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Recent Legislative and Judicial Developments in Continental Europe



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1

Introduction

Recent Legislative and Judicial Developments in Continental Europe is the latest installment in Guy Carpenter & Company Ltd's ("Guy Carpenter's") legislative update series, designed to provide our international clients and markets with a concise overview of key trends in the Continental European legal environment. These issues have had an impact on insurers and reinsurers or are expected to have an effect in the near future.

Guy Carpenter has produced this report thanks to a continued valued cooperation with the insurance practice of law firm Heuking Kühn Lüer Wojtek and its network of legal experts, acknowledged as leading insurance law practitioners in their respective jurisdictions across Continental Europe. The objective has been, as in previous reports in this series, to focus on the legislative or judicial developments that we consider to be of greatest impact in each selected country. It has not been our goal to produce an exhaustive review of the entire scope of legislative changes and judicial rulings of the past year in Continental Europe, but rather to highlight the main developments that we and our legal colleagues perceive as being worthy of attention and, where necessary, further in-depth study.

As our legal colleagues in Heuking Kühn Lüer Wojtek continue to expand their network, further Continental European jurisdictions may be included in future issues.



This issue of *Recent Legislative and Judicial Developments in Continental Europe* covers the period March 2010 to September 2010.

2

Recent Developments with Regard to the Principle of Utmost Good Faith in Insurance Law in Austria

Austrian Supreme Court Defines “Non-Statutory Duties to Inform” on the Part of the Insurer

In a decision of the Austrian Supreme Court in November of last year, the court specified a further case of non-statutory duty to inform on the part of insurers, which derives from the principle of utmost good faith applicable in insurance law.

According to this decision, the insurer must expressly inform any insured party who is in qualified arrears with a premium payment (for example, non-payment of the outstanding premium after the insurer has set a grace period and informed the insured party of the legal consequences, but the policyholder instead simply pays the next premium installment). The insurer needs to inform the policyholder that he will only regain insurance cover when the premium in arrears has been paid. If the insurer does not inform, even though it was aware that the insured party misunderstood whether insurance cover existed, such an omission to inform may be held against it.

The Case¹

The decision at issue concerned a contract for third-party motor vehicle insurance. The premium was due quarterly under the terms of the contract.

The insured party failed to pay the premium due for the quarterly period from September 1, 2005, to December 1, 2005. Even after a qualified payment reminder and the initiation of a grace period of 14 days, in accordance with the statutory provisions, the amount in arrears remained outstanding. In spite of these arrears, the insured party still received a bill from the insurer for the premium in respect to the following quarterly period (December 1, 2005, to March 1, 2006). The insured party paid this premium on December 12, 2005, using the original payment slip provided by the insurer.

The insured party was involved in a motor accident in which it was at fault on December 17, 2005, whereupon the insurer made a payment of about EUR5,000 to the other party involved in the accident as the injured third party.

¹ OGH November 18, 2009, 7 Ob 220/09t.

Only after being notified by the motor vehicle registration authority and being asked to submit proof of insurance did the insured party transfer the outstanding premium for the quarterly period from September 1, 2005, to December 1, 2005, on January 26, 2006, using the original payment slip, which had been enclosed with the payment reminder.

In the case at hand, the insurer sought to recover the payment made to the injured third party by taking action for recourse against the insured party, on the basis that the insurer had been released from all payment obligations in respect of the insured party because of the premium in (qualified) arrears.

Underlying Austrian Legal Background

Section 39 of the Austrian Insurance Policy Act (*Versicherungsvertragsgesetz, VersVG*)

As regards default on a renewal premium, Section 39 of the Austrian Insurance Policy Act provides that the insurer can notify the insured party in writing of a grace period which must be at least two weeks. In this case, it must inform the insured party that if any insured event occurs after the expiry of the grace period, the insurer will be free of any obligations to make payments in the event that the outstanding premium is still in arrears at this point in time. Moreover, it must inform the insured party of the insurer's special right to terminate according to Section 39 (3) of the Austrian Insurance Policy Act, which played no role in the case at hand.

Supplementary Case-Law of the Austrian Supreme Court on Section 39 of the Austrian Insurance Policy Act

According to settled case-law of the Austrian Supreme Court, the insurer is only released from the obligation to make payments for the time subsequent to the expiry of the grace period notified. Moreover, the freedom from payment obligation ends with the payment of the outstanding premium.²

It has equally been established that the consequences of default also last beyond the next date when a premium is due until the outstanding premium which was subject to the qualified reminder has been paid.

If further premium payments are made, the Supreme Court assumes that such payment is to be credited against the oldest outstanding premium arrears unless otherwise agreed.³

² Grubmann, *VersVG6 (2007) § 39 E 52.*
³ Grubmann, *VersVG6 (2007) § 39 E 54.*

The Ruling

In the introduction to its decision on November 18, 2009, the Supreme Court invoked in detail the three prerequisites for the insurer to be released from its payment obligations under Section 39 of the Austrian Insurance Policy Act in the case of default on the payment of a renewal premium. According to the statutory doctrine and the applicable case-law, these prerequisites are:

- *Qualified payment reminder (with a grace period and information on the legal consequences),*
- *Expiry of the grace period before the insured event occurs and*
- *Premium in arrears when the insured event occurs.*

The Austrian Supreme Court commented in its decision relating to the question of whether the insurer was free from payment obligations in the specific case at hand. The prerequisite for success in the recourse claim against the insured party, and the only relevant factor, is whether the premium paid on December 12, 2005, by the insured party was for the previous quarterly period (September 1, 2005, to December 1, 2005) or for the following quarterly period (December 1, 2005, to March 1, 2006).

It is undisputed that the first two prerequisites, qualified payment reminder and expiry of the grace period before the occurrence of the insured event, were fulfilled.

In its legal evaluation of the case, the Supreme Court rightly went on to hold that when the insured party defaults on premium payments, the insurer in principle only becomes liable once again if the insured party also pays the premium, which was due first, and was subject to a qualified payment reminder, and then only provided this payment is made before the insured event occurs.

In assessing the specific facts of the case, the Austrian Supreme Court did not assume in accordance with the payment sequence established generally in Austrian civil law and in accordance with previous case-law on insurance issues that the premium paid was to be credited against the older and more burdensome debt (unless otherwise agreed).

Rather, the Austrian Supreme Court considered that the insured party had specifically assigned the payment to the later quarterly period (December 1, 2005, to March 1, 2006) by using the original payment slip, which specifically declared the payment to be for this period. In this respect, the court did not need to apply the above-described “default” rules for cases of doubt.

It could have come to the conclusion, as did the appeal court, that the insured party was in qualified arrears at the time of the insured event, which would have released the insurer from its payment obligations.

Nonetheless, the Supreme Court did not allow the insurer's recourse claim. Instead it held that the insurer had infringed its non-statutory duty to inform. In the view of the Supreme Court, the insurer should have referred the insured party to the fact that paying the premium for the quarterly period from December 1, 2005, to March 1, 2006, would not alter the fact that insurance coverage would only be restored when the outstanding premium for the earlier quarterly period had also been paid.

In the opinion of the Supreme Court, the insurer ought to have realized that the insured party mistakenly believed that there was insurance cover. Thus, due to the principle of utmost good faith applicable in insurance law, the insurer could not rely on freedom from payment obligations under Section 39 of the Austrian Insurance Policy Act in this case.

Implications

In relation to the decision described above, it is interesting to note that the Supreme Court regarded as irrelevant whether the insurer actually realized that the insured party misunderstood the existence of insurance coverage or not. In the opinion of the Supreme Court, it at least ought to have recognized this.

The associated question of whether the insurer itself was in legal error is also apparently insignificant in the eyes of the Supreme Court. Clearly, the insurer is expected to have the relevant knowledge of the legal situation and thus can be faulted for the omission to inform.

As far as it was possible to ascertain, this decision has not yet been discussed in legal literature (at least not in depth), which explains why it is also not very well-known in insurance practice.

In our opinion, the practical relevance of this case is nonetheless obvious. All comparable cases appear not to be infrequent. Neither is it improbable that an insured party would raise in defense a belief that the insurance coverage was reinstated by the payment of the subsequent premium. Thus, unless already in place in individual cases, a *modus operandi* should be implemented in everyday business operations and premium administration in order to avoid such issues in the future.



