conduct permitted by the legislator (e.g., easements, treasuries, inheritance partition, mandate contract, etc.), from a created risk (e.g., use of mechanisms, instruments, devices or substances that are dangerous in themselves), or from an erroneous conduct in good faith (e.g., unlawful enrichment).

Objective civil liability can also be classified into contractual civil liability and non-contractual civil liability. The former arises from the breach of an obligation agreed in a contract, while the latter arises from the principle of not causing harm to another person. This distinction is important, since the statute of limitations for claiming payment of damages is different. In the case of non-contractual civil liability, Article 1934 of the Civil Code establishes a statute of limitations period of two years from the date on which the damage was caused; however, the general statute of limitations period for claiming damages arising from contractual civil liability is 10 years, in accordance with the provisions of Article 1159 of the Civil Code, since there is no case that determines a shorter statute of limitations period.

The damage

Pecuniary detriment can be understood as damages and injuries. According to Article 2108 and Article 2109 of the Civil Code, damage is understood as 'the loss or impairment suffered in the patrimony due to the non-fulfilment of an obligation' and injury as 'the deprivation of any lawful gain, which should have been obtained with the fulfilment of the obligation', respectively.

Therefore, the concept of damage can be understood broadly as any harm suffered to a subjective right, or more strictly as harm to certain rights that may result in an economic penalty in certain circumstances.

In this sense, damage refers to any material or moral detriment suffered by a person due to an action contrary to law or morality. It can be classified into material damage, which affects the patrimony or property of a person, including physical damage, and moral damage, which causes suffering or emotional damage that may be difficult to evaluate economically.

Indeed, Article 1916 of the Civil Code adds a damage known as 'moral', and defines it as 'the impairment that a person suffers in his feelings, affections, beliefs, decorum, honour, reputation, private life, physical configuration and appearance, or in the consideration that others have of him. It will be presumed that there was moral damage when the freedom or physical or psychological integrity of persons is illegitimately violated or impaired.'

Causation

Article 2110 of the Civil Code establishes that the damages must be an immediate and direct consequence of the non-performance of the obligation, whether they have been caused or must necessarily be caused.

The damage caused must be a direct and immediate consequence of the fact that originated it, since, there may be facts that do not comply with these characteristics, for example:

- when the liable party is considered as unimputable;
- when the liable party acts with a vitiated will such as error or violence;
- when the fact has its origin in the law itself or by consent of the victim; or
- in the exercise of a right (such as freedom of expression), among others.

II YEAR IN REVIEW

One of the most important civil liability cases is known as the ***Admivac*** case,[2] since it was a crucial event for the recognition of new compensation types that have allowed Mexican courts to include various legal concepts in Mexican legislation in an attempt to regulate civil liability in Mexico in a more extensive manner. Although this case is public and can be consulted by readers, we will briefly summarise it here to exemplify and give more context on the subject of this chapter.

On 16 September 2010, a minor died from electrocution in water while using a kayak inside the facilities of the Mayan Palace Hotel. The parents of the minor sued Admivac, SA de CV (Admivac), using an ordinary civil action. The following claims were made: (1) compensation for moral damages for the death of their son; (2) derived from the strict liability of the claim, the damages generated as a consequence of the transfer of their deceased son, as well as the funeral and exhumation expenses, which amounted to 77,798 Mexican pesos; and (3) the expenses and costs generated in the lawsuit.

The first sentence ordered the payment for moral damages compensation in the amount of 8 million Mexican pesos. This judgment was appealed and the respective judicial authority modified the first sentence to order the defendant to pay compensation for pain and suffering damages in the amount of 1 million pesos. As a result of this, both parties filed direct *amparo* lawsuits against the decision, which were overseen by the First Chamber of the Mexican Supreme Court of Justice (the highest court in Mexico).

The First Chamber of the Mexican Supreme Court of Justice determined that the arguments of the parents of the minor were well-founded, through the study of the concept of moral damages and the constitutionality of Article 1916 of the Civil Code. The First Chamber ruled that, according to Mexico's legal tradition, moral damages are determined by the non-pecuniary nature of the type of damage. In this sense, the conceptualisation of moral damages focuses its object and content on the non-pecuniary interests that may be affected.

It was determined that in the case under analysis, Admivac's liability had been incurred, which resulted in the damage-repair of such non-pecuniary damage. Likewise, the First Chamber clarified that damages to rights or interests of a pecuniary nature may also be sued autonomously and it was specified that in order for this to be claimed, the existence of civil liability must be proven. It was determined that the death of the minor was the cause of tort liability, because although the minor knew the risks of using the kayak and the regulations established that its use was under the responsibility of the user, this did not exclude the liability of the company.

In this sense, it was determined that the damage was caused by the negligence or carelessness of the hotel and a non-contractual liability was established, since these damages cannot be accepted by means of a contract for the provision of services between the hotel and the guest. The Supreme Court continued to analyse the types of 'punitive damages' and the 'right to fair compensation' and concluding with the establishment of a parameter to determine the amount of compensation for moral damages. As a result, Admivac was ordered to pay an amount of approximately 30 million Mexican pesos.

Of course, this judgment led Mexican judges to issue new criteria and introduce new legal concepts such as punitive damages or damages to the life project, among others, as we will point out in the following section.

III THE LEGAL FRAMEWORK

i New types of damage

The concepts of damage, injury and moral damages have been expanded on several occasions by the Mexican courts. In this regard, we will now turn to the legal types of damage that, over the years, the Mexican courts have recognised in civil liability cases.

Emerging or consequential damages

Emerging or consequential damages refers to the real and effective loss suffered by the victim's assets as a result of a harmful event. It includes direct and immediate damages, such as property damage in a traffic accident. It is the concrete kind of damage suffered in the victim's patrimony, which implies the loss of an asset or right that was part of that patrimony. Also considered as consequential damages are those that are indirect but have an immediate relationship with the previous damages (e.g., medical expenses).

Loss of profits

This refers to the profit or benefit that the victim ceases to obtain as a consequence of the damage suffered. Loss of profit is applied in a more restrictive manner than consequential loss and requires a burden of proof to demonstrate its quantification and the causal link between the act or omission of the liable party and the economic loss. The difficulty lies in proving whether the act or omission effectively caused the damage and whether the expected benefit would have been obtained had the act or omission not occurred. It is important to note that consequential damage refers to the pecuniary loss suffered, while loss of profits refers to the loss of a possible benefit that was considered reasonably achievable at the time of the act or omission. Although there may be cases of future consequential damages, such as the cost of future repairs or medical treatment, lost profits refers to benefits not obtained and which could have been obtained prior to the filing of the claim.

Moral damages

Moral damages affect intimate aspects of a person, such as life, honour, dignity, reputation, image, social esteem or physical health. These damages are difficult to repair, since it is not possible to restore someone's life or completely restore someone's reputation. The way to repair these damages is usually economic, but their quantification is complicated due to their subjective nature. The burden of proof is on the person claiming compensation, which can also present difficulties. It is possible to claim both moral damages and pecuniary damages in cases where there has been damage to a person's image, such as the loss of an advertising contract. In these cases, compensation can be claimed both for the amount that would have been received for the contract and for the moral damage caused.

Bodily or physical damages

Bodily or physical damages are those that affect the health or physical integrity of persons. There are different definitions of bodily injury, depending on the medical or legal field in which they are used. From a medical-legal perspective, bodily injury refers to any physical or psychological alteration that affects the health of the person, limits their personal integrity or causes a decrease in their organic functioning. The concept of bodily harm can also be equated with that of physical injury, which is defined as any anatomical or functional alteration caused by external agents.

Property consequences

As a consequence of bodily injury there are consequential damages. There will also be loss of profits. Moral damage can be conceptualised as the impairment to a non-pecuniary right or interest. This distinction makes it possible to differentiate between damage in the broad sense, which is the injury to a non-pecuniary right or interest, and damage in the strict sense, which are the consequences of that injury. It is important to emphasise that the impairment to a non-pecuniary right does not always result in a moral damage of the same nature. In fact, many times an impairment of this type can generate both a moral damage and a pecuniary damage. Conversely, damage to economic rights may cause both pecuniary and non-pecuniary damages.

Non-patrimonial consequences

In addition to economic damages, there are non-economic damages that must also be compensated. These include physical and moral pain experienced by the victim, as well as damages that affect the victim's interest in achieving their goals. The loss of opportunities may also affect the victim's assets and should be compensated. The measure of reparation for these opportunities depends on the intensity or probability of their occurrence.

Aesthetic damage

Permanent aesthetic sequelae, such as scars or deformities, are compensable if they are perceptible to the naked eye. Aesthetic damage may have moral and, in some cases, patrimonial consequences. The aesthetic physical injury is considered to affect the bodily integrity and may cause moral damage and therefore there is indirect damage to the patrimony. The compensation for aesthetic damage is determined according to the affected orbit and can be considered as part of the moral or patrimonial damage.

Strictly moral damage

Bodily harm may imply reduction of functions and limitations in daily life, although they are difficult to prove and quantify. They are known as 'loss of the ability to enjoy life' or 'existential damage' and are considered a damage to moral interest rather than to economic interests. Non-pecuniary or moral damage affects personal property or rights and cannot be repaired in the strict sense. It consists of the pain and grief caused to the victim by the wrongful act, which may have repercussions in the pecuniary and moral order. Any negative alteration in the psychophysical state due to the action of another is considered as moral damage.

Full reparation of the damage and 'just compensation'

The concept of integral reparation of damage has evolved in the field of human rights. Four dimensions must be considered: organic injury, psychic and mental injury, the ecological-social dimension and the ethical dimension. Comprehensive reparation seeks to promote justice and remedy the harm caused by an act or omission.

In a specific case analysed by the First Chamber of the Supreme Court of Justice of the Nation, the right of crime victims to full reparation of damages was established. Since 1993, the Political Constitution of the United Mexican States has recognised this right, but it was in the 2002 reform when it was given greater relevance in the criminal process. It was established that the purpose of the criminal process is to clarify the facts, protect the innocent, avoid impunity and repair the damages caused by the crime. Mexican law establishes that the Public Prosecutor's Office is obliged to request reparation of damages in the corresponding cases, but the victim may also request it directly, and therefore, the judge may not absolve the convicted person from such reparation if they issued a conviction.

Finally, the right to reparation of damages must be fair and comprehensive, especially when dealing with victims of a crime. Fair compensation implies restoring the previous situation, and in the event that this is not possible, compensating for the damage caused. Reparation must nullify all consequences of the unlawful act and re-establish the situation that should have existed; therefore, 'fair compensation' must include the following elements: (1) restitution, (2) compensation, (3) rehabilitation, (4) satisfaction, and (5) a guarantee that it will not be repeated.

Damage to the life project

Damage to the life project is a concept that has been recognised in the world of law, especially in the Argentine Civil Code. However, it is still in the process of development and there is no solid jurisprudence on the matter, but it has already been applied in several judgments in Mexico.

The life project refers to the plans and goals that a person may have in their life. It is the vision that each individual has about how they want to live and what achievements they want to work towards. Damage to the life project occurs when a person's ability to carry out their plans and goals is significantly affected. It is a harmful act that causes an injury to someone's life plan. The consequences of the damage are of vital importance in determining its magnitude and must take into account both pecuniary and non-pecuniary aspects.

