

CHAMBERS GLOBAL PRACTICE GUIDES

Insurance Litigation 2024

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Barney Winckler and Ingrid Hobbs
Kennedys



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Global Practice Guides

Insurance Litigation

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2024

Chambers Global Practice Guides

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INTRODUCTION

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Kennedys is a global law firm with expertise in dispute resolution and advisory services, and over 2,300 people in 24 countries around the world. The firm handles both contentious and non-contentious matters and provides a range of specialist legal services, including corporate and commercial advice, but with a particular focus on defending insurance and liability claims. Defendant claims work is at the heart of Kenne-

dys' practice, and accounts for more than half of the firm's business. This is a global practice with unsurpassed capabilities and expertise that can deal with any type of claim in any country, from high-volume or catastrophic personal injury claims, to settling the largest multibillion-pound property, casualty, financial lines, marine or aviation claims.

Contributing Editors



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Global Overview – Insurance Litigation 2024

In this Chambers guide, insurance litigation includes disputes to which insurers or reinsurers are directly party, such as coverage disputes, as well as disputes in which they are not named but have a financial interest as indemnifiers of one or more parties. Thus, the guide addresses not only laws governing insurance contracts but extends to issues such as how litigation is funded and other relevant aspects of dispute resolution in each jurisdiction which may particularly impact insurers. Arbitration continues to grow in importance due to the widespread use of arbitration clauses in policies, which affords parties privacy and avoids precedents being set. Discussion of case law is therefore unavoidably of limited relevance to what may be a “true picture” of dispute outcomes.

Long-term issues

In recent previous editions of this guide, our overview has noted the ongoing litigation legacy of COVID-19, the rise of “ERG” issues, a rise in substantial employment liability compensation by financial institutions, the long-term rise in cyber exposures and claims inflation. All these trends remain live, with climate litigation in particular likely to be increasingly prominent in the courts in the next few years. We could add to

those the ongoing growth of litigation funding, as potential claimants rely on third parties to bring claims that would otherwise not be viable, often in a group litigation context. The growth of such claims has been marked in the UK (where opt-out claims may be brought in the Competition Appeal Tribunal), notwithstanding the decision in PACCAR Inc and others v Competition Appeal Tribunal, which led to swift amendments to multiple Litigation Funding Agreements to avoid potential enforceability concerns and prospective legislation by the UK government to ensure the continued viability of such funding to protect access to justice. Many businesses may be concerned that such funding can serve to promote costly litigation to the benefit of funders and lawyers where quicker and more cost-effective alternative solutions might be available to provide redress to consumers and others. Litigation funding nevertheless looks set to grow on the basis that it is attractive to certain investors and can be argued to help provide access to justice. This includes in the EU, which in coming years will see the transposition across member states of its Representative Actions Directive. Litigation funding (and forum shopping) look set to grow significantly as a result in at least some member states.

INTRODUCTION

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What next for insurance litigation?

Litigation volumes are often said respond to the overall health of the economy in a countercyclical fashion, with a lag before matters reach court. Pending the next major recession or economic shock, what seems clear is that claims that test the boundaries of the law will grow, often pioneered in the US, testing for example whether social media is “addictive” to the underaged and whether AI tools that scrape colossal amounts of data from the internet infringe copyright or other IP rights. Notwithstanding the close attention insurers give to emerging risks, such litigation has growing potential to test policy coverage in ways that may blindsides them.

Conclusion

As we always emphasise, while we may observe global trends, disputes are usually local and are resolved under widely varying rules that are particular to the forums in which the disputes are heard. We therefore trust that this guide will remain useful to anyone interested in disputes in which insurers have an interest.

AUSTRIA

Law and Practice

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GRAF ISOLA Rechtsanwälte GmbH was founded in 1994, and is one of Austria's leading independent business law firms, with 25 qualified lawyers, and offices in Vienna and Graz. The full-service firm advises on all areas of Austrian and European commercial law and has a client base from all sectors of Austrian and foreign industry and public authorities. The firm is internationally recognised for its diligent approach and efficient, creative and solution-oriented

handling of complex cases. The experienced litigation team focuses on complex litigation in the key areas of insurance and liability (financial loss), with a particular emphasis on insolvency litigation. In this area, the insolvency and litigation teams work together on disputes relating to directors' and officers' liability, auditors' and advisers' liability, capital maintenance and capital substitution rules, and shareholder disputes.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

The most important substantive law is the Insurance Contract Act (VersVG), which essentially regulates the legal relationship between the insurer and the policyholder. The Consumer Protection Act (KSchG) also plays a role, particularly if a consumer is involved in the contractual relationship.

In Austrian procedural law, in addition to the *Jurisdiktionsnorm* (JN), which governs the jurisdiction of courts and the venue of proceedings, there is also the *Zivilprozessordnung* (ZPO). The ZPO regulates the procedural rules for civil litigation before the state courts, outlining the framework for how cases are to be conducted, including the filing of claims, the conduct of trials, and the enforcement of judgments. Together, the JN and ZPO provide the foundational legal structure for determining the competent court and the procedural guidelines for civil litigation in Austria.

In addition to statutory provisions, court decisions from the highest courts or appellate courts must also be considered when evaluating a legal

issue. While Austrian law does not adhere to the principle of *stare decisis* (the Anglo-American doctrine of precedent), lower courts generally follow the rulings and legal interpretations of higher courts in most cases. Although these decisions are not formally binding, they exert significant influence on the judicial process and contribute to legal consistency.

1.2 Litigation Process and Rules on Limitation

Out-of-Court Proceedings and Statute of Limitations

Most insurance disputes begin with an out-of-court claim made by the policyholder or insured party for coverage of a loss or reimbursement of legal representation costs. Unless it involves an association action, this out-of-court claim is typically the starting point.

If the insurer denies the claim following its coverage review, the rejection can take either a “simple” or “qualified” form, as outlined in Section 12 of the Austrian Insurance Contract Act (VersVG). The distinction between the two forms of rejection is critical. In the case of a simple rejection, the claim is subject to a three-year statute of limitations. However, in the case of a qualified

rejection – where specific formalities must be followed – the policyholder or insured party has only one year to file a court action. Failure to initiate legal proceedings within this one-year period results in the claim expiring.

Legal Proceedings

In Austria, the competent court for insurance law matters is determined by the amount in dispute. District courts have jurisdiction over disputes involving amounts up to EUR15,000, while regional courts have jurisdiction over higher amounts.

Local jurisdiction is generally based on the domicile or registered office of the defendant, unless valid jurisdiction or arbitration clauses have been agreed upon in the contract.

Once a judgment has been issued by the court of first instance, it may be appealed to the responsible appellate court. Austria's civil litigation system has three levels of judicial instances. However, appealing to the Supreme Court (third instance) requires specific conditions to be met. A Supreme Court appeal (Revision) is only permitted if the case involves a substantial legal question – whether substantive or procedural – that is critical for maintaining legal consistency, certainty, or development. This may be the case, for example, if the decision of the appellate court differs from the case law of the Supreme Court or if there is a lack of consistent case law on the matter.

1.3 Alternative Dispute Resolution (ADR)

While alternative dispute resolution mechanisms are available in Austria, traditional civil litigation and out-of-court dispute resolution without the involvement of professional mediators remain the norm in insurance disputes.

Arbitration proceedings are relatively rare in Austria and occur only in specific areas, such as reinsurance law or warranty and indemnity (W&I) insurance.

In the consumer sector, arbitration clauses are only valid if agreed upon after a dispute has arisen. Although alternative dispute resolution options are available, they play a relatively minor role in practice. Consumers can, in certain cases, seek recourse through dispute resolution bodies, but their use remains limited. Two notable examples are the “Legal Service and Arbitration Board of the Professional Association of Insurance Brokers and Consultants in Insurance Matters (RSS)” and the state-recognised “*Verbraucherschlichtung Austria*” for consumer mediation.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Regulation No 1215/2012 (Brussels Ia Regulation) applies across the European Union, including Austria, and governs the question of jurisdiction in cross-border insurance disputes. Articles 10–16 of the regulation set out specific rules for determining jurisdiction in such cases. Insurers may be sued in the courts of the member state where (i) the insurer is domiciled, (ii) the policyholder (as the plaintiff) is domiciled, or (iii) (in the case of co-insurance) where the lead insurer is sued. If the insurer does not have a registered office in any member state, it may be sued in the member state where it has a branch, agency, or other establishment. On the other hand, an insured party can only be sued in the member state where they are domiciled.

The Rome I Regulation (Regulation (EC) No 593/2008) serves as the substantive counterpart

to the Brussels Ia Regulation, governing the law applicable to cross-border contractual obligations. As a general rule, under Article 3(1) of the Rome I Regulation, the contract is subject to the law chosen by the parties. However, this freedom of choice is restricted in many insurance contracts by Article 7(3) of the Rome I Regulation. In cases where no law has been chosen, the contract is governed by the law of the member state in which the risk was located at the time the contract was concluded.

Insurance relationships and disputes that do not fall within the scope of the Brussels Ia or Rome I Regulations are governed by Austria's national rules on international jurisdiction and applicable law, particularly those found in the *Jurisdiktionsnorm* (JN) and the Act on Private International Law (IPR Act).

2.2 Enforcement of Foreign Judgments

In Austria, foreign court decisions can be enforced, but the process varies depending on whether the judgment originates from a court in an EU member state or a third country. The primary legal framework governing the enforcement of foreign judgments in Austria is the Austrian Enforcement Code (EO).

Judgments from courts of EU member states are automatically recognised across the EU under the Brussels Ia Regulation (Article 36(1)). Consequently, no separate recognition procedure is required. The prevailing party only needs to obtain a certificate pursuant to Article 53 of EU Regulation 1215/2015 (enforcement confirmation) to initiate enforcement proceedings within the European Union. Additionally, courts in the state where enforcement is sought are prohibited (Article 5, Brussels Ia Regulation) from reassessing a judgment issued in another member state. However, certain grounds for refusal, as

outlined in Articles 45 et seq of the Brussels Ia Regulation, may still prevent recognition or enforcement.

For judgments from Switzerland, Norway, and Iceland, the Lugano Convention provides the relevant provisions, mirroring the Brussels Ia Regulation's rules on jurisdiction, recognition, and enforcement within these countries and the EU.

The enforceability of judgments from third countries is determined either by applicable bilateral or multilateral agreements or by the Austrian Enforcement Code. In the absence of such agreements, an exequatur procedure must be conducted to determine enforceability. Once a judgment has been declared enforceable through this procedure, enforcement proceedings can be brought before the competent enforcement court.

2.3 Unique Features of Litigation Procedure

In Austria, civil proceedings do not include a phase equivalent to the "discovery phase" found in some other legal systems. As a result, the outcome of a case heavily depends on the parties' submissions and the evidence they present. Austrian law has specific rules on the burden of proof, which determine which party must provide evidence to support a claim. If a relevant document is in the possession of the opposing party, the other party may, under certain conditions, request that it be produced.

A notable feature of Austrian civil proceedings is that evidentiary proceedings can be initiated and completed during the first hearing (preparatory hearing), allowing for a judgment to be issued at or shortly after this initial hearing. In more complex cases, particularly those involving expert witnesses, it is very unlikely that the case will be

closed at the first hearing. However, it is advisable for parties to present all submissions and relevant evidence by the first hearing, or at the latest, during this hearing.

In out-of-court dispute resolution, parties should also be aware of the requirement to pay a fee to the Austrian state if a settlement is reached. This fee ranges from 1% to 2% of the total settlement value, depending on whether the dispute is already pending in court. This can result in significant additional costs, especially in cases involving large claims.

Furthermore, German insurance law has had a substantial impact on Austrian insurance law, given that the Austrian Insurance Contract Act (VersVG), which came into force in 1959, is largely based on the German Insurance Contract Act of 1908. Despite numerous amendments, German case law continues to influence the Austrian insurance landscape. Consequently, many German insurers operating in Austria often use German insurance terms and conditions in their contracts with Austrian policyholders, frequently without significant adaptation to Austrian legal conditions.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

When the parties have validly agreed to resolve their dispute through arbitration, the ordinary court will typically declare that it has no jurisdiction, requiring the parties to submit their case to an arbitral tribunal as stipulated in the arbitration clause. The legal framework for arbitration is outlined in Sections 577 et seq of the Austrian Code of Civil Procedure (ZPO).

It is important to note that, under the Code of Civil Procedure, only disputes arising from or potentially arising in the future from a specific legal relationship can be subject to arbitration. Additionally, all relevant formal requirements must be met, and the dispute must involve a claim that is arbitrable.

For third countries such as Switzerland, Norway, and Iceland, the Lugano Convention provides analogous rules regarding arbitration.

In consumer matters, however, arbitration agreements can only be validly concluded between an entrepreneur and a consumer if the dispute has already arisen.

3.2 The New York Convention

Austria's accession to the New York Convention in 1961 is still in force today. Consequently, Austria recognises and enforces arbitral awards under the New York Convention, unless one of the grounds for refusal outlined in Article V of the Convention applies (the provisions of the Austrian Enforcement Code apply to the recognition and declaration of enforceability only to the extent that international law or EU regulations do not provide otherwise, see Section 614 (1) of the ZPO).

For arbitral awards rendered outside of Austria, the award must first be formally recognised and declared enforceable by the district court responsible for enforcement, in accordance with the New York Convention or other relevant multilateral or bilateral treaties. Once the foreign arbitral award has been declared enforceable, it is treated as a domestic arbitral award and thus has the same status as a judgment of an Austrian court.

In the interest of procedural efficiency, an application for the declaration of enforceability may be combined with a request for an enforcement order, allowing the competent court to decide on both applications simultaneously.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration in Insurance Disputes

Arbitration plays almost no role in “mass insurance” in Austria. This is largely due to the prohibition of arbitration clauses in consumer contracts before a dispute has arisen, which affects agreements between insurers and consumers. Moreover, even in insurance contracts with entrepreneurs, arbitration clauses are rare. As a result, disputes arising from insurance contracts are typically resolved in the ordinary courts.

In contrast, arbitration clauses are commonly included in international reinsurance contracts. They are also frequently found in W&I insurance agreements. However, these contracts are relatively few compared to the vast number of insurance contracts in the mass market.

Applicable Rules and Confidentiality

Sections 577–616 of the Austrian Code of Civil Procedure govern arbitration proceedings when the seat of the arbitral tribunal is in Austria. Nevertheless, the parties are free to submit their disputes to an institutional arbitration court. In Austria, the Vienna International Arbitral Centre (VIAC), established by the Austrian Federal Economic Chamber in 1975, is a prominent institution, and it operates under its own set of rules known as the “Vienna Rules”.

Arbitration proceedings are generally not open to the public. While the parties could theoretically agree to make the proceedings public, this is rare in practice.

Appeals Against Arbitration Awards

In Austria, arbitration awards cannot be challenged through ordinary legal remedies. The only way to challenge an arbitration award is by filing an action for annulment under Section 611 of the ZPO. The grounds for setting aside an award, as outlined in Section 611 of the ZPO, are exhaustive and cannot be expanded. The Supreme Court serves as both the first and final instance in such cases. Any action for annulment must be filed within three months of the service of the arbitration award.

Possible grounds for termination are the following:

- a valid arbitration agreement does not exist, or the arbitral tribunal has denied its jurisdiction despite the existence of a valid arbitration;
- agreement, or a party was under an incapacity to conclude a valid arbitration agreement under the law governing its personal status;
- a party was not given proper notice of the appointment of an arbitrator or of the arbitral proceedings or was for other reasons unable to present its case;
- the award deals with a dispute not covered by the arbitration agreement, or contains decisions on matters beyond the scope of the arbitration agreement or the plea of the parties for legal protection – if the default concerns only a part of the award that can be separated, only that part of the award shall be set aside;
- the composition or constitution of the arbitral tribunal was not in accordance with a provision of this Chapter or with an admissible agreement of the parties;
- the arbitral proceedings were conducted in a manner that conflicts with the fundamental

- values of the Austrian legal system (ordre public);
- the requirements according to which a court judgment can be appealed by an action for revision under Section 530, paragraph (1), numbers 1 to 5 have been met;
- the subject-matter of the dispute is not arbitrable under Austrian law; or
- the arbitral award conflicts with the fundamental values of the Austrian legal system (ordre public).

4. Coverage Disputes

4.1 Implied Terms

In Austria, the principle of freedom of contract generally applies, allowing parties considerable flexibility in drafting their contracts. However, this freedom is subject to certain limitations in the insurance sector, particularly under the Austrian Insurance Contract Act (VersVG) and, for consumer contracts, the Consumer Protection Act (KSchG).

The VersVG establishes the legal framework for insurance contracts, containing both discretionary provisions and others that are either absolutely mandatory or unilaterally mandatory in favour of the policyholder. Due to these unilaterally mandatory provisions, policyholders can negotiate terms with insurers that are more favourable than those provided by law.

While the Consumer Protection Act does not prescribe specific clauses in insurance contracts, it does prohibit certain clauses entirely or requires their negotiation in detail. The KSchG also ensures that contracts adhere to principles of fairness and transparency.

Although there is no statutory regulation of the principle of good faith (bona fide) in insurance law, the insurance relationship between the policyholder and the insurer is to a large extent governed by the principle of good faith according to case law. The principle of good faith requires both parties to act in good faith and not to deceive or withhold material information from the other party.

4.2 Rights of Insurers

Under Section 16 of the Insurance Contract Act (VersVG), insurers are protected under certain conditions if a policyholder conceals or misrepresents material facts when concluding the contract. Material circumstances refer to those factors that are likely to influence the insurer's decision to either enter into the contract or determine the terms under which the contract is concluded. If a policyholder fails to disclose or misrepresents such a circumstance, the insurer may have the right to withdraw from the contract.

If the insurer has specifically asked written questions regarding material circumstances, the failure to disclose information that was not explicitly asked about will only justify withdrawal if it was fraudulently concealed.

The information that insurers generally require before underwriting varies, but typically focuses on information relating to past or current claims against the policyholder, the policyholder's financial position and knowledge of potential risks.

4.3 Significant Trends in Policy Coverage Disputes

Identifying trends in insurance disputes is challenging due to the lack of official statistics. However, some observable patterns have emerged.

Disputes related to business interruption insurance stemming from the COVID-19 pandemic, which significantly impacted the insurance landscape in recent years, have been steadily declining.

Looking ahead, the growing digitalisation and the increasing use of AI tools are expected to bring cyber-insurance disputes into greater focus, a trend that has already been evident for some time. This increase is driven by the rising frequency of cyber-attacks and the fact that nearly half of all companies now have cyber-insurance, according to recent studies. At present, however, current research indicates that the majority of claims arising from cyber-attacks still relate to first-party losses rather than third-party liability.

There has also been an increase in disputes involving Directors and Officers (D&O) insurance. The COVID-19 pandemic and the Ukraine crisis have led to a rise in corporate insolvencies, with managing directors increasingly facing liability claims.

4.4 Resolution of Insurance Coverage Disputes

A significant number of insurance disputes can often be resolved out of court once policyholders receive a clear and understandable explanation of why their claim is not covered (eg, due to a breach of policy obligations or the exclusion of certain risks from coverage).

When an out-of-court agreement cannot be reached, coverage disputes are typically resolved in the ordinary courts. There are no special procedural rules for these cases; they are governed by the general provisions of the Austrian Code of Civil Procedure (ZPO). Such proceedings are usually handled by the commercial courts. In Vienna, due to the high volume of commercial disputes, a dedicated district court for commercial matters and a commercial

court have been established. In the other federal states, commercial jurisdiction is handled by the district and regional courts.

Disputes between insurance companies and their reinsurers are frequently resolved through settlements. If an amicable agreement is not possible, these disputes are generally adjudicated by arbitration tribunals rather than ordinary courts.

4.5 Position If Insured Party Is Viewed as a Consumer

If the policyholder is a consumer, in addition to traditional dispute resolution methods, they also have the option to appeal to an alternative dispute resolution board. For instance, as mentioned in **1.3 Alternative Dispute Resolution (ADR)**, consumers can seek assistance from the “Legal Service and Arbitration Board of the Professional Association of Insurance Brokers and Consultants in Insurance Matters – RSS” or the state-recognised “*Verbraucherschlichtung Austria*”.

If these alternative dispute resolution mechanisms do not lead to a resolution, the claims can still be pursued in court. However, it is important to note that a consumer can only be sued in the court of their place of residence. Additionally, arbitration agreements between an insurer and a consumer are only valid if made after the legal dispute has arisen.

4.6 Third-Party Enforcement of Insurance Contracts

As a general rule, third parties who are not policyholders and therefore not contractual partners cannot assert claims against the insurer under the insurance contract.

However, there are notable exceptions. For instance, individuals who are not parties to the

contract but are designated as “insured persons” within the policy may assert claims directly against the insurer. Additionally, in the case of motor vehicle liability insurance, an injured party in an accident may pursue damages not only from the responsible driver but also from the driver’s motor vehicle liability insurer. Similarly, patients may bring claims against a hospital’s liability insurer in cases of medical malpractice according to the Austrian Supreme Court.

If insolvency proceedings are initiated against the policyholder’s assets, injured third parties do not have a direct right of action against the insurer. However, they may seek separate satisfaction from the policyholder’s compensation claim, thereby obtaining a right to distinct recovery.

4.7 The Concept of Bad Faith

Austrian law acknowledges the concept of good faith and bad faith, which is reflected in various legal contexts. Although this principle is not explicitly codified in insurance law, it is deeply embedded in the legal framework governing the relationship between insurer and policyholder, largely as a result of established case law. As a result, neither party may act in bad faith by misleading the other about material facts. Should bad faith occur, the affected party retains the right to challenge or contest the contract.

4.8 Penalties for Late Payment of Claims

Austrian insurance law generally does not prescribe specific penalties for insurers in the event of delayed claim payments. However, under Section 11 of the Austrian Insurance Contract Act (VersVG), cash payments by the insurer become due once the analysis to establish the insured event and the extent of the insurer’s liability have been completed. If the insurer unjustifiably delays payment, the policyholder is entitled to claim statutory or contractual interest on the overdue

amount. Any agreement exempting the insurer from paying interest on late payments is invalid.

If there is a persistent or systematic delay in the payment of insurance benefits, then this may be a trigger for regulatory action as it may be an indication of potential solvency problems.

4.9 Representations Made by Brokers

When policyholders engage and authorise an insurance broker, they assume the risk that the broker may make inaccurate statements to the insurer or fails to properly fulfil the mandate. Consequently, the policyholder is held accountable for the broker’s actions or omissions.

If the policyholder incurs a loss due to the broker’s negligent behaviour, they may seek compensation from the broker. In such cases, the broker’s liability insurance should ideally cover the resulting damages.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In Austria, it is common for individuals or companies to be authorised to sign insurance policies, a role referred to as insurance agents. These agents are permanently entrusted by an insurance company to either broker or finalise insurance contracts. It is possible for them to represent multiple insurers, even if the products they offer are in direct competition.

A specific type of insurance agent is the underwriting agent, who typically receives broad authority from insurance companies. Underwriting agents are often empowered to negotiate terms and pricing, collect premiums, and handle claims. They generally operate in specialised sectors, such as transportation and logistics, rather than in the mass insurance market, where their expert knowledge is particularly valuable.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

One of the key areas where insurers cover the costs of defending claims is liability insurance. This includes claims related to professional, business, motor vehicle, managerial, and product liability. Coverage applies only to insured risks, provided that the policyholder has not triggered an exclusion clause. Generally, all court and out-of-court expenses that are necessary and reasonable for effective legal defence are reimbursed.

Another important area is legal expenses insurance, where the insurer protects the policyholder's legal interests and covers the costs of both court proceedings and pre-litigation advice. These costs are covered regardless of whether the policyholder is the plaintiff or defendant in the proceedings.

5.2 Likely Changes in the Future

No changes are to be expected with regard to the financing of the policyholder's defence costs.

5.3 Trends in the Cost or Complexity of Litigation

Court proceedings have generally become both more expensive and more complex in recent years. Costs have risen due to periodic adjustments in lawyers' tariffs and court costs, which are aligned with inflation, as well as increasing hourly rates for legal services. The growing complexity of cases also leads to longer proceedings, driving up costs further. Moreover, with the rise of digitalisation, there is often a significant increase in the volume of evidence, requiring more time and effort to review, adding to the overall expense and complexity of litigation.

5.4 Protection Against Costs Risks

One option for mitigating the financial risks associated with legal proceedings is legal expenses insurance. This type of insurance covers court costs, expert fees, and lawyer's fees (to the extent they are billed according to statutory rates rather than hourly rates). If the case is lost, the insurance also covers the opposing party's legal costs, which the losing party may be required to reimburse.

Another option for additional protection against cost risk is to engage a litigation financier. The extent of their financial contribution depends on the specific agreement, but litigation financiers in Austria typically only accept individual cases with a significant amount in dispute, as smaller cases are not considered financially viable.

However, when relying on legal expenses insurance or a litigation financier, it is important to recognise that these entities will often have considerable influence over the management of the case, given that they bear the financial risk.

In the realm of criminal law, cost protection can be obtained through criminal law insurance. Historically, Austrian law provided for very limited reimbursement of legal costs in criminal proceedings, even in the event of acquittal, leaving defendants "alone" with their defence costs. Although recent reforms have increased reimbursement amounts based on the type of court, these amounts still often fall short of covering the full costs of a criminal defence.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Under Austrian law, if a third party is responsible for the damage suffered by the policyholder

and the insurer has settled the claim, the policyholder's right to pursue damages against the responsible party is automatically transferred to the insurer. The extent of this transfer depends on the amount of the damage covered by the insurer. If the insurer settles the entire claim, the full right to recover damages is transferred to them; if only a portion of the damage is covered, the transfer is proportional to the amount settled.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

This principle (see 6.1 Right of Action to Recover Sums From Third Parties), is codified in Section 67 of the Austrian Insurance Contract Act (VersVG). Following the transfer of the claim, the insurer becomes the rightful holder of the claim. As such, the insurer can pursue legal action against the responsible party in its own name and seek compensation directly from them.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

One of the key factors shaping the insurance market and influencing related court cases is the rise of cyber-insurance, driven by the increasing digitalisation of businesses.

Additionally, the frequency of natural disasters, such as flooding in Austria due to climate change, is likely to lead to more disputes over coverage and the extent of insurance benefits in the future.

The ongoing impacts of the war in Ukraine, including the energy crisis, disrupted supply chains, and temporary raw material shortages, are also contributing to a rise in corporate insolvencies. This trend is evident in the insolvency statistics for the first half of 2024, which show a

26% increase compared to 2023. As insolvency administrators scrutinise the actions and potential mismanagement of directors, an increase in related lawsuits is to be expected. These lawsuits may involve Directors and Officers (D&O) insurance and/or criminal liability insurance.

7.2 Forecast for the Next 12 Months

The risks outlined in 7.1 Type and Amount of Litigation are likely to remain significant in the future. The unpredictable impacts of climate change, coupled with the growing risks associated with digitalisation – such as data breaches, cyber-attacks, and server failures – will continue to challenge the insurance industry and drive related disputes.

7.3 Coverage Issues and Test Cases

Due to the ongoing war in Ukraine, sanctions against Russia are frequently extended, affecting various aspects of insurance, including coverage and benefits. Insurance companies must regularly verify whether individuals or entities involved are subject to sanctions to avoid potential criminal liability when paying out benefits. Consequently, insurers will increasingly need to conduct thorough sanction checks to effectively implement any relevant sanction clauses.

While much attention has recently been focused on COVID-19-related cases interpreting business interruption policies, the Austrian Supreme Court has recently addressed issues raised by the Austrian Consumer Association concerning certain legal expenses insurance clauses. These include the applicability of catastrophe exclusions and the lack of transparency surrounding the term “exceptional circumstances”.

7.4 Scope of Insurance Cover and Appetite for Risk

The war in Ukraine has significantly impacted coverage and risk appetite across various lines

of business, particularly in political risk insurance. As a result, premiums in these areas are widely anticipated to rise.

In the realm of cyber-insurance, the implementation of higher retention levels and risk mitigation measures has led to a greater willingness to assume risk. However, this shift has also resulted in increased obligations for policyholders in the cyber-insurance sector.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

In Austria, ESG (environmental, social and governance) factors are increasingly shaping both underwriting practices and insurance litigation. Insurers are integrating ESG criteria into their underwriting processes, favouring companies with robust ESG practices. Consequently, there is a growing number of ESG-related claims, including those related to environmental liability and corporate governance failures. Additionally, potential claims may arise from “greenwashing” lawsuits, where companies face legal action from investors for making unsubstantiated or misleading ESG claims, or for failing to meet their net-zero commitments.

8.2 Data Protection Laws

Data protection regulations in Austria are primarily governed by the General Data Protection Regulation (GDPR) and the Austrian Data Protection Act (DSG). Additionally, Sections 11a et seq of the Insurance Contract Act (VersVG) provide specific provisions for insurers regarding the management of health data.

Data protection laws frequently lead to Directors and Officers (D&O) claims following cyber-incidents, particularly when management is alleged to have failed in implementing sufficient data protection measures. Consequently, D&O losses related to data breaches are becoming an increasing concern for insurers.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

In January 2023, the European Union adopted a new version of the Network and Information Security Directive (NIS2). EU member states are required to transpose NIS2 into national law by 17 October 2024.

The updated directive introduces enhanced risk management requirements and extends its coverage to additional sectors to bolster cybersecurity across the EU.

As of now, NIS2 has not been incorporated into Austrian law. The proposed legislation, known as the “Network and Information System Security Act 2024” (NISG 2024), failed to reach the necessary majority in the National Council in July 2024. Consequently, further negotiations will be required, and it is uncertain when the new legislation will come into effect.

Once enacted, the NISG 2024 may give rise to disputes related to breaches of duty by directors and officers. Notably, Article 21, paragraph 1 of the NIS2 Directive also stipulates personal liability for directors in this context.

BERMUDA



Law and Practice

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Carey Olsen is a leading offshore law firm, advising on the laws of Bermuda, the British Virgin Islands, the Cayman Islands, Guernsey and Jersey from a network of nine international offices. The Bermuda office comprises nine partners and over 30 other lawyers and fee earners. Since it opened in 2017, it has established itself as a leading law firm on the island and internationally. Several of its lawyers previously worked in the insurance and reinsurance departments

of other international law firms and are on the boards of insurance companies. This brings a practical, commercial dimension to the team's experience and advice. The firm is recognised by Chambers Global as a top-tier firm for many of its practice areas. It advises several businesses in Bermuda and leading international organisations from North America, Europe and Asia, including some of the largest global insurance and reinsurance companies.

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CAREY OLSEN

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Bermuda is a British Overseas Territory. The modern legal system of Bermuda is established by the Bermuda Constitution Order 1968, an Order in Council of the United Kingdom that established the Supreme Court as the primary court of first instance and the Court of Appeal as the court with jurisdiction to hear appeals from judgments of the Supreme Court. The Appeals Act 1911 further establishes a right of appeal from any judgment of the Court of Appeal to the Judicial Committee of the Privy Council in London. This ultimate right of appeal to the Privy Council, along with the common law, is one factor that has made Bermuda an attractive jurisdiction for insurers.

Bermuda's legal system is largely based on English common law. The Supreme Court Act 1905 further establishes that (subject to the provisions of any acts of the Bermuda legislature) the common law, the doctrines of equity and the Acts of the Parliament of England of general application that were in force in England at the date when Bermuda was settled on 11 July 1612 have force within Bermuda.

Insurance disputes that are litigated in the Bermuda courts are generally heard by the Commercial Court, which is one of the five divisions of the Supreme Court. The same procedural regime that governs all commercial litigation governs insurance disputes in the courts, which is contained in the Rules of the Supreme Court 1985 (1985 Rules).

The primary statute governing insurance-related activities in Bermuda is the Insurance Act 1978 (Insurance Act); insurance and reinsurance com-

panies are also subject to the provisions of the Companies Act 1981.

1.2 Litigation Process and Rules on Limitation

Litigation Process

The Supreme Court possesses and exercises the jurisdictions of the court of general assize, the court of chancery, the court of exchequer, the court of probate, the court of ordinary and the court of bankruptcy. There is also a Commercial Court, which deals exclusively with commercial (including insurance) and arbitration-related matters.

Appeals are common in Bermuda. The Court of Appeal has five Justices of Appeal, with the current President being Sir Christopher Clarke. Appeals are typically heard by three Justices. The Court of Appeal sits for three sessions of around a month per year.

Trials are conducted using the adversarial model between plaintiffs and defendants, with barristers making both oral and written submissions on their behalf. Bermuda has a fused legal profession and Bermuda litigators are both barristers and attorneys, although in special circumstances English King's Counsel are admitted to the Bermuda Bar.

Civil proceedings in the Supreme Court may be begun by writ, originating summons, originating motion or petition. The 1985 Rules prescribe which originating process to use on the basis of the facts and circumstances of the case.

A typical civil action is commenced by filing a generally endorsed writ of summons, naming the parties to the action and providing very brief details of the relief sought. If the defendant defends the claim, then a generally endorsed

writ must be supplemented by a statement of claim with the facts upon which the action is founded.

The party bringing the action is responsible for service. When a company is the defendant, a copy of the proceedings will be properly served if it is left at the registered office of the company in Bermuda. With respect to parties outside of the jurisdiction, the Supreme Court can be asked to make an order for service outside of the jurisdiction if the criteria in Order 11, Rules 1 and 2 of the 1985 Rules are met. A defendant who fails to respond as required under the 1985 Rules can have a default judgment entered against them.

Following the originating process to commence proceedings, the litigation process will move through the steps of interim applications, discovery and trial, closing with judgment.

Rules on Limitation

The Limitation Act 1984 sets out the applicable limitation periods. The majority of claims are subject to a limitation period of six years, which applies to claims for breach of a contract and in tort. A 20-year limitation period applies where the claim is based on a contract under seal or concerns the recovery of land and the proceeds of the sale of land or monies secured by a mortgage or a charge.

In contract law, the limitation period typically runs from the date on which the contract was breached. For a tort, the limitation period commences on the date the damage occurred. The Limitation Act 1984 makes provision for latent defects, as well as for cases where the cause of action could not, with reasonable investigation, have been discovered sooner.

Limitation is not an automatic bar to an action or recovery under it. A defendant must raise the Limitation Act 1984 as a defence and specifically plead the same.

1.3 Alternative Dispute Resolution (ADR)

Arbitration and mediation are the most common forms of ADR in Bermuda, which is a sophisticated hub for international arbitration of complex insurance and reinsurance disputes and has incorporated the UNCITRAL Model law into its domestic legislation via the Bermuda International Conciliation and Arbitration Act 1993. A branch of the Chartered Institute of Arbitrators was established in Bermuda in 1996, the primary function of which is to run arbitration training courses and to act as an appointing authority when asked to do so.

The court has repeatedly confirmed in judgments relating to the enforcement of arbitration agreements and awards that it will adopt a pro-enforcement stance on such matters, in keeping with Bermuda's obligations under the New York Convention (which has had the force of law in Bermuda since 1979).

The use of ADR is not mandated under the 1985 Rules, but that fact has not prevented the growth of its popularity and use, particularly mediation. The Supreme Court can impose costs consequences on a party where it has refused to engage in ADR and such refusal proves to be unreasonable. The Bermuda branch of the Chartered Institute of Arbitrators has localised procedural rules for mediation and arbitration, which are based on the UNCITRAL Rules.

Insurance and reinsurance contracts very often incorporate arbitration agreements, and confidential arbitration is the most common means of resolving insurance disputes in Bermuda.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes Choice of Law

Bermuda's conflict of laws rules regarding determining the choice of law in contract are the same as the "old" English common law rules. They were unaffected by the legislation binding the United Kingdom during its membership of the European Union, which was not applicable in Bermuda (for example, the Rome I Regulation).

If the parties to a contract choose a particular law to govern the contract, effect will generally be given to that choice. In the absence of an express choice of law, the court will seek to identify either:

- an implied or inferred choice discerned from the surrounding circumstances; or
- the system of law with which the alleged contract has its closest connection.

It is common for parties to Bermuda insurance and reinsurance contracts to select Bermuda law to govern the contract.

The only statutory provision that limits the parties' freedom to select the governing law of a contract is Section 11(2) of the Segregated Accounts Companies Act 2000, which provides that the governing instruments in relation to segregated accounts are deemed to be governed by Bermuda law.

For tort claims, the Bermuda court first considers where the tort was committed in substance. For torts committed outside of Bermuda, the court applies the double-actionability rule: the tort must be actionable under both the *lex fori* and *lex loci delicti*.

Jurisdiction

In general, when determining whether or not a proposed defendant is subject to its jurisdiction, the Bermuda court will consider whether the proposed defendant can be validly served within the Islands of Bermuda or whether a defendant has submitted, or has agreed to submit, to the jurisdiction of the Bermuda courts (for example, by contract or by taking steps in the litigation proceedings in Bermuda). If the proposed defendant has a foreign address, the plaintiff must obtain leave to serve the proposed defendant out of the jurisdiction, pursuant to Order 11 of the 1985 Rules.

However, the External Companies (Jurisdiction in Actions) Act 1885 permits a foreign company doing insurance business in Bermuda by an agent or branch to be sued in the name under which they carry on business in Bermuda. It further provides that service of process on the agent or manager of the company in Bermuda is good service, without the need for leave.

2.2 Enforcement of Foreign Judgments

Foreign money judgments can be enforced by or against insurers in Bermuda, either under the Judgments (Reciprocal Enforcement) Act 1958 (1958 Act) or under common law principles, provided that certain conditions are met. The method of enforcement is therefore dependent on the jurisdiction in which the judgment was given.

The 1958 Act allows money judgments (including arbitration awards that would be enforceable as judgments in the United Kingdom) from the superior courts of the United Kingdom (along with certain Commonwealth countries and overseas territories to which the Governor has declared the 1958 Act applies) to be enforced by registration of the judgment in the Supreme Court at any time within six years after the date

of the judgment. The judgment must be final and conclusive, and the sum must not be in respect of taxes, fines or penalties.

A foreign judgment from a country not catered for by the 1958 Act can be enforced in Bermuda under common law principles. Fresh proceedings must be issued in Bermuda, with the debt obligation created by the foreign judgment as the cause of action in the Bermuda proceeding. The foreign court must have had jurisdiction over the judgment debtor in accordance with Bermuda's conflict of laws rules.

Non-money judgments are not enforceable under the 1958 Act or common law. For example, a judgment ordering specific performance of a contract will likely not be enforceable, although it may be capable of recognition. Injunctions will also not be enforced – they may be recognised by the Bermuda courts as a defence to a claim or as conclusive of an issue in a claim but would not be sufficient to found a cause of action.

Arbitration awards are enforceable through the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards and Part IV of the Bermuda International Conciliation and Arbitration Act 1993.

Judgments that consist of an award of multiple damages will not be enforced in Bermuda.

2.3 Unique Features of Litigation Procedure

The 1985 Rules are similar to the English civil procedure rules that applied in 1999; as a result, practitioners and the courts utilise the 1999 edition of the English “White Book” and its commentary to assist in the interpretation and application of the 1985 Rules.

Unlike the modern English rules, the 1985 Rules do not impose any specific pre-action protocols. However, parties will still typically engage in pre-action correspondence pursuant to the overriding objective set out in Order 1A of the 1985 Rules, which obliges parties to assist the court in order to identify issues at an early stage and save costs.

Whilst English case law is persuasive in Bermuda, judges and lawyers in Bermuda will also look to the case law of other common law and offshore jurisdictions, such as Australia, Canada, New Zealand, the Cayman Islands, the BVI, Hong Kong and Singapore, particularly when issues arise for which there is no precedent in the Bermuda courts.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Arbitration clauses are common in commercial contracts of insurance and reinsurance concluded in Bermuda or by Bermuda-based insurers and reinsurers.

The Bermuda courts will generally enforce arbitration agreements, and have confirmed that that should be the ordinary approach in a number of judgments. The court's pro-enforcement powers extend to issuing anti-suit injunctions to restrain parties from acting in violation of an arbitration agreement. The presumption is that an anti-suit injunction will be granted where the arbitration agreement in question is valid and binding, and the respondent party has not shown strong reasons that the injunction ought not to be granted. The Bermuda court can grant such injunctive relief notwithstanding the jurisdiction in which

proceedings are commenced and regardless of whether the seat of the arbitration is Bermuda. A party in breach of an anti-suit order can be held in contempt of court, and any resulting foreign judgment could be held to be unenforceable in Bermuda.

3.2 The New York Convention

Bermuda is subject to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards, which has had force of law in Bermuda since the United Kingdom extended it to Bermuda in 1979. Part IV of the Bermuda International Conciliation and Arbitration Act 1993 provides a statutory enforcement regime for New York Convention awards.

The award creditor must file an application seeking leave to enforce the award. An originating summons must be issued on an ex parte basis, along with a supporting affidavit setting out the basic facts of the arbitration, the fact of the agreement to arbitrate, the hearing and the award. The affidavit should exhibit the arbitration agreement and the original award. Once the award creditor obtains an order granting leave to enforce, it will be served on the award debtor. An application to set aside the order can be made – in lieu of any such application, the award can be enforced as if it were a judgment of the court.

As noted in 2.2 **Enforcement of Foreign Judgments**, the 1958 Act also provides for the enforcement of awards from the United Kingdom (and other select countries) for the payment of money, so long as the award would be enforceable as a judgment in the United Kingdom.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is the prevalent form of insurance dispute resolution in Bermuda, making Bermuda a

sophisticated hub for the arbitration of complex insurance and reinsurance disputes. The vast majority of business lines, with the property and casualty at the centre of the Bermuda market, as well as the captive industry, utilise arbitration agreements as the primary form of dispute resolution clause.

In Bermuda, there are two arbitration statutes: the Arbitration Act 1986 (the 1986 Act) governing arbitrations between purely domestic parties, and the Bermuda International Conciliation and Arbitration Act 1993 (the 1993 Act) governing international arbitrations seated in Bermuda. The Acts themselves determine what arbitrations they apply to, and whether an arbitration is “domestic” or “international”. The 1993 Act incorporates the UNCITRAL Model Law into Bermuda law.

If Bermuda law applies to the interpretation of the arbitration agreement, a Bermuda arbitration will generally be confidential.

The 1986 Act provides for a right of appeal of an arbitration award to the Court of Appeal on any question of law arising out of the award. In the absence of consent of all parties, leave must first be obtained from the Supreme Court. There is no right of appeal under the 1993 Act, although a party could seek to challenge an award in the Court of Appeal on the very limited grounds that are taken from the New York Convention – eg, public policy or the dispute being incapable of resolution by arbitration.

4. Coverage Disputes

4.1 Implied Terms

Insurance and reinsurance contracts are subject to the same rules of contractual construction as

any other commercial contract, and terms can be implied as a matter of judicial construction.

There are two statutes that imply terms into insurance and reinsurance contracts.

First, for a contract written by a segregated accounts company, the Segregated Accounts Companies Act 2000 provides that the following are implied terms:

- that the parties select the law of Bermuda as the governing law and submit to the jurisdiction of the courts of Bermuda;
- that no party shall seek, whether in any proceedings or by any other means whatsoever or wheresoever, to establish any interest in or recourse against any asset linked to any segregated account to satisfy a claim or liability not linked to that segregated account;
- that if any party succeeds by any means whatsoever or wheresoever in establishing any interest in or recourse against any asset linked to that segregated account, that party shall be liable to the company to pay a sum equal to the value of the benefit thereby obtained by them; and
- that if any party succeeds in seizing or attaching by any means or otherwise levying execution against any assets linked to any segregated account of the company in respect of a liability not linked to that segregated account, that party shall hold those assets or their proceeds on trust for the company and shall keep those assets or proceeds separate and identifiable as such trust property.

Second, the Supply of Services (Implied Terms) Act 2003 implies terms regarding the period of time for completion under a contract and the consideration to be paid are reasonable, if not otherwise set. There is also an implied term that

that the supplier will carry out the service with reasonable care and skill. This is generally understood to be directed to consumer contracts.

4.2 Rights of Insurers

Insurance and reinsurance law in Bermuda is based on the English common law. However, unlike in England, the issues of non-disclosure and misrepresentation are not governed by statute (except in the case of life insurance). A recent divergence in the laws of Bermuda and England on these issues has arisen from the introduction of the Insurance Act 2015 in England. This modified the previously applicable common law remedies for non-disclosure and misrepresentation (collectively considered to be breaches of the duty of utmost good faith), which were also codified in the Marine Insurance Act 1906 (whilst this statute does not apply in Bermuda, some of its provisions are declaratory of the common law and as such are likely to be considered in determining the Bermuda common law). There have been no such revisions to the remedies in Bermuda. The duty of utmost good faith as it was characterised by the common law before the Insurance Act 2015 came into force in England (on 12 August 2016) continues to apply to all insurance contracts in Bermuda.

As a matter of principle, insurance contracts governed by Bermuda law are contracts of “utmost good faith” (also known as the principle of *uberrima fides*). This common law duty applies to insurance contracts in Bermuda and is imposed on both the insured and the insurer, as the parties to the contract. In placing and effecting the insurance contract, the intended insured party (and its broker) owe the following pre-contractual duties that comprise the duty of utmost good faith:

- a duty of disclosure, requiring the insured to disclose all material facts to the insurer; and
- a duty not to make misrepresentations.

Failure on the part of the insured to discharge these duties will give the insurer the remedy of avoidance *ab initio*. This has the same effects as rescission of a contract – it means that the parties are placed retroactively into the position they would have been in had the contract never existed. The insurer must be careful not to waive its right to avoid the contract or affirm the contract. The remedy of avoidance must be elected by the insurer. The parties can agree to limit the scope of pre-contractual duties and the requirement to make an accurate representation through their insurance contract(s).

A breach of a continuing warranty discharges the insurer from any further liability under the contract from the date of breach (but still allowing claims by the insured in respect of any loss occurring before the breach). This discharge is automatic, and the insurer need not make any election. In the case of a breach of an existing fact warranty, the fulfilment of the warranty is a condition precedent to the attachment of the risk and thus a breach would effectively void the contract *ab initio*.

4.3 Significant Trends in Policy Coverage Disputes

Given that the vast majority of coverage disputes in Bermuda are arbitrated confidentially, trends are difficult to identify.

Noteworthy coverage disputes in Bermuda often arise from areas of Bermuda-specific insurance innovation, such as the statutory segregated account regimes. Insurance companies utilise segregated accounts for rent-a-captive solutions, ILS transactions and the separation of

reserves amongst business lines, and unique coverage issues and disputes rise from these structures, which cannot always be determined by reference to the usual common law principles of coverage.

The Supreme Court delivered a seminal judgment in August 2023 that reinforced the integrity of the segregated accounts company structure and the separation of assets and liabilities as between segregated accounts. The judgment will likely be cited in all future insurance disputes that involve a segregated accounts company.

4.4 Resolution of Insurance Coverage Disputes

The majority of coverage disputes subject to Bermuda law are resolved by way of confidential arbitration. Mediation is also common.

Many insurance contracts for excess liability insurance and reinsurance written in Bermuda are written on the Bermuda Form. Disputes arising therefrom are resolved in Bermuda Form arbitration – that is, an English procedural law-governed arbitration of a contract governed by New York law. Bermuda Form arbitration agreements invariably provide for a seat in London or Bermuda.

4.5 Position If Insured Party Is Viewed as a Consumer

Most insurance business written in Bermuda is international insurance and reinsurance; on that basis, there is little consideration of consumer protections in Bermuda insurance law and procedure. It is worth noting, however, that the Consumer Protection Act 1999 protects consumers from unfair business practices, and that the insurers carrying on “domestic business” in Bermuda are obliged by the Insurance Code of Conduct of the Bermuda Monetary Authority

(BMA) to conduct their business with customers fairly and with integrity.

4.6 Third-Party Enforcement of Insurance Contracts

The Contracts (Rights of Third Parties) Act 2016 permits a third party to enforce a term of a contract where:

- the third party is identified in the contract by name, as a member of a class, or as answering a particular description; and
- the contract expressly provides in writing that the third party can enforce such term. This allows properly drafted cut-through provisions to provide a valid means of third-party enforcement rights in Bermuda.

The Third Parties (Rights Against Insurers) Act 1963 allows a third party to take direct action against an insurer in circumstances where its insured owes a liability but is insolvent. The Motor Car Insurance (Third-Party Risks) Act 1943 has similar provisions.

Finally, the Merchant Shipping Act 2002 also provides a statutory right to lodge proceedings to enforce a claim for oil discharge liability against a ship's insurer.

4.7 The Concept of Bad Faith

Bermuda law does not recognise any concept of "bad faith" as a basis for awarding damages against an insurer, for example due to its conduct during the administration or handling of a claim. There are no "damages on damages".

4.8 Penalties for Late Payment of Claims

There are no statutory remedies for the late payment of claims in Bermuda.

However, insurers and reinsurers are regulated by the BMA, which has wide-ranging enforcement powers, including the giving of directions (pursuant to the Insurance Act) to an insurer restricting the business it can write in circumstances where the BMA considers there to be a significant risk that the insurer will be unable to meet its obligations to policyholders.

Insurers are also bound by the BMA's Insurance Code of Conduct, which provides that insurers should implement policies that require them to address claims in a timely, fair and transparent manner and avoid any aggressive and coercive claims handling tactics and discrimination during the claims handling process. This is consistent with the principle, also contained within the Insurance Code of Conduct, that directors of a Bermuda insurer must act in the best interest of the company and its policyholders. In any event, insurers must conduct their business in a prudent manner in accordance with the Insurance Act, and compliance with the Insurance Code of Conduct is a determinative factor in the BMA's assessment of such prudent conduct of business.

4.9 Representations Made by Brokers

As a general principle, a broker acts as an agent of the insured or the reinsured, particularly when it is placing cover. However, brokers can have many roles and will often find themselves as dual agents, particularly in circumstances where they are placing both reinsurance and a retrocession. Section 29 of the Insurance Act, for example, makes a broker with authority to accept premium the agent of the insurer.

Therefore, whilst the insured certainly can (and often will) be bound by its broker's representations, this is unlikely ever to be straightforward. This is particularly the case in Bermuda, where

brokers are involved in more than one capacity – eg, with respect to captives.

It is worth noting that the BMA's Insurance Brokers and Insurance Agents Code of Conduct provides that an insurance broker must not recommend a transaction to a client unless it has taken reasonable steps to make the client aware of the risks involved, including any conflicts of interest and that, when providing advice to or arranging contracts of insurance for the client, a broker shall make full and adequate disclosure of all facts necessary for its clients to make an informed decision. The BMA has specific powers to grant and revoke a broker's registration in Bermuda under the Insurance Act.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Delegated underwriting and claims handling authority arrangements are often used by Bermuda insurers and reinsurers. Such arrangements are necessarily subject to appropriate oversight by the insurers as part of their overall risk management and material outsourcing requirements, and as such do not generally result in particular litigated issues in Bermuda.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Coverage for defence costs is provided in many types of liability policy, including professional indemnity and director's and officer's insurance policies. Different policies can provide for defence costs, in addition to the policy limit or within it.

In the context of Bermuda Form policies, defence cost coverage is often provided by way of endorsement.

5.2 Likely Changes in the Future

There is no indication that there will be any change in defence costs coverage in the coming years.

5.3 Trends in the Cost or Complexity of Litigation

The COVID-19 pandemic made it necessary for court proceedings to take place remotely, and the courts have maintained the ability to hear matters in this way. This has permitted judges to sit remotely, which has allowed for more efficient use of the court's resources. It has also allowed for clients, overseas counsel and even witnesses to attend hearings remotely when they would ordinarily have flown to Bermuda to attend.

Earlier in 2024, both the Supreme Court and the Court of Appeal introduced significantly higher court fees for court filings.

5.4 Protection Against Costs Risks

Bermuda has no third-party funding legislation but these arrangements are permitted in Bermuda, having been blessed by the courts, which have rejected arguments that such arrangements are unlawful.

Third-party funding can be used by any party and in any amount.

Contingency fees are prohibited in Bermuda by the Barristers' Code of Professional Conduct 1981, Rule 96.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Insurance contracts are contracts of indemnity and, as a matter of Bermuda law, an insurer has equitable rights of subrogation – ie, an insurer can receive recoveries from third parties that would serve to reduce the insured loss and bring proceedings in the name of the insured against liable third parties, having provided contractual indemnification to the insured.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

There is no legislative codification of subrogation rights in Bermuda – a court will consider the terms of the contract and apply common law principles. Subrogation claims are made in the name of the insured.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Insurers and reinsurers in Bermuda continue to monitor and navigate the effects of the COVID-19 pandemic, and the extent of reinsurance disputes that may reach Bermuda for resolution remains to be seen.

With respect to the war in the Ukraine, issues arise in Bermuda from the registration of Russian aircraft in the jurisdiction. The sanctions levied against Russian and Belarusian entities have caused issues for Bermuda insurers and other financial institutions to address, including with the regulatory authorities.

Bermuda's reinsurance sector is also uniquely exposed to the rise in natural catastrophes, particularly hurricanes in North America.

Each of these unprecedented factors creates an environment for insurance-related disputes. However, it is difficult to measure the impact in light of the preponderance of arbitrations for the resolution of insurance and reinsurance disputes.

7.2 Forecast for the Next 12 Months

It is conceivable that the Bermuda insurance market could be exposed to unique and novel claims and disputes in the coming year, in response to the evolving risks from industries such as digital assets and licensed cannabis cultivation, each of which can be insured in Bermuda. Cyber perils also continue to present new and developing challenges to insurers globally, particularly with the growth of AI technologies, and Bermuda is no different.

Bermuda's segregated accounts regime is another area that could create additional disputes. The BMA has recently issued a Guidance Note outlining its expectations for companies using segregated accounts to conduct regulated insurance business. This is due to become effective on 1 January 2025. Along with the Incorporated Segregated Accounts Companies Act, which was enacted in 2019, these innovative ways of conducting insurance business in Bermuda have the potential to create novel disputed issues amongst counterparties and with regulatory authorities.

7.3 Coverage Issues and Test Cases

The Bermuda court gave important judgments in 2022 and 2023 regarding the integrity of the segregation of accounts regime, in *Ivanishvili v Credit Suisse Life (Bermuda) Ltd* [2022] SC Bda

56 Civ and in Re Northstar Financial Services (Bermuda) Ltd and Omnia Ltd [2023] SC Bda 57 Civ.

7.4 Scope of Insurance Cover and Appetite for Risk

Individual insurers will have varying lines of coverage and portfolios of risk, and the management of these will inevitably be impacted by specific and general market developments from time to time, including litigation developments.

The Bermuda reinsurance market has generally reported that the impact of the COVID-19 pandemic on the (re)insurance industry in particular remains uncertain. The potential scale of the losses is such that substantial capital retention is generally required until there is greater certainty, locking up capital that could otherwise be used to back new underwriting and thus exacerbating the demands on capital.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Bermuda reinsurers are required specifically to consider and address ESG risk as part of their overall risk management framework. Climate change risk in particular has been identified by the BMA as a significant financial risk to insurers and, as a result, the underlying stability of the financial sector. As such, in addition to the general assessment of ESG risks in the con-

text of each insurer's business and operations, Bermuda insurers are expected specifically to take a proactive (and proportionate) approach to manage and, where possible, mitigate risks associated with climate change. This expectation applies to insurers in respect of both their underwriting activities and their operations and investments, and therefore can have a material impact on underwriting and risk management.

8.2 Data Protection Laws

While certainly important in its own right, Bermuda's data privacy laws (in particular, the Personal Information Protection Act 2016) are not generally expected to have a material impact on the underwriting and litigation of insurance risks by Bermuda insurers.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

There have been a number of detailed changes to both the general business and long-term business insurance regulations that have an impact on the calculation of the relevant capital and solvency ratios. These changes to the capital model will likely have a general effect on the nature and extent of risks to be underwritten as capital needs adjust, but no overall impact on insurance coverage, insurance litigation or claims that insurers will fund the defence is expected.

BRAZIL



Law and Practice

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

In Brazil, the resolution of insurance disputes is governed by a combination of the Brazilian Civil Code, the Consumer Defense Code (CDC), and specific laws such as Decree-Law No 73/66, which regulate the insurance market. The Superintendence of Private Insurance (SUSEP) is the primary regulatory authority for the sector and is responsible for overseeing and regulating insurance operations. Judicial disputes are generally resolved by state or federal courts (depending on the nature of the parties and the legal issue) in accordance with the procedural regime set out in the Code of Civil Procedure.

1.2 Litigation Process and Rules on Limitation

The litigation process in Brazil is governed by the Civil Procedure Code (CPC). The parties commence proceedings through an initial petition (statement of claim), and the proceedings include specific phases for the filing of a defence, production of evidence and judgment. As a general rule, the statutory limitation period applicable to claims is one year, as set out in Article 206, Section 1, II, of the Civil Code. The limitation period begins to run on the date the insured becomes aware of the fact that gives rise to the claim. In certain specific circumstances, a three-year limitation period applies.

1.3 Alternative Dispute Resolution (ADR)

While mediation and arbitration are encouraged methods of dispute resolution in Brazil, particularly for commercial disputes, their use in insurance disputes is still relatively uncommon. Arbitration is more prevalent in reinsurance contracts and in more complex disputes where the parties prefer a more specialised and expedited reso-

lution process. There is nonetheless a general trend towards increased recourse to arbitration in insurance disputes.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Disputes regarding jurisdiction and choice of law in insurance contracts in Brazil are typically governed by the Code of Civil Procedure and the Law of Introduction to the Norms of Brazilian Law (LINDB). In cases involving foreign insurers, Brazilian jurisdiction is usually asserted when the insured risk is located in Brazil or when the contract was entered into with a party that is resident or domiciled in Brazil.

2.2 Enforcement of Foreign Judgments

Foreign judgments can be recognised and enforced in Brazil if they are homologated (ratified) by the Superior Court of Justice (STJ). The homologation (ratification) process requires that the foreign judgment for which enforcement is sought be final and binding, issued by a competent authority, and that it does not violate Brazilian public policy.

2.3 Unique Features of Litigation Procedure

International insurers need to be aware of strong consumer protection laws in Brazil, particularly in relation to adhesion (standard-form) contracts. The Consumer Defense Code offers various protections, including the shifting of the burden of proof in favour of the consumer. That can have a significant effect on the outcome of the litigation.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Brazilian courts recognise and enforce arbitration clauses in commercial contracts, including insurance and reinsurance contracts. The Brazilian Arbitration Law (Law No 9,307/96) governs this area, and arbitration clauses are generally upheld as long as they are clearly worded and have been duly agreed upon by the parties.

3.2 The New York Convention

Brazil is a signatory to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards. Arbitral awards issued in other jurisdictions can be recognised and enforced in Brazil, provided they meet the requirements for homologation (ratification) by the Brazilian Superior Court of Justice.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is an increasingly significant form of dispute resolution in insurance, particularly in reinsurance contracts and for insurance of large-scale industrial risks. Arbitrations are governed by the Brazilian Arbitration Law, and the proceedings are generally private, with judicial review limited to issues of nullity of the arbitral award. The Brazilian Superior Court of Justice has ruled that the Civil Procedure Code does not automatically apply as a subsidiary form of regulation of the proceedings.

4. Coverage Disputes

4.1 Implied Terms

In Brazil, certain terms are implied in insurance contracts by operation of law. For example,

good faith is a fundamental principle in insurance contracts under the Brazilian Civil Code, requiring transparency and loyalty in the formation and execution of the contract.

4.2 Rights of Insurers

Insurers have the right to accurate and complete information about the risk to be insured before the inception of the policy. This in turn gives rise to a right to deny coverage or adjust the premium if the information provided by the insured was deficient.

4.3 Significant Trends in Policy Coverage Disputes

In the past 12 months, a major theme in coverage disputes has been the issue of the COVID-19 pandemic, particularly concerning insurance cover for interruption to business activities. There has also been an increase in litigation involving cyber-insurance, given the rising incidence of cyber-attacks. Engineering insurance continues to be a growing field. In addition, issues arising out of a finding of corruption, which is not covered by insurance, is a significant and recurring matter before the Brazilian justice system.

4.4 Resolution of Insurance Coverage Disputes

Insurance coverage disputes in Brazil are generally resolved through judicial litigation, although arbitration is becoming increasingly common, especially in more complex contracts. In reinsurance contracts, arbitration is widely used due to the international and specialised nature of these disputes.

4.5 Position If Insured Party Is Viewed as a Consumer

When the insured is considered a consumer, the rules of the Consumer Defense Code apply. These rules generally favour the insured. The

provisions include protections such as the reversal of the burden of proof and the possibility of judicial review of contractual clauses deemed abusive.

4.6 Third-Party Enforcement of Insurance Contracts

The current position of the Brazilian Supreme Court of Justice is that a third party is not entitled to enforce an insurance contract or sue an insurer directly (STJ Ruling No 529).

4.7 The Concept of Bad Faith

There is no specific concept of bad faith. Nevertheless, it is important to highlight that the Brazilian system is based on good faith, and certain specific standards are set out in law as a corollary of the fundamental duty of good faith.

4.8 Penalties for Late Payment of Claims

Brazilian law imposes penalties for the late payment of claims. If payment is not made within the stipulated period (usually 30 days after the submission of all necessary documentation), the insurer may be ordered to pay interest and/or monetary correction.

4.9 Representations Made by Brokers

In Brazil, the insured is bound by representations made by its insurance broker, who is considered the insured's formal representative. However, if the broker acts outside their authority or contrary to the interests of the insured, the insured may have legal recourse against the broker.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Delegated underwriting is not allowed in Brazil. However, claims handling authority arrangements are relatively common. Normally, insurers delegate these functions to third parties.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

In Brazil, insurers typically fund the defence of insureds in cases involving liability insurance, such as third-party liability for damage, professional liability, and directors' and officers' (D&O) liability insurance. The term for this protection under the insurance policy is "defence costs coverage".

5.2 Likely Changes in the Future

In the coming years, we may see changes driven by the increasing complexity of risks, such as cyber liability and environmental liability. These emerging risks could lead to more nuanced coverage requirements and a greater emphasis on specialised defence strategies. Additionally, regulatory changes and judicial decisions may further shape the obligations of insurers to fund defences, especially in sectors where new liabilities are developing.

5.3 Trends in the Cost or Complexity of Litigation

Over the past few years, there has been a noticeable trend toward increased costs and complexity in litigation, particularly in cases involving corporate liability and environmental claims. This is due to a combination of factors, including more stringent regulatory environments, the growing importance of compliance, and the rise in class actions. These trends are expected to continue, with litigation costs likely to rise as cases become more complex and require more specialised legal expertise.

5.4 Protection Against Costs Risks

Claimants can buy protection against costs risks in connection with such claims. This is typically

done through insurance coverage known as defence costs.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Brazilian law provides insurers with the right of subrogation, allowing them to recover sums from third parties responsible for causing an insured loss.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The right of subrogation, specifically in relation to insurance rights, is set out in Article 786 of the Brazilian Civil Code, which states that the insurer, upon payment of the indemnity, is subrogated to the rights of the insured against the third party responsible for the loss.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The pandemic is a past issue. However, environmental disaster-related matters have had a significant impact on the insurance industry, especially in agricultural insurance. Recently, the state of Rio Grande do Sul, in southern Brazil, experienced an environmental catastrophe that will have repercussions in the insurance sector, as, amongst other matters, numerous food crops were lost or damaged.

7.2 Forecast for the Next 12 Months

The trend, with respect to **7.1 Type and Amount of Litigation**, is unlikely to change since this is a recent event.

7.3 Coverage Issues and Test Cases

The factors mentioned have given rise to specific coverage issues and test cases of significant importance. For instance, environmental disasters like the recent catastrophe in Rio Grande do Sul have led to disputes over the interpretation of policy terms, particularly regarding the scope of coverage for agricultural losses.

7.4 Scope of Insurance Cover and Appetite for Risk

In response to the scenario noted in **7.1 Type and Amount of Litigation**, insurers have improved policy wording, terms, and adjustment proceedings, including the use of satellite technology.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

ESG factors are increasingly influencing both the underwriting and litigating of insurance risks. Certain risks may be declined if the applicant company lacks an acceptable ESG policy.

8.2 Data Protection Laws

The Brazilian General Data Protection Law (LGPD) has led to new procedures for the handling of data and a need for extra caution and care. Insurers handle sensitive data and other information provided directly by the insured and requiring the maintenance of confidentiality.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

Recent legislative and regulatory developments in Brazil have had a notable impact on insurance

coverage and litigation. The introduction of the LGPD has imposed new compliance requirements on insurers, particularly regarding the handling of personal data.

A draft Civil Code is currently being examined by Congress and, if passed, it may have a significant impact on provisions of insurance law.

Draft Law No 29/2017, currently before the Brazilian Congress, sets out certain key provisions for insurance relations in Brazil and certain proposed amendments to insurance law provisions of the Brazilian Civil Code. The bill is being debated and may undergo significant changes before its final approval.

Trends and Developments

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ADVOGADOS

Overview of the Insurance Sector in Brazil

In 2023, the revenue of the insurance sector exceeded BRL600 billion, a penetration rate of 6% of Brazilian GDP. Whilst that may be considered significant, it falls short of the figures for more developed economies, which have an average rate of 10%.

The Brazilian rate is nevertheless steadily increasing, a fact that has led the economic authorities to pay closer attention to the sector. The government has included as one of its economic priorities the securing of congressional approval for Draft Law No 29, which was first introduced in 2017. The draft law is aimed at overhauling the current legislative provisions on insurance contracts. It has already been passed by the Chamber of Deputies and is now before the Federal Senate. Draft Law 29/2017 deals exclusively with insurance contracts. If it passes into law, it will revoke the current 2002 Civil Code provisions that currently govern such contracts and will introduce a new framework. In its procedural aspect, the Draft Law is a step backwards for arbitration development as it does not allow the parties to opt for arbitrations based abroad, nor to choose any law other than the Brazilian one. In addition to restricting the autonomy of the parties, this prohibition can make it difficult

to take out insurance abroad, in cases where there is no capacity in the local market, if a foreign insurance company is not willing to litigate in Brazil under the local law.

The 2023 approval by the legislature of the Statutory Framework on Guarantees (*Marco Legal das Garantias*) (Law 14.711/23) is also worthy of note. This law fine-tuned the rules governing credit operations. One of the key innovations in the legislative provisions was the inclusion of counter-guarantee contracts in the list of instruments that can be enforced extra-judicially. This development has been welcomed by insurers, who are, in the main, optimistic about the practical benefits it will bring. The new Law also included provisions enabling recourse to surety bond (guarantee) insurance policies at any stage of court proceedings up to the date on which the final court order becomes final and binding (*res judicata*). In other words, these guarantee insurance policies may be furnished even during the enforcement phase of judicial proceedings.

Another relevant piece of legislation, currently before the Federal Senate having already been approved by the Chamber of Deputies, is Draft Complementary Law (PLP) 233/2023 which governs compulsory insurance cover for victims of

BRAZIL TRENDS AND DEVELOPMENTS

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road traffic accidents involving uninsured vehicles. The law aims to replace the current compulsory insurance scheme known as the DPVAT, with the introduction of the SPVAT scheme, led by the Caixa Econômica Federal, a state-owned Brazilian bank. This move by the government is constitutionally questionable, in that it will result in a public entity dominating this field of economic activity, being tantamount to nationalisation of the compulsory insurance scheme. However, if the law passes it will lead to resumption of compulsory insurance payouts to the victims of road accidents. These DPVAT payouts have been frozen since November 2023.

Constitutional issues are dealt with by the Brazilian Federal Supreme Court. There are presently a number of cases before the Court that are of particular interest to the insurance sector. In particular, the Supreme Court has reiterated its position that state laws introduced to legalise the so-called “vehicle protection associations” are unconstitutional and therefore invalid. These associations have purported to offer insurance-type services, but they are not regulated by law and are not overseen by any regulatory agency. They do not pay tax nor do they furnish any of the legal guarantees required of bona fide insurers in order to ensure that obligations to insured clients can be met. The growth of these players has become a serious problem for the sector, and especially for consumers in the vehicle insurance market.

The insurance sector is also waiting for the Supreme Court’s ruling on whether or not amounts paid out to beneficiaries following the death of the holder of one or more private pension plans are subject to the ITCMD tax (which is a tax on postmortem transmission of goods and on donations). Insurers argue that the ITCMD tax does not apply because the so-called VGBL or

PGBL plans that are in issue before the Court are in effect life insurance policies, and therefore not subject to inheritance taxation (Federal Supreme Court, Theme 1214, issue of General Repercussion).

In relation to home insurance under the Brazilian System of Finance for Purchasing a Home (the SFH), the Federal Supreme Court has issued a definitive ruling on the matter of jurisdiction to try disputes pertaining to the system. The court ruled that jurisdiction lies with Federal Courts. However, other important SFH-related issues are still pending resolution. In particular, the Superior Court of Justice has yet to rule on the correct determination of the commencement of the statutory limitation period with regard to insurance cover for physical damage to SFH-financed properties.

The private-law chambers of the Superior Court of Justice have nevertheless been particularly prodigious in forming solid case law on certain pressing issues of insurance law. In a recent ruling, for example, the Superior Court definitively rejected the possibility of early liquidation of guarantee insurance policies in tax enforcement proceedings, with the ratio decidendi being based on the provisions of the Statutory Framework on Guarantees (*Marco Legal das Garantias*) referred to earlier.

Finally, it is important to note that a silent revolution is underway in the Brazilian insurance sector, led by the regulatory agency SUSEP, in the form of implantation of an “open insurance” project. This project is aimed at establishing a marketplace for standardised information for the ultimate purpose of improving the experience of insurance clients that agree to share certain data. Insurance companies that are accredited by SUSEP will be able to access the consumer

BRAZIL TRENDS AND DEVELOPMENTS

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profiles of these clients, enabling them to offer specific and competitive products and services. The data processing companies involved will be known as “*Sociedade Processadora de Ordem do Cliente*” (SPOC) and the first such company has already been accredited, in early 2024, indicating that the pioneering SUSEP programme is at an advanced stage of implementation.

CHILE



Law and Practice

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Peralta, Sandoval, Llanaez & Gutiérrez is a distinguished law firm specialising in business law, notably in the insurance and reinsurance sectors. The firm's expertise in insurance litigation is particularly noteworthy. The firm's reputation rests on a team of highly experienced lawyers renowned for their handling of complex matters. They offer comprehensive and adept advice, ensuring clients receive proficient counsel tailored to their needs. The firm is committed to ethical standards and innovative legal strat-

egies. Peralta, Sandoval, Llanaez & Gutiérrez provides tailored counsel and strategic support, based on its substantial experience in insurance and business law, as well as complex litigation. Some of the firm's clients include Chubb Seguros Chile S.A., HDI Seguros S.A., Orsan Seguros de crédito y garantía, AIG, Aseguradora Porvenir, and Liberty Compañía de Seguros Generales S.A. Peralta, Sandoval, Llanaez & Gutiérrez is ranked by Chambers and Partners as Band 3 of 6 in Insurance.

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CHILE LAW AND PRACTICE

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

The resolution of conflicts in insurance matters has a particularly disjointed regulation, despite the comprehensive intention of Article 543 of the Commercial Code. In principle, the arbitration procedure is subject to mandatory legal arbitration, except when its amount is less than UF10,000 (approximately USD370,000) – UF meaning “*Unidad de Fomento*” – in which case the insured may optionally submit to ordinary justice.

Regardless of the insured’s choice, the insurance procedure is always subject to certain rules that make the evidencerequirements more flexible and, especially, that subject it to the system of the logical and reasonable rules of evaluation assessment, allowing the judge to decree evidence ex officio and admit means of evidence not contemplated in the Civil Procedural Code.

Notwithstanding the above, it has become common for the ruling on insurance matters to be known and resolved by two types of courts not contemplated in Article 543 of the Commercial Code.

Firstly, there are the Courts of Appeals through Habeas Corpus, especially in matters of health insurance. Secondly, there are the Local Police Courts in cases where the insured asserts their status as a consumer.

Finally, the legal and regulatory statutes applicable in insurance litigation are:

- DFL No 251 of 1931, regarding insurance companies, corporations, and the stock market;

- Commercial Code, Article 512 and what follows;
- Civil Procedural Code;
- Penal Code, Article 470 No 10;
- Supreme Decree 1.055 of 2012; and
- Law No 19.496.

