Essays

Claims-Made Insurance Policies in Italy: The Domestic Story and Suggestions from the UK, Canada and Australia

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Abstract

Liability insurance contacts can be divided into two main categories: loss occurrence based and claims-made based. While the Italian Civil Code (ICC) only considers and determines insurance contracts on a loss occurrence basis, since the end of the 20th century, the claims-made model has taken control of the market. This reception has posed various issues in the domestic legal system on which the Italian Supreme Court has recently ruled several times. In dealing with these domestic issues, it may be of interest to look at the suggestions coming from common law systems, where the model was conceived and particularly from individual common law jurisdictions, notably the UK, Canada and Australia.

I. Foreword

The aim of this paper is to depict briefly the reception in Italy of an 'alien contract'[1] of significant importance in professional practice: liability insurance.

To this end, I shall first address the main dichotomy in professional liability insurance contracts, *viz* loss occurrence and claims made; second, I shall give an account of the issues raised in Italy by claims-made policies and deal with the suggestions coming from certain common law jurisdictions (the UK, Canada and Australia).

II. Loss Occurence Versus Claims-Made Policy Model

Art 1917, para 1, Italian Civil Code (ICC) states:

> 'In liability insurance the insurer is bound to indemnify the insured for the damages which the latter must pay to a third person because of events occurring during the insurance period and resulting in the liability referred

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[1] Quoting G. De Nova, 'The Alien Contract' *Rivista di diritto privato*, 487 (2011): 'A contract governed by Italian law but conceived and drafted on the basis of a common law model and in particular a U.S. and /or a U.K. model can be depicted as an "alien contract" '.

to in the insured contract. Damages deriving form fraudulent acts are excluded'.

The choice of the Italian Civil Code, in shaping (professional) liability insurance, is in favour of the so called 'loss occurence' model, in which the trigger for coverage is an accident or untoward event causing damage or loss during the currency of the policy period. That means that the timing of the claim being brought against the insured to recover damages is irrelevant; so long as the loss occurs during the policy period, coverage is guaranteed.[2]

Dating mainly from the 1980s, we find the introduction of a different model of liability policy – the claims-made insurance policy – created in common law systems to enable the insurance industry to cope with 'long tails' damages (ie product liability, asbestos exposure, etc). They are those which arise a long time after their cause and may even result from an uncertain series of different co-causes.[3]

The claims-made policy has a completely different trigger than an occurrence-based policy; the filing and initial reporting of a claim during the policy period. The professional malpractice or loss or damage need not have occurred during the currency of the policy for coverage to exist. What matters is when liability was incurred, not when it was ascertained.[4]

Benefits for the insurance industry are evident; if professional liability policies were underwritten on an occurrence basis, it would be difficult for insurers to form a view as to their potential exposure. On the contrary, once the claims-made policy expires, the insurer can expect no further claims for that policy period, whereas an occurrence-based policy can require indemnification of an insured party for multiple years after the policy has expired and the insurer has gone off-risk.[5]

[2] In a loss occurrence (also called event-based) policy, 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', M.A. Clarke, *The Law of Insurance Contracts* (London-Hong Kong: LLP Professional Publishing, 3rd ed, 1997), 419.

[3] Claims made policy is still the most suitable model for pollution liability coverage: see ibid 429.

[4] On a claims-made scheme, 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', ibid 419.

[5] As pointed out by the Supreme Court of Canada in *Jesuit Fathers of Upper Canada* v *Guardian Insurance Co. of Canada*, 1 SCR 744 (2006): 'The development and growing use of claims made or hybrid policies was, in large part, a response to serious problems encountered by insurers in relation to occurrence-based policies. An occurrence-based policy works well where the damage resulting from a particular negligent act is immediately apparent (or becomes apparent shortly thereafter). It is less well-suited in cases of professional services such as medical, engineering or manufacturing services, where the damage from the negligent act may not be apparent for many years. First, the "long-tail" nature of the liability in the examples above makes it likely that many claims will be made well after the policy has expired. Second, the ongoing developments in law and science make it difficult for the insurer to estimate the potential liability arising from claims made many years in the future'.

