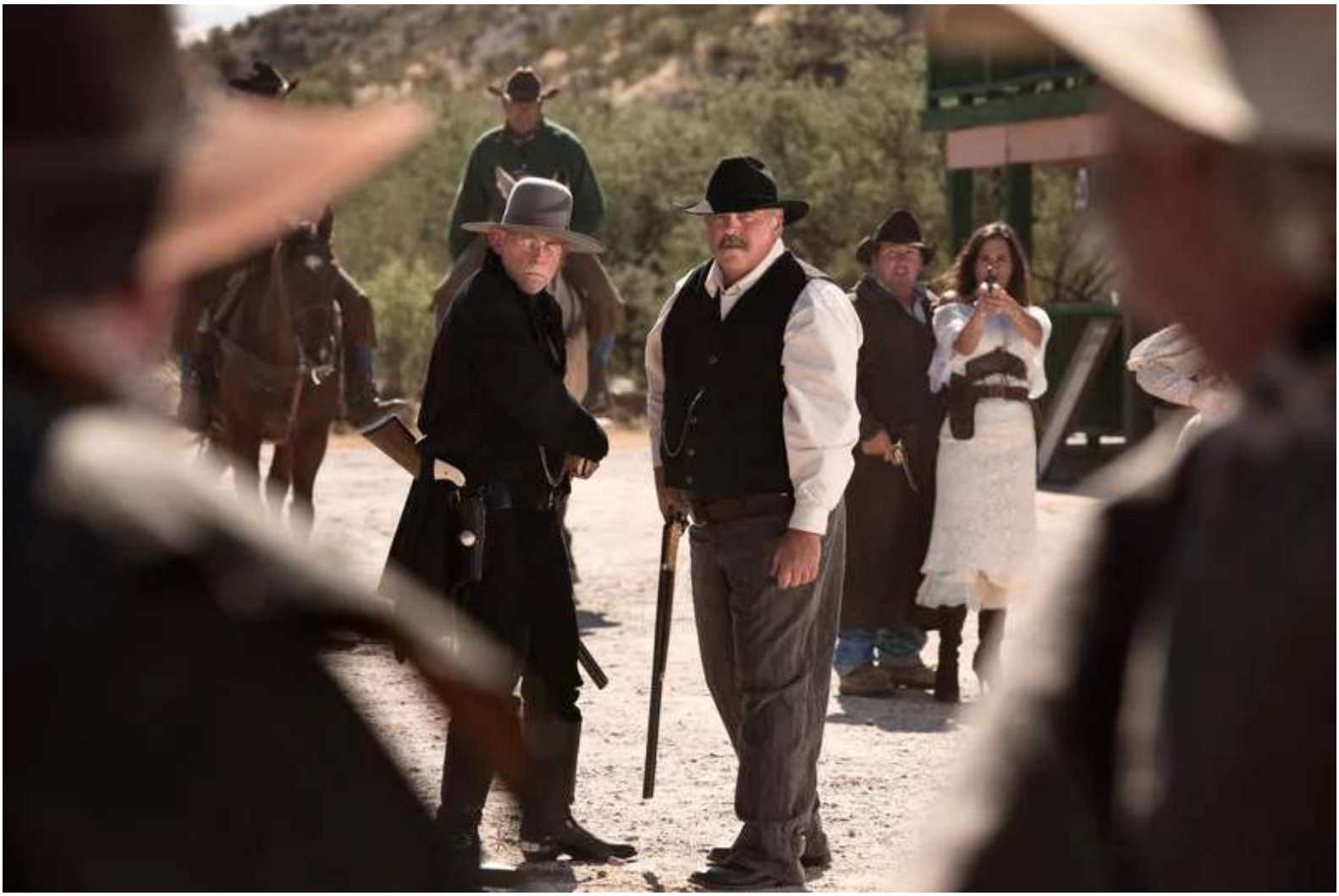
Possible Dangers Lurking in Claims-Made Policy Forms



The specialty lines insurance industry has come a long way since the early "Wild West" days of the 1970s. Since that time, claims-made policies have evolved significantly, but not necessarily in a positive way. In fact, claims-made policy forms have become the most dangerous insurance policies in the industry.

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Professional, D&O, and Fiduciary Liability

Given the passage of time, one would think that all of the foreseeable problems claims-made policies can create would have been resolved. Such is not the case. In fact, the situation has gotten worse, to the point where a host of potential coverage gaps can now be found in just about *any* claims-made policy, irrespective of whether one is insuring directors and officers (D&O) liability, fiduciary liability, employment practice liability insurance (EPLI), professional liability, or any other liability exposure currently being written on a claims-made basis.

This article is the first in a series to address the many pitfalls inherent in claims-made policy forms. We examine and explain the many hazards and consequent coverage gaps that may lurk in all claims-made policy forms. After all, if an insured cannot trigger the policy, what difference does it make what hazard the policy was intended to cover?

Problem #1: Insuring Agreements Do Not Stand Alone

I have often said that that there is only one "risk" in a claims-made policy. That "risk" is the probability of a claim being first made against the insured during the policy term. The specific hazard that gives rise to the claim (e.g., an attorney missing a statute of limitations for filing a claim on his client's behalf or a surgeon leaving a sponge in a patient's stomach) is yet another matter. Other so-called risk limiters, any of which could also preclude coverage for a given claim, include (but are not limited to) prior act dates or "retroactive dates," and prior and pending claim and litigation dates, also known as continuity or knowledge dates. Indeed, despite the evolution of claims-made policies since the early 1970s, the dangers of missing out on coverage for any given claim have not been mitigated.

Consider the paraphrasing of a standard claims-made-and-reported insuring agreement used by many insurance companies. Please see Figure 1.

FIGURE 1
STANDARD CLAIMS-MADE-AND-REPORTED POLICY LANGUAGE

"The claim must be first made against the insured and reported to the insurer during the policy term, and it must arise from wrongful acts subsequent to the retroactive date stated in the declarations, and further, no coverage will exist for claims first made and reported to the insurer after the end of the policy term unless, and to the extent, an extended reporting period applies. "

This is fairly standard language. What could be wrong with that?

As indicated above, the insuring agreement clearly refers to an extended reporting period. This is quite common, and such frequently used language appears in Figure 2.

FIGURE 2
STANDARD CLAIMS-MADE-AND-REPORTED POLICY LANGUAGE INCLUDING AN EXTENDED REPORTING PERIOD

SECTION VIII – EXTENDED REPORTING PERIOD

In the event of cancellation or nonrenewal of this Policy, by either the "Named 'Insured'" or the Company, for reasons other than non-payment of premium or material misrepresentation in the Application, you shall have the right to an Extended Reporting Period as follows:

Automatic Extended Reporting Period

Coverage as provided under this Policy shall automatically continue for a period of sixty (60) days following the effective date of such cancellation or non-renewal, but only with respect to "Claims" made and ""Wrongful Acts" committed before the effective date of such cancellation or nonrenewal.

How the "Cancellation or Renewal" Requirement Can Eliminate Coverage

The problem with such wording is that the extended reporting period language requires that there be a "cancellation or nonrenewal." What happens if the policy, instead, simply renews? In addition, what if the policy includes no automatic extended reporting period, such as the one noted in Figure 2?

In fact, if a policy does not contain a postpolicy reporting window provision (separate from the extended reporting provision), there may be no coverage if, for example, a claim is made against the insured a day or two prior to policy expiration, yet is not reported to the insurer until several days (or even weeks) after the policy term expires.

Despite the value of a postpolicy reporting window, an automatic 60-day extended reporting provision may only be available in the event of a cancellation or nonrenewal. In other words, if the insured renews with the same insurer and is served with the lawsuit just prior to renewal but doesn't report the claim until after the renewal takes place, there could be no coverage. Such a situation has happened frequently, and claims have, in fact, been denied as a result. That is one hidden danger in claims-made and reported policies.