It is important to point out that there are differences in the criteria, techniques and methodology for repairing or compensating damages caused to human beings and things. Therefore, it is essential to establish to whom the damage is directed in order to determine the consequences and the appropriate form of reparation.

Punitive damages

Punitive damages are part of the right to fair compensation. They fulfil the deterrent effect of compensation by preventing future wrongful conduct with the imposition of negative incentives to act with due diligence.

The Supreme Court of Justice of the Nation has pointed out that compensation achieves fundamental objectives in terms of social retribution. In the first place, by imposing on the responsible party the obligation to pay compensation, the victim obtains the satisfaction of seeing their desire for justice fulfilled. Such measures serve a dual function: to prevent people from causing harm to others in order to avoid having to pay compensation and, on the other hand, to cover all the costs necessary to avoid causing harm to others. The Supreme Court has also pointed out that limiting the payment of damages suffered to simple reparation would in some cases mean accepting that the person responsible would enrich themself at the expense of the victim, which, disregarding the legal duties of care, has a real cost or victim consequence. Through such exemplary sanctions a culture of responsibility is sought.

The problem with this novel concept is that there is no precise regulation, and therefore, there are no uniform criteria on the amount of compensation to be paid by the liable party. Therefore, the judges, in their discretionary powers, have issued sentences for exorbitant amounts based solely on the economic capacity of the liable party.

Elements of weighting

In the Mexican legal system, the quantification and valuation of moral damages is determined by means of weighting elements. Before the 1982 Reform, damages were quantified as one-third of the pecuniary damage. However, with the constitutional reforms, a fair and integral reparation is sought, and it is up to the judge to determine the weighting elements. The jurisprudence of the Supreme Court of Justice of the Nation establishes that the gravity and impact of the moral damages must be evaluated, as well as the circumstances in which they occurred. The legal operators must provide the judge with the necessary elements to determine the quantification of the moral damages. There is no specific amount, but an amount is assigned considering these elements.

Regarding quantification, it is emphasised that moral damages are subjective in nature and cannot be valued in the same way as material damages. There is no exact formula to determine amounts, since each case is unique and must be evaluated according to its particular circumstances.

It is established that the judge must take into account various elements to determine the amount of compensation for moral damages, such as the seriousness of the damage, the impact on the life of the affected person, the circumstances in which it occurred and the economic capacity of the responsible party. In addition, both insufficiency and unjust enrichment must be avoided when setting the amount of compensation.

ii Fora and dispute resolution mechanisms

Currently, companies and individuals in general have opted for the contracting of insurance policies to transfer the risk of a possible indemnity derived from some act or omission originated by civil liability. The Insurance Contract Law regulates insurance against liability in its Article 145, stating, 'the company is obliged up to the limit of the insured sum to pay the indemnity that the insured owes to a third party as a consequence of an event that causes a damage foreseen in the insurance contract.'

There are a diverse number of insurance products that have been marketed by insurance companies, among which we can highlight: (1) professional liability insurance (lawyers, doctors, accountants, financiers, auditors, insurance agents, among others); (2) general liability insurance (individuals or companies); (3) D&O insurance; and (4) environmental liability insurance, among others.

As pointed out in Section IV of this chapter, civil liability has become an important issue for insurance companies, both because of the loss ratio they have suffered in recent years, which has increased year on year, and because of the sums of money to which the insured have been condemned for damages, This results in the payment of high sums of money by the insurance companies, which they had not calculated, or in the creation of important reserves that affect their operations.

In addition to the above, Mexican insurance legislation contemplates the option of exercising an action called 'direct action' against the insurer without having to sue the insured (i.e., the direct action allows the injured party to file a civil liability claim directly against the insurance company, without having to file a prior claim against the party that caused the damage). This has become relevant due to the notorious increase of civil lawsuits filed against insurance companies by means of direct action.

It is normal for the insurance industry to question the legality of suing the insurance company directly without having proven the insured's liability and without the insured's intervention. However, on 13 January 2023, the Collegiate Circuit Courts determined that the applicable legislation validly allows victims of civil liability claims to file claims directly against the insurer without the intervention of the insured.

Therefore, it is important that insurers begin to take into account, within their risk projections, the possibility of a direct action being brought against them by the injured parties of a claim for the payment of an indemnity without the intervention of the insured.

IV OUTLOOK AND CONCLUSIONS

As can be seen, the new criteria of the Mexican courts have had a significant impact on the notion of civil liability, its scope and consequences. With the introduction of the types of damages mentioned in Section III.i of this chapter and specifically the criteria on 'just compensation' and 'punitive damages', the risk for insurance companies as to the amount of indemnities to be paid to their policyholders is very uncertain and possibly incalculable.

For this reason, in order to avoid or prevent these risks within liability policies (whatever the specific type of product), it is important that the text of the general conditions and, above all, the coverages and exclusions indicated therein are very clear and leave no room for doubt as to the types of damages included and the scope or limit thereof.

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Endnotes

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2 Resolution dated 26 February 2014, issued by the First Chamber of the Supreme Court of Justice in Direct *Amparo* No. 30/2013. Minister Speaker: Arturo Zaldívar Lelo de Larrea. It can be consulted at: https://www.scjn.gob.mx/derechos-humanos/sites/default/files/sentencias-emblematicas/resumen/2022-02/Resumen%20AD30-2013%20DGDH.pdf.

Chapter 15

Pakistan

Furkan Ali and Shabnam Noorali[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

The size of Pakistan's insurance industry is relatively small in proportion to its GDP. However, recent years have seen an upward trend in people opting for insurance products for financial security. This is due to an increase in public awareness led by innovation and marketing of new products mostly by private insurance companies.

Improvements have also been witnessed in the legal framework. The Securities and Exchange Commission of Pakistan (SECP) is the regulator of the insurance industry, and has been proactive in its approach to provide an enabling environment for the growth of the sector. The SECP has been responsive to technology-based solutions while ensuring that the general public is adequately protected.

The facilitative role of regulatory bodies and the emphasis on high paid-up capital of insurance companies is allowing insurance companies to undertake financial risks and expand their business, to be innovative, to maintain a competitive stance, and to enable the domestic insurance market to meet the challenges of the rapidly integrating financial markets of the world economy.

II YEAR IN REVIEW

Claims by insured persons or their legal heirs against insurance companies continue to be widely litigated throughout Pakistan. Rejected claims are usually challenged in the first instance before the Insurance Tribunal under Section 121 of the Insurance Ordinance 2000. However, the decisions of the tribunal are often appealed before the superior courts in Pakistan. Two cases pertaining to the rights and obligations of policyholders that have gone all the way to the Supreme Court, and one case of the Lahore High Court, which is significant insofar as the future of the tribunal is concerned, are discussed below.

i State Life Insurance Corporation v. Razia Ameer[2]

This case concerns a group insurance contract between the State Life Insurance Corporation and a government department. Pursuant to this contract, a schoolteacher had a premium deducted from his salary, and the insured amount was payable upon retirement. Due to ill health, the schoolteacher took early retirement and died shortly after. When his legal heirs filed the claim for payment of the insurance amount, the insurance company rejected it on the ground that the group insurance scheme did not apply to early retirees. The legal heirs filed a case before the Insurance Tribunal, which granted the insured amount, but declined liquidated damages. This decision was reversed in appellate court. The insurer thus filed an appeal to the Supreme Court.

The question before the Supreme Court concerned the interpretation of Section 118 of the Insurance Ordinance 2000. This provides that an insurance company is liable for liquidated damages if it fails to make payment within 90 days of it becoming due provided that the insured has complied with all the requirements, including the filing of complete papers, for claiming the payment, unless it proves that the failure was due to circumstances beyond its control.

In this respect, the Supreme Court upheld the reasoning of the appellate court that if all formalities are completed and if the claim is not satisfied within 90 days 'without any fault of the claimant when it becomes due, then under the implied term of every contract of insurance the liquidated damages must be granted.' The Supreme Court also noted that the insurer could not establish that it failed to settle the claim for reasons beyond its control.

This judgment has important implications. Although the law is itself quite clear, in 2022 the Lahore High Court had passed a judgment whereby it held that in order to claim liquidated damages, a claimant is required to establish that the insurer has shown contumacy and deliberate intent in denying the legitimate claim of a person. The Supreme Court in this case, however, lays down no such requirement. On the other hand, the Supreme Court has observed that every contract of insurance has an implied term that liquidated damages are

payable if the claim is not settled by an insurer within 90 days. The only test that a claimant has to satisfy is what is specified in Section 118 itself: that is, to show that the reason for the delay (1) is not due to any act of the claimant; and (2) is not for reasons beyond the control of the insurer.

ii State Life Insurance Corporation of Pakistan v. Atta ur Rehman[3]

This case concerned a life insurance policy. When the insured person died, his legal heirs filed a claim, which was rejected by the insurance company. The legal heirs thus filed a case in the Insurance Tribunal, which was decided in their favour. The appeal filed by the insurance company was also dismissed by the High Court, and it filed a second appeal to the Supreme Court. The main ground of appeal by the insurance company was that the insured person failed to disclose that he had a cardiac condition at the time of the issuance of the policy. It further claimed that this was in breach of the insured's duty to act in good faith and amounted to a material concealment, which vitiated the policy. The Supreme Court ultimately dismissed the appeal and upheld the judgments of the courts below.

In its judgment, the Supreme Court examined good faith requirements in insurance contracts. It observed that contracts of insurance have consistently been regarded as *uberrimae fidei* (i.e., of the utmost good faith), and Section 75 of the Insurance Ordinance 2000 has also codified this principle. The Supreme Court further reviewed the duty of disclosure in various insurance law texts and acknowledged that if an insured fails to disclose facts material to the insurer's appraisal of risk which are known to the insured, the insurer may avoid the contract of insurance if it can show that the nondisclosure induced the making of the contract.

In the case at hand, however, the Supreme Court noted that the insurance company had also conducted its own medical examination of the insured person through a doctor of its choice. The doctor found the insured person to be in healthy condition. Therefore, applying the law to the facts of this case, the Supreme Court held that although the insured person concealed his cardiac condition, such concealment did not induce the insurance company to enter into the contract of insurance. The court concluded that the insurance company was in fact induced into issuing the policy on account of the results of its own medical examiner. Thus, this case is significant insofar as the Supreme Court has held that although insurance contracts are inherently premised on good faith, the requirement of inducement is a critical one in determining whether failure to meet a good faith condition entitles an insurance company to vitiate a contract.

iii Premier Insurance Ltd v. Ihsan Yousaf Textile (Pvt) Ltd & others[4]

This case was filed by a textile company against the insurer after it rejected a claim that was filed following a fire at its factory which caused significant losses. In the first instance, the Insurance Tribunal granted the claim in the sum of 148 million Pakistani rupees along with liquidated damages. The insurance company thus filed an appeal to the Lahore High Court. There were a number of important elements that were considered by the Lahore High Court.