In short, claims-made means, for the insurance industry, avoidance of the 'long tail'. That is why, in the Italian market, it is nowadays quite impossible to find any offer of occurrence-based professional liability policies.

More uncertain are the effective benefits for the insured of claims-made coverage.

Very often, commentators who are in favour of this second policy model remark that the claims-made policy provides insured parties with immediate coverage for all past, present and future claims-made during the policy period; insurance need not have been in place when the wrongful act or damage occurred.

Nevertheless, there may be relevant negative issues for the insured on claims-made bases in comparison with the loss occurrence model shaped by Art 1917 Italian Civil Code. Firstly, claims-made policyholders may find it impossible to change insurance company once an actual claim has brought their risk potential to the attention of insurance underwriters. Secondly, if the misconduct that creates the professional liability occurs during the policy period but the claim is not raised in the same period, they may find it difficult to obtain a new claims-made policy when they have complied with the duty of disclosing circumstances that may result in a prospective claim although not yet made. Thirdly, professionals need to maintain insurance for new claims from year-to-year and must be able to obtain cover for potential claims about which they are informed in the current year.

III. Claims-Made Policies Under Italian Law

As stated above, Art 1917 Italian Civil Code describes liability insurance as a contract on a loss occurrence basis and there is no provision in Italian Civil Code that refers to a claims-made policy. However, Art 1917, para 1 is not deemed to be mandatory as per Art 1932, para 1, Italian Civil Code.

We must add that, as provided by Art 1322 Italian Civil Code, titled 'Contractual Autonomy':[6]

> '1. The parties can freely determine the contents of the contract within the limit imposed by law. 2. The parties can also make contracts that are not of the types that are particularly regulated, provided that they are directed to the realization of interest worthy of protection according to legal order'.[7]

[6] On the topic, briefly, G. Alpa and V. Zeno Zencovich, *Italian Private Law* (Abingdon: Routledge-Cavendish, 2007), 157.

[7] The translation of Italian Civil Code reported in this paper is from J.H. Merryman, *The Italian Civil Code* (Dobbs Ferry: Oceana Publications Inc, 1969). On Art 1322, para 2, briefly, G. Iudica and P. Zatti, *Language and Rules on Italian Private Law: An Introduction* (Padova: CEDAM, 2012), 115.

Therefore, the main questions are: can the parties modify and reverse the scope of liability insurance set out by Art 1917, para 1, Italian Civil Code?; to what extent can the insurer reshape the scope of the liability policy?; can the insurer do this if it leads to gaps in coverage that may affect not only the professional insured but even his clients, whom the coverage is intended by law to benefit?

The Italian Supreme Court (Corte di Cassazione) has addressed these issues in the quite restricted number of decisions filed on the topic.

In dealing with them, we must be aware that decisions of the Italian Supreme Court on claims-made policies have been sometimes inaccurately reported as being in favour of the feasibility and unquestionability of the model as per Italian law.

On the contrary, on a non-biased and close examination, the decisions appear more complex.

Starting with the decision made on 15 March 2005 no 5624, it does provide that claims-made polices may be valid under Art 1322, para 2, Italian Civil Code. However, the basis of the reasoning was to assert that these clauses fall under the definition of 'unfair terms' of Art 1341 of the Civil Code on standard terms and conditions of contracts and the requirement for specific approval in writing by the insured, these being void and unenforceable without it.

A subsequent decision, lodged on 17 February 2014 no 3622 was no greater a point in favour of the claims-made policy. In that case, the insurer alleged that the claims-made clause (shaped and imposed by the insurer itself) was void, in order to deny cover for claims-made during the policy period but relating to professional mistakes which occurred before the contract was entered into. Thus, we must regard the decision as a ban on the attempted unfair withdrawal from the contract more than as an assertion of indisputable validity of the claim made model.