It would be better to have an extended reporting provision (or postpolicy reporting window) that *always* gives an extra 30 or, better yet, 60 days to report a claim that is not tied to a "cancellation or nonrenewal" of the policy as illustrated in Figure 3 below.

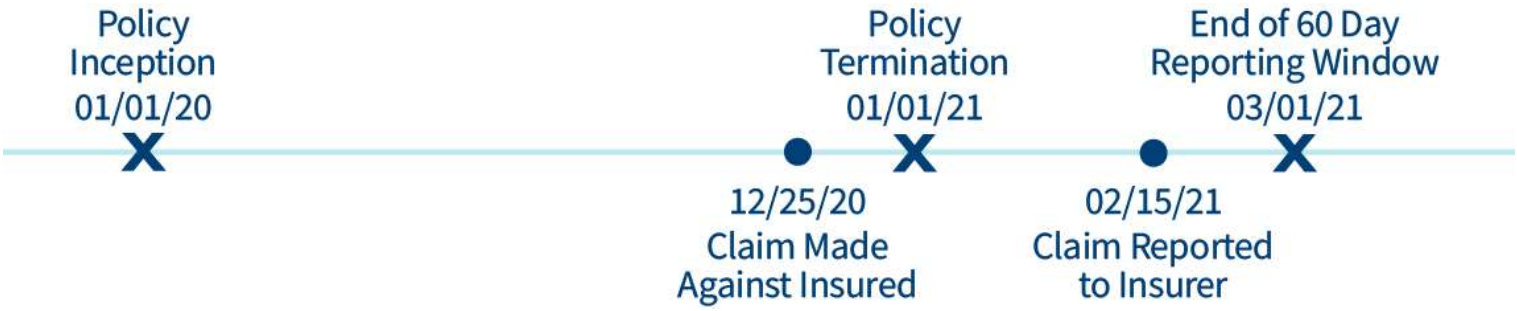
FIGURE 3
UNRESTRICTED 60-DAY POST-POLICY REPORTING WINDOW

Policy Term: 1/1/20-21

60-Day Post-Policy Reporting Window: 1/1/21-3/1/21

Claim Made Against Insured: 12/25/20

Claim Reported to Insurer: 2/15/21



In this situation, the insured received the claim on Christmas Day and as a result of normal disruptions occurring during the holidays was unable to report the claim to the insurer until after the January 1, 2020–21, policy period expired. However, since the policy is written with a 60-day postpolicy reporting window, and one that applies *regardless* of whether the policy is canceled, nonrenewed, or renewed, coverage for the claim applies. This is because (1) the claim was made against the insured during the January 1, 2020–21, policy term and (2) the insured reported the claim to the insurer on February 15, 2021, which was well within the term of the 60-day postpolicy reporting window.

Problem #2: "as Soon as Practicable" Creates a Roadblock to Coverage

Depending on the jurisdiction, even 30- or 60-day extended reporting periods that apply irrespective of whether the policy is canceled, renewed, or nonrenewed, and also allow an insured to report a claim after expiration, *still* may not help prevent coverage gaps.

When a 6-Month Reporting Delay Is *Not* "as Soon as Practicable"

There have been several court decisions on the East Coast whereby a claim was first made against the insured during the policy term and also reported to the insurer during the policy term. Yet, in one case, a claim denial was still upheld by the appellate court. The court's rationale for the denial was that the insured did not report the claim to the insurer for 6 months after it was made against the insured, even though the claim was reported to the insurer during the policy term. In that instance, and as will be explored below, the applicable policy's claim reporting requirements demanded that the "claim be reported to the insurer as soon as 'practicable.'" The court found that a 6-month delay was not as soon as practicable because there was no compelling reason to justify a delay of this duration. The problem faced by the insured in this situation is illustrated in Figure 4.

FIGURE 4
A 6-MONTH REPORTING DELAY IS *NOT* "AS SOON AS PRACTICABLE"

Policy Term: 1/1/20-21

Claim Made Against Insured: 3/1/20

Claim Reported to Insurer: 9/1/20

Time Lag between Making of Claim and Report to Insurer: 6 months

Problem #3: What Is a "Claim"?

In the context of an insurance policy, especially a claims-made policy, the definition of "claim" becomes extraordinarily important. Figure 5 provides two definitions of "claim." Note that the second definition has three subdefinitions of the term.

FIGURE 5
VARYING DEFINITIONS OF "CLAIM"

"**Claim**" means a written demand for monetary damages arising out of or resulting from the performing or failure to perform "Professional Services."

Definition Two

C) "**Claim**" means:

1. A written demand for **Loss** or nonmonetary relief against an **Insured** because of
2. A **Wrongful Act**;
3. Any **Suit**.

Based on these two definitions, a "claim" can be (1) a written demand, (2) knowledge of (a) a wrongful act, (3) any suit, or (4) a wrongful act. Still more variations (not depicted in Figure 5) include (a) a written demand for money or services, (b) a lawsuit, or (c) the commencement of an administrative proceeding. These are very common definitions that most insureds accept.

Why All These "Claim" Definitions Are Problematic

Recognizing that professional liability forms are virtually always written on a "claims-made-and-reported" basis, all of these definitions of "claim" create a serious coverage problem for insureds. The source of this problem arises from the fact that none of the aforementioned definitions require receipt of the claim *by the insured*. (Editor's note: in some lines of professional liability insurance, such as accountants, insurers in today's market require the insured to be personally notified within their policies' definitions of "claim." However, in a number of other lines, including D&O, EPLI, insurance brokers, and miscellaneous E&O, a significant number of insurers' forms still do not require that the insured be personally notified to trigger a "claim." Therefore, insureds should make sure that *all* definitions of "claim" require personal notification. Recognize that in Figure 5, in definition two, only the first definition satisfies this requirement, whereas the second and third definitions do not and are, therefore, unacceptable.)

For example, a "written demand" may have been *made against* an insured, yet not *received by* the insured. This sometimes occurs when attorneys *file* claims against insureds, but, for strategic purposes, may intentionally delay in actually *serving* insureds, and thereby do not actually notify the insured that a claim has been made against him or her. When this process occurs, an insured not only not know that he or she committed an alleged wrongful act for many months, but he or she may also not know that a lawsuit has been filed and not yet served. How does one report a claim/lawsuit that they do not know about?

A similar problem occurs with regard to administrative (versus legal) proceedings. For example, an employee may file a claim with the Equal Employment Opportunity Commission (EEOC). Yet, an insured may not know that the EEOC (or other regulatory agency) had begun an investigation months earlier but had not officially been informed of the claim or the investigation until a significant period of time had elapsed.

Thus, the most dangerous time for any policyholder is around a policy's renewal date because any of the aforementioned events constituting a "claim" may be something the policyholder does not know about and thus cannot report under the soon-to-be-expiring policy.

Claim Denial from "Claim" Definition Lacking an Insured's Receipt

One claim denial was recently upheld by an appellate court because a sealed indictment was not served on the policyholder until long after the policy expired. The indictment itself triggered the policy due to satisfying the "wrongful act" element in the policy's "claim" definition. This was despite the fact that the insured was unaware that the indictment had been handed down because it was sealed. The situation begs the question: how could an insured "report" something about which he or she had no knowledge? Despite the apparent impossibility of complying with the policy's language, the court nevertheless dispensed with common sense and decided to uphold the insurer's denial of coverage based on what it termed the policy's "clear and unambiguous" language!

What is the solution to the problem of claims being made against an insured—yet without the insured's knowledge of the claim? The obvious one is to include "receipt by the insured" wording within a policy's "claim" definition.