First, the Division Bench observed that the Insurance Tribunal that had given the judgment consisted of only one judge. This was contrary to the requirement in Section 121 of the Insurance Ordinance 2000, which states that the Insurance Tribunal shall comprise a chairperson, who shall be a serving or retired judge of the High Court, and at least two members having knowledge of life insurance, non-life insurance, actuarial science, finance, economics, law, accountancy, administration or other discipline that would enable them to discharge their duties to the tribunal. The High Court observed that Section 121 contained the word 'shall', and therefore, the composition of the Insurance Tribunal was a mandatory provision. It thus concluded that the judgment 'has been rendered by Tribunal, not constituted as per mandate of law and hence, the same is not sustainable in the eye of law.'

Second, the High Court also elaborated on how survey reports should be dealt with in light of various provisions in the insurance law regime. Specifically, the High Court held that that

if the tribunal or either party is not satisfied with the accuracy of a survey report, where required, the tribunal should direct the insurance company to arrange for another survey report under Rule 22 of the Insurance Rules 2022.

In view of the observations above, the Lahore High Court remanded this case to the Insurance Tribunal for a fresh decision by a tribunal that meets the requirements of Section 121 of the Insurance Ordinance 2000.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The field of insurance in Pakistan is primarily governed by the Insurance Ordinance 2000 read with the Insurance Rules 2017. In addition to this, there are also regulations governing specific areas of the insurance business such as the Insurance Accounting Regulations 2017, Insurance Companies Sound and Prudent Management Regulations 2012 and Corporate Insurance Agents Regulations 2021.

In recent years, the insurance industry in Pakistan has started to place increasing reliance on technology in distributing and selling insurance products, making it imperative for adequate measures to be taken to ensure that the information technology systems of the insurance companies and their partners and intermediaries are secure and resilient. Accordingly, the apex regulatory body for insurance companies in Pakistan, the SECP, recently issued the SEC Guidelines on Cybersecurity Framework for the Insurance Sector 2020, putting in place regulatory measures for threat and vulnerability reduction and deterrence.

In 2022, the SECP issued a master circular compiling all statutory and regulatory requirements and instructions issued via circulars and directives to the insurance sector from 2005 to the end of 2021. It contains requirements pertaining to, inter alia:

- licensing and registration of persons and entities operating in the insurance sector;
- financial and regulatory reporting;
- management expense limits;
- training and certifications of key insurance personnel;
- complaint handling;
- cybersecurity matters; and
- marketing incentives for small ticket insurance policies.

In keeping with its efforts to encourage innovation, more recently, the SECP also approved a new tech-based life insurance product equipped with insurance technology features such as artificial intelligence and data analytics that would allow insurance companies to track the health policyholders. The regulator has also made amendments to the existing legal framework to provide for digital insurers and insurance.

ii Insurable risk

The Insurance Ordinance 2000 divides insurance business into life and non-life insurance business. Life insurance business entails life business, capital redemption business and pension fund business, whereas non-life insurance business includes:

- reinsurance business;
- fire and property damage business;
- marine, aviation and transport business;
- motor third-party compulsory business;
- liability business;
- workers' compensation business;
- credit and suretyship business;
- accident and health business; and
- agriculture insurance, including crop insurance.

The type of risk that can be insured in Pakistan is extensive. This includes risks for:

- accidental or natural death, injury or incapacitation;
- loss of or damage to property;
- loss of or damage to, or arising out of or in connection with, the use of means of transport;
- loss of or damage to merchandise, baggage and all other goods in transit;
- liabilities incurred by third parties arising out of or in connection with the use of motor vehicles on land;
- liabilities incurred by workers arising out of or in connection with their employment;
- contracts for fidelity bonds, performance bonds, administration bonds, bail bonds, custom bonds or similar contracts of guarantee; and
- loss of or damage to agriculture-related property, including crops.

In relation to marine insurance, under Section 7 of the Marine Insurance Act 2018, every person who has an interest in a ship, goods or other movables that are exposed to maritime perils is deemed to have an insurable interest. This interest is such that they have a legal or equitable relation to the ship, goods or other movables being exposed to maritime perils in consequence of which they may benefit from the safety or due arrival of insurable property, or may be prejudiced by its loss, damage or detention, or may incur a liability in respect thereof.

Notwithstanding the above, there are certain types of risks that are to a large extent uninsurable. These include reputational risks, regulatory risks, trade secret risks, political risks and pandemic risks.

Under Pakistan law, for an insurance policy to be issued, the policyholder has to establish its insurable interest in the risk being insured. Courts in Pakistan have defined insurable interest, inter alia, as 'a right arising out of a contract in relation to the property/person insured which if . . . injured will cause . . . pecuniary loss to the insured'.[5] The courts have also cited with approval the ratio in *Lucena v. Craufurd*,[6] where it was held that an insurable interest is 'to be interested in the preservation of the . . . [insured property] . . . as to have benefit from its existence, prejudice from its destruction'. Therefore, under Pakistan law, for an insurable interest to exist, the policyholder must stand to suffer a direct financial loss if the event against which the insurance cover was bought occurs.

Pursuant to Rule 18 of the Insurance Rules 2017, no insurer shall reinsure knowingly outside Pakistan any insurance business or any part thereof underwritten by it in Pakistan without the permission of the SECP. Such permission may be granted if the insurance or any part thereof is in excess of the insurer's treaty arrangements, and the SECP is provided with documentary evidence that the excess cannot be reasonably placed within Pakistan or if the insurance business is of a special nature and there are no treaty arrangements for it.

Under Pakistan law, any contract to procure insurance of any property, liability or life from any specific or named insurer or insurers, other than insurers specified generally as a class according to objective criteria based on financial strength, is prohibited, except for all general insurance coverage for state-owned movable and immovable assets belonging to the federal and provincial governments, local authorities and statutory corporations, which is to be procured from the National Insurance Company Limited.

Section 165 of the Insurance Ordinance 2000 further states that the federal government may make rules imposing conditions on the ability of any person to insure outside Pakistan any risk in respect of any property or interests that are located in Pakistan at the time the insurance is effected. The federal government may also make rules imposing conditions on the ability of any insurer to issue life insurance policies denominated in currencies other than the Pakistan rupee to persons who are citizens of Pakistan and resident in Pakistan at the time the insurance is effected.

iii Fora and dispute resolution mechanisms

Insurance tribunals have been established under Section 121 of the Insurance Ordinance 2000. These tribunals are to comprise of a serving or retired judge of the High Court and at least two members having knowledge of life insurance, non-life insurance, actuarial science, finance, economics, law, accountancy, administration or other discipline that would enable them to discharge their duties to the tribunal. A recent judgment from the Lahore High Court has highlighted the importance of the constitution of the tribunal under Section 121.[7] In the case of *Premier Insurance Ltd v. Ihsan Yousaf Textile (Pvt) Ltd & others*, the Division Bench held that a judgment passed by a tribunal that does not meet the requirements of Section 121 is not lawful, and directed the case to be remanded to be decided afresh by a tribunal that is constituted in compliance with the legal provisions.

Section 122(1) of the Insurance Ordinance 2000 states that the insurance tribunal is to exercise all the powers of a civil court in relation to claims filed by policyholders against insurance companies concerning insurance policies. It is important to note that under Section 122(3) of the Insurance Ordinance 2000, no other court or tribunal is permitted to exercise jurisdiction with respect to any matter to which the jurisdiction of the insurance tribunal extends. To this extent, the insurance tribunal has exclusive jurisdiction.

There are, however, two caveats to the jurisdiction of the insurance tribunal:

- under Section 115, it only has jurisdiction in relation to cases where the insurance policy was issued after the promulgation of the Insurance Ordinance 2000.[8] Thus, claims that pertain to policies issued prior to 2000 cannot be filed in the insurance tribunal; and
- it only has jurisdiction in cases that are filed by the policyholder under Section 122.[9] Therefore, any claim by an insurance company is required to be filed in the civil court.

Under Section 124 of the Insurance Ordinance 2000, appeals from decisions of the insurance tribunal are heard by the High Court.

Section 125 of the Insurance Ordinance 2000 also establishes the office of the Insurance Ombudsman. Section 127 provides that the Insurance Ombudsman has the power to receive complaints and conduct investigations into allegations of maladministration against insurance companies.

IV THE INTERNATIONAL ARENA

Section 115 of the Insurance Ordinance 2000 states that in the event of a dispute pertaining to a policy of insurance issued by an insurer in respect of insurance business transacted in Pakistan, the policyholder shall be entitled to sue for any relief in respect of the policy in any insurance tribunal in Pakistan, and any question of law arising in connection with any such policy shall be determined according to the law in force in Pakistan.

The only exception to this provision is when it comes to matters concerning a policy of marine insurance. In relation to marine insurance policies, the Lahore High Court has observed that since marine insurance contracts are often international in nature and concern the rights of parties outside Pakistan, payment can be received and claims in relation to such policies may be filed in other countries.[10]

With respect to international awards, the promulgation of the Recognition and Enforcement (Arbitration Agreements and Foreign Arbitral Awards) Act 2011 (the 2011 Act) is a significant step towards recognition and enforcement of arbitration agreements and foreign arbitral awards pursuant to the United Nations Convention on the Recognition and Enforcement of Foreign Awards 1958. Previously, from 2005 to 2011, this was provided for under presidential ordinances, which have a temporary life of four months generally, and must be validated by the Pakistani legislature to be made permanent.

The 2011 Act provides for execution of a foreign award in Pakistan as if it is a decree of its own court unless grounds specified in Section 7 of the 2011 Act exist. In addition, the 2011

Act confers exclusive jurisdiction on the High Court, thus eliminating altogether one level of legal proceedings, and, given the unfortunate delays that can plague the legal system in this country, greatly speeding up the enforcement of foreign awards.

Section 44A of the Civil Procedure Code 1908 states that where a certified copy of a decree of any of the superior courts of the United Kingdom or any reciprocating territory has been filed in a district court, the decree may be executed in Pakistan as if it had been passed by the district court unless it is shown to the satisfaction of the court that the decree falls within any of the exceptions specified in Clauses (a) to (f) of Section 13 of the CPC. These exceptions include:

- where the judgment has not been pronounced by a court of competent jurisdiction;
- where the judgment has not been given on the merits of the case;
- where on the face of the proceedings the judgment appears to be founded on an incorrect view of international law or a refusal to recognise the law of Pakistan in cases in which this law is applicable;
- where the proceedings in which the judgment was obtained are opposed to natural justice;
- where the judgment has been obtained by fraud; or
- where the judgment sustains a claim founded on a breach of any law in force in Pakistan.

Thus, it is evident that if a judgment has been passed in a court of a reciprocating territory, the judgment is directly enforceable in Pakistan unless it falls within one of the narrow exceptions mentioned above. When viewed together with the 2011 Act, it is apparent that broadly speaking, if required, decisions rendered abroad can be implemented in Pakistan fairly effectively under the current legal framework.

V OUTLOOK AND CONCLUSIONS

Some of the key trends influencing the Pakistan insurance industry are digitalisation, health and life insurance, and travel insurance.

A key development is the increasing adoption of technology. This includes the use of digital platforms and mobile applications to make it easier for customers to purchase and manage their insurance policies. In August 2022, a new simplified registration regime for micro-insurers and digital-only insurers was introduced by the SECP with lower capital and solvency requirements. This helped to promote innovation, and product ranges within the country's insurance industry, thus helping drive the uptake of policies.