3

Recent Developments in European Union Motor Insurance Law

Follow-up on the Rome II Study

The Rome II Study on Compensation of Cross-Border Victims in the European Union, published by the European Commission (Commission) in January of 2009, focused on terms of compensation and limitation periods. It was issued after the entry into force of Regulation 864/2007 of the Law Applicable to Non-Contractual Obligations (also referred to as “Rome II”) and was subsequently made subject to public consultation. As has been previously noted, the Rome II Study was intended to form an integral part of a “Green Paper,” setting out future policy options as regards motor insurance and cross-border accidents in Europe. The subsequent consultation was essentially a means of obtaining the views of all interested parties on the effects of the application of foreign law to claims arising from cross-border road traffic accidents.

The Commission Services received 46 contributions to the public consultation, a large number of which came from the UK, Germany and France. In its Feedback Statement, published in October of 2009, the Commission summarized the responses with regard to quantification of damages and limitation periods which vary across the Union and may threaten to impede the free movement of persons and vehicles.

Regarding compensation awards, consultation contributions concerned eight policy options ranging from a very low to a high level of European integration.

- A large group of respondents to the consultation found that an assessment of the effects of the Rome II Regulation is premature, since it has been in place for only one year. According to this view, further measures to ensure full and fair compensation of victims should not be adopted until the impact of Recital 33 of the Regulation, which calls upon Member States to apply the “restitutio in integrum” principle, is apparent.
- Many respondents, in order to increase awareness of the differences in national compensation schemes among Europeans, considered that it would be beneficial if people in cross-border situations were informed about the differences in compensation awards between the Member States and the possibilities or options that exist to reduce or eliminate the risk of unexpectedly low compensation.

- Although a number of respondents embraced the option of creating EU guidelines on the types of recognized compensation items and the way these should be calculated, others pointed out the difficulties in agreeing on such guidelines given the wide disparity in EU member states' compensation systems. It was also mentioned that, on the one hand, it would be difficult to restrict harmonization to cross-border cases alone and, on the other, extending harmonization beyond such cases would not necessarily be justified.
- Respondents found the option of setting minimum EU standards for the types of recognized compensation items and ways of quantifying them, as well as the option of introducing minimum awards per type of injury, to be a good start in order to have the national legal systems gradually move towards harmonization. Again, however, respondents underlined the potential difficulties in standardization due to the differing economic and social conditions in the EU member states.
- The option of applying the law of the jurisdiction of the victim's residence "lex damni" has, in the opinion of some respondents, the advantage of providing compensation to the victim at a level that is perceived as fair according to the principles of the society in which he/she is a member. Others held that this option would result in a departure from the Rome II Regulation, the impacts of which are unknown.
- If compulsory driver's insurance that also covered passengers in the vehicle were to be introduced, the law of the jurisdiction of the victim's residence would be applicable, as described by some respondents. This would likely facilitate claim actions, some respondents argued. On the other hand, such compulsory insurance would raise insurance premiums for all drivers/keepers, the vast majority of whom do not frequently travel abroad by car. Some respondents also felt that this would lead to discriminatory treatment of car owners, since pedestrians and bikers would not be covered by the insurance.
- The final option related to compensation awards, suggesting the introduction of a EU-wide system. Visiting victims would settle their claims with their own third-party liability motor insurer and receive compensation in accordance with the law of the jurisdiction of their residence. This option was not highly regarded by the respondents to the consultation. Concerns were raised that this would undermine regular market forces and would be contrary to public policy that encourages safety and sound risk management.

With respect to limitation periods, nine options were considered by the consultation respondents. Again, the propositions varied as to the degree of integration that would result, ranging from simply providing victims with information to granting additional time to visiting victims or even introducing a general EU Regulation – *i.e.*, solutions that presume at least partial harmonization of national civil laws. Whereas many respondents recognized the practical need for a common set of minimum standards, others argued that direct harmonization of EU member states' limitation laws is likely to meet resistance and would be somewhat unrealistic. The option of applying the limitation period according to the law of the jurisdiction of the visiting victim's place of residence received greater support in the consultations. In this view, such a solution would render the system of limitation periods comprehensible from the point of view of the victims. Other respondents claimed that the legal certainty of the defendant would be harmed as a result of this option.

Reinforced Protection of Victims of Cross-Border Accidents

Pending further harmonization discussed in the Rome II Study and in the responses to the public consultation, EU motor insurance law has been consolidated with the aim of reinforcing the protection of victims of cross-border accidents in the EU. Directive 2009/103 – a consolidation of the five Motor Insurance Directives previously adopted in the period from 1972 to 2005 – sets out a framework for dealing with cross-border accidents in Europe.

The new Directive entered into force in October of 2009. It is broader in scope than the Rome II Study, but essentially has the same goal of better protecting third party victims of road traffic accidents. It obliges all motor vehicles in the EU to be covered by compulsory third party insurance, prescribes minimum amounts of compensation and establishes an efficient mechanism for the quick settlement of claims brought by “visiting victims.” These measures were introduced by previous Motor Directives and have, if at all, been only slightly amended in the new Directive. However, in addition to rendering the existing legislation clearer and more rational by gathering all relevant provisions in one single document, the Sixth Motor Insurance Directive reiterates the need to ensure full and fair compensation to all victims who have suffered very serious injuries. A comparable treatment should be guaranteed irrespective of where in the Union the accident occurs.

Additionally, the Directive sets out to provide specifically for exemptions from the obligation to be insured against civil liability. A list of exempt persons and of authorities or bodies responsible for compensation was subsequently published by the Commission in June of this year. It includes exemptions for certain public or private natural or legal persons such as States, companies of public authorities as well as exemptions for certain types of vehicles or vehicles bearing certain plates.

It should be remembered that issues of civil liability and the calculation of compensation awards remain the province of the EU member states. Accordingly, resolution of disputes should be sought at the national level.

Implications of Regulation 864/2007 on the Law Applicable to Non-Contractual Obligations

The Rome II Regulation, which entered into force in January of 2009, also had implications for the motor insurance sector. Especially in terms of compensation schemes and limitation periods, the Regulation can pose problems for “visiting victims,” i.e., people who have had accidents outside their EU member states of residence, since it provides that, in the case of a non-contractual obligation arising out of a tort, the laws of the country where the damage occurred shall be applicable.

A recent case before the High Court of England and Wales illustrates this with respect to quantification of damages. In *Jacobs v. Motors Insurers Bureau*, the question was whether the law of the jurisdiction of residence of the victim or the law of the country where the accident occurred should apply. The claimant, resident in the United Kingdom, sustained a serious injury in a road traffic accident in Spain. The registration plate of the car that caused the injury did not correspond to the vehicle, and no insurer could be identified. The claimant was, therefore, entitled to compensation by the British Motor Insurance Bureau (“MIB”), the British body set up in accordance with EU legislation to ensure the compensation of victims of accidents caused by uninsured or unidentified vehicles. Mr. Justice Owen held that the MIB is to apply Spanish law, as it assesses the claim. Having made the payment, the MIB has a subrogation claim against the Spanish compensation body.

The Rome II Regulation and the Sixth Consolidated Motor Insurance Directive are likely to be followed by other measures intending to move the varying national insurance systems towards harmonization.



4

Developments in France: Old News and Recent News

Newsworthy events observed in the first half of 2010 fell into two categories. “Old news” includes recent decisions that give confirmation to a now stabilized jurisprudence but do not constitute new case law. “Recent news” refers to discussions of revolutionary instruments which are not currently being used in insurance law, but may acquire major importance in litigation before French courts.

Old News: Decisions Regarding the Two-Year Time Limit Applicable in Insurance Matters

According to French Insurance Code, “*all legal actions arising from an insurance contract shall be barred two years as from the event that gave rise thereto*” (Art. L.114-1). This two-year time limit (prescription biennale) is ruled by provisions of Article L.114-1, L.114-2 and L.114-3 of French insurance law. They deal with the delay, the starting point of the time limit and the causes of interruption or suspension of the limitation period. In addition, Article R.112-1 provides that insurance policies shall include “remind” provisions of Insurance Code regarding the time bar applicable to the legal actions arising from an insurance contract. The two-year time limit generates an important part of insurance litigation: about half the decisions rendered by the *Cour de cassation* (French Supreme Court) in insurance matters are related to the *prescription biennale*.

