Dimitra KOURMATZIS, LLM*

PROFESSIONAL LIABILITY INSURANCE COVERAGE IN COMMON AND CIVIL LAW JURISDICTIONS

EVENT MADE AND CLAIMS MADE APPROACHES

Abstract: Author analyzes the professional liability insurance scheme in common law and civil law jurisdictions as well as claims made and event made insurance policies. Specifically, a deeper look is taken into how such policies are enforced, where and when such policies are mandatory, and what requirements are laid out for said policies. Author makes some general critique on the successful applicability of such policies as well as underlining how claims and event based policies manage to successfully cover insureds.

Key words: Professional liability insurance, claims made policies, event made policies, reporting period, run-off cover, tail coverage.

INTRODUCTION

In light of the current crisis, financial stability is the aim of all individuals practicing in any type of ‘risky’ business. In relation to this, professional liability insurance has provided a way in which professionals can attempt to protect themselves as well as the parties that they provide their services to. As such, it can be seen that professional liability has been dealt with both on a national (e.g. state provisions and professional bodies) as well as on a regional (e.g. EU Directive 98/5 for the facilitation of the profession of lawyers) level.

Professional Liability insurance or Professional Indemnity insurance provides cover for claims brought against the insured for errors made whilst said was providing professional services. In other words it "protect[s] a professional man against his legal liability towards third parties for injury, loss or damage arising from his own professional negligence or that of his employees."\(^1\)

Most individuals which undertake ‘risky’ business are either required via law, regulations or via common sense to enter into an insurance policy. Professional persons to whom this applies are usually lawyers, doctors, stockbrokers, accountants, architects, insurance brokers and other such individuals who provide services to patients/clients which are capable of causing financial or personal injury to the individuals previously mentioned.

Under civil law, it is the case that the state provides for the rules and regulations (in cases of courses where such rules and regulations are mandatory) concerning professionals. Therefore, the state is responsible for legislating upon issues concerning professio-

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* Author is an Associate Attorney-at-Law at I.K. Rokas & Partners Law Firm, e-mail: dkourmatzi@rokas.com.
nal liability insurance, as opposed to the common law system where, due to the absence of state legislation, the professional bodies themselves historically have come to legislate for themselves. As such, a number of professions, under the common law system, such as those mentioned previously, have imposed upon themselves the requirement of insuring their activities. This coverage therefore can either be imposed by virtue of statute (in the civil/continental law system) or by the rules of the profession itself (in the common law system) as occurs for example in relation to the professional legal bodies in common law systems such as in Spain, France and Belgium.

Insurance policies relating to professional liability cover actions which bring about liability. In other words no indemnity is provided for actions where liability does not arise. Therefore "liability insurance is any insurance protection which indemnifies liability to third persons, thus providing cover against consequent depletion of the insured’s assets." Policies are based on legal liability, moral liability is not insured. The provision of indemnity insurance presupposes that a loss has occurred. Consequently, what professional liability insurance aims at, is to provide third parties with remuneration in the cases where the professional (insured) has failed to diligently provide the task he was employed to undertake and from this failure damage has been caused.

A policy holder under a professional liability scheme is provided with two benefits. "First, this insurance provides a specific amount of money (the insurance policy "limits") from which to pay a settlement or adverse judgment in a professional liability claim. This benefit is referred to as "indemnity", or the "duty to indemnify." Second, this insurance pays for legal representation... This is referred to as the "duty to defend". The duties to indemnify and defend are universal in professional liability policies."

**MANDATORY PROFESSIONAL INSURANCE COVERAGE- WHEN, WHERE AND WHY**

The Common Law Approach (occurrence based v claims based)

The type of policy that an insurer will provide usually depends on the type of coverage that is needed. For example, in relation to lawyers, more often than not, claims made policies are those which are entered into. On the other hand, most auto insurance is of the event made policy type. The characteristics which distinguish the one policy from

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5 Smyth, Pg. 12/9.
6 Thornton, Russell G., Not-so-obvious considerations from professional liability, a Publication of the Baylor University Medical Center Proceedings, 2005.
7 Chineson, J., Insurance, Just in Case: Keep Yourself Covered- Professional liability insurance- what is it and how to get it, Legal Times, 11-17-2003.
the other are those which make one policy more or less favorable then the other in certain situations.