1.2 Litigation Process and Rules on Limitation

According to the rule of Article 543 of the Commercial Code, the contentious insurance procedure consists of three phases:

- a discussion phase that may or may not include response and reply depending on the amount involved;
- a conciliation phase; and
- a testing phase with a maximum duration of 20 business days, followed by a possible procedure to challenge the evidence, depending on the type of procedure.

Subsequently, the case is ready for a ruling to be issued, for which the court has a period of 60 days, a period that is often not met in ordinary courts. In general, except in arbitrations where remedies have been waived, all ordinary (appeal, annulment in form and substance) and extraordinary (claim) remedies are available in insurance litigation. In arbitrations with rejected appeals, non-waivable remedies (annulment of form due to incompetence and ultra petita, and complaint appeal) continue to be applicable.

Regarding the limitation period, the action derived from the insurance can be executed within four years from the date on which the respective obligation becomes payable (Article 541 of the Commercial Code). This rule has exceptions in the case of life insurance (the term is computed from the moment the beneficiary becomes aware of the existence of his/her right,

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with a limit of ten years) and in civil liability insurance (the term will never be less than that of the injured third party), as provided in the same provision.

In addition, special attention must be paid to cases regulated by the Consumer Protection Law (No 19,496), which establishes special statute of limitation periods when actions are carried out in accordance with this law, especially infringing actions (Article 26), which expires in two years and serves as a basis for establishing the supplier's civil liability.

1.3 Alternative Dispute Resolution (ADR)

ADR is not yet a prevalent form of dispute resolution in Chile; however, institutional dispute resolution centres – both general and those specialised in insurance – are increasingly promoting these mechanisms, especially mediation.

For instance, both the National Mediation and Arbitration Center of the Santiago Chamber of Commerce (CAM Santiago) and the National Arbitration Center (CNA) have specialised mediation areas and have promoted the use of multi-tiered dispute resolution clauses. Regarding institutional centres specialised in insurance, ARIAS-LATAM has recently also incorporated mediation into its services.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

The jurisdiction rule in insurance disputes is, in principle, mandatory. However, in litigation of an amount less than UF10,000 (approximately USD370,000), the insured may optionally submit to ordinary justice, in accordance with the provisions of Article 543 of the Commercial Code. The foregoing is without prejudice to what is stated

regarding the jurisdiction of the Courts of Appeal in matters of appeals and the Communal Courts in matters regarding consumer law.

2.2 Enforcement of Foreign Judgments

Foreign judgments may be enforced in Chile according to international treaties signed by Chile and the respective country or if, in the absence of a treaty, Chilean judgments are given executive force in the country of origin. The latter is in accordance with the principle of reciprocity.

When the judgment has had enforcement requested, prior notice must be given to the party against whom enforcement is requested. This will have a period equivalent to that for answering claims, and a period of evidence may be opened if the court deems it necessary to decide whether or not to grant the enforcement.

2.3 Unique Features of Litigation Procedure

According with the principle of equality before the law (Article 19 Nos 2 and 3, Chilean Magna Carta), there are no differences between Chileans and foreigners under litigation scenarios in Chile.

However, difficulties may arise in rather practical matters related to civil procedure and the means of proof that are limited by the Code of Civil Procedure. For example:

- it does not contemplate the telematic appearance for witnesses or the remote holding of hearings outside of states of emergency;
- it requires the need for translation of documents in a foreign language; and
- it does not regulate the receipt of evidence in other languages.

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In this sense, arbitration is a solution to these types of practical problems. It is a procedure that is usually more flexible and the means of proof is more extensive; depositions are recorded, and arbitrators usually speak English as a second language.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Arbitration provisions in insurance and reinsurance contracts are enforceable under Chilean law. Nevertheless, an insured may optionally submit a claim to ordinary justice in cases below UF10,000 (approximately USD370,000).

3.2 The New York Convention

As indicated in 2.2 Enforcement of Foreign Judgments, foreign judgments may be enforced in Chile in accordance with the international treaties (Article 242 of the Civil Procedure Code). The New York Convention is the most relevant international treaty in force in Chile on this topic.

3.3 The Use of Arbitration for Insurance Dispute Resolution

The use of arbitration is common in property claims with amounts over UF10,000. Likewise, in marine insurance, arbitration is also mandatory.

On the other hand, arbitration is private, and the parties pay the arbitrator's fees. Awards can be appealed before the respective court of appeal or second-instance arbitration tribunal.

4. Coverage Disputes

4.1 Implied Terms

In insurance contracts other than those involving "large risks", the mandatory nature of the rules of the Commercial Code (Ex-Article 542, paragraph 1) incorporates the sectoral legislation of the Code into insurance contracts, except if the contract is most beneficial for the insured.

The above means, in practical terms, that with respect to the insured who is not included in the second paragraph of Article 542 (damage policies, intermediated by a broker, between legal entities and with an annual premium greater than USD8,500), the rights established in the Commercial Code for the insured are inalienable.

4.2 Rights of Insurers

Precontractual risk declaration (Articles 524 and 525 of the Commercial Code) – after the reform of the Commercial Code in December 2013, it has been held that the scope of the insured's duty to report the risks is delimited by the specific information requested by the insurance company at the time of underwriting the policy and it is not an absolute duty to faithfully and without reluctance declare the risk being transferred. Although the issue is debatable, a conservative interpretation forces this restrictive interpretation of this duty of the insured to be kept in mind.

With this prevention, in the event that there may be an inexcusable error or inexcusable reluctance or inaccuracies, the company may do one of the following.

- If the claim has not occurred:
 - (a) request the nullity of the policy if the errors or reluctance are determining factors of the insured risk; or
 - (b) propose a premium adjustment or modifi-

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cation of coverage to what is not reported if the errors or reluctance are not decisive for the insured risk – if the modification is rejected, it must result in the termination of the insurance.

- If the claim has occurred – excludes or reduces compensation (in proportion with the premium), depending on the severity of the reluctance.

4.3 Significant Trends in Policy Coverage Disputes

- Regarding all-risk coverage – the grounds for compensation for damages due to stoppage that are not associated with compensable physical damages.
- Regarding first-demand guarantee policies – several issues have been discussed, among which the following are of particular importance:
 - (a) the suspension of collection/enforcement and/or payment of policies that guarantee contracts breached by the debtor company in the context of bankruptcy proceedings;
 - (b) the possibility of requesting background information from the insured and/or guarantor in order to properly exercise the right of reimbursement, without this implying a condition for the policy payment; and
 - (c) the issue of the multiplicity of authorities competent to address a breach when it also constitutes a violation of legal provisions integrated into the contract.
- Regarding to professional liability coverage (medical) – there is a notable increase in the amounts of judgments associated with health conditions requiring ongoing and future care (future consequential damages). This is not a discussion strictly about insurance, but rather

one that has a direct impact on insurance coverage.

- The possibility of applying the collective procedure established in the Consumer Rights Protection Law in the field of insurance.

4.4 Resolution of Insurance Coverage Disputes

The jurisprudence of the Superior Courts of Justice in Chile resolves cases on a case-by-case basis, that is, according to the specific merits presented by each case, both in law and in the facts that shape it. For this reason, it is not possible to assert that insurance or reinsurance disputes are generally resolved in a specific manner.

4.5 Position If Insured Party Is Viewed as a Consumer

A distinct trend can be observed when the insured also qualifies as a consumer, as in such cases the protective provisions of Law No 19,496 apply. This law grants a series of rights that facilitate the exercise of legal action, pre-establishes compensation amounts, imposes fines on the provider, eases the means of evidence, and subjects actions to a special jurisdiction, among other procedural and substantive benefits.

4.6 Third-Party Enforcement of Insurance Contracts

In Chile, direct action is not generally contemplated, which means that accident victims cannot directly sue the company with which the perpetrator of the damage is insured until the liability debt is declared by a judicial ruling. It is only at that moment (or with their agreement) that the victim acquires a right to claim that liability debt from the company. This is explicitly stated in Article 570 of the Commercial Code. However, direct action is one of the issues that generates the most controversy in legal doctrine.

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4.7 The Concept of Bad Faith

There is no definition of the concept of bad faith in Chilean legislation; rather, it is understood as that which opposes good faith, which in contractual matters is seen as an expectation of good business conduct. Without a doubt, bad faith is a concept that exceeds the mere idea of negligence, and there is no consensus in legal doctrine as to whether it corresponds precisely to the notion of fraud included in the final paragraph of Article 44 of the Civil Code, or whether it also includes fraud scenarios and situations of extreme negligence.

4.8 Penalties for Late Payment of Claims

In Chile, the process of notification, settlement and payment of claims is a regulated procedure with established deadlines, whose compliance is subject to the supervision of the Financial Market Commission (*Comisión para el Mercado Financiero*, also called CMF). The CMF is the authority that, by law, is responsible for ensuring the proper functioning, development, and stability of the financial market. Among its functions, it ensures that individuals or entities under its supervision comply with laws, regulations, statutes, and other provisions governing them, from the beginning of their organisation or activities, as applicable, until the conclusion of their liquidation; it can exercise extensive oversight over all their operations. This is stipulated in Article 1 of Law No 21,000. In exercising these powers, and following the appropriate administrative sanctioning procedure, the CMF can impose any of the penalties established in Title III of Law No 21,000.

An example of the exercise of these powers can be seen in the past 12 months with the increase in penalties applied by the CMF to credit- and guarantee-companies for non-compliance with

Articles 582 and 583 of the Commercial Code in the case of first-demand policies.

4.9 Representations Made by Brokers

The insurance broker (independent) is a sui generis agent, as they act in the interests of both the company and the policyholder, aiming to obtain the most beneficial coverage for the latter. In this context, the broker's liability is subject to the liability statute of agents, which, unless a special statute applies, is governed by the rules contained in the Civil Code that can be summarised as follows.

- The agent only binds the principal to third parties when they act within the limits of their faculties. If the agent exceeds these limits, they do not bind the principal to third parties.
- If the agent exceeds the limits of their faculties, they are generally not liable against third parties but only to the principal. They will only be liable to the principal if:
 - (a) they have not disclosed their faculties; and
 - (b) they have personally obligated themselves.

Nonetheless, the broker's specific declaration, the nature and circumstances of the advised parties, their context, and the relevance of the declaration in the specific legal transaction being executed will be determinative in constructing – with varying probabilities of success – a binding obligation for the insurance company based on the broker's action.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Chilean law does not provide for delegation agreements in insurance matters.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

The primary area in which insurers finance the defence of insured parties is found in liability insurance policies, where one of the coverages includes what are known as defence costs.

On the other hand, Article 572 of the Commercial Code states that the coverage of such insurance includes indemnification, as well as the expenses and costs of the legal process.

It is important to highlight that, as a general rule, the insurer only finances defence costs in civil proceedings. However, medical malpractice and motor vehicle insurance policies contemplate the possibility of financing the insured's defence in criminal trials.

5.2 Likely Changes in the Future

The authors do not foresee changes in this trend in the coming years. The liability insurance market is quite established. However, it is possible that sub-limits of coverage could be introduced in areas such as employer's liability insurance, which would reduce the exposure of insurers to a lesser extent.

5.3 Trends in the Cost or Complexity of Litigation

There has been an increase in compensation awarded by Chilean courts in the area of civil liability insurance, especially in the area of employment liability, medical malpractice/mala praxis (malpractice) and vehicle insurance. Particularly important have been those awarded due to pain and suffering and loss of profit.

5.4 Protection Against Costs Risks

In Chile, there are no coverages that allow protection against costs with respect to claims.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

According to Article 534 of the Commercial Code, upon payment of the compensation, the insurer is subrogated to the rights and actions that the insured has against third parties in relation to the loss.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

In such cases, the claim or lawsuit is filed in the name of the insurer, but subrogated to the rights and actions of the insured to whom the compensation from the insurance has been paid.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The pandemic has affected insurance litigation to some extent, as there have been claims from insured parties demanding payment for damages due to business interruptions caused by COVID-19 in sectors such as retail or construction. On the other hand, given the negative effects of the pandemic on the economy, there has also been an increase in litigation arising from coverage denials in surety policies.

7.2 Forecast for the Next 12 Months

It is likely that claims or lawsuits arising from warranty insurance will increase in both frequency and severity. This is because the Financial Market Commission (CMF) estimates that cer-

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tain types of surety policies must be paid, and then the insurer can claim against the insured if there is any reason for it.

7.3 Coverage Issues and Test Cases

There have been judicial processes aimed at obtaining a judgment from the judiciary regarding damages for business interruptions due to COVID-19. However, the outcomes, for now, have not been favourable for the insured parties.

7.4 Scope of Insurance Cover and Appetite for Risk

In the area of surety insurance, there has been a decrease in appetite for this type of risk, due to the strict position of the insurance regulator that such insurance must first indemnify and then discuss the appropriateness of the compensation (“pay first and argue after”).

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

There has not been a significant impact of ESG factors in the area of underwriting and litigating insurance risks. However, the insurance regulator requires insurers and regulated entities to report aspects related to these factors in their reports.

8.2 Data Protection Laws

On 26 August 2024, the National Congress approved new legislation regulating the Protection and Processing of Personal Data, also establishing the Personal Data Protection Agency.

The new legislation introduces substantial modifications to the current Law No 19,628 on the Protection of Privacy, increasing the level of pro-

tection in this area, creating a regulatory authority, delimiting the exercise of rights by interested parties, establishing new sources of legality for data processing, regulating international data transfers, and establishing a robust regime of liabilities and sanctions.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

On 1 September 2024, Law No 21595 on Economic Crimes came into force, introducing changes to the liability of legal entities. Under it, the list of economic crimes has been expanded, a renewed sanctions regime has been introduced, new criminal figures have been incorporated, and the criminal liability of legal entities has been extended further than what had been previously contemplated by the Chilean legal system.

All of the above may have consequences on D&O coverage that companies demand, because in several cases the payment of criminal defence fees has been included.

On the other hand, on 4 January 2023, Law No 21521 that Promotes Competition and Financial Inclusion through Innovation and Technology in the Provision of Services (Fintech Law) came into force. This piece of legislation recognised parametric (index-based) insurance in Chile. However, the Financial Market Commission must create a regulation that refers to the variables that may trigger this insurance, the insurable risks under this type of insurance and the characteristics of the insurance policies that are registered before the regulator.

Trends and Developments

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The Health Insurance Market in Chile

The Chilean Commercial Code refers to health insurance in the final paragraph of Article 588, which states:

“For health insurance, or the modalities of other insurances that include such coverage, the insurer is compelled to pay, in the manner stipulated in the contract, the medical, clinical, pharmaceutical, hospitalisation, or other expenses incurred by the insured, if they or their beneficiaries require medical treatment as a result of illness or accident.”

According to this definition, health insurance provides compensation or reimbursement for any medical expenses arising from an accident or illness. Health insurance involves the purchase of a policy that commits the insurance company to cover expenses related to medical treatments specified in the contract. These can include medical, hospital, clinical, or pharmaceutical expenses.

The insured must pay a monthly premium that covers them and their beneficiaries or dependents, and to claim reimbursement, it is necessary for the doctor or health provider to complete

the form provided by the insurance company in the event of an accident or diagnosis of an illness. This type of insurance can be contracted individually or collectively, and its coverage can complement public and private health insurance (also known as “complementary insurance”) or as “catastrophic” insurance that covers high-cost illnesses, characterised by significant deductible amounts and high coverage limits.

Complementary health insurances are mainly focused on collective contracts, subscribed by an employer, union, or internal unit of a company, as a benefit to their staff. These do not replace the mandatory public (FONASA) or private (ISAPRE) health insurance coverage and do not necessarily cover the same benefits. A complementary health insurance covers minor medical expenses not included in the mandatory public or private health insurance coverage of the insurable. However, a catastrophic health insurance will undoubtedly have a higher premium as it is designed to cover more costly medical expenses such as surgeries, hospitalisation, etc.

Complementary health insurances are generally focused on collective contracts subscribed

by an employer or a negotiating entity, such as unions or internal company units. In this modality, the rates are lower compared to individual health insurances, despite providing the same coverage. This occurs because of the high insurance claim rate characteristic of the sector, which, when managed collectively, allows for greater control of expenses, as well as the possibility of diversifying this risk and reducing costs.

On the other hand, there are catastrophic health insurances that are aimed at covering high-cost illnesses and/or accidents. They provide their coverage through reimbursements, have a deductible, and an annual maximum limit. A different case is indemnity insurances that do not have a deductible and, upon diagnosis of one of the diseases included in the policy, immediately pay the insured capital amount.

The health system in Chile

In Chile, we have a mandatory health system that can be public (FONASA) or private (ISAPRES), and both systems coexist affiliated with social security. The legal health mandatory contribution – which workers and pensioners must obligatorily make to finance health benefits – corresponds to 7% of the taxable remuneration or income with a cap of USD3,500.

The public health system (FONASA) is the public institution that administrates state funds allocated to health in Chile, to provide coverage to its beneficiaries.

Like the private health system (ISAPRES), staying in FONASA implies that affiliates (dependent and independent workers) are compelled to contribute monthly 7% of their taxable salary.

The private health system (ISAPRES) are private entities that operate based on an insur-

ance structure, which are authorised to receive and manage the mandatory health contribution (7% of the taxable remuneration) of workers and individuals who freely and independently selected them instead of the public health system (FONASA). With these contributions, ISAPRES finance health benefits and the payment of medical leaves. These health benefits are provided through the contracting of medical services financed by ISAPRES.

ISAPRES were created in 1981 by the Ministry of Health and since 2005 are supervised by the Health Superintendence. Today they provide health financing services to approximately 19% of the Chilean population and have allowed the expansion of private medical activity and the investment boom in clinics, medical centres, and laboratories, among others, in Chile.

Evolution of the health insurance market

In recent decades, the complementary health insurance market has shown a growing evolution.

The request for complementary health insurances has increased due to several factors, such as the progressive increase in family income, the perception of deficiencies in both private and public health insurances, especially with the insufficient protection suffered by FONASA patients and the lack of coverage for ISAPRES affiliates, as well as the lower value of premiums due to the lower average cost per claim, among other factors.

In its Statistical Bulletin on Health Insurance (1998–2007), the Chilean Association of Insurers (AACH) publishes useful data to size this market over the last decade. It considers health insurances other than ISAPRES or FONASA coverages, that is, complementary or catastrophic

insurances, whether sold as collective or individual insurances. According to this, the Chilean Association of Insurers (AACH), the health insurance market is characterised by a high level of concentration. Thus, in the case of individual health insurances, three insurance companies represented more than half (58%) of the direct premiums in this category, and in the case of collective health insurances, the three largest companies (Metlife Chile, Euroamérica, and Security Vida) concentrated 48.6% of the participation in the [direct premium of this sector](#).

Another relevant characteristic of this market is the dynamism driven by the health system reform, with the introduction of the “Health Guarantees Regime” which guarantees universal access, both to users of the private system (ISAPRES) and the public system (FONASA), to comprehensive benefits and explicit guarantees (enforceable rights) associated with those pathologies considered priorities for the country. A very interesting topic is the implications that this greater health insurance coverage could have not only on the type of claims covered by complementary or catastrophic health insurance but also on their direct cost and consequently on the resulting market premium. The introduction of the “Health Guarantee Regime” and a growing rate of use of this coverage, for the solution of the included pathologies, could mean lower costs for complementary insurance and therefore the possibility of lower premiums in this sector, which it would allow access to a broader market of potential policyholders (Department of Studies and Development, Superintendence of Social Security).

Since 2000, direct premiums corresponding to health insurance have shown a growth trajectory higher than GDP, with much more pronounced increases than those achieved by it. In 2001, the

health insurance premium registered the largest increase in the period 1998–2007, consolidating a growth rate in this sector higher than that presented in life insurance. In relation to this, the average increase in health insurance premiums, of 10.2%, far exceeded that of the life insurance market (7.9 %) and the GDP (3.8%). According to the Association of Insurers, the accumulated increase in health premiums in ten years is 134.5%, explained both by the increase in the number of insured people and by the greater per capita spending on health premiums, in line with the trend shown developed countries. For example, Americans’ health spending exceeds 15% of GDP, while in Chile this percentage is just over 4%. In fact, the amount spent by the State on the public health system in 2007 only represented 2.8% of GDP, while private spending on the private health system in the same period corresponds to 1.2% of GDP. For its part, the health insurance premium (other than the mandatory health system) during 2007 reached USD130 million, which meant a growth of 8.2% compared to the previous year, but represents only 0.14% of the GDP of that year (Department of Studies and Development, Superintendence of Social Security).

As we will see, this growth continued to rise. According to AACH studies, in the decade between 2011 and 2020, health insurances recorded an accumulated growth of 127.5%, a figure higher than the GDP growth, which grew by 15.8%. In turn, the direct health premium in 2020 amounted to USD900 million, with a growth of 0.8% compared to the previous year. Finally, for 2020, a total of 8,998,825 people were insured by a health insurance company, which represents an increase of 29.5% compared to 2019.

What is coming ahead in health insurance

After the ruling of the Supreme Court of 2022, popularly known as “the ruling of the Isapres case”, and its degree of political repercussion, which even motivated substantial legislative modifications giving rise to the so-called “short Isapres law” (Law 21,674) that seeks to modernise FONASA through the creation of the Complementary Coverage Modality (MCC) that allows this Organisation to create voluntary complementary health insurance for all contributors to the National Health Fund and their dependents.

In this way, FONASA members will be able to access a coverage scheme made up of private providers with guaranteed minimum co-payments by paying a complementary premium in addition to the mandatory health contribution, covering both outpatient and hospital services. To provide greater financial protection, catastrophic insurance is additionally contemplated for those who enroll in this modality.

Scope of the Complementary Coverage Modality (MCC)

- The MCC will incorporate special financial coverage that will allow its beneficiaries to access assistances that have a high cost. This insurance will be considered in the fixed premium of the Modality.
- The special financial protection that this insurance will provide will be borne by the insurance company, and will cover all co-

payments derived from a specific health problem that exceed, within a calendar year, the deductible established in the policy.

- Catastrophic insurance will operate with providers within the MCC network. Its activation will be the responsibility of the insurance company automatically, once the co-payments financed by the beneficiary exceed the deductible.

Conclusion

The uncertain scenario faced by the Isapres in the country has caused many of its members to migrate to FONASA. In this scenario, complementary health insurance has gained ground and – currently – insurers have made progress in creating products that allow FONASA members to acquire insurance that complements their current coverage and allows them to minimise their co-payments and risks, thus providing solutions to those who seek to be more protected in this context.

Thus, currently, insurance companies provide coverage to users of both public and private health systems.

Additionally, the insurance market is preparing to venture into the marketing of MCC policies, since everything indicates that this insurance should be in force in the second half of 2025.

CHINA

Law and Practice

Contributed by:

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SGLA Law Firm was founded in Shanghai in 2008, and became one of the largest domestic integrated law firms in 2020 as member firms of the Sino-Global Legal Alliance joined SGLA. Headquartered in Shanghai, the firm also has offices across key regional cities in China, including Beijing, Shenzhen, Chongqing, Guangzhou, Guiyang, Chengdu, Kunming, Nanchang, Dalian, Tianjin, Zhengzhou, Xi'an, Wuhan, Lanzhou, Nanjing, Haikou and Hefei. It also has a strategic co-operative partnership with well-known international firms. SGLA has a profes-

sional and experienced team in the following areas: insurance and reinsurance; shipping and logistics; aviation; foreign-related affairs; dispute resolution; foreign-related affairs; corporate and commercial; securities and capital markets; bankruptcy and restructuring; intellectual property; labour and employment; urban renewal and real estate; and criminal and compliance. SGLA aims to be the trailblazer for the new model of growth by scale for Chinese law firms.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

In China, the substantive issues of insurance disputes are mainly governed by:

- the Insurance Law of the People's Republic of China (the "Insurance Law") and its relevant Interpretation promulgated by the Supreme People's Court (the "Interpretations of the Insurance Law"); and
- the Civil Code of the People's Republic of China (the "Civil Code") and its related Interpretations promulgated by the Supreme People's Court.

The Maritime Law of the People's Republic of China (the "Maritime Law") is also applicable to marine cargo insurance and marine hull insurance.

Procedural issues are mainly governed by the Civil Procedural Law of the People's Republic of China (as amended in 2023) (the "Civil Procedural Law") and its relevant Interpretation promulgated by the Supreme People's Court. In respect of marine insurance disputes, the Special Maritime Procedure Law of the People's Republic of China shall be applied.

1.2 Litigation Process and Rules on Limitation

Litigation Process

Filing a lawsuit

The litigation process of an insurance dispute begins with the plaintiff (who could be the policyholder, the insured, the beneficiary, etc) submitting a complaint to the competent People's Court of the First Instance, stating the facts of disputes, claims, and attaching preliminary evidence.

Registering the case

The People's Court will register a case after examining the submitted complaint and finding it satisfactory according to registration requirements.

Mediation

After registration of the case, the court may attempt to mediate between the parties and seek a settlement.

Hearing

If the dispute cannot be resolved through mediation, the court will hold hearings to hear the statements and arguments of both parties, during which the cross-examination of evidence will be carried out.

Judgment or ruling

After the hearing, the court will hand down a judgment or ruling based on the facts and the legal provisions to resolve the insurance disputes concerned.

Appeal

Where a party disagrees with the first instance judgment, they have the right to file an appeal directly with the higher level People's Court, without needing to obtain any permission or "leave" from any court.

Final judgment or ruling

After registration of the appeal, the higher court will give final consideration to the case and make a final judgment or ruling. There could also be retrial proceedings, although such applications are not always approved by the courts having jurisdiction, and the corresponding enforcement proceedings will not be stayed unless any specific rulings to stay the enforcement proceedings are made.

General Rules on Limitation

The starting point of limitation

In accordance with the Civil Code and other relevant provisions in China, the time limitation regarding insurance disputes generally runs from the date when the parties know or should have known about the occurrence of the insurance incidents concerned.

Limitation period

According to the Insurance Law, the time limitation for the insured or the beneficiary of insurance (except for life insurance) to claim compensation or payment of insurance benefits from the insurer shall be two years, running from the above-mentioned date. With regard to life insurance, the time limitation is five years.

Suspension of limitation

Under any of the circumstances stipulated in Article 194 of the Civil Code, the time limitation may be suspended and expire six months from the date when the reason for the suspension is eliminated.

Interruption of limitation

The time limitation may be interrupted pursuant to the provisions of Article 195 of the Civil Code, and shall recommence from the time of the interruption or termination of the relevant procedures.

1.3 Alternative Dispute Resolution (ADR)

ADR is encouraged in China. A relatively popular method of ADR at present is mediation, a procedure organised by the court prior to the registration of a case, usually with a specialised judge (typically a retired senior judge) appointed by the court giving assistance to the parties. For certain cases with relatively low-value claims, the court might entrust a third-party agency to give assistance in mediation.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes Jurisdiction

Hierarchical jurisdiction

In China's legal system, the primary court will act as the first instance court in most insurance cases. However, insurance disputes that involve significant sums or cross-border aspects might be handled directly by higher level courts, such as intermediate courts or the high courts.

Territorial jurisdiction

Article 24 of the Civil Procedural Law provides that jurisdiction for actions arising from insurance contract disputes lies with the People's Court of the defendant's place of residence or the location of the insured object.

For property insurance disputes involving transportation vehicles or goods in transit, jurisdiction can be asserted by the courts in three potential areas:

- the place where the transportation vehicle is registered;
- the destination of the transportation; and
- the location where the insurance incident occurred.

For personal insurance contract disputes, the court in the jurisdiction where the insured person resides holds the authority. For actions arising from personal insurance contract disputes, the jurisdiction can be with the People's Court of the insured person's place of residence.

The new Civil Procedure Law came into effect on 1 January 2024 and expands the jurisdiction of the People's Courts for foreign-related civil disputes, adding a new provision to allow for the same jurisdiction as long as the foreign-related

civil disputes have other appropriate links with the People's Republic of China.

Agreed jurisdiction

In accordance with Article 35 of the Civil Procedural Law, parties in a dispute can decide on a specific jurisdiction through written agreements. Where a jurisdictional agreement clearly defines a court without violating the provisions of hierarchical jurisdiction and exclusive jurisdiction by law, the specified court should assume jurisdiction; otherwise, the regular rules of the civil procedural law apply.

In accordance with Article 36 of the Civil Procedural Law, where multiple courts with actual connections to the dispute are mentioned, the plaintiff is entitled to select any of them for filing the lawsuit. It is noteworthy that agreements concerning jurisdiction made between service providers and consumers using standard terms are invalid if the service provider did not adequately draw the consumer's attention to such clauses. Courts should uphold a consumer's claim that such an agreement is invalid. If there is a change in the defendant's address after a jurisdiction agreement is made, the court that was in the defendant's jurisdiction when the agreement was made retains jurisdiction, unless otherwise agreed upon by the parties.

The new Civil Procedure Law has added a new provision that parties to a foreign-related civil dispute may choose the People's Court for jurisdiction by written agreement, and the People's Court may also be deemed to have jurisdiction if the parties do not raise an objection to jurisdiction and respond to the defence or file a counterclaim.

Choice of Law

Insurance contracts usually specify the legal jurisdiction under which they are to be interpreted and applied. In respect of contracts of international commercial insurance and cross-border insurance, it is common for the parties to choose a particular applicable legal system in the contract (such as English law, US law, etc). Where the choice of applicable law is not specified in the insurance contract, the court will usually determine which country's law is applicable, pursuant to the rules of private international law. In China, the determination of the applicable law will generally be considered with reference to factors such as the location where the insurance contract is signed or performed or the location that has an actual connection with the dispute.

2.2 Enforcement of Foreign Judgments

In accordance with the Civil Procedure Law and relevant international conventions, foreign judgments can be applied for enforcement in China subject to the following conditions:

- the judgment must have entered into force in the foreign country (ie, the court in that country must have confirmed the judgment and it has legal effect);
- the judgment must not violate China's public policy principles (ie, the content of the judgment must not be contrary to China's basic legal principles and social public interests); and
- the judgment must not be contrary to China's civil litigation jurisdiction principle (ie, the content of the judgment must be within China's jurisdiction).

The new Civil Procedure Law has added a new provision that if a party applies to a People's Court for the recognition and enforcement of a legally valid judgment or ruling made by a foreign

court, and the dispute under consideration by the People's Court belongs to the same dispute, the People's Court may rule that the litigation should be suspended and the new party may apply for reconsideration to a People's Court of a higher level, within ten days from the date of the delivery of the ruling.

Exclusion of Foreign Judgments

The People's Court may exclude the enforcement of foreign judgments under certain circumstances, including if:

- the foreign judgment has no legal effect in China (ie, it has not been recognised or acknowledged in China);
- the foreign judgment is contrary to China's public policy principles (ie, the content of the judgment seriously violates China's basic legal principles and social public interests); or
- the foreign judgment is in conflict with China's own judgment (ie, in the same dispute, the People's Court has already made a judgment that is inconsistent with the foreign judgment).

It is important to note that the enforcement or exclusion of a foreign judgment usually needs to be decided through litigation proceedings. The parties must file an application to a competent court, which shall hand down a judgment in accordance with the relevant laws and international conventions.

2.3 Unique Features of Litigation Procedure

Special Rules on Jurisdiction

For insurance cases, different regions in China may be under the jurisdiction of specialised courts. For instance, in Shanghai, the second instance for insurance contract disputes is under the jurisdiction of the Shanghai Financial Court instead of the Shanghai First Intermediate Peo-

ple's Court and Second Intermediate People's Court, which have jurisdiction over other civil and commercial cases. Marine insurance cases are under the jurisdiction of specialised maritime courts.

Guarantee Required for Property Preservation Applications

In accordance with Article 100 of the Civil Procedure Law, a party who applies for the preservation of the other party's property shall provide a guarantee. However, as is stipulated in Article 9.6 of the Interpretation of the Supreme People's Court on Several Issues Concerning the Handling of Property Preservation Cases by the People's Courts, which came into effect on 1 December 2016, the People's Court may not require the applicant for preservation to provide a guarantee if the applicant is a financial institution or one of its branches (such as a commercial bank or an insurance company) with independent solvency, which has been established with the approval of the financial regulatory authority.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Chinese courts generally enforce arbitration provisions in commercial contracts, including those in insurance and reinsurance agreements. In accordance with Article 5 of the Arbitration Law of the PRC, if parties have an existing arbitration agreement, a People's Court should decline a claim brought by one party unless the arbitration clause is deemed void. In addition, if one party initiates litigation, after agreeing to arbitration, without revealing the arbitration agreement and the opposing party does not object before court hearings begin, the arbitration clause is consid-

ered waived and the court shall proceed with the trial.

However, it is noteworthy that, under certain circumstances, Chinese courts may refuse to recognise and enforce an overseas arbitration award on the grounds that the place of arbitration lacks a close connection to the subject matter of the dispute, which may be adjudicated and decided in accordance with the standards adopted in PRC law.

3.2 The New York Convention

China acceded to the New York Convention in 1986, with the reservation that the People's Republic of China only applies the Convention to:

- the recognition and enforcement of arbitration awards made in the territory of another signatory, on the basis of the principle of reciprocity; and
- disputes based on the contractual and non-contractual commercial legal relations recognised under the laws of the PRC.

Enforcement Procedure

The procedure for enforcing a foreign arbitration award pursuant to the New York Convention involves the following steps.

Application to a competent court

A party seeking enforcement of a foreign arbitration award in China must apply to the intermediate People's Court where the party against whom the enforcement is sought resides or where its assets are located.

Documentation

The party applying for enforcement must submit the original or a certified copy of the arbitration award and the arbitration agreement. Corre-

sponding translated documents in Chinese are also required if the original documents are in another language.

Grounds for refusing enforcement

Chinese courts can refuse the enforcement of a foreign arbitration award based on the grounds set out in the New York Convention, including but not limited to the following situations:

- the arbitration agreement is invalid;
- the party against whom the award is invoked was not given proper notice or was otherwise unable to present its case;
- the award deals with issues that are not contemplated by or do not fall within the terms of the arbitration agreement; or
- the award has not yet become binding or has been set aside or suspended by a court of the country in which it was made.

Local conditions

In practice, while China is generally supportive of international arbitration and has made efforts to harmonise its approach in accordance with international standards, parties seeking enforcement might face challenges. For instance, as mentioned above, Chinese courts may refuse enforcement if they opine that the place of arbitration lacks a close connection to the subject matter of the dispute.

The new Arbitration Law (draft version), which was adopted by the State Council Executive meeting on 31 July 2024, adds the possibility for the parties to agree on the place of arbitration in the arbitration agreement (in line with international arbitration practice), the court of review of the award and the court of enforcement of preservation, including the court of the place of arbitration.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Popularity of Arbitration

Due to the efficiency, flexibility and perceived neutrality of arbitration compared to litigation in local courts, both domestic and foreign parties have increasingly favoured arbitration for resolving commercial disputes in China in recent years, especially in sectors where disputes may be complex, involve technical expertise or have cross-border elements. In the insurance context, this often includes areas such as marine insurance, large-scale property insurance, reinsurance and liability insurance.

Privacy of Arbitration

As provided in Article 40 of the Arbitration Law of the PRC, arbitration sessions are not conducted publicly unless both parties agree to a public hearing. However, matters involving state secrets cannot be made public, even with mutual agreement.

Applicable Rules

The primary law governing arbitration in China is the Arbitration Law of the People's Republic of China. There are specific arbitration institutions, such as the China International Economic and Trade Arbitration Commission (CIETAC), which have their own sets of rules. For insurance-specific arbitration, parties could opt to refer to the China Maritime Arbitration Commission (CMAC) or another specialised arbitration body.

Appeal of Awards

Arbitral awards in China are generally considered final and binding. The concept of "appeal" as it exists in certain other jurisdictions does not apply in the same way to arbitral awards in China (even just for "legal issues"). However, parties are entitled to request a court to set aside an

arbitral award, but only on the specific grounds stipulated by the Arbitration Law, which include:

- where there was no valid arbitration agreement;
- where the award exceeded the scope of the arbitration agreement; or
- where there was bias or corruption among the arbitrators.

In addition, as is stipulated in the New York Convention, Chinese courts may refuse the recognition and enforcement of a foreign arbitral award on certain grounds.

The New Arbitration Law of the People's Republic of China (Draft Revision) has narrowed the grounds for revocation by deleting "falsification or concealment of evidence" as a reason, and the time for applying for revocation has been shortened from six months to three months. Furthermore, a party may apply for review by a higher court against a decision to set aside an award.

4. Coverage Disputes

4.1 Implied Terms

The laws and regulations that are binding for the parties to insurance contracts contain various provisions that can be applied as implied terms. Some of these provisions clearly prohibit the parties to the contract from making agreements that are inconsistent with the content of these provisions. Such provisions are common in the Insurance Law, mainly involving the basic principles of insurance contracts, as in the following.

The Insurable Interest

Pursuant to Articles 12, 31 and 48, the insured must have an insurable interest in the insured

when the life insurance contract is concluded, otherwise the contract is invalid. As for property insurance contracts, the insured must have an insurable interest in the insured object when an insured event occurs, otherwise the insured cannot claim compensation or payment from the insurer.

Limit on Death Insurance

Articles 33 and 34 of the Insurance Law stipulate that people without civil capacity cannot be insured if said life insurance requires death as a condition for the payment of insurance benefits (except for life insurance policies taken out by parents for the benefit of their minor children). In addition, in a contract where death is the condition for the payment of insurance benefits, the amount insured must be agreed to and recognised by the insured, otherwise the contract shall be invalid.

Obligation to Notify of Increased Degree of Danger

In accordance with Article 52 of the Insurance Law, the insured is obliged to notify any significant increase in the degree of danger of the insured object during the validity period of the property insurance contract. Where the insured fails to fulfil such obligation, the insurer shall not bear the insurance liability for an insured incident occurring as a result of the significant increase in the degree of danger of the insured object.

Limitation

The rules and regulations in China's legal system prohibit the parties to the contract from negotiating a change in the limitation of actions, yet clearly prescribe that the limitation of disputes over life insurance is five years, while the limitation of disputes over property insurance contracts is two years, which is one year shorter than the ordinary limitation provided in the Civil Code.

In accordance with the principle that special law is superior to general law, the two-year special limitation shall be applied in litigation regarding disputes over property insurance contracts, instead of the three-year ordinary limitation.

Other Provisions

Other provisions prescribe terms that could be applied as implied terms, provided that there is no agreement contrary to the provisions or no relevant agreement is made in the contract. The characteristic of these provisions is that the text thereof usually contains the wording "unless otherwise specified in the contract", as in the following.

Termination of insurance contract

In accordance with Article 15 of the Insurance Law, the insurer may specify the causes of termination in the insurance contract. Where no similar agreement is made in the contract, the insurer shall not be entitled to terminate the insurance contract unless the conditions for the termination of contract stipulated by law are met.

Bearing costs related to liability insurance

The insurer may stipulate in the insurance contract that the arbitration or litigation costs shall be borne by the insured. Where there is no such agreement, the insurer shall bear the costs, in accordance with Article 66 of the Insurance Law.

4.2 Rights of Insurers

Pursuant to Article 16 of the Insurance Law, the policyholder is obliged to disclose relevant information about the insurance objects or the insureds truthfully to the insurer.

Remedies for Breaches of the Obligation of Disclosure

Where a policyholder deliberately fails to fulfil this obligation, thus affecting the insurer's deci-

sion on underwriting or increasing premium rates, the insurer is entitled to terminate the contract without making compensation for any insured event that has occurred prior to the termination of contract, and the premium shall not be refunded.

Where a policyholder fails to fulfil the obligation due to gross negligence, thus affecting the insurer's decision on underwriting or increasing premium rates, the insurer is entitled to terminate the contract. Where there is a serious impact on the occurrence of an insured event, the insurer shall not be liable to make compensation for the insured event that has occurred prior to the termination of contract, provided that the premium shall be refunded.

However, an insurer who is aware that the policyholder has not provided truthful information at the time of establishing the contract shall not be entitled to the right to terminate the contract, and shall bear the insurance liability for the insured event.

This right to terminate the contract shall be exercised within 30 days from the date on which the insurer came to know about the trigger event for the termination; otherwise, it shall be extinguished. The insurer will no longer be entitled to such right where the contract has been concluded for more than two years.

4.3 Significant Trends in Policy Coverage Disputes

Improving Dispute Resolution

People's Courts all over the country are committed to establishing and improving multiple dispute resolution mechanisms. There has been an increase in the proportion of insurance disputes settled through pre-litigation mediation and in-litigation mediation procedures.

Electronic Insurance

There has been an increase in the number of cases where insurance contracts are concluded by electronic means, resulting in an increase in disputes regarding the insurer's fulfilment of the obligations to remind and to provide clear explanation. Such disputes mainly involve the specific application and understanding of Article 17 of the Insurance Law.

Increased Complexity

A large number of related cases have emerged through the development of new types of liability insurance, such as occupational liability insurance, directors and officers liability insurance, cyber insurance, property preservation liability insurance, etc. The legal relations involved in such cases are complicated, and there is still much controversy over issues on fact-finding and the specific ways of undertaking responsibilities.

4.4 Resolution of Insurance Coverage Disputes

Insurance terms or special agreements in insurance policies usually contain dispute resolution terms, agreed by the parties, to resolve disputes through negotiation, arbitration or litigation. In legal practice, it is more common to resolve disputes through litigation.

Similar to general insurance contracts, reinsurance contracts usually stipulate dispute resolution clauses. The difference is that, in practice, the parties to the contract seem to be more inclined to agree to resolve disputes through arbitration.

4.5 Position If Insured Party Is Viewed as a Consumer

The Insurance Law and other relevant rules and regulations do not distinguish between consum-

er insurance contracts and non-consumer insurance contracts, nor do they distinguish between consumer insurers and non-consumer insurers in respect of the rights and obligations of the insured. However, there is a tendency to protect the insured in accordance with some specific provisions.

Bias Towards the Insured

If a standard insurance term provided by the insurer includes contents that exempt the insurer from its liabilities (such as deductible amount, deductible ratio, principle of average, etc), the insurer shall make a reminder of the standard term that is sufficient to attract the attention of the policyholder, and the insurer shall clearly explain the content of the clause to the policyholder. Failure to do so renders the standard term invalid.

Such standard term shall be invalid if its stipulation exempts the insurer from its statutory obligations, increases the liability of the policyholder or the insured, or excludes the legal rights of the policyholder, the insured or the beneficiary.

The Insurance Law also provides that disputed terms should be interpreted according to common understanding, and the interpretation that is beneficial to the insured should be adopted if there are two or more interpretations.

Regarding the Insured as a Consumer

There is controversy as to whether the insured is regarded as a consumer, focusing on whether the insurance involved in the case should be recognised as “purchasing or using goods, or receiving services for daily consumption” under Article 2 of the Law of the People’s Republic of China on the Protection of Rights and Interests of Consumers (“the Consumer Protection Law”). If the answer is positive, the insured shall also

enjoy the relevant rights provided in the Consumer Protection Law.

For high-risk financial products such as insurance investment products, it is clearly prescribed in the Minutes of the National Court Work Conference for Civil and Commercial Trials that the insured’s claim that the seller’s agency should bear punitive compensation pursuant to Article 55 of the Consumer Protection Law on the grounds that the seller’s agency has committed fraud will not be supported.

4.6 Third-Party Enforcement of Insurance Contracts

In liability insurance cases, where the insured causes damage to a third party, the third party may directly enforce the insurance contract or sue the insurer for payment of the amount insured, provided that all of the conditions stipulated in Article 65 of the Insurance Law are met.

In certain fields of liability insurance, the provisions of the third party directly suing the insurer are different from those of general liability insurance. For example, in accordance with the Law of the People’s Republic of China on Road Traffic Safety and the Regulations on Compulsory Liability Insurance for Motor Vehicle Traffic Accidents, in the compulsory third-party liability insurance of the motor vehicle and commercial third-party liability insurance, the insurer could opt to compensate the third party directly for losses and damages caused by the insured vehicles, while the third party is entitled to sue the insurer directly. Another example is that in accordance with the corresponding provisions in the International Convention on Civil Liability for Oil Pollution Damage and the International Convention on Civil Liability for Bunker Oil Pollution Damage, which China has joined, a third party is entitled to sue the civil liability insurer

directly for oil pollution damages in addition to filing a claim.

4.7 The Concept of Bad Faith

There is no concept of “bad faith” in the Insurance Law or other relevant laws or regulations. However, certain rules and regulations embody the spirit of the principle of good faith, as in the following examples.

- Article 5 of the Insurance Law prescribes that parties concerned in insurance activities shall comply with the principles of honesty and trustworthiness in the exercise of rights and performance of obligations.
- It is prescribed in the Insurance Law and the Maritime Law that the policyholder or the insured must perform the obligation of truthful disclosure, otherwise they shall correspondingly bear adverse legal consequences. The Interpretation further prescribes that an insurer who is aware that the insured has not fulfilled the obligation of truthful disclosure but still receives the premium shall not be entitled to terminate the contract. This also reflects the requirement of good faith on the part of the insurance parties.
- In accordance with the Insurance Law, the insurer is obliged to provide a reminder and clear explanation, and to pay the insurance benefit in a timely manner, otherwise it will bear the corresponding adverse legal consequences.

4.8 Penalties for Late Payment of Claims

The Insurance Law stipulates that insurance companies must compensate the insured party or the beneficiary for any resultant losses and damages if they delay the payment of claims. However, they will not be subject to administrative penalties.

4.9 Representations Made by Brokers

Under Article 118 of the Insurance Law and Articles 2 and 48 of the Regulatory Provisions on Insurance Brokerages, insurance brokers that provide intermediary services for the conclusion of insurance contracts based on the interests of policyholders should sign a power of attorney with the principal, to stipulate the rights and obligations of both parties as well as other matters, in accordance with the law. However, the signing of the power of attorney does not mean that the broker is the agent of the insured, so the insured is not bound by the statements made by the broker, unless it is otherwise stipulated in the power of attorney that there is a clear authorisation that the broker can make statements on behalf of the insured.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Authorisation arrangements for insurance agencies and insurance brokers are relatively common in practice, and the Insurance law and relevant rules and regulations also have provisions on such arrangements. Many litigation disputes are caused by these arrangements, regarding matters including but not limited to:

- whether the party involved is an insurance agent or an insurance broker (in many cases);
- whether the effectiveness of relevant acts of an insurance broker is attributable to or shall bind the insured/policy applicant;
- whether the insurance broker is at fault in engaging in the insurance brokerage business and has caused losses to the policyholder or the insured; and
- whether the effectiveness of the insurance agent’s relevant behaviour is attributable to or shall bind the insurer.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Pursuant to Article 65 of the Insurance Law, the litigation fees, arbitration fees and other necessary and reasonable costs fall within the coverage of liability insurance if the costs are incurred by the insured responding to a lawsuit or arbitration caused by an insured event causing damages to a third party, unless otherwise stipulated in the insurance contract.

Many P&I clubs also provide insurance (Freight, Demurrage and Defence, referred to as “FD&D”) for legal fees and expenses arising from bill of lading disputes, charterparty disputes, collision accidents, salvage, towage, general average, insurance contracts, etc.

5.2 Likely Changes in the Future

With the practice of FD&D, an increase in the number of insurance companies providing similar insurance products may be witnessed in the future. In addition, if a third-party funding arbitration system is introduced and established in China in the future, insurance products supporting defence may increase accordingly.

5.3 Trends in the Cost or Complexity of Litigation

In the past few years, litigation costs have mainly included litigation fees, arbitration fees, appraisal fees, attorney fees, etc. With the development of diverse dispute resolution methods, there may be an increase in, for instance, mediation fees and other fees incurred by alternative dispute resolution mechanisms.

In addition, the field of application may gradually expand with the continuous development of defence insurance, and the complexity and

diversity of such litigation will increase accordingly.

5.4 Protection Against Costs Risks

In accordance with the relevant provisions, the claimant can buy insurance to guard against costs risks incurred in filing or preparing for litigation or arbitration for the claim, such as litigation fees, arbitration fees, appraisal fees and attorney fees. At present, such types of insurance in the Chinese insurance market are legal fee insurance, legal fee compensation insurance, etc, which are especially common in the field of intellectual property, as follows:

- patent enforcement insurance and intellectual property enforcement insurance to protect against investigation costs and legal fees arising from filing legal claims for compensation for the infringement of patent rights and intellectual property;
- loss insurance for intellectual property rights litigation costs to compensate for the costs incurred in filing lawsuits to protect against intellectual property right infringement;
- patent worry-free insurance to compensate for direct economic losses, investigation costs and legal costs arising from patent infringement by a third party;
- copyright infringement loss insurance, trade mark infringement loss insurance and geographical indication infringement loss insurance to comprehensively cover the direct economic losses, investigation costs and legal costs caused by infringements of the insured’s copyright, trade mark rights and geographical indications by a third party; and
- legal fee insurance for overseas intellectual property disputes and legal fee insurance for patent disputes at overseas exhibitions to compensate for legal fees incurred in intel-

lectual property rights and overseas patent infringement disputes.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

The Insurance Law clearly grants the insurer of property insurance the right of subrogation against a third party (see Articles 60–63 of the Insurance Law), while the insurer of a life insurance contract is not entitled to claim the subrogation from a third party (see Article 46 of the Insurance Law).

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

There are provisions on the subrogation rights of property insurers against third parties in the Insurance Law and the Interpretation of the Insurance Law. Since there is much controversy in practice, the Supreme People's Court is committed to improving the relevant provisions on the right of subrogation by promulgating the Interpretation and publishing guiding cases and typical cases.

- Pursuant to the relevant provisions, under a property insurance contract, the insurer needs to claim the right of subrogation from a third party in its own name.
- The Insurance Law stipulates that an insurer is not allowed to exercise the right of subrogation against the insured's family members or its constituents when seeking subrogation from a third party.
- In insurance contract disputes involving the right of subrogation in practice, the party being subrogated usually argues that the insured has already waived its right of subrogation. The standard of the courts when

hearing such cases is that the relevant waiver of the insured should be clearly stated, rather than through reasoning or ratification after the fact.

- Many insurers expressly promise to waive the right of subrogation of their affiliated companies or even business co-operation companies in the process of concluding insurance contracts. Such agreements specified in the contract are valid and binding for the parties thereto.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Driven by the impact of the COVID-19 pandemic, China has expedited the adoption of digital solutions for dispute resolution, including online arbitration, mediation and court hearings. While these approaches offer benefits like convenience, speed and cost savings, they also introduce concerns related to data protection, privacy and technical glitches.

Furthermore, the pandemic has increased the number and complexity of insurance disputes, especially in relation to health insurance, life insurance, business interruption insurance, travel insurance and liability insurance. Disputed issues include the definition and scope of force majeure, the causation and extent of losses, the interpretation and application of policy terms and exclusions, and the burden of proof and evidence rules.

7.2 Forecast for the Next 12 Months

Due to the impact of the COVID-19 pandemic, disruptions and uncertainties for individuals and businesses have increased the demand and complexity of dispute resolution, while there

may be a gradual recovery and normalisation of social and economic activities in China in the post-pandemic era, which may reduce the number and severity of pandemic-related disputes.

Furthermore, the efficiency of procedures such as litigation and arbitration were significantly impacted, and there were also more challenges and difficulties for conducting online or offline hearings due to travel restrictions, quarantine measures and health risks. However, with the resumption of work in the affected industries and departments, this issue has now improved.

7.3 Coverage Issues and Test Cases

In China, there have been several cases involving health insurance claims related to COVID-19 infections or deaths. Some insurers denied or scaled back coverage based on the exemption terms or other limitations related to infectious diseases or force majeure events. In response, some policyholders have contested these decisions, invoking consumer protection regulations or principles of contractual interpretation.

In terms of cases involving business interruption insurance with claims related to COVID-19 lockdowns or restrictions, some insurers argued that the relevant claims fell outside the scope of coverage, asserting that compensation and settlement necessitate physical damage to property or direct intervention by authorities. Conversely, some policyholders argued that the loss of income or profit due to an unforeseen event should also be included in the coverage. The outcomes of these disputes have varied, depending on the specific facts and circumstances of each case, such as the respective terms and conditions of the policies.

7.4 Scope of Insurance Cover and Appetite for Risk

The COVID-19 pandemic increased the demand for and awareness of insurance products, especially health insurance, life insurance and online insurance. However, this also means higher costs and risks for insurers due to potential increases in claims, disputes and other uncertainties. Therefore, some insurers may adjust their coverage, premiums or exemption terms to better match the current market trends and the needs of customers.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Environmental, social and governance (ESG) concerns have received widespread attention and discussion in China in recent years. In June 2022, the China Banking and Insurance Regulatory Commission released the Guidelines for Green Finance in Banking and Insurance Industries, the core content of which is to introduce the principles and requirements of ESG into the decision-making and management systems of financial institutions. For the insurance industry, the introduction of ESG relates to its core business's risk management and decision-making processes. This has encouraged insurance companies to make a series of adjustments in underwriting decisions, product development and risk assessment, which will have certain implications for insurance coverage and litigation.

Adjustment of Insurance Companies' Underwriting Strategy

Based on the characteristics of different industries or fields, insurance companies' underwriting strategies may be adjusted in responding to the ESG assessment system. This also means

that insurance companies may be facing higher due diligence and compliance costs. For example, companies involved in high pollution and high energy consumption may face stricter regulatory constraints, which implies that these companies may face higher claim risks. Accordingly, insurers should be more cautious when carrying out due diligence investigations into these companies, and should place stricter limitations on their coverage. Meanwhile, companies that adopt sustainable measures and actively fulfil their social responsibilities may receive preferential treatment from insurance companies.

New Insurance Products and Services

Many risks in the ESG domain are insurable risks, such as environmental risks from natural disasters and pollution, social risks from employee health and product liabilities, and governance risks like director liabilities. More ESG-related products and services are expected to emerge in the insurance market in the future.

Potential Increase in Litigation Related to Insurance Coverage

As public attention on ESG issues increases, insurance companies may face more ESG-related claims and litigation. For instance, victims may seek compensation in cases of accidents or pollution caused by poor environmental management, in which situations the companies may attempt to obtain compensation from their liability insurance.

Potential Reduction in Litigation Risk for Insurance Companies

Since ESG covers the interests of various stakeholders in the environment and society, it essentially forms a supervisory mechanism, which, at least theoretically speaking, could regulate corporate behaviour more effectively than the previous evaluation standards, thereby reduc-

ing the company's litigation risks. Therefore, it is believed that insurance companies will incorporate ESG more in their internal governance and control for assessment in the future.

8.2 Data Protection Laws

The legal framework for data protection in China is underpinned by a series of comprehensive laws and regulations that address both the broader issues of data security and the specific challenges related to personal data.

Legal Framework for Data Protection in China and Its Impacts

The Cybersecurity Law (CSL)

Enacted in 2017, the CSL seeks to ensure network security and protect cyberspace sovereignty. It established the minimisation principle in data collection, restricting the arbitrary use or transfer of data. Transfers require consent from the original data rights-holder, and individuals must also have access to their collected data and can request its deletion.

The Civil Code

Enacted in 2020, the Civil Code is the first comprehensive codification of civil law in China. It includes provisions on personal rights, including data rights, and clearly prescribes that businesses collecting user data must adhere to the principles of necessity, legitimacy and reasonableness.

Personal Information Protection Law (PIPL)

The PIPL was enacted in 2021 as the comprehensive national law for personal data protection, and emphasises lawful, legitimate and necessary data processing. It also addresses cross-border data transfers, which has a potential impact on multinational insurers.

Data Security Law (DSL)

While the PIPL focuses on personal data, the DSL (enacted in the same year) covers data security in a broader sense, encompassing both personal and non-personal data. It introduces a tiered data security system based on the relevance of the data to China's interests. Data deemed "important" requires a risk assessment for overseas transfer.

Relevant Guidelines and Regulations

In addition to the aforementioned core laws, there are several sector-specific guidelines, regulations and standards, usually provided by the China Banking and Insurance Regulatory Commission (CBIRC), which further define the expectations and responsibilities for financial industries, including insurance providers operating in China. For instance, the Regulations on the Management of Insurance Sales Behaviour (Draft for Solicitation of Comments) specifically stipulates that insurance sales activities should respect and protect the fundamental rights to information security of the policyholders, insured parties and beneficiaries, further specifying the principles and rules that insurance companies and insurance intermediary agencies must adhere to during the information collection and processing.

Impact of Data Protection Laws on the Insurance Industry

In the domain of underwriting, data protection laws can create both challenges and opportunities for insurance companies. The stringent rules on data collection might limit the type and amount of data that insurers can gather, which is critical for assessing risks accurately. Precision underwriting techniques that rely heavily on large datasets and employ AI and data analytics might face restrictions. This situation could affect product development and risk profiling.

Moreover, global insurers may find it challenging to consolidate data across borders due to data localisation requirements. As a result, while there is a push for insurers to innovate and offer personalised policies using personal data, they must navigate the regulatory landscape cautiously to ensure compliance and accurate risk assessment.

As for the litigating of insurance risks, insurers must exhibit heightened diligence during claims verification due to the rights individuals have under data protection laws, like data access and correction. If insurers contravene data protection regulations, they risk that litigation could lead to significant fines and reputational damage. Ambiguities in data collection or usage can also spur disputes between insurers and policyholders. Moreover, in legal scenarios, the way data has been protected might influence its credibility and admissibility as evidence, so insurers have to be meticulous in their data-handling processes to avoid potential pitfalls during litigation.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation Amendment of the Insurance Law

The Insurance Law is set for its fifth amendment, aiming to address prominent practical issues arising from its implementation, which, as understood from the corresponding discussions in the market, may include but not be limited to the following.

- Internal governance of insurance companies: the primary practical issues highlighted include the composition of the board of directors (especially the formation of independent

directors), the need for independent directors to possess relevant professional knowledge and industry experience, and the specific procedures on how directors can effectively fulfil their roles.

- Issues regarding standard terms: in accordance with Article 17 of the current Insurance Law, where an insurer adopts standard terms during the conclusion of contract, it must explain these terms to the policyholder. Where exemption terms are included, the insurer must sufficiently highlight and provide a clear explanation of the terms. However, in practice, ambiguities exist regarding definitions such as “clear explanation”. Furthermore, the scope of what constitutes an exemption term remains unclear. In addition, the introduction of the Civil Code has brought about changes in the portrayal of standard terms, causing subsequent application issues under the Insurance Law. These problems are expected to be addressed and rectified in this amendment.
- Inclusion of new insurance contracts: there has been a debate over whether the Insurance Law shall govern the new types of insurance contracts, which are roughly categorised into investment-type insurance contracts and health insurance contracts. The revision needs to define the nature of these new types of insurance contracts and thus to clarify the obligations and responsibilities of all parties involved.

D&O insurance

The newly revised Company Law of the People’s Republic of China came into effect on 1 July 2024 and establishes a directors and officers (D&O) liability insurance system by way of legislation for the first time. In recent years, D&O liability insurance has gradually come into the public’s view, and the rate of insurance coverage

has risen significantly as a result of the fraudulent incidents of listed companies such as Kangmei Pharmaceuticals and Ruixing.

D&O insurance provides legal litigation costs and liability compensation insurance for corporate directors and executives. The demand for it in the market is increasing due to factors such as the implementation of the new Securities Law, strengthened market regulation, and investors’ focus on corporate governance. This new kind of insurance may lead to a new kind of insurance litigation, which may be widespread in the future.

On 7 November 2023, the Convention Abolishing the Requirement of Legalisation for Foreign Public Documents came into effect in China. It greatly simplified the transnational authentication and circulation procedures of public documents, and also effectively improved the efficiency of foreign-related judicial procedures and reduced the burden on the parties concerned, which may have a profound impact on insurance litigation.

Impact on insurance litigation

As for insurance coverage, the amendment may place an emphasis on transparency and accountability, especially with the focus on board composition and the role of independent directors in insurance companies, which is anticipated to lead to stricter underwriting criteria, potentially reshaping the terms and design of insurance products. In addition, the move to provide more clarity on standard terms, especially exemption terms, will likely simplify insurance policies and reduce ambiguities. The introduction of new types of insurance contracts will also expand and diversify the range of available insurance products, offering consumers more specialised coverage options.

The upcoming amendment of the Insurance Law may aim to minimise policy interpretation disputes by seeking clearer definitions around terms and exemption clauses. By aligning with the interpretation of the Civil Code and pinpointing which terms are considered exemption terms, the chances of litigation arising from misunderstandings or ambiguous interpretations could decrease. However, the integration and classification of new insurance contracts may bring a temporary increase in litigation, as a result of the market adapting to and navigating the boundaries and interpretations of these contracts until standardised practices are firmly in place.

In addition, with better-defined standard terms and exemption terms, it is believed that insurers will have clearer criteria on which to base their claims decisions, potentially reducing the frequency of disputes and the consequent need for defence funding. However, the initial unfamiliarity with claims related to these fresh product offerings may mean insurers need to allocate more resources towards claim defences until practices become standardised.

The simplification of judicial procedures following the implementation of the Convention Abolishing the Requirement of Legalisation for Foreign Public Documents is reflected in the following.

- Simplification of the authentication process: the transnational circulation of public documents is simplified by the adoption of an additional certificate (Apostille) instead of the traditional consular authentication. The Apostille can be used directly in the Contracting States without the need for multiple authentications by embassies and consulates abroad, thus reducing time and formalities.
- Reducing the burden of the parties: the parties do not need to go through the cumbersome consular authentication, but only need to obtain additional certificates to use the relevant official documents.
- Subject qualification materials: when foreign enterprises or organisations conduct litigation in China, they only need to handle the subject qualification documents certified by The Hague, which makes the procedure more convenient.
- Power of attorney materials: the authentication of the power of attorney has been changed from “notarisation + authentication” to “notarisation + additional certificate”, which simplifies the process.
- Evidence review: evidence involving identity relations is prioritised for the application of Hague certification, and only additional certificates are required, without consular certification.

Trends and Developments

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AnJie Broad Law Firm has an insurance practice team that assists clients in a wide range of service areas, including insurance M&A, establishment and compliance operations of insurance institutions and finance work. It provides accurate policy advice and first-class dispute resolution services across numerous policy types and market sectors. Insurance dispute resolution is a core practice area and a team priority. The team of over 50 lawyers consistently acts on the toughest arbitration cases at the forefront of insurance dispute resolution, as

well as property insurance claims disputes, life insurance claims disputes, insurer's subrogation disputes, reinsurance contract disputes, insurance-fund product disputes and insurance institution investment disputes. The firm can offer both local insights and global reach, and has established an extensive co-operative network with first-class law firms in the US, the UK, Germany, France, Canada, Australia, Japan, South Korea, and other states and regions, which allows AnJie Broad to deliver top-tier global insurance-related legal services.

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CHINA TRENDS AND DEVELOPMENTS

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Insurance Litigation in China: an Introduction

The insurance industry is an important pillar of the financial and social security systems, and China's insurance industry has achieved rapid development in recent years. As of 31 December 2023, there were 352 members of the Insurance Association of China (IAC), 13 of which were 13 insurance group (holding) companies, 87 property insurance companies, 96 life insurance companies, 14 reinsurance companies, 18 insurance asset management companies and 70 insurance intermediaries.

Other than the members of the IAC, there are still more asset management companies and insurance intermediaries acting in the market. According to data released by the National Financial Regulatory Administration, the primary insurance premium income from January to July 2024 totalled RMB3.9423 trillion, an increase of 5.2% year-on-year.

With the continuous development of the insurance industry, the number of insurance litigation cases is also growing. As of September 2024, there were more than 1.24 million litigation cases in relation to insurance disputes from the China Judgments Online Database, mainly involving disputes over property insurance policies and life insurance policies, as well as some subrogation cases and a small number of insurance premium disputes cases. Litigation and arbitration are still the main ways to resolve insurance disputes, but the surge in insurance disputes has created a demand for the development of various dispute settlement systems.

Trends and developments

Disputes may arise regarding all aspects of the formation and performance of insurance policies, such as:

- the determination of the validity and application of the exclusion clause;
- whether the insurer meets its obligation to make an explicit explanation of the meaning of the exclusion clause;
- whether the incident is covered by the insurance policy; and
- whether the calculation of the loss is accurate.

Insurance litigation cases regarding new types of insurance policies continue to emerge as well. In addition to disputes arising out of the traditional insurance policies, such as motor vehicle liability insurance, work injury insurance, pension insurance and life insurance, cases related to cyber insurance, D&O liability insurance and green agriculture insurance are also emerging. Insurance litigation regarding these new types of insurance policies may involve multiple legal relationships and complicated facts, which creates difficulties and challenges for law practitioners and adjudicators. Some new types of insurance litigation are set out in detail below.

Increase in securities class actions leading to rapid growth in claims and litigation cases relating to D&O liability insurance policies

With the official implementation of the new Securities Law of the People's Republic of China in March 2020, PRC supervisory departments have continued to make breakthroughs in clarifying the scope of liability and compensation for responsible directors and officers, and have further strengthened the recourse against the actual controller of listed companies.

As of 2023, a total of 304 A-share listed companies issued announcement information about the purchase of D&O liability insurance, 174 of which were announcing the purchase of D&O liability insurance for the first time. This number

represented a slight decline, after three years of sustained rapid growth. Multiple factors were believed to contribute to the decline, such as the progressively diminishing impact of landmark cases imposing liabilities on directors and officers, and the cost-saving measures adopted by listed companies facing financial challenges.

However, it is noteworthy that the new Company Law of the People's Republic of China, implemented as of 1 July 2024, imposes stricter legal responsibilities on the actual controllers and director and officers of companies. This may lead to an increased need for the relevant parties to seek insurance coverage, thereby presenting new opportunities for the D&O liability insurance industry.

Under the influence of the stricter regulation, the risk of litigation involving listed companies related to misrepresentation and fraudulent statements has risen, the standard of directors and officers performing their fiduciary duties has been higher, and the corresponding disputes over D&O liability insurance policies have increased. Compared with other liability insurance litigation, D&O liability insurance litigation has fewer referable precedents, complex legal relationships and difficulties in the application of laws.

Situations will be more complex when foreign litigation procedures are involved. As many Chinese companies choose to be listed in the stock markets outside of mainland China, such as the Hong Kong Stock Exchange, the New York Stock Exchange or the NASDAQ, the class actions and investigations brought against insureds in those jurisdictions will make the claims under D&O insurance policies even more challenging, on matters such as:

- whether penalties imposed by foreign regulators are covered under the D&O policy;
- how to apply the foreign law to make the allocation of loss when covered and uncovered insureds are both sued;
- how to determine the reasonableness of the settlement amount entered in the proceedings in another jurisdiction when the D&O policy dispute is heard by a PRC court or arbitration tribunal, etc.

Insurance litigation in the Internet Plus era

With the rapid development of the social economy and internet service, online sales of insurance products are expanding rapidly, creating new opportunities for the development of the insurance industry. According to the Interim Measures for the Supervision of the Cyber Insurance Business issued by the China Banking and Insurance Regulatory Commission (CBIRC – the former China Insurance Regulatory Commission), insurance companies can operate cyber insurance business in several areas, such as personal accident injury insurance, term-life insurance and whole-life insurance, household property insurance, liability insurance, etc. In 2016, nearly 80% of Chinese insurance companies had started their cyber insurance business through different business models, such as constructing their own websites or co-operating with third-party platforms.

The development of cyber insurance without a well-established regulation system has triggered chaos. In 2019, the CBIRC and its branches received 19,900 consumer complaints about cyber insurance, which represented a year-on-year increase of 88.59% and seven times the complaint volume in 2016. The rapid growth correspondingly resulted in a surge of litigation cases related to cyber insurance policies. The formation of a cyber insurance policy is different

to that of a traditional policy, so the disputes are usually related to the formation process.

According to Article 3 of the Interpretation of the Supreme People's Court on Several Issues Concerning the Application of the Insurance Law of the People's Republic of China (II) (amended in 2020), if the policyholder or the policyholder's agent does not sign or seal the insurance policy in person, but the insurer or the insurer's agent signs or seals it on behalf of the policyholder, the policy should not take effect for the policyholder; however, if the policyholder has already paid the insurance premium, it should be regarded as its retroactive recognition of the act of signing or stamping on behalf of the policyholder. Therefore, whether the electronic signature is provided by the policyholder themselves and whether the electronic signature is valid are significant in the formation and inception of cyber insurance policies. The effectiveness of the cyber insurance policy also depends on whether the policyholder pays the premium in full and on time through electronic payment.

According to Article 17 of the Insurance Law of the People's Republic of China (the "PRC Insurance Law"), an insurer should highlight clauses that exclude the liability of the insurer on the insurance application form, insurance policy document or any other insurance certificate, for the attention of the policyholder in an insurance policy, and should explain the contents of such clauses to the policyholder, in writing or verbally; where there is no highlighting or explicit explanation, such clauses should be invalid. Due to the convenient and efficient characteristics of purchasing cyber insurance, the policyholder frequently asserts that the insurers fail to perform their obligation under Article 17 of the PRC Insurance Law. Therefore, in cyber insurance litigation, it is up to the insurers to prove that they

fulfil the obligation to inform the policyholder of the contents of the insurance policy truthfully through the internet sales platform.

Insurance litigation in the green economy

The demand for green insurance in the green financial market is increasing, and agricultural insurance plays an essential role in the growth of green insurance in China. China is currently one of the major countries in terms of agricultural insurance premium income, which totalled RMB142.97 billion in 2023. Faced with the direct or indirect risks brought by global environmental pollution, climate change and natural disasters, the corresponding disputes over agricultural insurance policies have increased. The main features are as follows.

- First, agricultural insurance policies litigation usually comes in the form of a series of cases – ie, different plaintiffs in the same area bring separate litigation cases against the same insurer for similar facts and reasons.
- Second, agricultural insurance products are generally policy-oriented, and subsidies from the local government are granted for public interest considerations. The PRC Agricultural Insurance Regulations clearly stipulate that the local financial department is the administrative agency of agricultural insurance, and the subsidies are determined by the local financial department. Therefore, when they hear the relevant cases, in addition to applying the PRC Insurance Law, the Civil Code of the People's Republic of China (the "Civil Code") and other laws, PRC courts also need to take into account the regulations issued by the local financial departments.
- Third, parties to agricultural insurance policies are prone to dispute the validity of the terms of the insurance policy and the manner of determining the loss resulting from

incidents. In practice, the two main disputed focal issues are whether the loss has really occurred and whether there is a fraudulent claim.

- Lastly, because the insureds of agriculture insurance policies generally have low incomes and are in a relatively vulnerable position, the PRC courts tend to protect the interest of the insureds by taking into account the principle of equity.

Litigation property preservation liability insurance

Litigation property preservation refers to the protection measures taken by the court to prevent the party (generally the defendant) from transferring, concealing or selling the property before the judgment is issued, so as to ensure the smooth execution of the judgment after it takes effect in the future.

In accordance with the Civil Procedure Law of the People's Republic of China, when receiving the application for taking preservation measures, the People's Court may require the applicant/plaintiff to provide a guarantee. In recent years, a litigation property preservation liability (LPPL) insurance policy is considered a qualified and legitimate method through which to provide a guarantee.

LPPL insurance generally covers the losses suffered by the defendant as a result of the wrongful or improper application for property preservation. When the applicant/plaintiff loses the case, the defendant will sue the applicant/plaintiff and the insurer to reimburse the losses caused by property preservation measures.

With the wide application of LPPL insurance in civil litigation cases, more and more disputes have arisen out of such insurance policy. The

following criterion will be considered in LPPL disputes:

- whether the applicant has subjective fault;
- whether the preservation measures are adopted in an improper manner;
- whether the defendant suffered any loss; and
- whether there was a direct causation between the improper preservation measures and the defendant's loss.

New Laws, Regulations and Trends

Planned amendment of the PRC Insurance Law

On 6 May 2024, the General Office of the State Council issued the "State Council's 2024 Legislative Work Plan", which indicates that the draft amendment to the PRC Insurance Law is planned to be submitted to the Standing Committee of the National People's Congress for deliberation. This signifies an acceleration in the pace of the new round of amendments to the PRC Insurance Law.

Formation of the State Financial Regulatory Administration

On 18 May 2023, the National Financial Regulatory Administration was formed on the basis of the CBIRC, and is responsible for the supervision of the financial industry, including the insurance industry.

Before this, the CBIRC had been in operation for more than five years. With the formation of the State Financial Regulatory Administration, the CBIRC will no longer exist.