In 2022, the life insurance sector accounted for the highest share of the total insurance industry in Pakistan, registering an annual growth of more than 28 per cent. The sector's growth can be attributed to increasing awareness of the benefits of life insurance during the covid-19 pandemic. The general insurance sector registered annual growth of more than 25 per cent in 2022, primarily attributed to the increased uptake of property insurance due to floods that affected the country throughout the year as well as increasing awareness about health insurance. In June 2023, the government announced that it would issue health cards for working journalists in the country whereunder beneficiaries could access free healthcare services at 1,200 institutions.

The period 2022–2023 also saw the launch of Pakistan's first self-survey enabled insurance app by TPL Insurance, which has resulted in over 400,000 mobile downloads and more than 100 million Pakistani rupees in digital sales in 2022, and also Pakistan's first buy now pay later insurance and digital bus travel insurance.

The year 2023 is witnessing a rise of insurtech start-ups. These start-ups are leveraging technology to disrupt the traditional insurance industry and offer new and innovative products and services. This trend is likely to create new competition for traditional insurance companies and may result in a more dynamic and innovative market.

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1 Furkan Ali and Shabnam Noorali are partners at FGE Ebrahim Hosain.
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Chapter 16

Sweden

Johan Gregow[1]

Summary

I INTRODUCTION
II YEAR IN REVIEW
III THE LEGAL FRAMEWORK
IV THE INTERNATIONAL ARENA
V OUTLOOK AND CONCLUSIONS

I INTRODUCTION

In Sweden, insurance litigation is often related to issues regarding insurance coverage. Moreover, there are cases related to indemnity insurance. The insurance company instructs counsel to defend the insured in line with the terms under the policy. There are plenty of subrogation cases, namely when the insurer has indemnified the insured and exercises subrogated rights in a claim against a third party. These cases are often settled by arbitration. Recent cases before the Supreme Court have covered issues regarding interpretation of provisions in the policy, third-party claims and the application of time limitation provisions.

In this chapter, we will provide an overview of general principles of Swedish insurance law and illustrate the recent case law.

II YEAR IN REVIEW

Over the past years important judgments have been rendered by the Supreme Court, some of which we shall cover below.

i Evidential value of a previous judgment and the concept of gross negligence Supreme Court case from 22 August 2023 (Case T 2755-22)

In certain cases, a party who has suffered damages may seek compensation directly from the liable party's insurance company (inter alia under a liability insurance). One such case would be when the liable party has entered into bankruptcy. A main principle is that the party who has suffered damages has the same right to compensation from the insurance company as from the liable party (i.e., the party who has suffered damage will not be in either a better or worse situation).

The Supreme Court has concluded that a judgment between the insured and the insurance company covering, inter alia, the issue of whether the insured is covered by the policy does not have legal force against the party that has suffered damage and that seeks compensation directly from the insurance company. However, such a judgment may have evidential value in a case between the party who has suffered damage and the insurance company. Such evidential value relates mainly to factual circumstances, according to the Supreme Court. Moreover, according to the Supreme Court, the court may also get an impression of the previous ruling which may influence the court's assessments (i.e., in the same way as other case law or doctrine).

In the insurance policy, it was stipulated that the insurance was not applicable if the insured had caused the damage by gross negligence. The concept gross negligence is not defined in the Insurance Contracts Act (ICA). Generally, it requires serious negligence if it shall be considered as gross negligence. Moreover, in many cases, it requires a conscious risk taking in order to constitute gross negligence. In the relevant case, it was concluded that if gross negligence would be attributable to the company (the insured), the relevant actions or omissions shall relate to the managing director or the site manager. In this case, the Supreme Court found that the insured had acted with gross negligence, i.e. based on omissions related to the site manager and the managing director who had failed to take reasonable measures in order to prevent damages (fire) and secure that the employees had undergone relevant training for their duties, etc.

ii Insurance mediation; Supreme Court Cases NJA 2019 Section 638 I and II

In 2019, the Supreme Court rendered judgments regarding the definition and scope of insurance mediation.

In one of the cases, the question was whether financial advice regarding investment of capital provided in connection with entering into an insurance contract constituted insurance mediation.

The investor had invested in financial instruments within the framework of a capital insurance policy, following advice from a registered insurance mediation company. The investment certificate became worthless and the insured lost the entire amount invested. Initially, the insured made claims against the insurance mediation company; however, this company entered into bankruptcy. The insurance mediation company was insured as stipulated under Swedish law. The investor filed claims against the insurance company. The insurance company alleged that the insurance mediation company's advice did not cover the capital insurance policy. Instead, the insurer argued that the advice related to the investments in the financial instruments, which were placed in the capital insurance product. Therefore, according to the insurance company, it had not been a matter of insurance mediation but of advice on investing in financial instruments.

In the second case, an insurance company had issued a liability insurance policy to an insurance mediation company. A number of individuals had handed over money to the insurance mediation company to invest these amounts in corporate bond products, which would be placed in a capital insurance product. However, it later emerged that the managing director of the insurance mediation company had embezzled the amounts. The insurance mediation company entered into bankruptcy. The insurance company rejected the claims seeking compensation for the individuals, alleging that the corporate bond products were fictitious and, thus, the managing director's actions did not constitute insurance mediation.

The Supreme Court sought a preliminary ruling from the European Court of Justice, which in its judgment found the following:[2]

- financial advice covering placement of capital in the context of insurance mediation relating to the conclusion of a capital life insurance contract falls within the scope of the Insurance Mediation Directive and should not be considered investment advice under the Markets in Financial Instruments Directive, also known as MiFID II;[3] and
- the concept of 'insurance mediation' includes work preparatory to the conclusion of an insurance contract, even in the absence of any intention on the part of the insurance intermediary concerned to mediate any actual insurance contract.

On the basis of the preliminary ruling of the European Court of Justice, the Supreme Court found – in both cases – that the actions concerned constituted insurance mediation.

Moreover, in the fraud case, the insurance company also alleged that the exception clause in the policy for damage caused by the insured intermediary intentionally or by gross negligence should apply to the individual suffering the loss.

However, the Supreme Court considered that the insurance mediation company was to be covered by liability insurance by statute. Therefore, there was reason to interpret the insurance policy to the benefit of the insurance mediation company's clients. In an overall assessment, the Supreme Court found that the exemption clause regarding damage caused intentionally or through gross negligence by the mediator did not apply to loss caused to the insurance mediation company's clients.

Thus, in both cases the insurance mediation company's clients were entitled to compensation under liability insurance issued to the insurance mediation company.

iii Interpretation of terms in a liability insurance; Supreme Court Case NJA 2018 Section 834

A design company was commissioned by a contractor to produce design drawings for a school building. The design company's delivery was defective, which delayed the contractor's performance for the buyer. Therefore, the buyer was entitled to liquidated damages from the contractor. The contractor, in turn, claimed damages from the designer corresponding to the costs for those liquidated damages. The design company claimed reimbursement under its liability insurance. However, the insurance company alleged that the design company's claim was not covered by the policy. The insurance company referred to an exception in the terms stating that the policy did not cover liquidated damages, penalties and punitive damages.

The Supreme Court interpreted the policy primarily on the basis of its wording. The Supreme Court found that the exemption clause should be interpreted as it only covered liquidated damages paid out by the insured. When the insured is under an obligation to compensate its contractual party for costs related to liquidated damages paid by a contractor to a third party, this is considered a claim for damages against the insured. The Supreme Court did not accept the insurance company's argument that the purpose of the exemption clause was to cover any liquidated damages irrespective of which party paid out the liquidated damages. The main reason for the Supreme Court's interpretation was that the stated purpose did not follow from the wording of the policy. Nor was there any firm industry practice that could give guidance for the interpretation. In summary, the insured was entitled to insurance coverage under the policy.

iv Third-party claims under the policy in relation to the insured's bankruptcy; Supreme Court Case NJA 2017 Section 601

A customer commissioned a service provider to carry out residential planning. The customer claimed compensation for design errors. The service provider, which entered into bankruptcy, was insured under a liability insurance policy.

According to Chapter 9 Section 7of the ICA, a third party that has suffered damage may take direct action against the insurance company in the event of the insured's bankruptcy.

The insurance policy contained a provision stipulating that claims for compensation under the policy had to be reported to the insurance company within six months of the claim being made against the insured, otherwise the insurance company was not liable under the policy.

The service provider never filed a claim for compensation under the policy within the six-month period. Therefore, the insurance company rejected the customer's claims as a third-party claim under the policy. The customer alleged that his claim under the policy was not time-barred by the insured's failure to report the claim within the time limit.

The Supreme Court found that the six-month provision also applied to third-party claims under the policy. Thus, the Supreme Court concluded that, because of the service provider's failure to report the claim within the time limit, the customer was not entitled to compensation according to Chapter 9 Section 7 of the ICA.

v The occurrence of damage under liability insurance; Supreme Court Case NJA 2017 Section 237

During the period from 1 January 2002 to 31 December 2009, a municipality was covered by a liability insurance policy. Two claims for damages were made against the municipality. These claims are hereafter referred to as the 'building permit case' and the 'school case'. The municipality reported the two claims for damages under the insurance policy.

In the building permit case, the facts were the following. In September 2008, the municipality had granted building permits for the construction of a building. During construction consultations in October 2008, it was noted that construction would start as soon as possible. At an inspection in October 2009, it was found that the building was almost completed. In December 2009, the county administrative board revoked the building permit. The county administrative board's decision gained legal effect in September 2012. The property owner made a claim against the municipality for damages corresponding to the costs for the construction and demolition of the building.

In the school case, the municipality had in the autumn of 2002 decided to place a student in a certain school. The student's education started in 2005. In 2010, it was found that the education placement was not justified. The student, who completed the education programme in 2012, made claims against the municipality for damages for, inter alia, the amount of student loans or, alternatively, loss of income due to delayed entry into the labour market.

In both cases, the municipality's insurer disputed insurance coverage, alleging that the damage had occurred after the end of the insurance period. In the building permit case, the insurance company argued that the damage occurred when the decision to cancel the building permit gained legal effect, namely in 2012, and further argued that it was at this point that it first became clear that the building had to be demolished, with the resultant economic loss.

In the school case, the insurance company alleged that the damage first occurred in 2012; that is, when the student was granted student loans to supplement his studies or, alternatively, when the student's work income was unrelated to his supplementary studies.

The relevant issue in the Supreme Court was the question of when the damage had occurred, namely whether the damage had occurred during the term of the policy or not. Initially, the Supreme Court stated that damage – with respect to liability insurance – is related to the basis for the claim against the insured. Thus, the occurrence of the alleged damage suffered by the party claiming compensation from the insured should be decisive.

For the Supreme Court, it was clear that an expression such as 'when the damage occurs' may have different meanings in different contexts. Thus, the term had to be subject to interpretation. The Supreme Court made an overall assessment based on the wording of the term, industry practice and the purpose of the term. Moreover, the Supreme Court anticipated that the parties' intention was to achieve fair and reasonable provisions in the policy. Thus, the terms of the policy should be interpreted in a way that implements fair and reasonable provisions.