Figure 6 provides additional definitions of "claim," all taken from existing policies. Many of these definitions do not require receipt of the claim by the insured. More to the point, there have been definitions of claim that trigger a claim against the insured when (1) a lawsuit was served on the insured OR (2) a written demand is made OR (3) an administrative proceeding has been commenced against an insured. Nevertheless, only one of these three definitions

(the first) requires actual receipt by the insured; the other two do not. Figure 6 provides additional definitions of the term "claim" as they appear in currently available claims-made policies. Importantly, some, *but not all,* of these definitions require that the insured be personally notified of the claim.

FIGURE 6
MORE DEFINITIONS OF "CLAIM"

- "'Claim' means a demand received by any Insured for money or services including the service of suit or institution of arbitration proceedings. 'Claim' shall also mean a threat or initiation of a suit seeking injunctive relief...."
- "Claim means a demand received by you for money or services, including the service of suit or institution of arbitration proceedings involving you arising from any alleged wrongful act. Claim shall also include any request to toll the statute of limitations relating to a potential claim involving an alleged wrongful act."
- "'Claim' means a written demand for monetary damages arising out of or resulting from the performing or failure to perform 'Professional Services.'"
- "'Claim' means a demand for money or services naming the Insured and arising out of an act or omission in the performance of professional services. A claim also includes the service of suit or the institution of an arbitration proceeding against the Insured."
- "Claim means: (1) a demand for money or services; or (2) a suit...."
- "'Claim' means a demand or assertion of a legal right made against any Insured, even if any of the allegations of the Claim are groundless, false, or fraudulent. Claim also means a Regulatory Action or a suit seeking injunctive relief relating to the Wrongful Acts specified in Section I., INSURING AGREEMENT."

A definition of "claim" that doesn't require receipt by the insured or actual knowledge that a "claim" has or will be made can become a major problem since, by definition, a "claims-made-and-reported" policy requires that the insured report claims during the policy term. Indeed, it is impossible to report a claim one does not know about.

Major Takeaways

By now, it should be apparent that claims-made policies contain a number of structural "minefields," any one of which could produce an unexpected claim denial. This article addressed three of these problematic areas. Based on these, an insured should seek the following when purchasing claims-made policies.

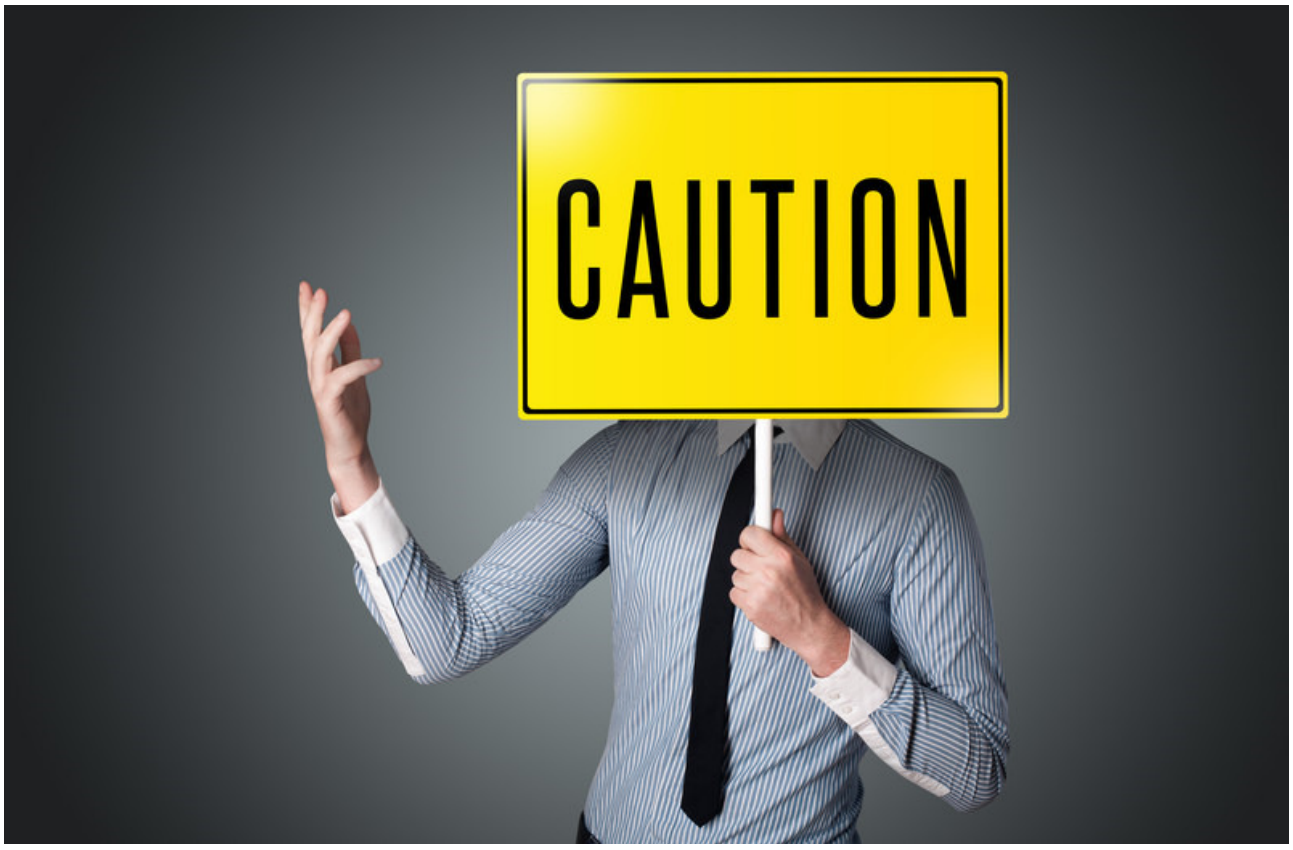
- Contain at least a 30-day (and preferably a 60-day) postpolicy reporting window. In addition, the provision containing this window must specify that the reporting window will be available to the insured, regardless of

whether the policy is being (a) canceled, (b) renewed, or (c) nonrenewed.

- Not use "as soon as practicable" claim reporting wording. Instead, the phrase "the claim should be reported to the insurer," and without any specific time requirement, is preferable.
- Define the term "claim" so that the definition includes a requirement that the insured be "personally notified" or "personally receive" the applicable lawsuit, administrative/legal proceeding, or demand that gives rise to the claim.

Upcoming articles will examine additional traps and how to avoid them.

More Dangers Lurking in Claims-Made Policy Forms



This article is the second in a series of three articles addressing the potential pitfalls embedded in claims-made coverage triggers. The final article in this series will examine three additional claims-made coverage trigger traps and explain how to avoid them.

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Professional, D&O, and Fiduciary Liability

If you haven't already, please check out the first three problems with claims-made forms as outlined in my March 2019 article. Then read on for more.

Problem #4: Other Hidden Dangers in the Definitions Section

In addition to the definition of "claim" (as discussed in my first article within this series), other definitions in claims-made policy forms can also be problematic for insureds. A policy's definitions can be industry-or coverage-specific, and both types may create the possibility of a coverage gap.

Problematic definitions sections are not necessarily particular to claims-made policy forms. Yet, the definitions discussed below are a regular feature in employment practices liability insurance (EPLI) policy forms, virtually all of which are written with claims-made coverage triggers.

No doubt, we have become numb to the expectation that EPLI policies *always* provide third-party extensions (i.e., coverage for wrongful acts committed *by* employees *against* third-party nonemployees, such as customers, versus "traditional" employment practices liability [EPL] coverage for wrongful acts committed *by* employees *against other employees*). Yet, importantly, third-party coverage is not always automatically provided within an EPLI policy. Therefore, one must verify that a third-party extension is, in fact, included within an EPLI policy form and is part of the quote received from the underwriter.

A "Third-Party Wrongful Act" Definition *Does Not* Assure Coverage

When an EPLI policy contains a definition for "third-party wrongful act" within the definitions section of the policy, one may assume that third-party coverage is automatically provided. Unfortunately, sometimes—but not always—there is language elsewhere within the policy stating that third-party coverage is not provided *unless* the box next to "third-party liability" (often deemed Coverage B within an EPLI policy) is checked off on the declarations page. If the quote is silent as to third-party coverage, how would one know whether third-party coverage is part of the policy until the insurer sends the insured the actual, physical policy, which may be months after the policy's inception date?