Among the numerous decisions recently rendered, we review several that bring to light interesting information regarding the duty imposed by Article R.112-1 and the sanction of this duty. Since 2002, case law fluctuated before it stabilized in 2005, and decisions rendered in 2009 and in 2010 confirm the applicable rules.

- *Provisions of Article R.112-1 do not mention any sanction in case provisions of Insurance Code regarding the two-year time limit are not reminded in the policy.*
- *Considering this, one could argue that there is no sanction to the duty imposed by Article R.112-1 and that provisions of this article do not prevent insurers from invoking the time limit. The Cour de cassation once took that view in 2002 (Cass. Civ. 1ère 22/01/2002, n° 98-18892).*

However, the French Supreme Court has systematically ruled since 2005 that “inobservance of provisions of Article R.112-1 is sanctioned by the impossibility to oppose the two-year time limit provided in Article L.114-1” (Cass. Civ. 2ème 02/06/2005, n° 03-11871).

- Regarding the duty for insurers to stipulate in the policy a reminder of provisions of Insurance Code applicable to the two-year limit, several interpretations were possible.

According to an interpretation favorable to insurers, it would be enough to refer to Articles L 114-1 and following, without even quoting their provisions. The *Cour de cassation* admitted in 2005 that the insurer complied with provisions Article R.112-1 when the policy stipulated only that “all legal actions arising from the present contract shall be barred two years as from the event that gave rise thereto according to provisions of Articles L.114-1 & L.114-2 of Insurance Code” (Cass. Civ. 2ème 10/11/2005, n° 04-15041, Bull. n° 283). However, this decision appears to be isolated.

It has now been established that insurance contracts shall, in accordance with provisions of Article R.112-1, mention the rules regarding the two-year limit, and that non-compliance with this duty is sanctioned through the inability of the insurer to allege the time bar against the insured (Cass. Civ. 2ème 07/05/2009, n° 08-16500).

In particular, insurers shall mention the causes of interruption of the delay enumerated in Article L.114-2; otherwise the delay is not opposable to the insured (Cass. Civ. 2ème 03/09/2009, n° 08-13094). Insofar as insurers did not write the policy in accordance with Article R.112-1, there is no way for them to invoke the time limit, even if it is demonstrated that the insured knew the rules applicable (e.g., the insured works in an insurance company: Cass. Civ. 2ème 25/06/2009, n° 08-14254).

A decision rendered in January of 2010 gives confirmation that insurers may not invoke the two-year delay when the rules applicable to this delay are not stipulated in the policy (Cass. Civ. 2ème 14/01/2010, n° 09-12590). Consequently, it has now been established that when they deal with insurance contracts subject to French law, insurers shall act according to the case law regarding Article R.112-1 of Insurance Code:

- When writing the policy, insurers shall ensure that provisions of the Insurance Code regarding the two-year time limit (Art. L.114-1 to L.114-3) are reminded, if not quoted in extenso;
- When dealing with a loss, it is necessary to check that the policy (which may have been issued years ago) complies with the now established case law. Otherwise insurers may not invoke the two-year limit as it is not opposable to the insured;
- Policies currently in force shall be reviewed and ideally an endorsement shall be signed with the insured in order to comply with provisions of Article R.112-1.

Recent news: the Priority Question of Constitutionality (*Question Prioritaire de Constitutionnalité*: QPC)

On March 1, 2010, it became possible in France to challenge application of provisions of an act of the Parliament before a court and to have these provisions referred to the Constitutional Council in order to rule on their conformity with the Constitution. Before that day, compliance of a Parliamentary act with the Constitution could be checked only prior to the promulgation of the act, at the request of the President of the Republic, the Prime Minister or Members of the Parliament (Art. 61 of French Constitution). Now the *Question Prioritaire de Constitutionnalité* (hereafter QPC, as it is now commonly called in France) may be raised by any person subject to trial before a French court. QPC stands for Priority Question of Constitutionality because it has priority over any other question, in particular the question of the conformity of an act with international conventions.

The Constitution of the Fifth French Republic was amended by a Constitutional Act dated July 23, 2008, which created a new Article 61-1: “if, during proceedings in progress before a court of law, it is claimed that a statutory provision infringes the rights and freedoms guaranteed by the Constitution, the matter may be referred by the *Conseil d’Etat* or by the *Cour de Cassation* to the Constitutional Council, within a determined period”.

An Institutional Act (*loi organique*) dated December 10, 2009 has been adopted in order to determine the conditions for the application of Article 61-1 of the Constitution. In short, a QPC may be raised before any court (for which the Supreme Court is either the *Conseil d’Etat* or the *Cour de Cassation*), provided that proceedings are in progress and the question is delivered to the Constitutional Council through the filter of the competent Supreme Court (*Conseil d’Etat* for administrative courts and *Cour de cassation* for judiciary courts).

This process was instantly recognized as successful, and as early as March 1, 2010, QPCs were raised. Since then numerous questions have been brought in various areas (criminal proceedings, civil law, labor law, tax law and others), and the Constitutional Council has already rendered decisions. It appears that the QPC is mainly used by persons subject to trial who consider themselves to be in weak positions: defendants before a criminal court or taxpayers challenging tax law. Indeed, the aim of QPC is to ensure that a statutory provision does not infringe on the rights and freedoms guaranteed by the Constitution. It is an instrument designed to create a balance of the rights between two parties in proceedings.

Heretofore, to our knowledge, a QPC has not been raised relating to an insurance matter. This may be the result of the fact that the French Insurance Code often protects the insured against the insurer, who is deemed to be powerful, skilled and well advised, while the insured, as a consumer, warrants protection. In these conditions the insured is not likely to claim that provisions of the French Insurance Code infringe rights and freedom guaranteed by the Constitution. Insurers may find reasons to raise a QPC, for example, against provisions of Insurance Code restricting the freedom of contracting.

QPC appears to have the potential to be an instrument that will be well utilized in litigation. Parties to a proceeding are likely to look not only at the provisions of law applicable to the case, but also at their conformity to Constitutional rules (which rules may arise not only from the Constitution but also from other sources, such as the Preamble, the Declaration of Human Rights of 1789 and the case law of the Constitutional Council characterizing constitutional rights on the basis of these texts).

Among the decisions rendered by the Constitutional Council, one indirectly concerns insurers, especially those covering employer's liability and directors and officers. In the case of an accident at work, the employee has a right to lump sum compensation from Social Security, and in counterpart the employer may in principle not be sought under common liability (Art. L.451 1 of Social Security Code). However, in case of *faute inexcusable* (inexcusable negligence) from the employer under Article L.452 1 of Social Security Code, the employee may seek employer's liability in order to receive compensation for damages listed in Article L.452 3 which are not indemnified by Social Security. In a decision rendered on June 18, 2010, the Constitutional Council held that the list given in Article L.452 3 is not limitative: provisions of said Article shall not, without infringing disproportionately the rights of the victims, prevent these victims from claiming against the employer compensation for all the damages which are not covered by Social Security (Cons. Const. 18/06/2010, n° 2010-8 QPC). This decision increases employer's liability and of course potential liability of their insurers.

Considering the variety of matters possibly subject to a QPC (almost every aspect of French law), this new instrument shall be integrated by those who practice litigation in the insurance area.



5

German Federal High Court Decision: Causal Link Between the Use of a Medication and the Occurrence of a Bodily Injury

In March of 2010, the Federal High Court of Justice (Bundesgerichtshof, in the following, “High Court”) handed down an interesting judgment regarding causality between the use of a medication and bodily injury suffered by the patient (Judgment of March 16, 2010, VI ZR 64/09).⁴ In addition, in this context the High Court reviewed the problem of contributive causation as well as the applicability of the principle of prima facie evidence.