In summary, the Supreme Court concluded that the damage was covered by the policy. Thus, according to the Supreme Court, it was irrelevant that the damage was only discovered and first confirmed after the end of the insurance period.

vi Termination of insurance contract; Supreme Court Case NJA 2020 Section 115

In this case, the Supreme Court found that the insurance company was liable to the insured, when the insurance company terminated the insurance contract without a solid investigation if there was basis for the termination. The facts were the following. Criminal investigations were initiated against the insured regarding fraud based on alleged untrue information provided to the insurance company concerning a claim under the policy. The insured disputed the allegation of fraud and was at a later stage (i.e., after the termination) found not guilty by competent courts. Moreover, the insurance company did not give the insured any opportunity to provide explanations related to the insured's claim under the policy prior to termination. According to the Supreme Court, the relevant circumstances did not constitute a right for the insurance company to terminate the insurance contract. The termination, including the failure to provide for a solid investigation of relevant facts prior to termination, constituted negligence and the insurance company was considered liable.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The ICA covers the relationship between the insurer and the insured. This is the core piece of legislation related to insurance under Swedish law. The ICA covers both commercial insurance and consumer-related insurance. It covers, inter alia, requirements on the information to be provided by the insurer to the insured, the insurance policy, limitations of insurers' liability, the premium, insurance coverage, adjustment of claims under the policy and third-party rights under the policy.

The ICA contains no provisions covering the interpretation of insurance policies. In fact, there is no legislation covering interpretation of contracts in general in Sweden. In the absence of legislation concerning the interpretation of insurance policies, the principles of

interpretation have instead evolved through legal doctrine and case law. The Supreme Court has created precedents on interpretation regarding, inter alia, exemption of liability clauses in insurance policies.

The Swedish Act on Insurance Distribution (AID) entered into force on 1 October 2018 implementing the EU Insurance Distribution Directive (IDD) into national law. The primary purpose of the IDD is to harmonise the rules for insurance and reinsurance distribution within the EU. The IDD also aims to achieve, when possible, equal competitive conditions and equal customer protection in respect of investments made directly in financial instruments compared to investments in life insurance (i.e., where the insurance premiums are invested in financial instruments). The AID covers mediation of all types of insurance.

The Swedish legislation goes beyond certain EU minimum rules in certain aspects. These include requirements for third-party remuneration and in relation to impartiality, as well as stricter rules on marketing.

The Insurance Business Act establishes the regulatory regime for insurance operations. The Swedish Financial Supervisory Authority (FI) is responsible for supervision, authorisation, sanction assessment, issuance of regulations and reporting matters for the insurance industry. FI has developed regulations based on Swedish legislation. The regulations relate to, inter alia, issues regarding applications for underwriting permits, knowledge and competence requirements, employee compensation systems and requirements related to the adjustment-of-loss process and impartiality. There are also special provisions on distribution of insurance-based investment products and certain kinds of pension insurance.

ii Insurable risk

According to Chapter 6 Section 1 and Chapter 8 Section 18 of the ICA, compensation may be made for any legal interest covered by the insurance.

According to mandatory law, illegal interests will not constitute a basis for entitlement to insurance compensation. Thus, the insurance must not cover loss of income that has arisen illegally. Moreover, the insurance policy cannot cover any payment obligation or loss arising from public sanctions decisions such as fines, environmental sanctions or confiscation of property. However, the insurance policy may provide for, inter alia, coverage of certain kinds of loss suffered by an employer caused by illegal actions by an employee against the employer. Certain kinds of administrative fees, such as GDPR penalties, should probably be considered non-insurable interests, with insurance against these being unavailable. However, according to certain legal doctrine it has been suggested that such administrative fees can be covered by insurance. The issue is not covered by any Swedish case law. Thus, the legal position under Swedish law is not entirely clear in this respect.

Since there are several different and mutually exclusive kinds of Swedish financial sanctions, arguments could be made that the assessment as to whether the costs for a certain financial sanction are insurable or not should be made on a case-by-case basis, taking into account, inter alia, the reasons behind the sanction concerned and the actions of the insured. The parties are free to agree to insure any interest other than that related to pure economic loss, actual damage or personal injury (e.g., insurance against moral damage). Moreover, there is no prohibition against the enrichment of the insured. However, another issue concerns whether the insurance policy should be interpreted as providing coverage that may give rise to such enrichment.

iii Fora and dispute resolution mechanisms

The ICA contains no provisions regarding disputes and litigation. Instead, litigation related to the determination and settlement of insurance indemnities is governed by the procedural rules for civil law cases laid down in the Swedish Code of Judicial Procedure.

The losing party can appeal Swedish court judgments in insurance litigation in the same way as in other civil proceedings. A judgment rendered by the district court (i.e., the court of

first instance) may be appealed to the court of appeal within three weeks of the judgment being rendered. Leave to appeal is a requirement if the case is to be tried on its merits in the court of appeal. Leave to appeal shall be granted if, inter alia, there is reason to believe that the court of appeal would arrive at a different conclusion from the judgment rendered by the district court. There are certain applicable limitations preventing the parties from invoking new facts or evidence in proceedings before the court of appeal.

A judgment rendered by the court of appeal may be appealed to the Supreme Court. Leave to appeal should only be granted if a Supreme Court judgment could provide guidance for similar cases (i.e., if there is a need for a precedent). Thus, the requirements for leave to appeal to the Supreme Court are high and, in practice, the court of appeal is the highest instance in the majority of cases.

An insurance policy may stipulate that disputes between the insurer and the insured shall be settled by arbitration, depending on the kind of insurance in question. In Sweden, mergers and acquisitions (M&A) insurance and reinsurance policies are primarily referred to arbitration. Subrogation disputes (i.e., when the insurer has indemnified the insured and exercises subrogated rights against a third party) are sometimes settled through arbitration. This is often the case in, inter alia, disputes between the insurer and the insured's contractor in the field of construction. As a main principle, an arbitration clause between the insured and a contractor is also applicable to the insurer in a matter of subrogation.

IV THE INTERNATIONAL ARENA

Sweden is a party to the 1980 Rome Convention on the Law Applicable to Contractual Obligations (Rome I). With only some exceptions, Rome I governs all the applicable national law for insurance contracts. According to Rome I, the basic principle is that the law chosen by the parties shall govern a contract. However, Rome I contains some restrictive choice-of-law rules regarding insurance contracts.

Furthermore, Swedish courts normally respect the choice of jurisdiction in an insurance contract. As agreements on applicable law are subject to the provisions in Rome I, agreements on jurisdiction are subject to the provisions in Regulation (EU) 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

Arbitration clauses in insurance policies between insurance companies and consumers are invalid. However, arbitration clauses are legally enforceable in corporate insurance contracts and certain types of group insurance for consumers.

For a foreign judgment to be enforced in Sweden, a treaty on enforcement between Sweden and the foreign state is required. Such treaties exist between, among others, EU and European Free Trade Association Member States. Sweden is a party to the Brussels Regulation, the Brussels Convention and the Lugano Convention.

The main rule according to the Swedish Arbitration Act is that a foreign arbitral award based on an arbitration agreement must be recognised and enforced in Sweden. The Swedish Arbitration Act specifies certain exceptional cases in which enforcement would not be approved. The provisions of the Swedish Arbitration Act conform to the United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958, to which Sweden is a party.

Moreover, the Swedish courts have the right to refuse the application of foreign law in recognising or enforcing a foreign judgment if it would lead to a result that is manifestly incompatible with public policy in Sweden.

V OUTLOOK AND CONCLUSIONS

M&A insurance has increased and is important in certain kinds of M&A transactions. Any disputes under M&A insurance are always settled by arbitration in Sweden.

Moreover, the importance of directors and officers insurance has also increased. There has been a substantial amount of litigation against former board members and auditors in Sweden in connection to, inter alia, withdrawal of banking licences and damage caused by alleged fraud.

The number of professional liability cases also seems to have increased, and these against law firms, among others. In the past, most cases were related to tax advice. Today, one can see an increased number of cases related to M&A advice in particular. This development may continue.

Furthermore, the concept of litigation funding is important and may increase further in the future, which may add to the number of insurance-related disputes.

The importance of cyber insurance has increased significantly over the past few years. This trend will most certainly continue.

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Endnotes

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2 Länsförsäkringar Sak Försäkringsaktiebolag and Others, C-542/16, EU:C:2018:369.
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Chapter 17

United States

Andy Frankel and Summer Craig[1]

Summary

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I INTRODUCTION

US courts recently have addressed a number of significant insurance-related issues, including the scope of a general liability insurer's duty to defend, the availability of business interruption coverage for losses arising out of the novel coronavirus disease (covid-19), the scope of a 'securities claim' in a directors' and officers' (D&O) liability insurance policy, the availability of coverage for ransomware payments, and the application of a war exclusion to losses arising out of a malware attack. Going forward, courts undoubtedly will continue to address the parameters of cyber-related coverage, as well as coverage disputes arising out of covid-19, PFA 'forever chemicals' and climate change events. Insurance-related issues will also continue to be litigated in bankruptcy cases commenced by policyholders as a means to resolve mass tort claims.

II YEAR IN REVIEW

i General liability

Duty to defend

Several courts have addressed duty to defend in the context of lawsuits commenced against policyholders by local governments and other entities to recover alleged losses incurred by plaintiffs in addressing the opioid crisis.

In *Acuity v. Masters Pharmaceutical Inc*,[2] the Ohio Supreme Court ruled that a liability insurer had no duty to defend a pharmaceutical wholesale distributor in underlying opioid-related lawsuits brought by West Virginia cities and counties alleging economic losses caused by the opioid epidemic. The underlying suits alleged that the policyholder failed to monitor and report suspicious opioid pharmaceutical orders which contributed to an epidemic that caused financial harm to the government entities. The Ohio Supreme Court explained that the governments' alleged economic losses, including medical expenses and treatment costs, are not damages 'because of' bodily injury, as required by the policies, because they are not specifically tethered to any particular injury sustained by a person. The Court was not persuaded by the policyholders' argument that the phrase 'because of bodily injury' should be interpreted broadly in favour of triggering the duty to defend.

The Delaware Supreme Court recently decided a similar matter centring on whether damages sought by government plaintiffs in underlying lawsuits for the increased cost of responding to the opioid epidemic were 'for' or 'because of' personal injury. In *Ace American Insurance Company v. Rite Aid Corporation*,[3] the Delaware Supreme Court ruled that insurers were not obligated to defend Rite Aid in underlying opioid-related lawsuits because the suits sought economic damages, not personal injury damages.