The Emotional Distress Carve-Back: Another Problematic Definition

In addition, there are other dangers within the definitions section of EPLI policies that are equally subtle. A key question is whether there are separate definitions for an "employment practices wrongful act" and "third party wrongful act"? Since there usually are, one must coordinate the two definitions with the exclusions section of the policy. For example, the bodily injury exclusion usually contains a carve-back for emotional distress that arises from an employment practices wrongful act. But, if there is a separate definition for a third-party wrongful act, one must ask whether the bodily injury exclusion carve-back *also* applies to that definition? Thus, coverage should also be provided for emotional distress that arises out of the third-party wrongful act (e.g., a customer who is discriminated against by an employee and claims damages for both discrimination *and* for emotional distress). If not, a correcting endorsement will be required to make sure that the bodily injury carve-back applies to any third-party wrongful acts, in addition to a first-party employment practice wrongful act. This is illustrated in Figure 1.

FIGURE 1
EMOTIONAL DISTRESS CARVE-BACK WORDING *NOT* APPLYING TO THIRD-PARTY CLAIMS

The following Exclusions apply to this Coverage Section A: First-Party Employment Practices Liability...

E. Bodily Injury and Property Damage. The Insurer shall not be liable for Loss involving any Claim for

1. bodily injury, sickness, disease, or death of any person; or
2. damage to, destruction of, or loss of use of any tangible property;

except that Paragraph 1 of this Exclusion will not be applicable to First-Party Employment Practices Liability Claims for emotional distress, shock, humiliation, or mental anguish.

How Does the Policy Define "Third Party"?

Yet another problematic definitional issue within EPLI policy forms is the question of how the policy defines "third party." Is it "Any non-employee with whom the insured interacts," or is the definition limited to "current or former clients, or customers"? Obviously, it is best to have

language that is as broad as possible, in which case "anyone with whom the insured interacts" is far superior to limiting coverage to only those claims made against the insured by "a current or former client or customer." This is illustrated by the wording in Figure 2 below.

FIGURE 2
RESTRICTIVE DEFINITION OF "THIRD-PARTY CLAIM"

Definitions Section-Third Party Claim

We consider it reasonable for you to foresee that a **Claim** may be brought against you if a current or former client or customer has expressed dissatisfaction. This includes, but is not limited to: A current or former client or customer making a complaint to a supervisory employee of **Discrimination** or **Harassment** by your **Employee(s)**; or A current or former client or customer threatening to hire an attorney...."

Problem #5: "Time Bombs" and Traps in "Claim" Reporting Provisions

The claim reporting provisions within claims-made policies can also be problematic for an insured.

When Does the Automatic Extended Reporting Provision Apply?

Claims-made policies routinely contain automatic extended reporting provisions that allow insureds to report claims within 30 or 60 days following policy expiration. Yet, under some policies, the automatic extended reporting provision is available only in the event the policy is canceled or nonrenewed, *but not* if it is simply renewed; thus creating another "time bomb."

Claims Reporting Time Bombs

Another potential coverage gap inherent in claims-made policies is that many such forms contain what amounts to claims reporting "time bombs." That is, such policies require that claims be reported to the insurer within 30 days of the insured's receiving the claim. Thus, under a policy

with a 1/1/20-21 term, a claim received on June 1, 2020, but not reported to the insurer until August 1, 2020, would not be covered. This is despite the fact that the claim was reported well before the policy expired.

In one instance, we have even seen language requiring that a claim be reported no later than 10 days after the insured has received it! The worse yet is that insureds (or their insurance brokers) may not expect to find a claims reporting "time bomb" provision in the conditions section of the policy, and yet, such "time bomb" restrictions are sometimes placed there rather than in the policy's claim reporting section.

Harsh as they may appear, these restrictions can nevertheless be legally enforceable. This is because various courts have interpreted such wording to be "clear and unambiguous." In effect, policies containing reporting restrictions of this nature are no longer "claims-made-and-reported" policies. Rather, this language transforms them into "claims-made-and-reported in 10 days" policies! Such provisions are not only substandard and unusual, but they can also give rise to devastating consequences for any policyholder, notwithstanding the litigation that will thereafter arise.

Figure 3 offers an example of two such time bombs.

FIGURE 3
CLAIM REPORTING PROVISION CONTAINING A "TIME BOMB"

V. CONDITIONS

A. Reporting of Claims and Potential Claims:

"You must provide written notice to our **Appointed Representatives** within thirty (30) days, but in any case, no later than 10 days before the response date for the claim, expiration date of this Policy or any applicable **ADDITIONAL REPORTING PERIOD**, when any **Insured** receives a **Claim** or when any **Insured** first becomes aware of any **Claim**; and immediately forward to us every demand, notice, summons, legal papers and/or other process received by you or your representative thereafter"

Problem #6: "Time Bombs" in "Incident Reporting" Provisions

Anyone who has been involved with claims-made policy forms is well aware of the "Incident Reporting" provisions that exist in most, if not all, such policies. These are important provisions, in that, if an insured becomes aware of facts or circumstances that might give rise to a claim in the future, yet an actual claim has not yet been made when that policy expires, then any such "incident," if reported prior to policy expiration, will be considered a "claim" under the now-expired policy.

The Need To Provide Specific Information

"Incident reporting" provisions almost always also require that certain specific information relevant to the "incident" or "circumstance" be provided to the insurer. Such information generally includes (but is not limited to) the following.

- The date the wrongful act arose that could give rise to a future claim
- The persons involved
- The events giving rise to the anticipated claim
- The manner in which the insured became aware of the incident or circumstance
- The estimated damages associated with the incident or circumstance

By requiring such details, an insured is prevented from simply listing all of its transactions within the past year as potential claims.

"Laundry Listing" Incidents Will Not Be Considered "Claims"

Thus, an insurer would not accept as a potential claim from an accountant, a list of all the tax returns she filed on behalf of every one of her clients, within the 6-month period prior to the expiration of her accountants' professional liability policy. This approach, known as "laundry listing," which was prevalent in the 1970s and 1980s, was often abused by insureds, a situation to which insurers responded by requiring that insureds provide specific details about the incident. Accordingly, many insurers now require as many as five specific items that must be disclosed for them to qualify as an "incident" reported during the policy term and thus eligible for coverage in the event the incident matures into an actual claim. Figure 4refers to one such provision.

FIGURE 4
REPRESENTATIVE INCIDENT REPORTING PROVISION

X. If during the **policy period**, any **Insured** becomes aware of any act or omission which may reasonably be expected to be the basis of a **claim** against any **Insured**, including but not limited to any notice, advice or threat, whether written or verbal, that any person or entity intends to hold the **Insured** responsible for any alleged act or omission and gives written notice to the **Company** with all available particulars, including:

a. The specific act or omission;
b. The dates and persons involved;
c. The identity of anticipated or possible claimants;
d. The circumstances by which the **Insured** first became aware of the possible **claim**; and
e. Potential damages or injury,

then any **claim** that is subsequently made against the **Insured** arising out of such act or omission will be deemed to have been made on the date such written notice was received by the **Company**. Said documents and information should be mailed to the **Company** at the following address:

"Incident Reporting" and "Claim Reporting" Are *Not* Synonymous

Importantly, an incident report of a potential claim is different from reporting an actual claim. As noted above, it is best to have the insured obtain a policy that does include automatic extended reporting provisions of 30, 60, or even 90 days to report a *claim* after the policy expires, so long as a claim was first made during the policy term.