Then came the decision of the Joint Division of the Italian Supreme Court, filed on 6 May 2016 no 9140, in which the Court stated that the so called 'mixed' claims-made policies (those providing coverage only if: i) the claim is made during the policy period and ii) also if the event – ie the professional's misconduct – occurred in a limited previous period) may be declared void because the underlying interests sought by the contract do not deserve protection under the applicable law and that such assessment must be carried out, pursuant to Art 1322, para 2, by the lower courts (tribunals and courts of appeal). The decision did not offer any guideline for such evaluation, except for the note that the suitability of the policy is not likely to be found where the claims-made clause, regardless of how it is conceived, exposes the insured party to 'coverage gaps'. Moreover, the Supreme Court decision stated that if the clause were found to be null and void, the statutory provision of Art 1917 para 1, Italian Civil Code would apply to the contract, which would therefore remain valid but would be construed

as a loss occurrence policy.[8]

More recently, the Third Division of the Supreme Court, with a decision rendered on 28 April 2017, no 10506, nominally following the previous decision of the Joint Division, stated that a claims-made clause that prevents the insured from obtaining coverage for malpractice (in that specific case, medical) which occurred in the policy period but not resulting in a proper claim made in the same period is not directed to achieve interests which are worthy of protection and therefore the policy remains enforceable, except for the claims-made clause, as a loss-occurrence insurance as per Art 1917 para 1.

To date, rulings on claims-made policies are far from being over.

On 19 January 2018, the same Third Division of the Supreme Court filed a request to the First President of the Court to obtain a new decision of the Joint Division on the lack of power of the parties to amend and modify the trigger of insurance coverage described by Art 1917 para 1 (ie loss occurrence basis).

A claims-made policy that was an alien contract, coming to Italy from a common law tradition, would be of some interest in seeking to verify if the domestic debate has taken into the due account the suggestions and indications given by the legal system of origin.

IV. Definition of Claims, Coverage Gaps, Deeming Clauses: Suggestions Coming from Common Law Jurisdictions viz the UK, Canada, Australia

As discussed above, insurance coverage is triggered, in the claims-made model, by the filing of a claim during the policy period.

Therefore, first, the definition of claim – statutory or contractual – becomes crucial. Actually, the issue concerning the trigger in a claims-made policy may be more subtle. Insurance can also be shaped as a 'claims-made and reported' policy: that is, the insured obtains coverage only if in the contractual period i) he received a claim and ii) he reported and notified it to the insurer.

As was noted in *Reid Crowther & Partners Ltd.* v *Simcoe & Erie General Insurance Co.* by the Supreme Court of Canada (21 January 1993):

> 'Another type of restriction of coverage in "claims-made" and hybrid

[8] On this decision and on the others made by Italian Supreme Court, S. Landini, 'The Worthiness of Claims Made Clauses in Liability Insurance Contracts' 2(2) *The Italian Law Journal*, 509 (2016). On the same topic, in the Italian literature, S. Monticelli, 'Responsabilità dei professionisti: la clausola claims made tra abuso del diritto ed immeritevolezza' *Danno e responsabilità*, 701 (2013); G. Volpe Putzolu, 'La clausola claims made – Rischio e sinistro nell'assicurazione r.c.' *Assicurazioni*, 3 (2010); P. Gaggero, 'Validità ed efficacia dell'assicurazione della responsabilità civile claims made' *Contratto e impresa*, 401 (2013); R. Pardolesi, 'Le sezioni unite sulla clausola claims made: a capofitto nella tempesta perfetta' *Foro italiano*, I, 2026 (2016); U. Carnevali 'La clausola claims made e le sue alterne vicende nella giurisprudenza di legittimità – il Commento' *Contratti*, 387 (2017).

policies is found in what are referred to as "claims-made and reported" policies. Coverage under such policies applies only to claims which are both made of the insured and reported to the insurer during the policy period. This type of policy creates obvious problems for insureds regarding claims discovered and/or made by third parties just before the expiry of their coverage. In his article "Professional Liability Insurance: The Claims-made and Reported Trap" (1991), 19 W. St. U. L. Rev. 165, Lee Roy Pierce, Jr. writes at p. 171:

> Claims-made and reported policies are less expensive because it is statistically probable that a certain number of insureds will find it impossible or impracticable to timely report their claims. Thus, premium costs to the group are reduced because it is statistically probable that many insureds (who actually encounter the insured loss) will forfeit coverage.
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> In Pierce's view, this situation is antithetical to the purpose of purchasing liability insurance, which is for the insured to trade a contingent loss (uncertainty) for a certain loss (the premium paid to the insurer).