Under UK law a distinction should be made between the event which the insured’s liability arises from, and the claim made by third parties to the insured. This distinction is important due to the fact that there are two forms of insurance policies which can be entered into. The first type of policy (i.e. the occurrence/event made policy) is based upon the event (that varies from policy to policy) from which the liability of the insured stems from, whereas the second type of policy is based upon the claim of a third party (regardless of whether it is imminent or has actually been lodged). In other words in event made policies what interests the insurer is the existence of an event and in claims made policies that which interests the insurer is the likelihood or the actual existence of a claim. As such, standard claims based policies provide coverage for acts having occurred either within or before the policy period (since the time period of the claim not the event is what is of importance). On the other hand, standard event made policies will only provide indemnity for those events which have occurred within the applicable policy period.

An insurer under UK insurance law has the option to opt for either an event (or occurrence) based policy where coverage is provided "against liability arising out of acts of the insured occurring during the policy period, no matter when a claim is eventually lodged against the insured"8 or a claims made policy where the insured is covered "against all claims that are made during the policy period, regardless of when the activity giving rise to the claim occurred."9 More specifically, the event made policy makes the responsibility of notification of the insured a little trickier in relation to the responsibility of notification of the insured event. This is due to the fact that the insured must be aware that the event (under an event made policy) bringing about liability has occurred. Alternatively, with a claims made policy, it is highly probable that the inception of a claim (in the sense that said claim is some form of legal action) shall be made known to the insured, due to the legal procedure of lodging a claim. Therefore, "the difference between the two kinds of policies is that the insurer bears the risk of uncertain claims future under an occurrence policy; a claims based approach shifts much of that risk back to the insured... [this is due to the fact that] claims made or "discovery" policies, by placing insurers in the position of obtaining extensive information about potential claims before commencing (or renewing) the coverage of an insured, enable insurers to avoid having to indemnify insured for a significant proportion of the potential claims that exist at the date of commencement (or renewal) of coverage"10 In other words, by being informed about what potential liabilities arise, insurers can avoid making payment upon said by not renewing insurance policies. As such, generally speaking in claims made policies the insurer (as well as the insured) is better informed, in relation to potential liabilities, whereas in event made policies neither of the two contracting parties has a complete picture of what the circumstances are.

**The United Kingdom**

Often, in the UK, for example, it is a requirement set out by the professional institutions themselves, such as the Law Society of England, where one has to be a member of

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8 Clarke pg. 419.
9 Clarke pg. 419.
10 Clarke pg. 420.
the institution in order to practice the profession.\textsuperscript{11} Specifically, when discussing the Law Society, a self-insurance scheme is in operation, which one way or the other has been viewed as being somewhat obligatory.\textsuperscript{12} A similar example can be seen in relation to Royal Institute of British Architects and the Architects registration Board which state in their guidelines, respectively, that since "Members practicing architecture are exposed to the risk of being sued for negligence or breached of contract. Some form of insurance should therefore be held which will generally cover liabilities arising from such claims. Holding appropriate insurance cover is a requirement of an RIBA Registered Practice....In the UK, the Architects Registration Board requires all practicing registered persons to be covered by a professional indemnity insurance (PII) policy."\textsuperscript{15} A variation of the mandatory regulation of PII (Professional Indemnity Insurance) has also been adopted by the Institute of Chartered Accountants in England and Wales, where PII is required "if you hold a practicing certificate and are a resident in the UK or the Republic of Ireland’ or are engaged in public practice in the UK or the Republic of Ireland."\textsuperscript{14} The requirement to have insurance is a regulatory one, in this case, as well as one which is a result of the professional authorization of accountants. In other words, under the Rules and Regulations of the Institute of Chartered Accountants, an accountant cannot be granted a practicing certificate if he/she has not obtained the insurance coverage required. Consequently, one can see that under UK law an increase in the requirement of compulsory insurance is a trend being caught by a number of professional institutions.

Many of the aforementioned Professional Institutions have laid out the mandatory nature of Professional Liability Insurance as well as the manner in which said insurance is to operate. The Solicitor’s Regulation Authority, which is the regulatory body of the Law Society of England and Wales in relation to solicitors, operating under the auspices of the Ministry of Justice and HM (Her Majesty’s) Courts Service, states, for example, under the Solicitors’ Indemnity Insurance Rules 2008, that in reference to civil liability insurance will indemnify each insured "provided that a claim in respect of such liability: (a) is first made against an Insured during the Period of Insurance; or (b) is made against an Insured during or after the Period of Insurance arising from Circumstances first notified to the Insurer during the Period of Insurance."\textsuperscript{15} A similar approach has been followed by the Institute of Chartered Accountants which states that "all the principles and senior staff in a practice should be aware of the importance of notifying insurers promptly of both claims and circumstances which may give rise to a claim."\textsuperscript{16}

\textbf{The United States}

In the United States, there are similar provisions concerning the necessity for insurance, however unlike in England and due to the fact that the U.S. has a federal system, each state is allotted its own system, and therefore generalizations cannot be made.