Most recently, in *Westfield National Insurance Company v. Quest Pharmaceuticals Inc*,[4] the United States Court of Appeals for the Sixth Circuit affirmed a Kentucky district court holding that insurers had no duty to defend or indemnify a pharmaceutical company in underlying opioid litigation brought by cities and other government agencies alleging misconduct that contributed to a nationwide epidemic of opioid abuse because the claims failed to allege damages 'because of' bodily injury. Addressing this matter of first impression under Kentucky law, the Sixth Circuit concluded that claims seeking compensation for losses incurred by government agencies in addressing the opioid crisis were not damages 'because of' bodily injury. The Court reasoned that 'because of' requires a connection between the damages sought in the underlying suits and particular individual bodily injury, which was not present here. The Court noted that the Supreme Courts of Delaware and Ohio have employed similar reasoning in finding that insurers were not obligated to defend underlying opioid suits.

ii Covid-19 business interruption

Reversal of appellate decision in favour of policyholder

In ***Cajun Conti LLC v. Certain Underwriters at Lloyd's, London***,[5] the Louisiana Supreme Court reversed a rare state appellate court decision in favour of a restaurant owner seeking covid-19 coverage. The Supreme Court reinstated a trial court's judgment in favour of insurers, finding that covid-19 did not cause 'direct physical loss of or damage to' insured property. The court noted that the alleged losses were not 'physical in nature,' as it 'never repaired, rebuilt or replaced any property.' The restaurant owner's case had been the first covid-19 coverage suit to reach trial in February 2021. As discussed in Section V, the Louisiana Supreme Court's ruling joined recent pro-insurer decisions by the high courts of Ohio, Maryland, Connecticut, New Hampshire and Oklahoma. Insurers have prevailed on the merits in the vast majority of trial and appellate decisions.

iii Cyber

Coverage of ransomware payments

Ransomware, a form of malware designed to extort ransom payments from companies or individuals by encrypting data and demanding payment for decryption instructions, has become increasingly common and sophisticated. Courts recently have addressed the scope of coverage for ransomware payments under computer fraud provisions of commercial crime policies.

In *EMOI Services, LLC v. Owners Insurance Company*,[6] the Ohio Supreme Court ruled that a business owner's policy that requires 'direct physical loss of or damage to' property does not cover losses stemming from a ransomware attack. When EMOI was the victim of a ransomware attack, it paid the hacker and then sought coverage from its insurer. The insurer denied coverage, noting that a data compromise endorsement explicitly precluded coverage for ransomware payments and that an electronic equipment endorsement did not apply because it required 'direct physical loss of or damage to' property. The trial court agreed and dismissed the suit, reasoning that there was no physical loss, and additionally, even assuming that EMOI's software was damaged while it was encrypted by the hackers, most system files became fully functional once the ransom payment was made.

An intermediate appellate court reversed, ruling that issues of fact existed as to whether the attack resulted in direct physical loss. The appellate court noted that the electronic equipment endorsement covered 'direct physical loss of or damage to media' and that 'media' was defined as 'materials on which information is recorded such as film, magnetic tape, paper tape, disks, drums, and cards.' The policy further stated that 'media' included 'computer software and reproduction of data contained on covered media.' Viewing the evidence in a light most favourable to EMOI, the appellate court ruled that the company's computer servers may be considered 'media' because they 'constituted materials on which EMOI's information was recorded.' Additionally, the court ruled that EMOI had raised an issue of fact as to whether its software incurred 'direct physical damage' because the record established that portions of the software remained unusable even after decryption.

The Ohio Supreme Court reversed and reinstated the trial court's grant of summary judgment in the insurer's favour. The court held that under the 'clear and unambiguous' language of the electronic equipment endorsement, there must be direct physical loss of or damage to property, which does not include damage to software. Although the term 'computer software' was included within the definition of 'media,' the court explained that it is included only insofar as the software is 'contained on covered media', which means media that has a physical existence. As the court emphasised, all examples of media in the definition of that term are of a physical nature ('film, magnetic tape paper tape, disks, drums, and cards'). The court stated: '[T]he policy requires that there must be direct physical loss or physical damage of the covered media containing the computer software for the software to be covered under the policy.' Because EMOI did not incur damage to its physical media, any loss or damage

to software was not covered. Rejecting the notion that software itself could sustain direct physical loss or damage, the court explained that software is 'essentially nothing more than a set of instructions' and lacks a 'physical existence.'

The war exclusion

In ***Merck & Company, Inc v. Ace American Insurance Company***,[7] an intermediate New Jersey appellate court affirmed a trial court ruling that a war exclusion does not bar coverage for property damage claims arising out of a malware attack known as NotPetya that had infected Merck's global computer network systems. When Merck submitted a notice of loss to its 'all risk' property insurers, they issued reservations of rights, raising a hostile/warlike action exclusion. The insurers noted that a cyber-consultant had concluded that the cyber-attack was 'very likely orchestrated by actors working for or on behalf of the Russian Federation.' The exclusion applied to 'loss or damage caused by hostile or warlike action in time of peace or war, including action in hindering, combating, or defending against an actual, impending, or expected attack: (a) by any government or sovereign power (*de jure* or ***de facto***) or by any authority maintaining or using military, naval or air forces; (b) or by military, naval, or air forces; (c) or by an agent of such government, power, authority or forces[.]' While the insurers conceded that the term 'warlike' might not apply, they contended that 'hostile' encompassed antagonistic actions that reflect ill will or a desire to harm, such as a malware attack by a government actor. The appellate court rejected this contention, reasoning that the plain language of the exclusion 'requires the involvement of military action.'

iv Directors and officers

Securities claim

In ***Verizon Communications v. National Union Fire Insurance Company of Pittsburgh, Pennsylvania***,[8] the Delaware Superior Court held that a bankruptcy trustee's fraudulent transfer suit against Verizon counted as a covered securities claim under the company's D&O policy, requiring Verizon's insurers to cover the company's settlement of claims with the bankruptcy trustee that accused Verizon of luring then-insolvent FairPoint Communications into a 'disastrous' acquisition of Verizon's outdated telephone equipment and infrastructure. The court found that the trustee's suit was 'brought derivatively' on behalf of an entity that was created by Verizon for delivering the outdated assets to FairPoint in a merger, and which qualified as a covered organization under the D&O policy at issue. The court also found the trustee to be a security holder for the Verizon-created entity, which meant that the lawsuit brought by the acquiring company FairPoint was a covered securities claim.

III THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The regulation of insurance in the United States is primarily performed by the states. In 1945, the US Congress passed the McCarran-Ferguson Act,[9] which provides that: 'No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.'[10] Under the McCarran-Ferguson Act, federal law pre-empts state insurance law only if it specifically relates to the business of insurance.

The law of insurance in the United States generally falls into one of two broad categories: the regulation of entities that participate in the business of insurance; and the regulation of the policyholder–insurer relationship. State law pertaining to the regulation of entities generally comprises statutes enacted by state legislatures and administrative regulations issued by state agencies, such as departments of insurance.

Each state also has statutory and common law applicable to the policyholder–insurer relationship. State statutes address a range of topics, including, among others, the disclosure obligations of the parties to an insurance contract, the nature of a policyholder's

notice obligations and the circumstances in which a victim of tortious conduct may sue a tortfeasor's insurer directly. State common law is an important source of law for resolving disputes between policyholder and insurer. Practitioners must carefully assess potentially applicable law at the outset of a dispute, as insurance law (whether common law or statutory) varies by jurisdiction.

ii Insurable risk

In the United States, the validity of an insurance contract ordinarily is premised on the existence of an insurable interest in the subject of the contract. An insurable interest may be defined as any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction or pecuniary damage.[11] The insurable interest doctrine was first adopted by courts,[12] and has since been codified in state statutes.[13] The purpose of the insurable interest requirement, as articulated by courts and commentators, is to discourage wagering and the destruction of life and property and to avoid economic waste.

iii Fora and dispute resolution mechanics

Litigation of insurance disputes

The US judicial system comprises two separate court systems. The United States itself has a system comprising federal courts and each of the 50 states has its own system comprising state courts. Although there are important differences between federal and state courts, they share some key characteristics. Each judicial system has trial courts in which cases are originally filed and tried, a smaller number of intermediate appellate courts that hear appeals from the trial courts and a single appellate court of final review.

Unlike state courts, which include courts of general jurisdiction that can address most kinds of cases, federal courts principally have jurisdiction over two types of civil cases. First, federal courts may hear cases arising out of the US Constitution, federal laws or treaties.[14] Second, federal courts may address cases that fall under the federal 'diversity' statute, which generally authorises courts to hear controversies between citizens of different US states and controversies between citizens of the United States and citizens of a foreign state.[15] For diversity jurisdiction to exist, there must be 'complete' diversity between litigants (i.e., no plaintiff shares a state of citizenship with any defendant) and the amount in controversy must exceed US$75,000.

Most insurance disputes are litigated in the first instance in federal or state trial courts. Federal courts commonly exercise jurisdiction over insurance disputes under the diversity statute. In this context, an insurance company, like any other corporation, is deemed to be a citizen of both the state in which it is incorporated and the state in which it has its principal place of business.

An insurance action that is originally filed in state court may be 'removed' to federal court based on diversity of citizenship of the litigants. In the absence of diversity of citizenship or some other basis of federal court jurisdiction, insurance disputes are litigated in state courts. In some cases, plaintiffs may seek to prevent removal by including a non-diverse party as a defendant. Such tactics may be challenged, for example, if it can be shown that the non-diverse party has no potential liability or if the party was fraudulently joined in order to prevent removal to federal court. The venue is typically determined by the place of injury or residence of the parties, or may be dictated by a forum selection clause in the governing insurance contract. The law applied to the dispute may likewise be dictated by a choice-of-law clause in the insurance contract or, in the absence of such a clause, determined by a court based on relevant choice-of-law principles, which may vary by state and are frequently decided on an issue-by-issue basis.

Arbitration of insurance disputes

Some insurance contracts contain arbitration clauses, which are usually strictly enforced. The Federal Arbitration Act (FAA)[16] and similar state statutes empower courts to enforce arbitration agreements by compelling the parties to arbitrate. If an insurance contract contains a broadly worded arbitration clause, virtually every dispute related to or arising out of the contract typically may be resolved by arbitrators rather than a court of law. One issue that has been a point of contention in matters involving an arbitration clause is whether a non-signatory to the agreement may be compelled to arbitrate a dispute with parties to the agreement. Resolution of this issue frequently turns on whether the non-signatory is deemed to be a third-party beneficiary to the agreement or is equitably estopped from arguing that its status as a non-signatory precludes enforcement of arbitration because it seeks to benefit from other provisions of the agreement.[17]

While all US states recognise the validity and enforceability of arbitration agreements in general, some states have made a statutory exception for arbitration clauses in insurance contracts. Complex legal issues may arise when an insurance contract obligates parties to arbitrate but applicable state statutory law prohibits the arbitration of insurance-related disputes. Although state laws that prohibit arbitration are generally pre-empted by the FAA, by virtue of the Supremacy Clause in the Constitution, state anti-insurance arbitration statutes may be saved from pre-emption by the McCarran-Ferguson Act. As noted, the McCarran-Ferguson Act provides that state laws enacted for the purpose of regulating the business of insurance do not yield to conflicting federal statutes unless a federal statute specifically relates to the business of insurance. Because the FAA does not specifically relate to insurance, courts have held that the FAA may be 'reverse pre-empted' by a state anti-insurance arbitration statute if the state statute has the purpose of regulating the business of insurance.[18] As discussed in Section IV, courts are split regarding whether the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (New York Convention), an international treaty that mandates the enforcement of arbitration agreements, may be reverse pre-empted pursuant to the McCarran-Ferguson Act.