The Facts

Beginning in 1993 the claimant in this case suffered pain and was medicated with various anti-inflammatory pain relievers. Since February of 2001 he has taken the analgesic “X” which was distributed on the German market by the defendant in this case. The claimant suffered a serious heart attack shortly after shovelling snow on January 13, 2010, at age 73.

In 2004, following the discovery of significant health hazards associated with the use of “X,” the distributor of the product (and defendant) removed the product from the market.

The claimant sued the defendant for his material damage and claimed compensation for pain and suffering (immaterial damages). He argued that his heart attack was solely caused by the medication “X,” which he had used on a daily dose of 25 milligrams since February of 2001. Furthermore, he alleged that the patient information leaflet supplied by the defendant was insufficient. With reference to already existing results from medical studies, the claimant argued that the defendant would have been obliged to take “X” off the market as early as 2000.

The Findings

The lower courts dismissed the claim. The claimant was admitted to appeal, but the High Court upheld the prior judgments.

⁴ Cf. BGH [2010] VersR 627 et. seq.

Missing Causal Link

The High Court ruled that the claimant, who was charged with the burden of proof, did not successfully provide evidence of the fact that the use of “X” had been the cause of the heart attack. In addition, the High Court decided that the claimant could not invoke any relief of the onus of proof in this case, i.e., the claimant had to bear the full burden of proof.

The High Court stated that the consideration of evidence by the lower courts with regard to the question of causality was free from legal faults. A medical expert provided a report and testimony during the hearing based on the findings of the available medical studies at the time. These findings showed no probable contributive causation from the use of “X” in this case. The medical expert was convinced that the age of the claimant combined with the preceding overstrain was the more probable reason for the heart attack. The lower courts had followed this argument.

Applicability of the Prima Facie Evidence Principle

The High Court further had to rule on the question of whether or not the principle of prima facie evidence was applicable in favor of the claimant. According to German law this principle is applicable if the occurrence of an injury is the typical consequence of a breach of duty with regard to general experience of life. For example, this principle has been applied in cases of AIDS patients who had been de facto infected with HIV-contaminated blood products during a blood transfusion. The assumption being that these patients neither belonged to a HIV-endangered risk group nor were they exposed to an increased infection risk by means of their individual lifestyles.

The High Court held that these cases were not comparable to the present case at hand. However, the court did not decide the question of whether and under which conditions the principle of prima facie evidence could be applicable in a case where a patient, after the taking of a medication associated with a specific risk, suffers bodily injury corresponding to that specific risk. The High Court ruled that the principle of prima facie evidence fails if proven or undisputed facts lead to the assumption that a breach of duty yields consequences that are out of the ordinary. In the case at hand, such facts, according to the High Court’s point of view, were given with regard to the claimant’s significant personal risk factors, which were, in particular, his progressed age and the particular strain of snow shovelling. The High Court held that under these circumstances the principle of prima facie evidence could not justify the claim.

Reversal of the Burden of Proof

The last legal aspect of the present judgment deals with the question of whether or not a reversal of the burden of proof could apply in this case. The courts have established this remedy in the area of medical malpractice in cases of gross faults in treatment. In such cases the medical practitioner had to release himself from the accusation of a gross fault for reasons of equity.

However, the High Court held that the present case is not comparable to medical malpractice cases. In addition, the High Court referred to a previous judgment of the same Senate, holding that the principle of reversal of the burden of proof with regard to cases of medical malpractice could not be transferred to product liability claims based on the violation of the duty to give warning of specific risks.

Different Legal Situation

The decision in this case could have been different since the German legislator on July 19, 2002 had enacted an amendment of sec. 84 para. 2 of the German Medicines Act (Arzneimittelgesetz – AMG). This new regulation introduced an absolute liability and thereby a supposition of causality in favor of any patient suffering bodily injury in connection with the taking of medication. According to the appropriate transitional rule, this new regulation was applicable for all bodily injuries caused by drugs beginning July 31, 2002.

As the claimant had suffered his heart attack in January of the said year, the High Court, in accordance with the lower courts held that the case of the claimant had to be judged on the basis of the previous version of sec. 84 of the German Medicines Act. Therefore, the full burden of proof regarding the causality remained with the claimant.

Conclusion

This case gave the High Court the opportunity of confirming its prior jurisdiction with reference to the various forms of the burden of proof. In many similar cases, the burden of proof is the decisive factor for the judgment – in this case, nevertheless, it worked against the claimant. However, the claimant's legal position is unsatisfying, as the judgment might have been different if the claimant had suffered his heart attack only seven months later and had not overstrained shortly before. Then he could have been entitled to the alleviation of the burden of proof enacted by the German legislator in the German Medicines Act in 2002.

Beyond that, it remains to be seen whether the High Court will have another opportunity to rule on the question of whether prima facie evidence will apply to cases governed by the German Medicine Act in its current version.



6

Latest Developments in the Field of Medical Malpractice in Italy

In the last decade, the scope of the liability as well as the amount of compensation for medical malpractice have been continuously increasing owing to several innovative rulings of the Supreme Court (Corte di Cassazione). Now, many insurance entities, once very active in this field, are beginning to lose interest in this business.

Having said that, we must welcome the attempts that the jurisprudence of the same Supreme Court recently made in order to mitigate the extreme consequences that a too strict approach to some of the most important and contradictory issues of medical malpractice could have brought.

We will address the issues of:

- i) allocation of the burden of proof between the damaged party and the defendant;
- ii) nature of liability for lack of informed consent, the kind of damages that can be awarded to the patient for such reason and under which conditions.

The Allocation of the Burden of Proof

Traditionally, in the matter of medical malpractice, the burden of proof rested quite heavily on the part of the plaintiff, since he had to give evidence that:

- i) he received medical treatment;
- ii) his health condition worsened after the treatment;
- iii) the doctor failed in executing the treatment by giving specific reason for such allegation;
- iv) the damage suffered was causally linked to such a medical failure.

Point iii) and iv) were deemed necessary because a common theory was that the obligations of hospitals and doctors were to use their best efforts to cure the patient according to best practices and medical guidelines, but without a guarantee for the result of their activity.

That is why, in order to sustain the allegation of malpractice, it was not sufficient to prove the requirements described in points i) and ii). It was necessary to explain and demonstrate what the doctor should have done according to the best standard and medical guidelines.

Recently, jurisprudence in the field of medical malpractice as well as in the area of contractual liability has almost abandoned the theory of the use of the best effort, stating that, when a contract is entered into between the parties, the debtor must perform his obligations with the due diligence required. Therefore, there is a presumption that such performance will result in a satisfactory outcome for the creditor. Then, the issue of having used the best effort or following the best practices becomes a matter to be demonstrated in practice by the debtor.

In its important case (see Cass.S.U. n.13533/2001) the Supreme Court – in plenary session – affirmed, quite blatantly, that the burden of the proof for the plaintiff was only to give evidence of the contract and damages possibly arising out of the performance of such contract. The debtor, however, needs to prove that he performed the contract with duty and care, meaning that he was not at fault or that his failure did not cause the damage.

In other words, the Court stated that it was no longer the duty of the plaintiff to give specific evidence on the element described in point iii).

This would make the defendants' task more difficult. It would also likely cause an increase in litigation between hospitals and patients.

More recently, however, the same Supreme Court in plenary session (see Cass.S.U. n.577/2008) slightly revised its theory by affirming that a general claim of bad performance of the contract was not sufficient to hold the hospital/doctors liable. The plaintiff, in fact, had the duty to make a specific allegation regarding the failure that was deemed to be the possible cause of the damage.

This clarification has certainly contributed to bringing more balance to the position of the parties and it could be understood in the sense that the Supreme Court had reinstated the duty to give evidence of the element in point iii).

However, this is not quite the case, since, even if it is true that the plaintiff has to identify the possible failure that could have caused the damage, the burden of proof for a specific allegation is not as rigorous as it was previously.

Lack of Informed Consent and Recoverable Damages

According to Italian law and practice, the liability of hospitals and doctors regarding lack of informed consent is based on a doctor's failure to adequately inform the patient about the risks implied in the execution of a medical procedure before its commencement.