\textsuperscript{11} Birds, John, "Modern Insurance Law", 4\textsuperscript{th} ed, Sweet and Maxwell London, 1997, Pg. 395.
\textsuperscript{12} Birds, pg. 395.
\textsuperscript{13} Code of Professional Conduct, Guidance Note 5, Royal Institute of British Architects Articles. 5.1 and 5-2.
\textsuperscript{14} Guidance and Information on Professional Indemnity Insurance, The Institute of Chartered Accountants.
\textsuperscript{15} Article 1.1.
\textsuperscript{16} Guidance and Information on Professional Indemnity Insurance, Section 2.2.
As a general observation however, it seems that, unlike the professional bodies in the UK, American institutions do not make professional liability insurance compulsory. For example, in relation to physicians, professional liability insurance is only mandatory when said physician has been disciplined.\(^{17}\) However, "notwithstanding the statutory scheme, general hospitals in New York typically require, as a condition of granting privileges to any physician...that the physician maintain professional liability insurance from an insurer in an amount satisfactory to the hospital."\(^{18}\) Professional liability insurance is also not mandatory for lawyers in the United States, except for Oregon, which is the only state where having insurance is compulsory for those lawyers in a private practice.\(^{19}\) As such, since there is no consensus from state to state in relation to the necessity for professional liability insurance, there is also no one set of rules to dictate what the procedure is in relation to either claims made or event made policies (as occurred with the Law Society of England as well as with the Institute of Chartered Accountants).

### The Civil/Continental Law Approach

Under civil law jurisdictions there are certain professions where insurance is mandatory. Therefore, the state regulates said professions and deems that those practicing certain professions must be equipped with professional liability insurance. Under the Greek legal system, for example, "even though the insurance contract, as a commercial contract, is strongly governed by the principle of contractual freedom, the State recognizing the social role of insurance obligates certain categories of individuals to have entered into and maintain valid insurance (mainly relating to civil liability)."\(^{20}\)

### PRINCIPLES OF PROFESSIONAL LIABILITY INSURANCE

#### Occurrence Made Policies

Under occurrence made policies what is important to the insurer, the insured, and the party which has suffered the loss is the occurrence of the insured event. In other words, the event is that which triggers the liability of the insured, the obligation of the insurer to provide compensation, and the loss of the third party. As previously mentioned each policy will determine which event will trigger the liability of the insured. As such, once the event has occurred within the period of insurance cover and said has been notified to the insurer, then the insurer is liable to provide indemnity to the third party via its insured. In other words, only acts during the specific policy period are covered. "They do remain available for claims that arise years after they have expired. [So] if an accident or event occurs during the term of an occurrence policy, that policy must respond to any

\(^{17}\) State of New York Insurance Department, OCG Op. No. 08-06-02.

\(^{18}\) State of New York Insurance Department, OCG Op. No. 08-06-02.

\(^{19}\) Mason, Darrel T., Mandatory Malpractice Insurance- It’s Time to Call the Question, 08/04/08, pg. 3.

future claim.\textsuperscript{21} The problem with occurrence made policies however is that in certain situations it is not easy to determine whether the actual event falls within the period of cover. For example, the event is easily defined in "cases of motor accidents but less so when the occurrence concerns damage, disease of injury of a kind that may be more or less latent for many years, such as asbestosis or cancer."\textsuperscript{22} Each case will be looked at and decided upon on an ad hoc basis, therefore not providing for a uniform legal regulation. From case law it arises that each judge, in each court, in each district, in each jurisdiction has created his own theory relating to when an event should be calculated as having occurred within the insurance policy period. Such an inconsistent manner of adjudicating differences makes the job of the insurer even more difficult, seeing as though no one set of standards or method of operation, is applicable. Either way, the event made policy shows that the divergence in the decision-making on such cases is unattractive for those which enter into said policies.

\textbf{Claims Made Policies}

A claims made policy "covers liability for claims made during the period of cover, even though the event giving rise to the claim occurred earlier."\textsuperscript{23} In order for said cover to be applicable there are generally four conditions which must be present. "1. the insured…professional must receive his/her first notification of a claim or potential claim situation during the policy period. 2. The claim or potential claim situation must be reported to the insurer during the policy period. 3. The negligent act, error, or omission giving rise to the claim must occur after a ‘prior acts’ or retroactive date that is set forth in the policy declarations. [in other words claims resulting from acts or services, respectively, which occurred or were provided prior to the inception date of the current or new policy are not covered –unless the policy expressly states that prior acts are covered or no retroactive date is applicable] 4. The insured must make a ‘good faith’ statement (in some cases, a certification or warranty) that the professional and the firm had no knowledge of the mistake, error or controversy on the date the coverage was purchased."\textsuperscript{24}