Changes of hierarchical jurisdiction

In China, there are four levels of courts:

- the primary courts;
- the intermediate courts;

- the high courts; and
- the Supreme People's Court.

In accordance with the judicial interpretations published by the Supreme Court on 17 September 2021, the following applies:

- if the amount in dispute for a civil case is less than RMB500 million (not inclusively), the primary court will have first instance jurisdiction;
- if the amount in dispute for a civil case is between RMB500 million (inclusively) and RMB5 billion (not inclusively), an intermediate court will have first instance jurisdiction; and
- if the amount in dispute for a civil case is more than RMB5 billion (inclusively), the high court will have first-instance jurisdiction.

It is rare for the Supreme People's Court to hear a case at the first instance.

Changes of territorial jurisdiction

In accordance with PRC laws, a lawsuit brought in an insurance dispute will fall under the jurisdiction of the People's Court where the domicile of the defendant or the insured object is located.

However, the territorial jurisdiction is subject to some exceptions. China has established some professional courts, such as the financial court, to handle litigations in some specific sectors. For instance, since 26 March 2021, the Beijing Financial Court hears insurance disputes over which the Beijing Intermediate People's Court has first instance jurisdiction. The Beijing Financial Court will also try the appeals for insurance disputes from the district courts of the first instance.

Impacts of the Civil Code

The Civil Code came into force on 1 January 2021, and its provisions have numerous, signifi-

cant impacts on the PRC Insurance Law and its judicial interpretations.

In accordance with the Civil Code, insurers have a specific explanation obligation not only with regard to clauses that exempt or diminish the insurer from liability as prescribed by the PRC Insurance Law, but also for those clauses in which the applicants, beneficiaries or insureds have major interests.

Another noteworthy point concerns the amendment of the statute of limitations. Article 188 of the Civil Code provides that the limitation period for a person to request the People's Court to protect their civil rights is three years, unless otherwise provided by law. However, before the Civil Code officially stipulated this statute of limitations, a two-year statute of limitations had long been implemented in China in accordance with the PRC General Principles of Civil Law, promulgated in 1987.

The PRC courts have been divided as to whether a two-year or three-year statute of limitations should apply to disputes involving property insurance policies, because the current PRC Insurance Law still stipulates that the period of limitation for the insured or beneficiary of non-life insurance to claim insurance benefits is two years. Up to now, most of the courts would hold that a three-year statute of limitations in accordance with Article 188 of the Civil Code should be applied in property insurance claims, as most courts believe that the two-year statute of limitations prescribed by the PRC Insurance Law was inherited from the abolished PRC General Principles of Civil Law, instead of the special provisions of the PRC Insurance Law.

Diversified dispute resolution mechanisms

Against the background of increasingly complex insurance policy types and an upsurge in disputes, the establishment of diversified dispute resolution mechanisms has become a new trend, in addition to the traditional dispute resolution measures of litigation and arbitration.

On 22 May 2020, the Supreme Court of the People's Republic of China, the Ministry of Public Security, the Ministry of Justice and the CBIRC jointly issued the Notice on Promoting the Reform of "Integrated Online Data Processing" for Road Traffic Accident Damage Disputes (Law [2020] No 142), which standardised and improved the relevant mediation mechanism. A series of relevant legal documents have since been issued, reflecting the importance of establishing and improving diversified dispute resolution mechanisms.

A diversified dispute resolution mechanism involves the resolution of a dispute through mediation in the form of non-litigation by insurance industry associations, arbitration institutions, courts and other third parties, when an insured and an insurer in a dispute cannot reach a settlement by themselves.

According to the different participants, there are three main forms of diversified dispute resolution mechanisms in the insurance industry:

- the first model involves the insurance industry association leading the parties in settling the dispute, with guidance from the CBIRC;
- the second model involves the administrative organs as the main body to lead the two parties settling the disputes; and

- the third model involves the arbitration institution as the main body to lead the parties settling the disputes through mediation or settlement, instead of arbitration procedures.

In recent years, valuable experience has been accumulated in the establishment of diversified dispute resolution mechanisms. However, there are certain shortcomings, as follows.

- First, the legal and regulatory system has not been well established. Although the Supreme Court of the People's Republic of China and the CBIRC have issued a series of legal documents, in practice, the legal status of the parties involved in mediation and the unified implementation of rules and regulations are still subject to further detailed laws and regulations.
- Second, the publicity and popularisation of diversified dispute resolution mechanisms need to be strengthened.
- Third, the multiple dispute resolution mechanisms require enhanced financial support.

Outlook and conclusions

China has shown great potential in the development of the insurance industry, achieving a rapid expansion of the market; the number of insurance litigation cases has also increased significantly due to the development of the market. With the gradual maturity of the insurance industry, the improvement of relevant laws and regulations and the development of diversified dispute resolution mechanisms, insurance litigation related to both traditional insurance policies and new types of insurance policies is expected to be more properly resolved in the near future.

CYPRUS



Law and Practice

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Chryssafinis & Polyviou LLC was established in 1903 and is one of the oldest and most prestigious legal practices in Cyprus, capable of handling complex and challenging cases in both the advisory and litigation domains. The firm currently employs over 70 staff members, around 30 of whom are highly trained and qualified lawyers with various specialisations, such as administrative law, banking law, company and commercial law (including mergers and acquisitions), competition law, constitutional law,

the law of defamation, employment law, insurance law and litigation. Local and international credit institutions, insurance undertakings, investment firms, energy companies and G7 member states, among others, trust the firm to legally advise and/or represent them in Cyprus. Chryssafinis & Polyviou has also developed an extensive and dynamic network of corresponding legal practices abroad, including some of the leaders in the field.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

In Cyprus, insurance disputes are governed by a wide range of legislation and procedural rules, as well as common law principles.

Statutory Regime

Insurance contracts

As insurance contracts are essentially private contracts, the Contract Law (Cap 149) governs disputes relating to the interpretation of insurance contracts, breach of contract, etc. Common law rules are also applicable in insurance contract disputes, as insurance policies have been widely interpreted and regulated by practice. EU Directives and related laws on consumer contracts and protection may also apply on insurance contract disputes, such as Law 93(I)/1996, which implements Directive 93/13/EEC on unfair contract terms in Cyprus.

Disputes relating to negligence

Cap 148 governs the regulation of general negligence disputes, including personal injury claims and medical negligence, while common law principles govern the resolution of tort law cases relating to insurance.

Specific legislation

The Cypriot Law on Motor Vehicles (Third Party Liability Insurance) (Law 96 (I)/2000) governs cases relating to motor accidents, and deals with insurance disputes at a contract level as well as personal injuries. It generally regulates the enforcement of insurance contracts' terms by third parties.

EU Directive 2009/103/EC on motor insurance has also been implemented in Law 96(I)/2000. Furthermore, Law 96(I)/2000 contains provisions regarding the Motor Insurers' Fund, which is a compensatory body for victims of uninsured and unknown drivers. It also deals with insolvent insurance companies that have been involved in car accidents and accidents that took place outside the jurisdiction.

The Law on Compulsory Insurance of Employers Liability (Law 174/1989) requires employers to conclude insurance contracts regarding liability concerning accidents and/or diseases caused in the professional environment.

Procedural Regime

Although parties to an insurance contract are free to choose the way in which their disputes are resolved, in Cyprus such disputes are usually

resolved in civil courts, and general civil procedure rules are applicable.

Civil Procedure Rules

In the new Civil Procedures Rules (CPR) that were implemented on 1 September 2023 in Cyprus, specific provisions deal with the resolution and initiation of insurance claims in District Courts, including specific pre-action protocols that must be followed. The old Civil Procedure Rules continue to govern cases filed before 1 September 2023, but no specific procedural rules on insurance claims can be found in the old rules.

Insurance disputes are heard by District Courts and on a second level by the Appeal Court. A third level of review was established in Cyprus in 2023, whereby an appeal from the Appeal Court is heard by the Supreme Court.

Arbitration

The Arbitration Act (Cap 4) governs domestic arbitration proceedings that can take place in Cyprus. Parties to an insurance dispute may incorporate an arbitration clause in their contract or agree to such dispute resolution method after the dispute has arisen. Arbitration is not very popular as a dispute resolution method for insurance claims in Cyprus and is not widely employed to resolve insurance claims.

Financial Ombudsman

Any individual can submit a complaint to the Financial Ombudsman against financial businesses, regarding a dispute of up to EUR170,000 in value, provided that the following conditions are cumulatively met.

- The complaint must be submitted by a consumer.

- Before it is submitted to the Financial Ombudsman, the complaint is submitted to the insurer in writing within 15 months from the date the consumer became, or ought to have reasonably become, aware of the harmful action/omission of the insurer. The latter must acknowledge receipt of the complaint (whether it responds to it is only relevant in terms of timing).
- The insurer must have been operating on the basis of a lawfully issued licence (or by virtue of the freedom of establishment) at the time the complaint refers to.

The Financial Ombudsman does not undertake the examination of complaints in the following circumstances:

- if the complaint relates to a transaction that does not fall under the competences of the competent supervisory authorities;
- if, on the day of their submission, a court of the Republic has already issued a decision on the same complaint or litigation procedures are in progress regarding those complaints;
- if the complaint is submitted to the Financial Ombudsman more than 22 months after the consumer became aware, or ought to have reasonably become aware, of the harmful action/omission; or
- if the transaction did not result in significant loss in the opinion of the Financial Ombudsman.

1.2 Litigation Process and Rules on Limitation

The CPR regulate, inter alia, the procedural stages of an insurance dispute in Cyprus, which is heard by Civil Courts of first instance. The new CPR have introduced the pre-action protocols that must be followed before the submission of a claim in court. Specific protocols apply to

personal injury claims arising out of an accident. The purpose of this pre-action requirement is to ensure that only necessary and genuine claims follow the judicial route through the courts.

The importance of the pre-action procedure is that a party may have to pay costs imposed by the courts in the following litigation proceedings if it fails to comply with the established steps. As a result, parties are strongly encouraged to pursue settlement discussions before the commencement of an action.

Initiation of a Claim

If the pre-action proceedings are not successful, the claimant may proceed with the filing of a claim form exposing the particulars of the claim. After the claim form is served on the defendant, the defendant may proceed with the filing of a defence and/or a counterclaim against the claimant. The claim form must contain all the significant facts upon which the claimant relies, together with the relevant documentation. Rules on proper pleading drafting can be found in the CPR.

Stages of Litigation

The CPR govern and determine specifically all stages of litigation, as well as any interim procedure that parties may choose to follow, pending litigation. Steps such as the disclosure of documents, witnesses and a timetable of the trial process are mandatory steps that parties have to follow. A pre-trial hearing must also be held before a Judge by the parties, before the actual trial.

The court remains the regulator of the proceedings and actively encourages parties to resolve their dispute through negotiation and settlement processes, before the commencement of the trial.

Rules on Limitation

In Cyprus, insurance disputes have a limitation period according to the type of claim that is pursued. In contract claims the limitation period is six years, while the limitation period for personal injury claims and general negligence disputes is three years. The relevant legislation for limitation periods is the Law on Limitation of Legal Rights of 2012 (Law 66(I)/2012).

1.3 Alternative Dispute Resolution (ADR)

Although ADR is increasingly encouraged in Cyprus, it is not a popular method of resolving insurance disputes and courts remain the main resolving authority. However, parties are encouraged by the courts and now the CPR to conduct negotiations, which take place on a “without prejudice” basis.

Arbitration

Rules on arbitration are established in Cyprus through the specific legislation on domestic arbitration (Cap 4). However, parties do not often incorporate such clauses into insurance contracts and do not usually agree to such dispute resolution method after a dispute has arisen.

The new CPR also provide specific procedural rules on the conduct of both domestic and international arbitration, as well as rules regarding the support and supervision of Civil Courts.

Mediation

Directive 2008/52/EC of the European Parliament and of the Council of 21 May 2008 on Certain Aspects of Mediation in Civil and Commercial Matters has introduced mediation in Cyprus as a dispute resolution method that can provide a cost-effective and quick extrajudicial resolution of disputes in civil and commercial matters through processes tailored to the needs of the parties. The Directive has been implemented in

Cyprus through the Law Regarding Mediation in Civil Disputes 2012 (Law 159(I)/2012), but mediation is not widely used in insurance disputes.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes Jurisdiction

Insurance contracts contain jurisdictional clauses that are widely upheld by Cypriot courts as a representation of parties' contractual autonomy in cases with foreign elements.

Applicable rules on jurisdiction

The applicable rules are:

- the Brussels Regulation Recast (1215/2012), which applies where both parties are domiciled in an EU member state;
- the Lugano Convention, which is applicable where only one party is domiciled in an EU member state and the other is domiciled in an EEA member state; and
- common law, which is applicable where the defendant is not domiciled in any EU member State or EEA member State. (CPR Rules in Part 6 contain provisions on Jurisdiction of Cypriot Courts).

Both Brussels Recast and the Lugano Convention contain detailed rules on insurance contracts regarding jurisdiction, in an attempt to safeguard the insured as the weaker party.

Cyprus is also a contracting party to the Hague Convention on Choice of Court Agreements 2005, which applies in extraterritorial cases with an exclusive jurisdiction agreement between the parties. It should be noted that the EU (of which Cyprus is a member state) has imposed limita-

tions on the applicability of the Hague Convention regarding insurance contracts.

Choice of Law

Cypriot courts typically uphold choice of law clauses once incorporated into parties' contracts.

Applicable rules on choice of law

The following rules apply:

- Regulation (EC) No 593/2008 on the law applicable to contractual obligations (Rome I), Article 7 of which provides specific rules on insurance contracts in an attempt to safeguard the insured as the weaker party; and
- Regulation (EC) No 864/2007 on the law applicable to non-contractual obligations (Rome II), which may also cover personal injury claims and motor claims.

2.2 Enforcement of Foreign Judgments

Foreign judgments by or against insurers may be enforced under the European and international rules or under common law rules.

Under European law, foreign judgments of other EU member states or EEA states are easily enforceable in Cyprus through Brussels Recast, the Lugano Convention and the European Enforcement Order Regulation (805/2004). Common law rules apply for the recognition and enforcement of judgments given in a state outside the EU or EEA, but the enforcement of such cases is not as easy as within the European regime.

In addition, the Convention of 2 July 2019 on the Recognition and Enforcement of Foreign Judgments in Civil or Commercial Matters entered into force on 1 September 2023 and facilitates

the recognition and enforcement of judgments between contracting parties.

2.3 Unique Features of Litigation Procedure

Insurance disputes in Cyprus are litigated in an adversarial manner, with the courts having an active role, both before and after the introduction of the CPR.

In particular, the new CPR obliges parties to follow pre-action procedures in an attempt to try and reach an out-of-court settlement before a claim is filed in court. Parties are also required to engage in ADR at any stage of the proceedings. Failure to pursue either pre-action procedures or ADR may result in sanctions in the form of costs, which the defaulting party may have to pay instantly.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

In Cyprus, arbitration clauses found in commercial insurance and reinsurance contracts are enforceable. Having ratified the New York Convention, Cyprus is deemed a pro-enforcement jurisdiction, for both for arbitration agreements and awards.

The relevant legislation in Cyprus regarding arbitration procedures and enforcement (of both agreements and awards) is as follows:

- the relevant Law for domestic arbitrations is Cap 4 (the Arbitration Act), which governs arbitrations without a foreign element; and
- the relevant laws for international arbitrations are the International Arbitration Act (Law

101/1987) and the Law ratifying the New York Convention (Law 84/1979).

Both laws give Cypriot courts the power to stay court proceedings upon the application of one party if the other party is in breach of an arbitration clause or agreement, unless the arbitration agreement is null and void, inoperative or incapable of being performed.

Both laws also set the necessary requirements for the type and form of the arbitration agreements or clauses. Arbitration clauses in Cyprus are viewed as separate contracts, as the courts follow the separability presumption of an arbitration clause, so that such clauses can be autonomous from the whole contract and, as a result, can generally be enforced.

3.2 The New York Convention

Cyprus has ratified the New York Convention with Law 84/1979, so courts in Cyprus operate with a pro-enforcement bias, following the provisions of the Convention in the enforcement of foreign arbitral awards (and agreements).

Foreign arbitral awards are enforceable in Cyprus under the provisions of the Law on International Arbitration in Commercial Matters (Law 101/1987), which is essentially based on the UNCITRAL Model Law on International Commercial Arbitration. It should be noted that the 2006 amendments to the UNCITRAL Model Law have not yet been adopted in Cyprus, although procedures to adopt them are currently underway.

Article 35 of Law 101/1987, which governs arbitration disputes of an international and commercial nature, provides that “a foreign arbitral award shall be recognised as binding” unless

there are valid grounds for refusing its recognition and enforcement.

Basically, and in combination with the New York Convention (and Law 84/1979), an application filed before the Cyprus courts needs to be accompanied by:

- a duly authenticated original award or a duly certified copy thereof;
- the original arbitration agreement or a duly certified copy thereof; and
- a translation of the above documents into Greek by an official or sworn translator, or by a diplomatic or consular agent.

Moreover, Section 5 of Law 121(I)/2000 sets out that, for recognition, the applicant (which may be either the relevant authority or the person in favour of which the judgment was issued) files an originating summons application on a by summons basis, which must be accompanied by an affidavit stating all relevant facts.

Under the new CPR, any application for the recognition and enforcement of arbitral awards is submitted in accordance with Form 92. Once the form is served, the respondent has to proceed with the filing of appearance.

Article 36 of Law 101/1987 sets out the limited grounds on which an application for recognition and enforcement of an arbitral award may be rejected, as follows:

- the contractual incapacity of the parties or the invalidity of the arbitration agreement;
- the lack of proper notice as to the appointment of the tribunal or of the arbitral proceedings;
- the fact that the award deals with a dispute that does not fall within the terms of the

submission to arbitration or goes beyond the scope of the submission;

- the fact that the composition of the arbitral tribunal or the arbitral procedure was not in accordance with the agreement of the parties;
- the fact that the award has not yet become binding on the parties or has been set aside or suspended by the competent court of the country in which, or under the law of which, the arbitration took place;
- the fact that the subject matter of the dispute is not capable of settlement by arbitration under the laws of Cyprus; and
- the fact that the recognition and enforcement of the award would contradict the public policy of Cyprus.

Moreover, the respondent may object to the summons on the grounds that the Cyprus courts lack jurisdiction, or if the award or judgment has been satisfied.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is not a common form of resolving insurance disputes in Cyprus, although certain insurance disputes are resolved by arbitration, such as disputes relating to reinsurance matters.

As mentioned in **3.1 Enforcement of Arbitration Provisions in Commercial Contracts**, the relevant law for domestic arbitrations is the Arbitration Act (Cap 4), which governs arbitrations without a foreign element. For international arbitrations, the relevant laws are the International Arbitration Act (Law 101/1987) and the Law ratifying the New York Convention (Law 84/1979).

Arbitration is a private method of resolving disputes, as confidentiality is one of the privileges of this dispute resolution method. It should also be noted that neither of the above laws con-

tain provisions regarding the possible appeal of awards regarding their substance. Awards can be set aside on the application of one of the parties only for the exclusive reasons stipulated in the above-mentioned laws.

4. Coverage Disputes

4.1 Implied Terms

Insurance contracts are private commercial contracts that are not individually negotiated. As such, implied terms regarding consumer protection and unfair contract terms apply regarding insurance contracts as well, by operation of the Law on Unfair Contract Terms (Law 93 (I)/1996).

Law 93(I)/1996 implements Directive 93/13 on unfair terms in consumer contracts, which sets out the context in which a contract term can be deemed unfair and all the necessary steps that member states should take to ensure effective protection of consumers regarding the conclusion of, *inter alia*, insurance contracts.

The terms of insurance contracts must comply with the requirement of good faith. Article 3 of the Directive specifies that “A contractual term which has not been individually negotiated shall be regarded as unfair if, contrary to the requirement of good faith, it causes a significant imbalance in the parties’ rights and obligations arising under the contract, to the detriment of the consumer”.

4.2 Rights of Insurers

In order to safeguard the risks deriving from a certain insurance policy, insurers have the right to request the following non-exhaustive list of documentation and/or proof from proposed insureds prior to the inception of an insurance policy.

- Regarding property insurance, they may request a property inspection and a valuation of both the property and the equipment.
- Regarding life insurance, they may request thorough medical documentation as well as medical history, examination results and possibly medical reports.
- Generally, the completion of a specific questionnaire in which the insured should disclose all the correct and true facts and every material circumstance, in line with the principle of utmost good faith, without omitting any significant fact that is directly relevant to the insurance contract.
- In addition, insureds are required to disclaim that all the provided information in their application and/or proposal form are the true and correct facts, which will form the basis of the insurance contract/policy. If any of the information provided by the insured is not factually correct and/or true, the insurer reserves the right to dismiss any potential claim made by the insured even while the insurance contract is still in force, as well as the right to render the insurance contract void *ab initio*.

4.3 Significant Trends in Policy Coverage Disputes

In the past 12 months, the significant trend in policy coverage disputes in Cyprus has been the rise of inflation, due to the economic implications of the COVID-19 pandemic and the war in Ukraine, causing the underinsurance of insureds. As a result, the compensation amounts have decreased significantly, causing a vast number of disputes in Cyprus.

In addition, the possibility of COVID-19 was not covered in any insurance contract before it actually happened. As a result, insurance companies were faced with an unexpected number of

claims relating to business interruption, as well as the inability to cover employees' salaries.

4.4 Resolution of Insurance Coverage Disputes

In Cyprus, insurance coverage disputes are usually resolved through court processes and litigation. The vast majority of disputes are resolved in an out-of-court settlement, now following the assisting procedure of the new CPR and the pre-action protocols that must be followed by the parties.

Arbitration and ADR in general are not popular methods for resolving insurance disputes, although reinsurance contracts frequently involve arbitration clauses, which are enforceable.

4.5 Position If Insured Party Is Viewed as a Consumer

The position for the resolution of a dispute involving consumers is no different from any other insurance coverage dispute, and litigation through court is the main method of resolving such disputes.

However, disputes involving consumers may be resolved by submitting a complaint to the Financial Ombudsman against financial businesses, regarding a dispute of up to EUR170,000 in value; see **1.1 Statutory and Procedural Regime** (Financial Ombudsman) for more detail.

4.6 Third-Party Enforcement of Insurance Contracts

The specific circumstances in which a third party can enforce an insurance contract or sue an insurer in connection with an insurance contract are as follows:

- in cases of motor accidents on the basis of Law 96(I)/2000, a third party can initiate an action against the insurer;
- in cases of accidents caused on a construction site, the injured may sue the insurer of both the main contractor and the subcontractor; and
- in cases where the insured is insolvent, Law 174/1989 gives third parties the right to initiate proceedings against the insurer.

4.7 The Concept of Bad Faith

The concept of bad faith is not found in any legislation in Cyprus.

However, Law 93(I)/1996 on unfair terms in consumer contracts implements Directive 93/13 on unfair terms in consumer contracts, which introduces the concept of good faith that has essentially been interpreted by the European and Cypriot courts.

4.8 Penalties for Late Payment of Claims

No penalties for late claims payment are imposed by legislation in Cyprus, although insurers must meet a reasonable timeframe in paying a justifiable claim.

4.9 Representations Made by Brokers

According to Contract Law, Cap 149, Article 186, an insured is bound by representations made by its broker, unless the broker has acted *ultra vires*. The relevant provisions of contract law regarding agency can be found in Section XIII of Cap 149.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In Cyprus it is not common to delegate claims to an external company handling authority arrangements, nor is it common to outsource underwriting matters. Usually, insurance companies have internal departments dealing with under-

writing issues. If an insurance company has to outsource matters, strict criteria are imposed by the Insurance Regulator and there are specific guidelines for such exercise.

In rare cases in which claims are handled externally, it is not common for such arrangements to give rise to litigation.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurers usually fund many areas of liability claims for the defence of insureds, including:

- motor accidents and personal injury claims;
- professional indemnity claims;
- public liability claims;
- claims brought by third parties; and
- employers' liability claims.

5.2 Likely Changes in the Future

Insurers' defence funding for their insureds regarding liability claims is unlikely to change in the future, since defence costs form part of insurance policies.

5.3 Trends in the Cost or Complexity of Litigation

The new CPR have introduced new, more comprehensive procedures regarding insurance claims in the form of specific pre-action protocols that must be followed. These procedures are accompanied by possible sanctions in the form of costs, which may be imposed if one of the parties to the litigation fails to comply with them once the action has been commenced. The reason for this new function of the CPR is to reduce litigation and to encourage parties to reach an out-of-court settlement.

This new development has had a huge impact on the reduction of litigation costs. However, insurance companies tend to request the involvement of external lawyers in handling insurance claims at an earlier stage, before the commencement of an action.

5.4 Protection Against Costs Risks

Protection against costs risks is not a standard insurance policy in Cyprus. It is an independent field of insurance that usually applies to professionals, in order for them to be covered in case an action is commenced against them. Such product usually forms an extension in the policy cover, and a separate sum is used to cover such claims and actions.

Notably, this product is requested to be bought by claimants in professional indemnity policies (medical, legal, architectural, and directors' and officers' liability).

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Insurers can recover sums from third parties in the form of subrogation. This principle has its foundation in common law and it constitutes a standard clause in insurance contracts.

On the basis of the right of subrogation, in case of a loss caused by a third party to their insured, insurers satisfy the claim of their insured and can subsequently pursue an action in the name of the insured to recover some or all of the sum of money they have already paid.

Subrogation applies to all insurance contracts that are contracts of indemnity, such as fire insurance, vehicle insurance, loss of profits

insurance, property insurance and liability insurance. However, it does not apply to life insurance nor prima facie, to personal accident insurance.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Subrogation is a principle arising out of common law and forms part of the insurance contract as a standard clause. Such claims are pursued in the name of the insured and concern the recovery of the whole and/or part of the sums already paid to the insured as a result of the loss incurred.

However, in Cyprus the right of subrogation concerning the Motor Insurance Fund is set out in detail in the Law on Motor Vehicles (Third Party Liability Insurance) (Law 96 (I)/2000), Article 30 of which states that the Motor Insurers' Fund has the right to pursue an action in the name of the person who has provided compensation.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The COVID-19 pandemic has been an unprecedented experience, raising multiple challenges in the insurance sector. Insurance companies were faced with an unexpected number of claims relating to business interruption as well as an inability to cover employees' salaries as a result of the pandemic. Insurance-related claims and lawsuits are and will, therefore, increase due to the consequences of the pandemic.

The COVID-19 crisis has also resulted in a significant increase in cyber risks but also in an opportunity for the insurance sector, due to cyber underwriting policies with the appropriate risk management.

7.2 Forecast for the Next 12 Months

It is possible that the consequences of COVID-19 will continue to affect the insurance sector in the ways noted in 7.1 **Type and Amount of Litigation**, although the implementation of new clauses in insurance contracts covering business interruption and pandemic loss clauses in general is likely to lead to a decline in insurance claims.

7.3 Coverage Issues and Test Cases

The factors mentioned in 7.1 **Type and Amount of Litigation** have rendered necessary the inclusion of business interruption clauses in insurance contracts, which in turn will result in the need to interpret those clauses in line with the new realities and effects of the COVID-19 pandemic.

7.4 Scope of Insurance Cover and Appetite for Risk

The factors mentioned in 7.1 **Type and Amount of Litigation** have affected the scope of insurance cover and influenced the appetite for risk, as it has become imperative for new clauses to be included in insurance contracts related to the effects of the pandemic, alongside evolving new factors such as cybersecurity and ESG.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

ESG factors affect insurance companies in their non-financial risks and opportunities.

In reference to the effects of insurance risks on underwriting, underwriters have had to implement ESG aspects into their risk assessment analysis, resulting in the creation of a more thorough risk assessment. These factors have

impacted the underwriting sector regarding not only motor insurance but also property insurance, from an early stage of the conclusion of the insurance contract.

Regarding the effect of ESG factors in litigating insurance risks, it appears that the result of lower coverage and/or discounts on insurance policies will have an impact on the number of claims ending in court. In addition, due to climate change, insurance policies covering property damage for certain areas that are rendered to be more dangerous than others will result, most probably, in an increase in litigation, since premiums will need to differentiate to a higher level. In implementing ESG factors, directors' and officers' liability claims could also increase in cases of poor governance.

On the other hand, improvements in the health and safety of workplaces could reduce the number of accidents and related claims.

8.2 Data Protection Laws

The Data Protection Law (Law 125(I)/2018) was adopted for the effective implementation of certain provisions of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and has impacted the underwriting and litigating of insurance risks.

Underwriting risks have been affected in the sense of thorough assessment procedures, as the implementation of the EU Directive has resulted in more restricted data processing within insurance companies and between them. In addition, many insurance companies need to employ external reinsurers and certain personnel for underwriting purposes. Investiga-

tions concerning insurance disputes have also been impacted, since Data Protection Laws permit only strictly necessary data to be collected and requested. As a consequence, litigation on insurance claims has become more difficult and unpredictable regarding the evidence that parties can provide throughout the trial.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation Insurance Coverage

One of the most significant legislative developments regarding insurance coverage has been the compulsory insurance of medical professionals and medical service providers who have entered the General Health System in Cyprus. As a consequence, the number of policies as well as possible litigation claims will increase in the coming years.

Interestingly, this will also affect the claims that insurers will fund the defence of, as litigation claims will rise.

Insurance Litigation

The new CPR set out specific provisions that govern the resolution and initiation of insurance claims in District Courts, including specific pre-action procedures that must be followed.

If these pre-action protocols are not followed by parties, the court reserves the right – once an action has been commenced – to impose sanctions on the defaulting party, in the form of costs that will have to be paid as soon as they are imposed.

Another form of sanction that courts may impose is the reduction of interest in the awarded sum of damages or to order that no interest will be awarded at all. The court may also order the stay of the proceedings if it rules there is a “lack of compliance with both the letter and the spirit of the pre-action Protocol”.

Another major development introduced by the new CPR is the parties’ obligation to disclose all the relevant documentation to their claim at a very early stage, and to provide the other side with the proof upon which they will base their claim if an action is commenced later on.

Proposed Legislation on Artificial Intelligence

The proposal for a Directive on adapting non-contractual civil liability rules to artificial intelligence (AI) is under discussion. Cyprus will eventually have to implement the Directive into national law.

The Directive’s main goal is to improve the functioning of the internal market by laying down uniform requirements for certain aspects of non-contractual civil liability for damage caused with the involvement of AI systems. The Directive recognises that the choice of suitable legal tools is

limited, given the nature of the burden of proof and the specific characteristics of AI that pose a problem for existing liability rules. In this respect, this Directive eases the burden of proof in a very targeted and proportionate manner through the use of disclosure and rebuttable presumptions. For those seeking compensation for damage, it establishes a possibility to obtain information on high-risk AI systems to be recorded/documentated pursuant to the AI Act. In addition to this, the rebuttable presumptions will give those seeking compensation for damage caused by AI systems a more reasonable burden of proof and a chance to succeed with justified liability claims.

As it concerns non-contractual civil liability cases, the Directive will have a possible impact on insurance claims and litigation involving an element of AI. For example, the Directive may apply to cases where a suit is commenced against the manufacturer for a defective AI feature, based on Directive 85/374/ECC regarding liability for defective products.

An additional consequence of the AI Directive would be that insurance companies may consider the coverage of disputes relating to AI in insurance contracts in the future.

INDIA



Law and Practice

Contributed by:

Neeraj Tuli, Rajat Taimni, Mandakini Khanna and Arjun Masters
Tuli & Co

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Tuli & Co was established in 2000 to service the Indian and international insurance and reinsurance industry. It is an insurance-driven commercial litigation and regulatory practice, which has working associations with firms in other Indian cities. While Tuli & Co's principal office is in

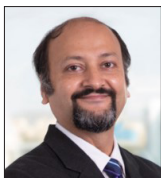
Noida and it has another office in Mumbai, the firm has a pan-Indian presence with insurance/reinsurance and complex commercial disputes before the Supreme Court, High Courts and tribunals across the country. Currently, 54 lawyers work for the firm.

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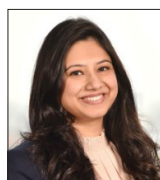
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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

The insurance sector in India is regulated by the Insurance Regulatory and Developmental Authority of India (IRDAI), and there are, in addition, several consumer-centric regulations setting out various practice directions and guidelines to be followed by insurers, reinsurers and insurance intermediaries.

The IRDAI can investigate, either on its own motion or following a complaint or any other information received from policyholders/third parties, any alleged breach by insurers, reinsurers or insurance intermediaries, and the punishment can include a monetary penalty of up to INR10 million (approximately USD123,000) for each breach, resulting directions and/or cancellation of the relevant registration.

Apart from supervisory proceedings before the IRDAI and proceedings before any other regulators, such as the Securities and Exchange Board of India (SEBI), the Competition Commission of India (CCI) or the Central Consumer Protection Authority (CCPA), insurance and reinsurance

disputes are generally adjudicated in the following forums.

- **Arbitral tribunal** – Most commercial general insurance contracts typically used to have a standard arbitration clause where any dispute on quantum – liability already having been admitted – could be referred to arbitration. This position has now changed on account of IRDAI's circular dated 27 October 2023 by virtue of which the insured and insurer are at liberty to enter into a separate arbitration agreement. See **3.1 Enforcement of Arbitration Provisions in Commercial Contracts** for a detailed discussion on this circular.
- **Civil courts** – Retail general insurance contracts, life insurance and health insurance contracts usually contain a jurisdiction clause in favour of the courts. For commercial general insurance contracts with an arbitration clause, insureds can approach a civil court when the dispute falls outside the scope of the arbitration clause.
- **Consumer forums** – Insureds can approach consumer forums with the relevant monetary and territorial (if applicable) jurisdiction. The right to approach a consumer forum is an independent option/remedy which cannot

be curtailed even by an existing arbitration clause.

1.2 Litigation Process and Rules on Limitation

Litigation Process

An insured may, depending on the underlying facts, raise a dispute before an arbitral tribunal, an appropriate civil/commercial court or a consumer forum. See **1.3 Alternative Dispute Resolution (ADR)** for a discussion on arbitration.

Disputes before a civil/commercial court

The Commercial Courts Act 2015 (the “CCA 2015”) prescribed the constitution of commercial courts for adjudicating commercial disputes of a specified value. The commercial courts have been set up at the district level as well as at the High Court level with the objective of having a more streamlined process for speedier adjudication of commercial disputes. It is mandatory to undergo a pre-mediation exercise before filing a commercial suit.

These courts are, effectively, civil courts with a specific mandate to hear only commercial matters. Insurance and reinsurance have been classified as “commercial disputes” under the CCA 2015. The pecuniary threshold for a dispute to be classified as “commercial” is INR300,000 (approximately USD3,575).

The commercial courts are governed by the Code of Civil Procedure 1908 (CPC) and the CCA 2015. If there is a conflict between the two, the CCA 2015 will generally prevail.

Civil courts in India are divided into district courts, high courts and the Supreme Court, in ascending order of hierarchy. There are approximately 688 district courts, 25 high courts and

the Supreme Court, which is the highest court of law in India.

Out of the 25 high courts in India, the high courts at Calcutta, Bombay, Madras, Delhi and Himachal Pradesh have original jurisdiction to decide matters, including commercial matters, where the quantum of dispute is higher than an ascertained pecuniary value and, in relation to Calcutta and Madras, within a designated territorial limit from the High Court. Disputes below the prescribed monetary value would go to the commercial court with appropriate territorial jurisdiction at the district level or an ordinary civil court where the value is lower than INR300,000 (approximately USD3,575).

In all other cases, commercial courts at the district level with the necessary territorial jurisdiction can hear insurance/reinsurance disputes which are valued at INR300,000 (approximately USD3,575) and above. The hierarchy and designations of commercial/civil courts at the district level may be different across states in India.

Disputes before a consumer forum

The consumer commissions have a three-tier hierarchy, with District Commissions at the lowest rung, followed by a State Commission (for every state) and a National Commission at the apex level. District Commissions have the jurisdiction to deal with complaints arising out of contracts for services or goods involving allegations of “deficiency in service”, where the consideration does not exceed INR5 million (approximately USD60,000). For the State Commission, the threshold is over INR5 million up to INR20 million (approximately USD240,000), whereas the National Commission can take up original complaints where the consideration is above INR20 million. The District Commission

and the State Commission must also have the necessary territorial jurisdiction.

Rules on Limitation

Limitation periods are generally governed by the Limitation Act 1963 (the “Limitation Act”), save for the limitation period to approach a consumer forum which is prescribed under the Consumer Protection Act 2019 (the “Consumer Act 2019”).

According to Schedule 55 of the Limitation Act, the limitation period of three years is calculated either from:

- the date of the occurrence causing the loss; or
- the date of denial of the claim under the policy.

Under the Consumer Act 2019, the limitation period is two years instead of three years.

Some insurance contracts specify timelines to report claims and others require the reporting to be “as soon as reasonably practicable”, both forms of which are typically expressed as conditions precedent to the insurer’s liability. Therefore, the court may refuse to impose liability on account of a delay in notification of a claim, even if some portion of the limitation period still remains available to the insured.

In situations where a loss has been notified to the insurer, and the claim has been rejected or the policy is avoided, the limitation period of three years will commence from the date of communication of such denial.

1.3 Alternative Dispute Resolution (ADR) Mediation

Mediation, conciliation and arbitration are recognised as ADR mechanisms. High courts and

district courts generally have mediation cells and mediation has particularly gained traction following the introduction of the CCA 2015, which makes mediation a prerequisite to bringing a suit.

The Mediation Act 2023 (the “Mediation Act”) was enacted to encourage institutional mediation for dispute resolution in India. While the Mediation Act was given assent by the President of India on 14 September 2023, only a few provisions have been notified at the date of writing.

Arbitration

On the adjudicatory front, arbitration is preferred for commercial disputes and most commercial contracts have an arbitration clause. The Arbitration and Conciliation Act 1996 (the “Arbitration Act”) has been amended over the years with the aim of making arbitration a more effective and attractive alternative to court proceedings.

There are set timelines for completing domestic arbitrations, while in international commercial arbitrations there are guidelines/best practices in relation to timelines.

There is also an option for “fast track” arbitration, where an award may be passed within six months if the requirements are met.

Settlement Outside Courts

Independently, where a court is of the view that there are elements of settlement that may be acceptable to parties before it, it may formulate the possible terms of settlement, take the view of the parties and refer the parties to either:

- arbitration;
- conciliation;
- judicial settlement, including settlement through *Lok Adalat* or

- mediation.

This power is derived from Section 89 of the CPC.

Such reference will require the consent of the parties where such consent/agreement is otherwise required under law, for instance in the case of arbitration.

Insurance-Specific ADR

Specifically for insurance disputes, the government of India has created the Insurance Ombudsman Scheme, which enables individual policyholders to settle their complaints out of court in a cost-effective and efficacious manner. An aggrieved policyholder can approach the Insurance Ombudsman provided their claim value is under INR3 million (approximately USD36,000).

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Retail general insurance, life insurance and health insurance contracts usually contain a jurisdiction clause in favour of the courts. Typically, standardised arbitration clauses were mostly found in commercial general insurance contracts where any dispute on quantum, liability having been admitted, could be referred to arbitration. This position has now changed on account of IRDAI's circular dated 27 October 2023, by virtue of which the insured and insurer are at liberty to enter into a separate arbitration agreement. See **3.1 Enforcement of Arbitration Provisions in Commercial Contracts** for a detailed discussion on this circular.

2.2 Enforcement of Foreign Judgments

The enforcement and recognition of foreign judgments and decrees in India are governed by, inter alia, Section 44-A and relevant orders of the CPC. Only a foreign judgment of a superior court of a reciprocating territory, as notified by the government of India, can be enforced before the appropriate court in India.

In this regard, the Indian government has notified several reciprocating jurisdictions, including Bangladesh, the Colony of Aden, the Colony of Fiji, Hong Kong SAR, the Republic of Singapore, the Federation of Malaysia, Myanmar, New Zealand and the Cook Islands, the Trust Territories of Western Samoa, Papua New Guinea, Trinidad and Tobago, the Sultanate of Oman, the UAE and the UK.

2.3 Unique Features of Litigation Procedure

Case Load

In India there are about 11,046,037 civil cases pending before various district and lower courts, about 4,354,682 before the high courts and 80,221 before the Supreme Court.

These statistics may not provide a completely accurate current position given that several of these matters may not even be in a position to be heard on account of the parties' non-compliance.

Nonetheless, it is generally accepted that the disposal rate of individual judges and courts is on the higher side.

Court proceedings in India can often be time-consuming and potentially expensive. The establishment of commercial divisions has somewhat reduced the length of time, but the process is still lengthy and potentially expensive.

Domestic arbitrations have specified timelines for completion. According to Section 29A of the Arbitration Act, arbitration proceedings are required to be completed within 12 months from the date of completion of pleadings (a maximum period of six months for completing pleadings). Parties may, by mutual agreement, extend the 12-month period by another six months. Any further extension can only be granted by a court upon an application by a party.

There are no specific mandatory timelines for concluding an international commercial arbitration (arbitration seated in India with one non-Indian party), but Section 29A of the Arbitration Act states that the tribunal will endeavour to conclude such proceedings within 12 months from the completion of pleadings.

Arbitration-related court proceedings are generally disposed of relatively expeditiously.

There are limited grounds to challenge a purely domestic arbitral award. The grounds available for challenging an award arising out of an international commercial arbitration are further limited, as the ground of “patent illegality” is not available.

Costs of Proceedings

Courts in India refrain from awarding actual costs, and if costs are awarded in court proceedings, they are nominal.

In arbitration proceedings, Section 31A of the Arbitration Act gives the discretion to the arbitral tribunal to award costs to a party. The Arbitration Act defines costs as fees and expenses of the arbitral tribunal and lawyers, administrative fees and any other expenses incurred in connection with the arbitration proceedings. The

costs awarded are typically “reasonable costs” as opposed to actual costs.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Indian courts generally strictly enforce arbitration clauses. This position also holds true for insurance and reinsurance contracts.

The seven-judge bench of the Supreme Court in its recent landmark decision in the case of *In Re Interplay Between Arbitration Agreements under the Arbitration and Conciliation Act 1996 and the Indian Stamp Act 1899* 2023 SCC OnLine SC 1666 overruled the earlier five-judge bench decision of *NN Global Mercantile Pvt Ltd v Indo Unique Flame Ltd* 2023 SCC Online SC 495 and held that an unstamped instrument containing an arbitration clause is valid and enforceable in law. The Supreme Court has also held that an arbitration agreement is a separate contract, and the invalidity of the underlying instrument does not render the arbitration agreement void. On 27 October 2023, the IRDAI issued a circular directing that all policies issued under the commercial lines of business shall have a mandatory arbitration clause, which stipulates that “the parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this policy”. In case parties mutually agree on an arbitration agreement, then the arbitration proceedings will be conducted as per the provisions of the Arbitration Act. The circular has further deleted arbitration clauses from all policies under the retail lines of business prospectively. For the existing retail policies, the existing arbitration clause shall remain valid until the term of the policy expires

unless a policyholder specifically requests the insurer to replace it with the clause mandated by the IRDAI. This also applies to all existing policies issued under the commercial lines of business.

A two-judge bench of the Supreme Court in another recent landmark decision in the case of *Bombay Slum Redevelopment Corporation Private Limited v Samir Narain Bhojwan* 2024 SCC OnLine SC 1656 held that the jurisdiction of a court while dealing with an appeal against an order which dealt with a challenge to an arbitral award, is limited to the restrictions provided in the Arbitration Act. The court is restricted from undertaking an independent assessment of the merits of the award and only has to determine if the award is within the scope of Section 34 of the Arbitration Act.

3.2 The New York Convention

India is subject to the New York Convention as well as the Geneva Convention. Enforcement of an arbitral award rendered in a recognised jurisdiction is governed by Part II of the Arbitration Act.

The party applying for enforcement of a foreign award is required to produce, as evidence, the following:

- the original award or a duly authenticated copy of the award;
- the original arbitration agreement or a duly certified copy of the same; and
- such other evidence as is necessary to prove that it is a foreign award.

Refusal to Enforce a Foreign Award

Enforcement of a foreign award may be refused on any of the following grounds (among others):

- a party to the arbitration is under some incapacity or the arbitration agreement is not valid under the law to which the parties have subjected it or under the law of the country where the award was made;
- no proper notice of the appointment of an arbitrator or of the arbitration proceedings was served, or a party was otherwise unable to present its case;
- the arbitral award is beyond the scope of the arbitration agreement;
- the composition of the arbitral tribunal was not in accordance with the parties' agreement or the law of the country where the arbitration took place;
- the award has not yet become binding on the parties, or has been set aside or suspended at the seat of the arbitration;
- the subject matter of the arbitration is not arbitrable under the law of India; and
- the enforcement of the award would be contrary to the public policy of India.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Most commercial general insurance contracts typically have a standard arbitration clause where any dispute on quantum, liability having been admitted, can be referred to arbitration. Under such limited arbitration clauses, the insured would be precluded from arbitrating disputes where the claim has been rejected in its entirety as not being covered under the policy or the policy has been repudiated. However, the insured may also choose to approach the consumer forum (if applicable), which is a summary procedure, or the relevant civil/commercial court.

The Supreme Court has recently settled the question of whether corporate insureds can be considered as "consumers" under the Consumer

Protection Act 1986 (the “Consumer Act 1986”). The Supreme Court in the case of *National Insurance Co Ltd v Harsolia Motors (2023) 8 SCC 362* has held that since insurance contracts are contracts of indemnity there exists no element of profit generation and therefore insurance disputes come within the purview of the Consumer Act 1986.

Applicable Rules

The arbitration clauses must be standardised and the arbitration is governed by the provisions of the Arbitration Act, including in relation to the procedural rules for conducting the arbitration. That being said, an arbitrator/arbitral tribunal, with the consent of the parties, may adopt its own procedural rules for conducting the proceedings as long as such rules are not in contravention of any non-derogable provisions of the Arbitration Act. The Arbitration Act is based on the principles of party autonomy, and the power to determine procedural rules governing the arbitration proceedings is enshrined in Section 19 of the Arbitration Act.

Challenge to an Award

Section 34 of the Arbitration Act provides a party with a right to approach a court to set aside an arbitral award. A court hearing a challenge of an award does not sit as a first appellate court over the decisions of an arbitral tribunal, and therefore, it cannot re-examine the evidence/merits to arrive at a different possible conclusion or finding.

The court’s scope of interference is limited to the grounds laid out in Section 34, which includes incapacity of a party to enter into arbitration, improper notice of arbitration, *ultra vires* jurisdiction, invalid composition of the arbitral tribunal, a conflict with the public policy of India, and patent illegality appearing on the face of the award.

Also, by way of the amendment to the Arbitration Act in 2015, the scope of “public policy” has been narrowed down to include only those instances where:

- the making of the award is fraudulent or corrupt;
- the award is in contravention of the fundamental policy of Indian law; or
- the award is in conflict with the most basic notions of morality or justice.

The scope of interference is further restricted where an arbitral award has been passed in an international commercial arbitration, in which case the ground of “patent illegality”, which includes perversity, is not available.

An application for setting aside an award must be made before the expiry of three months from the date on which the award was received by the party concerned. The courts can entertain the application beyond three months, but within 30 days, if the party concerned is able to demonstrate sufficient cause.

The order by the court under Section 34 of the Arbitration Act can be appealed, under Section 37, to the court with the necessary jurisdiction to hear appeals from the court in question. There is no statutory right to appeal from an order passed under Section 37. However, a party may prefer a special leave petition, under Article 136 of the Constitution of India to the Supreme Court. It is at the discretion of the Supreme Court to entertain such a petition, which it does sparingly.

4. Coverage Disputes

4.1 Implied Terms

Under Indian law, there are a number of terms that are implied into a contract of insurance. For instance, even though a policy may not expressly say so, all contracts of insurance are of utmost good faith and insurers are entitled to a fair presentation of the risk before its inception. The duty of utmost good faith places an obligation on the insured to voluntarily disclose all material facts relevant to the risk being insured. If there has been a misrepresentation or non-disclosure of a material fact, then an insurer can avoid the policy from its inception.

Another implied term is the right of subrogation, for which there is also statutory and judicial recognition. While there may not be a need for a separate contractual clause to trigger it, in practice, policies do contain subrogation clauses.

4.2 Rights of Insurers

Insurers are entitled to a fair presentation of the risk before a policy's inception and this entitlement is derived from the fundamental principle of insurance law that utmost good faith must be observed by the contracting parties. This forbids the insured from concealing what they privately know, with a view to drawing the insurer into a bargain based on their ignorance of that fact. Insurers can avoid the policy if there is fraud, misrepresentation or non-disclosure by the insured prior to the inception of the policy.

4.3 Significant Trends in Policy Coverage Disputes

In the past year, the courts have addressed a significant number of insurance-related issues, particularly in relation to interpretation of insurance policies, disclosure of material facts, and repudiation of claims by insurers on grounds of

non-production of documents. There has been a trend towards stricter interpretation of terms and conditions of policies. The Supreme Court has held that the terms of an insurance policy should be strictly construed, without altering the nature of the contract, as it may adversely affect the interest of the parties.

In terms of disclosure requirements for health insurance policies, the Supreme Court has held that if any query or column in a proposal form is left blank, then the insurer should ask the insured to complete it.

On the issue of overlapping insurance policies, the Supreme Court has held that a contract of insurance is one of indemnity. Double insurance is when an insured is indemnified by two or more insurers for the same risk. In instances where the insured has been fully indemnified for the loss by one insurer, the second insurer can decline the claim regarding the same incident.

4.4 Resolution of Insurance Coverage Disputes

Insureds in India can:

- resort to the dispute resolution mechanism set out in the policy document (usually arbitration in the context of commercial general insurance contracts);
- approach the internal grievance redressal mechanism of the insurer, the grievance cell of the IRDAI or the insurance ombudsman under the Redress of Public Grievance Rules 1998 (depending on the nature of the grievance); or
- initiate formal legal proceedings against the insurer before the consumer protection forums or the Indian civil courts.

Reinsurance contracts are also contracts of insurance and, therefore, the position on these is the same. In fact, the CCA 2015 defines a commercial dispute as including both insurance and reinsurance over the value of INR300,000 (approximately USD3,575).

4.5 Position If Insured Party Is Viewed as a Consumer

By operation of law, an insured can approach a consumer forum, inter alia, in relation to any claim against an insurer in India. This forum can be approached independently of any right that the insured may have under the policy terms, including its right to initiate arbitration proceedings.

The consumer courts follow a summary procedure, which does not usually involve detailed evidence or cross-examination of witnesses. The fee for filing a complaint before a consumer forum is also nominal, as opposed to before a civil court, where the fee is ordinarily determined based on the claim amount.

4.6 Third-Party Enforcement of Insurance Contracts

There is no equivalent law in India of the UK Third Parties (Rights Against Insurers) Act 2010. As a general rule, Indian law recognises the principle of privity of contract and consequently, a third party may not be able to bring a direct action or claim against an insurer.

That being said, it is common practice for third parties to name the defendant's insurer in motor accident-related proceedings. The Motor Vehicles Act 1988 (MVA) provides that the rights of an insured under a policy are transferred to a third party claiming against the insured in the event of the insured's insolvency. The MVA empowers the Motor Claims Tribunal to seek

the insurers' involvement in a third-party action against the insured if the tribunal believes the claim is collusive or if the insured fails to contest the claim. However, Section 164 of the MVA limits the insurer's liability concerning third-party insurance with effect from 1 April 2022 in the following terms:

- in the case of death, INR500,000 (approximately USD6,000); and
- in the case of grievous hurt, INR250,000 (approximately USD3,000).

There are presently no limits on the insurer's liability in cases of permanent disability or minor injury.

4.7 The Concept of Bad Faith

Insurance bad faith does exist in India, but it is not expressly codified. Both the insurer and the insured are required to disclose material information to each other, and insurers cannot avoid reasonably clear liability by acting in bad faith or by resorting to unfair trade practices.

There is also a separate constitutional duty on government insurers to act in a fair and reasonable manner before and after inception of the insurance policy.

4.8 Penalties for Late Payment of Claims

The IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations 2024 (the "PPHI Regulations 2024") requires insurers to set their own timelines for making a claim payment, and while no specific penalty has been set out under the PPHI Regulations 2024, insurers will be expected to deal with this matter in their respective board-approved policy. In addition, there are other civil penalties which can also be imposed on insurers, includ-

ing damages for breach of contract, compensation for deficiency in service, etc.

The Consumer Act 2019 has also introduced a centralised agency called the Central Consumer Protection Authority (CCPA). The CCPA has wide powers, including the power to initiate investigations and impose sanctions and penalties as may be required and allowed in the circumstances.

4.9 Representations Made by Brokers

The relationship between an insured and a broker is that of a principal and agent. An insurance broker is an agent of the insured and whether a representation made by a broker is binding or not would depend on whether the broker was authorised by the insured to make such a representation. In the absence of such authorisation, it is unlikely that representation made by the broker will be binding on the insured. It is pertinent to note that as the insured signs the proposal form, the insured must bear all the consequences arising out of the form.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

The PPHI Regulations permit Indian insurers to outsource activities that would usually be undertaken by the company internally, subject to the prescribed compliance requirements being fulfilled, and provided that the activities proposed to be outsourced do not fall within the ambit of the defined “core activities”. Broadly, Indian insurers are prohibited from outsourcing product design, underwriting, claim handling or actuarial functions to a third-party service provider, as these activities form a part of the company’s core functions.

In terms of delegating underwriting or claims handling to external parties, an Indian insurer is prohibited under Section 21 of the IRDAI’s “Mas-

ter Circular on Allied Matters of Insurers of 19 June 2024” from outsourcing “decision making in underwriting and claims”.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Professional indemnity (PI), directors’ and officers’ liability (D&O), errors and omissions (E&O), employment practice liability (EPL) and cyber-liability policies are examples of the types of policies that provide cover for defence costs incurred by insureds provided that the policy terms and conditions are satisfied.

5.2 Likely Changes in the Future

There is unlikely to be change in this area of the law in the next few years.

5.3 Trends in the Cost or Complexity of Litigation

There is familiarity and demand for liability insurance, and over the past five years there has been a steady upward trend in claims made under PI policies. 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 this firm has 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 insureds under liability policies, which means that claim severity is also on the rise.

PI and D&O claims are likely to continue to make up the largest share of claims. There is also likely to be a rise in EPL – while previously claims were usually made in other jurisdictions, a number of

claims have recently been made in India, with high-value settlements demanded.

The cyber-insurance sector is also seeing increasing interest and development in terms of the wording and post-claim support being offered by insurers, reflecting the increase in claim notifications and related quantum. This is specifically because of the remote working environment introduced by the COVID-19 pandemic.

5.4 Protection Against Costs Risks

An insured can avail of protection against its costs risks for third-party claims under different types of insurance policies, including PI, public liability, D&O, EPL, E&O and product liability policies.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Under the principles of subrogation, the insurer has the same right as the insured to recover a loss from the third party responsible for the loss/the wrongdoer.

Subrogation applies in all types of insurance, except life insurance and personal accident insurance. The right of subrogation has been recognised by statute under Section 79 of the Marine Insurance Act 1963 (the "Marine Insurance Act") and case law, including *Economic Transport Organization v Charan Spinning Mills Ltd* ((2010) 4 SCC 114), where the Supreme Court classified subrogation into three broad categories.

Subrogation by Equitable Assignment

This is not evidenced by a document. It is based on the insurance policy and the insured receiving

the claim amount. The insured cannot deny the equitable right of subrogation, even if there is no written evidence to support it.

Subrogation by Contract

This is evidenced by a document. The court recognises that insurers usually obtain a written letter of subrogation to avoid disputes about the right to claim reimbursement, or to settle the priority of claims between them or confirm the reimbursement amount under the subrogation, and to ensure the insured's co-operation. If the insured executes a letter of subrogation, the insurer's rights against the insured are governed by its terms.

Subrogation-cum-Assignment

The insured executes a letter of subrogation-cum-assignment. This enables the insurer to retain the entire amount recovered and sue in the name of the insured or in its own name if the letter so provides. The insured is then left with no right or interest and can no longer sue in its own name and for its own benefit.

A subrogation right cannot usually be waived. However, in some cases, the insurer and insured can agree to waive subrogation entirely, or in relation to specific individuals/entities.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The right of subrogation has been recognised by statute under Section 79 of the Marine Insurance Act and the insurer can exercise this right in the name of the insured.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Claims have been received by insurers in India where the insured has claimed for business interruption losses on account of the COVID-19 pandemic and the consequent lockdowns. However, since such policies require there to be a physical loss which, in turn, results in business interruption losses, the claims of insureds have often been rejected.

Currently, there are no authoritative rulings specific to claims of business interruption losses stemming from COVID-19-related disruptions.

7.2 Forecast for the Next 12 Months

As stated in **7.1 Type and Amount of Litigation**, there are presently no authoritative rulings on whether the COVID-19 pandemic and/or the lockdowns would amount to a physical loss, thereby enabling the consequent claim of business interruption. It is difficult to predict, particularly given the stage of the pandemic, whether any such ruling will be available in the next 12 months.

7.3 Coverage Issues and Test Cases

Unlike the Financial Conduct Authority business interruption insurance test case in the UK, there has been no test case in India. However, the COVID-19 pandemic did give rise to business interruption claims under property insurance policies. In some cases, insurers have denied liability for COVID-19 notifications on the basis that material damage to property is a prerequisite for an indemnifiable claim for business interruption, and the COVID-19 pandemic did not cause any physical damage or loss to the insured property.

Due to the COVID-19 pandemic, several regulatory changes were also introduced by the insurance regulator with the aim of stabilising the insurance market and securing the protection of policyholders' interests. In this regard, with a view to furthering the business continuity of Indian insurers and other insurance entities, and ensuring proper service to policyholders, the IRDAI issued directions on, inter alia, the handling of COVID-19 claims, extension of grace periods for premium payments, relaxation of regulatory timelines and expeditious servicing of insurance policies.

7.4 Scope of Insurance Cover and Appetite for Risk

Factors such as the war in Ukraine and the pandemic have made insurers a lot more cautious about the risk they are taking. Premiums have been revised to take account of potential losses, and the coverage afforded has been under review.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

The Indian insurance industry is a relatively new market compared to various global markets. As a result, the industry is still considered to be in a relatively nascent stage of development, particularly for various lines of insurance products which have recently been introduced in India. In relation to these products, the insurer's underwriting is derived, to some extent, from global claims experience, in the absence of specific Indian claims experience.

The IRDAI has recently introduced the IRDAI (Corporate Governance for Insurers) Regulations 2024 (the "CG Regulations"), which require all

insurers (including FRBs and Lloyd's India) to have a board/executive committee-approved ESG framework and monitor ESG activities. However, these regulations do not provide any specific guidance in terms of any activities to be undertaken, the contents of the ESG framework or reporting/disclosure requirements.

Recently, the Indian market has witnessed an increase in the volume as well as the quantum of claims reported, due to various ESG factors. Additionally, there has been a significant increase in premiums, particularly for life and health insurance, attributed to adverse mortality and morbidity rates, experienced in large part as a result of the COVID-19 pandemic.

8.2 Data Protection Laws

Broadly, the norms on data security and confidentiality in India arise from statutory law, that is, the Digital Personal Data Protection Act 2023 and the Information Technology Act 2000. In addition, certain similar norms under the Indian insurance regulatory framework are set out under the PPHI Regulations and the IRDAI Guidelines on Information and Cyber Security of 24 April 2023, which essentially place an obligation on insurers and insurance intermediaries to maintain the confidentiality of data. However, these norms also permit disclosure of data, after obtaining consent from the data owner, and remain subject to requirements to maintain data security and other similar requirements.

Typically, in terms of market practices in India, it is understood that gaining the express consent of customers would allow insurers to disclose information to concerned entities, despite the existence of the confidentiality requirements under the statutory and regulatory framework. For this purpose, it is a common practice for insurers to request such consent in the initial

proposal forms, which are signed by customers at the time of proposing/purchasing insurance. For capturing consent, insurers generally incorporate a broadly worded consent provision as part of the declaration under these forms. Thereafter, once the consent of the proposer/applicant is captured, this data is typically shared with reinsurers for their own underwriting and claim settlement purposes.

Furthermore, in terms of litigation, considering that the Indian data protection framework is in a nascent stage and the provisions set out under the current statutory framework are limited, there do not appear to have been any significant disputes of note concerning data protection in the insurance industry at the time of writing.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

The Indian insurance sector is highly regulated and there have recently been many significant regulatory developments in the sector. Some of these developments are listed here.

- The IRDAI has notified the IRDAI (Registration, Capital Structure, Transfer of Shares and Amalgamation of Insurers) Regulations 2024, which consolidate and repeal the erstwhile norms in relation to registration, permitted capital structure, transfer of shares and amalgamation of insurers. In furtherance of these regulations, the IRDAI also issued the “Master Circular on Registration, Capital Structure, Transfer of shares and Amalgamation of Insurers 2024” of 15 May 2024, which provides certain clarifications and prescribes the various forms referred to in the regulations.

- The IRDAI has notified the IRDAI (Corporate Governance for Insurers) Regulations 2024 and the “Master Circular on Corporate Governance for Insurers 2024” of 22 May 2024. These regulations, along with the master circular, provide a governance structure framework for all insurers (excluding FRBs) and include norms pertaining to the composition of the board along with its power, roles and responsibilities, required board committees, appointment and remuneration of KMPs, disclosure and reporting requirements.
- The IRDAI has notified the PPHI Regulations, which consolidate and repeal the earlier norms on the policyholders’ interests, advertisements by insurers, outsourcing by insurers, manner of receipt of premium, place of business of insurers, and procedural matters pertaining to nomination and assignment of insurance policies. In furtherance of these regulations, the IRDAI also issued the “Master Circular on Operations and Allied Matters of Insurers” of 19 June 2024, which specifies further norms on advertisements, outsourcing, places of business, grievance redressal procedures, group insurance and usage of trade logos by insurers.
- The IRDAI has notified the IRDAI (Expenses of Management, including Commission, of Insurers) Regulations 2024 and the “Master Circular on Expenses of Management, including Commission, of Insurers, 2024” of 15 May 2024, which together consolidate and repeal the recently revised norms on expenses of management of insurers and commission payable to insurance agents and intermediaries.
- The IRDAI has notified the IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations 2024, which consolidate various norms in relation to an Indian insurer’s (i) appointed actuary appointment as well as duties and responsibilities, (ii) valuation of assets, liabilities and maintenance of solvency margin, (iii) financial statements preparation, (iv) investments, and (v) loans and advances. In furtherance of these regulations, the IRDAI has also issued the “Master Circular on Actuarial, Finance and Investment Functions of Insurers” of 17 May 2024, which provides additional guidance on actuarial, finance and investment functions of insurers including FRBs exclusively engaged in reinsurance business, unless expressly specified otherwise at specific junctures.
- The IRDAI has notified the IRDAI (Insurance Products) Regulations 2024, which provide the required form and permitted features for life, general and health insurance products and consolidate and repeal the earlier norms on life insurance products (linked and non-linked), health insurance products, and micro insurance products. In furtherance of these regulations, the IRDAI has issued three master circulars on life, general and health insurance products, respectively to further specify the form and features of life, general and health insurance products as well as the filings with the IRDAI or internal committees as the case maybe.
- The IRDAI has notified the IRDAI (Registration and Operations of FRB and Lloyd’s India) Regulations 2024, which consolidate and repeal erstwhile norms on registration and operations of FRBs and Lloyd’s India.
- The IRDAI has notified the IRDAI (Re-insurance) (Amendment) Regulations 2023 of 22 August 2023, which amend certain provision under the IRDAI (Re-insurance) Regulations 2018 and the norms pertaining to FRBs and Lloyd’s India. The regulations, inter alia, amend the “order of preference” to be followed by Indian cedants while placing reinsurance business, where FRBs and cer-

tain IFSC Insurance Offices are now placed in the same category after the Indian Reinsurer and also specify the norms in relation to the minimum retention requirements applicable to insurers, FRBs and Lloyd's India.

- In addition, the IRDAI has issued the "Master Circular on Reinsurance 2024" of 31 May 2024, to specify norms on operational matters pertaining to FRBs and Lloyd's India, issuance/renewal of file reference number of Cross Border Reinsurers (CBRs), and the requirement of obtaining collaterals while placing reinsurance business with CBRs.
- The IRDAI has issued the "Master Circular on Submission of Returns" of 14 June 2024, to specify the returns and business statistics to be filed with the IRDAI under the various regulations.
- The IRDAI issued a gazette notification on 22 January 2024, which de-notifies the tariff wordings under certain classes of insurance business (ie, fire, motor, engineering miscellaneous and marine).
- The IRDAI issued a circular on 10 October 2023, to amend specific provisions of the

IRDAI's Master Guidelines on Anti-Money Laundering/Counter Financing of Terrorism (AML/CFT) 2022 of 1 August 2022, including in relation to having group-wide programmes against money laundering and terrorist financing, client due-diligence at the claim/payout stage of insurance policy, and KYC undertaken by a third party.

- The IRDAI has notified the IRDAI (*Bima Sugam*-Insurance Electronic Marketplace) Regulations 2024, to specify norms on the establishment, governance, functioning and other related matters of an insurance electronic marketplace called *Bima Sugam*.
- The IRDAI has issued the IRDAI (*Bima Vahak*) Guidelines 2023 of 9 October 2023, in furtherance of the exposure draft with the same title and which establish a dedicated distribution channel responsible for distribution of the *Bima Vistaar* product (a comprehensive insurance product proposed to be issued in due course) along with other products as approved by the IRDAI, at a local/village level.

ITALY



Law and Practice

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Clyde & Co Italy

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Clyde & Co Italy is the world's pre-eminent insurance and reinsurance law firm and works for major insurers, underwriters and brokers to provide the highest quality advisory and dispute resolution services in both established and emerging markets. Its team in Italy works on contentious and non-contentious matters across all insurance business lines from the Milan office established in 2023. It offers an unmatched depth of coverage and defence

capabilities across every line of insurance and reinsurance business, from the smallest claim to the most complex loss. It also provides a complete range of advisory services including advising on policy wording issues, product development and recoveries. Its fully integrated global approach provides clients with a seamless service across jurisdictions, including access to over 5,500 people operating from nearly 70 offices across six continents.

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CLYDE & CO

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime Statutory Regime

The statutory framework governing insurance contracts is primarily set out in:

- the Italian Civil Code (Articles 1882 to 1932);
- Legislative Decree No 209 of 2005 (Code of Private Insurance) dated 7 September 2005; and
- the regulations issued by the Italian Institute for Insurance Supervision (IVASS).

Procedural Regime

If no specific mechanisms for dispute resolution (arbitration, ADR) are provided, any dispute arising from insurance contracts will be heard in civil courts under the same rules for other civil law disputes provided in the Italian Civil Procedure Code.

Mediation is a mandatory pre-condition to commence civil proceedings based on an insurance contract. However, this does not apply when the insured seeks the joinder of the insurer within the underlying civil proceedings commenced by the claimant against the insured party (see **1.3 Alternative Dispute Resolution (ADR)**).

1.2 Litigation Process and Rules on Limitation

The Litigation Process

Standard civil proceedings begin with the service of a writ of summons, which must set out the factual and legal grounds of the claim and indicate the date of the hearing not earlier than 120 days from service (or 150 days for foreign defendants). The defendant has to file a statement of defence at least 70 days before the first

hearing, responding to the claimant's allegations.

The parties then have three consecutive terms (40, 20 and 10 days before the hearing) to file additional pleadings to specify their defences and submit new documents or request further evidence (witnesses, expertise etc). At the first hearing, the judge verifies if the dispute can be decided on the basis of the documents already submitted or if additional evidence is required.

When the case is ready for a decision, the parties are assigned three consecutive terms to submit their demands, conclusive pleadings and rebuttals. At the final hearing the judge reserves the judgement. No mandatory deadline for issuing the judgement is provided by the law. The judgement is provisionally enforceable and its enforceability is not suspended by the appeal. All pleadings and exhibits must be filed electronically with the court.

Rules on Limitation

Actions in tort are subject to a five-year limitation period from the date when the cause of action occurred or the later date when the claimant became or could have reasonably become aware of such cause of action.

For actions in contract the limitation period is generally ten years from the date when the breach of contract occurred although a shorter limitation period applies to certain contracts.

The running of the limitation period can be interrupted by either commencing court proceedings or sending demand letters, in which case a new limitation period starts to run.

1.3 Alternative Dispute Resolution (ADR)

The most recent reform of the Italian Civil Procedure Code in 2023 has encouraged ADR by:

- facilitating access to these procedures;
- simplifying the procedural rules governing ADR so decisions can be issued more quickly; and
- making mediation mandatory for certain matters.

Mediation and assisted negotiation procedures are mandatory for bringing standard civil proceedings on certain matters, including insurance, banking and financial contracts, leases of commercial properties, etc. If mandatory mediation is not carried out before commencing legal action, the judge:

- declares the legal action inadmissible;
- orders the parties to start mediation/ADR within 15 days; and
- suspends the case until mediation is completed.

Despite expectations about the benefits of this reform, reality shows that insurers prefer to settle the case out of mediation. Arbitration in insurance disputes is less common, except for reinsurance matters.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes Jurisdiction

In international disputes involving a party domiciled outside the EU, the jurisdiction of the Italian civil courts is established on the basis of the principles set out in Law No 218 of 1995 dated 31 May 1995. Under Article 3 of Law 218

of 1995, Italian jurisdiction exists whenever the defendant is domiciled or resident in Italy.

In disputes involving a party domiciled in another EU member state, jurisdiction is established according to EU Regulation 1215/2012 (the “Regulation”), which governs civil and commercial jurisdiction in the EU.

In particular, Article 4 of the Regulation sets out the general criteria for determining jurisdiction and states that, if a person has its domicile in a member state, that person can be sued in another member state unless other provisions of the Regulation prevail. In fact, Article 7 of the Regulation sets different rules for establishing jurisdiction in cases of contractual obligations, torts/delicts, actions for damages, etc. Article 25 of the Regulation also recognises jurisdiction regulated by a contractual clause agreed between the parties if the clause complies with the formal requirements provided in the Regulation.

Articles 11 to 16 of the Regulation set out the rules to determine jurisdiction when the defendant is an insurer, taking into account the risk of the insurance contract as well as the specific features of the dispute.

Choice of Law

When no valid choice of law is made in the insurance contract, the following rules apply.

- With regards to EU disputes, the Rome I Convention (Regulation 593/2008) clarifies that the applicable law is that of the country where the insurer has its habitual residence.
- With regards to disputes involving a party domiciled outside the EU, Law 218 of 1995 transposes the Rome I Convention. The

applicable law is therefore that of the country where the insurer has its habitual residence.

2.2 Enforcement of Foreign Judgments

In Italy, a foreign judgment is enforced on the basis of Law 218 of 1995 and EU Regulation 1215/2012. Regulation 1215/2012 recognises EU judgments delivered in another member state without any procedural formalities. This principle also applies to the enforcement of judgments delivered in another member state. International judgments issued outside the EU are enforced in Italy in line with Articles 64 and 65 of Law 218 of 1995 subject to some controls by the competent Court of Appeals.

2.3 Unique Features of Litigation Procedure

Italian Litigation Features

Particular features of litigation in Italy include:

- court fees are proportional to the quantum of the claim;
- the loser-pays rule normally applies;
- there is no general duty of disclosure in Italian court proceedings, but one party can ask the court to order the other party to disclose specific documents;
- the damaged party does not have direct action against the wrongdoer's insurer. Only the insured party can act against the insurer (with the main exceptions being motor insurance and medical malpractice insurance);
- the average duration of first instance proceedings is normally three years, but some cases and some courts can take longer; and
- first instance decisions can be appealed, and the appeal may lead to a completely new examination of the case while second instance decisions can be appealed before the Italian Supreme Court but it only reviews

issues concerning jurisdiction and the correct application of law.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

The Italian courts have recognised the validity of arbitration clauses included in insurance and reinsurance contracts since the introduction of arbitral rules in the Italian Civil Procedure Code. Article 819 ter of the Italian Civil Procedure Code allows the defendant to challenge the jurisdiction of the court in favour of arbitrators in its statement of defence. The latest reform of the Italian Civil Procedure Code in 2023 introduced new rules, which allow a party in cases involving lack of jurisdiction of the courts or of the arbitral tribunal to resume the case before the authority deemed competent.