Similarly, a standard form policy released in 1986 by the Insurance Bureau of Canada was the subject of a critical analysis by Thomas R. M. Davis in 'The New IBC Standard Form Commercial General (Claims-Made) Liability Policy" (1987), 5 Can. J. Ins. L. 77. In Davis' view, at p. 78:

> The purpose of the claims-made form is to enable insurers to predict current liabilities rather than underwrite unpredictable long-term liabilities (occurrence basis). There is no doubt that the claims-made form will accomplish this, primarily by shifting a significant part of the risk of unpredictable long-term liabilities back to the insured'.

In that case, an appropriate construction of the contract, made by the Court, relieved the insured from an unreasonable denial of coverage that could be opposed by the insurer.

As was noted in *Stuart* v *Hutchins* by the Court of Appeal for Ontario, (1998):

> '…where circumstances beyond the control of the insured render it physically impossible for the insured to comply with the notice provision, general principles of contract interpretation would come to the insured's aid, without need to resort to s. 129. Specifically, I think it would be open to the court to construe the notice provision as containing an implied term that non-compliance due to physical impossibility would not be fatal to coverage but that the insured be given a reasonable opportunity to comply'.

Secondly, it is worth noting that polices sold in the Italian market usually contain a definition of claim – which is necessary, given the absence of a statutory provision in Italian Civil Code describing claims-made insurance – with a very strict range that prevents the insured from reporting circumstances or mere potential claims that can likely result in a future effective claim.

This situation is well known in common law and English courts are fully aware of the same risk of coverage gaps mentioned by the Italian Supreme Court as a potential hazard for clients of the insured.

As was noted in the English leading case of *HLB Kidsons* (A Firm) v *Lloyds Underwriters*, before the Queen's Bench Division - Commercial Court, of the High Court, England and Wales, decided on 9 August 2007:[9]

> 'It is integral to the structure of claims-made policies being successively renewed from year to year, that provision is made for claims arising after the expiry of any one policy period out of circumstances of which the assured has first become aware during that period. Unless provision is made to treat such claims as having been made during that policy period, the concept of claims-made policies applying in successive policy years would create an unexpected and inappropriate gap in coverage. This is because of the obligation upon an assured to make disclosure to renewing insurers on the succeeding year and the possibility that, upon disclosure to renewing insurers of such circumstances of which the assured was aware at the end of the earlier policy year, renewing insurers might exclude any claims arising out of them, or only be prepared to accept liability at a premium that was commercially unacceptable to the assured. This would leave the assured with no cover in respect of such claims either under the earlier policy year during which he first became aware of the relevant circumstances or under the later year during which the claim might ultimately be made arising out of those circumstances. This analysis finds confirmation, for example, in the reasoning of Rix J in *J Rothschild Assurance Plc v Collyear* [1999] 1 Lloyds Rep IR 6 at paragraph 22, and of Moore-Bick J in *Friends Provident* at paragraph 13 and paragraphs 38-39'.

The contractual provision to which the Court referred was a typical *deeming clause* (General Condition 4 ('GC4') of the Policy), which read as follows, as quoted in the decision:

> 'The Assured shall give to the Underwriters notice in writing as soon as practicable of any circumstance of which they shall become aware during the period specified in the Schedule which may give rise to a loss or claim against them. Such notice having been given any loss or claim to which that

[9] See https://tinyurl.com/y758jpzy (my emphasis in the text) (last visited 30 June 2018).

circumstance has given rise which is subsequently made after the expiration of the period specified in the Schedule shall be deemed for the purpose of this Insurance to have been made during the subsistence hereof'.

The reasoning continues:

'22. The authorities concerning such clauses recognise that the purpose of a notification clause such as GC4 is twofold. First, it is intended to enable insurers to investigate potential claims at the earliest possible opportunity, before the trail of evidence goes cold, and to take, or require the assured to take, such steps as insurers think appropriate to minimise liability under the policy; see e.g. *Pioneer Concrete (U.K.) Ltd v National Employers Mutual General Insurance Association Ltd* [1985] 1 Lloyd's Rep 274 at 278, per Bingham J; *Rothschild Assurance* at 22, per Rix J*; Friends Provident* at paragraph 20, per Moore-Bick J; *McAlpine v BAI* [1998] 2 Lloyd's Rep 694 at 698, per Colman J; Clarke, The Law of Insurance Contracts, paragraph 17-4D4.

