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Inside This Issue

Insurance Coverage Issues and Current Trends in Cyber Exposures

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Claims Made Insurance Coverage—Over 50 Years Old and Still Developing

Over the past five years, over 150 appellate cases have upheld claim denials due to either late reporting of claims or failure to use the incident reporting provision of the policy. Interestingly, the single largest group of policyholders are attorneys, who are responsible for over 50 of the denials across the United States. This is rather astounding considering the fact that Claims Made Policies have been in existence for over 50 years.

Historical Development

In 1972, California Union Insurance Company entered into a Managing Underwriter Agreement with Equity General Agents located in Los Angeles, California. This was one of the first major pro-

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Letter from the President

Donald Patrick Eckler | *Pretzel & Stouffer, Chartered*

If you are reading this publication, then you know that one of the primary strengths of the PLDF is the quality of its members and the kind of outstanding, timely, and thought-provoking content they produce.

In the last year and following our virtual annual meeting that was accompanied by a series of webinars the weeks thereafter, the organization has expanded its offerings to include committee based and other webinars. The first of those was “Insurance 101 for Young Lawyers” sponsored by the Insurance Brokers E&O Committee and presented by Fred Fisher, Louie Castoria, and Scott Neckers. Though focused on young

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If no claims were made against the insured at the time of the procurement of the policy, but the insured believes or any reasonable person would believe that a claim could be made against them that would result in a lawsuit due to an error that already occurred, then the policy would not cover the insured unless the insured disclosed the error during the application process.

grams to write professional liability on a Claims Made basis. One of the problems with Occurrence-based policies was that the policyholder's alleged error was the "Occurrence Date." Since a Professional Error might take years to give rise to any damages, policyholders would have to keep their policies available far into the future should a claim be made against them long after their Occurrence-based policy had expired. This was another benefit of Claims Made forms.

The California Union Lawyers Policy was a full prior act policy, subject to the admonition that at the time the application was signed and dated, the Insured was not aware of any error or matter that could give rise against them at some later date during the policy term. The Policy further required that the claim be first made against the insured, arising out of an error they were unaware of at the time the application was signed.

The most common insuring agreement language found in most policies from 1972 through the 1980's were similar to that found in the Cal Union form:

> "INSURING AGREEMENTS…
> 1. Coverage…
> To pay on behalf of the insured all sums which the insured shall be· come legally obligated to pay as damages as a result of any claim made against the insured or any person, firm or corporation for whom the insured is legally liable, by reason of any act, error or omission in professional services rendered or which should have been rendered by the insured, his employees or by others for whom he is liable, in the conduct of the Insured's profession as an: Attorney ….

Paragraph 3 : "Certificate Period" further required that the "claim" could be covered if:…

> (B) Prior to 'the effective date of this insurance provided the insured had no knowledge of any claim or suit, or any act, error or omission which might result "in a claim or suit, as of the date of signing the application for this insurance and there is no previous policy or policies under which the insured is entitled to indemnity for such claim or suit."

Interestingly, unlike more modern forms to come, the word "claim" was undefined in the policy, definitions of "claim" didn't start appearing until the 1980's.

One of the features of the Cal Union policy, and one which exists even

today, is the incident reporting provision. In other words, if no claims were made against the insured at the time of the procurement of the policy, but the insured believes or any reasonable person would believe that a claim could be made against them that would result in a lawsuit due to an error that already occurred, then the policy would not cover the insured unless the insured disclosed the error during the application process. Since the insured would have to disclose an error on an application, how does one cover oneself when they are disclosing something that has not yet taken place? Surely the renewing insurer or any new Insurer would decline to cover that claim should it later be made, by adding a specific Claim Exclusion Endorsement, or by declining the account. Thus, the insured has the option of reporting a potential claim/matter that could give rise to a claim at some later date and yet still be covered by the expired policy that was sent the potential claim/matter. That is a feature, also significantly evolved, that still exists today as will be discussed below.

Nonetheless, up until approximately 1976 or 1977, the first major changes took place with the addition of a prior act limitations date. Up until that time, most policies were written with full prior acts subject to the admonition that the insured was unaware of any fact or circumstance as noted above. The Prior Act Coverage Limitation essentially required that to "trigger coverage", the insured needed to meet two conditions:

1. The "Claim" must be first made against the Insured during the policy term, and
2. The "Claim" must arise from an Act, Error or Omission (now consolidated to a "Wrongful Act") subsequent to the Prior Act Date of the Policy also known as the Retroactive Date).