In order for the process of indemnification to begin there must be a claim. Even though there have been numerous cases in the UK dealing with the meaning of the word claim, no one definition has been accepted. However, one can generally assume that "the meaning of claim is often affected by the context of the policy, in which the word is used."\textsuperscript{25} Under Texan common law however "any formal demand for money, services or any other demand for something by ‘right’ will constitute a claim."\textsuperscript{26} This is in line with the common law doctrine provides that for a claim to be made in accordance with common law there is a requirement that certain information needs to be communicated by the claimant to the insured (i.e. some kind of intention on the part of the third party to hold

\begin{thebibliography}{99}
\bibitem{22} Clarke pg. 422.
\bibitem{23} Clarke pg. 429.
\bibitem{25} Clarke pg. 430.
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the insured liable).\textsuperscript{27} As such a claim in negligence, or form money or other various claims can fall under the insurance policy, provided that the policy can be interpreted in such a manner as to provide for such types of claims. The time of a claim is also important, seeing as though it must fall within the period of cover so as for it to apply. The possibilities set out for claims which fall within the insurance policy are as follows: "(a) the occurrence of a state of affairs which may give rise to injury and liability later, (b) the occurrence of a state of affairs which may give rise to a claim, (c) the occurrence of a state of affairs which is likely to give rise to a claim, (d) notification of (b) to the insured, in other words, mere allegation, (e) notification of (c) to the insured; and (f) the institution of proceedings against the insured."\textsuperscript{28} Therefore, one can see, as previously mentioned, that via a claims made policy both the insured (who has a higher chance of indemnifying the third party, since an actual claim need not be lodged but the circumstances surrounding said will suffice) as well as the insurer (who is by far more well informed) are in a more beneficial position than in an event-made policy.

The claims made policy, as the event made policy, also requires a little judicial insight and interpretation. If proceedings have been instituted, then the insured shall most definitely have an obligation to notify its insurer. However, there are areas which are not so black and white. In the claims based policy the gray area arises in relation to interpreting when a potential claim exists. If the word claim is to be defined as potential then the potential claim must be real. An example of a definition of a claim was provided in the Canadian Supreme Court case the Jesuit Fathers of Upper Canada where "the authorities establish that as a general rule, for a "claim" to be made there must be some form of communication of a demand for compensation or other form of reparation by a third party upon the insured, or at least communication by the third party to the insured of a clear intention to hold the insured responsible for the damages in question."\textsuperscript{29}

Once more though, there are practical difficulties relating to the determination of when, what becomes real.\textsuperscript{30} Although practice has shown that an objective, as opposed to a subjective, basis shall be implemented in relation to whether or not a claim does exist.\textsuperscript{31} The likelihood of a claim will, therefore, influenced by a number of factors such as the relationship of the insured with the third party, the probability that the third party will take legal action, etc. Thus, it seems that, in opposition to the event made, even though there is a more unified legal background concerning event made policies, the judges will have the last word.

When dealing with a claim made approach the insured has two duties of notification. On the one hand, "at renewal date an insured is obliged to report (if he has not already done so) any occurrence likely to give rise to a claim"\textsuperscript{32}; on the other hand notification of all potential claims during the policy period must be made known to the insurer as well. The duty of the insured to inform his insurer about the existence of a claim before the conclusion of an insurance policy is highly important due to the fact that "failure to

\textsuperscript{28} Clarke pg. 431.
\textsuperscript{30} Clarke pg. 432.
\textsuperscript{31} Bradley, Beth D, ibidem.
\textsuperscript{32} Smyth, pg. 12/9.
report potential claims in an application may provide the basis for rescission, if based upon a material and knowingly false misrepresentation. Without reaching the extreme, however, an insured’s unintentional failure to report potential claims may affect coverage [since] ... many claims-made policies require that an insured report circumstances that may give rise to a claim. \(^{33}\) The consequences that the insured will have to face in the case where proper notice is not given within the policy period and before said period are quite harmful (as occurs in all insurance policies). If the insured does however inform the insurer yet fails to do so within the policy period the result shall be a denial of coverage.\(^{34}\) Once should also note that the notification provided (in so far as said is provided within the appropriate time limits) will only be effective in regards to the specific circumstances notified and the consequences of those circumstances. Said notification will not cover any unrelated defects/problems which were coincidently discovered as a result of further investigations.\(^{35}\) Hence, the duty to notify is a complex one not only in relation to the time at which notification must be provided but also in relation to the contents of said notification.