3.2 The New York Convention

Italy ratified the New York Convention in 1969 and then transposed the relevant provisions into the Italian Civil Procedure Code. Article 839 of the Italian Civil Procedure Code establishes the rules to recognise foreign awards in Italy. The party intending to enforce a foreign award must submit an appropriate application to the Court of Appeal where the counterparty is domiciled. If the award meets all of the necessary requirements, the Court of Appeal declares the foreign award immediately enforceable in Italy. Any interested party may challenge the Court's decision.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration in Insurance Disputes

Some insurance contracts still include arbitration clauses, but arbitration is normally disregarded

mainly because of its higher costs compared to court proceedings. However, a draft law is being prepared with a view to introducing insurance arbitration in small insurance disputes to reduce the courts' workload.

Rules of Arbitration in Italy

The parties are free to opt for arbitration. The parties' choice and the rules of arbitration are governed by Articles 806 to 840 of the Italian Civil Procedure Code. Under Italian law there is a difference between ritual and non-ritual arbitration with the former having the same effect as a court judgment and the latter having the same effect as a contract.

The parties can agree to settle a dispute within an arbitral tribunal in two different ways.

- By an arbitration clause: whenever the parties enter into an agreement, they can establish that any future dispute arising from that agreement will be settled by arbitration.
- By an arbitration agreement: which represents a separate agreement between the parties with the scope to refer a dispute to arbitration.

The final award can only be appealed in a strict number of cases before the Court of Appeal.

4. Coverage Disputes

4.1 Implied Terms

In setting the terms of an insurance contract, the parties are in principle free to negotiate the content of the contract of insurance provided that its terms do not breach internal public policy or have an illicit scope. Insurance policies distributed in the Italian market generally contain detailed terms and conditions. If the policy is

silent on particular issues, various provisions of the Civil Code and the Code of Private Insurance are implied.

In addition, according to Article 1932 of the Civil Code, certain provisions in the matter of insurance (eg, those regarding the insured's misrepresentation, reimbursement of legal costs to the insured and the breach of the insured party's duty of salvage) are mandatory and can only be departed from in a way that is more favourable to the insured party.

4.2 Rights of Insurers

Misrepresentation and non-disclosure rules are set out in Articles 1892 and 1893 of the Italian Civil Code. If the insured/policyholder, intentionally or through gross negligence, makes incorrect, incomplete or omissive declarations about material circumstances of the risk, the insurer can deny coverage and refuse to pay the indemnity (or is entitled to a proportional reduction of the indemnity where misrepresentation is attributable to simple negligence).

The insurer loses the right to challenge the contract if, within three months from the day on which he became aware of the insured's misrepresentation, they fail to notify the insured party of its intention to challenge the contract. However, this does not apply when the misrepresentation is discovered after the claim was made. In this case the insurer can refuse payment without breaching the contract.

4.3 Significant Trends in Policy Coverage Disputes

Over the last 12 months the Italian civil courts have addressed a significant number of insurance-related issues, including:

- claims made clauses – the debate around the validity of claims made clauses is not over and the Italian courts continue to issue some conflicting decisions. However, in general the Supreme Court has finally accepted claims made clauses upon certain conditions and the law has imposed claims made PI insurance onto some categories of professionals;
- misrepresentation and prior knowledge – this is one of the coverage defences most frequently raised by insurers in financial lines litigations and case law is particularly focused on the information requested by the insurer in the proposal form to ascertain whether non-disclosure can be attributed to the insured party's wilful misconduct, gross negligence or simple negligence;
- multiple insurance – in February 2024 the Italian Supreme Court ruled on the apportionment of the amount due by each insurer in case of multiple insurance, providing clarity on a long-debated issue; and
- interpretation of insurance contracts – the Italian Supreme Court is giving prominence, in the interpretation of insurance contracts, to the *contra proferentem* rule set out in the Civil Code and case law is using it as a *contra insurer* rule.

4.4 Resolution of Insurance Coverage Disputes

Notwithstanding coverage disputes being subject to mandatory mediation (see **1.3 Alternative Dispute Resolution (ADR)**), only a few disputes are settled within the mediation procedure with most of them ending up in court. Court proceedings involving coverage issues are often settled before the judgement is delivered, especially during the taking of evidence phase, which gives insurers access to lots of information and details that enable the parties to determine whether the

claim is grounded or not and try and settle out-of-court.

Reinsurance disputes are in principle governed by the same procedural rules as insurance litigation, although mediation is not mandatory. However, in reinsurance contracts arbitration is a very popular means of dispute resolution and the vast majority of reinsurance treaties provide for disputes to be resolved by London arbitration.

4.5 Position If Insured Party Is Viewed as a Consumer

If the insured party is a consumer, then its interests are protected under the Italian Consumer Code. In particular, clauses included in insurance contracts with consumers are subject to Articles 33 and 36 of the Consumer Code (Legislative Decree No 206 of 2005 dated 6 September 2005) which state that any clause excluding or limiting the consumer's rights or resulting in a significant imbalance in the consumer's obligations vis-à-vis the insurers is null and void.

4.6 Third-Party Enforcement of Insurance Contracts

Any third party with a claim against an insured party cannot enforce the insurance contract against the insurer nor sue the insurer directly. The insured party is the only party entitled to seek coverage under the policy and to bring any action against its insurer. The only exceptions relate to motor insurance and medical malpractice insurance.

4.7 The Concept of Bad Faith

The concept of bad faith does not exist under Italian laws. Certain provisions in the Italian Civil Code instead refer to the concept of good faith. Italian laws require good faith in the performance of contractual obligations. More specifically, the creditor and the debtor must behave in good

faith and they must preserve and respect the counterparty's interests in performing the contract.

Even though there is not a bad faith concept, in insurance litigation cases the civil courts have recognised the concept of *mala gestio*, which occurs when the insurer does not handle the claim in good faith. In this case, the insured party can seek compensation of the interest and damage suffered as a consequence of the conduct (see **4.8 Penalties for Late Payment of Claims**). They can also report the insurer's conduct to the IVASS.

4.8 Penalties for Late Payment of Claims

In Italy, penalties for insurers paying claims late were only present in motor liability claims and they were cancelled in 2018. Before the cancellation, an insurer who paid claims late was subject to an administrative fine, which increased as the delay increased.

Insurers nowadays therefore have no penalties. However, unjustified late payments may constitute a *mala gestio* conduct by the insurer in the execution of the insurance agreement, which is contrary to the principle of good faith governing all legal relationships (see **4.7 The Concept of Bad Faith**) and it entitles the insured party to claim:

- interest – if no interest rate is agreed, the legal interest rate is currently 2.5%, while the default interest on belated payments in commercial transactions is currently equal to 12%, which should be calculated running from the writ of summons' notification date. The legal interest rate is updated annually and the default interest rate biannually by the decree/communication of the Ministry of

Economy published in the Official Gazette; and

- damages – insurers will also bear any further damage the claimant/the insured party can demonstrate they have suffered due to the delay.

4.9 Representations Made by Brokers

Unless the insurance contract provides otherwise, insured parties are not bound by representations made by the broker. However, proposal forms and questionnaires are normally completed by the insured party.

Article 1 of the Italian Code of Private Insurance defines a "broker" as "any person professionally engaged in activities aimed at placing in direct contact with insurance or reinsurance undertakings, to which he/she is not bound by any commitment whatsoever, persons who intend to cover risks with his/her collaboration, assisting them in determining the content of the relevant contracts and collaborating, where appropriate, in their management and execution".

In light of this definition, case law treats the broker as the insured party's trusted advisor on all aspects relating to the insurance contract but they do not represent the insured party and their representations are binding on the insured party. However, the policy and/or a specific agreement may provide otherwise.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Delegated underwriting or claims handling authority arrangements are common in Italy. Insurance companies quite often outsource both underwriting and claim handling. The agreements normally provide for a capped authority, which can be only exceeded upon approval from the insurer. While claims between intermediar-

ies and insurance companies are possible, they are not common as commercial realities tend to prevail.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

As pointed out under 2.3 Unique Features of Litigation Procedure, liability insurance coverage necessarily includes cover for the costs of funding an insured party's defence. Article 1917 of the Italian Civil Code provides that the liability insurer has to pay the insured party's legal costs incurred in defending the claim up to a maximum of 25% of the policy limit. In addition, when the sum due to the damaged party is greater than the policy limit, legal costs are shared between the insurer and the insured party in proportion to their respective interests.

The rationale of this provision is that the insured party's defence is carried out in the interest of the insurer because, defending the claim, the insured party is also reducing the risk of the policy limit being eroded. The insurer's obligation to pay the insured party's legal costs is ancillary to the main obligation to pay the indemnity so that, if the claim is not covered, no legal costs will be paid by the insurer to the insured.

5.2 Likely Changes in the Future

The rules set out in 5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds above regarding the insured party's legal costs are compulsory. There are therefore unlikely to be significant changes in the near future.

5.3 Trends in the Cost or Complexity of Litigation

In Italy, there is a specific Ministerial Decree (No 55 of 2014) which sets out the criteria to establish courts and lawyers' fees between a minimum and a maximum, which are:

- the quantum of damages sought;
- the complexity of the litigation;
- the number of parties; and
- the competent judge.

These criteria are set out in a range that covers all the phases of the proceedings as well as their various complexity. As those criteria have recently been amended by Ministerial Decree No 147 of 2022, we do not expect further changes in the near future.

5.4 Protection Against Costs Risks

In Italy, there is no protection against legal cost risks for claimants. However, with respect to defendants' legal costs, there are some specific insurance standalone products aimed at covering defence costs (*tutela legale* or legal expenses insurance).

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Under Article 1916 of the Italian Civil Code – subrogated recovery action – the insurer is subrogated in the insured party's rights against any third party upon payment of the indemnity.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The insurer's right to bring subrogated recovery action is set out in Article 1916 of the Italian Civil Code. In order to exercise this right, the insurer

er must have paid the indemnity and informed the third party that it is now subrogated to the insured party's rights. The subrogated recovery action is brought by the insurer in its own name.

It is not uncommon to see the insured party and insurer as co-claimants trying to recover the deductible or the sum exceeding the indemnity and the indemnity respectively. The insured party is liable for any conduct that may prejudice the insurer's right of subrogation.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The main macroeconomic factors that have affected both the type and the amount of litigation and insurance-related litigation are as follows.

COVID-19 Pandemic

The COVID-19 pandemic represented a perfect condition for cyber criminals maximising their gain with the launch of an increased range and number of cyber-attacks. Threat actors leveraged the fact that the entire population was unexpectedly forced to work remotely from home, with fewer security measures available than in the workplace. The World Economic Forum reported that the pandemic led to a 50.1% increase in cyber-attacks and 30,000 cyber-attacks which were specifically COVID-19 related in the first quarter of 2020 alone.

This enormous threat to a technology-driven society inevitably also impacted the cyber-insurance sector, which faced a significant increase in the number of claims submitted by insured parties under their cyber policies for reimbursement of costs borne and losses suffered as a

consequence of the cyber-attack suffered. However, the unpreparedness of the insured parties, due to the high level of stress, anxiety and worry they were facing during the pandemic, to properly react to the cyber-attack and/or to comply with the cyber policy requirement, led to several coverage requests being declined. This in turn led to subsequent challenges by insured parties and coverage-related litigation.

COVID-19 also had a huge impact on other policies such as those covering business interruption (in Italy, mainly cyber, all risks and property) and all those covering medical expenses.

Russia-Ukraine War

Cyber-attacks have been used as an additional weapon during the Russia-Ukraine war. They have involved very cyber capable states and while some other insurance sectors have been able to exclude the claims by resorting to war exclusion, this was not that easy with reference to cyber insurance (see 7.3 Coverage Issues and Test Cases), where the conflict has had a huge impact.

Natural Disasters

Climate change has brought a huge increase in natural disasters in Italy, where floods, tornadoes and hail were not that common. This change was not expected and that is why insurers and insured parties did not factor it in during the underwriting phase where the insured parties did not buy policies covering this kind of risk and many insurers did not correctly assess the risk when issuing policies covering it. This uncertainty resulted in lots of litigation and new insurance products being developed by insurers (parametric insurance).

7.2 Forecast for the Next 12 Months

If we take a look at the next 12 months, we expect the following scenarios.

- COVID-19 claims will decrease: in Italy COVID-19 cases have already decreased and hopefully will decrease further in the next year. In any case, insurers have now drafted policies that take this kind of risk into account.
- Russia-Ukraine War: claims will be stationary unless the war ends. Where the war does end, claims will significantly decrease. However, we don't see the war ending in the next year.
- Natural disaster claims will decrease: in fact, the Italian legislator has required all corporate entities to take out natural disaster insurance by the end of 2024 (see **8.1 Impact of ESG on Underwriting and Litigating Insurance Risks**). This should lead to fewer disputes. By contrast, coverage disputes around these new policies will inevitably arise.

7.3 Coverage Issues and Test Cases COVID-19 Pandemic

The first coverage issue related to COVID-19 is that no one, including the insurance sector, was ready for the outbreak of the pandemic. This often resulted in a lack of pandemic exclusions, which brought insurers to cover those claims. Some policies provided for the exclusion of losses arising out of public authority orders, which led to requests for cover for BI losses being denied. The insured parties challenged these rejections multiple times.

One of the most important coverage issues related to COVID-19 concerned is its classification as a disease or injury, which is still uncertain.

Russia-Ukraine War

With reference to claims arising from the Russia-Ukraine war, insurers and insured parties have been litigating around the validity and strength of war exclusion within cyber policies. The reason for this is that, despite the existence of the exclusion, unlike traditional war scenarios, it is very often difficult to identify the perpetrator of a cyber-attack and if the attack has come from a war zone or not. Another issue is the lack of a clear and standard definition for the term "war" in the exclusion clauses of cyber-insurance products. The difficulty in attributing and proving cyber war events, on the one hand, and the lack of a clear definition of war on the other put insurers, who bear the burden of proof if a claim is denied, in an extremely weak position when litigating for declining coverage by invoking the war exclusion.

Natural Disasters

As outlined in **8.1 Impact of ESG on Underwriting and Litigating Insurance Risks**, natural disasters were often not included in the risk taken by insurers and this gap led the Italian legislator to intervene.

7.4 Scope of Insurance Cover and Appetite for Risk

The outbreak of the COVID-19 pandemic has certainly affected the scope of insurance contracts. One of the main direct effects in the policy wording is the insertion of a pandemic exclusion.

Furthermore, both the COVID-19 pandemic and the Russia-Ukraine war have significantly changed the appetite for cyber-risk. In fact, due to these two factors, Italy is now more conscious of the changes brought by technology, both in personal and professional life (remote working, e-commerce, etc) and this resulted in being

more sensitive to the risks related to technologies, particularly cyber-attacks.

The increase in natural disasters has also significantly affected the scope of insurance contracts as it persuaded the legislator to require corporate entities to take out insurance for those events. It also led insurers to design new insurance products such as parametric insurance (see **8.1 Impact of ESG on Underwriting and Litigating Insurance Risks**).

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

The most recent and important news concerning ESG is related to the Corporate Sustainability Reporting Directive (CSRD) which significantly changes the scope and nature of corporate sustainability reporting. The CSRD significantly expands existing rules on non-financial reporting.

According to the CSRD companies must record the effect of sustainability aspects on the financial position of the company and they must clarify the impact of sustainability considerations on operations. The report will need to include information on sustainability goals, the role of the executive board and the supervisory board, the most significant adverse impacts on the company, and intangible impacts not yet accounted for.

Italy is in the process of adopting the CSRD and on 30 August 2024 the Italian Council of Ministers definitively approved a Legislative Decree adapting EU Directive 2022/2464 (related to the CSRD) into Italian legislation. The Decree is effective after publication on 10 September 2024 in the Official Gazette of the Italian Republic.

This change will affect both the underwriting and claim handling of PI and D&O risks. Insurers will need to take the new obligation imposed on D&Os into account when drafting the policy and the policy proposal. They will need to consider that the risk related to D&O liabilities will slightly increase as this directive will put further obligations on them.

8.2 Data Protection Laws

Recent case law on the compensation rights of a data subject for non-material damages suffered as a consequence of a data breach pursuant to Article 82 of the General Data Protection Regulation (GDPR) will be considered and kept in mind by insurers in assessing their potential exposure under a cyber policy. While in the past (Supreme Court Decisions Nos 16402/2021 and 17383/2020) the requirements for the data subject affected by a data breach to seek non-material damages were very strict as they were awarded only in case of serious violation of its privacy right and of significant damage, the data affected subjects can seek and obtain compensation even when the violation of their privacy right is trivial and the damage only potential (Supreme Court Decision No 13073/2023 and ECJ C-340/21 and C-300/21).

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation Civil Procedure Reform

Legislative Decree No 149 of 2022 dated 10 October 2022 (the “Cartabia Reform”) came into effect in 2023. Though the Cartabia Reform involved the entire Italian justice system, significant civil procedure changes were specifically introduced to modernise the system and make

it more efficient. The Cartabia Reform was aimed at reducing the backlog of cases in the Italian courts as well as the length of civil proceedings.

Statutory Auditors' Liability

On 29 May 2024 the Italian Chambers of Deputies approved a proposed law on statutory auditors' liability. The law proposes bringing the moment when the limitation period starts to run forward and limiting the quantum of damages recoverable (to be based on the statutory auditors' annual fees). Final approval by the Senate is expected in the next few months.

Medical Malpractice

Seven years after the enactment of Law No 24 of 2017 (the "Gelli-Bianco Law") regulating medical malpractice in Italy, Decree No 232 of 2024 was approved on 1 March 2024 and implemented certain provisions of the Gelli-Bianco Law, such as the applicability of direct action by the damaged party against healthcare facilities' and health professionals' insurers, regulating the content and requirements of their insurance policies and setting the minimum mandatory standards for these policies.

Cybersecurity

The recent legislative and regulatory developments at European level on cybersecurity (NIS2 Directive No 2022/2555, are being implemented in Italy through the scheme of the Legislative Decree submitted by the Italian government to the Parliament for approval on 17 June 2024 – the DORA Regulation No 2022/2554 and Cyber Resilience Act) are expected to have a significant impact on both cyber and D&O insurance.

The common thread between all of these new legislative provisions is the strengthening of cybersecurity and digital operational resilience of European companies through introducing pol-

icies and procedures to be adopted by a broad range of entities for preventing and properly handling cyber-attacks (with a focus on supply chain aspects) and of strict reporting obligations and encouraging the sharing of intelligence and cooperation among member states with respect to cyber-attacks registered in each jurisdiction.

These legislative changes are expected to positively affect the cyber-insurance sector in multiple ways. It will not only facilitate the underwriting process (considering that intelligence sharing will result in a better understanding of risk and considering that the new mandatory cybersecurity measures to be adopted will make the risk assessment process much easier) but will also increase the underwriting opportunities (due to increased cybersecurity awareness among a broader group of stakeholders).

From a claims perspective it will also likely reduce the risk of successful cyber-attacks (considering the many preventative measures introduced by the new legislation) and most importantly, a decrease in related losses (considering all the measures introduced for a prompt handling of cyber-attacks and, subsequently, to mitigate the potential losses).

However, a negative aspect for D&O insurers is that the new European legislation has also expressly introduced management liability for the definition, approval and monitoring of the implementation of risk management measures (also with respect to non-executive directors and the supervisory board), which will result in new possible claims under D&O policies if the members of the board of directors and/or the supervisory board breach the new rules and obligations on cybersecurity set out by EU legislation.

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Motor Insurance

Legislative Decree No 184 of 2023 dated 22 November 2023 implemented EU Directive 2021/2118 and introduced several provisions into the Italian Insurance Code in terms of motor insurance regarding, inter alia, a new definition of vehicles, increases to the minimum limits for compulsory motor vehicle liability insurance, policies covering risk for multiple vehicles, a recovery action against the Italian Guarantee Fund and a quote generator comparing motor insurance prices.

Policies Covering Natural Catastrophes

As highlighted under **8.1 Impact of ESG on Underwriting and Litigating Insurance Risks**, Law No 213 of 2023 dated 30 December 2023 introduced a new category of compulsory insurance aimed at covering damage to companies' assets caused by natural disasters and catastrophic events.

Trends and Developments

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Clyde & Co Italy is the world's pre-eminent insurance and reinsurance law firm and works for major insurers, underwriters and brokers to provide the highest quality advisory and dispute resolution services in both established and emerging markets. Its team in Italy works on contentious and non-contentious matters across all insurance business lines from the Milan office established in 2023. It offers an unmatched depth of coverage and defence

capabilities across every line of insurance and reinsurance business, from the smallest claim to the most complex loss. It also provides a complete range of advisory services including advising on policy wording issues, product development and recoveries. Its fully integrated global approach provides clients with a seamless service across jurisdictions, including access to over 5,500 people operating from nearly 70 offices across six continents.

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ITALY TRENDS AND DEVELOPMENTS

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Case Law

Claims made

The validity or otherwise of claims made clauses has had a huge impact on insurance litigation in Italy over the last two decades. This debate stems from the fact that the Italian Civil Code was based on a loss occurrence scheme. According to Article 1917 of the Civil Code, cover under an insurance contract is triggered on the occurrence of a loss event within the policy period.

In order to clarify the validity of the claims made clause, the Italian Supreme Court issued, *inter alia*, the following decisions.

- Decision Nos 5624/2005 and 7273/2013: among the judgements initially rendered by the Supreme Court, these are the most relevant. The Supreme Court stated that claims made clauses are a lawful and valid expression of the parties' contractual freedom, but also made clear that judges should verify on a case-by-case basis whether a claims made clause is unfair for the purpose of Article 1341 of the Civil Code (ie, whether it results in an unfair limitation of insurers' liability) and are therefore unenforceable unless specifically approved in writing by the insured.
- Decision No 9140/2016: on this occasion, the Supreme Court ruled that the clause under examination cannot be considered unfair under Article 1341 of the Italian Civil Code as it defines the insurance grant and does not limit the insurers' liability. Conversely, the Court highlighted that under certain conditions the clause may be held null and void if it determines a significant imbalance between the rights and obligations of the parties under the insurance contract.
- Decision No 22437/2018: in 2018, the Joint Division of the Supreme Court finally acknowledged that claims made clauses are

fully accepted by the Italian legal system just like loss occurrence policies, so that they no longer require any test. The legislator meanwhile has imposed claims made PI insurance onto some categories of professionals.

Although the Supreme Court has now affirmed the validity of claims made clauses, some insured parties continue to challenge these clauses. While the validity of claims made clauses is no longer a real issue, we note that the debate has now moved on to the retroactive and/or the extended reporting period provided in these clauses.

Interpretation of Insurance Contracts

When the wording of an insurance contract gives rise to uncertainty, the standard rules on interpretation of contracts set out by Articles 1362 to 1371 of the Italian Civil Code apply. These are the rules to follow in order to establish what a contract, including a policy, really means.

- The parties' common intentions must prevail over the strict literal wording and the parties' conduct must be taken into account to understand their intentions.
- Contract terms and expressions must be interpreted in light of the whole contract or statement in which they appear.
- The contract must be interpreted in good faith.
- Contract terms must be interpreted so as to give them some effect instead of none.
- Contract terms which can have more than one meaning must be interpreted in the sense most suited to the nature and purpose of the contract.
- Standard contract terms drafted by one of the parties are interpreted, in case of ambiguity, in favour of the other party (*contra proferentem* rule).

In the last few years the Italian Supreme Court has increasingly given prominence, in the interpretation of insurance contracts, to the contra proferentem rule, stating that in interpreting insurance contracts, which will be drafted in a clear and understandable manner, the judge is not allowed to attribute a specific meaning to multiple meaning clauses, even if the meaning is theoretically not incompatible with their wording, without having resorted to all other interpretive criteria provided for by Article 1362 et seq of the Italian Civil Code, and, in particular, to the provision concerning interpretation against the drafter first. This Article has a specific purpose – if the clause has only been drafted by one contracting party, the poor clarity of the wording will be attributed to the contracting party because no contribution has been given in the relevant drafting by the other contracting party (Italian Civil Supreme Court, 23 September 2021, No 25849).

Litigation Against D&Os

The statutory auditors' reform

Financial crises statistically generate an increase in litigation. The COVID-19 pandemic has had a significant effect on the volume of claims against D&Os as the economic crisis that followed the pandemic had a strong impact on the number of companies that went into bankruptcy, which in turn resulted in an increase in actions against D&Os.

This increase primarily affected statutory auditors, who are often accountants and, as such, subject to mandatory PI insurance. The focus has therefore gradually shifted to statutory auditors, who have become the real “target” of liability actions (together with their insurers).

The reform announced is aimed at solving this issue by capping the statutory auditors' liability to a pre-fixed amount to be determined on

the basis of their annual payroll. Furthermore, the reform will also change the limitation period which will start running from an earlier date than the one regarding the directors.

On 9 April 2024 the proposal arrived before the Italian Parliament. The reform should soon be approved by the Italian Parliament and will certainly have a huge impact on the amount of litigation against D&Os or, at least, on the amount receivers will claim in court.

ESG

ESG considerations are also likely to impact litigation against D&Os. In fact, in addition to the Corporate Sustainability Reporting Directive (CSRD), Italy is in the process of adopting some environmental regulations that may affect litigation against D&Os.

Reference is made more specifically to per-fluoroalkyl substances and polyfluoroalkyl substances (PFAS), which are chemical compounds that have been used since the 1940s in many industrial sectors, including the food industry and can resist major natural degradation processes, partly because of their water and oil repellency. They have hit the news in the last few years because they are highly polluting and have a significant negative effect on health.

It is for this reason that American legislators put the focus on this issue and adopted regulations to prohibit the use of these substances, especially in drinking water, over certain limits. This led to a large number of claims and class actions against both the corporate entities and their D&Os.

Since both the European and Italian legislators are following the American path, we expect to see a significant increase in litigation against

D&Os arising out of such potential and future regulations as environmental studies show that most waters in Italy have PFAS over the “acceptable” limits.

Climate Risk

Climate change is a critical issue for the insurance industry in Italy, which is one of the European countries most exposed to the hydrogeological risk due to morphology, urban development and human activity. Despite the increasing frequency and severity of climate-related natural disasters, this risk has been underestimated by Italian consumers as well as by corporate entities.

To partly address the insurance protection gap in this area, Law No 213 of 2023 (the “Budget Law”) was passed on 30 December 2023 and has introduced a new obligation for companies with registered offices in Italy and for companies with registered offices abroad with a permanent establishment in Italy to take out insurance to cover damage to assets caused by natural disasters and catastrophic events occurring on national territory. The Budget Law defines calamitous and catastrophic events as those caused by earthquakes, floods, landslides, and inundations. However, procedures for identifying calamitous and catastrophic events eligible for compensation may also be referred to in the implementing decrees to be issued by the Ministries of Economy and Finance and of Business and Made in Italy.

Companies have to fulfil the obligation by 31 December 2024 and insurance companies will not be able to refuse to underwrite the risk. However, they will be entitled to offer coverage either by directly assuming the entire risk or in co-insurance, including through consortia of a plurality of undertakings.

Catastrophe risk can also be covered with parametric policies, which represent an innovative form of insurance offering coverage based on specific, predefined and measurable parameters, especially when the increase in premiums renders the standard way of risk transferring uneconomical.

In the Italian market, insurers are also offering hybrid policies in which compensation is triggered when pre-established parameters occur but, at the same time, material damages are adjusted too.

Class Actions and Third-party Funding

There are currently two types of collective action in Italy.

The first is the proper “class action” set out by Law No 31 of 2019 and new Articles 840 bis and ff of the Italian Code of Civil Procedure introduced in 2019 and effective since 19 May 2021. It has broad application as claimants are no longer limited to consumers (as was the case previously) but can also consist of business entities acting to protect their homogenous rights which have been prejudiced by companies or entities delivering public services.

The charges against the defendants can also consist of tort liability opt-in.

The second is the “representative action” set out by Legislative Decree No 28 of 2023 which was issued on 10 March 2023 and new Articles 140 ter and ff of the Consumer Code introduced in March 2023 to reflect EU Directive 2020/1828 and have been in force since 25 June 2023. Claimants can only be qualified consumer organisations listed with the Ministry of Enterprises, national public authorities and foreign entities listed with the European Commission.

Defendants are classed as professionals, meaning any individual or legal entity, either public or private, who breached EU regulatory provisions and therefore prejudiced the collective interests of consumers. Litigation funding is provided if there are no conflicts of interest or undue influence.

The Supreme Court has recently confirmed that litigation funders are not required to be registered under Article 106 of Legislative Decree No 385 of 1993 (the “Italian Banking Act”). This means that litigation funding does not imply any financial activity subject to authorisation pursuant to the Italian Banking Act. Litigation funding is quite new to the Italian market and is evolving rapidly.

New Product Liability Directive

The 1985 Product Liability Directive is being heavily amended and the new directive, which is expected to be released in 2026, will apply to products put on the market 24 months after it enters into force. The reform was prompted by constant technological progress. The main revisions being made to the directive will try to grant consumers greater protection and facilitate their chances to obtain compensation.

The most important features of the new legislation include the following.

- **Definition of product:** the new directive will include a larger range of goods under the definition of product. This will broaden the range of products covered to include software and AI systems.
- **Liable operators:** further subjects of the production/distribution chain will be held liable, such as the manufacturer of a component.
- **Damages:** the new directive will not only cover physical damage but also medically

recognised harm to psychological health and damage to personal data.

- **Burden of proof:** the directive will introduce presumptions of defectiveness and presumptions of causal link between damage and defectiveness. This will create a lower burden of proof for consumers to meet.
- **Expiry period:** the directive will introduce a 25-year expiry period for latent damages.

Not all of these provisions are likely to impact product liability disputes in Italy and insurance-related disputes. For example, as far as damages are concerned, the Italian courts have always recognised and compensated both psychological damage and pain and suffering. In terms of presumptions of defectiveness, the Italian courts may disregard these presumptions as the Italian Supreme Court has always provided a strict interpretation of defectiveness and experts are often appointed by judges to investigate the defectiveness of the product and ascertain the existence of the required causal link. Conversely, the new expiry period for latent damage as well as the inclusion of software and AI systems among products potentially defective may increase the number of claims against manufacturers and their insurers.

Cyber-Risk

The cyber-risk landscape is expected to be significantly impacted in various ways in the months ahead because of evolving technologies on the one hand and the recent development of EU cybersecurity legislation on the other. In terms of new technologies, the emerging use of AI has already been exploited and will continue to be in the future by threat actors who take advantage of new vulnerabilities in AI tools and additional opportunities to launch an increased number of new and/or more advanced cyber-attacks (such

as deep fake frauds and more sophisticated phishing attacks).

At the same time companies using AI technologies (such as chatbots) in client/customer service relationships are expected to be subject to greater exposure in terms of third-party liability claims for AI errors. Finally, the implementation of AI technologies in the operational and business processes of a company will most likely also have a financial impact on the amount of business interruption loss and/or of data recovery costs that a company might bear following a cyber-attack.

The potential negative impact of the spread of AI on cyber-risk could, however, be mitigated through the new rules on cybersecurity recently introduced by EU legislation (NIS2 Directive No 2022/2555 under implementation in Italy with the scheme of the Legislative Decree submitted by the government to the Parliament for approval on 17 June 2024, Dora Regulation No 2022/2554 and Cyber Resilience Act dated 12 March 2024).

All of these pieces of legislation are aimed at strengthening operational resilience by adopting a broad range of cybersecurity measures in terms of the prevention, handling and reporting of cyber-attacks and improving co-operation and supervision of member states to create shared intelligence on cyber-risks. The correct implementation and application of these new rules will result in a lower risk of successful cyber-attacks or a decrease in related losses at least.

W&I

Warranty & indemnity insurance is aimed at protecting the buyer (and less commonly the seller) from the breach of the representations and warranties contained in the sale and purchase agreement. After some initial resistance, this type of insurance is now increasingly used in M&A transactions in Italy (it has increased four-fold since 2016) as it provides the buyer with a clean exit and the seller with the right of recourse to a highly rated insurer.

With the risk transferred to the insurer, the due diligence plays a key role because the insurer will estimate the extent of the guarantee on the data and risks emerging from the due diligence reports. Compared to other insurance products, W&I litigation is extremely rare and most out-of-court disputes around coverage are often investigated and settled with the support of a forensic accountant.

JAPAN

Law and Practice

Contributed by:

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Hiratsuka & Co is a boutique law firm in Tokyo established in 1976, with four lawyers and one academic consultant, providing a full range of domestic and cross-border Japanese legal services. The firm handles various types of insurance, typical and non-typical, and has advised both insurers/reinsurers and insureds/reinsureds on matters such as fire insurance, earthquake insurance, liability insurance, marine insurance, erection insurance, satellite insurance and umbrella insurance. Another area

of expertise is recovery actions in Japan based on subrogation. **Hiratsuka & Co** also advises on Japanese insurance regulations and assists non-Japanese clients in obtaining insurance licences in Japan. The firm has been instructed by insurance companies and law offices from all around the globe, including Japan, the UK, the USA, France, Germany, Switzerland, Italy, Spain, Norway, Russia, Singapore, Australia, Hong Kong, China and Taiwan.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime Overview

Litigation is the public system for insurance dispute resolution. If parties to an insurance policy have concluded an arbitration agreement, the courts will heed the agreement and the dispute will be resolved not by litigation but by arbitration (see 3.3 The Use of Arbitration for Insurance Dispute Resolution). A dispute over an insurance contract may also be resolved by ADR, including court-assisted mediation and mediation by ADR institutions designated by the Insurance Business Act (see 1.3 Alternative Dispute Resolution (ADR)). The purpose of ADR is to facilitate resolution by the agreement of both parties; accordingly, if no agreement is reached, the procedure ends and the dispute is resolved by litigation or arbitration.

Provisional Remedy and Compulsory Execution

Before or in the course of litigation or arbitration, a provisional remedy procedure is available. The claimant must submit prima facie evidence that demonstrates that their claim exists and that it is necessary to preserve it, and deposit a counter-security with a Japanese court. After a judgment or an arbitral award becomes final and conclusive, a claimant may file a petition with the court to commence compulsory execution proceedings to collect its claim from a debtor's assets.

Litigation

The most important dispute resolution system is litigation. An insurance policy governed by Japanese law usually contains a jurisdiction clause whereby a specific District Court is agreed as the first instance court. In such case, the District Court is the first instance court, the Court

of Appeal that has jurisdiction over the place of the District Court is the second instance court and the Supreme Court is the final instance court. The number of judges is one or three in the District Court, three in the Court of Appeal and three to five in the Supreme Court (nine to 15 when the Supreme Court decides to hear the case en banc).

Time Until Judgment

Japanese courts have a non-mandatory target to finish the first instance procedure as quickly as possible within a period of two years. About 75% of all cases appealed to the Court of Appeal (not limited to insurance disputes) are finished within six months by judgment, settlement, withdrawal, etc. About 90% of all cases in the Supreme Court (again not limited to insurance disputes) are finished within six months.

1.2 Litigation Process and Rules on Limitation

Litigation Process

Up to the first hearing date

The plaintiff files a complaint with the first instance court specifying the parties, their legal representatives (in the case of a company, a person who has legal authority to represent the company), the gist of the claim and cause of action. After the judge finds the complaint to be in order, the court effects service of the complaint and issues a summons for the first hearing date to the defendant. After the service, the defendant must submit their answer to the court. Both the complaint and the answer are treated as stated in the first hearing date for oral argument.

Up to witness examination

After the first hearing date, the plaintiff and defendant alternately submit legal briefs (a document describing its case), an evidence expla-

nation and documentary evidence. The court may also designate the case for preparatory proceedings, where hearings are held in a meeting room without a public audience. The exchange of briefs and evidence usually continues until the issues are clarified and both parties' arguments are exhausted. If witness examinations are planned, the court confirms with the parties which facts will be proven by witness testimony.

Evidence

When submitting documentary evidence written in a foreign language, the party must submit a Japanese translation of the relevant parts, and the opposing party is entitled to object to the accuracy of the translation. If a party presents an expert's opinion to the court, the expert's report should be submitted first and the expert may then be examined in witness examination. An expert retained by a party is different from an expert designated by the court.

The Japanese judicial system does not adopt a discovery system such as those in place in England or the US, and a party seeking disclosure of evidence in the hands of an opponent or a third party must file a petition with the court for a court order to produce documents.

Up to the first instance judgment

If a party applies for examination of a witness and the judge considers such examination necessary, the witness submits their statement to the court a few weeks before the witness examination. The witness is then examined and cross-examined in a courtroom, with an interpreter in the case of a non-Japanese-speaking witness. Both parties submit the final brief, taking account of the results of the examination. Prior to or after the examination, the court often asks both parties about the possibility of settling the

case by amicable settlement. If no settlement is reached, the court renders judgment.

The second instance

A losing party in the first instance may file a petition for appeal within two weeks from the date of service of the original judgment, and must then submit detailed grounds for appeal within 50 days from the appeal. The opponent may file a written counterargument by the deadline designated by the second instance court (a Court of Appeal if the first instance court was a District Court). In practice, these submissions are of high importance as the judges examine them carefully in forming their initial impression of whether there are merits to the appeal. Ordinarily, the second instance judges are not willing to have additional hearing dates for further arguments. After the conclusion of oral arguments (which may take place on the first hearing date), the court may ask both parties about the possibility of settlement before deciding to render judgment.

The third instance

Judgments of the second instance courts may be appealed to the second appellate court, which is the Supreme Court if the second instance was presided over by a Court of Appeal. However, the grounds of appeal to the Supreme Court are very narrow and are limited to errors in the construction of the Constitution, among other barriers.

Rules on Limitation

General

Under Japanese conflict of laws rules, limitation is considered as a matter not of procedural law but of substantive law. Accordingly, the following applies if an insurance policy is governed by Japanese law:

- the right to claim an insurance payment, the right to claim a refund of insurance premiums and the right to claim a refund of a premium reserve are subject to a three-year limitation period from the time the right becomes exercisable;
- the right to claim insurance premiums is subject to a one-year limitation period from the time the right becomes exercisable; and
- limitation is effected when a party invokes the limitation after the expiry of the limitation period.

If an insurance policy is governed by a foreign law, the rights expire according to the limitation provisions set out in the foreign law.

Expiry of limitation period

It is possible to postpone the expiry of the limitation period, or to renew it, through certain events. For example:

- if a party commences litigation, the limitation period does not expire until the litigation is completed;
- if an agreement to hold negotiations on a claim is made in writing, the limitation period does not expire until one year (or an agreed time period of less than one year) has passed from the time of the agreement (or six months from the time of the notice of refusal of the negotiation); and
- if a demand is made, the limitation period does not expire for six months from the time of the demand.

Limitation is one of the most complicated areas of law and a Japanese lawyer's advice should be sought for specific cases.

1.3 Alternative Dispute Resolution (ADR)

ADR is widely used in the insurance field. Japan has three ADR institutions designated by the Prime Minister based upon the Insurance Business Act:

- the Sampo ADR Centre (for a dispute against a Japanese non-life insurance company);
- the Insurance Ombudsman (for a dispute against a foreign non-life insurance company); and
- the Life Insurance Counselling Office (for a dispute against a life insurance company).

All three institutions have complaint resolution procedures and dispute resolution procedures. Their systems are basically the same, as follows.

Complaint Resolution Procedure

An insured or a policyholder files a complaint with the ADR institution, which then provides necessary advice, notifies the relevant insurer of the complaint and requests them to respond swiftly. The insurer makes contact with the insured or the policyholder, and holds negotiations for the resolution of the dispute. If the dispute is not settled within a certain period, the institution may refer the insured or the policyholder to a dispute resolution procedure, and the complaint resolution procedure ends.

Dispute Resolution Procedure

An insured or a policyholder files a petition for dispute resolution with the ADR institution, which then appoints one or more committee members to handle the dispute resolution process. In the case of the Life Insurance Counselling Office, its internal permanent committee handles the dispute resolution process. The committee hears both parties' arguments and, if considered appropriate, proposes settlement terms. In principle, the insurers owe an obliga-

tion to accept certain settlement terms (special mediation terms in the case of the Sampo ADR Centre and the Insurance Ombudsman, and settlement terms in the case of the Life Insurance Counselling Office), while the insured or the policyholders do not.

Number of Cases

For the period from 1 April 2023 to 31 March 2024, the Sampo ADR Centre newly accepted about 4,550 complaint resolution cases and about 540 dispute resolution cases, the Insurance Ombudsman about 140 complaint resolution cases (the number of dispute resolution cases is not disclosed) and the Life Insurance Counselling Office about 3,800 complaint resolution cases and about 380 dispute resolution cases.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Jurisdiction

Agreement

Under the Japanese rules regarding international jurisdiction, parties to an insurance contract may agree on a country in which they are permitted to file an action with the courts. The agreement is not valid unless it is made regarding actions that are based on a specific legal relationship, and executed by means of a written document. An agreement that an action may be filed only with the courts of a foreign country may not be invoked if those courts are unable to exercise jurisdiction by law or in fact. A jurisdiction agreement in which the parties agree exclusive jurisdiction of the court that has the jurisdiction over the head office of the defendant is, in principle, valid, unless the agreement is extremely unreasonable and against public policy (the Supreme

Court judgment of 28 November 1975 Minshu 29.10.1554).

Other grounds

The Code of Civil Procedure of Japan provides certain grounds for the jurisdiction of the Japanese courts where no jurisdiction agreement exists. Typical examples are as follows:

- an action that is brought against a corporation whose principal office or business office is located in Japan; and
- an action on a claim for performance of a contractual obligation, on a claim for damages due to non-performance of a contractual obligation or on any other claim involving a contractual obligation if the contractually specified place for performance of the obligation is within Japan.

However, even when the Japanese courts have jurisdiction over an action (except when an action is filed based on an exclusive jurisdiction agreement specifying the Japanese court), the court may dismiss the whole or part of an action without prejudice if it finds that there are special circumstances due to which, if the Japanese courts were to conduct a trial and reach a judicial decision in the action, it would be inequitable to either party or prevent a fair and speedy trial, in consideration of the nature of the case, the degree of burden that the defendant would have to bear in responding to the action, the location of evidence, and other circumstances.

Choice of Law

General

Under the conflict of laws rules of Japan, the law that applies to an insurance policy is the law of the place chosen by the parties at the time of the conclusion of the insurance policy. In the absence of said choice of law, an insurance

policy shall be governed by the law of the place with which the insurance policy is most closely connected at the time of the conclusion of the insurance policy. The law of the habitual residence of the insurer is presumed to be the law of the place with which the insurance policy is most closely connected. The parties may agree to change the governing law otherwise applicable to the insurance policy, but such change may not be asserted against a third party when it prejudices the rights of such third party.

Consumer protection

There are special provisions regarding the choice of law for consumer contracts. For example, even when the law applicable to the consumer contract as a result of a choice or a change of governing law is a law other than the law of the consumer's habitual residence, if the consumer has manifested their intention to the business operator that a specific mandatory provision from within the law of the consumer's habitual residence should be applied, such mandatory provision shall also apply to the matters stipulated by the mandatory provision with regard to the formation and effect of the consumer contract. Notwithstanding said general rule, in the absence of a choice of law with regard to the formation and effect of a consumer contract, the formation and effect of the consumer contract shall be governed by the law of the consumer's habitual residence.

2.2 Enforcement of Foreign Judgments

Validity of a Final and Conclusive Judgment Rendered by a Foreign Court

A final and conclusive judgement rendered by a foreign court must satisfy the following requirements in order to be enforceable in Japan:

- the jurisdiction of the foreign court is recognised pursuant to laws and regulations, conventions or treaties;
- the defeated defendant has been served (excluding service by publication or any other similar service) with the requisite summons or order for the commencement of litigation, or it has appeared without being so served;
- the content of the judgment and the litigation proceedings are not contrary to public policy in Japan; and
- a guarantee of reciprocity is in place.

This general rule is applicable to enforcement by or against insurers in Japan.

General Procedure

A party who seeks enforcement in Japan of a final and conclusive judgment rendered by a foreign court should firstly file a lawsuit against an obligor for an execution judgment. After the execution judgment becomes final and conclusive, the party may apply with the Japanese courts for compulsory execution against real property, vessels, movables, claims and other property rights.

2.3 Unique Features of Litigation Procedure

Litigation Costs

When filing a lawsuit, the plaintiff needs to purchase revenue stamps and attach them to the complaint. The amount of the revenue stamp is roughly proportional to the claim amount. The cost of revenue stamps is included in the litigation costs, which are borne entirely or partly by a losing party. However, in practice, such cost is not claimed.

Legal Costs

Legal costs (attorneys' fees) shall be borne by each party and are not recoverable from the losing party. In the case of a claim in tort, the

Japanese courts often add 10% of the awarded amount as attorneys' fees. However, it is unrelated to the actual amount spent by the winning party.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

If a party files a lawsuit with a Japanese court for a dispute (including insurance and reinsurance) that is subject to an arbitration agreement and the other party requests dismissal without prejudice, the Japanese court will, in principle, dismiss the lawsuit without prejudice. There are exceptions to this general rule where:

- the arbitration agreement is null and void;
- the arbitration procedure cannot be carried out based on the terms of the arbitration agreement; and
- the other party requests dismissal pursuant to the arbitration agreement after it presented oral arguments on the merits.

These rules are applied regardless of whether the place of arbitration is in or outside Japan, or has not been fixed.

3.2 The New York Convention New York Convention

Japan is a contracting state of the New York Convention.

Enforcement of Arbitral Awards Handed Down in Other Jurisdictions

When the place of arbitration is outside Japan and a party seeks to enforce an award from that arbitration in Japan, the party must obtain an execution order of the arbitral award from the

Japanese courts, and then apply to the Japanese courts for compulsory execution against the respondent's assets. In the application, various documents must be submitted to the Japanese courts, including an arbitral award for which an execution order has become final and conclusive.

Execution Order

A party who intends to enforce an arbitral award may apply for an execution order with the Japanese courts. The court may not make a decision on the application without holding oral arguments or a hearing that both the applicant and the obligor-respondent can attend. The court dismisses the application if it finds that any of the grounds set forth in Article 45 paragraph 2 of the Arbitration Act (which are substantially the same as Article 5 of the New York Convention) exists. Otherwise, an execution order is issued.

3.3 The Use of Arbitration for Insurance Dispute Resolution Use of Arbitration

Arbitration is not a significant form of insurance dispute resolution in Japan.

Rules of Arbitration

If the place of arbitration is in Japan, the general rules provided in the Arbitration Act are applied to arbitration. According to these rules, the parties must be treated equally in an arbitration procedure, the parties must be given full opportunity to argue their case in an arbitration procedure, the rules of arbitration provided by the parties' agreement must be observed by the arbitral tribunal, etc. If the parties agree to resolve their dispute at an arbitration institution such as the Japan Commercial Arbitration Association, the arbitration rules provided by the institution are also applied.

Private Character

Arbitration is neither presided over by the national courts nor operated at the taxpayer's expense. In this sense, arbitration is private. On the other hand, Japanese law provides for general rules regarding the arbitration procedure; a claim by arbitration has the statutory effect of postponing the expiry of the limitation period, and an arbitral award is given the same effect as a final and conclusive court judgment. Considering these aspects, an authoritative academic has pointed out that arbitration has the character of a semi-public dispute resolution.

Appeal to Arbitral Award

If the place of arbitration is in Japan, a party may apply to the Japanese courts for a cancellation of the arbitral award. The court may not make a decision on the application without holding oral arguments or a hearing that both parties to the arbitration can attend. The court may cancel the arbitral award if certain grounds exist that are substantially the same as Article 5 paragraph 1(a)–(d) and paragraph 2 of the New York Convention.

4. Coverage Disputes

4.1 Implied Terms

Terms are not implied into a contract of insurance by operation of law. Japanese insurance contracts normally contain detailed terms and conditions. Disputes are resolved through the construction of specific terms in the contract.

4.2 Rights of Insurers

Principle – Insured's Obligation to Answer the Insurer's Questions

In concluding a non-life insurance policy, a life insurance policy or a fixed-amount accident and health insurance policy, an insurer-to-be has

the right to request the disclosure of facts with regard to material matters concerning the likelihood of the occurrence of loss to be compensated for under the relevant insurance policy. The policyholder/insured-to-be owes an obligation to disclose the facts requested by an insurer-to-be. This is a mandatory rule under the Japanese Insurance Act that may not be contracted out of to the disadvantage of the policyholder or insured.

If the policyholder or insured fails to disclose such facts or discloses false facts intentionally or by gross negligence, an insurer, in principle, may cancel the insurance policy. This is also a mandatory rule that may not be contracted out of to the disadvantage of the policyholder or insured.

Exception – Insured's Obligation to Voluntarily Disclose Material Matters

These mandatory rules are not applicable to certain non-life insurance policies that compensate damage arising from business activities, including marine insurance policies, property insurance policies or liability insurance policies regarding aircraft or nuclear facilities. Freedom of contract is widely admitted. For example, standard hull and machinery insurance policies provide that a policyholder/insured-to-be must disclose facts with respect to important matters that may affect the acceptance of underwriting or the decision of the contents of an insurance policy by the insurer-to-be (ie, in these cases, the scope of disclosure is not limited to facts requested by an insurer-to-be). Such standard policies commonly provide for the insurer's right of cancellation where the policyholder or insured failed to disclose facts or disclosed false facts.

4.3 Significant Trends in Policy Coverage Disputes

Litigation Cases

There are many cases in which insurers allege that the insured caused the incidents intentionally or by gross negligence, and rely upon exemption clauses in the insurance policies. The Japanese courts carefully consider the circumstances and background of the incident, occurrences after the incident and economic motivation, among other factors, in their fact-finding and judgment on the issues.

ADR Cases

Wide varieties of cases and issues are raised with regard to various types of insurance. It is difficult to see any trends. There has been an increase in the number of insurance claims relating to accidents involving water leakage and overflow. There have also been a number of cases where claims have been made for accidents involving dropped smartphones, based on a special clause for personal effects. There has also been an increase in the number of cases where claims have been made under the emergency response expense riders of overseas travel insurance and comprehensive business activity insurance policies for various expenses incurred as a result of being infected with COVID-19.

4.4 Resolution of Insurance Coverage Disputes

Generally, insurance coverage disputes are resolved through negotiation. If it turns out to be difficult, they are resolved by litigation, arbitration or ADR.

The position is slightly different for reinsurance contracts. Most reinsurance coverage disputes are resolved by negotiation; it is rare for them to be settled through legal proceedings.

4.5 Position If Insured Party Is Viewed as a Consumer

Principle

The position is almost the same where the law views the insured party as a consumer. The differences are as follows.

The Consumer Contract Act

The Consumer Contract Act provides a consumer's right of rescission of a contract. A consumer may rescind a consumer contract, for example, in the case of a consumer's mistake caused by a trader's material misrepresentation or by a trader's provision of a conclusive assessment of uncertain matters. If a consumer rescinds an insurance policy based upon these rights, they receive a refund of the insurance premium; however, this would not be a sufficient remedy in many cases.

ADR

For a dispute between a consumer and a trader of national import, a consumer may utilise mediation or arbitration by the Dispute Resolution Committee of the National Consumer Affairs Centre of Japan. However, it is unclear how many insurance disputes are settled by these procedures.

4.6 Third-Party Enforcement of Insurance Contracts

Principle

A third party may neither enforce an insurance contract nor sue an insurer in connection with an insurance contract. If a third party's claim against an insured is established by final and conclusive judgment, the third party may apply to the Japanese courts for a seizure order of the insured's claim against an insurer for insurance payment. The third party is entitled to directly collect the claim for insurance payment from

the insurer one week after service of the seizure order to the insured.

Execution of Statutory Lien in Liability Insurance

A third party who has a claim for compensation for damage against an insured under a liability insurance policy has a statutory lien over the insured's claim against the insurer for insurance payment (Article 22 paragraph 1 of the Insurance Act). Even if it does not have a final and conclusive judgment that establishes their claim against the insured, the third party may apply to the Japanese courts for a seizure order of the claim for insurance payment, based on the statutory lien.

Direct Claim Based on Insurance Policy

If an insurance policy contains a clause that allows a direct claim by a third party against the insurer, a third party may claim for payment against the insurer to the extent allowed by the clause. Such a clause is often contained in an automobile insurance policy.

Direct Claim Based on Japanese Law for Automobile Accidents

The Act on Securing Compensation for Automobile Accidents provides for compulsory automobile liability insurance, under which a person who puts an automobile into operational use for their own benefit is included as an insured. When the person is liable to compensate for damage to a third party, that third party may directly claim against the insurer for the payment of damage up to the amount of insurance coverage.

4.7 The Concept of Bad Faith

Japan does not have a concept of bad faith or bad faith breach of contract in the areas of insurance and reinsurance law.

4.8 Penalties for Late Payment of Claims Late Payment Interest

If an insurance policy is governed by Japanese law, an insurer is obliged to pay late payment interest if it fails to pay the insurance claim by the due date. If the interest rate is agreed in the insurance policy, the agreed rate is applied. If there is no such agreement, the statutory rate is applied. The current statutory rate is 3% per annum but it may be changed by ministerial order in the future. If an insurer failed to make the payment by a due date that was on or prior to 31 March 2020, the old statutory interest rate of 6% per annum applies.

Due Date

Even if the due date of an insurance claim is provided in an insurance policy, if the due date falls after the expiry of a reasonable period of time to confirm matters that need to be confirmed under the insurance policy for the purpose of payment of an insurance claim, the day on which such period expires is treated as the due date for payment of the insurance claim.

If the due date of an insurance claim is not provided in an insurance policy, the insurer is not responsible for any delay until an insurance proceeds payment is claimed and the period necessary to confirm the insured event, etc, pertaining to said claim expires.

An insurer is not liable to pay late payment interest for the period of delay in investigation that is attributable to a policyholder or an insured.

4.9 Representations Made by Brokers

Generally, an insured would not be bound by representations made by its broker. It is normally understood in Japan that when an insurance broker performs procedures such as application for insurance for its customers (ie, a person

who is to be a policyholder or an insured), the insurance broker acts not as an agent but as a messenger of the customer. Under this interpretation, the insurance broker has no authority to represent the customer as agent and, accordingly, an insured is not bound by the broker's representations.

However, in a specific case, the question should be examined carefully, taking factual backgrounds into consideration.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

General

Delegated arrangements such as those adopted between a Lloyd's syndicate and managing agents are not common in Japan. With regard to a Lloyd's syndicate, there is a precedent in which the Japanese court allowed a leading underwriter who was one of the members of a Lloyd's syndicate to pursue legal proceedings relating to an insurance policy on behalf of themselves and other members.

Co-insurance

Co-insurance is widely used in Japan. A leading underwriter and other underwriters usually conclude a business outsourcing contract. Based on the contract, the leading underwriter would issue the co-insurance policy papers, but the leading underwriter is not usually authorised to conclude the insurance contract on behalf of the other underwriters. In addition, the leading underwriter would deal with the administration of the insurance claim payment, but is usually not authorised to assess loss on behalf of other underwriters. Each insurer in a co-insurance owes separate liability to an insured in proportion to each underwriting ratio. In order to pursue 100% of the rights or obligations in a co-insur-

ance policy, all co-insurers must be the plaintiffs or the defendants.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

No statistics are published on the area of claims where insurers fund the defence of insureds or insurers make insurance payment for disputes costs.

Most liability insurance policies in Japan provide insurance cover for disputes costs. As long as the requirements for the cover are satisfied, insurers generally make insurance payments for the costs irrespective of the areas of claims. However, insurers of automobile insurance are specially allowed negotiation with the victims on behalf of the insureds. This allows insureds to save disputes costs, while insurers may negotiate for a smaller insurance payment.

5.2 Likely Changes in the Future

The situation is unlikely to change in the next few years.

5.3 Trends in the Cost or Complexity of Litigation

As Japanese society and the country's economy have become highly complex, litigation cases have inevitably come to contain complex elements, which has led to a general increase in litigation costs. More than half of the recently published court precedents in the area of liability insurance are automobile collision cases, which have traditionally been the most common type of case. However, there are also some cases concerning complex and high-value claims, such as those relating to a nuclear incident, asbestos

damage, oil pollution, directors' and officers' liability and expert malpractice liability.

5.4 Protection Against Costs Risks

Claimants can buy rights protection insurance for insurance coverage of legal costs or litigation costs (see 2.3 Unique Features of Litigation Procedure). In many cases, rights protection insurance takes the form of an additional endorsement to the automobile insurance, fire insurance or other major insurance policy. A few insurance companies sell rights protection insurance for natural persons as well as legal persons in the form of independent insurance.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

With respect to an insurance policy governed by Japanese law, the law gives an insurer a right of action to recover sums from third parties causing an insured loss to an insured.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Article 25 of the Insurance Act of Japan provides the following effects.

- When it has paid an insurance claim, the insurer shall be subrogated with respect to any claim against a third party acquired by an insured due to the occurrence of damages arising from an insured event (the "Insured's Claim").
- The maximum amount of subrogation is the lesser of:
 - (a) the amount of the insurance payment made by the insurer; or
 - (b) the amount of the Insured's Claim (if the amount of the insurance payment made

by the insurer falls short of the amount of damages to be compensated, the amount that remains after deducting the amount of the shortfall from the amount of the Insured's Claim).

- If the amount of the insurance payment falls short of the amount of damage to be compensated, the insured's right to receive payment of the un-subrogated portion of the Insured's Claim shall have priority over the subrogated claim.

Name

Under Article 25 of the Insurance Act, the Insured's Claim is transferred to the insurer by operation of law when the insurer has paid the insurance claim. Accordingly, the claim is exercised in the name of the insurer.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation Type of Litigation

There have not been drastic changes in the type of litigation in the year up leading up to August 2024.

The war in Ukraine has not affected the types of litigation in Japan, and there have been no other developments that have affected the type of proceedings in Japanese courts.

Amount of Litigation

According to court statistics, about 570,000 ordinary civil and administrative litigation cases were newly filed in 2023, which is an increase of approximately 12% from the number in 2022. In particular, there has been an increase of about 9,000 ordinary litigation cases before district

court, and an increase of about 50,000 ordinary litigation cases before summary court.

7.2 Forecast for the Next 12 Months

In the second half of 2023, there was an increase in the number of cases in which companies brought actions for damages against former directors, with cases filed against:

- former directors involved in the preparation and submission of securities reports with false statements;
- a former director who breached his duty to comply with laws and regulations in relation to a cease and desist order and surcharge payment order issued by the Fair Trade Commission under the Antimonopoly Act;
- former directors who had misappropriated company funds;
- a former representative director and a former director who were involved in improper accounting practices;
- a former director who engaged in transactions with a conflict of interest; and
- former directors who were found liable for breaches of duty in relation to alleged misappropriation of funds in subsidiaries.

As corporate scandals will not disappear and Japanese companies will continue to maintain their compliance with the law by taking strict action against misconduct, the number of cases in which companies sue their directors and officers is not expected to decrease.

7.3 Coverage Issues and Test Cases

As far as is known, there are no specific coverage issues or test cases deriving from COVID-19, the war in Ukraine, or otherwise.

7.4 Scope of Insurance Cover and Appetite for Risk Insurance Cover

In a broad sense, the COVID-19 pandemic and the war in Ukraine have affected the scope of insurance coverage available.

On 10 April 2020, the Japanese Financial Service Agency (FSA) requested insurance trade associations to take active measures to protect policyholders exposed to the risk of COVID-19. In response, some insurers introduced a retrospective revision of their insurance products to cover COVID-19-related losses and expenses, while others decided to apply accidental death clauses to COVID-related deaths. In addition, insurers have developed various new products covering COVID-19-specific losses, such as loss of earnings due to temporary closure or shortening of business hours and facility disinfection costs.

Meanwhile, the war in Ukraine has led to major Japanese insurers suspending war and strike coverage from cargoes carried near Ukraine in response to reinsurance trends.

Appetite for Risk

There is no evidence of published items that indicate that the pandemic or the war in Ukraine have changed appetites for risk within Japan.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

The Effect of Climate Change on Underwriting

The General Insurance Association of Japan (a trade association representing non-life insurance companies licensed in Japan) established

its Climate Change Response Plan in July 2021. The Plan states that its members shall:

- contribute to relieving and responding to climate change risks and assist in a smooth transition into a sustainable society; and
- aim for a decarbonised society by curbing their emission of greenhouse gases.

Various insurers have issued or amended their own climate change response papers to further the association's agenda. For example, in June 2022 a major insurer announced that by 2025 they would stop underwriting, investing in or lending to businesses that rely mainly on coal and have no greenhouse gas reduction plans.

The Effect of Climate Change on Insurance Litigation

Particular court precedents showing a connection between climate change and insurance litigation cannot be found.

8.2 Data Protection Laws

In Japan, the Act on the Protection of Personal Information has been in full force since 2005. With regard to underwriting, the following apply.

- Following recommendations by the Basic Policy on the Protection of Personal Information (Cabinet Decision of 2 April 2004, promulgated under delegation by the Act), non-life and life insurance companies have established and published personal information protection policies, which include the purpose of use of personal information, types of personal information to be obtained, methods of obtaining personal information, provision of personal information, protection and management of personal information, and requests for disclosure, correction and deletion of personal data. Each insurance company car-

ries out underwriting work in accordance with its respective personal information protection policy.

- Article 20(2) of the Act prohibits the acquisition of sensitive personal data (race, creed, social status, medical history, criminal and victim records, etc), except with the prior consent of the subject individual or as provided by the Act. Thus, insurers must obtain prior consent when acquiring such information.
- Article 28(1) of the Act prohibits the provision of personal data to third parties in foreign countries, except with the prior consent of the individual or as provided by the Act. In obtaining such consent, certain information must be provided to the individual, such as the data protection laws in that foreign country. Thus, insurers must provide such information and obtain prior consent when concluding reinsurance contracts with foreign reinsurers.

With regard to litigation, the following apply.

- Insurance companies must maintain a high level of information management because they handle highly sensitive information, such as an individual's physical characteristics. No court precedents regarding disputes over information management could be found.
- No court precedents regarding insurance claims over leaks of personal information could be found.
- A traffic accident victim is entitled to claim directly against the perpetrator's insurer under the Act on Securing Compensation for Automobile Accidents (see 4.6 **Third-Party Enforcement of Insurance Contracts**). In such cases, the victim may dispute whether they gave consent to the insurance company's obtaining a medical certificate from the victim's hospital. This is considered to

be mainly a question of fact-finding, and occasionally it has been found that the victim gave consent with regard to one hospital but not another. The courts pay due respect to the subject individual's right to privacy when considering such issues.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

The Code of Civil Procedure of Japan was amended in May 2022, introducing:

- the digitalisation of court procedures; and
- “fast-track” proceedings allowing for a quicker resolution of court disputes.

As of August 2024, the date of enforcement of the revised Code has not been fixed.

Under the current regime, the parties must, in principle, file court submissions by paper, and formal hearings must be attended in person. The amendment will make it possible to commence suit, file submissions and inspect court files electronically without resorting to paper. It will also allow court hearings and witness examinations to take place electronically.

There are currently no mandatory limits on the time by which litigation must be concluded. Although there is a law requiring first instance courts to aim for the conclusion of proceedings within two years, this is a best-effort provision that cannot be enforced. Furthermore, ordinary litigation is subject to two appeals. The amendment will make it possible for the parties to agree to apply for “fast-track” proceedings, whereby the proceedings must conclude within six months from the date of the first hearing, and a judgment must be issued within one month from the conclusion of the proceedings. A “fast-track” judgment cannot be appealed unless the claim was dismissed without prejudice to the merits. The draftsmen anticipated “fast-track” proceedings to be utilised in cases where the points of dispute are limited to the interpretation of contractual clauses or the application of law. As such, they may prove helpful in insurance coverage disputes.

However, the “fast track” has certain limitations. First, the proceedings are subject to a court determination that they would not prejudice fairness or proper procedure. The proceedings may not be utilised for consumer and individual labour disputes. Furthermore, any one of the parties has the right to demand a switch to an ordinary procedure. In addition, a losing party may file an objection against a “fast-track” judgment within two weeks from service, upon which the proceedings will revert to the position before hearings were concluded and transition into ordinary litigation.

KENYA



Law and Practice

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JWM Law LLP is a full-service, corporate-oriented law firm handling a wide array of litigation and corporate governance matters. The firm closely monitors events and trends and has developed a strategic sense for their dynam-

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Kenya's statutory framework for the insurance industry can largely be found in the Insurance Act (Revised 2022); the Marine Insurance Act (Cap 390); the Insurance (Motor Vehicle Third Party Risks) Act (Cap 405); the Insurance Statistics Regulations 1993; the Insurance (Insurance Appeals Tribunal) Rules 2013; and the Insurance (Policyholders Compensation Fund) Regulations 2010. Traditionally, insurance business in Kenya has been categorised under the broad headings of life (long-term) and non-life insurance (short-term). Non-life insurance comprises both compulsory and non-compulsory insurance coverage. Compulsory insurance under these legislative instruments includes motor vehicle third-party liability insurance, workmen's compensation, aviation liability insurance, marine liability insurance and professional indemnity insurance.

The key players in the statutory and procedural regime include the Insurance Regulation Authority, established under the Insurance Act with the mandate to regulate, supervise, and develop the insurance industry in Kenya. The IRA licences both insurers and insurance intermediaries as prescribed by the Insurance Act. The Association of Kenya Insurers is a key pillar of the industry and brings together 55 members and four associate members. Other players within the context of dispute resolution comprise advocates/lawyers, litigants, and third-party neutrals such as mediators and arbitrators.

The procedural regime is governed by the Constitution of Kenya, 2010, which, at Article 159, vests judicial authority in courts and tribunals, including alternative dispute resolution (ADR),

reconciliation, mediation, arbitration, and traditional dispute resolution, provided these are not in contravention of the Bill of Rights, repugnant to justice and morality, or otherwise contravene the Constitution or any written law.

1.2 Litigation Process and Rules on Limitation

The litigation process in Kenya flows from Article 159 of the Constitution. Parties can approach the Courts through the provisions of the Civil Procedure Act (Cap 21) and Civil Procedure Rules, 2010. The process adopts a common law "adversarial" system of dispute resolution. Essentially, parties can present their case to a court and move it, they serve their counterpart and invite them to participate in the proceedings where each party has an opportunity to provide evidence and witnesses who can be cross-examined. They make arguments supporting their positions and counter those of their opponent, ultimately leaving the judge to decide on the matter.

The Limitation of Actions Act sets the general rules of limitation of actions (Cap 22). Their primary purport is that an action must be taken to court within a prescribed period of time. Any action brought outside of the time limitations is deemed to be time-barred and incapable of being pursued. The courts, therefore, strike it out. Under this Act, torts become time-barred after three years, while contracts' limitation period is six years and 12 years for actions to recover land. The Public Authorities Limitation Act (Cap 39) adjusts the periods to one year and three years, respectively, for torts and contracts against public authorities.

Other important statutory provisions that outline time limitations include the Competition Act, which, at Section 86, bars any investigations

into alleged infringement three years from the date the infringement ceased. Per the Employment Act, the period is three years. Section 35 of the Arbitration Act, for its part, provides a statutory bar against initiating any challenge to a final award, even for a valid reason, where three months have elapsed since the delivery of the final award.

1.3 Alternative Dispute Resolution (ADR)

Following the promulgation of the Constitution, ADR has grown and evolved into an important pillar in dispute resolution. The most popular mechanisms include arbitration, mediation, and construction adjudication.

Arbitration is practised under the Arbitration Act of 1995 (amended in 2005) and is counted among UNCITRAL Model Law countries.

Kenya's Court Annexed Mediation (CAM) Programme was launched in 2016 and is now in more than half of the country's High Court Stations. The Chief Justice gazetted the Civil Procedure (Court Annexed Mediation) Rules, 2022, under which mediation is practised within the court process. These rules further provide for private mediation and the recognition and enforcement of mediation settlement agreements achieved through private mediation.

Construction adjudication is practised primarily within the construction sector through standard form agreements such as FIDIC. This includes increasing adoption of dispute review boards as a dispute avoidance measure.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

While Kenya subscribes to the philosophy that parties have a right to choose the substantive and procedural governing law for their contracts, insurance disputes have been deemed to be commercial contracts connected to Kenya, with the result that the only valid contractual choice is Kenyan law, and the appropriate forum for dispute resolution is Kenyan courts (United India Insurance Co. Ltd, Kenindia Insurance Co. Ltd & Oriental Fire & General Insurance Co. Ltd. C. East African Underwriters (Kenya) Ltd eKLR 1985).

2.2 Enforcement of Foreign Judgments

The Foreign Judgments (Reciprocal Enforcement) Act (Cap 43) guides the enforcement of judgments given in other countries, provided the country in question has a reciprocal framework. Kenya has reciprocal enforcement agreements with Australia, Malawi, Rwanda, Seychelles, Tanzania, Uganda, the United Kingdom and Zambia. Where a judgment is made in another country that does not have reciprocal treatment, the same is recoverable as a debt pursuant to common law principles.

The Supreme Court of Kenya in *Ingang'a & 6 Others v James Finlay (Kenya) Limited* (Petition 7 (E009) of 2021[2023] KESC 22 (KLR)) however, dismissed an appeal for recognition and enforcement of a locus inspection order from a Scottish court determining that decisions of foreign courts and tribunals are not automatically recognised or enforceable in Kenya, as these orders were not final orders per the doctrine of finality. They further adopted the United States doctrine of comity which is to the effect that the recognition of foreign decisions is not out of obligation, but rather out of convenience and

utility. The court articulated itself thus: “prioritizing citizen protection while taking into account the legitimate interests of foreign claimants. This approach is consistent with the adaptability of international comity as a principle of informed prioritizing national interests rather than absolute obligation, as well as the practical differences between the international and national contexts.”

2.3 Unique Features of Litigation Procedure

Kenyan law predominantly follows common law principles, though the courts tend to interpret statutes, legislation, and common law in a way that is tempered by Kenyan business realities and the cultures of its highly diverse communities. Courts frown upon rewriting parties’ contracts unless there is fraud or undue influence proven (*National Bank of Kenya Limited v Pipe-plastic Samkolit Kenya Limited & Another* (2001) KLR).

A unique feature of litigation procedure in Kenya is that the High Court has unlimited and original jurisdiction. However, the Constitution further established courts of equal status to the High Court being the Environment and Land Court and Employment Labour Relations Court. The High Court is then further split into administrative units that handle niche cases – eg, commercial, tax, admiralty, etc. There are also a large number of subject-matter tribunals in specialist areas – eg, the Insurance Tribunal, Energy, National Environment Tribunal and the like. This, therefore, requires parties to be particularly keen on the forum in which they file their cases particularly since the courts have endorsed an exhaustion of remedies approach (*United Millers Limited v The Kenya Bureau of Standards & 5 Others – Supreme Court of Kenya Petition (Application) No 4 of 2021*).

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Kenyan Courts are generally pro-arbitration and will take steps to enforce arbitration provisions in commercial contracts including those of insurance and reinsurance in pre-arbitration, arbitration and post-arbitration stages. Section 18(2) of the Arbitration Act enables an arbitral tribunal or a party with leave of the arbitral tribunal to seek assistance of the High Court in respect of any power granted to the arbitral tribunal to grant interim relief at Section 18(1). The courts approach this power with restraint and embrace of philosophy of judicial non-interference in arbitral proceedings (*Nyutu Agrovet Limited v Airtel Networks Kenya Limited; Chartered Institute of Arbitrators Kenya Branch*). Courts will only intervene in a matter where a matter is so grave, so manifestly wrong or has otherwise closed the door of justice to either of the parties (*County Government of Meru v Leopard Rock Mico Limited Civil Appeal No E013 of 2023*).

3.2 The New York Convention

Kenya is a signatory to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (New York Convention) and the same is domesticated via Section 36(5) of the Arbitration Act effective from the date of ratification, that is to say, 10 February 1989, with a reciprocity reservation. Accordingly, as a contracting state, Kenya must recognise and enforce foreign arbitral awards regardless of their country of origin. This obligation is nevertheless subject to certain limited exceptions aligned to the provisions as set out in the New York Convention itself as well as Kenya’s Arbitration Act.

3.3 The Use of Arbitration for Insurance Dispute Resolution

The Supreme Court of Kenya in *Dhanjal Investment Limited v Kenindia Assurance Company Limited* stated that arbitration proceedings, like judicial proceedings, are sacrosanct and must be treated with decorum. A significant number of policy agreements contain a dispute resolution clause, predominantly citing a tiered approach comprising negotiation, mediation, and arbitration.