It is important to outline that this special type of medical malpractice occurs only in those cases where no other fault or malpractice can be attributed to the doctor. This liability occurs even if the doctor cannot be found liable for his medical acts or treatments, as they have been done in compliance with the guidelines and best practices applicable in the given circumstances.

In summary, liability deriving from lack of informed consent makes the hospitals and doctors pay for the limits and drawbacks still present in medical science. The judges are perfectly aware of this risk and therefore on several occasions have tried to specify the exact nature of this responsibility and what kind of damages are deemed to be recoverable by the patients.

Jurisprudence has clarified that liability for lack of informed consent does not constitute a direct violation of the patient's health by a medical act or omission of the doctor, since this act or omission is assumed to have been done with the required professional skill and care, but rather the violation of the freedom of the patient to make an informed choice as to whether to undergo the medical treatment or not.

This specification bears very important consequences in the trial practice.

Indeed, the Supreme Court has stated that when a plaintiff intends to recover damages based on the theory of liability for lack of information, he must make a specific demand for it. A general allegation of medical malpractice is not sufficient for that purpose, since liability for faults and errors in performing medical treatments is substantially different from the liability derived from failure to inform the patient before acquiring his/her consent for that treatment.

The said specification regarding the nature of the liability has inspired other fundamental changes in jurisprudence in relation to the type of compensation which can be awarded to a patient who has not been correctly informed and has suffered personal injuries as an unfortunate outcome of the medical treatment.

Since the theory of liability for lack of informed consent was created, the liable party was responsible for the entire corporal and moral damages suffered as a consequence of the medical treatment, as if such damages had been actually caused by the lack of information provided to the patient, rather than by the inevitable unfortunate outcome of a correctly executed medical act.

This approach was perceived as not completely satisfactory from a legal standpoint. Moreover, this has brought good arguments to those who inferred that, through the theory of the liability for lack of informed consent, the Courts were making the hospitals pay for the gaps still existing in the medical science.

An attempt to correct this issue was made by a jurisprudence trying to clarify that the due compensation in cases of lack of information in the medical practice was aimed to compensate the non-patrimonial damage resulting from the violation of the freedom of the patient to choose the medical treatment he/she is advised to take. Therefore, the amount of the awardable compensation was to be calculated on the basis of a fair and discretionary evaluation by the judge, rather than on the exact degree of disability suffered by the damaged person. Based on this theory, a judge awarded damage compensation also in a case where the patient, who had not been correctly informed – and therefore was not put in the position to express his free and informed will – did not suffer body injuries as a consequence of the medical act.

At the beginning of this year, the issue has been discussed and solved in a more satisfactory way by the Supreme Court, which, in decision n.2847/2010, affirmed, in clear terms, that, in case of lack of informed consent, there must be some causal relationship between the lack of informed consent and the ultimate injury suffered by the patient. The damaged party must prove that had he/she been informed properly, he/she would not have consented to the medical treatment and that the medical outcome would have been different.

In addition – and this is crucial – the Supreme Court stated that the burden of proving the existence of the said causal relationship between the lack of informed consent and the body injuries, with all the specification described above, lies on the patient.

These findings are to be welcomed as they contribute to bringing more balance in the allocation of the risk of medical malpractice in cases where the unfortunate outcome of a legitimate and often skilled performance of a medical act is still not under the control of the medical profession.



7

Compensation for Loss of Life or Injury of a Relative in the Netherlands

The Conservative Dutch Approach

One of life's more horrific situations might involve the sudden death or major injury of a loved one, husband, wife or child caused by an unlawful action of a third party, a traffic accident or the deliberate and violent misbehavior against the loved one. Assuming that someone is at fault (which is of course the case if the action is a deliberate one), can the surviving or unharmed relative claim compensation from the party responsible for the loss of life or injury of the victim?

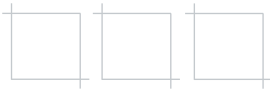
If the results involve matters such as deprivation of support, the answer is clearly yes. The articles 6:107 (Injury) and 6:108 (Loss of life) of the Dutch Civil Code address this. However, consider a process for compensating the pain and suffering of the surviving or unharmed relative. In the Netherlands, pain and suffering as a result of the loss of life or heavy injury of a relative is, unlike in many other jurisdictions, not compensable.

Earlier this year, on March 23, 2010, a draft bill that aimed to introduce this type of compensation was defeated in the Dutch parliament. The draft bill was approved by the second Chamber of the Dutch parliament (comparable with the UK House of Commons) but rejected by the first Chamber (comparable to the UK House of Lords). The arguments presented stated that this kind of damage cannot be quantified in monetary terms and would eventually lead to unhealthy and therefore undesirable legal proceedings. The Netherlands clearly missed an opportunity to align with other jurisdictions. Currently, claims for compensation for pain and suffering as a result of the death or heavy injury of a relative will not be acknowledged in the Netherlands.

Dutch case law makes a distinction between claims for pain and suffering (in Dutch: "affectieschade") and damage due to the shock received as a consequence of the loss of life or heavy injury of a close relative (in Dutch: "shockschade"). The Dutch Supreme Court ("Hoge Raad"), in its decision of February 22, 2002 [NJ 2002/240], ruled that pain and suffering ("affectieschade") were not compensable. However, its decision also stated that an unlawful action against a victim by the responsible party may at the same time lead to an unlawful act regarding the

surviving or unharmed relative. If one actually sees or is otherwise directly confronted with the death or heavy injury of a close relative, provided that this leads to a recognized physical disease, a damage claim by the remaining or unharmed relative for shock damage (“schockschade”) against the responsible party is possible. The case decided by the Dutch Supreme Court in this decision concerned a mother who had sustained consequent psychiatric damage having witnessed her young daughter being run over by a taxi bus. This case, while the taxi driver was clearly at fault, concerned an accident. But even in the situation of a violent and deliberate unlawful action, such as the murder of a relative, the Dutch rule states that compensation for plain grief is not possible. Compensation is only possible if a recognized psychiatric disease has been determined as a consequence of actually seeing or being directly confronted with the loss of life or heavy injury of this relative [Dutch Supreme Court, October 9, 2009 LJN B18583].

Many believe the Dutch Parliament missed an opportunity by not approving the draft bill. They question how compensation is not warranted in a situation where a person is shocked (or suffers pain and suffering) when he or she is informed that husband, wife or child has died or has been disabled for life due to the unlawful action of a third party. While difficult to understand, it is the current rule of law in the Netherlands. And would this have led to unhealthy and undesirable court proceedings? Most agree that the level of compensation under the draft bill would not have led to excessive monetary awards. Upon examination the draft bill actually contained limited compensation levels. It is true that loss of life or injury is impossible to quantify in money. Lack of compensation is, however, not a satisfactory rule of law, but the current rule of law in the Netherlands.



8

Draft Legislation – Possible Amendments to the Norwegian Insurance Activities Act – Non-Life Insurance

Background

Act Number 44 of June 10, 2005 (the “Insurance Activities Act”) relates to the activities of insurance companies, pension funds and pension companies. When the act was drafted, activities relating to non-life insurance were included in a separate chapter (Chapter 12) without any material review of the existing activities.

In various assignments to the Banking Law Commission, the Norwegian Ministry of Finance specified that a comprehensive review of the activity rules for non-life insurance should be initiated.

After several postponements, the Banking Law Commission submitted its Report Number 20, NOU 2008: 20, The Activities of Non-life Insurance Companies (Report), on October 29, 2008.

On the basis of the Report, the Ministry of Finance presented a white paper, Prop. 134 L (2009-2010), Amendments to the Insurance Activities Act (white paper) on May 28, 2010. The white paper’s main focus is the creation of a more thorough draft legislation of non-life insurance activities.

The draft legislation has been formulated for a new Chapter 12 in the Insurance Activities Act that will result in the enactment of the most important activity rules in the area of non-life insurance and a substantial enlargement of the scope of the legislation in this area. The draft legislation deals both with topics that have not been subject to regulation and certain material amendments to the current legislation.

According to the cabinet minister of the Ministry of Finance, the amendments are a necessary modernization of the regulations concerning non-life insurance companies. Their goals are to secure important consumer interests as well as to improve the competition between non-life insurance companies.