Another aspect of the claims-based policy is that insureds can protect themselves even after the policy terminates. This can be done by virtue of two methods. "One option is to obtain 'prior acts' coverage. Under this option the new insurer charges an additional premium to cover the insured for acts occurring before the inception date of the new policy...Another option is to purchase extended reporting period[ ERP], or 'tail' coverage [which] is purchased from the insurer and covers future claims made for incidents occurring during the time of the claims-made coverage. In effect, such coverage turns claims-made coverage into occurrence coverage."\(^{36}\) Such protection is important, due to the fact that under a claims-based policy the insurer avoids indemnifying its insured’s for a number of claims which may exist at the date of commencement or renewal of the original policy.\(^{37}\) If the insureds policy elapses and neither ‘prior acts’ coverage nor the ERP have been obtained then any claims made before the second policy or after the first policy will not be covered. However, if the insured obtains prior acts coverage then the new insurer will cover any claims made between the gap that might possibly exist between the first and the second policy (e.g. if the insured changes insurer). Furthermore, by obtaining the ERP an insurer is covered for claims which may arise not within the policy period but within the ERP. Through this manner the insured protects itself against claims arising under the previous policy, which under normal circumstances the insurer wouldn’t cover.

\textit{Claims-Made & Reported}

This form of policy follows the general concept of the claims-made policy. In other words the claim and the notification of said claim must both occur within the time period of the applicable policy or within the extended reporting period (ERP) if said is ap-

\(^{33}\) Bradley, Beth D, ibidem.  
\(^{34}\) Bradley, Beth D, ibidem.  
\(^{36}\) Clarke pg. 429.  
\(^{37}\) Clarke pg. 420.
plicable\textsuperscript{38}. Therefore, in order for the insurer to provide the insured with the agreed-upon insurance coverage, the insured must have notified the insurer about the potential claim within the applicable insurance period, and said claim must have been made during the same insurance period.

**Pure Claims Made**

This type of policy is somewhat of an exception to the general claims-made policies. Although it still requires that the claim be made during the applicable policy period the insurer "needs only report the claim 'as soon as practicable,' or promptly, and not necessarily during the policy term which, in essence can be anytime in the future."\textsuperscript{39} This means that in order for the insurer to provide the insured with the agree-upon insurance coverage, only the claim needs to have taken place within the insurance period, and not necessarily the notification of the claim.

**Tail-Coverage**

Tail coverage is coverage which comes into play after a claim made policy has ceased however the practice itself has not ceased. "Claims made policies usually provide a 90-day extended reporting period beyond the expiration of the policy during which claims that occurred during the policy can be reported."\textsuperscript{40} This means that the insured has the right to provide notification to the insurer about any claims which occurred during the policy period, however said notification can occur outside of the original policy period. Tail coverage is divided into basic tail coverage and full (supplemental) tail coverage.

1. Basic Tail Coverage

In other words the extended reporting period extends for five years after the policy expiration date and only covers claims due to occurrences "(1) that the insured reported during the policy period 60/90 days thereafter, (2) that occurred after the retroactive date in the policy to which the "tail" coverage is attached, (3) that are not covered by any other policy when the claim is made, and (4) if the aggregate [i.e. the total amount of monies available for all the potential claims which will arise in one given insurance period] limit of the policy is not yet exhausted"\textsuperscript{41}

2. Full Tail Coverage

\textsuperscript{39} Bernstein, W., ibidem.
\textsuperscript{40} http://www.harperrisk.com/Articles/6claimsmdvsocc.htm, Claims Made vs Occurrence, Sept 12, 2008.
\textsuperscript{41} http://www.harperrisk.com/Articles/6claimsmdvsocc.htm
A policy which provides for this type of coverage is similar to an event made policy in that "it excludes incidents that occur after the policy to which the tail is attached has expired or that occurred prior to the retroactive date of that policy." It begins to apply for events which have already been notified five years after the end of the policy date (i.e. when the basic tail ends) and for all other claims the policy begins 60/90 days after the policy period.