Where an insurance dispute is resolved through arbitration, the resulting award is generally considered to be binding, although there are grounds to vacate or modify an award under the FAA, similar state statutes and the New York Convention. The FAA describes four limited circumstances in which an arbitration award may be vacated by a court:

- where the award was procured by corruption, fraud or undue means;
- where there was evident partiality or corruption in the arbitrators;
- where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or if by any other misbehaviour the rights of any party have been prejudiced; or
- where the arbitrators exceeded their powers or so imperfectly executed them that a mutual, final and definite award upon the subject matter submitted was not made.[19]

One area of legal uncertainty is whether a court may vacate an award based on an arbitrator's 'manifest disregard' of the law. Although the manifest disregard standard is not listed in the FAA, some courts have ruled that an award may be vacated on this basis.

IV THE INTERNATIONAL ARENA

Complex jurisdictional issues may arise when an international insurance contract mandates arbitration of disputes but applicable state law prohibits such arbitration. In these circumstances, courts must address the interplay between governing state law and the New York Convention, which obligates the enforcement of foreign arbitration agreements. More specifically, such disputes require a determination of whether the New York Convention pre-empts state law such that arbitration is required or, conversely, whether state law reverse pre-empts the New York Convention pursuant to the McCarran-Ferguson Act such that disputes may be litigated in a court of law.

The Court of Appeals for the First Circuit recently ruled in *Green Enterprises LLC v. Hiscox Syndicates Ltd.*[20] that a Puerto Rico statute prohibiting mandatory arbitration of insurance disputes does not reverse pre-empt the New York Convention, and thus an arbitration clause in the insurance policy at issue must be enforced. The First Circuit reasoned that the relevant provision of the Convention is 'self-executing', that is, directly enforceable as a domestic law, without the aid of any legislative provision, and, therefore, not an 'Act of Congress' subject to reverse pre-emption under the McCarran-Ferguson Act.

The First Circuit's decision signals a growing consensus among federal circuit courts on this issue. While the Second Circuit has ruled that the Convention is not 'self-executing' and therefore that state law prohibiting arbitration of insurance disputes reverse-preempts the Convention, the Fourth, Fifth and Ninth Circuits have reached contrary conclusions. *Compare Stephens v. Am Int'l Ins Co*[21] with *ESAB Grp Inc v. Zurich Ins PLC*,[22] *McDonnel Grp, LLC v. Great Lakes Ins Se*,[23] *Safety Nat'l Cas Corp v. Certain Underwriters at Lloyd's, London*,[24] and *CLMS Mgmt Servs Ltd P'ship v. Amwins Brokerage of Georgia, LLC*.[25] Notably, the Ninth and First Circuits expressly ruled on the 'self-executing' issue, whereas the Fourth and Fifth Circuits did not reach that issue and instead held that, regardless of whether the Convention is self-executing, the McCarran-Ferguson Act does not apply to international treaties and instead limits reverse pre-emption to the domestic Federal Arbitration Act.

V OUTLOOK AND CONCLUSIONS

i Covid-19

The global spread of the novel coronavirus disease (covid-19) has had major impacts on businesses, financial markets and international commerce, which in turn has led to a flood of suits against insurers for coverage of losses. According to the University of Pennsylvania Carey School of Law Covid Coverage Litigation Tracker, as of the end of August 2023, there were approximately 2,389 covid-19 coverage cases filed in state and federal courts across the US. A central issue in these cases is whether there has been physical damage to insured property. The physical damage requirement is inherent in most business interruption provisions, which insure against a loss of business income caused by covered physical damage to the policyholder's own property. A physical loss requirement is also included in most civil authority provisions, which cover loss of income resulting from restrictions on access to insured premises by a government or civil authority.

Covid-19-related coverage litigation has centred on whether the loss of use of property that has become uninhabitable or unusable because of actual or potential covid-19 contamination constitutes a physical loss for purposes of business interruption coverage. The vast majority of courts, including 11 federal appeals courts and the high courts of 11 states (Connecticut, Iowa, Louisiana, Maryland, Massachusetts, New Hampshire, Ohio, Oklahoma, South Carolina, Washington and Wisconsin), have concluded that claims seeking coverage for covid-19 pandemic-related business losses are outside the scope of insurance coverage. The Vermont Supreme Court is the only state high court to have sided with a policyholder seeking covid-19 coverage.

Those courts to have rejected policyholders' covid-19 claims have ruled that policyholders' inability to use their property for their intended purpose (because of government restrictions on access, capacity, hours or type of service) does not constitute physical loss or damage to property, as required by most property policies. Courts have also ruled that the actual presence of the covid-19 virus on surfaces does not constitute physical loss or damage because the virus does not physically alter the policyholders' premises. Most courts have similarly rejected policyholders' efforts to obtain coverage under civil authority coverage provisions on the basis that there has been no physical loss or damage to property in close proximity to the insured property. A significant number of courts have also ruled that virus or communicable disease exclusions operate to bar coverage for covid-19-related claims, rejecting policyholder assertions that virus exclusions are ambiguous or inapplicable.

While insurers have prevailed on the merits in the vast majority of trial and appellate decisions, leading some policyholders to voluntarily dismiss claims, given the high stakes,

policyholders will be likely to continue to pursue coverage for their covid-19 losses, including via appeals to state high courts. Among the courts poised to weigh in are the high courts of New York, Louisiana, Nevada, Alaska and California.

ii Cyber breaches, data loss and computer fraud

Data breach incidents, cyberattacks and hacking activities designed to obtain financial gain or access to sensitive personal information continue to proliferate at an unprecedented rate. As such, courts undoubtedly will be called upon to address the parameters of both first-party property and third-party liability insurance coverage for myriad cyber-related claims. A growing body of case law is defining the scope of coverage for losses arising out of fraudulently induced wire transfers under computer fraud provisions. In the coming months and years, courts will continue to apply governing state law to decide whether various coverage or exclusionary provisions in general liability and crime policies encompass specific factual scenarios. Additionally, as highlighted and discussed in Section I, courts will continue to address novel questions of law, such as:

- whether cyber-related losses, including damage to software or other computer system components, constitute covered 'property damage' under general liability or first-party policies;
- whether and under what circumstances hackers' intentional taking of sensitive data constitutes a publication of private information sufficient to trigger personal and advertising injury coverage;
- the timing and number of losses or occurrences under applicable policy language; and
- the scope of coverage under D&O policies for cyber-related claims against a company by its shareholders or by regulatory agencies.

Furthermore, the applicability of certain exclusions, including those related to acts of war or terrorism, professional services or disputes based on contract, are likely to take centre stage in emerging cyber-coverage disputes.

Another recent development in this context is the issuance of formal advisories by US federal agencies relating to risks of ransomware payments. Specifically, the US Department of the Treasury's Office of Foreign Assets Control (OFAC) and its Financial Crimes Enforcement Network (FinCEN) concurrently issued formal advisories warning cyber insurance firms and others of the regulatory risks associated with ransomware payments to global bad actors, including certain designated persons and entities on OFAC's specially designated nationals and blocked persons (SDN) list pursuant to cyber-related sanctions implemented by the government. OFAC's advisory reiterates informal guidance, cautioning that, in the absence of a licence, it is a violation of law for a US person or entity to pay or facilitate a ransomware payment to a party on the SDN list, even if it did not know or have reason to know that it was engaging in a transaction of this kind. Relatedly, FinCEN's advisory explains about the regulatory risks for entities that process ransomware payments. These and other advisories serve as a message of caution to insurance companies offering cyber insurance products that reimburse policyholders for ransomware payments to take care in ensuring that those payments do not run afoul of recently enacted regulations.

iii Forever chemicals

Courts have long dealt with the limits of general liability coverage for property damage and bodily injury claims arising out of exposure to various harmful substances, such as asbestos, lead paint particles, carbon monoxide and toxic fumes. In many cases, policyholders have argued that such claims are not excluded from coverage by a pollution exclusion because they do not arise from traditional environmental contamination. An emerging area of litigation is whether claims arising out of exposure to PFA 'forever chemicals' are excluded from coverage by virtue of pollution exclusions.

Thus far, a handful of courts have addressed insurers' coverage obligations for PFA claims against policyholders in the face of pollution exclusions. In two cases, the court granted

insurers' motions to dismiss, concluding that pollution exclusions barred coverage for alleged bodily injuries and property damage arising out of PFA claims as a matter of law. See *Tonoga, Inc v. New Hampshire Ins Co*;[26] *Grange Ins Co v. Cycle-Tex Ins Co*.[27] However, other courts have ruled that insurers are required to defend suits alleging bodily injury and property damage arising out of exposure to PFA chemicals. See *Wolverine World Wide, Inc v. Am Ins Co*;[28] *Colony Ins Co v. Buckeye Fire Equip Co*.[29]

An Ohio federal district court recently declined to exercise jurisdiction over a declaratory judgment action relating to an insurer's duty to defend and indemnify underlying PFA claims. In *Admiral Insurance Company v. Fire-Dex, LLC*,[30] the court explained that resolution of the coverage issues, including application of total pollution exclusions, involved 'novel and unsettled matters of state law' which were best left for a state court forum.

Aside from pollution exclusion clauses, future coverage litigation in this context is likely to implicate other complex questions of fact and law, including issues relating to the date of allegedly covered bodily injury or property damage (see *Crum & Forster Specialty Ins Co v. Chemicals Inc*[31]), questions of causation between PFA exposure and any potential bodily injury, applicability of a 'discharge' requirement in many pollution exclusions for claims that arise out of PFA-containing products as opposed to environmental contamination, and the applicability of intended act exclusions, among other things.

iv Climate change

Climate change is an emerging concern for insurers, based on the increasing frequency of wildfires, storms, floods and other natural disasters. As such, future litigation is likely to implicate the scope of coverage under both first-party property and third-party liability policies for the catastrophic losses – both physical and economic – associated with such natural disaster events.

With respect to first-party policies, disputes may involve interpretation of policy provisions relating to causation, particularly where losses are caused by a complex interaction of perils, such as wind, rain and storm surge. Given that property policies often provide coverage for certain perils while excluding others, future litigation arising from weather-related events are likely to complicate this issue. Indeed, complex issues of interrelated causation frequently took centre stage in prior coverage disputes arising out of Hurricane Katrina and other major storms to impact the United States.

Coverage under third-party policies for damage caused by severe weather events are likely to be a source of litigation in coming years. In this context, a central issue for courts may be whether climate change or greenhouse gas emission claims give rise to a covered occurrence for purposes of liability coverage. The sole US court to address this issue thus far ruled that an insurer had no duty to defend or indemnify a policyholder for underlying nuisance claims relating to carbon dioxide and greenhouse gas emissions. In *AES Corp v. Steadfast Insurance Co*,[32] the court reasoned that the underlying claims did not allege an occurrence because the damage was not accidental, but rather the natural and foreseeable consequence of the policyholder's intentional emissions. Other courts may confront similar coverage claims arising out of policyholders' detrimental contributions to climate change. Outcomes are likely to depend on not only the particular factual scenario presented, but also policy language and applicable law. More specifically, future decisions are likely to turn, in part, on governing law relating to whether conduct may deemed an accidental occurrence if the resulting harm is expected or foreseeable, even if not intended.