Arbitration is private, and only the concerned parties participate in the process. The general rule of arbitration proceedings tends to rest upon the principle of party autonomy, with the Arbitrator being the master of procedure. The arbitrator adopts those provisions already agreed upon by the parties, effects the procedural rules of the seat, and otherwise ensures that both/all parties are heard and afforded an equal opportunity to prosecute and defend their respective cases.

The Arbitration Act, for its part, outlines the circumstances in which an arbitral award may be set aside and also makes provisions for limited instances of appeal. Appeals are only available in domestic arbitrations where the parties have agreed or where the Court of Appeal grants leave on the basis that the case involves a point of law of general importance that will be likely to affect one or more parties. That said, the pathways to appeal remain very limited, upholding the finality of arbitral awards, but reserving the rights of courts to correct manifest wrong or injustice.

4. Coverage Disputes

4.1 Implied Terms

Kenyan courts have observed that the implication of a term is a matter for the court and

whether or not it is implied tends to depend on the intention of the parties as deduced from their words of agreement and surrounding circumstances (*Bid Insurance Brokers Limited v British United Provident Fund* (2016) eKLR).

4.2 Rights of Insurers

Per Section 94(1) of the Insurance Act, insurable interest is essential for all policies.

In *AIG Insurance Company Limited v Benard Kiprotich Kirui* (2022) eKLR, the High Court adopted the definition of insurable interest to be a connotation of pecuniary or proprietary interest determined by (i) a direct relationship between the insured and the subject matter; (ii) the relationship must have arisen out of a legal or equitable right or interest in the subject matter; (iii) the interest bears any loss or liability arising in the event the loss or risk attaches; and (iv) the insured's right or interest in the subject matter must be capable of pecuniary estimation of quantification.

Thus, prior to the inception of the insurance contract, the insured is required to disclose all material circumstances that the insured knows or ought to know. Essentially, the insured must make a fair representation of the risk to the insurers, codifying the common law principle of *uberrimae fidei*. In *Silverstar Automobiles Limited v Fidelity Shield Insurance Co. Ltd* (2014) eKLR the plaintiff's claim on a burglary policy failed because the High Court examined the Policy plus Proposal and Declaration. The Plaintiff had answered in the affirmative to Question 6, which read, "Do you keep proper Stock and Sale books which are entered regularly not less frequently than once a month?". They had also accepted the terms and conditions which carried a Safe and Books Clause warranty that the plaintiff would keep a completed set of books, accounts

and all business transactions. The court found that the as the plaintiff had not met the warranty, the insurer's liability was excluded.

4.3 Significant Trends in Policy Coverage Disputes

The James Finlay cases in Scotland and Kenya's Supreme Court have opened up new frontiers in relation to the dispute resolution regime established by the Work Injury Benefits Act (Cap 236) aligned towards the doctrine of exhaustion of remedies. In November 2023, the Scotland's Inner House of the Court Session (highest civil appeal court) halted an "historic" case against an Aberdeen-registered company operating tea farms in Kenya brought by Kenyan tea workers on the basis that their claims could be dealt with under the WIBA regime. The appeal judges indicated that if their understanding of the practical operation of WIBA turned out to be ill-founded, or if the WIBA claims were not determined in accordance with the scheme, or if there were to be excessive delay, the court could revisit the question of substantial justice and consider whether the sist (halt order) should be recalled. The Supreme Court, for its part, received via appeal from the High Court and Court of Appeal seeking recognition and enforcement of a locus inspection order from a Scottish court regarding the tea workers' claims, which it declined to adopt on the grounds that the same was not a final order. The WIBA Act requires every employer to obtain and maintain an insurance policy with an approved insurer in respect of any liability that the employer may incur under the regime. The Act provides a claims settlement mechanism before the Director of Occupational Safety and Health, an office which is established by the statute on a no-fault basis. Compensation is issued per a defined scale depending on the nature and scale of the injury. In the first

instance, the courts do not have jurisdiction to hear the claims, and lawyers are not involved.

Both jurisdictions, in their respective determinations, have cemented the primacy of the doctrine of exhaustion of remedies into the insurance dispute resolution sphere. This doctrine is to the effect that the parties ought to exhaust processes set out under the law before engaging in judicial proceedings (*Odhiambo & Another v National Police Service & 3 Others*; *CIC General Insurance Limited & 6 Others (Interested Parties) (Petition E006 of 2023) [2023] KEHC 719 (KLR) (Constitutional and Human Rights (9 February 2023) (Ruling))*).

4.4 Resolution of Insurance Coverage Disputes

An insured person is expected to take the following steps in the process of dispute resolution.

- Parties can engage the mechanism set out in their dispute resolution clause. Most insurers set out an arbitration clause preceded by negotiation.
- IRA has a statutory mandate to handle claims, which it does pursuant to Section 204A of the Insurance Act, and it observes the provisions of the Consumer Protection Act. Within the last two years, IRA has issued fines to several insurance companies for failure to pay claims as well as a variety of licences defaults. The Regulator has published the IRA Resolution of Consumer Protection Complaints and Disputes Procedures to the following effect.
 - (a) The claim, complaint or dispute requires to be taken up with the insurance company/registered member in writing and ought also to be granted a reasonable opportunity to respond and issue their decision on the same.
 - (b) The Insurance Regulatory Authority will

further require the insured and insurance company/intermediary or service provider to dialogue as disputes may arise out of miscommunication or misinterpretation of policy terms and conditions.

- (c) Time limits – as a general rule, complaints and disputes should be made to IRA within three years of the act or omission complained about or disputed. Time starts to run from the time when the insured knew or ought to have known about the act or omission. Of importance is that it is unlikely that this would oust the operation of the Limitation of Actions Act.
- Section 169 of the Insurance Act establishes an Insurance Tribunal empowered to hear appeals under the Act, that is say, where a reinsurer declines business under Section 146 and the Commissioner of Insurance's decisions, Section 173.
- The Tribunal operates under the Insurance (Insurance Appeals Tribunal) Rules, 2013.
- Reinsurance contracts are also subject to the foregoing.

4.5 Position If Insured Party Is Viewed as a Consumer

Section 204A of the Insurance Act empowers the Insurance Regulatory Authority to settle disputes. Thus an insurance customer can lodge a written complaint to the Commissioner of Insurance against a regulated entity in respect of the provision of services (Section 204A(2)). The Commissioner's decision is subject to appeal in the Insurance Tribunal within 30 days.

4.6 Third-Party Enforcement of Insurance Contracts

The Insurance (Motor Vehicles Third Party Risks) Act (Cap 405) requires parties to take out third-party liability insurance in respect of all motor vehicles that belong to them. Section 10 then

provides a statutory obligation upon the insurer to settle any judgment in respect of liability attaching, provided appropriate notice is issued in line with the statute.

4.7 The Concept of Bad Faith

Kenya adopts the principle of *uberrimae fidei* to the effect that one must abstain from bad faith and act in good faith in an insurance contract. This is achieved through disclosure and candour, and misrepresentation or non-disclosure, once established, gives rise to an inference of breach of the *uberrimae fidei* principle with the potential consequence that the policy may be avoided (*James Kamau Kimani v Corporate Insurance Co. Limited* (2020) eKLR).

4.8 Penalties for Late Payment of Claims

Factors which contribute to late payment of claims include (i) insufficient allocation of funds; (ii) high workload upon insurance workers; (iii) delays in submission of claim; (iv) delays in submission of investigation reports; and (v) delays in claim documentation.

4.9 Representations Made by Brokers

Section 20(1) of the Marine Insurance Act (Cap 390) states that every material representation made by the assured or his agent to the insurer during the negotiations for a marine insurance contract before the contract is concluded must be true; if untrue, the insurer could avoid the contract. Accordingly, any insured under a marine policy is bound by representations made by their broker.

Such representations could be of fact or expectation of belief, where made in good faith. The materiality of the representation matters where it would influence a prudent insurer on the value of premium required; what is material is a mat-

ter of fact. Representations can be withdrawn or corrected before the contract is concluded.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

While insurers do delegate underwriting or claims to third parties, thus far this question has not been actively litigated upon. The caution under this model is for the insurance companies to ensure that such third parties carry out their business well, comply with regulations and treat customers right. Questions of conflict of interests may also arise and therefore insurers ought to ensure sufficient checks and balances.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

The main areas where insurers fund the defence of insureds are under general business (non-life) insurance, especially those claims emanating from statutory covers – eg, third-party motor vehicle liability and marine insurance.

5.2 Likely Changes in the Future

It remains to be seen if there are any changes in the future regarding funding the defence of insureds.

5.3 Trends in the Cost or Complexity of Litigation

As business complexity increases, the cost and complexity of litigation under these heads may increase.

5.4 Protection Against Costs Risks

An increasing number of insurance companies are offering contingent risks covers in respect of legal risks arising from litigation, tax liability and regulatory issues. These hinge on an under-

standing of the factual and legal circumstances surrounding each case, an assessment of the potential of the risk attaching, as well as an estimate of the loss likely to be suffered.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

As a general rule, the principle of subrogation is triggered when the insured is indemnified in respect of their rights. The court in *Jonathan Kyangu Kisilu and Mary Nzioki Kyalu (suing as the legal representatives of the Estate of Kyaluma Kyangu (Deceased) v Mombasa Fresh Company & 2 Others* (2021) eKLR) held that where the insurer came into the proceedings prematurely, its representative's affidavit in support of the application before the court was fatally defective for having been sworn by a stranger to the proceedings leading to its being struck out.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

To avoid falling into the trap set out at 6.1 **Right of Action to Recover Sums From Third Parties**, insurers will fund their insured's defence/prosecution of a claim but ensure that the proceedings are carried out in the name of the insured and legal documents are filed in the insured's name and for and on their behalf.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The COVID-19 pandemic, a prolonged season of drought, the global economic slowdown, and a general election in 2022 saw the newly elected regime introduce a universal healthcare cover-

age system through a triad of statutes: the Social Health Insurance Act, 2023, Primary Healthcare Act, 2023, and Digital Health Act, 2023, which collectively replaced the National Hospital Insurance Fund Act, 1998 (Amended in 2022). The Triad was intended to establish a universal health-care system accessible to all. However, the Acts were declared unconstitutional by a three-judge bench in July 2024. The court, however, granted the government 120 days to implement the court's ruling and afforded the attorney general the same period to file an appeal, primarily on the premise that there now exists a lacunae in the country's health insurance regime.

7.2 Forecast for the Next 12 Months

The outcome of the case mentioned in **7.1 Type and Amount of Litigation**, is bound to affect health insurance, and depending on the ultimate outcome, it may spark a reorganisation in the sector that could invite increased health insurance-related litigation.

7.3 Coverage Issues and Test Cases

Any test cases will likely emerge following the outcome of the constitutional petition relating to the social health insurance framework which is currently before the courts.

7.4 Scope of Insurance Cover and Appetite for Risk

The scope of insurance cover available has not yet been changed, nor has the appetite for risk.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Kenya, like a few other African countries such as Nigeria and Ghana, engaged regulatory consultants to assess the current status and regula-

tory practices in the respective jurisdiction with reference to ESG risks. The outcome was to the effect that African insurers do not typically consider ESG risks in underwriting, capital management and risk management decisions largely due to a lack of regulation, policy and voluntary initiatives.

It is important, however, to underscore that the country made a commitment to a nationally determined contribution (NDC) target of decreasing greenhouse gas emissions of 32% by 2030 at a total estimated cost of USD62 billion. The Central Bank of Kenya (CBK) has since issued a Guidance on Climate-Related Risk Management, considering the financial sector's role in addressing climate change with limited success. CBK further publicised the draft Kenya Green Finance Taxonomy, 2024 (KGFT) for public participation. This aims to establish a system for banks, issuers, and other financial sector participants to track, monitor and demonstrate the credentials of their green activities in an objective and credible way and stamp out greenwashing. The KGFT is couched in voluntary terms, but will likely have a significant impact on shaping the ESG discourse in Kenya's financial sector, including insurance underwriting and litigation.

8.2 Data Protection Laws

Kenya's data protection landscape came into effect on 25 November 2019, with the enactment of the Data Protection Act No 24 of 2019. Several regulations further came into operation on 31 December 2021 through the Data Protection (General) Regulations, 2021; the Data Protection (Registration of Data Controllers and Data Processors) Regulations, 2021; and the Data Protection (Complaints Handling and Enforcement Procedures) Regulations, 2021. The DPA created the Office of the Data Protection Commissioner (ODPC), with powers to impose fines

and sanctions for offences that are also articulated in the DPA regime.

The High Court has articulated that the ODPC has the power to receive, investigate and handle complaints leading to an award of compensation to victims in suitable cases (*Mercy Mwikali Mwanzia v Allan J. Rhodes* (Constitutional Petition No E115 of 2022) [2023]). However, only natural persons can lodge complaints with the OPDC. Further, the ODPC is required to finalise complaints within the statutory period prescribed by statute (*Gichuhi & 2 Others v Data Protection Commissioner; Mathenge & Another (Interested Parties)* (Judicial Review No.E0238 of 2023)).

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

The Anti-Money Laundering and Combating Terrorism Financing (AML/CTF) Laws (Amendment) Act 2023 came into effect on 15 September 2023. It amended a number of Acts, including the Insurance Act. The Amendment Act granted supervisory powers to regulators in the financial services sector, including IRA. The upshot of the impact will be discernible once IRA issues its guidance on the same.

LEBANON



Law and Practice

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Obeid & Medawar was founded in 2007 by Amer Obeid and Rachad Medawar. The firm operates in Lebanon, the UAE, and the Kingdom of Bahrain with a highly qualified team of trilingual lawyers from diversified backgrounds. Its practice spans from basic consultation to the widest spectrum of legal services. Obeid & Medawar has three main departments – Consultation; Litigation, Arbitration and Alternative Dispute Resolution; and Legislative Practice/

Policymaking, handling a wide range of practice areas including, but not limited to, corporate and commercial law; civil, administrative and labour law; real estate and construction law; insurance and reinsurance; banking and finance law; M&A; wealth management; management of family offices; IP law; aviation law and medical law.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime Statutory Regime

The insurance sector in Lebanon is governed by Decree No 9812 of 4 May 1968 (“the Law”). This Law outlines the regulations for insurance companies operating within the country, applying to both Lebanese and foreign insurers conducting any of the insurance activities covered under the Law’s listed branches and sub-branches.

In addition, insurance activities in Lebanon are regulated by decisions from the Insurance Control Commission (ICC) which operates under the Lebanese Ministry of Economy and (MOET). The ICC is the authority overseeing the insurance industry in Lebanon. It aims to protect the interests of policyholders and has the authority to enforce regulatory and supervisory frameworks through interventions and sanctions. The ICC issues decisions and directives that insurance companies must adhere to, and that can influence the handling of insurance disputes by setting standards and practices.

Insurance operations are also subject to the provisions of the Code of Obligations and Contracts, specifically Articles 950 to 1023.

Procedural Regime

Article 48 of the Law allows policyholders or the beneficiary to pursue claims against insurance companies before the Insurance Arbitration Council, established within MOET. This Council comprises experienced insurance professionals that can handle financial claims resulting from medication and hospitalisation insurance policies, as well as insurance policies covering vehicles, carriages and traffic accidents. However, its jurisdiction is limited to claims of LBP75 million or less, on condition that the plaintiff has not previously initiated a court action regarding the same matter.

While the laws governing insurance activities in Lebanon do not specify other dispute resolution mechanisms applicable for insurance disputes in Lebanon, the commercial and financial courts remain competent to handle insurance cases. Judges in these courts possess the necessary experience to handle various insurance disputes. Such disputes will follow the standard litigation procedure before Lebanese courts and regulated by the Lebanese Code of Civil Procedure.

1.2 Litigation Process and Rules on Limitation

Litigation in Lebanon is governed by the Lebanese Code of Civil Procedure, established by Decree-Law No 90/1983 and its subsequent amendments. Lebanon follows a civil legal system that adheres to the inquisitorial model, where the legal process is primarily conducted through written submissions, with a focus on formal documentation and written evidence.

The general rules on limitation concerning claims arising out of or in association with an insurance policy is two years from the event of the occurrence (Article 985 of the Lebanese Code of Obligations and Contracts). However, the two-year limitation period will not begin at the time of the incident in certain cases:

- if there is concealment of an insured risk, omission, incorrect or invalid disclosure, the limitation period will start from the date the insurer becomes aware of the occurrence;
- in emergencies, the limitation period will begin on the day the parties became aware of the occurrence, provided they can demonstrate that they were unaware of it before that time.

In addition, lawsuits that remain inactive for two years from the last valid procedural step may be dismissed by the court, either upon the request of a party or ex officio, on the court's own initiative.

1.3 Alternative Dispute Resolution (ADR)

In Lebanon, Alternative Dispute Resolution (ADR) is increasingly recognised and encouraged as a viable means of resolving disputes outside the traditional court system. Courts and legal professionals are becoming more open to ADR, particularly as it helps reduce the burden on the

judicial system and provides a more flexible and often faster method of dispute resolution.

The most recognised forms of ADR in Lebanon are Arbitration and Mediation. Arbitration proceedings are regulated by the Lebanese Code of Civil Procedure (CCP). The CCP contains a dedicated chapter (Chapter 2) on arbitration, distinguishing between local arbitration (Articles 762 to 808) and international arbitration (Articles 809 to 821).

For instance, the parties to an insurance contract may choose arbitration as an alternative dispute resolution method. However, it is important to note that clauses under an insurance policy issued in Lebanon concerning risks existing in Lebanon and falling under the branches stated in Article 2 of the Law are considered null and void if the chosen arbitrator is not domiciled in Lebanon and does not issue their award within the country.

Mediation was formally recognised in Lebanon in 2005 through the establishment of specialised mediation centres, each with its own rules and procedures. It has been endorsed through the enactment of Law No 82 of 18 October 2028 on Judicial Mediation and Law No 286 of 14 April 2022 regarding Conventional Mediation.

With the Judicial Mediation, the parties have the option to initiate mediation proceedings even after court proceedings have begun.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

As previously mentioned, the insurance sector in Lebanon is governed by regulations outlined by the Law. Subsequent amendments to the Law

have been limited, with no significant updates since 1999. Insurance law is currently being revised by parliament, and the new regulations might introduce significant changes to the legal framework for insurance companies in Lebanon.

In addition, and as already mentioned, insurance operations in Lebanon are subject to decisions issued by the ICC and its bylaws, and provisions outlined in the Code of Obligations and Contracts (Articles 950 to 1023).

2.2 Enforcement of Foreign Judgments

In Lebanon, the enforcement of foreign judgments, including those involving insurers, is governed by the Lebanese Code of Civil Procedure, in particular Articles 982 to 987.

Under such provisions, some conditions should be met in order for Lebanese courts to enforce the foreign decisions in Lebanon. In particular, (i) the foreign judgment should be final and not subject to appeal or further proceedings in the originating jurisdiction; (ii) the foreign country's legal system should allow the recognition in its jurisdiction of Lebanese judgements; (iii) the foreign court must have had proper jurisdiction over the case, and such court must have complied with Lebanese laws and principles of justice when ruling; and (iv) the foreign judgement should be compliant with the Lebanese public policy or fundamental legal principles.

For insurance disputes, in addition to the above, the judgement to be enforced should align with the relevant insurance laws and regulations in Lebanon.

In addition, Lebanon is a party to various international treaties and conventions that may affect the recognition and enforcement of foreign

judgements, such as those relating to arbitration and commercial matters.

2.3 Unique Features of Litigation Procedure

As previously mentioned, Article 48 of the Law provides for the establishment of arbitration councils to resolve disputes related to financial claims arising from insurance coverage. This option is available to individuals in addition to the standard litigation procedures before Lebanese courts, as outlined in the Lebanese Code of Civil Procedure.

A notable feature of these councils is that they offer a guaranteed right for individuals. Specifically, any provision in an insurance policy intended to exclude the jurisdiction of the insurance arbitration council is deemed null and void. Furthermore, cases brought before the insurance arbitration council are exempt from judicial taxes and stamp duties, though they are not exempt from costs. Finally, parties can file cases with the council without requiring legal representation, unlike in the courts.

Additionally, awards issued by an insurance arbitration council are only open to limited judicial recourse. The only options available for challenging these awards are opposition; opposition by third parties; and cassation, in accordance with the rules set forth in the Code of Civil Procedure.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Under Lebanese legislation, there are generally no significant restrictions on including arbitra-

tion clauses in commercial insurance and reinsurance contracts.

However, the Lebanese Code of Civil Procedure establishes exclusive territorial jurisdiction for specific insurance matters. For instance, disputes related to health insurance are governed by the courts in the insured party's place of domicile (Article 109), while accidents, including car accidents, are governed by the courts either located where the accident occurred in the insured party's place of domicile (Article 110). Additionally, disputes related to fire insurance matters fall under the jurisdiction of the courts where the fire occurred (Article 111).

In addition, arbitration clauses included in an insurance policy issued in Lebanon concerning risks located within Lebanon and falling under the branches stated in Article 2 of the Law are deemed null and void if they stipulate that the arbitration will be conducted by an arbitrator who is not domiciled in Lebanon or if the chosen arbitrator does not issue their award within the country (Article 11 of the Law).

Based on the above, parties to an insurance contract may opt for arbitration as an alternative dispute resolution method, as long as the dispute does not pertain to any of the restricted matters outlined above and complies with the above-mentioned limitations.

3.2 The New York Convention

Lebanon ratified the New York Convention on 9 November 1998, with a reservation based on reciprocity. This means Lebanon will only recognise and enforce arbitral awards issued by other contracting states that are also parties to the convention.

Lebanese courts have enforced several foreign arbitral awards under this convention. A legitimate interest is required for a court to accept jurisdiction over such proceedings. The applicant must produce as evidence: (i) the arbitral award (either the original or a certified copy); and (ii) the arbitration agreement. The proceedings are conducted *ex parte*, where the judge will only verify: (i) the existence of the award; and (ii) whether the recognition of the award would be manifestly contrary to international public policy.

The competent court for granting *exequatur* depends on the type of dispute. The president of the Beirut First Instance Court handles civil and commercial matters, while the president of the Council of State deals with administrative matters.

Foreign awards must be translated into Arabic for enforcement, and the court will verify that recognising the award does not breach Lebanese public policy, as per Article 814 of the Lebanese Code of Civil Procedure. Decisions denying recognition or enforcement can be appealed. However, decisions granting recognition or enforcement can only be appealed within 30 days of notification in specific cases, for example, if: (i) the award was made without a valid arbitration agreement; (ii) it was delivered by arbitrators not appointed according to the law; (iii) it exceeded the mission for which the arbitrator or arbitrators were appointed; (iv) it was delivered without due respect for rights of defence; or (v) it violated international public policy. Appeals can be made to the Court of Cassation, but it will only review legal grounds, not factual ones.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration in Insurance Dispute Resolutions in Lebanon

Lebanon is known for being arbitration-friendly. Under Article 964 of the Lebanese Code of Obligations and Contracts, arbitration is permitted for disputes arising from insurance contracts, reflecting a positive attitude towards arbitration in this field. Consequently, parties may choose arbitration to resolve insurance disputes, with the exception of specific limitations strictly and expressly outlined in applicable laws. Therefore, aside from the limitations mentioned in **3.1 Enforcement of Arbitration Provisions in Commercial Contracts**, all other insurance disputes can be resolved through arbitration.

As mentioned, for insurance claims below LBP75 million, and related to medical and hospitalisation insurance, as well as vehicle and traffic accident insurance, disputes are handled by the Insurance Arbitration Council (ICC) within the Ministry of Economy and Trade.

That said, there are no particular areas of insurance that are predominantly resolved through arbitration. However, large-scale insurance contracts are more likely to be settled through arbitration compared to smaller-scale insurance cover.

Applicable Rules and Regulations

Insurance disputes in Lebanon are mostly governed by common law rules and principles under the Lebanese Code of Obligations and Contracts, the Lebanese Code of Civil Procedure, and the provisions of the Law. Unlike public litigation proceedings, these disputes are handled privately and confidentially.

Challenging the Arbitral Awards in Lebanon

In domestic arbitration, awards can be challenged through:

- an ordinary appeal before the Court of Appeal, although this is not available for awards rendered on an *ex aequo bono* basis unless explicitly reserved in the arbitration agreement;
- a recourse in annulment before the Court of Appeal based on grounds specified in Article 800 of the Lebanese Code of Civil Procedure; or
- a retrial before the Court of Appeal under Article 808 of the above-mentioned code, subject to specific conditions.

For administrative matters, only one level of recourse is available. Objections to decisions denying enforcement can be raised before the judicial section of the Council of State.

In addition to information above applicable to international arbitrations, appeals against decisions granting recognition or enforcement of an international award or recourses in annulment for awards rendered in Lebanon are limited to the grounds specified in Article 817 of the Lebanese Code of Civil Procedure.

4. Coverage Disputes

4.1 Implied Terms

Certain terms are inherently included within insurance contracts, as follows.

- The Duty of Information, which requires the insured party to provide all relevant information to the insurer at the time of entering into the agreement. This allows the insurer to accurately assess the risks involved and to

be informed of any changes that may subsequently increase these risks.

- The Duty of Good Faith, which requires honest and complete disclosure by both parties, as mandated by general legal principles governing contracts.

Other implied terms may vary depending on the type of insurance contract and the general legal principles of common civil law, specifically the Code of Obligations and Contracts, which outlines rules regarding both the form and substance of the contract.

4.2 Rights of Insurers

The insurer is not liable for damage or destruction caused intentionally by the insured party, or for damage resulting from the latter's omissions or mistakes, even if such damage would otherwise be covered by the policy (Article 966 of the Lebanese Code of Obligations and Contracts).

Additionally, the insurer is not liable for any damage that was not disclosed at the time of the policy agreement.

4.3 Significant Trends in Policy Coverage Disputes

In Lebanon, recent insurance coverage disputes have centred around several key trends, as follows.

- *War risk insurance* – the recent regional tensions, particularly the ongoing conflict between Israel and Palestine, have impacted Lebanon, as a neighbouring country. Insurers now classify southern Lebanon as a war zone, leading to the introduction of cancellation provisions in their policies. These clauses often include limited or no coverage for medical risks, property damage, and other related

issues if it occurred in this zone (Article 969 of the Code of Obligations and Contracts).

- *Climate change and emerging diseases* – there have been disputes over whether insurance policies cover damages from natural events such as floods and fires, particularly during relevant seasons. In addition, as climate change leads also to the emergence of new diseases and viruses in Lebanon, insurers are increasingly negotiating how these evolving risks will affect future insurance cover.
- *Pandemics and epidemics* – following the COVID-19 pandemic, insurance companies are now offering additional cover for pandemics and epidemics at additional costs, to avoid any conflicts in the future.
- *Ambiguity in policy* – wording disputes have also increased due to unclear or ambiguous policy terms. Insurers and policyholders have faced legal battles over the interpretation of policy limits and exclusions, highlighting issues with policy drafting and clarity.

4.4 Resolution of Insurance Coverage Disputes

Disputes are typically resolved through negotiation between the insurer and the insured party, aiming to settle issues amicably without or before proceeding to court, thus avoiding additional costs. This approach applies equally to both insurance and reinsurance contracts.

4.5 Position If Insured Party Is Viewed as a Consumer

The Lebanese legal framework offers several consumer protections for insurance policyholders. The Consumer Protection Law (No 659 of 2005) ensures the provision of high-quality services to consumers. These provisions apply to all contracts between professionals and consum-

ers, provided they do not contradict the legal provisions governing insurance companies.

Moreover, consumers have the right to file complaints before the Consumer Protection Directorate, which is responsible for safeguarding the rights of purchasers of insurance products and services.

Additionally, Article 983 of the Code of Obligations and Contracts describes as null and void: (1) any clause imposing forfeiture penalties on the insured party for violating laws and regulations, unless that violation was an extremely serious; and (2) any clause imposing forfeiture penalties the insured party for failure to directly inform the authorities of emergencies or to present required documents.

Moreover, owners of motorised vehicles must obtain insurance policies covering third-party liability for bodily injury and material damage. Similarly, employers of foreign workers must obtain insurance policies covering death, disability, and medical expenditures for these workers. The insurance companies are bound by the pricing rate of these insurance policies set by the ICC.

4.6 Third-Party Enforcement of Insurance Contracts

Third parties cannot file a direct claim against an insurer unless they have suffered damage and their policy expressly permits this.

Third parties can pursue an indirect claim against the insurer on behalf of the insured party through a subrogation of rights, provided the legal conditions for subrogation are met and the insured party has not already filed a claim.

4.7 The Concept of Bad Faith

While Lebanese law does not specifically define the concept of “bad faith”, it places great importance on the principle of good faith in negotiating, concluding, and terminating contracts. However, acts of bad faith are certainly penalised in various areas of Lebanese law. For instance, in insurance contracts, if an insured item has been destroyed at the time the insurance contract is concluded, the contract is deemed null and void. Heavy penalties are imposed on the insured party having acted, as such, in bad faith (Article 981 of the Lebanese Code of Obligations and Contracts). Additionally, any false declaration or concealment of information by the insured party, if carried out in bad faith, will also render a contract null and void (Article 982 of the Lebanese Code of Obligations and Contracts).

4.8 Penalties for Late Payment of Claims

If an insurer consistently delays payments or fails to settle claims within a reasonable time limit, the insured party may take legal action. Courts can award damages or impose penalties, in addition to the initially covered amount as stipulated by Article 970 of the Code of Obligations and Contracts.

For example, if an insurer delays payment of a valid claim, they may be required to pay interest on the overdue amount from the time it was due until it is paid, as per Article 265 of the above-mentioned code. Additionally, insurers may be liable for compensating the insured party for any extra costs or losses incurred due to the delay, in accordance with Article 257 of the same code.

Lebanese law also mandates that insurers compensate the insured party for damages if the insurer delays responding to a request or renewing the insurance beyond 15 days of notification,

as outlined in Article 984 of the Lebanese Code of Obligations and Contracts.

These penalties are intended to ensure timely fulfilment of obligations by insurers and to protect the rights of policyholders.

4.9 Representations Made by Brokers

In Lebanon, the insured party is typically bound by representations made by their broker, as long as the broker was acting within the scope of their authority. The insured party should carefully review and verify all information provided by the broker to avoid potential issues with the insurance contract.

If a broker makes false representations or omits important information, the insured party might still be bound by these representations. However, if the insured party can prove that the broker acted outside their authority or engaged in fraudulent behaviour, the insured party may have grounds to dispute the validity of the representations.

However, it is worth mentioning that, in Lebanon, there are three types of insurance intermediaries, each serving different roles in the marketplace (Article 38 of the Law).

- *Independent insurance brokers* – these brokers offer technical advice and work on behalf of the insured party, aiming to represent their interests. They can be either individuals or entities authorised by insurers. They are independent from insurance companies and must disclose any direct or material relationships with insurers that could affect their impartiality. Brokers help clients by presenting options from multiple insurers and guiding them to choose the most suitable policy.

- *General insurance agents* – these agents are licensed to conduct business on behalf of insurance companies but are not employed by them. They work independently and can be either individuals or entities authorised by insurers. General agents typically work under an agency agreement that is renewed annually and may represent multiple insurance companies.

- *Insurance delegates* – these are individuals who work exclusively for and under the responsibility of a single insurance company, broker or general agent. They may also work for others in a secondary capacity, provided it does not conflict with their primary role and they have authorisation from their main employer.

Insurance companies will be held responsible, in the civil field, for any errors committed against the public by the independent broker, if it is proved that they either represent an insurance company or operate for its benefit. Likewise, the insurance companies will be held responsible, in the civil field, for any errors committed against the public by its general agent; and any clauses to the contrary in the agency contracts shall be considered as null and void. Insurance companies, as well as the general insurance agent, and the independent insurance broker, if they are juridical persons, shall be held responsible for the errors of their delegates.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

It is common practice in Lebanon for insurance companies to delegate underwriting or claims handling to other parties or entities, such as brokers, or Third Party Administration (TPA), or other intermediaries. This is a form of outsourcing which is not restricted within the country.

The relationship between these parties and insurance companies is governed by the scope of authority granted to them, as detailed **4.9 Representations Made by Brokers**.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Professional Liability Insurance primarily protects professionals against legal costs and expenses incurred in their defence if they are alleged to have provided inadequate advice, services, or designs that result in financial loss for their clients. This insurance covers claims related to business or professional practices, including negligence, malpractice, or misrepresentation. The key aspect of this coverage is indemnity for third-party claims.

Additionally, insurance coverage for legal costs in the defence or settlement of claims is available in various types of insurance policies, either as optional coverage or as a standard feature. This includes, but is not limited to: (i) General Liability Insurance (for risks associated to bodily injury, property damage, and personal injury claims); (ii) Directors and Officers Liability Insurance; (iii) Employment Practices Liability Insurance; and (iv) Product Liability Insurance.

It is important to carefully review policy terms to understand what is covered and what is not, as exclusions for certain types of claims or legal costs might apply, as well as any limits on the coverage amount for legal expenses.

5.2 Likely Changes in the Future

The areas where insurers fund the defence of the insured party may evolve (decrease or increase) based on emerging trends in litigation claims

that will appear with time. These changes will be influenced by the key themes outlined in **4.3 Significant Trends in Policy Coverage Disputes**, as well as other future developments affecting the insurance sector in Lebanon.

5.3 Trends in the Cost or Complexity of Litigation

In recent years, the Lebanese economic and financial crisis has led to a rise in insurance claims, influenced by inflation and other market factors.

More complex disputes have emerged regarding coverage for business interruptions and financial losses. Policyholders and insurers have often clashed over claims related to the economic downturn and its impact on business operations. Litigation costs, including those for insurance claims, have also increased, reflecting the adaptation of the Lebanese judicial system to current market rates.

However, the cost and complexity of litigation related to insurance claims may change further based on the significant trends that will affect the insurance sector in the future.

In addition to the above, it is worth mentioning the Beirut Port Explosion on 4 August 2020 that resulted in numerous insurance claims for damages. The complexity of the case and the involvement of various parties indicate that a resolution may be long delayed. Should the explosion be classified as an accident, insurance and reinsurance companies could face significant financial liabilities, potentially leading to a crisis in the insurance sector due to the high volume of claims. On the other hand, if the explosion is classified as an act of war, insured parties will not be covered unless the policy specifically includes coverage for acts of war.

This could further destabilise the already unsettled regional politics, adding to the severe crises Lebanon already faces.

5.4 Protection Against Costs Risks

Claimants can protect themselves against the risks of litigation costs by purchasing insurance that covers expenses related to disputes and court settlements – ie, legal defence costs as described in **5.1 Main Areas of Claims Where Insurers Fund the Defence of Insured Parties**.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Insurers are entitled to recover amounts from third parties responsible for causing an insured loss.

According to Article 972 of the Lebanese Code of Obligations and Contracts, once an insurer has paid an insurance indemnity, it is subrogated by right to all the rights and claims of the insured party against any third parties involved. This means the insurer can pursue recovery from those third parties who are at fault for the loss. However, the same article imposes a limitation to this right. Specifically, the insurer's right to subrogation is limited to third parties who are not the insured party's children, successors, ascendants, employees, or individuals living in the same household. Additionally, if the subrogation of rights is impossible due to actions or omissions by the insured party, the insurer may have the right to refrain from providing coverage.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Please see **6.1 Right of Action to Recover Sums from Third Parties**.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

As mentioned, the insurance sector in Lebanon has been significantly affected by various factors, including ongoing financial and economic challenges. This has led to numerous disputes over the settlement of insurance premiums, with insurance companies hit by a significant drop in the amount of insurance being taken out.

The Lebanese insurance sector was also rocked by the Beirut Port Explosion of 4 August 2020, which caused extensive destruction across Beirut, resulting in over 200 deaths, more than 7,000 injuries, and the displacement of 300,000 people. The explosion inflicted damage exceeding USD15 billion, affecting homes, businesses, and essential services.

Insurance and reinsurance companies have faced a surge in claims related to the incident. However, all litigation concerning coverage for damages from the tragedy has been suspended pending the outcome of the investigation into the cause of the explosion, ie, whether it was an accident, an act of war, or of indeterminate cause. This uncertainty complicates the claims process, particularly since insurance policies often exclude coverage for acts of war or similar events. Political and security issues have repeatedly held up the investigation. A definitive determination by the authorities is crucial for resolving these claims and expediting the process.

Additionally, global developments such as new diseases, climate change, and pandemics have compelled insurance companies to reassess and update their policies to address these new emerging risks, which have not been consistent features of the insurance landscape until now.

7.2 Forecast for the Next 12 Months

The insurance sector, like other sectors in Lebanon, has adapted to economic and financial challenges by adjusting premium pricing, and revising policies to address discrepancies and ambiguities.

With greater clarity added to policies, insurance litigations are expected to decrease in the future. However, we believe that certain protective provisions should be mandated in insurance policies, and this will require changes in the applicable laws.

7.3 Coverage Issues and Test Cases

The developments outlined in 4.3 **Significant Trends in Policy Coverage Disputes** have urged insurance companies to update their policies to address them more precisely. This includes specifying coverage for war zones using different colour categories, addressing pandemics and epidemics, and detailing coverage for new or emerging diseases, as well as risks emerging from unexpected climate changes.

7.4 Scope of Insurance Cover and Appetite for Risk

Please see 7.3 **Coverage Issues and Test Cases**.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

There is no comprehensive global regulatory framework for ESG in Lebanon.

8.2 Data Protection Laws

Lebanon does not have comprehensive data-protection legislation, and there are therefore no specific restrictions or requirements governing the transfer of customer data in this field.

However, with awareness around privacy concerns increasing, particularly in connection with Law No 81 of 10 October 2018 related to electronic transaction and personal data, we cannot rule out the possibility that the competent authority will take action in this regard in the near future.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

Amendments to current insurance law have been minimal, with no substantive changes since 1999. While there have revisions applicable to the insurance sector, none have specifically addressed insurance coverage of litigation or claims related to the right of defence. A new draft law for the organisation of the insurance sector was introduced in 2004 and later approved by the Council of Ministers, and still awaits the review and approval of Parliament. We anticipate that the new regulations could introduce significant updates to the legal framework for insurance companies in Lebanon.

MAURITIUS



Law and Practice

Contributed by:

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The Chambers of Gavin Glover SC

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The Chambers of Gavin Glover SC is deeply rooted in a rich legal heritage and is a prominent set of barristers in Mauritius. The Glover family has been associated with the law for three generations. Harold Glover, Gavin's grandfather, served as a Supreme Court Judge and Electoral Commissioner, while his father, Sir Victor Glover, became Chief Justice in 1976. Established in 1985 by Gavin Glover as a sole practice, the Chambers expanded in 2007, leading to a move

to its current premises at River Court in 2009. Now housing 14 other barristers, the Chambers of Gavin Glover SC offers expertise in areas such as Arbitration, Civil and Commercial Litigation, Criminal Law, Family Law, and Insurance. As a member of Mackrell International, a leading global network of independent legal firms, the Chambers provides top-tier legal services to both local and international clients.

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Gavin Glover SC was called to the Bar of England and Wales and the Mauritian Bar in 1985. A former President of the Mauritius Bar Association, he took silk in 2010. As Head of Chambers, he

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Nabil Moolna studied politics in Paris and law at Bristol. He was called to the Bar of England and Wales in 2017 and to the Mauritian Bar the following year, when he first joined the

Chambers of Gavin Glover SC. After a brief stint as candidate for the National Assembly, the former journalist worked as an independent practitioner before returning to the Chambers in 2023. Nabil is mainly involved in criminal and civil litigation before the District Courts, Intermediate Court and Supreme Court, where he either conducts cases himself or appears as junior to Gavin Glover.



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THE CHAMBERS OF GAVIN GLOVER SC

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

In Mauritius, the Financial Services Commission (FSC) is entrusted with the regulation and supervision of insurance activities. The FSC licenses insurance and reinsurance companies and insurance agents, brokers, managers and salespersons. It is empowered, under the Financial Services Act 2007, to conduct inspections and investigations into the businesses of its licensees. It can give mandatory directions and has enforcement powers with respect to its licensees for the following:

- issuing a warning;
- issuing a public censure;
- disqualifying a licensee from holding a licence or a licence of a specified kind for a specified period;
- disqualifying an officer of a licensee from a specified office or position for a specified period;
- imposing an administrative penalty; and
- revoking a licence.

The Insurers Association of Mauritius (IAM), which was set up in 1972, is an independent and non-governmental organisation representing the insurance industry in all dealings with the government or any organisation on legislative and other matters. The IAM has issued the Insurance Code of Practice 2019 which provides clear and consistent standards for the insurance industry. The Code is binding on all insurers, and is monitored by the Ombudsperson for Financial Services together with the IAM.

Statutory Regime

The legal framework that regulates the insurance sector consists of statutes, regulations and rules

made by the FSC, as well as codes and guidelines set out by the FSC and the IAM.

The main statutes are:

- the Insurance Act 2005;
- the Mauritian Civil Code;
- the Financial Services Act 2007; and
- the Captive Insurance Act 2015.

Procedural Regime

Depending on their nature and on the underlying facts, insurance disputes may be adjudicated in one of the following ways.

- *Out-of-court dispute resolution*: as insurance contracts are private contracts, the parties may agree on a specific out-of-court dispute resolution mechanism, such as mediation or arbitration.
- *Court dispute resolution – civil litigation*: most insurance coverage disputes are contractual in nature. The parties can, in the absence of an exclusive jurisdiction clause in favour of arbitration, or if a dispute falls outside the scope of an arbitration clause, raise the dispute before the appropriate civil or commercial court in Mauritius.
- *The Motor Vehicle Insurance Arbitration Committee (MVIAC)*: this was set up under the Road Traffic Act to deal with minor road accidents involving material damages only, and not more than two vehicles. It has exclusive jurisdiction to determine disputes – between two insurers or between a policyholder and an insurer on liability and/or quantum – which have not been resolved amicably on the basis of an Agreed Statement of Facts Form or a Minor Road Accident Report Form and not involving any of the following:
 - (a) bodily injury to persons travelling in the motor vehicles;

- (b) injury or other prejudice to any other person;
- (c) damage to other structure or property;
- (d) a motor vehicle which does not have a valid insurance *vignette* (certificate);
- (e) a motor vehicle being driven by a person not holding a valid driving licence;
- (f) a motor vehicle driven by a person under the influence of alcohol or drugs; or
- (g) a state-owned vehicle.

The MVIAC sits in one or more divisions and each division consists of the chairperson or vice-chairperson (who are barristers); and two other members (who have suitable qualifications or wide experience in transport, traffic management, insurance, automobile engineering or motor surveying).

A party who is dissatisfied with the decision of the MVIAC can challenge it before the Supreme Court by way of judicial review.

- *The Ombudsperson for Financial Services:* this office is administered and managed by an Ombudsperson and was set up under the Ombudsperson for Financial Services Act 2018. The Ombudsperson is mandated to hear and determine complaints from consumers against financial institutions (which include insurance companies). An individual can only have recourse to this course of action if they have already filed the complaint with the entity and feels aggrieved by the decision of the entity, or has not received a response to the complaint within ten days (or some other statutory delay). After investigating a complaint, the Ombudsperson may make an award for compensation and give such directives as they may determine to financial institutions. Any person dissatisfied by the decision of the Ombudsperson may,

within 21 days, apply to the Supreme Court for a judicial review of the decision or award.

1.2 Litigation Process and Rules on Limitation

The litigation process in Mauritius is adversarial in nature. In civil proceedings, each party has to prove their case on a balance of probabilities. Depending on the quantum of the claim, civil proceedings are instituted before one of the District Courts; the Intermediate Court; or the Supreme Court (Civil or Commercial Division).

A District Court has jurisdiction over disputes of up to MUR250,000; the Intermediate Court over disputes of up to MUR2 million and the Supreme Court over disputes which exceed MUR2 million.

Where the matter in dispute does not exceed MUR100,000, a District Court has jurisdiction to hear and determine the matter in accordance with the small claims procedure as set out under Part IIA of the District and Intermediate Courts (Civil Jurisdiction) Act.

In 2008, one of the administrative measures taken under the directives of the Chief Justice was the creation of a specialised Commercial Division of the Supreme Court for the timely dispatch of specific court cases. The Commercial Division has jurisdiction to hear and determine, among other things, any contractual or quasi-contractual matter other than a matter which falls within the jurisdiction of the Land Division.

Whilst courts will support parties resolving their disputes amicably and/or through ADR methods, there are no formal rules in Mauritius relating to pre-action conduct.

However, a party to an insurance contract cannot sue the other party for breach of contract

unless the claimant has previously requested the party being sued to perform their obligations under the contract save where the contract has dispensed with this requirement of prior notice or where the contractual obligation had to be performed within a defined timeframe which has lapsed.

The proceedings commenced before the District Courts and the Intermediate Court are governed by the District and Intermediate Court Rules, whilst those commenced before the Supreme Court are governed by the Supreme Court Rules 2000. The litigation process usually commences with the claimant, known as the plaintiff, lodging and serving on the defendant a plaint with summons before the Supreme Court and a praecipe before the District and Intermediate Court. The commencement of proceedings and further pleadings before the Commercial Division are made online via the electronic filing system.

Limitation

Pursuant to Article 1983-37 of the Civil Code, all actions under an insurance contract are prescribed by a limitation period of five years as from the event giving rise to the action. However, this period only starts to run:

- in the event of a reluctance, omission, false declaration or inaccuracy about the risk, from the day the insurer became aware of it; and
- in the event of a loss, from the day on which the relevant parties have knowledge of the loss, if they prove they have ignored it until then.

When the claim of the insured party against the insurer is dependent on a third party, the limitation period starts only from the day that third party brings an action against the insured party or was compensated by the insured party.

1.3 Alternative Dispute Resolution (ADR)

Whilst there are no formal rules requiring parties to consider ADR before commencing court proceedings in Mauritius, ADR is now becoming increasingly popular in large commercial disputes.

The main forms of ADR used in Mauritius are arbitration and mediation, and the two main bodies that offer ADR services in Mauritius are the Mauritius International Arbitration Centre (MIAC) and the Mediation and Arbitration Centre of Mauritius (MARC).

Arbitration

Arbitration as an alternative method of dispute resolution is becoming increasingly popular in Mauritius, particularly in large commercial disputes. The legal framework in Mauritius draws a distinction between domestic and international arbitration. Domestic arbitration is regulated by the Code of Civil Procedure, whilst international arbitration is governed by the International Arbitration Act 2008 (the IAA 2008), which is inspired by the UNCITRAL Model Law on International Commercial Arbitration, the Convention for the Recognition and Enforcement of Foreign Arbitral Awards Act 2001 (which transposes the New York Convention) and the Supreme Court (International Arbitration Claims) Rules 2013 (which sets out rules on the procedure for applications before the Supreme Court on international arbitration matters).

Mediation

As an alternative dispute resolution mechanism, mediation is still rare in Mauritius. In fact, mediation is the only method of ADR that forms part of the court procedure under the Supreme Court (Mediation) Rules 2010 and the Intermediate Court (Mediation) Rules 2019.

Pursuant to the above rules, the Chief Justice or the President of the Civil Division of the Intermediate Court can, if they deem it appropriate, refer to mediation before a Judge of the Supreme Court or a Magistrate, civil suits, actions, or matters which have been brought and are pending before the Supreme Court or Intermediate Court. In addition, any party having a claim pending before the Supreme Court or Intermediate Court can make an application to the Chief Justice or the President of the Civil Division of the Intermediate Court for the matter to be referred to mediation. The main purpose of mediation under the rules is for the parties, in all good faith, to resolve the civil suit by a common agreement or to narrow down the issues in dispute. The mediation Judge/Magistrate regulates the proceedings while offering guidance with an informal and flexible approach. Any formal agreement reached is recorded by the mediation judge or magistrate setting out the terms of the agreement in the form of a memorandum.

In 2023, 59 cases were received by the Mediation Division of the Supreme Court.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

It is common for insurance contracts in Mauritius to contain clauses pertaining to jurisdiction and choice of law, and the Mauritian courts will generally recognise and enforce the choice of jurisdiction and governing law agreed between the parties. However, the court may not decline jurisdiction in favour of a foreign jurisdiction if the choice of that foreign jurisdiction goes against the public policy of Mauritius.

2.2 Enforcement of Foreign Judgments

In Mauritius, there are two distinct regimes under which foreign judgments can be enforced, as follows.

- UK judgments may be enforced in accordance with the procedure set out under the Reciprocal Enforcement of Judgments Act 1923. However, this enforcement procedure is available only in respect of money judgments which are rendered by a superior court in the UK, and the application must be made to the Supreme Court within 12 months after the date of the judgment.
- All other foreign judgments may be enforced through an application for exequatur in accordance with Article 546 of the Code of Civil Procedure. An exequatur of a foreign judgment can only be granted if the judgment satisfies the following conditions:
 - (a) it is valid and can be executed in the country in which it was delivered;
 - (b) it is not contrary to any principle affecting public order;
 - (c) the party against whom it was delivered has been properly summoned to attend the proceedings; and
 - (d) the court that delivered it has the jurisdiction to deal with the matter submitted.

2.3 Unique Features of Litigation Procedure

Hybrid Legal System

Mauritius has a hybrid legal system due to its past French and British colonisation. As a general rule, the main areas of private law (including insurance matters) are French in origin, whilst evidential rules follow the English system. Magistrates and judges usually apply both English and French sources of law for guidance, depending on the context, when adjudicating upon a novel issue of law.

Case Load

In Mauritius, court proceedings are often time-consuming, and it may take up to a few years before a case is in shape and heard and judgment is delivered. According to the Annual Report of the Judiciary 2023, at the end of that year there were 4,227 civil cases outstanding before the District Courts; 2,189 civil cases outstanding before the Intermediate Court; and 3,551 civil and commercial cases outstanding before the Supreme Court.

Whilst the establishment of the Commercial Division of the Supreme Court and the electronic-filing system have been helpful, the litigation process is still lengthy in Mauritius.

Costs

The Mauritian courts generally award costs to the successful party. These include attorney and counsel fees, court filing costs, costs of attendance of witnesses and the costs of any ancillary pre-trial applications. However, in practice, the costs recovered tend to be way off actual legal expenses, as they are capped by the 2012 Supreme Court Rules.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Courts in Mauritius will enforce arbitration provisions in commercial contracts of insurance and reinsurance provided that the dispute falls within the scope of the arbitration agreement and the defendant raises the objection pertaining to the jurisdiction before having filed any defence on the merits of the case.

In the case of an international arbitration, the defendant, objecting to the jurisdiction of the court to hear the dispute, must make an application pursuant to Section 5 of the IAA 2008 asking that the case be referred to a panel of three Designated Judges of the Supreme Court. The latter shall then decide whether the parties should be referred to arbitration or whether, on a prima facie, basis, there is a very strong probability that the arbitration agreement is null and void, inoperative or likely impossible to implement.

3.2 The New York Convention

Mauritius is a signatory to the New York Convention, given force of law by virtue of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards Act 2001 (the “2001 Act”). The reservation of reciprocity was removed in 2013, allowing arbitral awards rendered in non-signatory states to be recognised and enforced in Mauritius.

Enforcement of Foreign Arbitral Awards

The 2001 Act governs the recognition and enforcement of foreign arbitral awards (which include an award in an international arbitration under the IAA 2008 where the juridical seat was Mauritius). The procedural rules for such an application are set out in Rule 15 of the Supreme Court (International Arbitration Claims) Rules 2013, and may be summarised as follows:

- the application is made by way of motion to the Supreme Court (the “enforcement claim”), and initially without notice to any respondent;
- the written evidence in support of the enforcement claim must include the documents set out in Article IV of the New York Convention (the duly authenticated original award or a duly certified copy and the original or a duly certified copy of the agreement);

- the enforcement claim is dealt with by the Chief Justice who, if the above requirements are complied with, will issue a provisional order granting recognition of the award or authorising the enforcement of the award in the same manner as a judgment of the court, in the terms requested by the applicant or in such amended terms as are necessary;
- the Chief Justice may specify parties to the arbitration (in addition to the respondent) on whom the enforcement claim motion and the provisional order will be served, and service will be effected within 14 days of receipt of the provisional order;
- the respondent may apply to set aside the provisional order and the enforcement claim within 14 days of receipt or any longer period as specified by the order if it has been served outside the jurisdiction. The grounds on which the respondent can set aside the provisional order are limited to those contained within Article V of the New York Convention; and
- the award only becomes enforceable once the period given to the respondent to set aside the provisional order has lapsed, or if the respondent has been unsuccessful in such an application.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Whilst arbitration is not widely used to resolve insurance disputes in Mauritius, it is becoming increasingly popular in large commercial disputes. It was used, for example, at a very large insurance company to resolve disputes on the scope of professional liability cover and on losses relating to cyber-attacks.

It is possible that arbitration could be used more often in insurance disputes of a commercial nature and involving substantial sums in issue,

since it is less time consuming and can also be less costly than court proceedings.

For the time being, only limited types of policies have entrenched arbitration clauses.

Appeal Against Arbitral Awards

An award in a domestic arbitration may be challenged on one of the following grounds:

- by way of appeal on law or facts if the parties had not renounced their right of appeal in the arbitration agreement;
- by the Attorney General, if they consider that the enforcement of the award is against public interest; and
- by way of an application for the annulment of the award on the grounds that:
 - (a) there was no arbitration agreement, or it was null or no longer in force;
 - (b) the arbitral tribunal was irregularly constituted or the sole arbitrator irregularly appointed;
 - (c) the arbitrator has decided the dispute otherwise than in accordance with the terms of reference;
 - (d) the principles of a fair hearing have not been respected;
 - (e) the award fails to contain the contentions of the parties, their grounds in support of the contentions and reasons for the award;
 - (f) the award fails to mention the names of the arbitrators and the date of the award;
 - (g) the award is not signed by all the arbitrators or, if a minority of them refuses to sign, fails to mention that fact; or
 - (h) the arbitrator has violated a rule of public order.

International Arbitral Awards

The First Schedule of the IAA 2008 provides for a right of appeal, with leave of the court, on any question of Mauritian law arising out of an award. Section 39 of the IAA provides an exclusive recourse on limited grounds for the setting aside of an award made in an arbitration seated in Mauritius. The Supreme Court may set aside an arbitral award only where:

- the party making the application furnishes proof that:
 - (a) a party to the arbitration agreement was under some incapacity or the agreement is not valid under the law to which the parties have subjected it or, failing any indication thereon, under Mauritius law;
 - (b) it was not given proper notice of the appointment of an arbitrator or of the arbitral proceedings or was otherwise unable to present its case;
 - (c) the award deals with a dispute not contemplated by, or not falling within the terms of, the submission to arbitration, or contains a decision on a matter beyond the scope of submission to arbitration; or
 - (d) the composition of the arbitral tribunal or the arbitral procedure was not in accordance with the agreement of the parties or, failing such agreement, was not in accordance with the IAA 2008; or
- the court finds that:
 - (a) it is not possible to settle the subject matter of the dispute by arbitration under Mauritius law;
 - (b) the award is in conflict with the public policy of Mauritius;
 - (c) the making of the award was induced or affected by fraud or corruption; or
 - (d) a breach of the rules of natural justice occurred during the arbitral proceedings or in connection with the making of the

award by which the rights of any party have been, or will be, substantially prejudiced.

4. Coverage Disputes

4.1 Implied Terms

Insurance contracts in Mauritius carry a number of terms implied by law, even if not explicitly mentioned within them. The Civil Code, through Articles 1983-1 to 1983-92, establishes a legal framework for insurance contracts. This includes a number of essential obligations, such as a duty of full disclosure by the insured party.

For instance, Article 1983-20 specifically states that the insured party is bound, prior to the preparation of the contract, to declare all circumstances known to them that are relevant to the insurer in evaluating risk. Article 1983-33 recognises that the parties may decide freely on the duration of the insurance contract and the conditions for its termination, but adds that either party may, each year following an initial period of three years, terminate the agreement – except for life insurance contracts. Additionally, contracts in Mauritius are governed by a requirement for the parties to act in good faith originating from Articles 16 and 1134 of the Civil Code.

4.2 Rights of Insurers

Mauritian law provides insurers with a number of rights regarding the presentation of risk before a policy is initiated, as well as in the execution of the insurance contract.

For instance, the obligation of the insured party to make full and accurate disclosure is emphasised in Article 1983-30 of the Civil Code, which allows an insurer to consider voiding a contract in cases of intentional misrepresentation. Article

1983-50 grants an insurer the right of subrogation, allowing them to sue third parties responsible for damage up to the amount of the indemnity paid to the insured party. Article 1983-19 protects the insurer by stipulating that they are not responsible for losses caused by intentional or fraudulent misconduct by the insured party, even if a contrary agreement exists. The insurer also has the right to suspend cover if the insured party fails to pay premiums on time, upon issuance of a formal notice. Article 1983-21 ensures that the insurer can limit their risk in the event of non-payment.

4.3 Significant Trends in Policy Coverage Disputes

Over the past year, Mauritius has seen relatively few disputes concerning policy coverage. For example, at one of the island's leading motor vehicle insurers, out of 36 complaints put before the courts, only three concerned policy cover disputes – a mere 0.06% of all active policies. Instead, disputes predominantly concerned liability issues and claims for bodily injuries, especially in multi-party motor accidents. In scenarios where multiple vehicles are involved in a collision, determining liability among insurers often necessitates arbitration or judicial intervention.

4.4 Resolution of Insurance Coverage Disputes

Disputes over insurance coverage in Mauritius are rare but are typically resolved through litigation or arbitration. Arbitration is particularly popular for reinsurance contracts due to their international dimension, and because it is a confidential and efficient resolution method. Other cases with international features, such as those involving injuries to foreign tourists, can be resolved amicably through arbitration or out-of-court settlement, avoiding the prolonged delays associated with litigation in the island.

4.5 Position If Insured Party Is Viewed as a Consumer

The distinction between an insured individual viewed as a consumer and other insured parties of a corporate or commercial nature is not specifically entrenched in Mauritian law. However, a certain number of safeguards have been implemented over the years with the aim of offering additional protection for consumers in insurance contracts. For instance, the FSC, which regulates the insurance sector, has introduced guidelines concerning the advertising and marketing of financial products, including insurance products, to promote responsible, ethical, and professional behaviour among those involved in the promotion and marketing of these products to consumers in Mauritius.

4.6 Third-Party Enforcement of Insurance Contracts

Mauritian law allows third parties to enforce insurance contracts or sue insurers under specific circumstances. Article 1983-60 of the Civil Code provides that “third parties who are beneficiaries under a contract of insurance may enforce the contract directly against the insurer”. In liability insurance, for instance, a third party injured by the insured party's actions can claim compensation directly from the insurer.

Additionally, Article 1983-92 and the Road Traffic Act mandate that motor vehicle owners must have insurance covering third-party liability, ensuring that injured parties can seek compensation directly from the insurer irrespective of any defence the insurer might raise against the insured party.

4.7 The Concept of Bad Faith

The concept of bad faith is enshrined in Mauritian law and can be a very useful legal concept in the context of insurance contracts. Article 1134

of the Civil Code encapsulates the principle: “Agreements lawfully entered into have the force of law for those who have made them (...) They must be performed in good faith”. This means that both parties to an insurance contract are expected to act honestly and fairly. Should an insurer unjustifiably refuse to pay a valid claim or delay payment without reasonable cause, the insured party has the right to seek damages for breach of contract, relying on this fundamental principle of good faith.

4.8 Penalties for Late Payment of Claims

Penalties for late payment of claims can be enforced in Mauritian law. According to Article 1983-26, upon the occurrence of the risk, the insurer is obligated to pay the indemnity, or the sum specified in the contract, within the agreed timeframe. This outlines the insurer’s obligation to effect timely payment once a claim is validated, ensuring that the insured party receives their due compensation without unnecessary delay. Section 65 of the Insurance Act 2005 further emphasises this requirement by providing that, even in the case of the voluntary winding up of an insurer, this shall not prejudice the rights of a policyholder to payment in full of their claim.

These obligations can be enforced by the courts by the award of interest on late payments or the imposition of additional damages to compensate financial loss incurred by the insured party due to the delay. However, this is quite rare.

The recent arrival of the Ombudsman for Financial Services has also opened up a new avenue for disgruntled policyholders seeking fast and effective redress.

4.9 Representations Made by Brokers

Mauritian law recognises brokers as agents of the insured party. In accordance with Section

2 of the Insurance Act, an insurance broker is a person who arranges insurance business with insurers on behalf of prospective policyholders, or as a representative of a policyholder. A broker must be licensed by the FSC. Section 74 provides that an insurance broker is prohibited from providing services if it would create a conflict of interest with either the insurer or the policyholder. Additionally, the broker must disclose to a prospective policyholder any commission or remuneration they may receive from the insurer if the policyholder decides to enter into an insurance policy through their services. Thus, in application of general civil law rules, the representations of a broker are binding on the insured party, provided the broker has acted within their authority. However, if a broker makes unauthorised or inaccurate statements by acting outside of their authority, the insured party would not be bound by the broker’s representations.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

While the Insurance Act 2005 provides a regulatory framework for insurance operations in Mauritius, it does not explicitly mention delegated underwriting or claims handling by third parties. However, the Act does allow for the licensing and regulation of third-party service providers, which include insurance agents. The insurer and the insurance agent are both subject to a number of legal obligations, and the FSC retains the authority to ensure compliance. In some cases, accredited agents, internal agents or sales agents working solely for a specific insurer are permitted to provide quotations for specific classes of business, based on established and agreed conditions, such as:

- for motor vehicles, on limited insured amounts and specific vehicles; and

- for houses, on concrete buildings with a limited insured amount of MUR4 million, excluding premises situated at Port Louis and other flooding-prone areas.

This is mostly done in an attempt to improve the response time for clients and to allow sales teams to be more efficient. The process is subject to a regular audit control by insurers.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurers typically bear the cost of defending insured parties in cases involving bodily injury claims and third-party liabilities. For example, when an insured party is sued following a motor-vehicle accident, the insurer covers both the damages awarded and the legal defence costs. The aim is to protect the insured party from potentially crippling legal expenses. Tortious liability insurance also frequently involves insurers funding defence costs – eg, when a guest is injured on the insured party's property and seeks damages. A successful party may be awarded legal costs by the courts at the end of the case, but these are capped by the Supreme Court Rules at a much lower sum than the market rates.

5.2 Likely Changes in the Future

The practice of insurers covering the defence of insured parties in bodily injury and third-party claims has been consistent for decades, and is unlikely to change in the foreseeable future. As long as the legal and regulatory framework remains stable, insurers are expected to continue to provide this critical support. This ensures that insured parties can rely on their insurers

to cover legal costs in cases that fall within the policy's coverage.

There is an ongoing inquiry by the Competition Commission of Mauritius on an alleged collusive agreement between insurers in regards to the capping of the amount of liability in Public Liability policies for construction companies, which may lead to a more regulated environment in the near future.

5.3 Trends in the Cost or Complexity of Litigation

There have not been any major changes in the cost or complexity of litigation. However, there has been an increase in claims related to cyber-attacks, particularly from banks after COVID-19, where specialised loss adjusters and forensic experts had to be appointed. These cases, however, have not escalated to litigation. Over the past ten years, the cost per point awarded by the Courts for Permanent Incapacity has seen a substantial increase, rising from MUR15,000 to MUR50,000.

Court judgments typically do not provide detailed breakdowns for permanent incapacity, moral damages, or loss of earnings, but rather award a global lump-sum compensation. Recent case law, particularly the judgment in *Phoenix Insurance v Moollan* 2024 SCJ 314, indicates a similar upward trend in loss of earnings claims.

5.4 Protection Against Costs Risks

Claimants can obtain protection against costs risks, depending on the type of insurance cover they possess. For instance, motor and household policies generally do not offer this protection. However, cyber-insurance often includes coverage for defence costs when policyholders are sued by their clients. Third-party liability policies may also cover legal defence costs. This

cover is crucial for managing the financial risks associated with legal proceedings, ensuring that the insured party is not left bearing substantial legal fees.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Articles 1983-1 to 1983-92 of the Civil Code, which deal with the substantive provisions on insurance, envisage the underwriting of risks under two main groups:

- “*assurances de personnes*” – which concerns the insuring of risks in connection with the life or physical integrity of a person; and
- “*assurances de dommages*” – which is subdivided into “*assurances de choses*” and “*assurances de responsabilité*”, and covers threats to the assets and property of an insured party, whether directly or indirectly, when that party is sued by a third party.

The law draws a fundamental distinction between “*assurances de personnes*” and “*assurances de dommages*” on the issue of subrogation of an insurer into the rights of its insured party.

Whereas an insurer who has paid out indemnity insurance for “*assurances de dommages*” is, pursuant to Article 1983-50 of the Civil Code, subrogated (up to the amount of the indemnity) in the rights of the insured party, and can claim from third parties who have caused the damage giving rise to the liability of the insurer, Article 1983-66 of the Civil Code prohibits such subrogation for “*assurances de personnes*”.

However, even in the case of “*assurances de dommages*”, the insurer has no recourse against

the children, descendants, ascendants, siblings, attendants, employees, workers or servants of the insured party, and, generally, any person living in the home of the insured party, except in the case of malicious acts committed by one of these.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

See 6.1 Right of Action to Recover Sums from Third Parties.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The type and amount of litigation in Mauritius, particularly in the insurance sector, have been somewhat influenced by various macroeconomic factors, including the COVID-19 pandemic and geopolitical tensions such as the Russia-Ukraine conflict. COVID-19 led to an increase in business interruption claims and disputes over coverage for pandemic-related losses.

Additionally, the Russia-Ukraine conflict has further driven up reinsurance costs and motor insurance premiums, as inflation in spare parts and freight costs has significantly affected the Motor Line of Business.

The FSC has also noted a rise in litigation involving supply-chain disruptions and travel insurance claims in its annual report issued in 2023, reflecting the broader effects of these global challenges on the insurance industry in Mauritius.

7.2 Forecast for the Next 12 Months

The impact of the pandemic and geopolitical tensions is expected to continue to influence liti-

gation trends over the next 12 months. Factors such as changing economic conditions, regulatory responses, and the ongoing fallout/evolution of the pandemic will likely shape future litigation patterns. The FSC anticipates an increase in claims related to digital transformation risks and cybersecurity as businesses adapt to new operating environments in the post-pandemic era.

Moreover, the hardening of the reinsurance market is expected to persist, with Mauritius being particularly vulnerable due to climate change and natural catastrophes. Most insurers have had to trigger excess of loss covers following the flash flooding resulting from cyclone Belal in January 2024. Coverage for cyclones and floods, which were previously standard named perils, is now subject to special acceptance or has been removed, particularly in specific geographic areas prone to flooding.

7.3 Coverage Issues and Test Cases

The COVID-19 pandemic has given rise to significant insurance cover issues and test cases, particularly in relation to the interpretation of the term “catastrophe” within reinsurance contracts. One of the key issues has been whether the pandemic qualifies as a catastrophe, and the extent to which it triggers coverage for loss of profits. This has been a major area of interpretation, with varying outcomes depending on the specific wording of reinsurance contracts and the jurisdictions involved.

In addition to pandemic-related disputes, climate change has emerged as a critical issue in the reinsurance industry, driven by the increasing frequency and severity of natural catastrophes. This has led to massive claims globally and raised questions about the sustainability of current reinsurance models. While some mar-

kets, such as those in Kenya and the UK, have seen discussions about potential restrictions from reinsurers following events such as riots, these discussions have not yet fully materialised in the Mauritian market.

Overall, the pandemic and the growing impact of climate change have underscored the need for clearer contract terms and robust risk assessment in the reinsurance industry, as these factors continue to challenge traditional coverage framework.

7.4 Scope of Insurance Cover and Appetite for Risk

The scope of available insurance cover and insurers’ appetites for risk have been influenced by the aforementioned factors. Areas prone to flooding and specific types of buildings are now considered higher risk, leading insurers to reduce or eliminate coverage for certain perils. For instance, some insurers are now offering renewals without cyclone and flood cover in areas that have experienced significant claims, reflecting a broader trend of insurers becoming more selective in underwriting to manage their exposure to environmental risks.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Environmental, Social, and Governance (ESG) factors are minor factors of influence for underwriting and litigation in the insurance sector in Mauritius. For example, electric vehicles, which are perceived to have higher fire risks and repair costs, are being insured at higher premiums. Photovoltaic farms and solar equipment also face challenges in securing insurance coverage due to cyclone risks.

As global awareness of ESG issues grows, insurers are likely to integrate these considerations more explicitly into their underwriting decisions, potentially leading to changes in the types of coverage offered and the terms of insurance policies.

8.2 Data Protection Laws

Data protection laws are having a growing impact on the underwriting and litigation of insurance risks, particularly in the areas of cybersecurity, professional indemnity, and liability insurance. Insurers now require detailed documentation from policyholders, including their data protection policies, protocols, and IT security measures. This information is crucial for assessing the risks associated with data breaches and other cyberthreats. In the event of a cyber-attack, the adequacy of these measures may become a central issue in litigation, with insurers closely examining whether the insured party has met the required standards.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

Regulatory developments in Mauritius have slightly affected insurance coverage, litigation, and the defending of claims by insurers. Regulations introduced by the FSC have strengthened policyholder protections and enhanced the financial stability of insurers. These developments include stricter corporate governance requirements, improved risk-management practices, and increased capital adequacy standards. The FSC's solvency guidelines are also expected to increase the resilience of the insurance sector. Consequently, insurers may need to adopt more rigorous procedures for evaluating claims and managing disputes, ensuring compliance with the new regulatory standards.

SOUTH KOREA



Law and Practice

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Dentons Lee is a South Korean law firm that has evolved since its inception in 1961 from an intellectual property-focused services firm into a full-services law firm with 60-plus lawyers based in Seoul who complement the Dentons global network of officers and legal professionals. The firm has a diverse roster of exceptional attorneys and other legal professionals to represent and advise clients in complex disputes in South Korea and abroad in litigation cases as

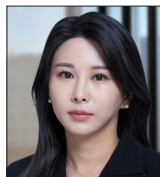
well as arbitration proceedings. In addition, the firm is well positioned to provide comprehensive legal services with key strategies and creative solutions leading to victories, settlements and favourable outcomes. Thanks to its connection with Dentons, Dentons Lee is part of a global network with offices in major commercial hubs around the world, enabling it to engage in concerted prosecutions and defences in both civil and criminal disputes in most jurisdictions.

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SOUTH KOREA LAW AND PRACTICE

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime Litigation

South Korea is a civil law, as opposed to a common law, jurisdiction. The resolution of disputes is primarily based on general and special laws and regulations with the judges in South Korean courts interpreting these in each case. Changes to the law are decided by the national assembly, which is the legislative body in South Korea. By contrast, common law is based on judicial decisions and legal precedents, and judges play a significant role in shaping the laws of the country through binding precedents.

As a civil law jurisdiction, the courts of South Korea rely primarily on codified statutes and the legal framework as their main source of authority. However, in resolving disputes, particularly when statutory law does not provide clear guidance, the courts may also consider judicial precedents. In such instances, decisions from other jurisdictions, notably Germany, the United Kingdom and the United States – where insurance law is more deeply developed – may be cited and argued by litigants. While these foreign precedents are not binding, South Korean courts may find them persuasive when determining their own rulings.

Legislation and court proceedings

The Court Procedure Act, for claims for damages and equitable relief, and the Criminal Procedure Act, for claims with a criminal component, govern the manner in which disputes proceed in the South Korean courts, which generally involves the submission of pleadings with the formal submission of a petition and reply, a sequence of hearings administered by the court (which may also be done remotely), preparation and filing of pleadings and replies, the submission of evi-

dence, the taking of witness statements, and the valuation of damages followed by closing remarks (if elected). Those who are interested third parties also have a right to intervene in the case in order to protect their interests and make arguments on their own behalf.

The court may recommend and administer settlement procedures for both parties in court and may also accept and approve a party-initiated settlement outside of court.