THE END OF THE PRACTICE

"Run-off" cover after the Practice has ended

When an individual ceases to provide services this does not mean that the risk of a claim vanishes. The threat of liability still lurks. In order to secure the rights of both the insured, who is potentially at risk, and the third party, who will potentially face a loss, most of the Professional Bodies under common law jurisdictions have set out a requirement in relation to the cessation of practice. For example under regulation 2.7 of the Institute of Chartered Accountants "a member who ceases to be engaged in public practice in the United Kingdom or the Republic of Ireland must use his best endeavors to ensure that he is covered by arrangement which satisfies these regulation for at least two years from the date he ceased in public practice. The terms and extent of any cover must be equivalent to that provided by his firm's previous qualifying insurance." In other words, this regulation has been put into force so that claims for work done while the accountant was in practice are still covered even if said claims arose after the practice ceased. The Run-off cover provisions for solicitors under UK law are similar. The Indemnity Insurance Disclosure Guidelines explain that "Where a practice has ceased and there is no successor practice, the qualifying insurer on cover at the date of closure of the practice will be liable to provide 6 years’ run-off cover from the date of the expiry of the policy. Any claims or circumstances notified after the firm has closed will be handled by the qualifying insurer providing this run-off cover." As one can see, a number of professional bodies set out rules and regulations concerning run-off cover. Some provisions (as those of the accountants and solicitors practicing in the UK) are self-explanatory. Others, such as the provisions for architects practicing UK law, have no definitive answer on how long an architect must be covered. Furthermore, one can see that the run-off cover period varies from profession to profession, likely due to the severity of the risks that third-parties face from potential acts of the professionals.

CONCLUSION

Professional liability insurance exists so as to protect third party individuals from being caused any further damage from the negligent acts of professionals and indemnify

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42 [http://www.harperrisk.com/Articles/6claimsmdvsocc.htm](http://www.harperrisk.com/Articles/6claimsmdvsocc.htm)
43 Professional indemnity insurance regulations and guidance, regulation 2.7.
any damage which has already taken place. From the inception date, duration, and the end of a practice, policies both events made and claims made have this common goal.

The two types of policies vary in a number of areas, the most important and significant being that an event made claim requires the event to occur during the policy period whilst the claims made policy requires knowledge (and as such reporting of said) of the existence of the claim during the respective policy period.

The claims made policy which is more popular when concerning professional liability insurance, is divided into stages. The stage of coverage (where the claim must be reported) and the stage following coverage (run off and tail coverage).

Under common law jurisdictions specifically, due to a lack of a central state legislation, most professional bodies which undertake business involving financial risk, make it a requirement for the professionals registered under their society/institute/association to have professional liability insurance. This is not always the case when concerning civil law jurisdiction (where only in certain cases has the state made professional liability insurance mandatory).

Konstantina SOULTATI*

**ISSUES ARISING FROM EU LAW ON REORGANIZATION MEASURES AND WINDING-UP PROCEEDINGS OF INSURANCE UNDERTAKINGS**

**ABSTRACT**

In light of the financial crisis EU rules governing the reorganization measures and winding-up proceedings of insurance undertakings adequacy is likely to be tested; Principles of unity and universality have been introduced by Directive 2001/17 under which said measures or proceedings imposed on an Insurance Undertaking shall be subject to a single set of rules, however, in the absence of harmonization on EU level of member–states legislations governing the above several issues arise.

Key words: reorganization, insolvency, liquidation, financial stability, unity and universality

1. The still pending financial treadmill that swept credit and financial institutions worldwide appears to have a smaller impact on insurance undertakings which have been less affected in comparison to the above. This of course is a shortsighted view, as it has been already contested systematic risk may admittedly not be so imminent with respect to insurers, as it is the case with credit institutions, yet their exposure to market fluctuations in coalition with the decrease of real estate property values which form a significant part of Insurers’ assets should not be overlooked. Under no circumstances should we further fail to acknowledge modern group of companies’ strict interconnection; most Insurers are nowadays affiliated with credit institutions hence their financial strength is at stake.45

* Attorney-at-Law, M.D. Commercial law, Athens.
In Greece last August the Insurance Supervisory Authority (PISC) undertook administrative measures against an Insurance Undertaking which failed to comply with its solvency requirements due to vast decrease in market value of the financial instruments that formed part of its technical reserves and further announced in the public press that such procedures are likely to apply to many other Greek established Insurers, only to retreat a few days latter before the insurance industry outcry due to differentiation between the credit institutions and insurance undertakings regulatory approach in dealing with problems of financial soundness at such times of difficulty. Irrespective of the factual background it should be further noted that while there have been cases in the past where the Regulator withdrew the license of a Greek established Insurer on account of it failing to provide for its financial soundness, it was the first time that the provisions on reorganization had been applied. Said provisions derive from EU community law, however, with the exception of basic guidelines drawn by EU legislators, it is member – states national legislation that governs Insurers winding – up and reorganization procedures.