23. Secondly, the clause enables the assured to obtain an extension of cover in respect of a claim made after expiry of the Policy (and which would otherwise fall outside the scope of the Insuring Clause), provided the claim arises out of a circumstance of which the assured became aware during the period of the Policy and in respect of which he gave notice in accordance with the clause. GC4 protects the assured from the difficulty that would otherwise arise under a claims-made policy in the event of his becoming aware during the policy period of circumstances which he recognises might give rise to a claim but which did not result in a claim being made prior to expiry of the policy. Again, the authorities recognise that, since the assured would be bound to disclose the existence of such circumstances when seeking insurance for the following year, he might find it difficult to obtain cover in respect of that potential loss at a commercially acceptable premium, if at all. GC4 enables the assured, in such a situation, to obtain an extension of the existing insurance to cover the loss, if and when a claim materialises; see e.g. *Rothschild Assurance* at 22, per Rix J; *Friends Provident* at paragraph 13, per Moore-Bick J; *Tioxide Europe Ltd v CGU International Insurance Plc* [2005] Lloyd's Rep IR 114 at paragraph 56, per Langley J. If the assured notifies in accordance with the clause, insurers are bound to provide him with cover in respect of a claim arising from the circumstances notified, even though the claim is made after expiry of the policy period. Thus the clause acts as a "trigger for the extension of cover"; see *Friends Provident Life and Pensions v Sirius* [2006] 1 Lloyd's Rep IR 45 at paragraph 11, per Mance LJ.'

Much of reasoning in the decision is focused on the assessment of the

compliance by the insured (Kidsons, a firm of chartered accountants which had sold to clients tax avoidance schemes which had proved ineffective and were successfully challenged and rejected by the Inland Revenue office), which had a duty to report 'relevant circumstances' which may result in a claim 'as soon as practicable'. Nevertheless, the relevant point, for the domestic Italian market where this common law contractual model has landed, is that the Court finds a deeming clause provision 'integral' to the structure of claims-made policies being successively renewed from year to year. In other words, a deeming clause is and must be part of the *naturalia negotii* of an insurance coverage split, as is usually arranged by insurers, into short periods of one year each; much shorter in respect of the more lasting practicing activity of the professionals.

In conclusion, the UK common law system gives a clear indication in construing claims-made policies combined with the facility to obtain coverage, reporting, 'as soon as practicable', circumstances of which the insured may become aware during the insurance period and which may give rise to a loss or claim against them also after the completion of the same period.

Such a clear indication is not present in the Canadian common law system.

The leading case *Jesuit Fathers of Upper Canada* v *Guardian Insurance Company of Canada* and *ING Insurance Company of Canada* was decided by the Supreme Court of Canada on 10 January 2006 (*Jesuit* v *Guardian*).

The factual background is delivered as follows in the decision:

> 'The Jesuits operated and administered an Indian residential school from 1913 until its closure in 1958. In 1988, they purchased a comprehensive general liability policy which provided for errors and omissions insurance with respect to professional services. The policy was for a one-year period and was renewable annually. By January 1994, the Jesuits had, through various means, become aware of both general and specific allegations of abuse of students at the school. In the case of C, his lawyer had informed the Jesuits by letter dated January 27, 1994 of the former student's claim, detailing how he had suffered physical and sexual abuse, as well as cultural and physical deprivation. C's lawyer also had inquired about the possibility of a negotiated settlement. Counsel for the Jesuits wrote to the insurer on March 18, 1994 to raise the possibility that the Jesuits might be facing other claims in the near future. The letter identified the offending Jesuits, the dates and locations of offending acts, the nature of the possible claims and the names of 10 victims, including C. After receiving information about the claim and possible claims, the insurer refused to renew the policy beyond September 30, 1994. Numerous additional claims alleging similar allegations were made after the expiration of the policy. With the exception of C's claim, the insurer refused to defend any claims arising from the operation of the school because those claims were only "first made" after the expiry of the policy and were not covered by the policy. In the Ontario Superior