Yet, unlike a "claim reporting provision," an "incident reporting provision" commonly *does not* give the insured additional time after the expiration of the policy to report an incident. In fact, the vast majority of "incident reporting provisions" require that the incident be reported *prior to policy expiration*. This is a critical distinction and makes it incumbent upon the broker to verify that the insured understands the difference between reporting an *incident* during the policy term versus reporting a *claim* during the policy term or during any postpolicy reporting window.

Time Reporting Restrictions within "Incident Reporting"

Provisions

Incident reporting provisions may also have a "time bomb" associated with them. As stated above, I consider time-reporting restrictions to be substandard language and highly restrictive. Nonetheless, I have seen one policy where the insured, like the "claim reporting provision," was required to report an "incident" within 30 days after learning of it. Thus, under a policy with a 1/1/20-21 term, if an insured first becomes aware of an "incident" on July 1, 2020, but does not report it to the insurer until September 1, 2020, coverage for the incident will not apply because it was not reported to the insurer within 30 days of the insured's becoming aware of it. This is despite the fact that the insured reported the "incident" well before the policy expired.

The figure below provides an example of such language. Notice that the provision also *does not* allow for incident reporting during an extended reporting period (i.e., the report must come "no later than the expiration date of this Policy").

FIGURE 5
INCIDENT REPORTING PROVISION CONTAINING A "TIME BOMB" RESTRICTION

You must provide written notice to our **Appointed Representatives** within thirty (30) days, but in any case, no later than the expiration date of this Policy when any of your **Management or Supervisory Employees** first become aware of a **Potential Claim** in which an **Insured Event** is committed or alleged to have been committed on or after the **Retroactive Date**, if any, and prior to the end the **Policy Period** that may subsequently give rise to a **Claim**. Any **Claim** subsequently made against any **Insured** arising from the **Potential Claim** reported to Underwriters during the **Policy Period** shall be deemed, for the purpose of this insurance, to have been first made and reported during the **Policy Period.**

Important Takeaways

This second article about claims-made coverage trigger minefields has addressed three additional, structural aspects of claims-made policies that could potentially give rise to coverage denials. Here are additional critical points to check within claims-made policies.

- **EPLI policy definitions**—First, make sure that a claims-made EPLI policy's covered acts definition, as well as covering *first-party* wrongful employment practices acts, also covers *third-party* employment practices acts. In addition, confirm that the policy's definition of

"third-party employment practices wrongful act" also encompasses coverage for "emotional distress" (as does the policy's definition for "employment practices wrongful act." Lastly, verify that the EPLI policy's definition of "third party" uses the broad "any non-employee" wording versus the restrictive "current or former customers or clients" wording.

- **"Claim" reporting provisions**—First, recognize that some automatic extended claim reporting provisions, while they allow insureds to report claims 30 or 60 days after a policy is canceled or nonrenewed, may not allow the insured to do so if the policy is simply renewed. Also, be alert to the fact that some "claim" reporting provisions require the insured to report "claims" with a certain period of time (usually 30 to 60 days) after becoming aware of the claim. Such policies will exclude "claims" reported to the insurer outside such time frames—despite the fact that the claim was reported well before the policy expired.
- **"Incident" reporting provisions**—Confirm that your insureds understand that, with regard to the policy's "incident reporting" or "notice of potential claim" provision, the potential claim sometimes must be reported *before* the current policy term expires, *not* within 30 to 60 days following policy termination, as is the case with reporting an "actual" claim made against the insured (as is allowed with postpolicy reporting windows). Moreover, be cognizant of the fact that, while many "incident" reporting provisions require incidents to be reported prior to policy expiration, an incident reporting provision with a time limit, or "time bomb," would require the insured to report incidents within 30 (or perhaps only 10) days after becoming aware of the incident—despite the fact that the policy may still be months away from expiring!

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Claims-Made Coverage Trigger Dangers

This article is the third in a series of three articles addressing the potential pitfalls embedded in policies written with claims-made coverage triggers. My purpose in pointing out the many dangers lurking within the language of claims-made policy forms in this series is simple.

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May 2019

Professional, D&O, and Fiduciary Liability

The goal of insurance is to assure that insurers make a profit, while at the same time, their policies should provide a reasonable expectation that their policyholders will be protected against a given hazard. Yet, when policies contain language that creates uncertainties, the costs and expenses are increased for insureds and insurers alike. Uncertainty increases unnecessary litigation, from which neither party gains. Uncertainty can turn a single claim against the insured into four additional lawsuits, which, again, benefits no one. And finally, the uncertainty resulting from ambiguous language within claims-made policy forms can doom any insurer's program of coverage because, in the long run, the program becomes actuarially unsustainable, an outcome that is harmful to all.

This article takes a look at extended reporting periods, other dangers in the conditions section (mergers and acquisitions, hammer clauses, and allocation clauses), and the workers compensation claim exclusion. If you haven't already, see my March 2019 and April 2019 articles addressing previously discussed pitfalls of claims-made policies.

Problem #7: The Dangers Inherent in Extended Reporting Provisions

Extended reporting provisions (ERPs) in claims-made policy forms have existed for a long time. ERPs were once considered to provide a type of "retirement coverage" under which the insureds would have coverage for claims made against them during the extended reporting period term, provided the claims arose from wrongful acts that took place prior to the expiration of the policy. In other words, even when one is retired, he or she can still be sued "tomorrow" (i.e., during their retirement) for something they did "yesterday." ERPs addressed this so-called "retirement exposure." Unfortunately, ERP provisions have gotten more complicated since that time.

Circumstances under Which an ERP Is Available

Currently, some claims-made policies distinguish between an ERP that, on the one hand, may be triggered due to a cancellation or nonrenewal of coverage and, on the other hand, an ERP that is provided when one's business or company is acquired. The latter, known as "runoff provisions," provide the same coverage as ERP provisions but are only triggered when the insured is acquired, rather than retiring, going out of business, or having their coverage canceled or nonrenewed.

Price of the ERP

The vast majority of claims-made policies specify the price the insured must pay for an ERP—typically a percentage of the expiring policy premium. In addition, some policies may even provide coverage options for several different ERP terms (e.g., 2 years, 3 years, or 5 years) in addition to the standard 1-year ERP option.

There are, however, a small handful of claims-made policies that do not specify a premium for the ERP endorsement provided by the policy. Instead, the policy only states that premium will be calculated "in accordance with the rates and rules in effect at the inception of the policy." Thus, at the inception of the policy, there would be no way to know what premium would be charged when an insured seeks to buy an ERP in the future.

This is substandard language because, as already noted above, the vast majority of claims-made policy forms provide a 1-year ERP (or longer) for a specific premium, which is nearly always quoted as a percentage of the expiring policy's premium. This approach eliminates a certain degree of uncertainty for the insured, as opposed to the policies that do not specify a percentage for the ERP.

The figure below provides representative substandard wording of an ERP provision.

FIGURE 1
SUBSTANDARD LANGUAGE:
ERP PREMIUM NOT STATED AT THE INCEPTION OF A POLICY

B. Optional "extended reporting period"

1. If this Policy is canceled or non-renewed by either us or by you, then the first of you named on the Declarations shall have the right to purchase an optional "extended reporting period". Such right must be exercised by you within sixty (60) days of the termination of the policy period by providing: a. written notice to us; and b. with the written notice, the applicable additional premium which will be calculated *in accordance with the rates and rules* in effect on the inception date of this Policy.

ERP Election and Application

Another aspect of ERPs that varies from insurer to insurer is the time limit within which an insured must notify the insurer of its election to purchase the ERP. A small minority of forms require the insured to make this election prior to the expiration of the policy, whereas most others permit the insured to make this decision up to 30 or 60 days postexpiration.

Furthermore, insureds should not assume that multiyear ERP options are automatically provided in every policy. This is not the case. In fact, a larger proportion of insurer forms offer only a 1-year option than do those that provide additional options, such as 2 years, 3 years, and 5 years.