Alternatives to Litigation

Arbitration

Arbitration is an alternative to litigation in the South Korean courts, subject to the agreement of both parties, and has become more prevalent in cross-border agreements. In South Korea, the local arbitration institution is the Korean Commercial Arbitration Board (KCAB). Other arbitration institutions are also frequently selected, such as the Singapore International Arbitration Centre, the International Commercial Court and the Hong Kong International Arbitration Centre, among others, all of which utilise their own respective arbitration rules. The appeal to selecting arbitration over a court procedure in South Korea is highlighted by a number of factors such as the ability to fix a seat in a neutral venue, the ability to select experts on an arbitration panel, the ability to select the language for the dispute which may make the dispute resolution more cost-effective (South Korean courts require all submissions to be made in Korean), and the chance to avoid the rotation of judges which occurs annually in the South Korean courts, among others.

Mediation and administrative proceedings

Disputes involving insurance matters may also be resolved through mediation either by contract or pursuant to the administration of a

South Korean court. Claims which are lodged by insureds as consumers may also be heard through an administrative proceeding under a regulatory authority such as the Financial Supervisory Service or the Korea Fair Trade Commission (KFTC).

1.2 Litigation Process and Rules on Limitation

South Korea has three levels of judicial review:

- a trial at the court of first instance or the district court;
- an appeal which may be reviewed de novo at the court of second instance or a high court; and
- the court of last resort in the third instance which is the Supreme Court of South Korea.

The adversarial nature of litigation in South Korean courts involves a single judge for disputes for claims less than KRW200 million; however, for claims in excess of KRW200 million, a dispute will be reviewed by a panel of three judges (a presiding judge and two associate judges).

As in other jurisdictions with a similar judicial system, a petition will be lodged by a plaintiff to the district court where the key issues of facts and arguments in law are made to the judges, but the case will only proceed subject to the prescribed limitation in years, based on the subject matter and grounds for the dispute.

There are no specific rules of evidence from a procedural and evidentiary perspective; however, a judge will consider any evidence offered by a party while reserving the right to determine its value, veracity and relevance as well as its admissibility into the record. The litigation proceeding in the trial involves the submission of briefs and replies, and the introduction of evi-

dence, including the taking of testimony from witnesses. Appeals are available to non-prevailing parties upon the issuance of a decision at the district court, and then again at the high court for a final appeal at the Supreme Court.

The statute of limitations for commercial contractual disputes in South Korea is generally five years. The limitation on ordinary contracts is ten years. Insurance claims are subject to a three-year limitation from the date a claimant becomes aware of the accident, loss or damages, which is generally the “date of the loss” as reported by the insured and acknowledged by the insurer. South Korean law does not allow for the waiver of an applicable statute of limitation; moreover, it cannot be raised as a defence to the claim.

1.3 Alternative Dispute Resolution (ADR)

It has become more common for parties to a contract to include resolution through amicable discussions prior to any formal dispute resolution being exercised by one party against the other. In lieu of litigation and arbitration, alternative dispute resolution (ADR) mechanisms also exist in South Korea as effective means to resolve disputes on a voluntary basis through mutual agreement before a neutral mediator. The method of conciliation is also used in South Korea and supported by the Civil Conciliation Act which sets out a procedural framework for commercial parties to follow during the dispute resolution process.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Choice of law and dispute resolution clauses are commonly included in insurance contracts with respect to the manner in which a dispute is to be resolved and under which particular law a

contract is to be interpreted. Generally, South Korean courts will uphold such clauses as valid and enforceable pursuant to the agreement of the parties. However, challenges may be made by a party against another party:

- should there be a tenuous or lack of nexus with the venue and/or law;
- should the clause be unconscionable, oppressive or excessively burdensome to a party;
- should the clause be against public policy or morality;
- should the law and/or venue conflict with the local laws/regulations of South Korea; or
- should there be an absence of consent or agreement.

Moreover, a choice of law provision will generally be upheld by the South Korean courts pursuant to Article 25 of the Conflict of Laws Act allowing for the application of either South Korean law or foreign law to govern the contract interpretation or the dispute according to the *lex loci* of the contract. However, certain laws are mandatory and will apply irrespective of a governing law clause that designates the law of a foreign country to a particular issue (eg, antitrust and competition law) in accordance with Article 7 of the Conflict of Laws Act. Notably, a choice of law clause will still be enforceable even in the event that another set of laws exists in another jurisdiction with a more significant nexus to the subject matter of the dispute, pursuant to Article 8 of the Conflict of Laws Act.

2.2 Enforcement of Foreign Judgments

In order to enforce a foreign judgment against a defendant such as a local insurer in South Korea, a petition must be made to the South Korean court that has jurisdiction over the matter, in accordance with the Civil Procedure Act as well

as international treaties on reciprocity such as the Hague Convention.

The prerequisites for an enforcement order to be commenced are:

- a final and binding foreign judgment with no further right to appeal the decision;
- the original jurisdiction of the parties and subject matter of the dispute in question was proper and legal;
- the existence of reciprocal agreements with South Korea for the enforcement of foreign judgments;
- the judgment does not violate the public policy, laws or other moral standards of South Korea, otherwise, the foreign judgment may not be enforced by the South Korean court; and
- a certified translation in Korean must be submitted with the petition so that it can be confirmed that all the terms and conditions and the decision are fully understood by all the parties.

It is cautioned that administrative rulings, criminal matters and other non-commercial judgments or rulings may be subject to additional scrutiny by a South Korean court hearing the enforcement proceeding.

2.3 Unique Features of Litigation Procedure

As prefaced above, South Korea is a civil law jurisdiction where the judicial review of claims is based on written laws and regulations rather than relying upon and referring to case precedents.

Costs Owed by Foreign Litigants

As in other countries, if a foreign litigant files a petition against a local South Korean defend-

ant with a Korean court, the litigant must pay certain court fees for the administration of litigation. In addition, the foreign litigant must pay a stamp duty to the South Korean court, as well as security costs, which is to ensure that claims are made in good faith and to promote an equitable dispute resolution procedure. The costs are calculated as attorneys' fees based on a formula in consideration of the claim amount made in the petition to the court.

Limited Discovery and Pre-trial Procedures

South Korea has limited discovery and pre-trial procedures for the disclosure and collection of evidence in relation to a litigation which is silent in the Civil Procedure Act. The litigants may present evidence directly to the court where the judge(s) will determine its admissibility. If admissible, they will then consider the evidence for relevance and value. Generally, any requests for witness testimony or document requests are made to the South Korean court which will then direct the same and/or compel the other litigant to comply with the court's order (failure to comply may lead to court-imposed fines).

Class Actions

The concept or the procedure to bring a class action in the South Korean courts is not well developed. However, collective actions may be brought in certain areas where plaintiffs who have similar claims may appoint a representative to act on behalf of the claimants. The procedure for class actions was implemented in the Securities-Related Class Action Act as a special act that is a companion to the Civil Procedure Act, which came into effect in 2005 in response to the conduct of large companies in South Korea to the detriment of consumers and investors. In order to be certified as a class action, there must be a minimum number of plaintiffs and an objective threshold for having an interest in the dispute

(eg, the total affected shares as a proportion of all outstanding shares of the litigants). Subsequently, the national assembly pushed forward the Act on the Class Action for the Protection of the Public Interest in 2016, which is a broader law that aims to allow a large number of injured persons to form and be certified as a class, such as in consumer claims in health-related litigation and environmental issues, as well as for welfare issues in South Korea.

Rotation of Judges

The South Korean courts also have a judicial rotation system where judges are assigned to different panels at the Korean courts from year to year in an effort to provide a diversity of cases for judicial review and to promote neutrality and fairness in the litigation process. Each judicial panel, whether comprised of one judge or three judges (see **1.2 Litigation Process and Rules on Limitation**), will be subject to rotation in February of each year depending on the number of years spent in such judicial panel. As a result, a litigation case that spans a number of years may be reviewed by different judges and the judge(s) who heard the case at the commencement of the litigation may not be the same judge(s) at the time the judgment is rendered. The continuity of a single case being heard by different judges due to rotation is maintained in the court record.

Official Language in Court

The official language of South Korea is Korean and this is also the official language of the South Korean court system. Therefore, all cases lodged and heard by the judges in the South Korean courts are administered in Korean. In turn, all oral arguments, pleadings, evidence, requests, closing arguments and all notices and judgments are in the Korean language. Therefore, parties to a contract should consider the efficiency, speed and costs when litigating in

Korean in the South Korean courts, as opposed to fixing the language in an arbitration clause and proceeding under the rules of an international arbitration institute.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

A South Korean court will hold that an arbitration agreement is valid and enforceable subject to the general requirements set forth in the Arbitration Act of South Korea. In enforcing an arbitration agreement, a South Korean court will look at the intent and desire to arbitrate a dispute arising under a contract and the mere existence of an arbitration agreement, although “pathological”, will be upheld as the original intent of the parties, and the manner in which a “pathological” arbitration clause is enforced may default to the Arbitration Act of South Korea. Therefore, parties to a contract should carefully consider and draft an arbitration clause if it is their respective intent to arbitrate disputes, and this should cover the seat and venue of the arbitration, the rules of arbitration to be applied, the number of arbitrators, the language to be used, etc.

3.2 The New York Convention

South Korea agreed to the New York Convention in 1973 in order to have reciprocal arrangements and to establish the country as a commercial hub for foreign investors into South Korea, as well as to provide comfort and clarity on the rule of law and enforcement of judgments for South Korean investors in other countries through the promotion of international arbitration.

South Korean courts will generally enforce foreign arbitral awards in accordance with the New

York Convention, unless it is found that enforcement of the judgment violates public policy or there are procedural issues that would make enforcement inappropriate. Enforcement actions continue in the South Korean courts and notably, a number of foreign judgments were ruled unenforceable over the past year, in particular where enforcement of interim measures conflicted with local laws or rules, including the Arbitration Act.

3.3 The Use of Arbitration for Insurance Dispute Resolution

The preferred dispute resolution method in South Korea remains litigation in the courts, especially between insureds and insurers. However, arbitration agreements have been negotiated and made part of reinsurance agreements, slips, etc, especially between local South Korean insurers and foreign reinsurers. Given this change in contract drafting with respect to dispute resolution, a number of insurer-reinsurer disputes have taken place or are pending at this time over both coverage matters as well as other technical aspects in dispute.

The rise of arbitration cases to resolve insurance and reinsurance disputes is attributable to a number of reasons:

- reinsurance contracts are often concluded on a cross-border basis;
- one party wishes to resolve the dispute in a foreign language other than Korean and/or to use a more universal language and/or to avoid costly charges for translation and interpretation; and
- the parties wish to present and argue the merits of the case before an expert panel of arbitrators with significant history and experience in the insurance industry or with technical/scientific backgrounds.

As a result, while many arbitrations involve insurer-reinsurer disputes, those that are arbitrated often involve complex coverage disputes in property insurance falling under the local “Package Insurance Policy”, engineering claims, professional liability and others. However, many claims relating to the foregoing continue to be litigated in the South Korean courts.

In insurance and reinsurance disputes, the parties frequently refer to and select the rules of leading arbitration institutes such as the Singapore International Arbitration Centre, the International Commercial Court and the Korean Commercial Arbitration Board.

Arbitral awards are binding, final and confidential.

4. Coverage Disputes

4.1 Implied Terms

Pursuant to the Korea Commercial Code (KCC), certain terms and conditions may be implicitly read into an insurance contract, especially when the insured is a consumer for whom the terms cannot be altered or modified to the detriment of the insured. Additionally, the Financial Consumer Protection Act and the Standardised Contracts Regulation Act serve as critical sources of insurance law, which imposes various obligations on insurers to ensure fairness in the execution and application of insurance contract terms and conditions.

In the event that an insurer receives a portion or all of the insurance premium at the time an insurance application is provided by a policyholder/insured, the insurer must notify the applicant of its underwriting decision to accept or reject the risk within 30 days (unless otherwise agreed). In

addition, if the insurer fails to provide a response within this period, the insurer is deemed to have accepted the insurance risk as provided for in the application.

Once a policyholder has entered into an insurance contract with an insurer, the policyholder must pay the insurance premium (either the total insurance premium payable or as a first instalment) without delay. In the event that a policyholder fails to pay the premium and does not remedy the failure within two months from the date of the insurance contract, the contract will be deemed to have been cancelled (unless otherwise agreed by the parties).

In addition, if a policyholder or an insured fails to disclose any material facts, intentionally makes misrepresentations at the time the insurance policy is executed, or engages in acts of gross negligence, the insurer can terminate the insurance contract within one month from the date on which the insurer becomes aware of such facts, or three years from the execution date of the insurance contract.

During the insured period, a policyholder/insured must immediately notify the insurer of any material changes to any risk they become aware of, or the occurrence of an accident. Otherwise, the insurer may terminate the insurance contract within one month from the day on which the insurer becomes aware of such fact.

At the inception of the insurance contract, the insurer must explain important clauses of the insurance contract (eg, insuring clauses, exclusions and termination provisions); otherwise, such clauses may be deemed unenforceable against the insurer. This requirement applies equally to insurers transacting with corporate insureds and individual insureds. South Korean

courts frequently apply the rule of *contra proferentem* in disputes against insurers when policy wording is unclear and/or ambiguous in favour of the insured.

Under the Standardised Contracts Regulations Act (SCRA), a standard form contract must:

- be construed impartially in accordance with the principles of trust and good faith;
- not be construed differently for different customers who are similarly situated; and
- be construed in favour of the customer if the wording of the contract is unclear or ambiguous.

4.2 Rights of Insurers

There are a number of protections afforded to insurers during the solicitation, application and underwriting phases. According to the KCC, certain circumstances may render an insurance contract void from inception; that is, void *ab initio*.

As explained in Article 644 of the KCC, in the event that the occurrence of an accident is based on a risk or that which is incapable of materialising, the insurance contract will be null and void based on the fundamental and universal requirement of any insurance product (Article 644 of the KCC). Additionally, where there is no insurable risk at the time of execution of the insurance contract, then it will also be viewed as null and void. However, this rule is inapplicable if the insurer and the insured are unaware of the foregoing facts and/or circumstances. Additionally, where a loss occurs prior to the effective date of the insurance contract, then the insurance contract will not cover the loss and the insurer has no liability to the insured.

Pursuant to Article 669 of the KCC, if insurance premiums are substantially more than the amount of risk insured (ie, expansive, unnecessary or duplicate coverage) as a result of fraud by, or intentional misconduct on the part of, the insurer or its agent, the insurance contract will be considered void.

In addition to the exceptions listed above, Article 103 of the Civil Act may also render an insurance contract void. Previously, a Korean court ruled that if an insured entered into several insurance contracts intending to receive multiple payments from insurance proceeds for the same single loss, this constituted fraud with an element of unjust enrichment.

Consequently, insurers have protection under the KCC to void insurance contracts entered into based on fraud, incomplete information and non-disclosure.

4.3 Significant Trends in Policy Coverage Disputes

In 2023 and 2024, a number of trends materialised in relation to coverage matters which may lead to disputes between and among insureds, insurers and reinsurers, as well as third parties.

Recently, several large claims arising from incidents such as fires, explosions, natural disasters, flooding, product recalls and product liability, and other significant accidents have led to disputes in South Korea such as the following:

- differences in the scope of coverage, which also relate to the interpretation of the insuring clauses and exclusions;
- questions surrounding the cause of the alleged accident leading to the acceptance or rejection of a claim;

- application of “other insurance” provisions and determination where other insurance exists and should be applied, or to exhaust any other coverage that may exist, or be primary to other existing insurance;
- the exhaustion of primary coverage or other layers of liability before seeking indemnification;
- scrutinisation of the insurable interest relating to the loss being claimed;
- the method of dispute resolution;
- inadequate notification to insurers/reinsurers and the timing thereof; and
- coverage disputes due to difference in contracts where the insurance and reinsurance may not be “back to back” in terms of terms and conditions.

4.4 Resolution of Insurance Coverage Disputes

There are number of methods for the resolution of original insurance coverage disputes in South Korea.

Original insurers will engage in direct negotiations with insureds as a preliminary procedure for the resolution of a coverage and claim dispute. The Financial Supervisory Service is also authorised and has a complaints procedure, as well as mediation as a method of dispute resolution, which will generally involve consumer-facing claims and those of smaller claim amounts, but in any event this is non-binding. The Korea Insurance Development Institute (KIDI) also has an arbitration system for insurance claims related to technical matters, as well as those relating to actuarial issues. Nevertheless, the most common dispute resolution forum in an adversarial proceeding is the Korean court.

In regard to disputes between original insurers and reinsurers, the parties will make attempts to

resolve the dispute outside of a formal dispute resolution procedure. Historically, most insurer-reinsurer disputes were brought to the South Korean courts with the original insurers making demands to have all disputes brought before the court. However, there is now a trend where insurers and reinsurers resort to arbitration, especially where a local insurer and a foreign reinsurer in South Korea are involved, or a dispute has arisen pursuant to a cross-border reinsurance transaction.

See also **1.1 Statutory and Procedural Regime** and **1.3 Alternative Dispute Resolution (ADR)**.

4.5 Position If Insured Party Is Viewed as a Consumer

Consumer Protection

Generally, South Korea has a strong emphasis on consumer protection across all financial services, including insurance. The government has established robust consumer protection laws concerning the solicitation and sale of insurance products. An example of the degree to which the South Korean government seeks to protect its citizens as consumers is evident in the SCRA, which ensures the fairness and suitability of standard insurance contracts. In addition, the recent Financial Consumer Protection Act (FCPA) introduces further protections for consumers and is designed to protect the rights and interests of financial consumers by following principles and obligations under the FCPA such as: the principle of suitability and appropriateness; the duty to explain important terms and conditions; prohibition of unfair business practices, unlawful solicitation activities, and false and misleading advertising; and the provision of all relevant financial product documents, among others.

It is also noted that an original insurer may be viewed as a “consumer” of reinsurance, which also provides protection to the insurer from any improper conduct that disadvantages or harms the insurer. However, there is some ambiguity in the application and criticism thereto as a transaction between an insurer and a reinsurer is viewed to be between sophisticated companies that do not warrant the protection afforded under the FCPA.

Remedies

Individual consumers who have purchased personal lines insurance such as life, automobile, or certain health insurance, have the right to seek remedies under their insurance contracts through the civil courts in South Korea. In addition to litigation, consumers may file grievances and claims directly with the Financial Supervisory Service as in **4.4 Resolution of Insurance Coverage Disputes**. Consumers may also file grievances and claims with the KFTC.

4.6 Third-Party Enforcement of Insurance Contracts

Statutory Right of Direct Action

Against an insurer

Pursuant to the KCC, third parties have a statutory right to pursue direct actions against an insurer without first filing a claim against the insured. However, when calculating the quantum of damages in a third-party claim, the court does not take into account the terms of the insurance contract between the insurer and the insured. As clarified by the Supreme Court of South Korea, an insurer may still assert any defences against a third-party claimant that the insurer would have had against the insured under the terms of the insurance contract. This statutory right of direct action promotes fairness, efficiency and convenience for individuals who have suffered property damage or personal injuries caused by

the insured through a procedural mechanism for insured parties to seek redress directly against and from the insurer.

Against a reinsurer

In South Korea, an insured generally does not have the same direct right of action against a reinsurer as it does against an insurer, unless there is a specific arrangement or agreement (eg, a cut-through clause) that provides for such right in the reinsurance contract. A cut-through clause allows the insured to directly make a claim against the reinsurer if the primary insurer becomes insolvent or fails to meet its obligations. Such clauses are uncommon in standard reinsurance contracts, which typically bind only the insurer and the reinsurer. In the absence of a cut-through clause, there is no privity (direct legal relationship) between the insured and the reinsurer, thereby prohibiting any direct action by an insured directly against a reinsurer.

The reinsurance framework in South Korea follows global standards where the reinsurer’s obligations are primarily to the insurer, and not to the insured, unless a special arrangement (cut-through clause) is made. Courts and regulations in South Korea reinforce this principle, emphasising the contractual nature of the reinsurance relationship.

If exploring a specific scenario where this might come into play, it would depend on the terms of the reinsurance agreement and any relevant case law on the matter in South Korea.

4.7 The Concept of Bad Faith

In South Korea, the legal concept of “bad faith” does not exist in law as it does in other countries; however, according to the Civil Act, the concept of “bad faith” is often raised in the context of obligations and contracts. While the term itself

may not be explicitly stated in any statute, the principle can be found in various articles related to contracts and obligations to be performed by a party. There is no clear definition of “bad faith” in law; however, reference is made to Article 748 of the Civil Act which provides that where a person is enriched through their bad faith, then they must return the benefits received by them together with interest, and if another party suffers any damages as a result of said bad faith, then compensatory damages must be paid to that party as well.

In general litigation, when bad faith actions and conduct are introduced in court, these may influence the court and its ruling. South Korean courts are conscious of and will consider any acts of dishonestly or abuse when ruling on a case, which may affect damages, remedies or even the validity of certain claims.

4.8 Penalties for Late Payment of Claims

As a matter of general application, a statutory interest of 5% per annum accrues on a simple basis for the period during which the claim remains unpaid, starting from the date the claim was submitted to the insurer until the date the payment is made. Unlike other jurisdictions where insurers may remain “off the hook” for late payment interest if a reasonable amount of time is taken to conduct loss adjustment, there are no similar rules under South Korean law that apply specifically in determining liability for interest accrued on payment of insurance proceeds. Even if there is any policy wording which may provide for a reasonable period of loss adjustment during which no interest will accrue until the time where the final amount due has been determined, it is advisable for insurers to still make payment of the minimum amount payable under the prevailing circumstances, notwith-

standing the validity and application of any such contractual provisions.

Therefore, the customary practice in South Korea for claims processing and payment of insurance proceeds is for the insurers to make an initial payment of a non-controversial amount that they are comfortable with (together with statutory interest) to at least stop the clock on interest over a significant portion of the total claim that the insurers might ultimately agree they are liable for, followed by an upward adjustment once the loss adjustors’ final report has been issued and the amount is conclusively determined.

4.9 Representations Made by Brokers

In South Korea, insurance brokers are typically appointed by insureds seeking coverage for their business. The relationship between the broker and the insured is governed by the terms of the broker agreement and the broker owes a duty of loyalty to its client as an insured of an insurer. In cases where representations made by the broker are false, mistaken or inaccurate, it is not common for the insured to pursue a claim against its broker for professional liability on the grounds that an error and/or omission has occurred. The concept of errors and omissions is not widely recognised in the insurance industry and marketplace in South Korea and such claims are therefore infrequent.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In South Korea, claims handling is considered a “core function” of a licensed insurer and reinsurer which must be performed by the insurer or reinsurer itself. In principle, the claims-handling function should not be delegated to a third party, although a licensed attorney is permitted to handle claims in South Korea on behalf of an insurer. However, any delegation or outsourcing

of the claims function would be in violation of the Insurance Business Act, as the licensed insurer or reinsurer should handle claims in its own right, as well as a violation of the Attorney Act for the unlawful practice of law.

Nevertheless, insurers (and reinsurers) may utilise the services of a claims adjuster or a loss adjuster to assist in the investigation of a claim. It may also review the coverage terms and conditions and make findings and conclusions to the claim. However, the claims decision – as to whether to accept or reject the claim, as well as to make a decision on the amount and payment of the claim – must only be made by the insurer (or reinsurer).

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

As a preliminary matter, an insurer must defend a claim in accordance with Article 720 of the Commercial Code of South Korea and the obligations under a liability insurance policy. The duty to defend is triggered by the filing of a claim for the insured or it may be made by a third party against the insurer, which requires the insurer to provide a defence by covering the costs for attorneys' fees, court costs, stamp duties and all other related costs typically known as loss adjustment expenses. Insurance cases in which an insurer is required to defend its insured often arises in third-party claims against the insured for property damage and personal injuries.

In South Korea, the duty to defend requires payment based on law and, in contract, it frequently involves property claims.

5.2 Likely Changes in the Future

The number of disputes is increasing, despite the fact that many disputes are not initiated by claimants for various reasons, including the decision not to pursue litigation or other dispute resolution options. Against this backdrop, third-party funding (TPF) may be a way to pursue remedies and damages for claimants while minimising the financial burdens and risks involved when engaging in disputes.

TPF in disputes refers to a third party providing financial support to a party involved in a legal dispute or litigation. The third party receives a portion of the awarded damages or settlement if the case is successful. However, if the case is unsuccessful, the third party loses its money. In this sense, TPF reduces the financial burden on the parties involved and enables them to commence or resolve legal disputes.

There is no framework for TPF mechanisms in South Korea; however, TPF does exist, even though it is not frequently utilised. One of the main reasons for the lack of clarity and ability to utilise TPF is due to the application of the Attorney Act of Korea which prohibits the receipt of legal fees and awards for damages by non-lawyers. On the other hand, there is a movement to systemise and create a framework, including a body of law, to govern TPF in South Korea. This is driven by the desire to create an international hub in Northeast Asia utilising the Korea Commercial Arbitration Centre to help facilitate the administration of cross-border disputes and keep pace with global trends, as countries such as Singapore, Hong Kong and the UK already have a more active TPF market. Given the foregoing, there may be further discussions and debates in South Korea relating to TPF from a judicial, legislative and political perspective.

5.3 Trends in the Cost or Complexity of Litigation

Claims litigation costs have increased, driven by expenses related to attorneys, investigations, experts, appraisers and other considerations. However, the total costs for claims handling, including attorneys' fees in relation to the defence and other disputes involving insureds, insurers and reinsurers, have increased overall in the last year. Technology, financial and cyber-related claims have all increased, as have motor claim expenses due to the rise in the number of automobiles purchased in the past year. Moreover, claims disputes now require additional costs and expenses related to confirming or negating cause, interpretation of policy wording such as insuring clauses and exclusions, and other novel issues, such as number of occurrences (ie, one occurrence versus multiple occurrences), etc. In addition, increased claims costs are also attributable to the recently implemented accounting standards under IFRS 17 and K-IFRS in 2023, requiring more market-consistent valuations and affecting how insurers calculate their liabilities, which has led to stricter accounting practices and claims-handling practices for insurers.

5.4 Protection Against Costs Risks

Protection for defence costs, legal expenses and similar costs is permitted in South Korea; however, this is not widely used and the penetration rate for such cover remains low. The specific product for such protection is known as legal expense insurance (LEI).

LEI covers the cost of legal advice, representation and litigation, and is designed to protect individuals and businesses from the high costs associated with and incurred in legal disputes for both plaintiffs and defendants. In particular, LEI provides cover for court costs, attorneys' fees, expert witness fees, and other litigation-related

expenses, regardless of whether the insured is prosecuting or defending the case.

Judgment preservation insurance has also been introduced into the South Korean market. This is a specialised insurance product that protects the value of a judgment rendered by a court or a settlement by the parties in favour of a plaintiff. The insurance product is typically purchased personally by individuals or by companies that have won a dispute pursuant to an order or an award and wish to preserve the value of the award, and ensure that it is not reversed, reduced or modified. It is understood that judgment preservation insurance is sold on a cross-border basis.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Paying a claim pursuant to an insurance contract gives the insurer subrogation rights to make a claim against a third party. Rights in subrogation automatically arise in favour of an insurer by operation of law and no formal assignment or agreement is necessary to claim them. However, in the event that an insurer does not pay the full amount of the claim to the insured, any rights the insured holds against the third party will take precedence over any subrogation rights in favour of the insurer.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The right to subrogation exists in Article 682 of the Commercial Act, which states that "in the event that a loss has occurred due to actions by a third party, an insurer which has paid the insured amount shall acquire, to the extent of the amount paid to the insured. Also, the rights of the insured against a third party; provided,

however, that if the insurer has paid the insured amount as insurance proceeds in part, then the insurer may exercise such rights in so far as the rights of the insured are not prejudiced.”

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

In South Korea, several factors have affected insurance-related litigation in recent times. The post COVID-19 pandemic period has seen an increase in insurance claims related to business interruption as well as business failures, health insurance, and travel disruptions. Many companies commenced or defended disputes over coverage and claims, as insurers and insureds argued over the interpretation of policy terms and coverage limits. Additionally, the pandemic brought about an increase in employment-related disputes due to furloughs, lay-offs, and changes in working conditions. As a result, insurers have plans to add “infectious diseases” as a business interruption cover to compensate for losses.

Other global economic challenges and fluctuations, exacerbated by the pandemic and geopolitical tensions, have impacted litigation especially in commercial insurance sectors for both insurers and insureds. The global supply chain disruptions due to geopolitical events have led to an increase in disputes over contractual breaches and insurance claims related to cargo and logistics in the face of political unrest around the world, sanctions and other consequences. Additionally, the rise of digital technologies has also influenced litigation, with new products and technologies putting contract wording to the test, as underwriters and claims professionals did not anticipate including claims related to

cybersecurity, data breaches, and infringement or misappropriation of intellectual property.

At the same time, property claims have become more frequent, with larger losses due to natural disasters, floods, fires, etc. The large number of claims has forced insurers to consider the ongoing offering of certain types of coverage for property insurance.

7.2 Forecast for the Next 12 Months

The frequency and cost of claims continue to increase due to political, economic, social and environmental factors.

However, insurers have not been significantly or negatively impacted by recent events in South Korea; rather, the insurance industry has remained strong without any decrease in premiums. Brokers as well as agents have made adjustments to leverage alternative insurance distribution channels, including through innovative insurtech products, websites, mobile apps, and other digital platforms. As a result, the insurance industry in South Korea has largely managed to sustain and mitigate the potential adverse effects of recent events around the world.

Additionally, increasing focus on digital products, new investment opportunities, environmental sustainability and climate change will likely lead to more litigation related to environmental regulations, insurance claims for climate-related damages, and corporate responsibility issues.

7.3 Coverage Issues and Test Cases

The defence to the performance of a contract for *force majeure* with respect to indemnity was tested in the South Korean courts, but no legal precedents resulted in new legal standards. In

respect to COVID-19 death claims, the South Korean courts did clarify that the pandemic did not result in an “accident” covered by a personal accident insurance contract. Moreover, no business interruption claims involving COVID-19 were confirmed.

7.4 Scope of Insurance Cover and Appetite for Risk

In particular with property claims in the South Korean insurance market, the severity, volume and amount of damages related to property claims in 2023 and 2024 forced insurers to cease the sale of property insurance products, which has impacted some of the leading insurers in the South Korean market. However, other insurers have made the decision to broaden coverage with higher premiums, introduce new insurance products and to aggressively market alternative insurance products for protection.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

In response to the increasing frequency of disaster risks, including pandemics, cyber-attacks and climate change, there have been ongoing discussions involving the insurance industry, non-government organisations, and the South Korean government. These discussions are focused on addressing the need for insurance coverage to manage unforeseen risks and gaps.

Environmental Impairment Liability Insurance

South Korea is currently among the ten worst countries in terms of carbon dioxide emissions, contributing significantly to the global carbon footprint. In response to government mandates, environmental impairment liability insurance has been mandatory for applicable businesses since

1 July 2016. This coverage addresses most pollution-related risks but has not been thoroughly tested concerning commercial activities linked to carbon emissions and the greenhouse effect, due in part to a lack of conclusive scientific evidence and specific fault attributable to individual insured parties. As the debate over global warming continues on the global stage, it is anticipated that claims will eventually be made against large companies that contribute to climate change, especially in light of South Korea’s commitment to achieving net-zero emissions by 2050 under the Framework Act on Low Carbon Green Growth.

ESG-Related Insurance

As part of South Korea’s environmental, social, and governance (ESG) agenda, insurers have taken preliminary steps to address climate control issues from the boardroom to their underwriting practices.

For example, many South Korean insurers have introduced eco-friendly car insurance included in the Electric Vehicle Battery Guarantee programme, which guarantees the amount of depreciation that comes at a great cost to consumers in the case of damage to the battery of an electric vehicle, and the Electric Vehicle Self-Accident Guarantee, which guarantees injuries sustained by the insured due to electric shock and fire accidents. KB Sonbo has developed the “Step Discount Special”, an eco-friendly health-care special offer that takes into account the health and environmental protection of customers and offers a 3% discount on auto-insurance premiums for a limited number of insured persons who have achieved their daily goal through a step measurement programme recognised by the insurance company, within 90 days of the date of the insurance subscription. The special agreement is that it has met the needs of con-

sumers who have reduced their use of public transportation due to COVID-19. Other local South Korean insurers have also created new insurance programmes for ESG-related risks.

8.2 Data Protection Laws

Data protection laws continue to be strict and stringent, and local insurers and reinsurers are marketing cybersecurity insurance policies. However, this insurance product has not been purchased widely and even when procured has not been tested, despite the risks and vulnerabilities in South Korea with respect to data breaches, cyber-attacks, ransomware, etc. In fact, certain local insurers have made management decisions to reduce capacity or withdraw the sale of cybersecurity insurance policies in South Korea. In addition, with the growing AI industry around the world, new and varied risks will arise challenging underwriters, as well as claims personnel, to deal with novel claims that may alter policy wording as well as premiums.

Over the course of 2023–2024, a number of cyber-related incidents occurred such as:

- ongoing ChatGPT phishing scams;
- an alleged North Korean cyber-attack on the Korean Internet & Security Agency (KISA);
- ransomware attacks on hospitals across the country;
- data breaches at various local banks;
- acts of cyber-espionage involving South Korean military defence contractors; and
- disruption of online classes due to cyber-attacks at universities.

It is inevitable that the recent events cited will force insurers and their underwriters to re-design insurance policies to address the changing risks.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

A number of current events and developments have led to changes in laws and regulations in South Korea. Some of the new legislation that will impact insurance coverage and potential claims disputes is set out below.

Tax Reform Legislation

On 31 December 2023, South Korea enacted the 2024 Tax Reform legislative bill effective on 1 January 2024. This comprehensive tax reform introduced updates to international tax compliance requirements aligned with the OECD Guidelines; adjustments for entities involved in overseas expansion and investments; and new regulations for stock-based compensation filings for corporations. The contingent risk exposure raises issues with respect to potential D&O claims made by shareholders against directors and officers of companies who may engage in poor management and bad decision-making in relation to overseas expansion and investments. It may also expose insurers to claims for warranty and indemnity insurance for unknown or undisclosed tax liabilities subsequent to the closing of a cross-border transaction.

Personal Information Protection Act (PIPA)

South Korea has also enacted significant amendments to the Personal Information Protection Act (PIPA), effective 15 March 2024. The revisions introduced stricter consent requirements for personal data collection, a mandatory 72-hour breach notification, and expanded individual rights such as data portability. They also impose more severe penalties for non-compliance and enhanced guidelines for cross-border data transfers, while introducing new rights for data

subjects, stricter requirements for Chief Privacy Officers (CPOs), and enhanced obligations for data processors regarding overseas transfers and liability insurance. In the event of wrongful disclosures of personal information and/or subsequent data breaches, the underwriting of cybersecurity policies as well as any liability insurance may be re-defined according to the amendments to PIPA.

Recent Regulatory Developments Introduced by the FSC

In addition, recent regulatory developments on network separation deregulation in the financial services sector, introduced by the Financial Services Commission (FSC) in August 2024 (as discussed in **8.2 Data Protection Laws**) will have a profound impact on insurance coverage, litigation and claims. The introduction of the regulatory sandbox for Generative AI and cloud-based applications (“SaaS”), alongside the processing of pseudonymised personal information, provides insurers with opportunities to adopt innovative technologies in the claims handling and underwriting process. However, this also introduces new types of risks and liabilities, and insurance coverage may need to evolve to address potential issues including cybersecurity, data breaches or system failures. Insurers may face claims related to the performance or shortcomings of AI systems and cloud-based services, which will affect coverage and litigation strategies. In the event that, as planned by the FSC, regulatory exceptions are expanded to per-

mit the direct processing of non-pseudonymised personal credit information in the coming year, insurers will be required to implement additional security measures. This transition could result in significant changes to data management and risk assessment processes, increasing demand for coverage related to sensitive credit information, including data breach and cybersecurity insurance. Insurers may also encounter legal challenges concerning the adequacy of security measures, potentially leading to disputes over compliance with evolving regulations. Insurers may face claims related to the performance or shortcomings of AI systems and cloud-based services, which will affect coverage and litigation strategies.

ESG Regulations

In regard to environmental and other ESG regulations, the Ministry of Environment and the FSC have launched ESG initiatives aimed at strengthening regulations around sustainable practices and addressing greenwashing. The government is considering mandating companies to disclose corporate governance reports and sustainability reports, which is planned to be implemented sequentially starting in 2026 (the exact timeline is still undecided). It is expected that non-compliance could result in D&O claims lodged by shareholders against corporate leaders, including directors and officers, for failing to meet ESG compliance standards and making poor governance decisions.

Trends and Developments

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Dentons Lee is a South Korean law firm that has evolved since its inception in 1961 from an intellectual property-focused services firm into a full-services law firm with 60-plus lawyers based in Seoul who complement the Dentons global network of officers and legal professionals. The firm has a diverse roster of exceptional attorneys and other legal professionals to represent and advise clients in complex disputes in South Korea and abroad in litigation cases as

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SOUTH KOREA TRENDS AND DEVELOPMENTS

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DENTONS **LEE**

Introduction

The insurance industry in South Korea, as with all other major global insurance markets, remains in the “hard market” cycle which has persisted for several years. While there is speculation that a “soft market” is looming, this may not take full effect in 2025. This is evident with local insurers and global reinsurers in the insurance market who have strengthened and tightened underwriting practices and standards with increasing premiums and reduction in capacity, resulting in a less competitive environment and fewer discounts, benefits or other financial incentives for those who purchase insurance, both for commercial and personal reasons, as it correlates with higher frequency of claims, reduced profits and other external political, economic and social factors – all of which are also currently true in South Korea.

As mentioned above and in this background to 2024, there are a number of trends in relation to contentious matters involving insurers, reinsurers, policyholders and insureds, as well as third-party claimants, that occur in the South Korean insurance market. The following are a number of significant trends and developments that have recently come to the fore in South Korea.

Increase in Property and Casualty Claims

The increase in the number of insurance claims is symptomatic of all insurance markets, and South Korea is no exception. In South Korea, insurers have experienced rising claims across all lines of business with the key metric of the “loss ratio” increasing, based on higher amounts of claims paid with adjustment expenses against premiums earned.

The Financial Supervisory Service (FSS) which acts as the “executive arm” of the Financial Services Commission in South Korea also monitors

claims activities for all licensed insurers and has stated that the number of insurance claims has gradually increased in recent years across all insurance product types. The number of life insurance claims, as well as those arising under health and accident insurance policies, has also steadily increased in recent years according to the FSS. The Korea Insurance Development Institute (KIDI) has also compiled data that translates into an annual increase in claims volume of 8% to 10% per annum in key insurance products in South Korea.

Given the rise in insurance claims, insurers have considered and continue to consider the rising claims per line of business, which has led to some insurers reducing capacity, reducing underwriting or withdrawing from certain lines of business as a countermeasure.

Electric Vehicles and Lithium Ion Batteries

The modern-day boom of electric vehicles (EVs), given state-of-the-art technology and increasing consumer and commercial consciousness of the environment and the need to reduce the global carbon footprint of traditional automobiles, has also led to an increased number of fires or thermal events occurring in vehicles. In turn, the insurance industry has responded to numerous claims under property insurance policies, product recall insurance policies, electrical energy storage system insurance policies and others.

EV owners in South Korea have also experienced dangerous thermal events across the country. In particular, approximately 77,000 Hyundai Kona EVs were recalled globally and in South Korea so that the lithium ion battery packs could have battery management system updates and software updates. Hyundai Automobile and LG Chem along with LG Energy Solution investigated these thermal events. In addition, similar “ther-

mal events” have occurred and been reported in the General Motors Bolt make and model. Fires have also been reported in other EVs, such as Tesla’s Model S and Model X electric vehicles, which experienced “thermal runaway” events due to rapid heating within the batteries. Most recently, in August 2024, a Mercedes-Benz EQE sedan which was parked and in idle mode exploded in an underground parking lot in the city of Incheon, leading to a fire that damaged an additional 140 vehicles with 40 of them completely burned as a total loss. The explosion and subsequent fire also caused a power outage for approximately 480 households in neighbouring apartment buildings, and 23 people were hospitalised due to smoke inhalation, including children and firefighters. Mercedes-Benz and the local South Korean authorities are investigating the event, which involved an EV with batteries manufactured in China by Contemporary Amperex Technology Co, Ltd.

The lithium ion battery market in South Korea is comprised of three leading manufacturers – LG Chemical and now LG Energy Solution (a spin-off of LG Chem), Samsung SDI and SK On. In response to these fire events, lithium ion battery manufacturers continue their respective research and development into lithium ion battery cells, electric vehicle battery packs, the operation of EVs, etc. Currently, the cause of the fires (known as thermal events and thermal runaway events) has still to be confirmed, with disputes arising between and among EV owners, EV manufacturers and their insurers and reinsurers.

Fires have also ensued in electrical energy storage facilities in South Korea. In response, the insurance industry has developed and now offers electrical energy storage systems coverage and products (“EESS Insurance”). EESS Insurance provides protection to facilities that store energy

for later use, in particular with renewable energy applications, to address the supply and demand for energy. Generally, EESS Insurance is comprised of coverage components for property damage, business interruption, liability insurance and cybersecurity insurance. Similarly, the fire events in electrical energy storage facilities have been investigated, but questions remain as to the cause of the fires occurring at such facilities. The demand for clean energy will continue to grow and the insurance market continues to offer coverage options, while also managing the claims that have been made.

Directors’ and Officers’ Liability

Over the course of the past few years through to 2024, directors’ and officers’ insurance claims have been covered under the financial lines insurance products, which is attributable to a number of factors.

Firstly, there is increased and heightened “shareholder activism”, from ordinary shareholders through to institutional investors, holding corporate leaders and management accountable for decisions made in relation to corporate governance, environmental issues, as well as mergers and acquisitions. A number of factors have contributed to this heightened awareness and aggression on the part of investors. Secondly, the South Korean government has strengthened its regulatory oversight over large conglomerates commonly referred to in Korean as “chaebol” companies, targeting non-compliance with laws and regulations as well as acts of malfeasance in the business practices and decisions made by directors and officers of the company. Thirdly, as in many other countries, investors now demand that the board of a company places key decisions on environment, social and governance (ESG) matters at the company on the agenda of meetings. In doing so, shareholders’ suits also

reflect the trend that South Korean companies must implement and at least keep pace with the rest of the world with respect to ESG activities, including management of climate-change risks, non-compliance with environmental laws/regulations, and issues that involve employee labour disputes.

A number of key directors and officers (D&O) claims have materialised and been lodged against insurers. A data centre owned and operated by Kakao suffered from a large fire in 2022 leading to countrywide service outages on multiple Kakao platforms, including KakaoTalk (the messaging app), KakaoPay (the payment services app) and others, which in turn created critical interruptions for many South Koreans.

A D&O claim was lodged against the directors and officers of Kakao alleging negligence in their corporate fiduciary duties by failing to implement and operate proper back-up systems, disaster recovery protocol and mitigation procedures. The underlying claims leading to the D&O claim were the result of damages suffered by users and third parties made against Kakao. In another case, as a consequence of the merger between Korean Air and Asiana Airlines, the directors of Hanjin Group (the parent company of Korean Air) faced controversy, criticism and a host of lawsuits claiming that competition would be reduced due to the merger of the two large commercial and passenger airlines, to the detriment of consumers. Allegations were also made against the directors of Korean Air for poor decision-making and mismanagement, and they attracted a fierce regulatory review by the Korea Fair Trade Commission, as well as strong opposition from international stakeholders. It is believed that their D&O insurance will need to cover legal expenses and liabilities amounting to tens of millions of dollars.

Along with other D&O claims being made by investors and shareholders with subsequent claims being made to D&O insurance carriers, other broader implications may follow. It is inevitable that there will be heightened regulatory scrutiny of corporate governance, especially for those companies engaging in energy, infrastructure, technology and other industries with a broad reach in the public sector, in addition to having a direct impact on the private sector. Moreover, with the increase of D&O claims and the impact and severity of same, regulatory reform and legislation will continue to keep regulatory authorities and lawmakers active in addressing such issues in South Korea.

Warranty and Indemnity Insurance Claims

Insurance brokers and insurers have faced challenges in the sale of warranty and indemnity (W&I) insurance in South Korea due to the lack of deals, the lack of awareness of sellers and buyers on the benefits and protection of W&I insurance coverage, and the local commercial culture of securing indemnities in lieu of insurance to cover breaches of representations and warranties in stock purchase agreements. However, the market has further developed, with many transactions looking to W&I insurance to smooth out deals and to provide post-closing protection to buyers based on such representations and warranties. The leading brokers for W&I insurance have recently reported that there have been more M&A transactions in 2024 as compared to 2023. In addition, a number of claims have been made against insurers for losses under W&I insurance contracts. One emerging trend due to failed acquisitions by South Korean investors, has been a more cautious approach to M&A on a cross-border basis due to risks, such as capital costs, economic uncertainties and geopolitics, while inbound investments by minority interests have noticeably increased.

Coverage Interpretation in Differences in Contract

In South Korea, disputes may arise due to the interpretation of policy wording in reinsurance contracts which, in principle, should be “back-to-back” with the underlying insurance contract. However, certain contributing factors have led to disputes over differences in contract, also known as “DIC”.

One of the unique challenges faced by foreign reinsurers in South Korea is cultural and language issues. Insurance contracts, claims information and documents, as well as claims reports, adjuster’s reports, and investigative reports including government documents are typically prepared in the Korean language with another version of the same document in English or other foreign languages of countries that have a globalised economy such as that of South Korea. Ultimately, DIC and disputes will arise due to policy wording leading to misunderstandings and misinterpretations where terms are “lost in translation”. As a result, a growing number of insurance contracts, reinsurance contracts, reinsurance slips, etc, are prepared in English to avoid disputes regarding the original intent of the parties.

The main guidance in interpreting insurance contracts is provided in the Insurance Business Act and the Civil Act which are also supported and confirmed by judicial decisions in South Korea. The principles of contract law apply to insurance contracts. The laws stipulate that the parties to a contract, including insurance contracts, must act in good faith and deal fairly with one another, and judges will seek to apply the literal and/or plain meaning interpretive principles based on the express language of an insurance contract. Moreover, the courts will seek to broaden coverage in favour of the policyholder or insured on

the basis that the insurance was procured and purchased for the benefit of insurance coverage, without unfair and undue disadvantages being imposed by insurers. The foregoing rules continue to be cited and followed by the courts in South Korea in 2024.

Reinsurance Claims and Disputes

Jurisprudence in South Korea recognises the principles of “follow the fortunes” or “follow the settlement” in which a reinsurer is liable to the ceding insurer for reinsurance proceeds as long as the underlying insurance claim was paid within the “four corners” of the insurance contract. Nevertheless, challenges to the foregoing may be made by the reinsurer and upheld by a court or an arbitration panel if the insurance proceeds were paid outside of the insurance contract, for bad faith, fraud, where an ex gratia payment was made or where there are violations or breaches pursuant to the reinsurance arrangement and other special facts or circumstances. There is a history of cases in South Korea where the courts have ruled in favour of the insurer based on the foregoing rules and principles, which are consistently applied in insurer and reinsurer disputes.

Presently, there are a number of such disputes which challenge the “follow the fortunes” and “follow the settlement” principles as interpreted and enforced by the South Korean courts, which may or may not lead to a different interpretation and application of same, especially when a large portion of the ultimate financial responsibility is with the reinsurer and not the insurer. For example, there are ongoing differences in opinion in the interpretation of claims co-operation clauses in reinsurance contracts and to what extent and degree “co-operation” is necessitated for compliance with the obligations to perform under the contract.

Notably, it is also evident that arbitration dispute resolution mechanisms have been more prevalent given the rise of insurer-reinsurer disputes with international arbitration institutions. This is likely the result of foreign counterparties such as reinsurers seeking an allegedly more neutral venue, having a panel of insurance and industry experts, avoiding voluminous and arduous translation work should the language of the dispute resolution be fixed (eg, English), seeking a speedier resolution as opposed to a long drawn-out trial in the courts, as well as cost savings, since all evidence must be submitted in Korean in the South Korean courts.

SPAIN



Law and Practice

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B&A, Blanco y Asociados Abogados

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B&A, Blanco y Asociados Abogados was founded in Madrid in 1987. It provides legal services throughout Spain and specialises in insurance law on industrial risks and corporate civil liability. Its professional services are usually employed for the filing of insurance claims, which is one of the firm's specialties. Its professional services are also usually employed for judicial claims of controversial incidents involving large insurance risks. A significant part

of the judicial proceedings the firm handles require a deep knowledge of civil and commercial law in general and insurance law in particular, as well as extensive experience in procedural law in courts of justice and arbitration proceedings. The firm's activities also include regulatory (both in relation to insurance companies and insurance brokers) and litigation in all lines of insurance.

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Fernando Blanco Giraldo is the founding partner of B&A, Blanco y Asociados Abogados and head of the insurance law department at the firm. He is one of the most renowned

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Fernando Blanco Gamella of B&A, Blanco y Asociados Abogados has more than ten years of experience combined with extensive knowledge in insurance law and civil liability.

He is well known among leading insurance companies and policyholders as he has handled several matters abroad in the UK and Latin America related to civil liability, defective products, construction and D&O, including mediation on international issues. He has extensive experience in the courts in the civil, criminal, labour and administrative divisions and in the instance courts, appeal courts and Supreme Court. He is also frequently employed to adapt international policy wording to Spanish local regulations and to represent international companies that haven't got representation in Spain before the courts.

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BLANCO
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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

As far as insurance is concerned, there are several regulations that are relevant. The main regulation is Law 50 of 1980 dated 8 October 1980 on insurance contracts, which regulates the content of the contract itself and the relationship between the insured party and the insurer. It contains a set of general provisions that all insurance contracts must comply with and also deals with the main lines of insurance that operate in the market.

In terms of regulations that affect insurance companies and insurance mediators there are also multiple rules. Two in particular are worth highlighting. The first is Law 20 of 2015, dated 14 July 2015, which covers the regulation, supervision and solvency of insurance and reinsurance companies. It also regulates the activity of national and foreign insurance companies. The second is Royal Decree Law 3 of 2020, dated 4 February 2020, which transposes EU Directive 2016/97 of the European Parliament and of the Council, dated 20 January 2016, on insurance distribution into Spanish law.

As in other jurisdictions, insurance contract disputes are often settled through judicial or arbitration proceedings. Judicial proceedings can be pursued in different jurisdictions: civil, criminal, social and contentious-administrative, depending, of course, on the nature of the dispute in question. Each of these jurisdictions has different procedural regimes. Law 1 of 2000, dated 7 January 2000, on civil procedure is relevant for matters not stipulated in other specific procedural laws.

There are also different types of courts. These are the first instance, instruction, courts of appeal (provincial courts, high courts of justice in some cases) and, as a last resort, the Supreme Court. The Supreme Court only handles cases of great technical complexity. To refer a case to the Supreme Court, the contentious matter must have cassation interest or involve the case deviating from the applicable case law.

1.2 Litigation Process and Rules on Limitation

Civil Proceedings

The litigation process depends on the relevant jurisdiction. In the civil jurisdiction, all litigation begins with a statement of claim in which the identification details and circumstances of the plaintiff and the defendant and the domicile or residence where they can be summoned must be stated, the facts and legal grounds must be numbered and set out separately, and the details of the request must be clearly and precisely stated.

Once this has been done, the court will admit the claim and transfer it to the defendant so that within 10 or 20 days (depending on the type of trial) he/she may proceed to reply to the claim. The court then sets a date for the pre-trial hearing (at which the evidence to be presented at the trial is proposed, as well as other formalities such as the possibility of making complementary allegations, providing new documentation, etc). Finally, a date is set for the trial at which the proposed evidence is presented and each party then has time to present their conclusion of the evidence and the law applicable to the case.

Once the trial has ended, the judge issues a judgment. The average duration of a civil procedure in the first instance is usually between 10 and 36 months from the filing of the claim until

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the judgment, depending on the location of the court and the workload pending. This judgment can be appealed before the court of appeal (a *audiencia provincial*) and then potentially the Supreme Court if the requirements are met.

In insurance disputes with large financial claims (the so-called large risks) knowledge of procedural law and the strategy to be developed is essential, so the professional experience of a firm is logically a highly valued asset. It is simply a matter of professional solvency.

Criminal Proceedings

In terms of criminal proceedings, the procedure begins with a complaint or a criminal lawsuit in which the plaintiff sets out the facts that he or she considers to constitute criminal offences. The investigating court (*juzgado de instrucción*) is responsible for investigating the facts. Once the investigation phase has concluded (generally a maximum of 12 months, although it can be extended), the judge decides whether or not to prosecute the person under investigation.

At this stage, the opinion and allegations of the public prosecutor's office are usually considered. If the judge considers that the facts constitute a crime and that the proceedings carried out prove that it was committed by the person under investigation, the judge issues what is known as an "accommodation order" and all the investigation proceedings are transferred to the criminal court (which is a different body from the previous one) in charge of holding the trial and issuing a judgment, or to the provincial court, which is a collegiate body, depending on the offence. The ruling issued can be appealed potentially all the way to the Supreme Court.

Judicial Proceedings in Labour Cases

Judicial proceedings before the labour jurisdiction require an initial attempt at conciliation between the parties and if there is no agreement, the judicial process can be initiated. Once the claim has been filed and prior to the trial, a new act of conciliation is attempted, this time in the court itself, and if there is no agreement, the trial proceeds. The trial is verbal, with evidence being taken in it and the conclusions being presented.

The ruling is issued in the following five days (normally it is issued sooner than this) and, as in the other jurisdictions, it can be appealed before the High Court of Justice and potentially all the way to the Supreme Court.

Contentious-administrative Proceedings

As far as the contentious-administrative jurisdiction is concerned, the judicial procedure is very similar to the civil procedure, although in this case the administrative file is of particular importance. It should be remembered that all proceedings before the contentious-administrative jurisdiction result from a previous process that has been followed by the injured parties against the corresponding administrative authorities (local councils, tax authorities, etc).

The procedure is initiated with a notice of the contentious-administrative appeal (this is the name given in this jurisdiction to the first document filed), at which point a file number is assigned and the corresponding public body is notified so that within 20 days it can deliver the entire administrative file. Subsequently, with all the documentation, the corresponding lawsuit is filed. The rest is similar to the procedure in the civil jurisdiction.

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Limitation Periods

The limitation periods depend to a large extent on the action being brought. The general time limit for an insured party to bring an action against their insurer is two years from the date of the loss for non-life insurance and five years for personal insurance under Article 23 of the Insurance Contract Act.

For matters not expressly regulated, for example, when the insurer compensates the insured party and is subrogated in its position to exercise recovery actions against the third party that effectively caused the damage, the action will be time-barred depending on the action in question (five years for contractual actions and one year for non-contractual actions).

The limitation period in traffic accident actions is one year after the injured party has reached a stable condition (ie, the extent of any permanent injuries is known).

1.3 Alternative Dispute Resolution (ADR)

During the course of 2023, the Spanish courts issued more than 5,600 judicial decisions involving insurance policies.

There are legal mechanisms for the resolution of conflicts between insurers and insured parties and these are always aimed at complementing judicial proceedings. These mechanisms consist of submitting the parties to arbitration procedures or civil or commercial mediation procedures.

In addition, insurance companies are obliged to attend and resolve the complaints and claims that the policyholders, insured persons, beneficiaries, injured third parties or rightful claimants may file, but these must always be related to their legally recognised interests and rights with-

in the policy contracted. For these purposes, the entities must have a customer service department or service in charge of attending to and resolving complaints and claims. Of course, this service has to be independent and external from the insurance company.

However, it should be noted that, particularly in the case of large claims, arbitration is a solution that is rarely used, with companies preferring to resort to judicial proceedings. This is because the leading insurance law specialists either work for insurance companies or for companies, which is understood to compromise their impartiality.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

The Insurance Contract Law is mandatory and is the basic regulation of the contract. However, in the case of so-called large risk insurance, the voluntary regulation that the parties consider appropriate may be applied preferentially because for this type of contract the Insurance Contract Law is not mandatory.

In terms of jurisdiction, Article 22 of the Organic Law 6 of 1985, dated 1 July 1985, on the judiciary, states that in insurance matters, the Spanish courts will be competent when the insured party, policyholder or beneficiary of the insurance has their residence in Spain. The insurer may also be sued before the Spanish courts if the damaging event occurs in the Spanish territory and it is liability insurance or insurance relating to real estate. In civil liability insurance, the Spanish courts are also competent to hear the action brought by the injured party against the insured by virtue of the provisions on non-contractual obligations.

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In addition, in other types of actions in which insurance policies may be affected, we must be aware of the type of action that is intended to be exercised. The Civil Procedure Law establishes in general terms that the judge competent to hear any matter will be from the defendant's residence. Failing that, those who do not have a habitual residence or residence in Spain may be sued in the place where they are within the national territory or in the place of their last residence in it and, if jurisdiction cannot be determined in this way, in the place of the plaintiff's residence.

Likewise, companies will be sued, in general, where they have their registered office. In the event that the insurer is domiciled outside of Spain, EU Regulation 1215/2012 of the European Parliament and of the Council dated 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters applies.

2.2 Enforcement of Foreign Judgments

According to Article 36 et seq of EU Regulation 1215/2012 of the European Parliament and of the Council on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, judgments given in a member state that are enforceable in that member state will also be enforceable in the other member states without the need for a declaration of enforceability. Therefore, judgments of the member states are directly enforceable in Spain. This is directly applicable to all judgments affecting insurance companies.

Similarly, court decisions from Denmark, Iceland, Norway and Switzerland are also enforceable in Spain by application of the Council Decision of 15 October 2007 on the signing, on behalf of the Community, of the Convention on Jurisdiction

and the Recognition and Enforcement of Judgments in Civil and Commercial Matters (Lugano Convention).

In relation to third countries (non-EU members), the Hague Convention or, alternatively, the "exequatur" procedure regulated in Law 29 of 2015, of 30 July 2015, on international legal co-operation in civil matters, may be applicable.

2.3 Unique Features of Litigation Procedure

One of the major problems we encounter when litigating in Spain on behalf of foreign entities relates to representation. In order to litigate cases involving EUR2,000 or more in Spain, insurers must have the representation of a representant (*procurador*) and a lawyer. This requirement must be met by both natural persons and legal entities.

The representant is the person who exercises the procedural representation of the litigants and they must have a power of representation issued by the person or persons who have, within the organisation, the authority to grant and guarantee the powers of representation.

In many cases, this task is complex, as insurers have internal structures with a different distribution of power and competences and, in many cases, finding the right person can be an arduous and laborious task. In any case, a law firm with procedural experience has sufficient power models in favour of the representant to appear in court on behalf of the party that appoints them.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Spanish courts and tribunals may enforce all awards rendered by arbitrators at the request of one of the interested parties. In this regard, commercial insurance and reinsurance contracts usually include dispute resolution clauses of various kinds, the most frequently used being submission to the competent courts and tribunals. The contracts also include the possibility of the parties submitting to arbitration proceedings for the resolution of disputes, although this option is usually less common and only applicable, in any case, to non-life insurance.

If the parties submit themselves to arbitration, the courts will refuse to hear these disputes. Once the arbitral award has been issued, courts will only hear the case where the rules of the arbitration procedure have been infringed, excluding the hearing of the substance of the matter resolved by the award, which is not appealable.

3.2 The New York Convention

In 1977, Spain signed the Instrument of Adherence to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards, signed in New York on 10 June 1958. The purpose of the Convention is to promote the extraterritorial enforcement of arbitral awards, and it has currently been endorsed by more than 159 countries.

In this sense, the jurisdiction to enforce arbitral awards belongs to the courts of first instance of the place where the award was issued, with the procedure being initiated by one of the parties through a claim for enforcement, attaching the enforceable title, the arbitration agreement

and the documents proving that the award was duly notified to the parties. This procedure concludes with the corresponding judicial ruling on enforcement, as if it were a normal judgment. The enforcement of awards is usually admitted without objection by the courts.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Spain is a country where litigation is becoming the most common way to resolve disputes. Arbitration is becoming the second most common way to resolve disputes. However, these procedures tend to be more expensive (depending on the amount claimed) but also don't last as long.

There are some insurance companies that frequently submit to arbitration procedures for the resolution of disputes. This includes those involved in credit insurance, where the contracting parties are exporters, distributors or companies.

While various arbitration institutions have attempted to promote its use in the field of insurance in recent years, the truth is that its use is limited. On the other hand, it must be assumed that the Spanish Arbitration Law regulates this procedure, based on the fact that natural or legal persons may submit the contentious issues, by prior agreement, to the decision of one or more arbitrators.

Arbitration is a form of single instance dispute resolution (some arbitration courts unusually established double instance procedures in which appeals were possible). The possibility of appealing an arbitration award in Spain is very limited, the only possible means being those indicated in Article 43 of the Arbitration Law on annulment action and review action.

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In terms of the first option, this type of action can only be carried out if the arbitration procedure has breached procedural rules to resolve the disputed issue. The review action is limited to the options established by Article 510 of the Civil Procedure Law.

This covers when the award has been issued, decisive documents are recovered or obtained that could not have been available due to force majeure or due to the actions of the party in whose favour it had been issued, if the award was issued based on documents that one of the parties was unaware of at the time of its issuance that they had been declared false in a criminal proceeding, or whose falsehood was later declared criminal.

In short, the judicial review of awards is restricted and is usually difficult for the competent courts to accept.

4. Coverage Disputes

4.1 Implied Terms

Spanish case law states that in accordance with the rules of interpretation of contracts, the real or effectively intended will of the parties must be sought. To this end, the literal meaning, as a criteria for interpretation, is the initial assumption, insofar as it constitutes the starting point from which meaning is attributed to the statements made, the specific intention of the contracting parties is investigated and the business purpose projected in the contract is adjusted or delimited.

When the terms are clear and leave no doubt about the intention of the contracting parties, the literal interpretation prevents, under the pretext of the interpretative work, a declaration that

is really clear and precise from being modified. This is the response of the rule contained in the first paragraph of Article 1281 of the Civil Code (“if the terms of a contract are clear and leave no doubt about the intention of the contracting parties, the literal meaning of its clauses will be followed”).

On the contrary, literal interpretation also helps to show that contracts, due to their lack of clarity, the existence of contradictions or gaps, or the conduct of the contracting parties themselves, contain interpretable provisions, so that the work of interpretation must follow its course, with the criteria for interpretation at its disposal (Articles 1282 to 1289 of the Civil Code), in order to provide those provisions with a meaning in accordance with the intention really desired by the parties and with what is imperatively provided for in the contractual order.

Notwithstanding the above, the Insurance Contract Law grants the parties the freedom to agree on the content of the insurance that they consider appropriate in everything that does not oppose what it determines as minimum content. For example, with regard to fire insurance, it states that “fire is considered to be the combustion and burning with flame, capable of spreading, of an object or objects that were not intended to be burned at the place and time in which it occurs”, which logically requires that damages due to explosion or others must be included in the coverage by the will of the parties, as they are outside the legal concept of fire.

4.2 Rights of Insurers

The policyholder must, before the conclusion of the insurance contract, submit to a rigorous insurance questionnaire in which they must declare all the circumstances known to them that may influence the assessment of the risk.

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They will be exonerated from this obligation if the insurer does not submit a questionnaire to them or when, even if it is submitted, the circumstances are involved that may influence the assessment of the risk and are not included in it.

In this regard, the insurer may terminate the contract by means of a declaration addressed to the policyholder within a period of one month, counting from the time it becomes aware of the policyholder's reservation or inaccuracy in the questionnaire. The insurer will be entitled, unless there is fraud or gross negligence on its part, to the premiums relating to the period in progress at the time of making this declaration.

It should be added that the application for insurance does not bind the applicant, but if the insurance is proposed by the insurer, the insured party is bound by this proposal for a period of 15 days. By agreement of the parties, the effects of the insurance may be retroactive to the time when the application was submitted or the proposal was made.

4.3 Significant Trends in Policy Coverage Disputes

Since the COVID-19 crisis began in 2020, some lines of business such as healthcare, travel and event cancellation, or credit insurance, among others, have been seriously affected with a corresponding increase in claims.

Business interruption insurance has also been affected. This is not yet entirely evident, but we believe that in the coming months we are likely to see an increase in claims. However, given the time elapsed and the limitation periods for the exercise of actions, with the exception of some very high claims filed by large companies, it is not foreseeable that there will be a significant

deviation in claims from the usual pre-COVID-19 parameters.

In contrast to the above, it is possible that in the coming months there will be an increase in claims against D&O insurance due to the possible worsening of the economy. The more deteriorated a company's profit and loss accounts become, the greater the risks that corporate managers will have to take, and D&O insurance is famously the type of insurance where the effects of ill-considered corporate risk-taking are most keenly felt.

4.4 Resolution of Insurance Coverage Disputes

Disputes related to insurance contract coverage are usually settled by the courts of the insured's residence. In the case of disputes concerning the interpretation of certain policy clauses, disputes are usually settled in the first instance by the civil courts. Disputes arising from reinsurance contracts are settled in the same way.

4.5 Position If Insured Party Is Viewed as a Consumer

In Spain, policyholders, who are individuals, are usually considered consumers and the vulnerable party in the contract. For this reason, if at any time there is a dispute regarding the interpretation to be given to any clause of the policy, this should always favour the insured, considering the circumstances of the case.

Furthermore, the Insurance Contract Law is drafted precisely to protect the contracting consumers, with various provisions being more favourable to them than to the insurance companies. Article 3 of the Law is a clear example: "The general conditions of cover which in no case should be prejudicial to the insured, must be included by the insurer in the proposal form if

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there is one and in any event in the policy documents or in a supplement, which shall be signed by the insured to whom a copy shall be given. The general and particular conditions shall be drafted in clear and precise terms. Those clauses limiting the rights of the insured shall be plainly marked and specifically accepted in writing.

The general conditions of the contract are subject to supervision by the Public Administration in the terms set forth in this Act.

If the Supreme Court declares that a particular clause in the general conditions of a contract is null and void, the competent Public Administration shall take steps to oblige all insurers to modify identical clauses contained in their own policies.”

4.6 Third-Party Enforcement of Insurance Contracts

Circumstances of a third party enforcing an insurance contract or suing an insurer in connection with an insurance contract primarily arise in civil liability insurance. At this point it is important to highlight the importance of Article 76 of the Insurance Contract Law, which states: “The prejudiced party, or their heirs, shall have direct action against the insurer in order to demand compliance with the obligation to indemnify, without prejudice to the right of the insurer to re-claim against the insured in the event of the damages to the third party being due to the fraudulent conduct of the insured. The direct action is immune to the exceptions which the insurer may have against the insured. The insurer shall have the right, however, to oppose the action by alleging the exclusive blame of the prejudice party and the personal exceptions that the insurer has against the latter. In order to exercise the direct action, the insured shall be obliged to inform the prejudiced third party or

their beneficiaries of the existence of the insurance contract and its contents.”

Any injured party can therefore claim directly from the insurer of the person or persons who caused the damage without it being necessary to sue them as well.

The situation in which a third party can sue an insurer is a frequent scenario in our jurisdiction. Let us think of any action or omission that causes bodily or property damage to a third party. That third party can, by virtue of the damage caused, file a claim for non-contractual civil liability against the person who caused the damage and his insurance company, or simply against the latter.

4.7 The Concept of Bad Faith

Article 7.1 of the Spanish Civil Code states that rights must be exercised in accordance with the requirements of good faith. Extrapolating this precept to Article 19 of the Insurance Contract Law, the legislator established that: “The insurer shall be obliged to pay the indemnity, except when the loss has been caused in bad faith by the insured.”

This concept of bad faith has been interpreted by the Supreme Court in the sense that bad faith is “the malicious intention to cause damage contrary to law,” so “what is relevant is that it must be a conscious and voluntary act of the insured. It must be an intentional and malicious act of the insured.”

4.8 Penalties for Late Payment of Claims

There are no administrative sanctions specified in Spanish insurance legislation, although for unjustified delay in the payment of compensation, Article 20 of the Insurance Contract Law

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requires insurers to pay interest for each day of delay.

In this regard, it is understood that the insurer delays if it has not paid the compensation within three months from the date of the loss or if it has not paid the minimum sum that it knows is owed within 40 days following receipt of the notification of the loss.

Compensation for delay will be imposed at the request of the court and will consist of the payment of interest equal to the legal monetary interest in force at the time of accrual and will be increased by 50%. The interest is considered to be accrued daily without having to be claimed judicially. However, if two years pass from the date of the loss, the annual interest may not be less than 20%.

Judicial proceedings are usually long and, in many cases, from the time the loss occurred until the first instance court judgment is issued, could take between 15 and 24 months or more, so that, taking into account the amounts claimed, the interest payable under Article 20 could lead to significant amounts being owed.

4.9 Representations Made by Brokers

The statements made in the insurance questionnaire by the broker or insurance company about the risk to be insured are not binding on the policyholder. In this sense, Article 10 of the Insurance Contract Law states that the insurer may rescind the contract by means of a declaration addressed to the policyholder within one month from the date on which the insurer becomes aware of the non-disclosure or inaccurate representation by the policyholder.

The statements are always from the policyholder themselves, so the broker cannot replace them

unless they have a special power of representation, which is unusual.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Insurance companies usually manage claims internally for medium and large risks. In mass risks, there are usually delegated authorities for the management of the files, as occurs with the management of policy underwriting where insurance agents are involved.

In recent years we have seen an increase in the type of organisations that offer multidisciplinary services to insurance companies in claims management until they are brought to court, at which point they are normally managed by law firms that specialise in the matter.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Civil liability insurance includes coverage for legal costs, whether in the civil or criminal jurisdiction, although in the latter case compensation for damage is also claimed by the injured third party in the process. Financing includes payment of the costs of the process to the losing party, in which case the insurer also pays the legal costs incurred by the winning party in the procedure.

5.2 Likely Changes in the Future

The problem with civil liability insurance is that the assumption of legal costs is required by law, so it is unclear if this will change in the coming years. In addition, due to the competition that exists in the market (especially in relation to some insurance lines such as D&O or professional civil liability), entities have been increas-

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ing coverage and limits with lower premiums for years, creating an intrinsic risk for this type of policy. However, this trend has ceased post COVID-19 and the attitude of companies is to increase premiums with less coverage.

In the coming years, the entry of litigation funds willing to acquire litigation and assume the costs of the most expensive processes allows us to foresee a significant increase in litigation.

5.3 Trends in the Cost or Complexity of Litigation

Legal costs in Spain depend on the economic value of the dispute. Years ago, bar associations in Spain issued Guiding Fee Criteria that lawyers took into account when billing for their services in court. These Criteria are for guidance purposes only and may be modified by the competent judges who hear the matter.

In terms of the complexity of litigation in the insurance field, more and more types of coverage are available on the market due to the circumstances of a constantly changing market, which require greater specialisation that will possibly also extend to the judicial world, as the complexity of the policies and the most important claims is increasing.

5.4 Protection Against Costs Risks

The Spanish market offers legal defence insurance, where the insurer undertakes, within the limits established by law and in the contract, to cover the costs that the insured party may incur as a result of their intervention in an administrative, judicial or arbitration procedure and to provide them with the judicial and extrajudicial legal assistance services derived from the insurance coverage (Articles 76(a)-(g) of the Insurance Contract Law).

This type of insurance has some requirements that differentiate it from other insurance, such as:

- it must be the subject of an independent contract or may be included in a separate chapter within a single policy, in which case the content of the guaranteed legal defence and the corresponding premium must be specified;
- the insured party will have the right to freely choose the representant and the lawyer who will represent and defend him/her in any type of procedure; and
- the insurance excludes coverage for the payment of fines or sanctions.

Of course, there are also the agreements that can be adopted with litigation funds, which is already a reality that will foreseeably increase.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Article 43 of the Insurance Contract Law states that the insurer after paying the compensation will be entitled to exercise the rights and actions that by virtue of the loss belonged to the insured party against those persons liable for the loss, up to the compensation amount limit. The insurer will not be able to exercise those rights that have been subrogated in prejudice of the insured party. The insured party will be responsible for those prejudices that, by his acts or omissions, have been caused to the insurer in his subrogation rights.

The insurer will also not have the right of subrogation against any person whose acts or omissions give rise to liability on the part of the

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insured party, in accordance with the Law, nor against those who caused the loss and are, with regard to the insured party, a direct relative or a collateral relative within the third civil degree of consanguinity or adopted parent or adopted child that lives with the insured party. This rule will have no effect if the liability arises from bad faith or if the liability is covered by means of an insurance contract. In this case, the subrogation will be limited in its scope in accordance with the terms of the contract.