2. Ever since the introduction of EU established Insurers single license by the so-called third life and non-life Directives, the convergence of member –states legislation regarding the promotion and protection of insurance undertakings financial soundness was inevitable. An EU single insurance market called for leveling the playing field between member-states insurance supervisory approach not only with the view to promote competition and succeed in establishing EU integration but also in order to safeguard the protection of insureds interest throughout the Community. Such provisions mainly, yet not exclusively, refer to EU insurance undertakings obligation to establish adequate "technical provisions" based on coordinated actuarial principles and to maintain a Solvency margin and a Guarantee Fund, as well as home-country Regulators exclusive powers to pursue "any measure necessary" to safeguard the interests of the insured persons, if the Insurance Undertaking fails to comply with the Solvency margin and Guarantee Fund requirements.


46 At the time PISC imposed the measures the financial crisis had not reached press headlines yet, however it was apparent that the Athens Stock Market which had already suffered a local crisis in 2000 and had been strangling henceforth had already begun to be influenced by US market.

47 The mutual recognition of authorizations and prudential control systems by EU/EEA member-states thereby providing for a single administrative authorisation to perform insurance activities which is valid throughout the EU/EEA and apply the principle of supervision by the home Member State.


50 See art. 13 of the preamble of Dir. 92/96, as well as the preamble of Council Directive 91/674/EEC of 19 December 1991 on the annual accounts and consolidated accounts of insurance undertakings. Official Journal L 374, 31.12.1991, p. 7–31: "such coordination is also urgently required because insurance undertakings operate across borders; whereas for creditors, debtors, members, policyholders and their advisers and for the general public, improved comparability of the annual accounts and consolidated accounts of such undertakings is of crucial importance".

51 See art. 10 and 12 of Dir. 96/96 and art. 11 and 13 of Dir. 92/49.
As already remarked EU legislation does not contain technical implementing measures, it merely establishes the core principles and respective guidelines on their implementation; national legislation would instead provide the measures applicable for the prevention of insolvency or winding-up situations. It should be further pointed out that prior to EU Directive 2001/17 it has been confirmed by ECJ that the provisions laid down by EU law aiming at guarantying the financial stability of insurance companies did not contain coordinating rules concerning the liquidation of an insurance undertaking. The case referred before the European court concerned the question whether national legislation providing for priority of claims arising out from an employment relationship as regards the guarantee fund ranking above insurance claims contradicts EU legislation. The case had been referred to ECJ following an action brought before Greek highest administrative court, Simvoulio tis Epikratias by Epikouriko Kefalaio, a body set up by law 489/1976 which is competent to compensate road traffic accident victims, if a Greek Insurance Undertaking is subject to insolvency proceedings or has its license withdrawn. Epikouriko Kefalaio, questioned the decision by Greek former Insurance Regulator (Minister of Development) to release property that had been allocated to the guarantee fund of the Undertaking whose license had been withdrawn in order to meet preferential claims arising from an employment relationship. On ruling the above ECJ in line with Advocate General opinion referred to the unequivocal statement by the Community legislator concerning the scope of the insurance directive as stated in article 2 of Dir. 2001/17 preamble. Following the implementation of the Directive on the reorganization and winding-up proceedings of insurance undertakings such issues must be considered resolved, however one has to question the above remark.

3. The Insurance Winding-up Directive is presumed to be the consequence of the single passport and home-country supervision principles and in respect of the latter it has further introduced the principles of **unity** and **universality** with the aim to ensure that there will be only one set of rules governing the reorganisation or the insolvency proceedings of EU/EEA Insurance Undertaking irrespective of their establishment in various EU/EEA member states. In opposition to the solution undertaken with Regulation 1346/2000, secondary proceedings are not to take place, **mutual recognition** and direct applicability of the measures undertaken by the home country has been instead provided. The above differentiation over EU cross-border insolvency treatment has been criticized to an extent, either because the two systems imposed on community level are not in harmony, or because this differentiation towards the insurance and credit sector is

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53 Judgment of the Court (First Chamber) of 16 September 2004, Case C-28/03, Epikouriko kofalaio (i.e. Auxiliary Fund) v Ypourgos Anaptyxis (i.e. Minister of Development), point 24, European Court reports - 2004 Page I-08533.
54 Opinion of Mr Advocate General Geelhoed delivered on 10 June 2004, Epikouriko kofalaio v Ypourgos Anaptyxis, Case C-28/03, points 26-28, European Court reports 2004 Page I-08533.
55 “The insurance directives providing a single authorization with a Community scope for the insurance undertakings do not contain coordination rules in the event of winding-up proceedings”.
57 See art. 10 of the preamble of Dir. 2001/17.
not completely justifiable\textsuperscript{58}. It has been however contested that the above sectors have been excluded from the Insolvency Regulation scope from application so that for a "tailor–made regime" to be applied on them\textsuperscript{58}.