Ensuring ERP Limits Are Adequate To Cover Claims in Multiple Years

Another critical point to recognize is that EPRs are an incomplete solution to the need for postretirement coverage (or any postpolicy coverage for that matter). Recognize that, under an ERP, the insured is obtaining just one limit of liability, and that limit must provide coverage over at least a year, and perhaps more, in the event the insured obtains a 2-, 3-, or 5-year ERP. Thus, during the extended reporting term, multiple claims could potentially be made against the insured, thus significantly reducing or even completely extinguishing whatever limit was initially purchased. At that point, it may be difficult (or even impossible at a reasonable premium) to secure an additional ERP that replenishes the original limits.

This inherent limitation of ERPs becomes extremely important when one company is acquired by another. In such a situation, the buyer of the company would be forced to contact the seller of the company, years after the transaction was concluded, to inform the seller that there are no additional limits available under the ERP that was originally

purchased to cover claims made against the seller for wrongful acts that arose prior to being acquired. In this situation, the seller must now provide funds to purchase additional ERP limits (which is normally an express condition found within the original sale agreement).

Automatic Coverage for Newly Acquired Companies

A related concern involving acquisitions is whether an insured can negotiate with its insurer to simply pick up the exposure of any companies the buyer acquires. In other words, if Company A the buyer, is a well-managed, profitable company with a loss-free track record, good management, and solid operations, obviously any underwriter would like to insure them. When an application from Company A indicates that it is purchasing Company B, which also has the same qualities of an excellent track record, loss history, and management, why is it that Company B is suddenly considered a poor risk? Often the answer is "That's the way it's always been done."

Yet, unfortunately, if everyone thought like that, we'd still be communicating with smoke and drums! It would appear that if Company A is buying Company B, and both are "good writes," Company B could reasonably be automatically covered and scheduled as an additional named insured under Company A's policy, and with prior acts coverage (for Company B's acts prior to it being acquired by Company A).

Problem #8: Other Dangers in the Conditions Section

Merger and acquisition language, also known as change in control language, is usually found in the conditions sections of claims-made policy forms. However, sometimes a policy's definition of "insured" may also contain acquisition/change in control wording, so broker beware. As will be explained below, and regardless of *where* merger and acquisition/change in control language is found within a claims-made policy, a substantial coverage gap can arise when there is a conflict between such language and an insured buyer's intent to cover the prior acts of a company it is acquiring.

Covering the Prior Acts of the Acquiree

A common pitfall associated with merger and acquisition/change in control language occurs when, for example, Company A acquires Company B. Simply scheduling the name of Company B as an additional named insured, together with Company B's retroactive date on Company A's policy, will not provide coverage for Company B's wrongful acts that took place before the acquisition was completed. This is because the standard policy language pertaining to merger and acquisition/change in control situations states that the acquiring company's policy (in this instance, Company A) excludes coverage for any wrongful act that took place prior to the transaction date of any merger and acquisition.

Therefore, and in addition to adding an endorsement affirmatively covering the acquired company's acts prior to being acquired, yet another endorsement to Company A's merger and acquisition/change of control provision is *also* required to void the policy's standard change in control provision that excludes coverage of any acquired company's prior acts.

Coverage disputes associated with merger and acquisition/change in control language have already been ruled on by various appellate courts, nearly all of which have denied coverage of an acquiree's prior acts, given the fact that such coverage conflicts with the merger and acquisition/change in control provision. Such courts noted that the merger and

acquisition/change of control section was not *also* endorsed to provide coverage of prior acts and, therefore, supersedes the endorsement that affirmatively covers the acquired company's prior acts.

Hammer Clauses

"Hammer clauses," another provision commonly found in the conditions section of claims-made policies, have been around for a long time. A standard "hammer clause" requires an insurer to seek an insured's approval prior to settling a claim for a specific amount. However, if the insured does not approve the insurer's recommended settlement figure, the hammer clause states that the insurer will not be liable for any additional monies required to settle the claim *or* for the defense costs that accrue from the point after the insurer made its settlement recommendation.

For example, assume an insurer suggests an insured settle a claim for $100,000. The insured refuses and, ultimately, the claim settles for $200,000. In addition, another $50,000 in defense costs are incurred from the time of the insured's initial refusal to settle and the eventual settlement. In this situation, the insured will be responsible for both the additional $100,000 in settlement costs as well as the additional $50,000 in defense costs, for a total of $150,000. The insurer is only responsible for the $100,000 settlement offer that was originally proposed.

A "softer" alternative to the standard "hammer clause" (known as a "coinsurance hammer clause") provides for a sharing of defense and indemnity costs (between the insured and the insurer) incurred after the insured refuses to consent to a settlement proposed by an insurer. The most common sharing percentage is 50/50 but can sometimes go higher (e.g., 80 insurer/20 insured). The effect of such clauses is to reduce the amount of additional indemnity and defense costs that an insured could potentially incur if it refuses to consent to a settlement amount recommended by an insurer.

Using the figures in the previous example, and assuming a 50/50 sharing percentage, the insured would only be responsible for paying half of the additional $100,000 settlement and half of the additional $50,000 in defense costs, for a total of $75,000, versus $150,000, as noted above.

Buyers and brokers should seek policies containing the so-called soft hammer clause. Or, alternatively, it would be advantageous to request that their current policy be modified to provide a "soft" hammer if it contains a "traditional" hammer clause.

Allocation Clauses

Another potentially troublesome condition found within claims-made policy forms is the so-called allocation clause. Until recently, such clauses were only found within directors and officers (D&O) liability policies. Allocation provisions specify the manner in which coverage will be "allocated" between covered and uncovered items. In D&O forms, the issue of allocation arises between covered/uncovered acts and covered/uncovered persons.

Allocation provisions are complex, and a complete discussion of such clauses is beyond the scope of this article. However, the key point to recognize is this: until recently, such provisions were restricted to D&O policy forms. However, within the past several years, allocation clauses have begun appearing within claims-made professional and errors and omissions liability policies. Therefore, buyers and brokers should be on high alert for the presence of these provisions and must understand the ways in which they can reduce or even preclude coverage under a wide variety of claim scenarios.

Problem #9: The Workers Compensation Claim Exclusion

One peculiar, yet potentially dangerous exclusion sometimes found within claims-made policies is one that I noticed within an environmental architect and engineer's professional liability policy. Surprisingly, the policy was offered by a well-known and respected managing general agent. The language I will discuss below has been appearing frequently in recent years.

Although virtually every type of insurance policy contains a workers compensation exclusion (except a workers compensation policy itself), the following exclusion is one of the most egregious I've ever seen. It is highly substandard, and frankly, there is no logic in having it appear in *any* policy. It states the following.

> The Company shall have no obligation whatsoever under this policy to make any payment of any kind for either "damages," "claims expense," or any coverage or payment provided..., or pay, for any defense, for: ...
>
> > M. any "claim" for bodily injury or death to any person, whether or not an employee of the "named insured," if benefits from the bodily injury or death are collectible or compensable under any workers compensation law or disability benefits law.

The logic of this exclusion completely escapes me. If an insured environmental architect or engineer's professional negligence is responsible for causing bodily injury to a claimant, and the claimant is collecting workers compensation benefits from his employer in conjunction with such bodily injury, why should coverage under the architect or engineer's professional liability policy bar coverage?

In the event the insured architect/engineer actually *was* negligent in causing the injury, the workers compensation insurer of the worker's employer should be entitled to subrogate against the architect/engineer's professional liability insurer and be reimbursed for any medical or lost-time benefits it paid the worker. On the other hand, if it turns out that the architect/engineer was not negligent in causing the injury, the architect/engineer should *still* be entitled to coverage for defense against any lawsuits filed by the injured worker, the injured worker's employer, and the employer's workers compensation insurer.

The fact that the injured worker may be receiving workers compensation benefits from his employer (who might *not* be the insured under the environmental engineer's professional liability policy) is not something that increases the hazard or reduces the insurability of the insured environmental engineer, meaning the rationale for this exclusion is shaky at best. Once again, broker beware.