In the event of the insurer and the insured party concurring against the third party liable for the loss, the amounts recovered will be shared between them in proportion to their respective interests.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The regulation of the right of subrogation to claim the damage caused by a third party is regulated by Article 43 of the Insurance Contract Law. In this case, the insurer has to base its claim on having paid the compensation to the insured party, thereby providing all of the respective rights.

The case law has established a series of requirements for the insurer to be able to exercise the recovery action. These are:

- the existence of an insurance contract;
- the reality of a loss covered by the contract;
- the effective payment, sufficiently accredited, of the compensation that corresponds to the insured, in accordance with the contract; and
- the direct liability of a third party, against whom the repetition action is exercised, which in turn requires the causal relationship between the action of the third party and the loss (that is to say, based on the existence of

a claim of the insured against the third party liable, as a consequence of the same damage that gave rise to the indemnity).

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Following COVID-19, Spain was largely paralysed, like most EMEA territories. The Spanish government implemented a series of measures to totally or partially restrict the movement of people throughout the territory, both national and foreign. In addition, the government paralysed businesses of all kinds, affecting all sectors of economic activity in the country (industrial, services, etc).

Due to the drastic drop in economic activity, the loss rate fell in all lines of insurance, with the direct effect being a decrease in litigation at all levels. Over the course of 2022 and 2023, activity has been recovering and the number of litigation cases has increased proportionally.

7.2 Forecast for the Next 12 Months

In 2024, economic activity has fully recovered in some sectors, while others remain at pre COVID-19 levels. Some of the sectors that are still at pre COVID-19 levels are the construction, artistic and recreational activities or agriculture sectors, while the industrial, tourism or services sectors have rebounded compared to the years before the pandemic. This data confirms a possible trend to know where more claims may be generated and, therefore, an increase in litigation, although there is usually no direct correlation.

We expect an increase in litigation for 2025, although it will be contained and depending on the insurance line in question. We expect a

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slight increase in vehicle insurance or construction, while the forecasts in other sectors such as healthcare remain the same.

7.3 Coverage Issues and Test Cases

Litigation, and insurance litigation in particular, is very common in Spain. According to Ministry of Justice statistics, more than 5,600 judgments were issued in all jurisdictions on matters related to insurance contracts last year. For this reason, there is no specific factor that will significantly cause an increase in litigation as a result of coverage problems. The Spanish system normally protects consumers, so they submit coverage problems to the competent courts.

7.4 Scope of Insurance Cover and Appetite for Risk

There are certain risks that are not usually insured in the local market (food industry, waste treatment, etc) so their outlook has not changed for some time. On the other hand, after COVID-19 there has been an increase in claims in certain sectors, so there has also been a considerable increase in premiums (D&O and cars in particular). At the same time, there are lines such as cyber-insurance where insurance coverage is increasingly reduced. Even so, premiums tend to remain high due to the risk associated with this type of cover.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

ESG factors currently significantly influence the underwriting and litigation of insurance risks. Environmental risks, such as climate change and natural disasters, directly impact insurers when adjusting premiums or even denying coverage to companies with a substantial environmental

impact, although the Spanish Insurance Compensation Consortium compensates for damages caused by natural disasters (earthquakes, tidal waves, extraordinary floods, volcanic eruptions etc) and other force majeure events (terrorism, rebellion, sedition).

Social factors, such as poor labour practices, are under constant and detailed scrutiny by insurers. Companies that do not demonstrate a solid commitment to these best practices may face serious issues in securing insurance.

How a company is managed and operated with criteria such as transparency and ethics is fundamental. Poor governance may indicate potential legal risks.

These factors also affect litigation trends, with an increase in claims related to natural disasters and social responsibility. Insurers are becoming increasingly cautious about underwriting companies exposed to such risks due to the potential legal issues and lawsuits that may arise.

8.2 Data Protection Laws

Data protection laws are increasingly influencing the underwriting and litigation of insurance risks. Insurers, brokers and companies in general must comply with various regulations related to the collection, use, and maintenance of personal data, which directly affect their risk assessments and potential pricing adjustments. Compliance with these obligations involves investment costs that may be passed on to the insured party.

Non-compliance with these regulations is leading to significant legal actions and high fines. Non-compliance can affect the coverage provided by insurance companies as well as the management of claims.

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Another relevant aspect is data security breaches or misuse of data, which is a fundamental issue that companies must address in their policies, implementing changes in insurance terms or premiums.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

There have been no major regulatory changes in the insurance sector in recent years. The last legislative amendment affecting the sector was to Royal Decree-Law 3 of 2020, dated 4 February 2020, which amended the Insurance Distribution Law. The amendment came into force on 20 March 2024.

However, there has been a profound legislative amendment in relation to the Civil Procedure Law that affects all types of actions (summons, appeals, how to draft claims, etc) This directly affects any insurance litigation as the Civil Procedure Law affects all types of actions in the civil jurisdiction.

Trends and Developments

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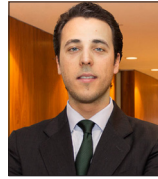
SPAIN TRENDS AND DEVELOPMENTS

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Trends and Evolution of the Insurance Sector in Spain

The current insurance landscape in Spain reflects a significant transformation in the sector, which has been influenced by technological, economic and regulatory factors.

When it comes to technology, the emergence of AI, blockchain and predictive analytics is changing how insurers operate. These tools enable more accurate risk assessment and improve operational efficiency, especially in claims processing and service customisation.

We have also seen how the implementation of new regulations, such as in terms of environmental, social and governance (ESG), has gained prominence, grouping the most relevant non-financial factors of a company into these three areas. The objective, in principle, is to direct the operations of insurance companies towards greater sustainability, consumer protection and fair competition in the market.

Customer orientation and personalisation are becoming increasingly crucial. Insurers aim to offer products tailored to the individual needs of customers, thereby improving their experience and responding to the day-to-day activities that need to be insured in order to provide greater security and peace of mind to policyholders and, therefore, to society as a whole.

Insurers in Spain are evolving rapidly thanks to technological advancements, new regulations and a complex macroeconomic environment. These trends are redefining the way insurers manage risk and operate in the marketplace.

As is always the case, these changes are being reflected in the design of products and the way insurers and other players in the sector operate.

However, it will still take time for these changes to reach insurance litigation in Spain and while we are beginning to see a small shift in extrajudicial claims and the courts, it is certainly still timid.

We will therefore address several issues that are relevant in the courts in Spain or that deserve, due to their relevance, to be analysed in this chapter.

Unit-linked Life Insurance

Unit-linked life insurance has gained popularity in Spain as a savings and investment product. This type of insurance combines life coverage with investment in a variety of financial assets, allowing policyholders to benefit from market returns.

Unit-linked insurance is life savings insurance, where the funds constituting the insurance premium are contributed by the policyholder but are invested, in the name and on behalf of the insurer (which, in most cases, enters into a contract with an insurance agent acting as intermediary or manager), in financial assets, with the policyholder bearing the investment risk. Its main characteristics are as follows.

- **Flexibility:** these products are basically the same as a mutual fund portfolio. The policyholder can adapt the investment to the market conditions at the time by establishing the investment term, the value of the premium, the hedges and the investment itself. Sometimes, the unit-linked type of insurance underwritten involves entrusting the management of this investment to a professional manager who carries out the investments in accordance with the investment strategy previously established by the policyholder on a

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form that he/she fills out at the time of taking out the insurance policy.

- Liquidity: the policyholder can redeem the policy whenever it is needed.
- Risk assumed by the insured: unlike other savings insurance policies that guarantee a minimum return, in unit-linked policies the return depends on the performance of the chosen assets.
- Taxation: as an investment and savings product, capital gains from unit-linked insurance are taxed as savings income and it is possible to defer taxation in the area of personal income tax to the moment in which a redemption is made or the occurrence of the open contingency takes place. In addition, if the beneficiaries are different from the policyholder, the capital will be subject to inheritance and gift tax, which is subsidised in some cases in some autonomous communities.
- It is not part of the inheritance in case of death: you can choose who will collect the insurance if you die, and it may not be your heirs. In fact, this product has traditionally been used to direct money to people who were not the protected heirs. This is one of the most attractive features of this type of insurance and has allowed policyholders on many occasions to have the freedom they long for in the family sphere and give their money to whoever they deem appropriate and not who the Spanish Civil Code states.

However, despite the fact that these insurance policies offer numerous advantages, their concept and essential characteristics have not caught on with policyholders who, when their investment or savings expectations are dashed, take legal action claiming, in most cases, nullity of the investment due to error or lack of consent or, alternatively, termination of the contract due to breach of contract.

Claimants often also argue at first that the product underwritten is a life insurance policy. It is argued that the policies in question do not meet the requirements for a life insurance contract and it is generally asserted that the existence of an investment or savings cannot be associated with the nature of life insurance. One of the criticisms expressed is that there should be no transfer of risk. However, this is a transfer of investment or savings and not a transfer of risk.

This issue has already been resolved by the Spanish Supreme Court and by the European Union Court of Justice who have confirmed that the unit-linked insurance contract is a fully valid life insurance policy.

A unit-linked product is a life-savings insurance product. Although it may resemble a financial product, it is a life insurance contract and therefore has the same characteristics and elements as life insurance.

Article 83 of Law 50 of 1980, of 8 October 1980, on insurance contracts states: "Through life insurance, the insurer undertakes, through the collection of the stipulated premium and within the limits established in the Law and in the contract, to pay the beneficiary a capital sum, an income or other agreed benefits, in the event of death or survival of the insured, or of both events jointly."

The parties to unit-linked insurance are, as in any other life insurance, the policyholder, the insured party and the beneficiary. The only difference to other life insurance policies is that the premiums paid for this type of insurance are invested in mutual funds or baskets of mutual funds and, as anticipated, the policyholder assumes the investment risk. When the insured event occurs (death or survival), the policyholder

either decides to surrender the insurance, or the policyholder or beneficiary does not receive an indemnity corresponding to the amount determined when the policy was taken out, but rather the value of the policy at that moment (which will obviously depend on market fluctuations).

In short, unit-linked life insurance offers significant advantages in terms of flexibility and profitability potential, but it also carries certain risks. The key to avoiding legal claims is to ensure clear and transparent communication about the concept, risks and features of the product, as well as providing appropriate advice that aligns with the client's profile and expectations.

Vaccination and Informed Consent on Adverse Effects

Spanish Supreme Court case law limits the position of the insurance company in healthcare insurance contracts. It has determined that the insurance company is not a mere intermediary between the doctor and the insured party but a guarantor of the service. This means that the contract is not only limited to covering the damage caused to the insured party when he has to assume the costs for the restoration of his health but is aimed at providing the health services included in the policy through doctors, clinics and adequate facilities.

The benefit the insurer is obliged to provide in healthcare insurance is, therefore, a service to be provided, consisting of rendering a medical, surgical or hospital service when requested by the insured party. The Supreme Court has ruled on this matter on several occasions and determined that the insurer is obliged to ensure not only that a health service is provided but also that the performance of the services by the centres or professionals is adequate.

Applying this to the context of vaccinations provided for in the vaccination schedules of minors and as a result of some relevant resolutions, it is worth asking whether there is any requirement for coverage to be effective in the context of Spanish case law where the parents of the minor are not informed of the adverse effects of these vaccines.

Article 8 of Law 41 of 2002, of 14 November 2002, on patient autonomy establishes that any action in the field of a patient's health requires the patient's free and voluntary consent. In the case of minors, this consent is given by "representation". The majority doctrine agrees that written informed consent is not necessary for paediatric vaccination.

In terms of the content of this information, it seems logical to think that it should include complete and understandable verbal or written information on the vaccines that their children can receive, including all authorised and indicated vaccines, whether they are financed by the national health system or not and on the benefits and risks of vaccination, non-vaccination, frequent or infrequent side effects, and how to deal with them. This would make it possible to express doubts and ask for additional information in order to be able, finally, to give free consent on the acceptance of the proposed vaccinations.

However, the Supreme Court has ruled on this issue on several occasions and determined that with regard to financed vaccines and vaccination campaigns, it would be sufficient to inform verbally about the mild consequences, duration and palliative measures, as well as the typical risks (see, among others, the judgments of 25 March 2010, 10 November 2011 and 2 January and 30 January 2012). The Supreme Court has

stated that “the duty of information cannot be understood as generic or in terms of hypothetical probability, nor does it cover the requirement of excessive and disproportionate information with the curative or preventive purposes of medical science, such as that relating to non-normal risks, not foreseeable according to the medical literature, or based on specific characteristics of the individual, which previously could not have been manifested as relevant or susceptible to a medical assessment”.

However, there are other courts that initially did not follow the jurisprudential line of the Supreme Court. They considered that when the risk is so “particularly serious, even if it is an atypical risk because it is infrequent” there is a duty to inform (see the judgment of the High Court of Castilla-León, 2 January 2012), but this opinion has recently changed.

The High Court of Justice of Castilla-León itself in its recent ruling of 8 February 2024, accepts the reasoning of the Supreme Court against its own 2012 ruling and states that only frequent and general adverse effects must be reported and not infrequent ones, no matter how serious they may be.

It therefore seems that in a case in which one of these infrequent but possible adverse effects manifested itself after a vaccination, we would not be faced with a case of defective performance of the healthcare service due to lack of information.

It seems therefore that both the Supreme Court and the other courts, at the moment, are clear – there is an obligation to only report frequent and general adverse effects prior to the administration of a childhood vaccine in order to under-

stand that the insurer is providing the correct healthcare.

The Impact of the Product Liability Directive on Product Liability Policies

Since the adoption of Directive 85/374/EEC on 25 July 1985, significant changes have occurred in the chain of placing products on the market. On 28 September 2022, the proposal for a Product Liability Directive was published and was finally approved on 12 March 2024.

In general, many of the changes introduced by the new directive respond to this need for updating. However, others raise particular practical questions.

- The definition of “defectiveness” changes: the new directive maintains the classic description of “defect” in the product (“it shall be considered defective when it does not offer the safety that a person has the right to expect”). However, Article 7 introduces a list of “circumstances” to be taken into account when assessing the defectiveness of a product, which include the reasonably foreseeable use of the product, the effect on the product of its ability to continue to learn or acquire new characteristics after it has been placed on the market or put into service, the reasonably foreseeable effect on the product, the safety requirements of the product, any recall of the product or any other relevant intervention by a competent authority or economic operator, the specific needs of the group of users for whose use the product is intended, in the case of a product whose purpose is precisely to prevent damage or any failure of the product to fulfil that purpose.
- Burden of proof and presumption of defect and causal link in some cases: another of the main novelties that changes the current

burden of proof is found in Article 10, which contains a series of presumptions regarding the defective nature of a product:

- (a) when the defendant breaches the obligation to disclose relevant evidence;
 - (b) when the claimant proves that the product does not comply with mandatory safety requirements established in Union or national law that are intended to protect against the risk of the damage produced; and
 - (c) when the damage is due to an obvious malfunction of the product during normal use or under ordinary circumstances, the causal link between the defectiveness of the product and the damage will also be presumed when it has been established that the product is defective and the damage caused is of a type typically compatible with that defect.
- The limitation period for bringing an action is increased from ten to 25 years in cases of latency of personal injury: the new directive extends liability to 25 years in cases where the claimant has not been able to initiate proceedings due to latency of personal injury.

Some of these changes may generate legal uncertainty and practical problems in their application and will certainly have a clear impact on product liability policies. The modification affecting the burden of proof is an example of this.

Although the new directive is careful to make it clear that this change does not imply a reversal of the burden of proof, the reality is quite different. The presumptions included in the new directive (among others, the one that indicates that the defect is presumed when the defendant has not provided sufficient evidence of its non-existence) leave the classic obligation to prove

the defect, the damage and the causal relationship between the two behind.

If manufacturers have to prove that the product is safe, the reversal of the burden of proof is clear and reinforces, in the claimant's favour, the objective nature of liability, leaving manufacturers at a disadvantage as these presumptions will become a "catch-all" where all unfounded claims will have a place.

The concept of defectiveness is another of the modifications where the new directive moves away from the classic theory of civil liability, leaving manufacturers in a difficult situation when it comes to disassociating, for example, the withdrawal of a defective product from the market. In these cases, manufacturers' liability will once again be a kind of strict liability, leaving them without the right to a process with all the procedural guarantees that, in theory, are included in the Spanish Civil Procedure Law.

Faced with these changes, "Product CR" policies will have no choice but to adapt. Insurance companies will have to carry out an analysis of the increased risk they will have to cover in this new scenario (which, being a higher risk, will obviously have an impact on the agreed premium). On the other hand, they will have to modify the clauses of the coverage of this type of policy and include previously unforeseen exclusions such as, for example, damage resulting from the withdrawal of a product.

In addition, the extension of the manufacturers' liability period to 25 years from the date the product is put into circulation in cases of latent damage may affect the time coverage of these policies, limiting them to damage occurring strictly during the term of the contract. Coverage would otherwise be extended ad infinitum.

In short, the changes introduced by the new directive will mean a major revolution, not only in terms of the burden of proof for insurers that their product complies with the applicable regulations, but they will have to go further and, in order to try to avoid a sort of strict liability, they will have to allocate enormous resources in the post-marketing phase of the product and in the modification of their product liability policies.

Cut-Through and Pay to Be Paid Clauses in Insurance and Reinsurance Policies and its Validity Under Spanish Law

In accordance with Articles 77 and 78 of Law 50 of 1980, of 8 October 1980, on insurance contracts, the insured party is not entitled to demand any type of benefit directly from the reinsurer. The insured party must claim the full amount of the indemnity from the insurer, and the insurer, in turn, would have the right of recourse against the reinsurer.

However, in practice, especially in large risk policies (eg, aeroplanes, ships), there are clauses that allow the insured party to claim directly from the reinsurer. These “cut-through”, “simultaneous payment” or “pay to be paid” clauses, which come from Anglo-Saxon law, transform the reinsurer into the material insurer, leaving the insurer as a formal figure or involved in “fronting”.

“Cut-through” clauses allow the insured party to approach the reinsurer directly to demand payment of the reinsured sum, thereby avoiding the application of Article 78 of the Insurance Contract Law.

“Simultaneous payment” clauses provide that the insurer is not obliged to pay the insured party until it receives the funds from the reinsurer. In addition, the insurer will only pay the insured party the amount received from the reinsurer,

even if this amount does not cover the total indemnity claimed. These clauses circumvent the second paragraph of Article 77 of the Insurance Contract Law, which obliges the insurer to pay the indemnity without prejudice to its right of recourse against the reinsurer. Despite the apparent contradiction with Articles 77 and 78 of the Spanish Insurance Contract Law, these clauses may be valid and admissible in certain cases.

Article 77 refers to “internal reinsurance”, where the insured party does not participate in the agreement between insurer and reinsurer. If the reinsurer binds itself directly to the insured party, this would be “external reinsurance” and would therefore not be subject to the limitation of Article 78.

If the reinsurer assumes a direct obligation to the insurer and the insured party, this covenant could be valid by offering more guarantees of recovery to the insured party. Although these clauses seem incompatible with Article 78, they are valid in external reinsurance cases. This is because the precept is not mandatory and benefits the insured party by allowing them to claim from two different entities.

“Simultaneous payment” clauses present major problems as they reduce the rights of the insured party. The insurer is only liable if it previously collected a sum from the reinsurer and only for the amount collected. This leaves the insured party dependent on the reinsurer, which may not be authorised to operate in Spain and, therefore, this scenario complicates collection when payment does not occur voluntarily.

The situation changes if we go into policies insuring large risks, for which Article 44 of the

SPAIN TRENDS AND DEVELOPMENTS

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Insurance Contract Law declares the precepts of the Law as non-mandatory.

In summary, “cut-through” clauses do appear to be recognised and valid under Spanish law, while “pay to be paid” clauses are not. However, given the limited number of rulings to date, we will have to wait for the evolution of case law in this area to determine their definitive application and validity.



Law and Practice

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Kennedys is a global law firm with expertise in dispute resolution and advisory services, and over 2,300 people in 24 countries around the world. The firm handles both contentious and non-contentious matters and provides a range of specialist legal services, including corporate and commercial advice, but with a particular focus on defending insurance and liability claims. Defendant claims work is at the heart of Kenne-

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime Statutory Regime: An Overview

In England and Wales, insurance contracts are regarded as private contracts. Insurance disputes are accordingly subject to the general rules on contract law. These rules are derived from a mixture of common law and statute. There is also sector-specific legislation that applies to insurance contracts, with different legislative regimes for consumer and business contracts.

Statutory Regime: Consumer Contracts

The statutory framework governing consumer insurance contracts is largely set out in the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA), which came into force on 6 April 2013.

CIDRA defines a consumer as “an individual who enters into a contract of insurance wholly or mainly for purposes unrelated to the individual’s trade, business or profession”. CIDRA contains detailed provisions about the information that consumers must provide to insurers when applying for insurance and insurers’ remedies

for pre-contractual misrepresentations as well as contractual breaches. General consumer protection laws, such as the Consumer Protection Act 2015, also apply to consumer contracts.

Statutory Regime: Business Contracts

The regime relating to business insurance contracts (and reinsurance contracts) is contained within the Insurance Act 2015 (IA 2015), which came into force on 12 August 2016. The IA 2015 applies to contracts entered into on or before 12 August 2016, as well as to variations to contracts of insurance agreed after that date. The IA 2015 reformed the law in relation to pre-contractual misrepresentation and non-disclosure in business contracts. It also updated the law in relation to warranties and fraudulent claims in both business and consumer contracts.

Statutory Regime: Sector-Specific Legislation

Other sector-specific legislation includes the Third Parties (Rights against Insurers) Act 2010 (which allows third parties to enforce a term of an insurance contract in the event that it purports to confer a benefit on the third party); the Enterprise Act 2016 (which creates a legal right to enforce prompt payment of insurance claims); and risk-

specific legislation, such as the Life Assurance Act 1774 and the Fire Insurance Duty Act 1782.

Procedural Regime

As insurance contracts are private contracts, they may provide specific mechanisms for resolution of disputes. For example, arbitration is particularly prevalent in many business insurance and re-insurance contracts. Where no specific dispute resolution mechanism is included in the contract, insurance disputes are typically heard in the civil courts. However, consumers or small business owners may also make complaints to the Financial Ombudsman Service.

Financial Ombudsman Service

The Financial Ombudsman Service (FOS) may review complaints for consumers or small businesses against insurers in the UK after the internal complaints process within the insurance company has failed to resolve an issue. The FOS is an independent body which seeks to resolve disputes, without involving the courts, based on what is fair and reasonable in all the circumstances (the FOS is not strictly bound to follow legal precedent). If a matter is referred to the FOS, it will first be reviewed by a case handler who will assess the parties' respective positions before recommending how a dispute should be resolved. If the parties are unsatisfied with the recommendations, the dispute can be referred to an ombudsman. Decisions of the ombudsman are binding on insurers, and can therefore only be challenged by judicial review.

Civil litigation

The Civil Procedural Rules (CPR) make up the procedural code governing litigation and specify the rules to be followed at each stage of court proceedings. Specific guides may also apply in certain courts, such as the Commercial Court.

For low-value personal injury claims in road traffic accidents, or employers' liability (EL) and public liability (PL) claims, proceedings can be issued through the Electronic Claims Portal. Claims pursued via the Electronic Claims Portal are subject to strict procedural rules and fixed fees to keep costs low and speed up the process to resolve disputes.

Other disputes involving insurance are addressed through the court system. Disputes are allocated to a court based on the value of the claim. For disputes valued at less than GBP100,000, the claim will generally be allocated to the county court, while disputes worth more than GBP100,000 will generally be addressed in the High Court. Particularly complex cases of high value may be heard in the Commercial Court, a subdivision of the High Court. Further details about the court procedure can be found in the sections that follow.

1.2 Litigation Process and Rules on Limitation

Rules on Limitation

In England and Wales, the limitation period varies depending on the type of claim. Insurance disputes are typically regarded as claims for breach of contract. The Limitation Act 1980 (as amended) provides that an action founded on a simple contract, such as an insurance contract, must be brought within six years of the date on which the cause of action accrues.

For ordinary claims in contract, the cause of action typically accrues six years from the date of the breach of contract. However, the position is more complicated in relation to insurance contracts. For liability policies (ie, policies covering third-party losses), the cause of action normally accrues when the liability of the insured is ascertained. This may be in the form of an agreement,

an arbitral award or a judgment. In other forms of insurance (such as marine, property and life insurance), the cause of action will usually be deemed to accrue when the relevant insured event occurs.

The limitation period for other types of claims against insurers will differ. For claims brought by policyholders against insurers for late payment of insurance claims, the limitation period is one year from the date on which the insurer has paid all sums due in respect of the insurance claim. In relation to claims for contribution commenced by one insurer against another, the limitation period is two years from the date on which the right of recovery accrued.

The Litigation Process

Overview

As noted in **1.1 Statutory and Procedural Regime**, the procedural rules to be followed at each stage of court proceedings are set out in the CPR.

Typically, insurance contract disputes with a value greater than GBP100,000 will be heard in the High Court, and particularly complex cases will be heard in the Commercial Court, a subdivision of the Business & Property Courts (part of the High Court). Claims of lesser value will usually be heard in the county courts.

The litigation process in England and Wales is adversarial (as opposed to inquisitorial) in nature, with each party trying to prove their case on the “balance of probabilities”. Litigation in England and Wales can be expensive, but the legal system in the jurisdiction is thorough, fair and well regarded internationally.

The English legal system operates on the principle of open justice, which in practice means that,

save in exceptional circumstances, the public can access key court documents and attend hearings and trials.

A final overarching point of note is that, in litigation in England and Wales, the presumption is that the losing party will pay the winning party’s costs (subject to the court’s discretion and certain specific costs-protection legislation, such as qualified one-way costs shifting (QOCS) – see **2.3 Unique Features of Litigation Procedure**).

Pre-action conduct

There are specific procedural rules relating to pre-action conduct. These rules are contained in the CPR Practice Direction (PD) on Pre-action Conduct and the associated pre-action protocols that apply to particular types of civil claims, such as the Pre-action Protocol for Personal Injury Claims and the Pre-action Protocol for Construction and Engineering Disputes.

The PD and pre-action protocols set out the steps the court expects parties to take prior to commencing proceedings. The purpose of these rules is to encourage parties to exchange sufficient information so as to be able to:

- understand each other’s position;
- make decisions about how to proceed;
- try to settle the issues without proceedings;
- consider a form of alternative dispute resolution (ADR) to assist with settlement; and
- reduce the costs of resolving the dispute.

Parties that have failed to comply with the relevant pre-action provisions may face costs sanctions in any subsequent litigation.

Commencing proceedings

In the event that the parties are unable to resolve a dispute pre-action, a claim may be com-

menced by a claimant issuing a claim form and serving a copy on the defendant. The claim form may be accompanied by particulars of the claim, setting out the case and the facts relied on, or these may be served on the defendant up to 14 days after service of the claim form.

Following service of the particulars of the claim, the defendant should file an acknowledgement of service confirming whether or not the matter is disputed. If the claim is disputed, the defendant has the opportunity to file and serve a defence, setting out its position.

Subsequent stages of proceedings

Once the parties' statements of case have been served, the court will allocate the claim to a "track" depending on its value and complexity and the parties will be encouraged to agree a timetable to trial (known as directions). These directions will be approved or amended by the court at a case management hearing. The directions will typically include deadlines for the following:

- disclosure of documents;
- exchange of witness statements;
- exchange of expert reports;
- a meeting of experts and preparation of a joint report of the experts;
- a pre-trial review hearing; and
- the trial.

The court plays an active role throughout the litigation process and, depending on the size and complexity of the case, several case management hearings may take place to ensure the proceedings run smoothly. Parties are typically encouraged to consider settlement options throughout the course of the proceedings. In the event that settlement is reached, the parties

must notify the court and the litigation process will end.

Trial

The majority of insurance contract disputes are settled by agreement between the parties. However, if settlement is not achieved, the matter will progress to trial.

Each party will present their case at trial, with witnesses and experts being cross-examined on their evidence. The duration of the trial will vary depending on the complexity of the matter.

The remedies available will depend on the subject matter of the case but may include:

- damages;
- restitution;
- declarations;
- injunctions; and/or
- orders for specific performance.

A judge's final decision takes the form of a reasoned written judgment, which will usually also address costs.

Appeals

If a party wishes to appeal, it must first seek permission from the court. This can be sought from the lower court where the decision was made, or from the appeal court.

For insurance disputes heard in the Commercial Court, appeals can be made to the Court of Appeal.

Parties can appeal on the grounds that the decision of the lower court was wrong or unjust due to a serious procedural or other irregularity. Permission will be granted if there is a real prospect of success or some other compelling reason.

Appeals from the Court of Appeal can be made to the Supreme Court. Applications for permission can only be made to the Court of Appeal, or to the Supreme Court, if permission is refused by the Court of Appeal.

1.3 Alternative Dispute Resolution (ADR)

Alternative dispute resolution (ADR) is encouraged and widely used in different forms to resolve disputes in England and Wales.

The CPR specifically requires the court and the parties to consider whether ADR is appropriate.

Many insurance contracts specify that a particular form of ADR must be used as an alternative to litigation. The most common forms of ADR used in England and Wales include:

- arbitration;
- adjudication;
- mediation; and
- negotiated settlement.

Some of the main advantages of ADR include: costs benefits (it is often much cheaper for all the parties to resolve disputes through ADR); the ability to retain confidentiality; and maintaining commercial relationships.

Arbitration

Arbitration is one of the most common forms of ADR used in insurance disputes and arbitration clauses are often incorporated into business insurance and reinsurance contracts.

The arbitration procedure will depend upon the precise terms of the relevant clause but this may specify that the arbitration is to be conducted under the rules of a particular institution, such as the London Court of International Arbitration

(LCIA) or the International Chamber of Commerce (ICC).

Arbitration proceedings are governed by the Arbitration Act 1996 (AA 1996), which provides that an arbitral award can only be challenged in certain, limited circumstances. The AA 1996 also provides that the court can execute powers in support of arbitration proceedings, such as securing the attendance of witnesses.

Adjudication

Adjudication is a process whereby an independent adjudicator, who is an expert in the relevant subject matter, will make a decision on the matter using information presented by the parties, as well as their experience and expertise. Adjudication is often used in construction disputes.

The process usually takes place within a 28-day timeframe and begins when either party submits a Notice of Adjudication. The timetable set is strict, and the decision will be unenforceable if given outside the timeframe. Adjudication allows parties to resolve the dispute in a timely manner without incurring the costs associated with litigation or arbitration.

Mediation

Mediation is also commonly used in England and Wales. It involves a neutral third-party mediator attempting to reach agreement based on the issues and options for resolution. Mediation can be significantly cheaper than either litigation or arbitration and can be used to resolve a range of insurance disputes.

The most common type of mediation used is facilitative mediation, whereby the mediator does not make a decision, but assists the parties in reaching a commercial settlement.

Mediation is common in construction professional indemnity disputes as it is confidential and enables the resolution of disputes with a result both parties have accepted, so the professional relationship can be maintained.

Negotiations and the “Without Prejudice” Framework

“Without prejudice” negotiations are often used to reach a settlement and this is encouraged by the courts. Where negotiations are conducted without prejudice (with or without legal representatives acting as intermediaries), details of these negotiations cannot be put before the court (except, in some instances, on the question of costs). This encourages the parties to make genuine attempts to reach an out-of-court settlement and ensures that confidentiality is maintained.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes Jurisdiction

Jurisdiction clauses are common in insurance contracts. The English courts will typically respect jurisdiction clauses subject to certain exceptions, usually aimed at protecting the weaker party to a contract.

The applicable rules to determine jurisdiction, which were historically determined by the domicile of the parties, depend on whether proceedings were commenced on or before 31 December 2020 (the end of the Brexit transition agreement).

Proceedings commenced on or before 31 December 2020

For proceedings commenced on or before 31 December 2020:

- in cases where both parties were domiciled in an EU member state, the rules are contained within the Recast Brussels Regulation (1215/2012);
- if only one party was domiciled in an EU member state and another in an EEA member state, the Lugano Convention on jurisdiction applies; or
- in cases where the defendant was domiciled outside of the EEA, jurisdiction would be determined under the common law.

The Recast Brussels Regulation and the Lugano Convention both contain specific rules relating to insurance contracts which are designed to protect the insured as the weaker party to such agreements.

Under the common law rules, jurisdiction will be determined in accordance with Part 6 of the CPR. The common law rules are less prescriptive and the English courts will typically respect the choice of jurisdiction specified in a contract. This is particularly the case where a contract contains an exclusive jurisdiction clause.

Proceedings commenced on or after 1 January 2021

As of 1 January 2021 (the end of the Brexit transition agreement), the Recast Brussels Regulation ceased to apply and the UK also ceased to be treated as a member of the Lugano Convention. The UK’s application to join the Lugano Convention was rejected in April 2021.

The current position is that, for proceedings commenced after 31 December 2020, the relevant rules will be contained within either:

- the Hague Convention on Choice of Court Agreements 2005 (the “Hague Convention”); or

- the common law rules.

The Hague Convention (which became law in its own right in the UK on 1 January 2021) applies only to international cases where there is an exclusive jurisdiction agreement in favour of one of the states in which the Hague Convention applies. The application of the Hague Convention is subject to several limitations. The most important for present purposes is the exclusion of insurance contracts (in the case of EU member states and the UK). However, there is a “carve-out” for reinsurance contracts, large risks and certain other choice-of-court agreements in insurance cases.

Where the Hague Convention does not apply, parties to a contract will be reliant on the common law regime referenced above.

Choice of Law

As with jurisdiction clauses, the English courts typically uphold choice-of-governing-law clauses, subject to certain exceptions.

The pre-Brexit position

For contracts made after 17 December 2009, Regulation (EC) 593/2008 on the law applicable to contractual obligations (Rome I) applies.

Article 7 of Rome I provides specific rules for insurance contracts. It differentiates between contracts covering “large risks” and other insurance contracts.

For large risks, the insurer can choose which law governs the risk. If the insurance contract does not specify the applicable law, the location of the insurer’s head office will determine the choice of law unless the contract is more closely related to another country, in which case the law of that other country will apply.

For all other insurance contracts, the parties may choose the applicable law from a number of specified options. Where the applicable law has not been chosen by the parties, the contract will be governed by the law of the member state in which the risk was situated at the time the contract was concluded.

Where the risk is situated outside the EU, the contract will be governed by the choice of law rules in Rome I (Articles 3 and 4). Article 3 provides that the parties may choose the applicable law. Where the applicable law has not been chosen, the rules specified in Article 4 will apply.

It should be noted that Article 7 expressly does not apply to reinsurance and the general rules will apply in relation to these contracts.

The post-Brexit position

Little has changed in relation to choice of law as a consequence of Brexit.

Rome I continued to apply to the UK during the transition period and was incorporated into law after 31 December 2020 via the Law Applicable to Contractual Obligations and Non-contractual Obligations (Amendment etc) (UK Exit) Regulations 2019 (SI 2019/834), which is now known as the “UK Rome I”. As such, the principles detailed above continue to apply.

2.2 Enforcement of Foreign Judgments

Foreign judgments may be enforced against insurers under one of several distinct regimes depending on the date the proceedings were instituted, the country in which the judgment was reached, the date of the judgment and the type of judgment.

The European Regime

The main European regime remains applicable to the enforcement of judgments given in proceedings instituted in EU/EFTA courts before the end of the Brexit transition period (31 December 2020). The relevant rules are contained within the Brussels Recast Regulation (1215/2012), the Brussels Regulation 2001 (44/2001), the Brussels Convention, the Lugano Convention and the European Enforcement Order Regulation (805/2004).

The Commonwealth Regime

To enforce a judgment in England and Wales that has been handed down in a Commonwealth country (and some other countries) the “statutory regime” may apply.

Part II of the Administration of Justice Act 1920 (AJA 1920) sets out the procedure for the reciprocal recognition and enforcements of the UK courts and certain Commonwealth courts. Under AJA 1920, a judgment obtained in Commonwealth countries that have entered into reciprocal arrangements with the UK may be registered with the English High Court (and the equivalent courts in Scotland and Northern Ireland) and enforced as if it had been a judgment of the High Court.

The Foreign Judgments (Reciprocal Enforcement) Act 1933 contains similar provisions to the AJA 1920 but extends the possibility of recognition and enforcement to all nations with which the UK has reciprocal arrangements. As with the AJA 1920, foreign judgments may be registered with the English High Court (or its equivalent in other parts of the UK).

The UK Regime

The rules concerning the recognition and enforcement of judgments between the courts

of the constituent parts of the UK are contained within the Civil Jurisdiction and Judgments Act 1982 (CJJA). Broadly, the CJJA confers upon an interested party the right to apply for a certificate from the court issuing the judgment. The certificate may then be registered with a court in another part of the UK within six months of its issue. Following registration, the registering court will be granted the same powers of enforcement as the original issuing court.

The Common Law Regime

The common law regime is the default regime and applies to judgments issued in all countries not already covered by a specific regime.

This regime requires the party seeking to enforce the judgment to bring new proceedings in the courts of England and Wales, where the foreign judgment is sued as a debt. In accordance with CPR part 24, the party seeking to enforce the judgment may apply to the court for summary judgment once proceedings have been issued, on the grounds that the defendant has no real prospect of successfully defending the action and there is no reason why the case should go to trial.

Enforcement under this regime will only be possible where the foreign judgment is for a debt or other specific sum of money (but not fines, taxes or other penalties) and where the foreign judgment is final and conclusive.

2.3 Unique Features of Litigation Procedure

As previously detailed, the default method for resolving large disputes in England and Wales is by way of litigation in court. The system is adversarial in nature but the courts typically play a fairly active role in case and costs management. Two key features of the jurisdiction that

international insurers should be aware of are the following.

Costs Rules and Regimes

The general rule in civil litigation in England and Wales is that the unsuccessful party pays the successful party's costs. In the absence of unreasonable conduct, the successful party can usually expect to recover 65% (or more) of its legal costs from the losing party.

However, the general rule on costs is subject to the court's discretion. In exercising its discretion, the court will typically consider: the conduct of the parties; whether a party was only partly successful; and any admissible offers-to-settle that are drawn to the court's attention.

There are also certain notable exceptions to the general costs rules. For example:

- where litigation is subject to qualified one-way costs shifting (QOCS) (personal injury claims from 1 April 2013), defendants will generally be ordered to pay the costs of successful claimants but will not be able to recover their own costs if they successfully defend the claim; and
- if a fixed-costs regime applies (for certain small claims and enforcement proceedings specified in CPR part 44), the amount of costs that may be recovered will be capped.

ADR

International insurers should also be aware that the CPR requires parties to a dispute to consider ADR (before and after the commencement of proceedings). Failure to engage in ADR can lead to costs sanctions being imposed by the court.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Arbitration clauses in insurance and reinsurance contracts are enforceable in England and Wales. The jurisdiction is widely regarded as pro-arbitration and the courts will generally seek to uphold arbitral awards.

The key provisions governing arbitration in England and Wales are contained in the AA 1996. A written arbitration agreement or clause must be clear enough to show that the parties intended to incorporate the clause as an agreement to arbitrate but it need not be signed or contained within a single document.

In accordance with the AA 1996, where a party starts court proceedings in breach of an arbitration agreement or clause, the other party can apply for a stay of the court proceedings, which must be granted unless the arbitration agreement is null and void, inoperative or incapable of being performed.

If required, arbitral awards may be enforced by the courts in England and Wales. There are two principal routes through which an award may be enforced:

- it can be enforced "in the same manner as a judgment or order of the court"; or
- the award can be converted into a court judgment.

To enforce the award under either route, the enforcing party must make an application to the court for permission. This is usually done on a without-notice basis and involves submitting an

arbitration claim form and witness statement attaching the arbitration agreement and award.

If permission is granted, the award can be enforced in the same manner as a court judgment, including, for example, awards of damages, specific performance and/or injunction.

3.2 The New York Convention

The UK has been a party to the New York Convention since 1975. Accordingly, the UK will recognise and enforce arbitral awards from other contracting states.

The AA 1996 gives effect to and implements the New York Convention. An application to enforce a New York Convention award is usually made without notice to the respondent by issuing an Arbitration Claim Form in the English courts, supported by witness evidence alongside an authenticated original award or certified copy, the original arbitration agreement or a certified copy, and an official translation if the award or agreement is in a foreign language.

The court may then give permission to recognise the award and the respondent will usually be served with a copy of the order and original application. Thereafter, a respondent may apply for the order to be set aside. In the event that the order is not set aside, the arbitral award will be treated as if it was a judgment made within the jurisdiction of England and Wales.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is a common method of resolving insurance and reinsurance disputes in England and Wales. Contracts governed by English law often contain London-seated arbitration clauses and the same is often true of Bermuda excess liability insurance policies.

The ICC and the LCIA are two of the most frequently chosen institutions.

Provisions of the AA 1996

The AA 1996, alongside common law, governs arbitration in England and Wales. The AA 1996 contains both mandatory and non-mandatory provisions. The mandatory provisions are listed in Schedule 1 to the AA 1996 and include, for example, the right of the parties to stay legal proceedings for a matter referred to arbitration, and the powers of the court to extend time limits or remove an arbitrator. The “non-mandatory provisions” are all of the provisions that are not listed in Schedule 1. The non-mandatory provisions will apply in circumstances where the parties have not made their own arrangements by agreement.

The Arbitration Process

The arbitration process involves an arbitrator or panel of arbitrators who will gather evidence from the parties and make a decision on the dispute. The arbitration process is private, so third parties cannot attend hearings. This makes arbitration a preferred method of dispute resolution for many involved in international transactions and commercial dealings, which are typically kept private and confidential.

Decisions on the merits of a dispute by an arbitral tribunal are typically binding and may only be appealed in limited circumstances within 28 days of the date of an award.

The grounds for challenging an arbitral award are contained within the AA 1996 and include:

- the award was made without jurisdiction (Section 67);

- there has been a serious irregularity that has caused, or will cause, substantial injustice (Section 68); and
- an appeal on a point of law (Section 69).

Importantly, the parties may agree to exclude a right to appeal on a point of law under the AA 1996 (but not on the other grounds). Readers should also be aware that certain institutional rules governing arbitration proceedings (such as the LCIA rules) do not permit appeals, subject to certain limited exceptions.

4. Coverage Disputes

4.1 Implied Terms

Insurance and reinsurance contracts are subject to the same general principles as other commercial contracts in England and Wales. Terms may therefore be implied into such contracts by legislation, by the courts, from previous dealings between the parties and by industry customs. The following legislation implies terms into insurance and reinsurance contracts.

Insurance Act 2015

IA 2015 implies certain terms into a contract of insurance. Under Section 13A of the IA 2015 (introduced by the Enterprise Act 2016), there is a term implied in every contract of insurance that, if the insured makes a claim under the contract, the insurer must pay any sums due in respect of the claim within a “reasonable time”. See **4.8 Penalties for Late Payment of Claims**. Parties to consumer insurance contracts cannot contract out of the relevant provisions of the IA 2015.

Consumer Legislation

A range of legislation lays down implied terms in consumer contracts, including insurance

contracts, for the protection of the consumer. A notable example is the Consumer Rights Act 2015 (CRA). The material requirements of the CRA, when applied to insurance contracts, are as follows:

- every consumer insurance contract contains an implied term requiring the insurer to perform the service with reasonable skill and care;
- every consumer insurance contract contains an implied term providing that anything said or written to the consumer by or on behalf of the insurer that is taken into account by the consumer in making a decision about the contract, or service after entering the contract, is given contractual force;
- if the parties have not agreed the premium, and the contract is silent on how it is to be fixed, the contract contains an implied term that the consumer must pay a reasonable amount for the service, and no more; and
- if the contract does not expressly fix the time for the service to be performed, and does not say how it is to be fixed, the contract contains an implied term that the insurer must perform the service within a reasonable time.

The parties are not permitted to contract out of or breach any of these provisions, and doing so will grant the consumer the right to damages.

4.2 Rights of Insurers

Business Insurance Contracts

The IA 2015 applies to business insurance contracts that were entered into after 12 August 2016. The “old” regime, as set out in Sections 18 to 20 of the Marine Insurance Act 1906 (MIA 1906) and interpreted by common law, will accordingly apply to policies entered into or varied before 12 August 2016.

The Duty of Fair Presentation Implied Into Insurance Policies by the IA 2015

The IA 2015 provides that, in the case of non-consumer insurance contracts, the insured has an implied duty of fair presentation of the risk.

The IA 2015 provides some guidance as to what “fair presentation” of the risk entails, including:

- the requirement on the insured to disclose:
 - (a) every material circumstance which is known, or ought to be known, by the insured’s senior management and the individuals responsible for arranging the insured’s insurance; and
 - (b) sufficient information to put an insurer on notice that it needs to make further enquiries;
- information can be considered to be “material” if it would influence the judgement of a prudent insurer in setting the premium and/or the terms of the insurance and/or determining whether to accept the risk; and
- the insured “ought to know” what should have been revealed by “reasonable search” of the information available to it (information held internally and by the insured’s agents).

Any representations as to expectation or belief should be made in good faith. A presentation will be “fair” if the information provided to the insurer is:

- reasonably clear and accessible; and
- the facts disclosed are substantially correct.

Remedies for Breaches of the Duty of Fair Presentation

In the event that the insured breaches the implied duty of fair presentation, an insurer can seek a remedy only if it proves that it was induced by the breach to enter the contract of insurance on

the terms that it did, or at all. The remedy available to the insurer will depend on whether the breach was deliberate or reckless.

If the insured’s breach of the duty of fair presentation was deliberate or reckless, the insurer:

- may treat the contract as having been terminated from the time when the contract or variation was concluded; and
- need not return any of the premiums paid.

If the insured’s breach is not deliberate or reckless, various proportionate remedies may apply, depending on what the insurer would have done if the insured had complied with its duty:

- if the insurer would not have entered into the contract at all, on any terms, the insurer may refuse all claims under the contract and the contract will be treated as if it never existed, but the insurer must return any premium paid;
- if the insurer would have entered into the contract but on different terms (other than terms relating to the premium), the contract is to be treated as if it had been entered into on those different terms, if the insurer so requires; or
- if the insurer would have entered into the contract but would have charged a higher premium and imposed different terms, the contract will be treated as if it contained those different terms and the insurer will be able to reduce the amount to be paid out on a claim in proportion to the amount of the increased premium.

Consumer Insurance Contracts

CIDRA (referred to in **1.1 Statutory and Procedural Regime**) contains the provisions regarding the consumer insured’s duty of utmost good faith.

CIDRA requires consumers to take reasonable care not to make a misrepresentation to an insurer when a contract is entered into or varied. It is therefore less onerous than the “old” duty of disclosure, which implied on an insured a duty of “utmost good faith” (as set out in the MIA 1906), which required consumer insureds to volunteer all material information to insurers, and it can be distinguished from the duty of fair presentation placed on business insureds under the IA 2015.

The remedies available to insurers for misrepresentation under CIDRA are also proportionate to the failings of the insured. CIDRA provides that:

- where a misrepresentation is deliberate or reckless, the insurer may rescind the contract while retaining the premium, unless it would be unfair on the consumer to do so;
- where a misrepresentation is careless, the remedy available to the insurer will depend upon what it would have done had there been no misrepresentation;
- if the insurer would not have entered into the contract on any terms, it may avoid the policy and refuse all past claims but must return the premium;
- if the insurer would have entered into the contract but on different terms, it may choose to treat the contract as if those terms applied; or
- if the insurer would have charged a higher premium in relation to a risk, any claim under the policy will be reduced proportionately.

4.3 Significant Trends in Policy Coverage Disputes

There have been several significant trends in policy coverage disputes over the last 12 months.

COVID-19-Related Insurance Claims

As a result of the COVID-19 pandemic, there was a surge in related insurance claims, most nota-

bly, claims under property policies with extensions for non-damage business interruption (BI). These claims were largely brought as a result of BI losses caused by the government-mandated closure of certain categories of business to prevent the spread of COVID-19.

In 2020, the Financial Conduct Authority (FCA), with the assistance of eight insurers, brought a test case on behalf of affected policyholders which considered various sample policy wordings and was designed to resolve uncertainty as to whether these BI policies respond. The High Court held that certain of the sample policy wordings (“prevention of access” clauses) were not in response to nationally imposed restrictions, due to the local nature of the cover provided.

However, the High Court found that certain other sample policy wordings containing “disease” clauses and “hybrid” clauses respond to the nationally imposed restrictions. This finding was the subject of an appeal to the Supreme Court. In January 2021, the Supreme Court upheld the High Court’s ruling that these policies are triggered. In reaching that decision, the Supreme Court found that each and every case of COVID-19 within the radius stipulated by a BI policy was an equal and effective cause of the nationally imposed restrictions on businesses.

The decision in the FCA Test Case left a number of unanswered questions which generated a range of satellite litigation and appeals heard during the period 2021 to 2024 (see, for example, *Various Eateries Trading Ltd v Allianz Insurance Plc* [2024] EWCA Civ 10; *Gatwick Investments & Ors v Liberty Mutual Insurance* (and related cases) [2024] EWHC 124 (Comm)). While the decisions delivered in these cases have brought some clarity, several coverage issues

remain to be resolved (for example, whether “at the premises” clauses respond in the same way as other clauses in BI policies).

More recently, in *Unipolsai Assicurazioni SPA v Covéa and Markel International v General Reinsurance AG* [2024] EWHC 253 (Comm), the High Court considered an appeal in respect of two separate arbitration awards relating to the aggregation of COVID-19 BI losses under catastrophe excess of loss reinsurance treaties. The High Court judgment of Foxton J is currently under appeal, with a judgment expected in September 2024. Given that the aggregation language under consideration by the Court is widely used in similar reinsurance treaties, the outcome of the appeal is eagerly awaited because of the impact it may have on the reinsurance market.

GDPR-Related Claims

There has been growing interest as to whether risks of failing to comply with the GDPR can be and are insurable.

On the basis that English law prohibits the insurance of punitive fines, and given that policies will likely specifically exclude cover for such fines, it is unlikely that the risks of failing to comply with the regulation will be insurable.

However, it is possible that insurance may cover the costs of participating in regulator investigations or any follow-on proceedings. It is therefore expected that the number of insurance coverage disputes arising out of failure to comply with data protection regulations will continue to rise.

Civil claims relating to data breaches are increasing, with defendants increasingly turning to insurers to defend and indemnify these claims. Assessing the value of these claims can

be complex and there are already a number of claims in the court system on this question.

Artificial Intelligence and Cyber-Related Claims

Disputes relating to a failure to appreciate the scope and impact of artificial intelligence have been increasing and this continues to be a developing area for insurance claims. In addition, it is anticipated that, given the growing prevalence of cyber-attacks, the frequency of such disputes will likely increase.

4.4 Resolution of Insurance Coverage Disputes

As discussed in 1.3 **Alternative Dispute Resolution (ADR)**, the English courts encourage ADR before and during litigation. Disputes may be resolved through a variety of different ADR mechanisms including, but not limited to, arbitration, adjudication and mediation. If disputes cannot be resolved via ADR, then they will be heard in the courts.

Mediation is one of the most commonly used means of resolving insurance disputes, as it provides considerable flexibility and confidentiality and is less expensive than court proceedings.

The most commonly used resolution mechanism for reinsurance contract coverage disputes is arbitration. This is because reinsurance contracts commonly contain arbitration clauses, which will typically be upheld by the English courts.

4.5 Position If Insured Party Is Viewed as a Consumer

If the law views the insured party as a consumer, the position is different.

Consumers (and small businesses and certain charities and trusts) may take complaints to the Financial Ombudsman Service (FOS), which was established under the Financial Services and Markets Act 2000 (FSMA).

The FOS may make awards of up to GBP150,000. Complaints made to the FOS may be resolved far more quickly than disputes resolved by way of litigation, but the FOS is not bound by strict legal precedent, which means its decisions are difficult to predict. The FOS is also typically regarded by those in the insurance industry as a pro-consumer organisation.

4.6 Third-Party Enforcement of Insurance Contracts

The Third Parties (Rights against Insurers) Act 2010

The Third Parties (Rights against Insurers) Act 2010 (as amended) or TP(RAI)A permits a third party with a claim against an insured to bring proceedings directly against the insurer in the event of the insured's insolvency. The act does not apply to reinsurance contracts.

The TP(RAI)A will specifically apply if:

- an insolvent insured incurs a liability to a third party against which they are insured; or
- an insured subject to such a liability becomes insolvent.

Of particular note, the TP(RAI)A does not require the third party to have established liability prior to bringing proceedings against an insurer, although the third party may not enforce their rights against an insurer before liability is established. The TP(RAI)A also allows a third party that considers itself to have a right of action to obtain information about an insured's contract of insurance from a party that it reasonably believes may

possess such information, such as an employer or agent. A party that receives such a notice is required to provide as much information as it can within 28 days.

The Contracts (Rights of Third Parties) Act 1999

Under the Contracts (Rights of Third Parties) Act 1999 or C(ROTP)A, third parties are permitted to benefit from contractual terms where they are identified by name or by class in the insurance contract. This may, for example, take the form of reference to a subcontractor by a contractor in a construction all-risks insurance policy, or an employer taking out personal accident/injury policies for the benefit of employees. It is possible to exclude the C(ROTP)A entirely from a contract of insurance.

The manner in which the interest of a third party is noted in the policy will affect whether a benefit is conferred on the third party, or whether the third party is given a right of enforcement. It should also be noted that any third-party claim has the potential to be defeated by any defence available to the insurer against an insured claim. A notable example would be a breach of the duty of fair presentation.

4.7 The Concept of Bad Faith

There is no concept of bad faith under English law.

4.8 Penalties for Late Payment of Claims

As noted in 4.1 Implied Terms, under Section 13A of the IA 2015, damages can be awarded to insureds for late payment of claims. Section 13A was added to the IA 2015 by the Enterprise Act 2016 and implies a term into all consumer and non-consumer insurance contracts that the insurer must pay any sums due to the insured in respect of a claim within a "reasonable time".

The term “reasonable time” is not defined and is therefore decided on a case-by-case basis having regard to the relevant circumstances, including but not limited to the type of insurance, the complexity and/or value of the claim, compliance with relevant statutory or regulatory rules or guidance, and factors outside the insurer’s control.

Section 13A states that a reasonable time will include a reasonable time to investigate and assess the claim. If the insurer shows that there were reasonable grounds for disputing the claim, the insurer does not breach the term implied merely by failing to pay the claim (or the affected part of it) while the dispute is continuing. However, the conduct of the insurer in handling the claim may be a relevant factor in deciding whether that term was breached and, if so, when. Recent case law has confirmed that “reasonable time” will include defending a claim in court, even if that defence ultimately fails, as long as the defence itself is not unreasonable.

Damages can be awarded for breaches of Section 13A, in addition to the insured’s right to enforce payment of the sums due and the right to interest on those sums. A claim under Section 13A must be brought within one year of payment by the insurer.

4.9 Representations Made by Brokers

Insurance brokers are independent agents appointed by an insured. Their primary function is to obtain agreement and understanding between an insured and an insurer in order to place appropriate insurance cover. In accordance with the principles of agency, it is generally accepted that a broker acts as the agent of the insured. Therefore, in theory, an insured is bound by representations made by its broker. However, in practice, it can be more complicated.

In the case of consumers, Section 9 and Schedule 2 of CIDRA specifically outline the circumstances in which certain classes of person (including brokers) can be regarded as agents of an insured.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Insurers commonly use delegated authority arrangements to outsource certain functions to third parties, including underwriting and claims handling activities. While it is possible that this type of arrangement may give rise to litigated issues or disputes, this is a relatively rare occurrence.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

There are many types of insurance policies in England and Wales which include cover for the costs of funding an insured’s defence. Notably, such cover is usually provided under liability insurance policies, such as employers’ liability and public liability policies. This compulsory insurance routinely funds the defence of insured businesses for claims of bodily injury or disease sustained by their employees in the course of their employment. Similarly, professional liability cover also provides defence costs cover for any claims brought against professionals.

5.2 Likely Changes in the Future

Defence costs cover is often compulsory for certain types of insured business or professional. For that reason, there are unlikely to be significant changes in the prevalence of defence costs cover under liability policies.

5.3 Trends in the Cost or Complexity of Litigation

Significant efforts have been made by the UK government to streamline the litigation process in recent years. Notable examples include the following.

- The introduction of the Claims Portal, which (as noted in **1.1 Statutory and Procedural Regime**) is an online hub which facilitates the resolution of low-value, straightforward claims, and in certain cases avoids the need to issue court proceedings altogether. The portal was first introduced to facilitate the resolution of motor claims but was more recently expanded to cover employers' liability and public liability claims valued between GBP1,000 and GBP25,000.
- Reform of the CPR. In 2019, the courts introduced a disclosure pilot scheme in an effort to reduce the costs of disclosure in cases heard in the Business & Property Courts. Feedback in relation to the scheme – particularly in relation to its ability to reduce costs – has been mixed. However, the scheme became permanent in October 2022.

Despite attempts to reduce the time and cost of litigation, the litigation process often remains time-consuming and expensive. It is expected that the process of streamlining civil litigation will continue in future, in an attempt to widen access to justice. The increasing move towards technology by the courts – hastened by the COVID-19 pandemic – is also likely to result in the continued reduction of litigation costs in the longer term.

5.4 Protection Against Costs Risks

Protection against costs risks is readily available and legal expense insurance is very common in England and Wales. There are two types of legal

expense insurance, namely “before the event” and “after the event”. Due to after-the-event insurance being purchased when legal action is already contemplated, it tends to be offered as a standalone policy.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

In circumstances where an insurer has paid out money to an insured for a loss under a policy, it accrues subrogation rights to pursue an action, in the name of the insured, to recover some or all of the loss from the third party who caused or contributed to the original loss.

The right of subrogation is based on the principle of indemnity, which prevents the insured from being over-compensated by recovering sums from both its insurer and a culpable third party. Consequently, the right will not arise until the insurer has paid the insured the indemnity under the policy.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Subrogation claims must be pursued in the name of the insured. Subrogation rights arise under common law and any recoveries are subject to an established order of priority between the insured and the insurer in the event that there are both insured and uninsured losses. Subrogation rights (often re-stating the common law position) are commonly set out in insurance policies.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation COVID-19

Notwithstanding that COVID-19 restrictions have been lifted in the UK, insurers continue to measure the impact of the pandemic. Although the Supreme Court judgment handed down by the UK Supreme Court in January 2021 following the FCA Test Case resolved many BI coverage issues, insurers are yet to settle all BI claims. A number of outstanding legal questions are yet to be determined and there are other cases concerning BI coverage issues currently going through the courts – see **7.3 Coverage Issues and Test Cases**.

War in Ukraine

The effects of the war in Ukraine continue to be monitored across the insurance market. The early effects of the war have been seen primarily in the aviation and marine markets, where insurers are grappling with the issue of whether there is cover for claims under the “War Risks” or “All Risks” sections of cover provided within certain policies. This issue is the subject of a mega-trial commencing in October 2024 – see **7.3 Coverage Issues and Test Cases**.

As the war progresses and the impact of EU/US sanctions and Russian counter-sanctions becomes clearer, other classes of business are increasingly affected by claims, particularly political risk and trade credit.

Insurers must now also consider the stringent sanctions regime when they insure Russian businesses or interests.

7.2 Forecast for the Next 12 Months

It is likely that insurance litigation will be dominated by the fall-out from the Ukraine war over the next 12 months and beyond. It is also expected that there will be a rise in litigation concerning PFAS chemicals in both the US and Europe, with a corresponding impact on UK insurers (see **7.3 Coverage Issues and Test Cases**).

7.3 Coverage Issues and Test Cases Litigation in Relation to the Ukraine Conflict

The Commercial Court has ordered a joint trial of six similar sets of proceedings in which claims are being brought against multiple insurers under contingent and possessed insurance policies for the alleged loss of aircraft that have not been returned to lessor policyholders following the Russian invasion of Ukraine and the imposition of western sanctions against Russia. The claims in this “mega-trial” are significant (with a quantum of several billion dollars) and impact more than 30 insurers and Lloyd’s syndicates. A 12-week trial will commence on 2 October 2024.

Separate claims have also been brought by lessors against (re)insurers of separate “operator” policies, being insurance policies taken out by the Russian airlines which leased and operated the aircraft, under which the aircraft were insured by Russian insurers and reinsured in (among other locations) the London market. Whilst these actions are not as far advanced as the claims concerning the contingent and possessed, they will be equally as significant, both in terms of the quantum involved and the number of insurers impacted.

A judgment handed down in March 2024 in those operator proceedings confirmed that notwithstanding the exclusive jurisdiction clauses in favour of the Russian courts contained in the operator insurance and reinsurance policies,

the operator claims in relation to aircraft leased to Russian airlines will continue to be heard by the English Commercial Court. In a judgment in June issued in other proceedings, Henshaw J dismissed an application by operator reinsurers to resist exclusive jurisdiction clauses in favour of Ukrainian courts, holding that claims in relation to Ukrainian aircraft must proceed before the Ukrainian courts.

One of the issues to be determined in both the contingent and possessed and the operator claims is whether there is cover under the “War Risks” or the “All Risks” section of the policies. Certain insurers and Lloyd’s syndicates subscribe to both sections. The outcome of the dispute will have major implications for the aviation market, as well as for reinsurers. The contingent and possessed proceedings will consider some novel points of law, including the test for total loss in non-marine insurance.

7.4 Scope of Insurance Cover and Appetite for Risk

The COVID-19 Pandemic

It is clear that the COVID-19 pandemic has impacted insurers’ appetite for infectious disease risk – in the short term, at least. Given the ongoing effects of the pandemic and the repeated implementation of “lockdowns” as a means of controlling the spread of COVID-19, many insurance policies have been amended to include blanket exclusion clauses for COVID-19, and these are now a common feature of most travel, health and BI policies.

In time, the appetite for underwriting pandemic-related risks is likely to grow, as insurers are able to price such risks more accurately and repair their balance sheets from the COVID-19-related losses they incurred. However, for now, the appetite for such risks remains limited.

The War in Ukraine

The war in Ukraine has also impacted insurance cover and appetite for risk in several classes of business including marine, aviation, trade credit and political risk. Premiums are widely expected to increase across all associated lines of business.

Litigation Concerning PFAS (Polyfluoroalkyl Substances)

PFAS are used in the manufacture of a range of everyday household products, such as Teflon cookware, cosmetics and food packaging. There has been a proliferation of PFAS-related litigation in the US and Europe, by individuals who claim that they have suffered bodily injury as a result of exposure to PFAS and by individuals and businesses whose property has been contaminated by PFAS. Within the last year, PFAS manufacturers have concluded multi-billion dollar settlements of PFAS claims. The growing trend for PFAS litigation has been aided by increased regulation and scrutiny of PFAS manufacturers and users, as moves towards a potential ban of PFAS in Europe has begun.

In February 2023, five EU member states (Denmark, Germany, Netherlands, Norway and Sweden) applied to the European Commission seeking a ban in relation to the manufacture and sale of over 10,000 PFAS chemicals.

In April 2023, the UK’s Health and Safety Executive (HSE) published a report recommending limitations on the use of PFAS in various products including firefighting foam, cleaning products and textiles, although the HSE is yet to confirm whether it is leaning towards a more widespread ban. Against this background, it is expected that claims will be made under insurance policies covering a diverse range of business lines. It is expected that the use of PFAS exclusions for

different classes of insurance and tighter wordings will increase as litigation activity grows and further regulatory measures are put into place.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Insurers are increasingly aware of environmental, social and governance (ESG) risks. The environmental element of this includes consideration of climate change-related risks.

Climate-Related Risks

Climate change risk is a significant area of concern for insurers, which are experiencing climate-related losses and expecting the numbers of these losses to grow. The risks span three main areas.

- Physical risks from extreme weather conditions – such risks are already causing an increase in insurance claims – eg, losses caused by flooding, wildfires and drought, as well as business interruption and supply-chain cover claims.
- Transition risks – those risks resulting from adjustments made for the transition to a low-carbon economy.
- Liability risks – risks related to the financial impact of claims.

Trends in Climate Litigation

The climate litigation landscape is already active and is set to continue to develop rapidly, especially as climate science develops and draws clearer links between emissions and climatic events.

For example, insurers are already handling climate-related D&O claims, arising from litigation

brought against company directors alleged to have failed to prepare their organisations for the net zero target.

In addition, claims targeting companies over their emissions are increasing, with US courts, in particular, becoming more willing to establish a “climate change duty of care”. At present, proving causation is a significant hurdle for claimants but this could change as climate science develops.

Civil action groups are becoming more organised, paving the way for increased strategic climate litigation with potential consequences for changes in the law, as well as changes to policy wordings and coverage across all lines of business. Activists are becoming increasingly creative in their means, and litigation is often used as a weapon to seek disclosure of corporate climate risk, and to force corporates to tighten and comply with their own climate policies.

The Rise of PFAS Litigation

As public awareness of the environmental and health concerns associated with PFAS grows, along with knowledge of the significant settlements which have been achieved in recent PFAS litigation, it is anticipated that there will be an increase in PFAS-related claims globally. This litigation will be the subject of claims under a range of different types of insurance policies, although it remains to be seen whether such claims will be capable of attracting cover.

Within the last year, there has been a rise in PFAS-related litigation geared towards companies across a number of EU jurisdictions, notably in the Netherlands, which has become a hotspot for collective actions. This is due to its well-established class action framework, combined with an increasing number of experienced

US class action law firms having set up Dutch offices to advance large-scale environmental litigation.

In France, a criminal investigation and legal proceedings are underway against a large chemicals plant which is alleged to have discharged PFAS into the Rhône, causing environmental harm. Similar environmental actions, against different PFAS manufacturers, have been brought in Belgium, Italy and Sweden.

This appetite for litigation will also be fuelled by an increase in unregulated third-party litigation funding across the EU, and the newly implemented EU RAD which requires each member state to have a collective redress mechanism in place. This increases the pool of countries in which litigation funders and international law firms can opt to litigate PFAS-related lawsuits.

Underwriting

The number of climate change liability claims in the UK (and other jurisdictions, including the US) is likely to increase over the coming decade, as climate science improves and extreme weather events become more frequent, resulting in potentially large liabilities for the London insurance market and posing new challenges for the insurability of climate-related events. As shareholder activism in the ESG space more broadly continues to increase, a corresponding increase in D&O claims is also anticipated.

To the extent that climate-related risks are covered, insurers are now considering increased premiums to match the increased risk in underwriting property policies in particular. It is also becoming much more common for insurers to include climate change-related exclusion clauses within insurance policies.

Insurers are also increasingly including clauses that mandate compliance by their insureds with obligations to improve environmental and sustainability standards. Many insurers are also reconsidering their underwriting decisions and are no longer taking on new business which does not meet their ESG thresholds.

As PFAS litigation continues to grow, it is likely that chemical manufacturers and companies that use PFAS in their products will be subject to wholesale PFAS exclusion clauses in their insurance policies.

Due to the rise in strong public sentiment against corporations seen to be undermining the ESG agenda, punitive damage jury awards and collective actions are inherent features of ESG-related litigation. These social inflation trends are increasingly resulting in settlement demands and jury verdicts that are significantly higher than ordinary economic inflationary increases (particularly in the US). Claims inflation trends need to be taken into consideration by underwriters in order to competitively price risks they are seeking to underwrite, and set accurate financial reserves for existing and future claims liabilities.

8.2 Data Protection Laws

Data protection laws in the UK largely reflect the GDPR regime and other legislation derived from the EU prior to the UK's departure. The government proposed to reform the existing regime by virtue of the Data Protection and Digital Information (No 2) Bill, which was introduced to Parliament in March 2023. Following the announcement of the UK general election, the Bill was not passed during the "wash-up period". However, as the Bill enjoyed broad parliamentary support, it may well be reintroduced under the new Labour government. The Bill aims to create a new pro-innovation data protection framework

that simplifies the current rules and reduces the regulatory burden on businesses. GDPR has created practical challenges for insurers in managing personal data, particularly with the highly intermediated business in the London market. It is hoped that the Bill will alleviate those challenges in the future. In litigation terms, the right to make data subject access requests gives claimants the opportunity to seek information by ways other than pre-action disclosure, while the right to compensation for even inadvertent data breaches is contributing to growing class action risk, which claimant law firms are keen to take advantage of.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

One of the most significant developments in England and Wales that has affected insurance coverage is Brexit, which has seen various UK insurers establishing subsidiaries in the EU. It has been reported that 35 UK insurers founded branches in EU member states in response to Brexit and an estimated 29 million insurance contracts had, by the end of the Brexit transition period on 31 December 2020, been transferred to new offices.

In future, this may result in a greater number of insurance coverage disputes in the courts of EU member states, although it is expected that the English courts will continue to retain their dominance as the preferred European destination for insurance coverage disputes.

Trends and Developments

Contributed by:

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Gatehouse Chambers is a leading chambers for complex insurance claims across a variety of disciplines. The team comprises over 50 members, nine of whom are silks. Whilst most members are based in London, members advise on coverage disputes internationally, dealing with issues that arise in relation to coverage/avoidance, the inter-relationship of multiple layers of insurance and co-insurance. Paul Reed KC, Catherine Piercy KC, Michael Wheeler KC and Simon Kerry represented two out of three parties in the leading case on co-insurance. David

Pliener KC and Louis Zvesper represented the insureds in the leading case on business interruption claims as a result of COVID-19. John de Waal KC has published Risk & Negligence in Property Transactions and Paul Reed KC, along with members of Gatehouse, has written two leading texts: Construction All Risks Insurance and Construction Professional Indemnity Insurance. Members also contribute to Insurance Broking Practice and the Law and other specialist texts.

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Introduction

Insurance claims are continuing to grow in number and size in light of issues such as technological failures, advancements in the use of AI, the continued effects of the pandemic and the identification of complex and widespread building defects. This has put into sharp focus the need to account for cyber-attacks and technological failures in policies, as well as the use of artificial intelligence by insureds in the performance of their services. It has also meant that there has been increased attention on the scope of cover and of exclusion clauses, as well as more consideration of the consistency (or otherwise) of excess layers.

Seemingly in recognition of the recent challenges being faced by insurers, the FCA has published a discussion paper on simplifying the rules governing the sale of insurance to business, saying the changes could “significantly reduce the time needed to take on new customers, or renew their contracts”. However, our experience is that insurers are paying closer attention than ever to the particular risk being insured and the scope of cover they are willing to provide, and clearly excluding from cover issues which they are not prepared to have fall within their risk. It will be interesting to see how any simplification in procedures affects the cost and nature of policies which are available.

This chapter highlights six key developments and trends in insurance litigation, which may impact on the nature and scope of policies available in the future.

Technology Failures and Cyber Attacks

The CrowdStrike outage

On 19 July 2024, the American cybersecurity company CrowdStrike distributed a faulty update to its “Falcon Sensor” security software, which precipitated what is considered to be the largest IT outage in history, with more than eight million computer systems running Microsoft Windows disrupted. The effects were felt across the world, with airports, hospitals, television stations and financial systems plunged into chaos: in England the Royal Surrey NHS Trust declared a critical incident and cancelled radiotherapy appointments, meanwhile 991 emergency lines went down in Alaska.

The consequences

It was not long until focus turned to the financial impact of the outage. Parametrix estimated that approximately 25% of companies in the Fortune 500 had experienced disruptions as a result of the outage and that the companies in that list (excluding Microsoft) had suffered total losses of USD5.4 billion and the total worldwide losses have been estimated to exceed USD10 billion.

Parametrix predicted that the biggest total loss was suffered by the healthcare industry (USD1.94 billion) but the largest loss per company was in the airlines sector, where each affected company was estimated to have suffered more than USD143 million in losses. Nonetheless, Parametrix estimated that only 10–20% of those losses would be insured.

Cyber insurance

The CrowdStrike outage drew attention to one of the most innovative and dynamic areas of the insurance industry: cyber risk. Globaldata's 2023 report "Thematic Intelligence: Cyber Insurance" found that the global cyber insurance industry was worth more than USD16 billion in premiums in 2022, forecasted to grow to more than USD33 billion by 2027. However, Globaldata's 2023 SME Insurance Survey found that only 32% of SMEs in the UK had any type of cyber insurance. It appears safe to assume that awareness of cyber risks will continue to grow over time, particularly if events such as the CrowdStrike outage continue to occur and to receive such widespread media coverage.