Court of Justice, the trial judge construed the insurance contract as a claims-made policy. He found that C's claim and the claims on behalf of the nine victims mentioned in the March 18, 1994 letter to the insurer fell within the temporal limit of the policy and that the insurer had a duty to defend against them. The Court of Appeal upheld the decision (…). Numerous additional claims, approximately 100, were made after the expiration of the policy. These claims involved allegations similar to those reported in the Zimmerman Letter including physical, sexual and cultural abuse at the Spanish School resulting from the lack of proper supervision of staff and students by the Jesuits. These are the claims that the appellant submits should be covered by the Policy even though the specific demands for compensation were not made during the policy period. After receiving information about the claims and possible claims arising out of the operation of the Spanish School in the Zimmerman Letter, Guardian refused to renew the Policy beyond September 30, 1994. The Jesuits ultimately obtained coverage from a different insurer but any claims arising from the operation of the Spanish School were explicitly excluded from coverage for sexual and physical abuse'.

The first issue which the Court addressed was the definition and scope of the term 'claim':

'Since the insurance contract was a claims-made policy, the meaning of a "claim" in that policy will determine whether a duty to defend was triggered in the circumstances of the present case. The policy does not define a claim, but the clause limiting the scope of the insurance coverage refers to claims "first made" suggesting that a claim must be actively made as opposed to merely being discovered. This interpretation of the word "claim" is consistent not only with the wording of the policy, which distinguishes between an "occurrence or circumstance" and a "claim", but also with the definition of "claim" under the common law, which requires a third party to communicate an intention to hold the insured responsible for damages'.

Then the Court dealt with the extension of coverage in claims-made policies:

'In a claims-made policy, the liability only arises if the claim is actually made during the policy period. Many claims-made policies offer even more restricted coverage. For example, the policy might exclude from coverage any negligence of which the insured is aware prior to the coverage period even if no claims have been made. This leaves the insured in the situation where, although consistently insured over a period of years, there are still certain claims that do not fall within the purview of the policy – namely, claims where the underlying damages (and related negligence) are discovered

in one policy period but the claim is not made by a third party until a subsequent period'.

The Court, being fully aware of the possible lack of coverage in claims-made policies, noted that policies with a more comprehensive protection are available on the Canadian market, among them, on one side, claims-made policies enlarged with a deeming clause and on the other, occurrence-based policies. As stated by the Court:

> 'Given the potential for gaps in coverage with certain forms of claims-made and hybrid insurance policies, the insurance industry has developed additional coverage. It comes with a price (…) Another clause is the "Notice of Circumstance Clause", which permits the insured to report during the policy period circumstances that may give rise to future claims. Any claims related to those circumstances made after the expiry of the period are deemed made during the policy period. This form of coverage was available on the market when the Guardian policies were last renewed. (…). Other commercially available insurance policies would have covered claims-made even after the end of the policy period. In particular, an occurrence based policy or a policy with an occurrence-based extension would have covered claims-made after the end of the coverage period where the circumstances giving rise to the claims were discovered during the coverage period. The Jesuits, however, never purchased such a policy and cannot now claim coverage under it'.

Therefore, it was mainly the availability on the market of these policies offering greater coverage and the failure of the Jesuit Fathers to purchase them, that impeded a construction of the Guardian policy in favour of the Jesuit Fathers.

In other words, as the policy did not include a deeming clause (also known as 'notice of circumstance clause') in spite of the fact that it was commercially available upon the last renewal, the Supreme Court inferred that the Jesuits did not desire this coverage to be included in the policy. Hence, in consequence, a refusal to take on additional coverage – the deeming clause – was considered an implied rejection of this coverage that would have barred the insured from claiming these terms at a future date.

The insurance policies offered in Italy being so different, where presently professionals cannot find an occurrence-based policy and can hardly find a claims-made with deeming clause policy (and if any, at a prohibitive price), the reasoning of *Jesuit* v *Guardian* is of little help in dealing with the issues raised in Italy by the Supreme Court Joint Division decision no 9140/2016, ie the assessment, as per Art 1322 Italian Civil Code, on the merits of the underlying interests sought by the particular contract entered into by the parties (the so

called 'Worthiness' of the contract).