Important Takeaways

Extended Reporting Provisions

- Be aware of the particular circumstances under which a policy's ERP is actually available: cancellation, nonrenewal, going out of business, or retirement?
- Know the specific premium for the ERP option(s) being offered at the inception of the policy, and request an actual premium quotation if one is not already stated.
- Understand how soon—following policy expiration—the insured must elect to buy an ERP.

- Recognize that an ERP's limit may not be adequate if it will be providing coverage over multiple years.
- Identify the conditions under which ERPs will cover an acquired company's prior acts, and attempt to arrange "automatic" coverage with your underwriter for all such acquisitions.

Other Important Provisions within Conditions Sections

- Spot conflicts between merger and acquisition/change in control provisions and endorsements whose intent is to cover an acquired company's prior acts. Endorse the change in control provisions in a manner that "voids" the exclusion found within such provisions that bar coverage for an acquired company's prior acts.
- Negotiate "softer" hammer clauses if your policy contains a "standard" hammer clause, or select policies already containing "soft" hammer clauses.
- Look for allocation provisions in professional and E&O policies, understand their significance, and know the ways in which they can restrict coverage.

The Workers Compensation Exclusion

- Be familiar with the way in which the workers compensation exclusion can limit the extent of coverage otherwise provided by professional and E&O policies (particularly for exposures with more potential for bodily injury). Attempt to negotiate removal of this exclusion.

Beware of "Absolute" Insurance Policy Wording

In July 2009, a partner in a prominent law firm authored an editorial that appeared in the firm's monthly digest of recent appellate decisions. The editorial discussed "absolute exclusions." Such exclusions have been deemed "absolute" because they even exclude claims that are remotely—but not directly—related to the specific acts targeted in the exclusion. The effect of such language is to defeat coverage in situations where it could otherwise be reasonably expected that coverage would apply.

Frederick J. Fisher, JD, CCP
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Professional, D&O, and Fiduciary Liability

The ultimate—and troubling—theme of the attorney's article was the following concluding statement.

> Nevertheless in today's market, perhaps putting aside the "hard" financial institution and financial services, D&O/E&O markets, astute brokers, and policyholder counsel will resist vigorously the 'super absolute' language. Beauty, however, is truly in the eye of the beholder and, as an insurer's coverage lawyer, I prefer super absolute beauty!!

In essence, this attorney was saying that absolute language is preferable—from the insurer's standpoint—a view that, of course, would severely restrict coverage for insureds and thereby result in claim denials in situations where an insured would presume that coverage would be available.

This article examines "absolute" policy wording and describes the dangers it presents for an insured. It begins by explaining exactly how "absolute" wording pertains to a policy's exclusions. The article then provides two case studies in which "absolute" exclusionary wording eliminates coverage where it could reasonably be expected to apply.

Next, it analyzes the manner in which "absolute" wording has worked its way into prior and pending and retroactive date provisions, offering examples of how "absolute" wording can produce adverse results for an insured. The article concludes with several takeaways that can assist a policyholder in minimizing the effect of "absolute" policy language.

"Absolute" Exclusions and How They Impair Coverage

The best way to understand the operation of "absolute" exclusions is to closely examine the exact policy wording and then analyze the effect of such exclusions in a claim situation. The figure below provides representative wording of an "absolute" exclusion.

Representative Wording of an "Absolute" Exclusion

... the Insurer shall not be liable to make any payment for Loss in connection with a Claim made against any Insured... based upon, arising out of, directly or indirectly resulting from or in consequence of, or in any way involving:

1. damage to or destruction of any tangible property, including the loss of use thereof; or
2. bodily injury, sickness, disease, death; or assault or battery of any person; or
3. invasion of privacy, wrongful entry, eviction, false arrest, false imprisonment, malicious prosecution, libel, slander, mental anguish, humiliation, emotional distress, oral or written publication of defamatory or disparaging material...

Source: Berkley Insurance Company; ExecSuite; Directors, Officers and Corporate Liability Insurance Coverage Section; ML 36400 (rev. 03–18)

The critical phrases in this exclusion are "based upon," "arising out of," "directly or indirectly resulting from," "in consequence of," and "in any way involving." Such phrases indicate that coverage, *even for events that are distant from the essential nature of the act depicted in an exclusion*, will not be available to an insured.

The Dangers of "Absolute" Language in Exclusions: Two Case Studies

In this section, we will see how "absolute" exclusions impact the outcome of two claim situations. The first case study involves a claim under an insurance agents and brokers professional liability policy; the second pertains to an insurance company errors and omissions (E&O) liability policy.

Case One: Insurance Agents and Brokers Professional Liability Policy

Imagine you are an insurance broker who is asked to obtain an environmental engineer's professional and pollution liability insurance policy for one of your clients. Also, imagine that your own insurance agents and brokers professional liability policy contains an exclusion for pollution liability. If that exclusion is written on an "absolute" basis, it could foreseeably preclude coverage for the following claim brought against you.

Your client environmental engineer is sued in conjunction with a pollution incident caused by his alleged faulty design of a wastewater treatment plant. Coverage for the claim against your client environmental engineer is denied by the insurer who underwrote the environmental engineer's professional and pollution liability policy that you sold the client. As a result, the client sues you for providing a policy that failed to cover the single most critical exposure associated with your client's profession: a pollution incident.

In this situation, the "absolute" pollution liability exclusion within *your* insurance agents and brokers professional liability policy could foreseeably preclude coverage for a claim brought by your client against you, alleging that you were negligent in providing him with a defective policy. This is because the insurer could assert that the claim made against you was "based upon," "arose out of," "directly or indirectly resulted from," was "a consequence of," or "involved" pollution—however remotely! As bizarre as this conclusion may appear, coverage denials under this and similar types of circumstances are becoming increasingly common because "absolute" exclusions are now more frequently appearing in claims-made policies.

Case Two: Insurance Company E&O Liability Policy

In another example of how an "absolute" exclusion defeated coverage for a seemingly covered claim, consider the case of an insurance company that purchased E&O insurance with the intention of protecting itself against bad faith lawsuits.

The insurer issued a pollution liability policy to one of its insureds. The insured was sued by a third party for pollution, and the insurer, in turn, denied coverage. Following the denial, the insured sued the insurer, alleging bad faith. Yet, because the *insurer's own* insurance company E&O liability policy contained an "absolute" pollution exclusion, coverage

for the bad faith lawsuit against the insurer was denied. This was despite the fact that the insurance company was *not* the polluter and, ironically, the insurer's premium volume received for writing pollution liability coverage was used (in part) to calculate its premium when purchasing its E&O policy! Such language—to at least one attorney's delight—is being upheld by courts with increasing frequency.

The exclusion of the bad faith claim was, of course, not the original intent of the insurance company E&O liability policy. Rather, exclusions often appear in insurance policies because other policies are more expressly designed to cover that particular type of hazard. For example, in almost every liability policy issued, there is a workers compensation exclusion (except in a workers compensation policy). Accordingly, none of these policies (i.e., automobile liability, commercial general liability, directors and officers [D&O] liability, and so forth) would be called on to pay a workers compensation claim because a workers compensation policy was available to address that hazard. Yet, when a policy contains "absolute" language, if the claim is even remotely connected to the exclusion, it is entirely possible that such an exclusion will be upheld in court; as was indeed the case when the insurance company's E&O insurer denied coverage for a bad faith claim because it was related—however tangentially—to a pollution incident.

Limit the Scope of "Absolute" Exclusions to the Insured's Activities

One key question associated with "absolute" exclusionary wording in the above two examples is whether the exclusion was limited to the activities of the "insured" insurance broker or insurance company. In other words, does the exclusion say that no coverage will apply to "any claim arising directly or indirectly from any pollution or environmental hazards ...," *or* does it say that we don't cover "any claim arising directly or indirectly from any pollutants or environmental hazards as may be caused by acts of the Insured" (insurance broker/insurance company)? The latter wording would have afforded coverage in both claim examples, whereas the former wording would not.