Summary of the Draft Legislation – Areas That Have Not Been Subject to Regulation

We describe here sections of an abstract from the white paper in order to summarize the draft legislation. The examined articles mostly comprise the topics that have not been subject to regulation in Chapter 12 of the Insurance Activities Act. The summary includes possible new provisions that Norwegian insurance companies will have to comply with if the legislation becomes law.

- Article 12-1 of the draft legislation prohibits the marketing and sale of insurance against penal sanctions (for example, traffic violations and illegal downloading via the internet), provided the insurance is considered to be in defiance of the legal system. However, insurance against civil liability (e.g., automobile insurance) or against directors and officers liability is excluded from the prohibition.
- The Ministry of Finance has the authority to determine if the insurance is de facto in defiance of the legal system. The Norwegian courts of law have judicial review of the individual decisions adopted by the Ministry of Finance.
- Pursuant to the current law, the extent to which non-life insurance companies can administer account arrangements (self-insurance schemes⁵) on behalf of legal or individual persons is not clarified. Article 12-2 stipulates that non-life insurance companies can assume administration of self-insurance schemes, provided that the non-life insurance company also assumes the insurance of the legal or natural person. As such, the non-life insurance companies have to assume an underwriting risk in part even if the non-life insurance companies do not provide an insurance service per se, but instead undertake to administer payments and allocations under the self-insurance scheme.
- Article 12-3 involves a duty for the non-life insurance company to ensure that its insurance agents comply with the Insurance Contracts Act Articles 2-1, 2-2, 11-1 and 11-2 in connection with entering into an insurance agreement with the insured. The said articles of the Insurance Contracts Act relate to information that the insured shall receive prior to entering into an insurance agreement (for example, through an insurance certificate). The insurer will be associated with the agent by means of information given by the agent. Furthermore, Article 12-3 stipulates that an insurance claim under an insurance agreement can be filed directly with the agent, in which case the insurance claim shall be regarded as filed with the insurance company in accordance with the Insurance Contracts Act Articles 8-5 and 18-5.

⁵ A self-insurance scheme means that legal or individual persons carry the underwriting risk themselves instead of paying an insurance company to do so.

- Articles 12-5 and 12-6 of the draft legislation relate to the scale of premium rates and the calculation of premiums of non-life insurance. The proposed rules are meant to ensure that the calculation of premiums for non-life insurance is based to a greater extent on detailed and somewhat differentiated risk elements. Pursuant to Article 12-6, non-life insurance companies have, among other duties, a duty to re-estimate the premiums in case of non-conformity between the premiums and the risk-assumed. Article 12-6 even imposes on the non-life insurance companies a duty to raise the premiums that constitute an insufficient security compared to the responsibility under the insurance agreement.
- Articles 12-10 to 12-16 concern the technical insurance reserves in the non-life insurance industry. Among other things, the Ministry of Finance has recommended certain rules that depart somewhat from the rules in the current regulations concerning reserves. The reserves a non-life insurance company shall establish, pursuant to Articles 12-11 and 12-16, are the following:
 - *Premium reserves (Nw: premieavsetning)* – cf. article 12-11;
 - *Reserves relating to non-accrued risk (Nw: ikke avløpt risiko)* – cf. article 12-11;
 - *Outstanding claims reserves (Nw: erstatningsavsetning)* – cf. article 12-12;
 - *Security reserves (Nw: sikkerhetsavsetninger)* – cf. article 12-13;
 - *Reinsurance reserves (Nw: reassuranseavsetninger)* – cf. article 12-14;
 - *Other reserves to cover risk-bearing derived from the Insurance Activities Act (Nw: andre avsetninger til dekning av risiko avledet av forsikringsvirksomheten) and natural hazard reserves (Nw: naturskadeavsetninger)* – cf. article 12-15; and
 - *Guarantee reserves (Nw: garantiavsetninger)* – cf. article 12-16.
- Based on recent amendments in the insurance contract legislation concerning insurance companies' right to refuse to accept insurance policies for individual customers, the Banking Law Commission and the Ministry of Finance have proposed in Article 12-17 the establishment of a special distribution and allocation scheme for necessary insurance.
- The objective of establishing such schemes is to ensure that customers who would otherwise not have been able to purchase what may be regarded as fundamental insurance (e.g., loss of or damage to residence, personal accident, illness, etc.) will be able to purchase these insurance policies on acceptable terms and conditions even if special risk factors are present.

- The proposed schemes will entail that all non-life insurance companies will help cover losses that may arise, however, the details of such schemes have not been prepared and the Ministry of Finance proposes that such schemes shall be governed by secondary Norwegian law (Nw: forskrift).

Conclusion

The draft legislation has not been adopted by the Norwegian legislators, but it focuses on new requirements for non-life insurance companies' compliance. However, according to the Banking Law Commission and the Ministry of Finance, an implementation of the draft legislation will require limited resources from both the authorities and the private sector, including the non-life insurance companies.



We therefore anticipate that the amendments will be approved by the Norwegian parliament.

9

The Supreme Court Rules on the Initial and Final Date for the Calculation of the Special Default Interest in Spain

In previous issues of this publication in 2008 and 2009 we dealt with the punitive interest that insurers must pay if they delay the settlement of claims without justified cause pursuant to the provisions of Section 20 of the Spanish Insurance Contract Act 1980 (ICA). On those occasions, we advised that the Spanish Supreme Court had fixed the method to calculate it and provided certain guidelines for ascertaining when an insurer's delay in settling claims may be justified.

In a decision dated April 9, 2010 (JUR\2010\131423), the Supreme Court has clarified the starting and final dates for the calculation of the default interest rate.

Background

During a cycling race one of the participants ran over a worker in charge of pointing out road detours to the cyclists. The worker fell to the ground, hit his head and died. The accident took place on August 10, 1999. His widow, acting on behalf and representation of his children, sued both the organizer of the race and the third party liability insurer.

Court Decisions

The First Instance Court found in favor of the claimant, ordering the organizer of the race and the insurer to pay jointly and severally a certain compensation. The Court also ordered the insurer to pay the special default interest accrued from the date of the loss (August 10, 1999) until the date of the deposit in the Court's bank account of the amount of payment the insurer considered appropriate under the circumstances known to it (May 7, 2002).

The claimant, the insurer and the organizer of the race appealed. For purposes of this commentary, we will just refer to the positions sustained by the claimant and the insurer in respect of which should be the initial and final dates for the calculation of the default interest.

The Court of Appeal (Audiencia Provincial of Madrid) dismissed the insurer's appeal and confirmed that the special default interest was to be paid from the date of the loss (the accident) as the insurer had not proved, according to Section 20.6 of ICA, that it was not aware of the loss before the third party's claim reached it. This section provides that where the injured third party or his heirs are concerned, the default interest accrues from the date of loss, save that the insurer proves that he was not aware of the loss before the claim was reported or the direct action, which injured third parties may bring against insurers, was filed in court. In these events, the default interest will accrue from the date of the claim or the filing of the direct action in court. Obviously this nuance can mean a significant difference in the amount to be paid, particularly if two years have elapsed and the insurer is ordered to pay interest at the rate of 20 percent per annum. The Court dismissed the insurer's alleged ignorance of the accident on the basis that the race had been broadcast on television in the course of which the images of the accident had been shown.

The Court of Appeal also held that the final day cannot be the date of the deposit in the Court's bank account of the amount that the insurer considered appropriate to pay under the circumstances because it did not express its intent to pay. Accordingly, the Court partially reversed the First Instance Court decision and ruled that the final day for the calculation of the special default interest rate is the date on which the insurer effectively pays to the claimant the compensation awarded by the First Instance Court.

The insurer appealed to the Supreme Court arguing, in summary, (i) that the TV broadcasting of the cycling race did not prove that it had actual knowledge of the loss and, (ii) that the special default interest should accrue from the date of the notification of the claim, when it knew for the first time about the loss, while the final term shall be the date of the deposit.