Similar coverage disputes may arise in connection with pending cases against oil and gas industry giants, which face civil and regulatory litigation over their alleged role in global warming. Litigation has also been filed against the federal government and various state governments based on the alleged failure to safeguard the environment. To the extent that these defendants seek insurance coverage, complicated issues pertaining to justiciability, fortuity, actual property damage and trigger and allocation of coverage are likely to follow.

v Mass tort bankruptcy

As a consequence of the rapid expansion of mass tort litigation in the US over the past few decades, there has been a substantial increase in the number of companies seeking refuge from such claims under federal bankruptcy laws. Bankruptcy provides a means for a debtor to aggregate all claims against it and emerge as a reorganised entity after resolving its liability. Resolution of mass tort claims within the bankruptcy process has its roots in asbestos litigation. More recently, overwhelming liability caused by other types of mass torts has spawned diverse cases such as the Purdue Pharma opioids bankruptcy, talc bankruptcies (Imerys Talc America, Cyprus Mines and Johnson & Johnson subsidiary LTL Management) and sexual abuse bankruptcies (Boy Scouts of America (BSA), Catholic Church and USA Gymnastics).

When a debtor is the target of significant number of tort claims, the debtor and its tort creditors – normally adverse to one another outside bankruptcy – may seek to jointly propose a bankruptcy plan that aims to facilitate the tort creditors' access to proceeds of the debtor's insurance policies. This issue has arisen in asbestos-driven and other mass tort bankruptcy cases, causing insurers to raise objections to plans of reorganisation or liquidation that insurers regard as threatening to violate their contractual rights.[33] Generally, the rights and obligations of the debtor and its insurers under insurance policies are not altered because of the debtor's Chapter 11 filing,[34] as the filing of a bankruptcy petition does not alter the scope or terms of a debtor's insurance policy;[35] nor does it permit a policyholder to 'obtain greater rights to the proceeds of [an insurance] policy'.[36] The property interests of debtors in bankruptcy and their contractual counterparties are generally created and defined by state law.[37]

Nonetheless, given the efforts of debtors and tort claimants in some cases to accelerate and expand insurers' potential coverage obligations through bankruptcy plans, which give rise to a host of bankruptcy issues and potential coverage defences, careful insurers often scrutinise plans that may appear to override the applicable terms of insurance policies and potentially create rights against insurers that may not otherwise exist. Several bankruptcy plans contain 'insurance neutrality' language purporting to protect state law coverage rights and defences; however, such provisions have not always prevented debtors, bankruptcy trusts or claimants from attempting to seek coverage and override insurers' contractual and common law defences as a result of bankruptcy court rulings.[38]

Coverage disputes may be litigated or resolved consensually during the course of a policyholder's bankruptcy case. When a policyholder files for bankruptcy, its insurers may confront issues regarding the scope of a bankruptcy court's jurisdiction over coverage disputes. The critical determination is whether the dispute is a 'core' proceeding or a 'non-core' proceeding under the federal bankruptcy code. Courts have reached conflicting conclusions on this issue. In addition, where a prior coverage action has been commenced, which raises state law issues that can be timely adjudicated in state court, bankruptcy courts are required to abstain so that the issues can be resolved in the state court forum.[39]

Settlements in the bankruptcy context can take the form of policy 'buybacks', coverage-in-place agreements or other similar structures. In a coverage-in-place settlement, the insurer and the policyholder typically agree on a lump settlement payment for past amounts owed, and establish a formula for payment indemnification or defence costs, or both, moving forward. In a buyback agreement, the insurer pays a lump sum to the policyholder to resolve a coverage dispute – i.e., the insurer effectively buys back the policy from the policyholder and the policy is then cancelled. In one closely watched case, the bankruptcy court overseeing the BSA bankruptcy issued a 274-page ruling confirming aspects of a plan of reorganisation proposed by the BSA to deal with more than 80,000 claims of childhood sexual abuse. See *In re BSA*.[40] The bankruptcy court's ruling touched on a number of insurance-related issues. Among other things, the court approved the creation of a US$2.7 billion settlement trust to be funded by contributions from the BSA, its local councils and charter organisations, and the insurers that settled with the BSA. The plan calls for the settling insurers to make cash contributions to the trust and for the insurers to buy back the insurance policies. The insurers will be released from future liability related to the sex abuse claims in exchange for their contributions to the trust. A group of non-settling insurers opposed confirmation of

the plan, saying that it would impermissibly affect their contractual rights under the policies they issued to the BSA and related entities. Following the bankruptcy court's final order confirming the plan, certain non-settling insurers filed a notice of appeal, as did a relatively small number of abuse claimants who opposed the plan. The bankruptcy court's decision was thereafter affirmed on appeal by the federal district court in a 155-page opinion.[41] The appeal is currently pending in the United States Court of Appeals for the Third Circuit.

In a development that could significantly impact mass tort bankruptcies, the US Supreme Court recently agreed to hear a challenge to the bankruptcy plan in the Purdue Pharma bankruptcy. Faced with criminal charges and thousands of claims alleging that Purdue fuelled the opioid crisis by its sale and marketing of painkiller OxyContin, Purdue filed for bankruptcy protection in 2019. Following extensive mediation, the vast majority of claimants, the debtor, and various third parties agreed to a comprehensive plan that would compensate individual and governmental claimants (such as states and cities that had sued Purdue and related parties) billions of dollars through a trust funded by Purdue and other related parties. Notably, the plan requires the Sackler family, former Purdue shareholders who were also the targets of opioid litigation, to make payment into the trust of approximately US$5.5 billion. Under the Plan, non-debtor parties such as the Sacklers will receive broad releases and injunctive protections in exchange for their contributions to the trust.

Despite overwhelming support for the plan, a small number of objecting parties appealed the confirmation order. Disagreeing with numerous decisions upholding third-party releases of non-debtor parties, the federal district court reversed, finding that such releases are not authorised under the Bankruptcy Code.[42] On 30 May 2023, that decision was reversed by the United States Court of Appeals for the Second Circuit, which held that in appropriate circumstances, bankruptcy courts may approve releases to non-debtor parties facing liabilities arising from the debtor's conduct in exchange for substantial contributions to the debtor's plan.[43] Thereafter, the Solicitor General, on behalf of the United States Trustee, filed an emergency application for a stay in the US Supreme Court, arguing that the Bankruptcy Code does not authorise the releases contained in the plan and that if the plan becomes effective, the doctrine of 'equitable mootness' could eliminate the government's ability to appeal the Second Circuit's decision. The Supreme Court granted the stay and, at the government's suggestion, treated the application as a petition for writ of certiorari, which it also granted. The Supreme Court agreed to hear the case on an expedited basis, and directed the parties to brief and argue '[w]hether the Bankruptcy Code authorizes a court to approve, as part of a plan of reorganization under Chapter 11 of the Bankruptcy Code, a release that extinguishes claims held by nondebtors against nondebtor third parties, without the claimants' consent.'

Although Congress explicitly authorised non-debtor releases and protections in the context of asbestos pursuant to 11 USC Section 524(g), as noted above, bankruptcy filings modelled on Section 524(g) have become common (albeit with varying degrees of success) in other contexts, including not only opioids, but to resolve litigation relating to talc, sex abuse, earplugs, breast implants and other mass torts. These cases typically require funding from non-debtor third parties to be successful, which in turn is usually conditioned on the ability of bankruptcy courts to provide finality to the third parties through releases and injunctive or other forms of bankruptcy court protections. Broadly speaking, proponents argue that bankruptcy courts offer the best and only vehicle to achieve finality by fairly and equitably resolving both present and future claims, and that non-debtor releases and other protections are limited to certain parties that share an identity of interest with the debtor, such as insurers, officers and directors, and past and present corporate affiliates of the debtor, and require significant contributions by such third parties. Critics generally argue that Congress has only authorised such protections in the context of asbestos, and that bankruptcy protections should only be available to parties that file for bankruptcy and are thereby subject to the strictures of the Bankruptcy Code.

The Supreme Court intends to hear argument during the December 2023 argument session, with a ruling likely by summer 2024.

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Endnotes

1 Andy Frankel is a partner and Summer Craig is counsel at Simpson Thacher & Bartlett LLP.
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17 See, e.g., Phila Indem Ins Co v. SMG Holdings, Inc, 257 Cal. Rptr. 3d 775 (Cal. Ct. App. 2019); Wilson v. Willis, 827 S.E.2d 167 (S.C. 2019).
18 See, e.g., Standard Life Ins Co. v. West, 267 F.3d 821, 619–21 (8th Cir. 2001) (Missouri statute's insurance arbitration bar reverse pre-empts FAA pursuant to McCarran-Ferguson Act).
19 9 U.S.C. § 10(a).
20 68 F.4th 662, 676–77 (1st Cir. 2023).
21 66 F.3d 41 (2d Cir. 1995).
22 685 F.3d 376 (4th Cir. 2012).
23 923 F.3d 427 (5th Cir. 2019).
24 587 F.3d 714 (5th Cir. 2009).
25 8 F.4th 1007 (9th Cir. 2021).
26 159 N.Y.S.3d 252 (N.Y. App. Div. 3d Dept. 2022).
27 No. 4:21-CV-147, 2022 WL 18781187 (N.D. Ga. Dec. 5, 2022).
28 No. 1:19-cv-00010, 2021 U.S. Dist. LEXIS 200978 (W.D. Mich. June 15, 2021).
29 No. 3:19-cv-00534, 2020 U.S. Dist. LEXIS 194709 (W.D.N.C. Oct. 19, 2020).
30 No. 1:22-CV-1087, 2022 U.S. Dist. LEXIS 198034 (N.D. Ohio Oct. 31, 2022).
31 No. H-20-3493, 2021 U.S. Dist. LEXIS 146702 (S.D. Tex. Aug. 5, 2021).
32 725 S.E.2d 532, 619–21 (Va. 2012).
33 See, e.g., In re BSA, 642 B.R. 504, 551, 645–58 (Bankr. D. Del. 2022) (discussing insurer's objections to Boy Scouts of America's proposed plan of reorganisation because, among other things, the proposed plan impermissibly sought to modify its insurance contracts).
34 See In re Amatex Corp, 107 B.R. 856, 865-866 (E.D. Pa. 1989), aff'd, 908 F.2d 961 (3d Cir. 1990).
35 In re MF Glob Holdings Ltd, 469 B.R. 177, 193 (Bankr. S.D.N.Y. 2012).
36 In re Denario, 267 B.R. 496, 499 (Bankr. N.D.N.Y. 2001).
37 Butner v. United States, 440 U.S. 48, 51–54 (1979).
38 For a comprehensive illustration of the competing arguments and issues that can arise in such situations, see Fuller-Austin Insulation Co v. Highlands Ins. Co, 38 Cal. Rptr. 3d 716 (Cal. App. 2006).
39 See 28 U.S.C. § 1334(c)(2).
40 642 B.R. 504 (Bankr. D. Del. 2022).
41 Nat'l Union Fire Ins v. BSA (In re BSA), 650 B.R. 87 (D. Del. 2023).
42 In re Purdue Pharma, LP, 635 B.R. 26, 29 (S.D.N.Y. 2021).
43 Purdue Pharma, L.P. v. City of Grande Prairie (In re Pharma LP), 69 F.4th 45, 57 (2d Cir. 2023).