In simple terms, cyber insurance covers the losses relating to damage to, or loss of information from, IT systems and networks. Generally, a cyber insurance policy has two distinct components:

- first-party cyber insurance, which covers the costs associated with investigating and responding to a cyber event and the financial impact on an organisation's business operations; and
- third-party cyber liability insurance, which provides the organisation with financial indemnity as a result of claims for damages as a result of a cyber event.

Historically, the best-known cyber incidents have arisen from malicious attacks, such as the WannaCry ransomware attack in May 2017 and the NotPetya malware which surfaced in Ukraine the following month. However, the CrowdStrike outage was different and demonstrated that enormous disruption (and consequential losses) can arise with no bad actors involved.

That distinction has important implications for the insurance industry. Loretta Walters of the Insurance Information Institute told Reuters that "although standard cyber insurance covers cloud downtime due to security failure, operational failure or system failure of the insured's own operations, it typically does not cover downtime due to non-malicious cyber events at a third-party network service provider". Further, even where non-malicious outages are covered, policies frequently limit losses to the proven loss of net profit or expenses associated with loss mitigation and are subject to a minimum outage time of between eight and 48 hours.

"Silent cyber"

Not all claims for cyber losses are made under specialist cyber insurance policies. In fact, it is conceivable that successful claims could be made under other property, business interruption, errors and omissions or kidnap and ransom policies where cyber losses are not expressly or impliedly excluded from cover. In recent years, concern therefore grew amongst insurers and regulators about the potential exposure arising from so-called "silent cyber" insurance, which could present a substantial unforeseen risk to insurers, who will not have considered exposure to cyber losses when calculating the premium or assessing their broader portfolios.

On the other hand, "silent cyber" was also a cause for concern amongst policyholders. Many

policyholders assumed that cyber losses would be covered by other types of policy which were not written with cyber risks in mind. That was apt to confuse, and insureds therefore ran the risk of discovering that cyber losses were not covered when a claim was made.

UK regulators therefore set about clarifying the cover provided for cyber risks in non-cyber policies. Lloyd's bulletins Y5258 and Y5277 in 2019 and 2020 required all syndicates to clarify the cover provided for cyber risks in all policies, and were implemented in 2020 and 2021. In practice, the result was that cover for cyber risks was removed from many non-cyber policies.

Business Interruption

Analysts predict that cyber insurance losses will be driven by claims for business interruption, which will keep focus on business interruption insurance after recent years in the spotlight following the COVID-19 pandemic. Readers will be aware of the seminal decision in *The Financial Conduct Authority v Arch Insurance (UK) Ltd* and several high-profile business interruption claims in the months and years that followed, including *Stonegate Pub Company Limited v MS Amlin Corporate Member Limited*, in which barristers from Gatehouse Chambers represented Stonegate.

Developments in the law concerning business interruption insurance have continued apace in recent months, but there is little sign that the flow of important decisions will slow. To take two examples:

- permission to appeal was granted on issues concerning causation and furlough in *Jacobs J's decision in Gatwick Investment Limited v Liberty Mutual Insurance Europe SE*, with an appeal expected next year; and

- the Court of Appeal is expected to hand down its judgment in the London International Exhibition Centre proceedings, concerning "at the premises" cover, later this year.

It remains to be seen how the burgeoning case law surrounding business interruption arising from the COVID-19 pandemic will be applied to claims concerning cyber risks, but Allianz's "Risk Barometer" for 2024 ranked cyber incidents and business interruption as the first and second greatest concerns, respectively, for businesses in 2024. The CrowdStrike outage proved those concerns to be well-founded and we do not expect them to abate in 2024/25.

It is likely that business interruption will continue to occupy centre stage in insurance litigation over the coming year. Cyber risks will inevitably be a key focus of insurers and policyholders alike, but significant attention is also likely to be given to other potential causes of business interruption such as climate change and civil unrest, whose presence in the world of insurance litigation can only be expected to grow.

Use of Generative Artificial Intelligence

Linked to technological failures is the increased use of technology by professionals. Until recently, AI has primarily been used by the insurance industry in order to gather better data and optimise the underwriting process. However, it is now increasingly being used by professionals to perform services. A recent Forbes study revealed that nearly all business owners believe ChatGPT will benefit their operations, with more than half already leveraging AI across a wide range of business activities.

AI can be used to create content, analyse data, identify trends and perform calculations. Publicly available systems, like ChatGPT, can answer

questions to provide “advice”. In the legal sector, AI can be helpful for carrying out research, contract comparisons and due diligence. However, there is no control over the accuracy of data and software programmes may not always produce the “right” answer.

This leads to two issues: (i) what scope of cover is provided to software developers; and (ii) whether the use of AI is consistent with the scope of cover provided under a service provider’s professional indemnity policy or the producer’s product liability policy. Both of these are likely to be tested in the near future.

Insurers currently appear to be dealing with AI failures on a case-by-case basis but are themselves adapting to its growing use. For example, Munich Re has launched a product for users of AI, which covers losses where an AI model does not deliver. Other insurers are choosing to ask specifically about the use of AI on proposal forms and renewals and to make specific provision and exclusions for AI in existing policies. These are all likely to be hot topics for insurance litigation in the near future.

Exclusion Clauses, Liability Limits and the BSA

Scope of cover and limits of liabilities continue to be topics of interest and debate in relation to professional indemnity and product liabilities policies, not only as a result of the continuing identification of fire and structural defects in high-rise developments, but also as a result of the new remedies available when such defects are identified under the Building Safety Act 2022. One of the aims of the Building Safety Act 2022 was to improve safety standards across the industry by requiring more approvals, better record-keeping and, consequently, more accountability. Insurers also seem to be signalling for the same trend by tightening up their terms.

One example is the exclusion of cover in relation to cladding or clauses limiting or excluding claims relating to fire safety since the Grenfell fire. These exclusions often apply regardless of the height of the building and attempt to remove cover for fire safety claims, including the costs of re-design, remedial works, alternative accommodation or any other financial losses. Litigation concerning the scope of these exclusions/limitations is emerging, given that many companies simply do not have the assets to meet the claims they face without insurance cover. Consequently, the effectiveness of the clauses is key to the claimant’s recovery.

In June 2024, the Royal Institute of Chartered Surveyors announced its decision to amend its Professional Indemnity Insurance Requirements and Minimum Approved Wording for regulated firms in the UK and Ireland in relation to fire safety. For policies issued from 1 July 2024, listed insurers must provide prospective fire safety claim cover in the UK and Ireland for professional services carried out on buildings of five storeys or more. There also appears to have been a softening of approach more generally by insurers, with many now at least offering a reduced limit of liability in respect of such claims.

This is a welcome change to the construction industry, but what will likely continue to be contentious is the extent to which group companies are covered in relation to new remedies available under the Building Safety Act 2022. The Building Safety Act 2022 makes provisions for some claims to be brought against associated companies to those who own the freehold of buildings which have fire safety or structural defects or associated companies to the developers of such buildings. Whether such claims are covered by existing insurance policies is likely to be tested in the near future, given decisions such as Triath-

Ion Homes LLP v Stratford Village Development Partnership, where companies associated with the developer were ordered to pay for the remedial works to tower blocks in the former Olympic Village in Stratford, even though the associated companies did not have an interest in the developer at the time of the development of the blocks.

Excess Layers

Professional indemnity insurance is often arranged in layers. Sometimes this means an individual company has an excess layer tower, with a primary insurer providing a limit of an indemnity and excess insurers providing further cover. In other cases, a parent company with numerous subsidiaries may take out a master policy covering all subsidiaries, with each subsidiary procuring a local policy which provides primary layer cover. The master policy thus operates as an excess layer policy.

The terms of the different layers of cover are not always consistent. Given the growing number and size of insurance claims, members of Gatehouse are now seeing increased consideration of the terms of cover of excess layers and towers, in relation to notification, exclusions and limitations. There is little case law in the UK on excess layers insurance, but that may be set to change, as we have seen an increasing trend of primary layers and excess layer insurers disagreeing on coverage decisions or on claims management.

Third-Party Claims

Finally, with insolvencies at record levels, we have noticed an increasing number of claims by third parties against insurers under the Third Party (Rights against Insurers) Act 2010. This Act enables claimants to bring claims directly against the insurers of potential defendants where the defendants have become insolvent.

The Outer House of the Court of Session has recently considered what a third party needs to establish to advance a claim against insurers in *Scotland Gas Networks Plc v QBE*. In this case, liability had been obtained by way of the equivalent of default judgment. This means there had been no trial to decide the insured's liability or the value of the claim; judgment was entered as a result of a procedural failure by the defendant.

Despite this, the court held that it was not open to liability insurers to dispute the insured's liability to the third party. This appears to be a departure from the English cases of *Astrazeneca v XL* and *Omega Proteins v Aspen Insurance*, with the result that the third party had better rights against the insurer than was intended by the 2010 Act. The outcome of this case, coupled with the current economic climate, is likely to lead to yet further claims by third parties directly against insurers where the insured is insolvent.

Conclusion

Numerous challenges continue to be faced by insureds and insurers to meet the demands of the risks faced across different industries, many resulting from the increased use and reliance on technology. Our experience is that insurers are taking robust positions and prepared to be more proactive than they may have been previously, undoubtedly because the volume and size of claims continue to grow. Insurance litigation can be expected to continue to produce interesting case law as new policies and terms are tested.

USA



Law and Practice

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Thompson, Coe, Cousins & Irons, LLP (Thompson Coe) has been providing legal services to clients both regionally and nationally for more than 70 years. It has more than 250 attorneys across offices in Austin, Dallas, Houston, San Antonio, New Orleans, St Paul, New York and Honolulu. The firm is recognised for its civil litigation capabilities, and its diverse group of attorneys have the experience, resources and capacity to respond to the multi-service demands of clients across multiple states and industries.

Thompson Coe offers comprehensive legal services in the areas of insurance litigation and coverage; product liability; mass torts; property and casualty litigation; labour and employment; business and commercial litigation; professional liability; appellate law; insurance regulation; state legislation; and business transactions, among others. Thompson Coe is recognised as a Band 1 law firm for insurance in Texas in the Chambers and Partners USA Guide 2024.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Insurance law in the USA is mainly governed at the state level.

State Legislatures

In the first instance, this involves the state legislature, which promulgates laws related to insurance. These laws form legal frameworks within the state regulating the development and sale of insurance products, and the conduct of people and businesses in the insurance industry. This body of laws is often referred to and compiled in “codes”.

State Agencies

Typically, the legislated code delegates significant authority to state executive officials to develop the regulatory framework in the state. This authority is usually located in an agency, or “insurance department”, the head of which is often titled the insurance “commissioner”. The commissioner and their regulators flesh out the legislative framework, enacting more detailed policies regarding, for example, the creation and sale of insurance products in the state. A state insurance department also plays a significant role in governing brokers, agents, adjusters, and rating organisations, along with insurers themselves.

The regulation of insurance companies is focused on licensed companies, sometimes referred to as authorised or admitted companies, and can include domestic companies, foreign insurers, or alien insurers. Alien insurers are companies organised under the laws of a foreign jurisdiction. They may be able to obtain a certificate of insurance as a licensed insurer subject to certain trusteed asset and surplus require-

ments. Surplus lines insurers must typically be authorised in a domiciliary state or country and meet certain capital surplus requirements. A risk retention group is another form of potentially regulated entity. These are a type of captive insurer subject to limited regulation under state law. Finally, some specific types of insurers may not be subject to all types of regulation, such as rate and policy form regulation, and exemptions would be identified in specific statutes in a state exempting such insurers from some laws. These may include farm mutual, county mutual, Lloyds, reciprocal exchanges, and fraternal benefit societies.

The Courts and Common Law Precedent

In addition to legislative and executive actions, insurance law in the USA is heavily impacted by the judiciary, both state and federal, and the common law precedents they set that can control particular insurance issues and disputes. These include the mechanics of a state’s regulatory scheme (the validity and scope of state legislation and regulatory actions), the validity and interpretation of particular policies, and the application of policies to the universe of factual disputes. It is important to note that from state to state, jurisdictions will vary greatly in the amount and depth of developed case law available.

Federal Role

Finally, the federal government also influences many aspects of insurance law nationally. For example, in addition to the regulation of US entities generally (particularly securities regulations and disclosure requirements), unique federal insurance issues may arise in relation to certain interstate transportation or maritime operations.

As discussed above, the primary regulation of the business of insurance is by a state department of insurance. The commissioner of that

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department may be elected or appointed by the governor and the appointment may be subject to confirmation by the state legislature. The state department of insurance regulates forms, rates and the solvency of most types of policies in the state, including most types of property, casualty, life, accident and health, and long-term care insurance.

The state department will typically be subject to the input of state legislative committees with jurisdiction of insurance issues. These may include insurance committees and business and industry committees. Of course, the legislature also appropriates funds for the activities of these agencies.

Reinsurance credit and accounting for domestic insurers may be governed by separate legislation and regulations. This includes reinsurance assumed for reinsurers that meet accreditation and certification requirements, including certain standards adopted by the National Association of Insurance Commissioners (NAIC) and reciprocal jurisdictions in the case of a covered agreement between the United States and European Union.

In some states, the state law enforcement official, for example, the attorney general, may have authority to enforce deceptive and unfair trade practices, as well as the authority to enforce actions against unauthorised insurance. Usually, the state's comptroller is responsible for the reporting and collection and auditing of all insurance taxes.

Writing of Insurance and Reinsurance

In many states, an authorised or licensed insurer must obtain a certificate of authority identifying the lines and types of insurance they are authorised to write. An applicant for a licence

will need to demonstrate the competence, fitness and reputation of its officers, directors and other persons having control of the insurer, and officers or directors may not be qualified if they have been convicted of a felony involving moral turpitude or breach of fiduciary duty.

Those applying for a licence or to form a new company must typically demonstrate that the proposed officers, directors or attorney have, in fact, a good record and sufficient insurance experience, ability and standing to make a success of the proposed company.

Minimum capital and surplus requirements are necessary and these may vary by type of insurer (property/casualty, life and health, etc). A state's commissioner may also require larger amounts of capital and surplus depending on the nature of the risks being underwritten or reinsured.

Premium Taxation

Insurance companies must pay taxes on premiums written on risks located in a given state, which can vary widely. Surplus lines taxes may be required to be collected and reported by licensed surplus lines agents, and independently procured insurance obtained by a business must be reported for tax purposes. In addition to premium taxes, a state may impose maintenance taxes, which will vary by line and type of insurance. Foreign insurers are commonly subject to retaliatory taxes for business written in the state based on the tax rate in their state of domicile.

Overseas Firms Doing Business in the Jurisdiction

Alien insurers are able to provide reinsurance as accredited or certified reinsurers in most circumstances and may also qualify as eligible surplus lines insurers. Overseas insurers may qualify for a licence to write business directly,

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typically by meeting trusteed asset and surplus requirements with assets in the United States. An exception to unauthorised insurance is often made for an insurance contract independently obtained from an unlicensed insurer such as an overseas-based insurer, provided that all the negotiations for such insurance occur outside of the state and the applicable independent, procured premium taxes are paid.

Fronting

Fronting (100% quota share reinsurance agreements) is commonly allowed as a type of reinsurance with domestic or licensed insurers. The reinsurer must be solvent and licensed, or meet any accreditation or certification requirements in a given state. Approval for total assumption reinsurance agreements varies across the USA.

Transaction Activity

Approval for the acquisition of a domestic insurer will pay particular attention to any person who will own 10% or more of the stock or have control of a domestic insurer, because of a presumption of control at that level. Investors in publicly held companies that acquire more than 5% of the stock of the publicly held company may be required to file notices with the Securities and Exchange Commission, stating whether their investment is intended to be used for control. Passive investors who file a Schedule 13G filing and reference Rule 13d-1(b) may be able to overcome a presumption of control without filing a separate disclaimer.

1.2 Litigation Process and Rules on Limitation

Insurance disputes of all kinds are usually resolved through litigation or arbitration. However, since most reinsurance contracts or treaties contain mandatory arbitration provisions,

litigation of a reinsurance dispute is unusual in most jurisdictions.

Litigation is commenced when either party to the policy files a complaint or petition in a court of competent jurisdiction and the other party is formally served with a copy of the pleading.

The party that is being sued then has a relatively short time to file a written answer to the other party's allegations. The lawsuit must be filed within a specified time after the dispute arose. That time varies between states from as little as two years to as much as ten years. Statutes of limitations are enforced very strictly. Some policies include a contractual provision identifying the time in which a suit must be brought and the courts will generally enforce these provisions if the contractual time period is not unreasonably short.

Any entity that is either a named insured or an additional insured (either expressly named or identified by group or class) can initiate a lawsuit to enforce its rights under an insurance policy. In most states, a party asserting a claim against an insured cannot file a lawsuit against the wrongdoer's insurer until after the claimant has been awarded a judgment against the insured. However, Alabama, Arkansas, Louisiana, Minnesota, New York, Pennsylvania, Rhode Island and Wisconsin all recognise a claimant's right to file a direct action against the wrongdoer's insurer in some circumstances, with those circumstances varying between the states.

1.3 Alternative Dispute Resolution (ADR)

Mediation has been an integral part of litigation in the United States for several decades, including in insurance disputes. Most courts will either order mediation or strongly suggest the parties consider mediation. Federal courts will some-

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times make a magistrate judge available to serve as a mediator at no cost to the parties. In state court, mediation is usually available through a mediation service or a lawyer or retired judge. The cost, which can range from a few hundred to several thousand US dollars a day, is divided among the parties.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Jurisdiction in American courts is composed of two elements: subject matter jurisdiction and personal jurisdiction.

Subject matter jurisdiction is created by the constitutional and statutory provisions of each individual jurisdiction. Since subject matter jurisdiction is a matter of state law, the courts will not allow parties to a contract, including an insurance policy, to create jurisdiction in a court. Personal jurisdiction, which addresses a party's amenability to being sued in a particular location, is not as strict and therefore a party may consent to being sued in a jurisdiction as a matter of private agreement. Therefore, courts will typically enforce a forum selection clause to which the parties have agreed if the court has subject matter jurisdiction.

The decision of what substantive law will govern an insurance dispute varies between jurisdictions. Some states have statutes concerning what substantive law will apply to certain types of disputes. In the absence of a statute, if an insurance policy contains a choice-of-law provision, a court will usually enforce that provision, although there may be limited situations in which the law of the chosen jurisdiction is so opposed to the public policy of the forum state that one or more provisions of the other state's law will not

be applied. If there is no statute or contractual provision, the decision of what substantive law to use is a matter for the court to resolve.

In the past, many courts applied the law of the jurisdiction where the insurance policy was negotiated and delivered, but as state lines have become less important in insurance transactions, most courts have adopted more flexible tests. The most prevalent is the "most significant relationship", in which the court considers various public and private interest factors involving the parties, the location where the claim arose, the nature of the claim, the interests that states who have some connection to the dispute have in the application of their respective laws, and other systems.

These factors are derived primarily from the Restatement (Second) of Conflicts of Laws which identifies the factors a court must consider and includes a specific provision for choice of law in insurance disputes. The test is very subjective and can result in inconsistent decisions between jurisdictions and even between courts in a single jurisdiction. Decisions on jurisdiction, court selection and choice of law all involve legal matters that are resolved by the court.

2.2 Enforcement of Foreign Judgments

Every jurisdiction has its own statutes and rules for the enforcement of judgments. Judgments from another jurisdiction in the United States are entitled to enforcement under the Full Faith and Credit clause in the United States Constitution. To satisfy this obligation, most states (California and Vermont being the exceptions) have adopted all or part of the Uniform Enforcement of Foreign Judgments Act, under which a judgment from another state court or federal court can be "domesticated" in the forum state and then enforced in that jurisdiction. In some states

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this is as simple as filing an authentic copy of the out-of-state judgment in a state court of competent jurisdiction, providing notice to the judgment debtor.

If the judgment debtor does not file an objection within 30 days, the judgment creditor can enforce the judgment in the state where it has become domesticated. The exact method of filing, giving notice and allowing the judgment debtor to object vary from one state to another. If the judgment debtor does object, it is usually not allowed to attempt to re-litigate the merits of the dispute and is limited to arguing that there was some procedural or judicial irregularity that would make enforcement of the judgment fundamentally unfair. There is no federal treaty for the enforcement of a judgment entered outside the United States but many of the individual states have adopted a variation of either the 1962 Uniform Foreign Money-Judgments Recognition Act or the 2005 Uniform Foreign-Country Money Judgments Recognition Act. In the few states that have not adopted either of these treaties, there are common law methods for enforcement of a non-US judgment, although they may be less efficient or effective.

2.3 Unique Features of Litigation Procedure

One notable feature of the American litigation system is the rampant use of expert witnesses on a wide variety of subjects. Although experts are supposed to be used only when they have special training, expertise or experience on matters that are beyond the knowledge or understanding of a typical juror, parties to an insurance suit may often try to gain a tactical advantage through the use of experts who are known to be especially friendly towards the insureds or insurers.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Both the federal court system and all state court systems favour arbitration in commercial disputes and the enforcement of arbitral awards. Under the Federal Arbitration Act, which applies to the majority of arbitral awards, a party seeking to enforce an arbitral award must seek confirmation of the award in a court of competent jurisdiction within a year of the arbitral award being made. A court can vacate an arbitral award only if the court determines that:

- the award was procured by corruption, fraud or undue means;
- there was evident partiality or corruption on the part of the arbitrators;
- the arbitrators were guilty of prejudicial misconduct during the course of the hearing; and/or
- 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.

Some states have begun to prohibit or limit mandatory arbitration clauses in some types of consumer insurance policies.

3.2 The New York Convention

The USA has joined the New York Convention on the enforcement of foreign arbitral awards.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitral awards are routinely enforced in courts throughout the United States in commercial and reinsurance arrangements, but some states are starting to limit the enforcement of mandatory

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arbitration clauses in certain consumer transactions or statutory causes of action available to individuals. The United States is a signatory to both the UN Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the “New York Convention”) and the Inter-American Convention on International Commercial Arbitration (the “Panama Convention”), and American courts are very receptive to the enforcement of arbitral awards from outside the United States.

4. Coverage Disputes

4.1 Implied Terms

The interpretation of an insurance policy is normally a question of law for the court to resolve. Insurance contracts are interpreted the same way as other contracts, with two exceptions.

First Exception: Interpretation of a Policy Giving Effect to Provisions

In the first exception, a reviewing court must try to give effect to the intent of the parties as expressed in the contractual language. A court should examine the entire contract and try to interpret the policy in such a way that all the policy provisions are given effect and no policy provision becomes meaningless. The policy language is to be given its ordinary and generally accepted meaning, unless the policy shows that the words were meant to be used in a technical or specialised sense. Courts will sometimes rely on industry custom and practice in interpreting a word that has an established meaning in a certain industry or profession.

A court should not interpret a policy in a way that rewrites the policy by imposing an additional duty or obligation on either the insured or the insurer and the policy. Extrinsic evidence is not allowed to interpret or change clear and unam-

biguous policy terms. Despite these rules, many courts show a tendency to interpret a policy in a way that is more favourable towards the insured, under the theory that the insurer was the author of the document and should not benefit from any imprecision or inconsistency in the policy language.

A few jurisdictions require that a court interpret the policy with consideration for the reasonable expectations of the insured. One exception arises when there is ambiguity in the policy language. If the insured can offer a reasonable interpretation of the ambiguous language, a court will generally adopt that interpretation even if the insurer can offer a more reasonable interpretation. Extrinsic evidence can be used to help resolve ambiguous language.

Second Exception: When a Policy Provision Is Against State Public Policy

A second exception arises when a policy provision is against the public policy of the state, where the substantive law controls the interpretation of a policy. As an example, some states will not allow an insured who is found liable for punitive damages to escape liability by passing the economic loss to the insurer, and will therefore not enforce a policy term purporting to cover punitive damage claims.

In liability claims, which form a substantial portion of insurance disputes in litigation, the applicable substantive law usually distinguishes between an insurer’s duty to defend its insured and its duty to indemnify its insured. The duty to defend is considered a broader duty and is based on analysing the factual allegations in the insured’s petition or complaint against the applicable policy terms and conditions. Traditionally, extrinsic evidence was not allowed and an insurer’s duty to defend was often resolved

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on a summary basis without trial. More recently, some jurisdictions have gone outside the language of the documents and have required an insurer to consider facts known to the insurer which would support the existence of a duty to defend. Specific jurisdictions may allow other extrinsic evidence in some circumstances.

The insurer's duty to defend is based upon the actual facts, regardless of the insured's allegations, and a determination of the duty to defend usually cannot be made until the underlying litigation between the insured and the third-party claimant has been resolved.

4.2 Rights of Insurers

Right to Information

An insurer will normally require the insured to complete an application requesting all information the insurer believes it will need to evaluate and underwrite the risk. The insured has an obligation to provide full and complete answers to all the requests from the insurer. It is common for the application to be incorporated into and made a part of the insurance policy. An insurer generally has no affirmative duty to proactively seek information but, in most instances, an insurer will have no ability to avoid coverage based on information in the possession of the insured but not requested by the insurer. This process applies to both consumer insurance contracts and commercial insurance contracts.

If the insured fails to disclose information requested by the insurer during the negotiation of the policy, the insurer can simply decide not to offer a policy to the insured. If the nondisclosure by the insured of information requested by the insurer is not discovered until after the issuance of a policy, the insurer can seek to rescind the policy through a judicial proceeding but, in most jurisdictions, an insurer must show that the non-

disclosure was material to the underwriting decision and that the insured intended to defraud the insurer. If the insurer does not become aware of the withheld information until after a claim is made against the insured and the withheld information is material to the risk that resulted in the claim, the insurer can seek rescission but must usually show intent to defraud on the part of the insured. If the withheld information is not relevant to the claim, rescission is usually not available. Since the insurer's scope of coverage is defined by the terms of the policy, any conditions, limitations or exclusions not set forth in the written policy cannot be enforced by the insurer.

Rights Regarding Warranties

American courts have traditionally treated a warranty as a promise in the insurance policy by the insured to either represent that a fact is true or that the insured has agreed it will do or not do a specified act. Whether an obligation in a policy constitutes a warranty is determined by reading the policy as a whole and the obligation does not have to be denominated as a warranty to be treated as a warranty. Instead, the focus is on whether the policy language as a whole shows that one party intended to rely upon the truth of a representation made by the other party.

The consequences of a breach of warranty vary depending on the materiality of the representation to the loss or claim. The effect of a misrepresentation by an insured must be material to the claim or loss at issue. In extreme cases, breach of a warranty by an insured can relieve the insurer of any obligation under the policy.

To alleviate the especially harsh consequences that may result from some types of breach of warranty, many states, either by statute or by judicial precedent, will not allow a breach of warranty by the insured to relieve the insurer of its

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duties unless the misrepresentation expanded the risk covered by the policy, or the insurer can establish fraud on the part of the insured.

Historically there has been some lack of consensus as to whether a policy provision should be treated as a warranty, a condition, or a coverage term. The growing trend in American courts is to give greater weight to the substance of a policy term than its title. Therefore, although a policy provision may be placed in the conditions section, a court may interpret the provision as a warranty, a coverage term or an exclusion. Despite the label, implied warranties are disfavoured and are seldom recognised.

Duties Imposed on an Insurer

In consumer policies and some commercial policies, state statutes or state court judicial duties may impose duties on an insurer (such as a duty to perform a thorough investigation before making a claims decision or an obligation to pay within a certain time once coverage becomes reasonably clear) that act much like a warranty. The consequences of the breach of a condition vary due to a variety of factors. In many jurisdictions, an insurer's breach of what may be considered a condition precedent, such as a duty to give timely notice or to co-operate with the insurer's investigation, may be excused if the insurer has not been prejudiced by the breach. Generally, conditions are enforced more strictly against an insurer than against an insured.

4.3 Significant Trends in Policy Coverage Disputes

See 5.3 Trends in the Cost or Complexity of Litigation.

4.4 Resolution of Insurance Coverage Disputes

Federal or State Court?

The American court system is complex and often confusing. There is a federal court system consisting of federal district courts, a limited number of appellate courts, and a single Supreme Court. The federal courts have limited jurisdiction and generally have jurisdiction over:

- claims involving a federal statute or right; and
- disputes between citizens of different states or between a United States citizen and a foreign entity or person where the amount in controversy is in excess of USD75,000.

There is a general feeling that a federal judge (who is appointed for life) may be less protective of local interests than a state judge (most of whom are elected), so insurers generally prefer federal court to state court.

It is quite common for an insurer to file a claim in a federal court seeking a declaration of rights and obligations under the policy when a disputed claim arises. If an insured files a suit in state court, the insurer has 30 days in which it can remove the case to federal court if the amount in controversy and the citizenship of the parties satisfy the minimum jurisdictional requirements of the federal court. As a result, the petition or complaint filed in smaller consumer claims will include statements about the citizenship of the parties or the amount in controversy in an attempt to prevent the case from being removed to federal court.

The Litigation Process

Each of the 50 states, plus the District of Columbia and American territories and dependencies has its own judicial system and the litigation processes can vary substantially. In broad strokes,

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once an insurance suit is filed, there will be an initial period where the defendant, either the insurer or insured, can challenge the court's jurisdiction or the legal sufficiency of the plaintiff's pleading. If the case survives this phase, the parties will begin taking discovery. Many states now require the parties to exchange certain relevant information before additional discovery begins.

Discovery can consist of:

- depositions of witnesses (either orally or in written questions);
- interrogatories served upon the opposing party asking about facts known to the party and legal positions taken by the party;
- requests that the opposing party produce documents in its possession, custody or control that are relevant to the dispute;
- requests that the opposing party admit or deny certain facts;
- site inspections of property; and
- physical or mental examinations of a party if the party's physical or mental health is in issue.

Additional discovery methods may be allowed in some jurisdictions. The discovery process often becomes very contentious in litigation and the parties may seek judicial intervention to resolve the dispute, although most judges expect the parties to resolve these types of disputes amicably. The ability and the intention of judges to intervene in these disputes varies greatly across the country.

At any time during the case, although usually after substantial discovery, a party may seek dismissal of the case through a procedure known as summary judgment, in which the party can try to convince the court that there are no mate-

rial facts in dispute, that the applicable law is in favour of the moving party, and that the case should therefore be terminated. If the case is not resolved on summary judgment, the case will proceed to trial on the merits.

In most jurisdictions, either party can request that the factual disputes in the case be presented to a jury for resolution. Insureds often request a jury on the assumption (sometimes well founded) that the average jury will not be favourable to an insurer. After the trial, the parties will submit proposed judgments to the court and the court will prepare and sign the court's judgment. The losing party will usually have the right to appeal the judgment to the first-level appellate court as a matter of right but any higher appellate review is discretionary with the higher court. Keep in mind that procedures will vary substantially between the various states.

4.5 Position If Insured Party Is Viewed as a Consumer

If a state considers insureds as "consumers" – typically under "bad faith" or extra-contractual statutes such as "deceptive trade practices" – an insurer may be liable for penalty sums for certain actions. See 4.7 **The Concept of Bad Faith.**

Consumer policies tend to be more highly regulated than commercial contracts or reinsurance contracts and many of the forms and provisions in a consumer policy are either mandated by or must be approved by the appropriate state regulatory party. Despite that, there is no appreciable difference between the rules applicable to additional beneficiaries under a consumer policy and the rules applicable to a commercial policy. There is insufficient precedent on additional beneficiaries under a reinsurance contract to draw general rules.

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4.6 Third-Party Enforcement of Insurance Contracts

There are multiple ways in which someone other than an original insured can obtain rights under an insurance policy. Firstly, either at the time of the negotiation of the policy or after the policy is issued, an insurer may agree to add additional persons or entities as named insureds under the policy. These named insureds generally have the same policy rights as the original insured. Secondly, a policy may allow for the protection of additional insureds, either by specifically naming the additional insureds or by describing a class or group of additional insureds (such as an endorsement in a policy issued to a contractor extending coverage to all parties the insured is contractually obliged to name as additional insureds, or a renter's policy that provides additional coverage to the owner). These additional insureds may not have the same scope of coverage as the named insured, depending on the scope of coverage contained in the policy naming or identifying the additional insured. (As an example, a renter's policy may limit the additional coverage to damage caused by the tenant but not to damage caused by the owner.) In homeowner, property, or similar policies, a lender, mortgagor, or lienholder may be protected through a loss payable clause that directs payment to the protected party instead of the named insured in some instances. In all these situations, the insurer may request information from the insured about the intended beneficiaries and the insured is obliged to give full and complete answers. Implied beneficiaries tend to be disfavoured and are not often allowed. An insured who wants to protect additional parties through a policy should make that intention clear to the insurer, and make sure that intent is reflected in the policy language.

4.7 The Concept of Bad Faith

An insured often attempts to impose extra-contractual liability ("bad-faith" liability) upon an insured for alleged irregularities in claims handling. Most jurisdictions now have comprehensive statutory schemes imposing certain obligations on an insurer in handling and resolving a claim. A successful insured can recover amounts beyond the policy limits in some situations, but there is great variance between the states on what extra-contractual penalties can be imposed.

4.8 Penalties for Late Payment of Claims

Most jurisdictions have statutory or regulatory timelines dictating when an insurer must make a claims decision and make payment to the insured. The amount of the penalty varies between states but can be as much as 18% per annum on the amount that was wrongfully withheld or was delayed in payment.

4.9 Representations Made by Brokers

In the consumer market (also known as the personal lines market and primarily involving home, auto, health, and life insurance), an insurer may use an exclusive agent who is acting on behalf of the insurer but the agent may also have duties of honesty and disclosure to the insured. In other consumer policies, the insured may use the services of an independent agent who may be acting on behalf of the insurer in performing some duties, but be acting on behalf of the insured in performing other duties.

The duties of an agent vary from state to state but generally include duties of honesty and an obligation to obtain the insurance requested by the insured or to explain to the insured why the coverage is not available. An agent for the insured usually does not have a duty to recommend coverage or explain policy terms to an

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insured. If an agent assumes those duties, the agent is obliged to perform them as a reasonably prudent agent would do.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In commercial policies, especially those involving non-admitted surplus lines carriers or London market entities, the common practice is for the insured to retain the services of a retail broker to act on its behalf and for the insurer to retain a wholesale broker to act on its behalf. In commercial policy negotiations, there is little direct contact between the insurer and the insured or its retail broker or between the insured and the insurer or its wholesale broker.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurer funding for defence of an insured naturally arises most commonly in the context of liability policies, such as commercial general liability, D&O, and certain package policies. It is important to note that in some instances the defence costs may reduce or “erode” the overall policy limits, leaving few funds for indemnification.

5.2 Likely Changes in the Future

These contractual defence obligations are standard and should not change in the near future.

5.3 Trends in the Cost or Complexity of Litigation

The US has seen an uptick in WRAP policies in the construction industry, which allow general contractors, for a higher premium of course, to “wrap” all their subcontractors under the general contractor’s policy. With fewer parties actively involved in the litigation, the general contractor

and its insurer then have greater control over the costs and resolution of the case.

5.4 Protection Against Costs Risks Litigation Funding

Litigation funding (“LF”) has caught the eye of legislatures and courts alike. LF is used frequently by plaintiffs’ attorneys, is on the rise, and is often not known about by defendants. Conservative estimates put the LF industry at USD2.3 billion, although the Swiss Re Institute suggests it is much higher. The loans can be provided to litigants or attorneys. The Government Administration Office defines LF as “an arrangement in which a funder that is not a party to a lawsuit agrees to provide nonrecourse funding to a litigant or law firm in exchange for an interest in the potential recovery of the lawsuit.” Telltale signs of LF include unusually high medical specials (especially in soft tissue injuries); medical treatment for seemingly unrelated conditions; treatment by providers outside of their specialisms; accelerated medical treatment; and location of medical treatment.

The LF investors include a range of parties, from private equity groups to individuals. The non-recourse nature of the funding is what distinguishes LF from a traditional loan. Interest, not surprisingly, is attached to recovery. LF exists in commercial/corporate contexts (IP, antitrust, asset recovery, fraud, and class actions on behalf of large corporations) and is used by large law firms, as well as in the large personal injury/mass tort arena. LF also exists in the consumer arena, but the loans are typically small and used by plaintiffs to fund living expenses or medical treatment, as opposed to funding litigation. Consumer recipients have drawn the most attention from state legislatures due to the greater potential for abuse.

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Downsides to LF

The downsides to LF include:

- with no personal stake in a case, the “money down” makes the funding deal similar to a bet at a casino;
- LF could put plaintiffs in a position that a reasonable offer to settle cannot be accepted because the financial obligations of the loan cannot be met;
- accidents should not be investment opportunities because this perverts the justice system;
- LF can promote and prolong litigation because defence counsel is forced to divert additional time and money away from productive defence of the case;
- if the funder holds the purse strings, the funder may exert control over litigation strategy to the plaintiffs’ disadvantage;
- a defendant should be entitled to know whether unnecessary medical procedures are being promoted by a funder to increase case value; and
- a defendant wants to know whether a lien exists to be satisfied.

Upsides to LF

Not surprisingly, the proponents of LF contend:

- disclosure of LF is unnecessary and irrelevant;
- LF shifts the risk of adverse litigation outcomes and because it is non-recourse, the funder’s and plaintiff’s interests are aligned;
- LF to a law firm benefits the client by providing the resources necessary to provide the best experts, etc, needed for the case; and
- a plaintiff could benefit by not settling early because the attorney could not afford a lengthy, expensive lawsuit.

Other issues of concern are the potential conflict of interest between a client and their attorney if the attorney put the funder’s interest ahead of the client’s interest. Maintaining independent professional judgment by the attorney is an additional consideration.

On the federal level, the Litigation Funding Transparency Act was presented to Congress in both 2018 and 2021, and was not passed on both occasions. Under the proposed act, disclosure of LF and the agreement itself were required in federal class actions and multi-district litigation.

Response From the Legislature

Nevertheless, some federal courts have taken notice and require disclosure of LF (but not the agreement itself) by local rule: District of Arizona; Central District and Northern District of California; Middle District of Florida; Northern District and Southern District of Georgia; Northern District and Southern District of Iowa; District of Maryland; Eastern District and Western District of Michigan; District of Nebraska; District of Nevada; Eastern District, Middle District and Western District of North Carolina; Eastern District, Western District and Northern District of Oklahoma; Middle District of Tennessee; Northern District and Western District of Texas; Western District of Virginia; and Western District of Wisconsin. The 3rd, 4th, 5th, 10th and 11th Circuits of the federal appellate courts have also adopted local rules.

While state legislatures primarily seek to protect consumers, the courts have a differing perspective. The existence of LF alerts the court to issues best addressed in pre-trial conferences; aids in compliance in the matter of financial disclosures and recusal obligations; highlights potential conflicts of interest; and who should participate in

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settlement conferences due to potential resolution issues.

As mentioned above, some states have addressed LF by statute or common law with mixed results, including: Delaware, Illinois, Kentucky, Maryland, Minnesota, New Jersey, North Carolina, Ohio, Pennsylvania, Texas, Utah, West Virginia and Wisconsin. Even the United States Tax Court has jumped in holding that although LF payments are structured as loans, including the non-recourse payments makes them “income” rather than a “loan” for tax purposes. Therefore, it a good idea for attorneys to consider tax and accounting implications for their clients.

Insurers should expect LF to continue in one form or another. Some states may refrain from legislation, but the courts will likely start implementing their own local rules to address issues surrounding the disclosure of LF and possibly even the LF agreement itself. Additionally, courts may issue opinions where statutes or the existence of LF at least raises issues of fairness for defendants, to understand what factors may be at play in order to further resolution.

The Alternative Risk Transfer (ART) Market

The USA insurance market also includes the alternative risk transfer (ART) market. In this market, companies purchase coverage and transfer risk outside traditional commercial insurance mechanisms. This may include the following:

- risk retention groups (RRGs);
- insurance pools;
- captive insurers;
- risk mitigation provided by wholly owned subsidiaries of a company;
- contingent capital;
- derivatives; and
- insurance-linked securities.

The alternative risk transfer market is primarily delineated between risk transfer through alternative products and risk transfer through alternative carriers.

6. Insurers’ Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Most consumer and commercial policies expressly recognise an insurer’s right of subrogation against the wrongdoer once a claim is paid. Some jurisdictions also recognise common law subrogation rights in favour of the insurer, but those rights may be based on equitable or other considerations so a contractual subrogation right is preferred.

6.2 Legal Provisions Setting Out Insurers’ Rights to Pursue Third Parties

There are two important limitations on an insurer’s subrogation rights. Firstly, in the absence of an express contractual provision, an insurer usually cannot exercise that right against its own insured because to do so would undercut the exact risk transfer which is the purpose of insurance. Secondly, in many types of policies, such as construction liability policies, an insurer will be asked to waive its subrogation rights and a provision to that effect will be included in the policy either as a term of the original policy or as an endorsement. The insurer may charge a higher provision for waiving subrogation.

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7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Regarding climate and natural disaster risks, insurers and related institutions appear to be experimenting with a variety of responses:

- reorganising, or at least re-thinking the way they see themselves as many policyholders do – ie, as “financial safety nets”;
- increasing reliance on technology for better evaluation of climate-related issues on classification, underwriting and rating of risks; and
- reorientating customer-facing services to take a more active role in risk prevention (additionally, such risks may push a new demand for and increase in industry consolidation).

7.2 Forecast for the Next 12 Months

Climate change and the attendant insurance risk are unlikely to change in the near future.

7.3 Coverage Issues and Test Cases

No truly seminal cases in this area have taken root at this time.

7.4 Scope of Insurance Cover and Appetite for Risk

These factors have also led some carriers to pull out of certain markets, especially coastal regions like California, Texas and Florida.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

There has been a slight potential for pull-back by the insurance industry on some ESG considerations in the past year. However, insurtech, or “the innovative use of technology in connection

with insurance”, unsurprisingly continues to be a topic at the forefront of the insurance industry’s attention. Issues to monitor include:

- innovations in improved customer experiences, particularly among established insurance businesses;
- consolidation and the blending of automation and analytics technologies; and
- data-driven ESG analysis and risk exposure.

These are in addition to trends such as embedded insurance, accelerated learning and artificial intelligence, which will continue to play an important role going forward.

Regulators nationwide are naturally keeping a close eye on insurtech developments. This includes traditional concerns regarding consumer protection, capital and reserve requirements, and solvency evaluations. But it will also push these regulatory bodies further into new territories of digital data privacy, cybersecurity and AI. For certain states, ESG considerations will also play an increasing important role.

8.2 Data Protection Laws

Data use and security, and climate and natural disaster risk continue to be the leading risks and areas for concern in 2024. While many states, and the federal government in some cases, are taking an active role in guiding and developing protections or guard rails for these issues, many other jurisdictions are allowing more experimentation. The use of AI in the classification, underwriting and rating of risks is one such area.

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9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation Florida Tort Reform

Perhaps one of the most notable changes affecting insurers writing policies in Florida moving forward will be the significant tort reform enacted by the Florida legislature in 2023. Florida is one of the most litigious jurisdictions in the US, and the tort reform was intended to quell some of that litigation by giving businesses and insurers greater protection against lawsuits. The legislation was directed at tort claims, and some enactments were directed at bad faith in insurance. The legislation applies to causes of action accruing on or after 23 March 2023. Some of the changes are enumerated below.

One major change was to Florida's comparative fault scheme. While Florida had been a traditional, "pure" comparative negligence state, the legislation aligns Florida with the majority of other states having a "modified" scheme. Under the old scheme, a plaintiff was entitled to recover a percentage of damages proportionate to the degree of fault of the defendant. Now, if a plaintiff's percentage of fault is more than the defendant's percentage of fault, the plaintiff cannot recover. The change, however, does not apply to medical negligence.

Another noteworthy change is that the legislation reduced the limitations period for general negligence claims. The limitations period for general negligence is now two years instead of four years.

Possibly looking to the Texas statutory model, Florida modified the admissible evidence available to prove past and future medical expenses.

Previously, a plaintiff could board the entire amount of the medical bills charged for the services rendered. Evidence of adjustments or reductions by healthcare insurers was prohibited. Now, generally, evidence presented to prove past damages for medical expenses is limited to the amounts actually paid, regardless of the source of payment. Admissible evidence varies with the existence of healthcare coverage, Medicare, or Medicaid. Importantly, if past medical care was obtained under a letter of protection, evidence of what health insurance would have paid for the necessary treatment, plus a plaintiff's share of the expenses, is now admissible. Moreover, a letter of protection must be disclosed, overruling *Worley v Central Florida YMCA, Inc*, 228 So. 2d 18 (Fla. 2017).

Premises liability claims involving negligent security also received attention. Under the new legislation, a jury can now consider the fault of all persons contributing to an injury, including a non-party who injured the plaintiff by committing a crime on the defendant's property.

Florida legislation also addressed insurer bad faith. Significantly, a claimant, an insured, or their representatives have the duty to act in good faith in providing information to insurers, making demands, setting deadlines and making settlement attempts, and a fact finder may consider it bad faith to reduce the damages awarded. Also, the legislation clarified that mere negligence cannot support a finding of bad faith against an insurer. An insured's statutory entitlement to recover attorneys' fees upon prevailing against an insurer has been eliminated, except in declaratory judgment actions to determine coverage. The use of non-contingency multipliers to calculate attorneys' fees is now prohibited.

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While the impact of these enactments must make their way through the Florida courts, the number of baseless lawsuits in the bodily injury arena should decrease. For those suits that go forward, insurers and defendants should have a more level playing field.

The Illinois Supreme Court Turned the Tables for Construction Defect Coverage

Illinois courts for over 20 years have interpreted the standard commercial general liability (CGL) definitions of “occurrence” and “property damage” to refuse coverage for faulty construction. However, a new day has arrived for contractors, owners and developers, to the detriment of insurers – see *Acuity v M/I Homes of Chicago, LLC*, No 129087, N.E.2d (Ill. 30 November, 2023). Previously, Illinois courts generally found coverage only in the event of damage to other real property or the personal property of owners.

The underlying lawsuit was filed by a townhouse owners’ association for breaches of contract and the implied warranty of habitability against the general contractor/successor developer/seller of the townhouses. The association generally alleged that the general contractor’s subcontractors used defective materials, caused faulty workmanship, and failed to comply with building codes. The damage alleged was uncontrolled water leakage and moisture in locations of the buildings where it was not “intended or expected” and causing resulting property damage to the townhouses and other property – such as windows and patio doors, as well as damage to the interior of the units.

The general contractor tendered its defence as an additional insured under a subcontractor’s policy, which denied and filed a declaratory judgment action. The general contractor argued that the association merely alleged “the natural

and ordinary consequence of defectively performed work”, which was not an accident, and therefore, not an “occurrence”. The insurer further urged that the association only sought economic loss – the cost of repairing and replacing the defective construction work, which was not “property damage”. The association countered that damage to “other property” was alleged beyond the repair and replacement of the faulty work, meaning “property damage” caused by an “occurrence” existed, implicating the insurer’s duty to defend.

The trial court found in favour of the insurer, concluding that property damage resulting from faulty work was not an “occurrence” because it was a natural and ordinary consequence of the construction project and not an accident as required under the policy. While the trial court agreed that damage to other property was sufficient to implicate coverage, it found that was not the case before it, which focused on recovering damages to the townhouses and not damage to other property.

On appeal, the parties agreed that Illinois law found coverage only in the event of damage to other real property or personal property of owners. The appellate court agreed with the parties’ interpretation of Illinois law but criticised and questioned that approach because it focused on the courts’ analyses driven by broad policy considerations and not by policy language. Nevertheless, the appellate court was duty bound by precedent, but reversed the trial court conclusion that the association had sufficiently pleaded damage to other property, triggering a duty to defend.

The Illinois Supreme Court granted leave to appeal. The Supreme Court noted upfront that it had “not yet analysed the specific coverage

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provisions at issue here in the context of a construction defect case, but the issue has been the subject of much litigation in the appellate court". Like the intermediate court, the Supreme Court recognised the multitude of opinions in which the issues of "occurrence" and "property damage" were decided and the various reasons for their holdings, while acknowledging that the opinions were based on policy considerations rather than contract construction. Accordingly, the court reasoned that it would not begin by analysing the parties' premises but would first return to legal principles to bring clarity and provide a disciplined legal framework.

Following a discussion of Illinois law on the duty to defend and the construction of policy language, the court turned to the insurance agreement. The court gave little discussion to the meaning of "property damage" pointing out that tangible property suffers a "physical injury" if the property is "altered in appearance, shape, color or in other material dimension". Since the allegations against the general contractor sufficiently alleged "property damage" to the interior of the units by leaks and moisture damage, the requirement was met.

With respect to an "accident", the court indicated that no opinions had interpreted its meaning in the context of construction defects. In accordance with contract construction law, the first court reviewed "accident" interpretation by

courts in other contexts, followed by the dictionary definition. The court then held that "the term 'accident' in the policies at issue reasonably encompasses the unintended and unexpected harm caused by negligent conduct".

Applying that definition to the construction defect allegations before it, the Supreme Court noted that the association did not allege intentionally performed sub-standard work. Instead, according to the court, the allegations reflected inadvertent construction defects. The court concluded this despite the insurer's assertion that any portion of a completed project caused by faulty work can never be an accident because it is always the natural and probable risk of doing business. The court addressed that assertion by pointing out that the notions of business risk were specifically expressed in the exclusions of the policy. Therefore, the court held that the duty to defend was implicated and remanded the case to the trial court to address the effect of the exclusions on the duty to defend.

The importance of this new opinion to insurers writing general liability coverage in Illinois is that it is likely to increase the number of construction defect lawsuits in which the insurers must defend. What should be surprising to insurers is that in a state like Illinois, no Supreme Court precedent existed in such a commonplace claim until now.

Trends and Developments

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Thompson, Coe, Cousins & Irons, LLP (Thompson Coe) has been providing legal services to clients both regionally and nationally for more than 70 years. It has more than 250 attorneys across offices in Austin, Dallas, Houston, San Antonio, New Orleans, St Paul, New York and Honolulu. The firm is recognised for its civil litigation capabilities, and its diverse group of attorneys have the experience, resources and capacity to respond to the multi-service demands of clients across multiple states and industries.

Thompson Coe offers comprehensive legal services in the areas of insurance litigation and coverage; product liability; mass torts; property and casualty litigation; labour and employment; business and commercial litigation; professional liability; appellate law; insurance regulation; state legislation; and business transactions, among others. Thompson Coe is recognised as a Band 1 law firm for insurance in Texas in the Chambers and Partners USA Guide 2024.

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Christina Culver represents clients in insurance coverage matters. She provides guidance for coverage and bad faith disputes through each phase of the resolution, including pre-

litigation coverage analysis, strategic discovery, motion practice, alternative dispute resolution, trial and the appellate process. Her practice at Thompson Coe focuses on complex, multi-party insurance coverage litigation and bad faith litigation concerning general liability, directors' and officers', environmental, construction, professional liability, travel, and accident and health coverage. Christy is licensed in Texas and Louisiana and handles litigation across the United States. She is a ranked practitioner in insurance in Texas in the Chambers USA Guide 2024.



Cy Haralson of Thompson Coe focuses primarily on insurance coverage and defence, including complex, multi-party insurance coverage and bad faith litigation involving general liability,

environmental pollution, construction defects, directors' and officers' coverage, errors and omissions coverage, and property insurance. His extensive property insurance experience includes pre-suit resolution and litigation of property damage, insurance coverage and bad faith claims including hurricane, hail, mould, foundation, theft and fire losses.



Kevin Risley of Thompson Coe has first-chair trial experience in more than 25 cases, running the gamut from insurance coverage to product liability and personal injury, to banking and

commercial litigation, and constitutional law. He has been lead appellate counsel on more than 150 cases including more than 50 cases that have resulted in written opinions. He has substantial experience in a broad variety of procedural issues including jury charge preparation and objections, personal and subject matter jurisdiction, mandamus, injunctive and other extraordinary relief, setting aside default judgments, and appellate jurisdiction. Kevin also regularly serves as an expert witness on issues of reasonableness and necessity of attorneys' fees.



Jody Stasney provides insurance carrier clients of Thompson Coe with direct representation in matters of coverage and bad faith. She advises insurers at state and

national level, regularly rendering coverage opinions and litigating coverage issues and bad faith. Jody has significant experience in all lines of commercial insurance, including general liability, excess/umbrella liability, property, auto and professional liability. Jody has handled several coverage issues arising under the liability portions of the homeowners' policy. She also regularly serves as monitoring/coverage counsel for excess insurers, advising them on the potential liability and exposure under their policies. Jody also advises insurers in matters involving the Stowers doctrine.

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Artificial Intelligence (AI)

Artificial intelligence presents both huge upsides and downsides to the insurance industry. The benefits are obvious: reduced operating costs after recovery of investment, more precise underwriting and profitability, more efficient claims handling – including the ability to identify high-risk claims earlier in the process – improved investment analytics, and streamlined compliance reporting. While most insurers believe in the use of AI technology, the industry has been somewhat slow in transferring to a more AI-centric business model. The reasons include uncertainty about what regulations will be put in place, concern that the technology is improving so rapidly that such a major investment should be postponed until the technology turnover slows, a difficulty in integrating AI elements into existing IT systems, concerns of data privacy and security, and the reluctance of some older executives to embrace the new technology.

Lack of access to sufficient data is also offered as a justification for the delay in transition, but tools such as blockchain technology and the internet of things may provide substantial help in gathering and ordering data.

For the present, most companies seem willing to move slowly into the AI world and will probably not make major investments until the technology is better established.

Climate Change and Natural Catastrophes

Between 1980 and 2010, the United States experienced an average of five severe natural catastrophic events a year. That annual average grew to 15 between 2011 and 2022 and reached 28 events in 2023. The impact of those events on underwriting profitability, reserve adequacy, and funds available for investment is immense. Many carriers are no longer writing coverage in areas

such as Florida and California. Their departure leaves some risks uninsured and others covered by non-admitted carriers, with resulting higher premium costs.

The number of severe weather events is universally expected to continue the upward trend and the pressure on property, health and life insurers will continue to increase. Both investors and regulators are demanding that carriers gain a greater understanding of their climate-risk exposures and develop business models to prepare for sudden and unanticipated changes in climate patterns.

Personalised Insurance and Customer Service

As consumers' daily lives grow more digitally controlled, insurance consumers want the purchase of insurance and the resolution of claims to be as simple as ordering a shared ride or having dinner delivered to their door. The insurance industry was forced to move in this direction by the COVID-19 pandemic, and the digital focus on customer interaction continues.

One of the consequences of greater access to consumer data is what some insurers are calling "personalised insurance": a fully automated process that begins with a more individualised analysis of an insured's needs, includes more comprehensive risk-management advice, advances to a policy that is more customised to the individual insurer, and provides a data-driven claims process.

Insurtech

The combination of increased AI capability and greater consumer individuality has led to a new type of insurer known as an insurtech company. Insurtech is premised on the belief that the insurance industry is ripe for innovation and disrupt-

tion through technological innovations designed to make the current insurance model more efficient and more competitively priced. According to market research company, Grand View Research, the total insurtech industry revenue value in 2022 was USD5.4 billion. The revenue forecast for 2030 is USD152 billion. Insurtech insurers are facing some resistance from established insurers and from some regulators, but most observers agree that the insurtech market will continue to grow dramatically over the next few years.

Embedded Insurance

Embedded insurance is coverage that is directly related to the purchase of an item, such as having the option to buy phone insurance as part of the purchase of a mobile phone or having travel insurance added when an airline ticket is purchased. In a 2023 survey by insurance company Chubb, 81% of financial executives involved in purchasing insurance products expressed the opinion that embedded insurance will move from a “nice-to-have” option to a “must-have” necessity.

Nuclear Verdicts

Nuclear verdicts – awards that are much higher than expected based on the facts of the case – continue to grow at an alarming rate. A survey by Marathon Strategies found nuclear verdicts, which totalled USD4.9 billion in 2020, grew to USD18.3 billion by 2024, an increase of 370%. The median of nuclear verdicts increased by 92%, from USD21.5 million to USD41.1 million, over that same period.

There is some suggestion that this dramatic rise in verdicts is fuelled by successful plaintiffs’ attorneys whose use of AI and other analytics tools identifies particular cases and venues where the possibility of a substantial verdict is

more likely. Whatever the source, the carriers’ response is an increased effort to determine cases with the potential for a nuclear verdict at an early stage in the claim-handling or litigation process.

Litigation Funding

Litigation funding refers to when a third party, such as a private investor, a partnership or a hedge fund, provides money to a plaintiff or plaintiff’s counsel to finance the cost of litigation. The funder receives an agreed-upon percentage of the recovery, whether through trial or settlement, but receives nothing if the litigation is unsuccessful. One study found that the amount of litigation funding grew by more than 400% from 2012 to 2017 and the practice has continued to grow since then. The Institute for Legal Reform estimates that commercial litigation investments in the United States alone total USD15.2 billion.

The practice is highly controversial. Its proponents assert that litigation funding provides better resources to claimants and makes justice more accessible to litigants. Opponents liken the practice to bankrolling a gambler at a casino and claim it creates multiple conflicts between the claimant, lender and attorney. Some legal scholars have raised concerns that the practice is a form of champerty, an English law doctrine that prohibits third parties from providing financial assistance to a claimant in return for a piece of the recovery. That is still the law in England and in many American jurisdictions, although in a more relaxed form in some states. The use of litigation funding is largely unregulated and its legality and ethical propriety remain undetermined.

Cybersecurity

Cybersecurity issues present both an opportunity and a risk for the insurance industry. The opportunity lies in the potential for adverse consequences from cybersecurity attacks and data breaches. This is a risk that can be quantified and insured against and that continues to grow. Ransomware attacks increased by 77% in the first quarter of 2023 and the entire cybersecurity market is expected to triple between 2022 and 2027.

That growth could be even greater as the level of geopolitical strife continues and one or both of the contentious parties seeks a financial or an information advantage.

The other side of the coin is the risk of loss to an insurer that is the victim of a cybersecurity breach. For many of the same reasons the increased use of AI will reshape how insurance companies do business, the risk of a data breach or other security invasion is increasing for insurers and other businesses.

Attorney-Client Privilege

Attorney-client privilege is designed to protect certain confidential communications between an attorney and their client relating to legal advice from being exposed. The privilege is a concept of the law of evidence and is derived from statutory and common law in all 50 states. It is the oldest recognised privilege in US jurisprudence and traces its origins back as early as the reign of Queen Elizabeth I in the 16th century. However, not all communications between an attorney and a client are protected by the privilege.

Generally, the communication must be: (i) seeking legal advice; (ii) from a legal professional in their capacity as such; (iii) related to that legal

purpose; (iv) made in confidence; and (v) made by the client.

Despite the central importance of this privilege, it has been eroded in recent years. A few representative cases are discussed below.

In-house counsel

Travelers Property Casualty Company of America v 100 Renaissance, LLC, 308 So. 3d 847, 857 (Mississippi 2020) (“Travelers”), rehearing denied (14 January 2021)

In *Travelers*, the Supreme Court of Mississippi addressed whether the attorney-client privilege was waived when a disclaimer letter was drafted by the insurer’s in-house counsel and sent under the adjuster’s signature. The court said yes. After denial of a claim, the insured sued *Travelers* for bad faith and deposed the adjuster. In the transcript, the adjuster disclaimed any knowledge of the statute:

“Q: Just looking at the statute, the plain language of the statute right here, okay, [Section] 83-11-101(2), you looked at before. Is there coverage under that statute, under the plain reading of that statute?”

Q: In your opinion.

A: I don’t know. I’m not an attorney. I don’t know anything about statutes. That’s what we have General Counsel for. I deal with policy language, what’s in the policy.”

Ultimately, the Supreme Court of Mississippi held that the adjuster’s testimony put the attorney-client privilege at issue, waiving the privilege. Her testimony was bereft of any knowledge or information as to why the claim was denied. The decision was based primarily on the fact that the second denial letter was written after

in-house counsel's involvement and was signed by the adjuster. The court noted that, "Generally, it may be expected that the person who signs a letter has personal knowledge of the matters set forth in the letter." Furthermore, the court found that the adjuster lacked the necessary personal knowledge:

"Travelers sent the denial letter to Renaissance in an effort to explain its arguable and legitimate basis to deny the claim. The letter was signed by [the adjuster]; but based on her deposition testimony, it clearly was prepared by someone other than [the adjuster], most likely [in-house counsel]. If so, [in-house counsel] did not act as legal counsel and give advice to [the adjuster] to include in the denial letter. Instead, the denial letter contained [in-house counsel's] reasons to deny the claim. [The adjuster's] signature was simply an effort to hide the fact that [in-house] counsel, not [the adjuster] had the personal knowledge of Travelers' reasons to deny the claim and to use the attorney-client privilege as a sword to prevent Renaissance from discovering the reasons from the person who had personal knowledge of the basis to deny the claim.

Because the claims handler relied substantially, if not wholly, on in-house counsel to prepare the denial letter, then the reasoning of in-house counsel should be discoverable."

Anderson v Trustees of Dartmouth College
2020 WL 5031910 (District of New Hampshire,
25 August 2020)

In this case, an expelled pro se college student obtained discovery of numerous documents the college had withheld as privileged. The plaintiff asserted a variety of claims against Dartmouth College after he was expelled. He filed a motion to compel discovery of hundreds of documents Dartmouth was withholding on the grounds of

attorney-client privilege. Rather than mechanically protect the documents as a default, the court looked at them and, after dividing them into four groups, found some documents discoverable despite the privilege.

- Group 1 were emails in which an attorney in the general counsel's office provided legal advice to another Dartmouth employee outside of the general counsel's office. To the extent these emails contained threads of forwarded emails between the plaintiff and the college, those emails were discoverable.
- Group 2 were emails between an attorney in the general counsel's office and a staff member of that office. Again, unless any actual legal advice was provided, those communications were discoverable.
- Group 3 were emails between two or more employees that an attorney in the general counsel's office was later copied on. Emails between non-lawyers merely forwarded to the college attorneys were discoverable, along with emails sent to groups of college recipients, including both lawyers and non-lawyers.
- Group 4 were emails between non-attorneys discussing legal advice given by an attorney. These were discoverable, although the actual legal advice was not.

Saran v Chelsea GCA Realty Partnership, 174 A.D.3d 759 (Supreme Court New York 2019)

In this litigation, the defendants inadvertently disclosed to the plaintiff certain confidential and allegedly privileged emails, including emails between the defendant's CEO and in-house counsel. In the discovery dispute, the court noted, "because the attorney-client privilege obstructs the truth-finding process, its scope is limited to what is necessary to achieve its purposes" and "because in-house counsel may serve other company roles, with mixed business

and legal responsibility, and their involvement in the company may blur the lines between legal and nonlegal communications, there is a heightened need to apply the privilege cautiously and narrowly in the case of in-house counsel, lest the mere participation of an attorney be used to seal off disclosure". With this harsh view of the privilege, the court ruled that the communications related more to the business of the defendants than legal issues and therefore the privilege did not apply.

Counsel actions during claim investigation

*Curtis Park Group, LLC v Allied World Specialty Insurance Company, 20-CV-00552-CMA-NRN, 2021 WL 4438037, at *7 ("Curtis Park Group") (District of Columbia, 28 September, 2021)*

In *Curtis Park Group*, the court held that an insurer's outside counsel could be deposed, as the court concluded that he had been "a key person in the claims investigation process". In a Colorado coverage action, the deposition of Allied World's coverage counsel was sought. Because coverage counsel was also Allied World's defence counsel, the court considered a three-part test: "where the party seeking to take the deposition has shown that: (1) no other means exist to obtain the information other than to depose opposing counsel; (2) the information sought is relevant and nonprivileged; and (3) the information is crucial to the preparation of the case". Applying these factors, the court ultimately allowed the deposition despite the attorney-client privilege. As to the first element, "other available means", the engineer's oral report and communication between coverage counsel and Allied World regarding the reservation of rights was not completely contained in prior discovery and depositions. As to the second and third elements, the information sought was crucial because "what the insurer knew and when it knew it is crucial to resolving" an insurance bad-

faith claim. Allied World needed to explain how it concluded that a construction defect caused the deflection, and how the engineer's evidence, conclusions and communications informed the denial letter. Colorado authorities therefore hold that when an attorney acts as a claims adjuster, it is not protected by either attorney-client privilege or work product doctrine.

*Canyon Estates Condominium Association v Atain Specialty Insurance Company, No 2:18-CV-1761-RAJ, 2020 WL 363379, at *1 ("Canyon Estates") (Western District of Washington, 22 January 2020)*

In *Canyon Estates*, the court held that Great Lakes Insurance Company, SE, did not rebut the Washington state presumption that "there is no attorney-client privilege relevant between the insured and the insurer in the claims adjusting process". *Canyon Estates Condominium Association v Atain Specialty Insurance Company, No C18-1761-RAJ, 2019 WL 6173231, at *1 (Western District of Washington, 20 November 2019)*. In the coverage action after a denial, the magistrate held that Great Lakes did not rebut the presumption to attorney-client privilege or work-product doctrine because claims counsel was retained long before litigation and drafted the initial and subsequent denial letters. The magistrate held that the claim file up to and including the date of the second denial was not protected and was discoverable. Great Lakes maintained that its outside counsel was kept separate from the claim investigation and did not participate in the claims-handling functions. The court disagreed.

The disclaimer letter had been drafted by the insurer's outside counsel, and the district court found that "assisting an adjuster in writing a denial letter is not a privileged task". The court also held that work-product protection did not

apply because Great Lakes was not added to the lawsuit until after the letters were drafted. Thus, after an in-camera review, the district court held that information related to the drafting of the declination letters and the deposition of the drafting counsel were permitted under the statutory presumption.

*Otsuka America, Inc v Crum & Forster Specialty Insurance Company, 2019 WL 4137024, at *2 (“Otsuka America, Inc”) (Supreme Court, New York, 30 August 2019)*

In *Otsuka America, Inc*, communications between Crum & Forster and its outside counsel (including the attorney’s coverage opinion letter) were not privileged because determining whether a claim is covered is “part of the regular business of an insurance company” and prior to the date, Crum & Forster disclaimed coverage. The documents were also not work product because “attorney work product only applies to documents prepared by counsel acting as such, and to materials uniquely the product of a lawyer’s learning and professional skills, such as those reflecting an attorney’s legal research, analysis, conclusions, legal theory or strategy”, and which have a supporting attorney affidavit. In determining coverage, counsel categorically acted as investigators not attorneys.

Tort Reform

State-by-state tort reform also continues to alter the risk and exposure landscape. Florida provides the most recent example. One major change was to Florida’s comparative fault scheme. While Florida was a traditional, “pure” comparative negligence state, the legislation now aligns Florida with the majority of other states having a “modified” scheme. Under the old scheme, a plaintiff was entitled to recover a percentage of damages proportionate to the degree of fault of the defendant. Now, if a plain-

tiff’s percentage of fault is more than the defendant’s percentage of fault, the plaintiff cannot recover. The change, however, does not apply to medical negligence.

Another noteworthy change is that the legislation reduced the limitations period for general negligence claims. The limitations period for general negligence is now two years instead of four years.

The Florida legislation also addressed insurer bad faith. Significantly, a claimant, an insured, or their representatives have the duty to act in good faith in providing information to insurers, making demands, setting deadlines, and making settlement attempts, and a fact finder may consider it bad faith to reduce the damages awarded. Also, the legislation clarified that mere negligence cannot support a finding of bad faith against an insurer. An insured’s statutory entitlement to recover attorneys’ fees upon prevailing against an insurer has been eliminated except in declaratory judgment actions to determine coverage. The use of non-contingency multipliers to calculate attorneys’ fees is now prohibited.

Multiple Claims – Multiple Insureds - Bankruptcy

The Fifth Circuit’s opinion last year in *Law Office of Rogelio Solis, PLLC v Curtis*, 83 F.4th 409 (Fifth Circuit 2023) and its procedural aftermath and appeal will likely affect the way insurers in Texas have long understood their potential Stowers obligations and exposure in liability claims in which there are multiple plaintiffs (typically with multiple counsel representation) and not enough liability insurance.

Following an appeal from the bankruptcy court’s decision against the insurer, the federal district court certified a question to the Fifth Circuit: was

“Whether the pre-petition payment of insurance proceeds to a tort claimant creditor of a debtor constitutes a ‘transfer of an interest of the debtor in property’ under 11 U.S.C. § 547 when such payment is made by an insurer of the debtor pursuant to a valid Stowers settlement demand under Texas law”. The Fifth Circuit answered the question affirmatively, but left unanswered, for claimants and insurers alike, the dilemmas presented by finding that liability policy proceeds paid to avoid Stowers exposure under Texas Farmers Insurance Company v Soriano, 881 S.W.2d 312 (Texas 1994) belong to a policyholder’s bankruptcy estate.

The Solis facts are straightforward. The insured, Josiah’s Trucking LLC (“Josiah’s”), owned a tractor-trailer that collided with a vehicle in which Carlos Tellez (“Tellez”) and Anna Isabel Ortiz (“Ortiz”) were travelling. Both were killed in the accident. Tellez and Ortiz were each survived by wrongful death beneficiaries, the Tellez family and the Ortiz family.

Josiah’s was insured for USD1 million by Brooklyn Specialty Insurance Company RRG, Inc (“Brooklyn”). Both families engaged counsel and began the claims process, with the Ortiz family engaging the Law Firm of Rogelio Solis, PLLC (“Solis”) and the Tellez family engaging Escobar & Cardenas, LLP. The Tellez family engaged in settlement discussions with Brooklyn and filed suit. The Ortiz family, however, made a Stowers demand to Brooklyn for the policy limits, which Brooklyn accepted, transferring the proceeds to the Solis IOLTA account. On the same day, Brooklyn informed the Tellez family that the policy limit had been exhausted. Approximately one week later, the proceeds were distributed to the Ortiz family and Solis.

The following week, the Tellez family commenced an involuntary bankruptcy against Josiah’s. The Trustee then commenced an adversary proceeding against the Ortiz family and Solis seeking to avoid and recover the transfer of the Brooklyn policy proceeds under the Bankruptcy Code. Solis and the Ortiz family moved to dismiss the adversary proceeding contending that the Trustee failed to allege a transfer of the debtor’s property because Josiah’s had neither legal title nor a contractual right to receive the policy proceeds, and otherwise lacked control over their disbursement.

The bankruptcy court denied the motion, first concluding that the Trustee’s complaint, alleging over USD8 million of potential claims from the accident in light of the USD1 million policy limit, satisfied the “limited circumstances” in which a debtor may have an equitable interest in liability insurance proceeds such that they can be classified as property of the estate, citing *In re OGA Charters, LLC*, 901 F.3d 599 (Fifth Circuit 2018). The bankruptcy court then considered whether the pre-petition payment affected the debtor’s equitable interest in the proceeds, concluding it did not.

In the Fifth Circuit, Solis argued that the district court’s conclusion that the debtor held an equitable interest in the policy proceeds was incorrect because the debtor has no legal or equitable rights to the policy proceeds under Texas law, disputing OGA. The Ortiz family and Solis went so far as to argue that OGA must have been incorrectly decided based upon Texas law regarding an insured’s right to liability policy proceeds. The Fifth Circuit, however, emphasised that it was bound by the “well-recognized rule of orderliness”, and therefore, must follow circuit precedent. The Fifth Circuit emphasised that the OGA opinion did not bestow on a debtor

the right to pocket the proceeds but served to reduce claims and permit a more equitable distribution of available assets in the liquidation of the estate.

While the Fifth Circuit did not address Soriano, the court was forced to admit that in OGA the policy proceeds had not been disbursed, and the court had not answered the question of whether the transfer of proceeds could be avoided under Section 547 of the Bankruptcy Code. Nevertheless, the court reasoned that Section 547(b)'s use of "an interest of the debtor in property" means "property that would have been part of the estate had it not been transferred before the commencement of bankruptcy proceedings". The court found that the policy proceeds would have been the property of the estate at the time the petition was filed if they had not been transferred. Accordingly, the court affirmed the opinion of the bankruptcy court.

Notably, following the Fifth Circuit's refusal to rehear the matter en banc, the Solis parties requested a direct appeal and filed a Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit on 14 May 2024. The Trustee waived a Response, but the Supreme Court nevertheless requested a response on 11 July 2024, which was filed on 12 August 2024. It was distributed for Conference at the court for 30 September 2024.

The Supreme Court has been addressing insurance issues that end up in the bankruptcy courts in its opinions this year. This may signal the potential for the court to solve not just the Soriano issue, but also when, if ever, liability policy proceeds will be considered part of the bankruptcy estate.

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