The Supreme Court dismissed the appeal. The Court first established that the insurer's knowledge of the circumstances and consequences of the loss may come from the information provided by the third party or by the insured or from its own sources. Based on Section 20.6 of ICA, the Court rejected the insurer's arguments and ruled that the insurer cannot expect that the default interest will accrue from the date of claim when it has not proved that it had no knowledge of the loss prior to the claim. This is the only event, continues the Court, in which the default interest will not accrue from the date of loss.

Further, the Supreme Court declared that the insurer was in default because it did not pay the full indemnity within three months from the loss, nor did it pay within 40 days of notification of the loss at least the minimum amount it understood it had to pay under the circumstances known to it as required by Section 18 of ICA. The Court also confirmed that the final day for the calculation of the default interest cannot be the date of the deposit because the insurer did not express its intent to pay.

It is clear from this judgment that the insurer will face substantial difficulties in proving that it did not have knowledge of the loss prior to the claim or the court action. This is a sort of *probatio diabolica* which consequences insurers must consider carefully when dealing with a loss.

Amendment of the Spanish Accounts Audit Act

In our report published in April of 2010, we referred to the potential impact on professional indemnity policies of the Draft Bill on the amendment of the Spanish Accounts Audit Act (AAA). At the time we said that one of the most significant proposed changes was the introduction of a new paragraph 2 in Section 11 of the AAA concerning the limitation of the civil liability of statutory auditors and audit firms. The proposed reform provided that both the auditor and the audit firm would only be jointly and severally liable where the cause of the damage could not be individualized or the degree of contribution to the harmful result of the agents involved could not be established precisely.

During the legislative process several amendments to the Draft Bill were included, among others, the suppression of the joint and several liability rule in Section 11.2, being its final wording as follows: *“The liability of auditors and audit firms shall be enforceable in proportion to the direct liability for the damages and loss of profits they could cause by their professional activity. The liability of an auditor or of the audit firm shall be enforceable on a personal and individualized basis, excluding any damage caused by the audited company itself or a third party.”*



Law 12/2010 of June 30, amending the Accounts Audit Act (approved by Law 19/1988 of July 12), was published on July 1, 2010, and took effect on July 2, 2010.

10

Statistical Improbability Not Sufficient to Rebut Claim for Car Theft Under Motor Policy in Sweden

It is a well known fact that fraudulent insurance claims create very serious and costly problems for European insurance companies, including those in Sweden. Perhaps efforts by insurers to fight fraudulent claims occasionally have gone too far. Obviously the Courts agreed in a recent judgment handed down by the Svea Court of Appeal (Sw. Svea hovrätt), in which it was held that statistical improbability of a car theft was not, per se, sufficient to rebut a claim under a motor policy.

The owner of a private car of 2004 model notified the police and his insurance company that his car had been stolen in October of 2004. The car was equipped with an electronic antitheft device called an immobilizer. The owner retained the two original car keys in his possession after the theft. The car was never found.

The car was insured under a motor policy that included protection against theft. It was understood that the value of the car was SEK175000.

According to the owner and an accompanying friend, the car was parked at around 8:30 pm at a parking space close to a commuter station and close to European highway 6 (E 6). There were no other cars at the parking space. When they returned at around 10:00 pm, they discovered that the car was gone.

The insurer disputed the car owner's entitlement to insurance indemnity on the ground that the car had not been stolen that night and that, accordingly, no loss had occurred that fell within the scope of the insurance policy.

Studies performed by Larmtjänst AB (a nationwide alarm and rescue enterprise) show that 90 percent to 92 percent of all vehicles that are stolen in Sweden are found within 10 days. The remaining 8 percent to 10 percent are vehicles that are stolen through organized theft operations that may include export to other countries (normally very expensive and exclusive cars) or involve cases of insurance fraud. The car stolen in this case was neither very expensive nor very exclusive.

According to available statistics from Larmtjänst AB only two cars of the same make and model, the Volvo V 70, equipped with the same kind of immobilizer, were stolen and never recovered in the region during 2007.

An extensive theft protection project carried out by Larmtjänst AB in 2004 investigated the percent of stolen cars with modern theft protection devices that had been stolen with a key or by manipulation of the theft protection devices, respectively. The results showed that almost 100 percent of the cars that were found had been accessed with the cars' original keys.

The car was locked, and its alarm was activated. No car keys were missing after the alleged theft. The immobilizer prevents the car from being started without access to its own keys.

Some kind of transport of the car away from the parking place was improbable, because this requires planning and was not possible due to the fact that the car was never frequently parked in this area. Further, towing, hoisting or transport of the car would entail a significant risk of detection.

Under Swedish law insurers can defend a claim by putting the claimant (the insured) to proof of loss and then challenge that proof rather than allege fraud, which normally is very difficult, if not impossible, to prove. Accordingly, when an insurance company disputes an insured's entitlement to insurance indemnity, the insured has the onus of proving the circumstances of the loss to establish that the loss falls within the scope of the insurance policy.

The level of proof required is satisfied if, on an overall assessment of all circumstances, it is more probable than not that the loss falls within the scope of the insurance policy.

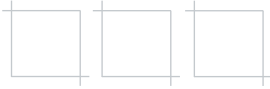
It was established by the examination of the owner and his friend that the car was parked at the parking place at the relevant time and that the car was no longer there when they returned.

It was understood that the car was equipped with a so-called immobilizer and that all car keys were left in the owners' possession. Therefore, a theft had been possible either by an exchange on site of the components of the immobilizer or by the car being towed away from the site.

The Courts agreed with the insurance company that it was not probable that the components were exchanged. Such operation takes a lot of time, advanced technique and in depth knowledge as to how the system operates.

The Courts disagreed with the insurance company on the possibility of the car being towed. Considering the fact that the parking place is located close to E6, further planning did not seem necessary to steal the car using a truck to hoist and transport the car. For persons with access to that kind of vehicle, it would be possible to search for suitable objects to steal without planning exactly which car to steal and where. The Courts did not share the view that it is improbable. On the contrary, the Courts found it not improbable that someone had been “cruising” with a break-down truck and chose to steal the car. In addition, the Courts took the view that the risk of detection is low if a car is towed away from a parking space devoid of people. And towing away a car would not be an indication of an ongoing theft.

It is emphasized by the Courts that the statistics presented by the insurance company mean that the mere fact that a car is equipped with an immobilizer and is not found shows that it is more probable that an insurance fraud has been committed than the car has been stolen. However, lacking a clear exclusion to that effect in the policy conditions, a claim cannot be denied solely by reference to the statistics and these two circumstances.



Hence, the car owner was considered to have proven that it was more probable than not that the car had been stolen, and he was awarded the claimed amount.

11

Run-Off Portfolio Transfer by Means of a Captive under Swiss Law

An insurer that discontinues the underwriting of new business is said to be in run-off. Irrespective of the reasons for discontinuing the underwriting activity, the run-off of a business gives rise to obligations with regard to the administration of the existing portfolio. In theory, the run-off business continues until all insurance contracts are terminated. The problems arising from a long-lasting passive run-off give a strong incentive to insurers to shorten the run-off period. However, run-off scenarios affect in particular the casualty insurance industry, as the run-off business volume in casualty insurance (including motor liability insurance) is even higher than in other insurance lines of business.⁶

The implementation of Solvency II in the European Union and the Swiss equivalent, the Swiss Solvency Test (SST), are expected to intensify the situation, as they require insurers to maintain and demonstrate adequate capital resources and to maintain appropriate risk management structures that impact run-off portfolios in particular.⁷

This article scrutinizes the question as to the extent Swiss primary insurance portfolios can be shifted to a UK-based captive by means of a portfolio transfer. The article outlines the reasons for a practical need for such a portfolio transfer by presenting the instrument of the Solvent Scheme of Arrangement (“Solvent Scheme”) in run-off scenarios. An attempt will be made to give a short overview of the relevant Swiss regulations concerning portfolio transfers in order to extrapolate the characteristics in law.

Need to Shorten Run-Off

The rationale for run-off might be related to the entire insurance company or only concern a line of insurance or merely one insurance tariff. In many cases, run-off scenarios are chosen solely because of a lack of profitability of an insurance line.

⁶ Cf. *Speck Schweizer Versicherung* of May 28, 2010, p. 22 et seq.