The Effect of a Policy's "Claim" Definition

Recognize that the preamble to a set of exclusions often includes a reference to the term "claim" (e.g., "This policy does not afford coverage for any *'claim'* based on, arising out of, involving or in any way related to ...").

Therefore, the manner in which a policy defines the term "claim" can have the effect of either *reinforcing*, or *neutralizing*, the application of the "absolute" exclusions within a policy.

For example, if a policy states that a "claim means any legal action brought against an insured for a wrongful act," the insureds in both of the aforementioned case studies would probably find themselves with a coverage denial. This is because the "claim" definition does not indicate that the wrongful act be committed by the insured. Since the two coverage denials originated from acts *not* committed by the insured agent and insurance company, respectively, this definition of "claim" would only reinforce the policy's "absolute" pollution exclusion.

Contrast this definition of "claim" with one stating that a "claim means any legal action brought against the insured arising out of a wrongful act by the insured." This "claim" definition would (or should) neutralize a policy's "absolute" pollution definition so that unless the insured committed the actual wrongful act that gave rise to the claim, the exclusion would not apply. Therefore, since the insurance agent and insurance company, respectively, did not cause the pollution that gave rise to the claims brought against them, the "absolute" exclusion would not apply, and coverage should be available in both instances.

Limit the Scope of "Absolute" Exclusions Using "Carve-Backs"

In other instances, policies may contain so-called carve-backs for "absolute" language, which apply to certain exclusions. For instance, in one policy I have reviewed, there were 48 exclusions that used "absolute" language. However, at the end of the exclusions section there appeared blanket carve-back wording (applying to five exclusions) wherein it stated "with respect to exclusions E, F, I, M, and U, these exclusions shall not apply to a claim caused by *your* alleged failure or actual failure ..." (emphasis added).

While such wording may be effective in limiting the extent to which the "absolute" nature of certain exclusions could restrict coverage, there is *still* the problem of how the "absolute" nature of the other 43 exclusions in the policy could impede coverage!

Limit the Inconsistent References to "Insured"

Similar to the problems noted above as to the selective use of carvebacks is the problem of selective use of references to the insured. In other words, it is not uncommon for policy to use absolute exclusions for all exclusions listed. However, some may refer to insurance activities, and others may not. Thus, it is imperative that all absolute exclusions refer to the insured and their activities.

Retroactive Date and Prior and Pending Litigation Provisions

In addition to appearing within exclusions, "absolute" policy language is also more frequently being found in (1) retroactive date language and (2) prior and pending litigation provisions. These are dangerous provisions given how broadly they are now being interpreted as a result of the "absolute" language they contain. Indeed, claims that one would think were otherwise covered are instead being denied because of "absolute" language.

"Absolute" Language in Retroactive Date Provisions

Prior to the inclusion of "absolute" language (exemplified below), coverage under the retroactive date provision in a claims-made policy would apply in a relatively straightforward fashion to claims that were caused by wrongful acts that took place *after* a specified date. Now, claims-made policies routinely use language stating the following.

> Coverage will not apply *based upon or arising out of, in whole or in part, directly or indirectly*, from any wrongful act that took place prior to the Retroactive Date specified in item xx on the Declaration page....

The danger of such language is twofold. The phrases "arising out of" and "directly or indirectly" mean "connected with." Therefore, such language could operate in a manner that excludes coverage for a wrongful act committed by "anyone"—as opposed to just the "insured."

Consider the case of a company's assistant controller who is not an officer of the company and thus not an insured under its D&O liability policy. The company's D&O policy incepts on January 1, 2020, and also contains a retroactive date of January 1, 2020.

Beginning in 2016, the assistant controller intentionally booked all of the company's "shipments" of its products as "final sales" and did not take into account any returns of such goods. This has had the effect of inflating the company's earnings by roughly 15 percent for each fiscal year since (and including) 2016. In 2020, the assistant controller's accounting maneuver is finally discovered by an outside auditor, who requires that the company restate its earnings for 2016, 2017, 2018, and 2019. Following the public announcement of the restatement on June 1, 2020, the price of the company's shares drops significantly. A month later, on July 1, 2020, the company receives several shareholder class action lawsuits alleging accounting fraud in the company's overstatement of its earnings and naming all of the company's directors and officers in the lawsuits.

The company's D&O insurer denied coverage for these claims, pointing out that, because the assistant controller *reported to* the company's chief financial officer (CFO) (an officer and thus an insured), the claim "arose out of" acts with which the insured directors and officers were "directly or indirectly" "connected" and that took place prior to the policy's January 1, 2020, retroactive date. The denial was upheld despite the fact that the company's CFO played no role in the accounting fraud and had no knowledge of it until it was revealed by the audit.

"Absolute" Language in Prior and Pending Litigation Provisions

"Absolute" language is now appearing in prior and pending litigation date provisions, as follows.

> [The] insurer is not obligated to pay damages or claim expenses for any claim *based upon or arising out of, either directly or indirectly,* any legal actions, arbitration, or other adjudicative proceeding instituted and pending prior to the effective date of policy, whether or not any Insured was named as a party to such legal action, arbitration, or other adjudicative proceeding....

The following claim scenario illustrates the way in which such language could operate to defeat coverage where it would otherwise be expected to apply. On July 1, 2018, the owner of a construction project sues Architect A who designed the building's heating, ventilation, and air conditioning system. Then, a year later, on July 1, 2019, the owner amends his original lawsuit (against Architect A) and adds Architect B, who designed the building's electrical system, to the litigation.

Assume that Architect B has an architect's and engineer's professional liability policy with a January 1, 2019–2020 term and a January 1, 2019, prior and pending litigation date. In this situation, Architect B could potentially have no coverage under her architect's and engineer's professional liability policy if that policy contained the above-noted "absolute" wording. Although the owner's first lawsuit did not assert any negligence against Architect B, the fact that the suit involved *the same project* on which Architect B was also participating will allow the insurer to argue that the suit against B arose "indirectly from ... such legal action" and that it was filed earlier in time than the policy's prior and pending litigation date and thus barred from coverage. Despite the apparent unfairness of this result, in many states, courts have found such language to be "clear and unambiguous," thus upholding the insurer's coverage denial.

Important Takeaways

Unfortunately for insureds, the attorney's statement noted at the beginning of this article was quite prescient because in the decade since he wrote the editorial, insurers' use of "absolute" policy language has increased significantly. At the same time, courts are now serving as allies to insurers as they are more likely to interpret absolute policy language in a

manner that denies coverage in situations where it was otherwise expected.

The following tips can help to protect an insured from the dangers and, ultimately, the unexpected coverage denials that can result from "absolute" policy language.

- **Look for "absolute" language everywhere**. Recognize that, given current trends, "absolute" language can—and will—appear in nearly every section of claims-made policy forms. Be aware of such language, not only within exclusions but in other sections of a policy, as well.
- **Limit the impact of "absolute" exclusions.** Limit their scope by (a) inserting language so that a particular exclusion only applies to the insured's own activities and (b) adding blanket "carve-back" language listing the exclusions to which "absolute" language *does not* apply to the insured's own activities. Attempt to maximize the number of exclusions that fall under this blanket.
- **Analyze a policy's definition of "claim."** A policy's "claim" definition requiring that the wrongful act be committed *by the insured* will protect the insured from a claim denial in many foreseeable situations. Seek policies using such a definition, or negotiate the "claim" definition in your current policy so that it contains such a requirement.
- **Neutralize the effects of "absolute" language in retroactive date and prior and pending litigation provisions.** Negotiate to remove "absolute" language from such provisions. If this is not possible, consider purchasing a policy *not containing* "absolute" language within these provisions.