Therefore, the most important guidance, for the topic in question, comes from Australia.

The most relevant Australian case is *FAI* v *Australian Hospital Care Pty. Limited* decided on 9 July 1999 by the Supreme Court of Queensland and subsequently, on 27 June 2001 by the High Court of Australia.

The factual background is as follows: The insured hospital had a professional indemnity policy with FAI on a claims first made and notified basis. Among the standard conditions there was one which provided that if the hospital became aware of any occurrence which may subsequently give rise to a claim and gave notice of that occurrence during the period of the policy, then any subsequent claim arising out of the occurrence would be covered (a 'deeming clause' or 'occurrence' clause). During the coverage period, the hospital received a letter from a former patient's solicitor informing them that a claim may be raised against the hospital in respect of treatment received by the patient but the hospital did not give notice of this occurrence to the insurer during the period of cover, as the patient's solicitor inquiry had apparently concluded that there was no malpractice. The central issue addressed in court was whether section 54(1) of the Insurance Contracts Act 1984 (No 80, 1984: ICA)[10] precluded FAI from refusing to pay the hospital's claim on grounds that it failed to give to FAI, within the period of cover, notice of any occurrence which may have given rise to a claim.

On the Reasons for Judgment – written by Judge Derrington of the Supreme Court of Queensland in the decision filed on 9 July 1999 – it is, first of all, worthy of note that the premium was to be considered comprehensive for the coverage of a whole, composed of the simple claims-made clause *plus* the deeming clause, the combined working of both being necessary to avoid gaps of coverage. He notes:

> 'The similarity of the structure of the two parts [ie claims made, on one side, and "occurrences notified clause" or "deeming clause", on the other side] is obvious, and both aspects of the promised indemnity were similarly factored into the insurer's computation of the premium. The second part of the cover was introduced because of a serious hiatus in the earlier part. Under that system, if the insured became aware of a possible claim that might not be made during the period of its existing policy, it would have

[10] Section 54(1) Insurance Contracts Act reads as follows: 'Subject to this section, where *the effect of a contract of insurance would*, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act'.

> been in a most unhappy position, particularly, but not only, if changing insurers. Because the claim would not be made within the period of the existing policy it would not come within that cover. In addition, because the insured would be obliged to disclose the known possible claim in its proposal for the new policy, that policy would usually expressly exclude it from the cover, and/or there would be a general exclusion that would catch it. This second form of complementary cover was introduced to provide against such a contingency, which is far from uncommon, and it is important in its own right for that purpose. It is validly called an extension only because it extended the formerly inadequate cover to provide an efficient totality. Any tendency to regard it as a feature in some way outside the basic contract and coming into existence only upon the fulfilment of its conditions is not justified and is contrary to its purpose. It was a significant term of the contract providing an important area of cover which might not otherwise have been available to the insured'.

Less important, for the implication on the subject matter of this paper (ie the relevance of common law decision in dealing with the issues posed by the Italian Supreme Court decision) is the subsequent judgment made on the case by the High Court of Australia and filed on 27 June 2001.

The majority of the panel considered that if a contract has an 'occurrences notified clause' – ie a deeming clause – as the FAI policy had and the insured becomes aware of an occurrence that may subsequently give rise to a claim during the period of cover, the coverage is in principle due under Section 54 Insurance Contracts Act, which deals with acts or omissions occurring after the contract of insurance was entered into, and the insurer may only reduce its liability to the extent to which its interests were prejudiced as a result of that act.

In the case decided, as noted above, the policy has a deeming clause, so Section 54 (1) Insurance Contracts Act applies. Had there not been such a clause, Section 40 (3) Insurance Contracts Act[11] would have applied instead, providing a more favorable position for the insurer, because in that case the insured, to seek coverage against claims arisen from circumstances of which he has become aware, must have given notice of them and would not be covered if he has omitted so to do.