The Insurance Winding-up Directive further provides for a general rule over the law applicable to insurance reorganisation and insolvency proceedings, establishing the \textit{lex fori concursus}, i.e. the home member substantive and procedural law. The latter shall govern all the conditions for the opening, conduct and closure of the reorganisation and winding-up proceedings as laid down in article 9, including the rules governing the distribution of proceeds from the realisation of assets, the ranking of claims. Derogations to the above rule are however introduced by articles 19-24, e.g. employment relationships are to be governed by lex contractus, third parties right’s in rem by lex rei sitae.

In order to safeguard insureds’ interests, the Insurance Winding-up Directive grants member states with two options which are construed to provided equal level of protection, each member state may provide insurance claims with absolute precedence over any other claims with respect to assets representing technical provisions or a special rank which may only be preceded by claims on salaries, social security, taxes and rights in rem over the whole assets of the Insurance Undertaking\textsuperscript{60}.

4. The Insurance Winding-up Directive does not purport to harmonise member states law concerning reorganisation measures and winding up proceedings\textsuperscript{61}; it merely provides for a definition of the above\textsuperscript{62}. Differentiation is hence inevitable and it has been already noted that there might be national measures which certainly fall into one category or the other\textsuperscript{63}. This inevitable raises a question as to the treatment of claims deriving out not only from the insurance policy but from other contractual relationships as well, mainly employment ones, in the event of the competent Insurance Regulatory Authority prohibiting the Undertaking’s free disposal of assets. Article 10 of the Directive only applies upon the enforcement of winding-up proceedings; issues such as payment of salaries are to be dealt irrespective of its provisions when reorganisation measures are being imposed.

Another practical issue concerns the impact of reorganisation measures EU/EEA-wide in the absence of a uniform treatment on EU level. Should for a example a home–country Insurance Regulator prohibit the Undertaking’s free disposal of assets, such a decision would be immediately effective in every branch it has within the EU/EEA. In certain jurisdictions, e.g Germany\textsuperscript{64}, it is expressly provided that such a measure does not include payment of salaries, while others including Greece, Malta and Portugal fail to provide for any solution to the matter, thus it leaving it up to the Insurance Regulatory Authority absolute discretion to decide how to deal with said payments. One could of course argue that if lex contractus provides that the employment relationship is not to be terminated by the imposition of said measures, the mere purpose of pursuing the continuation

\textsuperscript{58} Gregor Maderbacher, "The European Insolvency Regulation: A Balance after Four Years", p. 4, Vienna, available at www.era.int
\textsuperscript{60} See art. 10.
\textsuperscript{61} See art. 9 of the preamble of Dir. 2001/17.
\textsuperscript{62} See article 2 of Dir. 2001/17.
\textsuperscript{64} See art. 89 para 1 of the German VAG (versicherungsvertragsrect).
of the Undertaking’s operation should entail salary payments taking place, however, in
the absence of an explicit approval by the Regulator this is not acceptable in various
EU/EEA jurisdictions.

The absence of such uniform rules entails a degree of uncertainty as to the frame-
work of operation of an Undertaking when such measures are imposed. The exchange of
information and the publication procedures imposed by the Insurance Winding-up Direc-
tive$^{65}$ serves as a counter balance to that effect but it remains to be seen if they are adequ-
ate for that respect.

**SUMMARY**

EU legislation has introduced a wide range of provisions aiming at safeguarding
the financial stability of EU/EEA based Insurance Undertakings and providing for har-
monized rules within the EU/EEA and has further provided absolute discretion on Insu-
rance Regulatory authorities to pursue "any measure necessary" to safeguard the interests
of the insured persons, if the Insurance Undertaking fails to comply with the Solvency
margin and Guarantee Fund requirements. Said measures however are not harmonised on
EU level; the Insurance Winding-up Directive (Dir. 2001/17) merely provides for a gene-
ral rule over the law applicable to insurance reorganisation and insolvency proceedings,
establishing the lex fori concursus, i.e. the home member substantive and procedural law
as a general rule. Since the Insurance Winding-up Directive does not purport to harmoni-
se member states law concerning reorganisation measures and winding up proceedings,
differentiation is hence inevitable. This entails practical issues concerning the impact of
said measures as to the framework of the Undertakings operation, e.g. when the Regu-
lator prohibits the Undertakings free disposal of assets. The exchange of information and
the publication procedures imposed by the Insurance Winding-up Directive serves as a
counter balance to that effect but it remains to be seen if they are adequate for that re-
spect.

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$^{65}$ See art. 5 of the Dir. 2001/17.