⁷ *Ibid.*

A “passive” run-off, for example, where an insurer ceases its underwriting while letting its remaining contracts expire by reaching their term, might last decades. What is more, during this entire period the insurer is obliged to bear the administrative costs and liabilities arising from the run-off business. In many cases, the loss ratio of such run-off portfolios is very high. This is due to the fact that the ongoing downsizing of the risks on grounds of expiry, cancellation or settlement brings a decreasing spread of risks.

On the other hand, the premium net income of run-off portfolios is very low, which gives a strong incentive to the insurer to foreclose these inactive portfolios and to attend to its active business instead. To sum up, the problems arising from a long-lasting passive run-off are well-known to insurers and give rise to their eagerness to considerably shorten the run-off period.

Instruments to Shorten the Run-Off

The closing of the portfolio can be achieved by different means, such as commutation, portfolio transfer, debt collection or retrospective reinsurance.

These instruments – notwithstanding portfolio transfer⁸ – suffer from the flaw that they can be applied only if accepted by the insured. If but one insured person fails to agree, another solution has to be found at least for the person in question.

Only by implementing a Solvent Scheme is it possible to achieve the shutting-down of the portfolio in its entirety with binding effect on all insured parties, notwithstanding their individual disapproval.

Solvent Scheme under British Law

Pursuant to the British Company Act 2006 Part 26, a Solvent Scheme is used for a so-called “solvent liquidation” by way of a mandatory arrangement.

To summarize briefly: For the scheme to be approved, a majority of creditors (50 percent in number and 75 percent by value of those voting) must vote in favor of the scheme. In addition, the arrangement has to be approved by a competent British High Court. If the scheme is sanctioned by that court, the order of the court must be registered at the Office of the Registrar of Companies.

As a result, the Solvent Scheme brings about a commutation with all policyholders and allows a final distribution to be made to creditors. In addition, it compels policyholders to accept a one-time payment in return for excluding all future claims that might still arise from past policies.

⁸ See *infra* Chapter IV. 1. in detail.

For a solvent scheme to be implemented, the British Company Act 2006 further requires that either the portfolio or a subsidiary company be located in the United Kingdom or that there be a substantial link to the United Kingdom.⁹

For the insurer, this procedure has an advantage in that the entire portfolio of active insurance contracts or the whole line of business in question is terminated. This might have a positive effect even for creditors, as they obtain direct payments. Furthermore, they are released from the risk that the insurer might become insolvent in the future.

However, the applicability of solvent schemes for Swiss portfolios is unclear. In the following, an attempt will be made to give a succinct answer to the question of whether the mere formation of a captive company or the utilization of an already existing captive might constitute a substantial link to the United Kingdom which would allow an active run-off by implementing a solvent scheme.

Further clarification is needed as to whether the termination of insurance contracts resulting from the implementation of a British solvent scheme would be recognized under Swiss law.

Substantial Link to the United Kingdom by the Formation of a Captive

The formation of a captive by a Swiss insurer in the United Kingdom could create a substantial link which would allow the transfer of the portfolio to said captive in order to run it off by a Solvent Scheme.

Requirements for the Portfolio Transfer

In Switzerland, the transfer of portfolios is subject to the authority of the Insurance Supervisory Authority and is regulated specifically by the Swiss Insurance Supervisory Act (Versicherungsaufsichtsgesetz – VAG).

Pursuant to Article 62 para. 1 VAG, which is the applicable regulation for primary insurance portfolio transfers, the supervisory authority only gives approval to portfolio transfers insofar as the interests of the insured are safeguarded collectively. Furthermore, the Swiss regulation strengthens the influence of the supervisory authority, which is entitled to specify the conditions of the transfer by specifying volume and content via its approval.

If the portfolio transfer brings a different contractual partner (instead of the assignor) the policyholders have to be advised of the transfer. In such cases each policyholder has the right to cancel the contract within three months (Article 62 para. 3 VAG).

⁹ Cf. Labes [2008] ZfV 698 (699).

However, according to Article 35 VAG, the regulation of Article 62 VAG explicitly does not apply to reinsurance portfolios. As a result, acceptance of all the reinsured is needed to grant reinsurance portfolios transfers. This would be a challenging endeavor.

Portfolio Transfer to UK-Based Captives

As far as portfolio transfers to a UK-based captive are concerned, two questions seem particularly worthy of being highlighted:

- *Are the interests of the insured with regard to such a transfer still being adequately safeguarded?*
- *Is a captive formed for the sole purpose of facilitating a run-off by way of a Solvent Scheme still an insurance company within the meaning of the Insurance Supervisory Act (VAG)?*

Safeguarding the Interests of the Insured

The interests of the insured, according to Article 62 VAG, could be at risk if the portfolio transfer to a UK-based captive is not made on the grounds of continuing the insurance business, but exclusively in order to terminate the whole portfolio by way of a solvent scheme. In this case, it seems questionable as to whether the interests of the insured are still sufficiently safeguarded, as the solvent scheme could even be executed against or without the will of the minority.

In contrast to that, the legislator did not (explicitly) prohibit a portfolio transfer by way of a solvent scheme. It should be noted that the regulation could also facilitate the restructuring and the closing of special lines of business for all insurance entities. In addition, the supervisory authority has discretionary power with regard to the volume and content of the approval and to impose conditions for its approval, as it is regulated explicitly in Article 62 VAG.

To summarize, the interests of the insured do not per se give rise to the assumption that a portfolio transfer to a UK-based captive with the intent to implement a Solvent Scheme is not permissible.

Captive as Insurance Company

Article 62 VAG requires the entity to which the portfolio is to be transferred to be an insurance company. In general, even a captive could be such an insurance company. However, this could be disputed if the captive is formed for the sole purpose of liquidating the portfolio, but not to conduct any active business.

For Switzerland, according to Article 11 para. 1 VAG, it is crucial that there be a causal link (unmittelbarer Zusammenhang) between the normal insurance business and the intended run-off business. That is the case only if “running-off” portfolios are considered to be directly linked with normal insurance business. A captive whose sole purpose is such could be considered an insurer. At this point it has not been decided if this link is still given in a sufficient way when the portfolio transfer goes to a UK-based captive and whether such a solvent scheme which is governed by British law is even accepted under Swiss law.

Summary

Although criticism has been expressed by some, a solvent scheme can be an appropriate instrument for a rapid and comprehensive liquidation of a Swiss primary insurance portfolio or line of insurance business.

However, the founding of a captive in the UK just for that purpose might not be appropriate, as such a captive would risk not being regarded as an insurance company. The Swiss supervisory authority will in all likelihood distinguish between such cases where the portfolio transfer is made to an already existing captive, which serves different purposes (with the latter more likely being regarded as an insurer and thus as an admissible assignee for the transferred portfolio).

For Swiss primary insurers, as far as the question of portfolio transfers is concerned, it remains doubtful if the competent supervisory authority will agree that the interests of the insured are sufficiently safeguarded when confronted with a solvent scheme scenario. Even if the supervisory authority were to accept such a portfolio transfer, it would hold additional discretionary power with regard to the volume and content of the approval and it might impose conditions before granting its approval.



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Conclusion

The latest key legislative and judicial developments reported in this issue of our legal update reveal a level of conservatism amongst both judges and legislators that is sounding a note of caution over the pace at which legal liability should expand in Continental Europe.

This conservatism is evident in the reluctance of judges and legislators to bow to pressure from the legal community to reverse the burden of proof for individual claimants in Italy, Spain and Germany and in the refusal of the Dutch Parliament to pass legislation introducing pain and suffering awards in tort law.

A note of caution is also evident in the reaction across the European Union to the proposals of the Rome II Study on the compensation of cross-border victims of motor accidents. The general consensus at the present time is that it would not be appropriate to allow victims to import the legal regime of their country of residence, and that the law applicable in the country where the accident occurs should continue to apply. This view is reflected in the decision of *Jacobs-vs-MIB* to apply Spanish compensation law (rather than the more onerous English law) to the English victim of an accident in Spain.

Nevertheless, the underlying long-term pressure to extend liability to a more standardized level across Europe remains, and in future issues of our legal update we are likely to witness fresh legal challenges to increase both compensation levels and the scope of legal liability in due course.

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