For that reason, Australian counsel to the insurance industry suggest that it considers removing from their policies provisions relating to the notification of

[11] Section 40(3) Insurance Contracts Act states: '(3) Where the insured gave notice in writing to the insurer of facts that might give rise to a claim against the insured as soon as was reasonably practicable after the insured became aware of those facts but before the insurance cover provided by the contract expired, the insurer is not relieved of liability under the contract in respect of the claim, when made, by reason only that it was made after the expiration of the period of the insurance cover provided by the contract'.

circumstances, leaving their insured parties, in that regard, to rely only on Section 40.

For purposes of this paper, any possible overlap between Section 40(3) and 54(1) Insurance Contracts Act is irrelevant and its impact is confined to the Australian domestic market.

What is crucial is that, without doubt, Section 40 Insurance Contracts Act provides that *whatever are the terms of the contract*, if the insured becomes aware of circumstances which might lead to a claim, he can notify these circumstances to the insurer and any claim later arising from those circumstances will be in any case covered by the policy.

In other words, Section 40(3) is a statutory provision that extends the scope of the contract, despite the insurer's intention. It broadens coverage in claims-made policies, including claims made after the policy period (on condition that it arises from a circumstance notified during the policy period).

V. Final Remarks

Both Italian and common law decisions emerging from several jurisdictions (primarily UK and Australia) highlight the importance (either for the insured professional or the professional's client) that a liability policy does not result in coverage gaps.

In avoiding insurance coverage gaps, the loss occurrence model is the best option; the coverage lasts until it is time-barred by the statute of limitations (called in Italian Civil Code '*prescrizione*'), with the right of the client to sue the professional insured for damages. Art 2952, paras 3 and 4 Italian Civil Code confirm that:

> '(3) In liability insurance, time-limit [of insured's rights against the insurer] runs from the day on which the injured third party requested compensation from the insured or filed an action against him. (4) *Notice to the insurer* of the request of the injured third party or the action filed by him suspends the course of time-limit until the claim of the injured person has been liquidated and made collectible, or *until the right of the injured person is time-barred*'.

Thus, it is unsurprising that the Italian Civil Code (Art 1917) considered and decided upon only insurance contracts on a loss occurrence basis.

In respect of a claims-made policy, to avoid such coverage gaps, UK decisions construe the principle that permits the facility to notify, during the policy period, circumstances from which future claims may arise, as 'integral' to it; Australian decisions ground this facility, in absence of an express deeming clause, on the statutory provision of Section 40(3) Insurance Contracts Act; Canadian decisions rely upon the 'sanctity of contract' but only because they

consider it a feasible option, for the insured, to choose a policy that contains a deeming clause, there being no lack of offer in the Canadian insurance market.

Having reported (more completely and accurately than is usually done by Italian insurance counsel) the legal environment in which the claims-made model arose and from which it was imported into the Italian market, it appears clear to me that one of the main aspects Italian lower courts (tribunals and courts of appeal) have to consider – in ascertaining, as prescribed by the Italian Supreme Court, whether or not the specific claims-made policy entered into by the parties results in gaps of coverage and therefore is not valid as per Art 1322 Italian Civil Code – it is, without doubt, the facility which the insured retains to notify, during policy period, any circumstance of which he becomes aware, that might lead to future claims. In other words, the presence of a deeming clause or the construction of the insurance contract enlarging its scope in that direction is crucial for the enforceability and validity of the policy under Art 1322, para 2, Italian Civil Code.

The solution proposed here is not only grounded in law but may also result in a fair and reasonable balance of economic interests. The facility to report circumstances as per the deeming clause, on one hand will cause a scaling-up of the coverage, excluding insurance gaps, to the insured's detriment but on the other hand, will entitle the insurer, upon the renewal of the contract, to increase the premium proportionally to the increase of risk measured by the new potential liability related to the notified circumstance.[12]

[12] *Kidsons* (A Firm) v *Lloyds Underwriters*, [2007] EWHC 1951, n 9 above, para 20: 'On the other hand, the assured benefits under a claims made policy: i) from coverage for claims made during the policy period; ii) from coverage for claims made after the policy period arising from circumstances first known during the policy period; and iii) *from the insurer being able to estimate his liabilities more accurately and thereby to set fair premiums for the succeeding policy year*' (my emphasis).