During the 1980s, insurance companies strengthened the incident reporting language. Up until that time, policyholders were submitting "laundry lists" of potential claims to insurance companies such as every transaction or matter they handled that year. Eventually, insurance companies started adding language to the incident reporting provision requiring that the prospective insureds identify the name of the claimant, the nature of the error, the potential damages, and any potential cause of action that might be alleged.

In 1981, policies underwent another major development in—the addition of language requiring that a claim "be first made against the insured, and that the claim must "be reported to the Company during the policy term." The first policy to use such language, however, was not a lawyer's policy but an architect and engineers policy issued by Republic Insurance Group. It was not until later in the 1980s, when American International Group (hereinafter referred to as "AIG") included similar language in its professional liability policies, that most others followed. That language has since become the norm in a majority of policies.

Underwriting Considerations, the Application and Initial Claims Analysis

For well over a Century, insurers have held that an insurance company would never want to cover a building that was already burning. When dealing with claims made policies, insurers are always concerned regarding whether the insured knew about any potential error or wrongful act, and when they knew it. This line of inquiry could have a direct impact on the issue of whether the insured was honest on an application, specifically when the insured either denied that they were aware of any fact or circumstance of a claim might be made.

In January 1995, the International Risk Management Institute published an article I authored entitled **Technical Aspects of Professional Liability Claims.** In said article, I discussed three important dates that had a direct impact on whether a particular claim was covered, or even properly disclosed on an application:

Key Dates in Claims-Made Policies

"Claims personnel must be sensitive to three important dates when determining if a claim falls within the coverage of a given policy. These dates, which may sometimes be different or the same, include:

1. The date(s) of error (whether the insured agrees there was an error or not). This is the date that the insured allegedly failed to file the lawsuit or when the broker failed to renew or order an insurance policy for a client. This date may be significant in those state jurisdictions that follow or have upheld prior act limitations on professional liability policies. ….
2. The date of "occurrence." This is the date on which an event takes place that sparks the making of the claim. This is not to be confused with the traditional insurance usage of the word "occurrence." This could be the date the claimant finds out his suit was dismissed due to the error of the lawyer. It could be the date a client had his insurance claim denied due to the absence of coverage caused by the broker's failure to renew a policy.
3. The date of first notice to the insured. This is the date when the insured first

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became aware that a claim could be or was made against him. Often, a professional liability policyholder may become aware that his error has damaged a client before the client is aware of it and before the claimant actually makes a claim against the professional.

These dates may have a profound impact on whether a claim is covered under any of the claims-made forms currently being used by underwriters. Equally true, these concepts are also used by underwriters in analyzing an application from the perspective of determining whether the probability of a claim being first made during their policy terms is within a normal range or unacceptably higher.

Given the inherent nature of a "Claims-Made Form," the aforementioned dates address the legitimate concerns of underwriters as to what the applicant knows, and when they knew it:

> Knowledge of a Professional error that any reasonable similar professional would expect could become a claim. Such a circumstance is why Incident Reporting Provisions exist, to give the insured a way to be covered later by reporting the incident at that point. This would be true even as the applicant/insured might attempt to remediate the problem.
>
> Failure to timely report a "Claim" as required by the policy.
>
> Failure to disclose such an "incident" on an application either directly by answering "No" to any such question or violating Warranty Statement that may exist in the application, often right before the signature.

Yet, as we know, still to this very day, claims are being denied due to failure to disclose them, report the claim in a timely manner and /or failure to avail oneself of the Notice of potential claims provisions. Lets be practical, the Notice-Prejudice rule is no longer being followed in a majority of States as to "Claims-Made and Reported" policies. Don't let embarrassment stand in the way of one's financial security.

Trends in Cyber Space

As we are all aware, cyber insurance provides coverage for a business entity's liability arising from the misappropriation of a customer's personal or financial information, but not surprisingly, this coverage has limitations as well. For an insurance broker, procuring cyber policies can be particularly difficult because unlike other types of coverage, such as general liability, they are not as standardized and must be particularly addressed to the special needs of the client. It is important to note that this coverage does not extend to ssuch exposures as financial loss sustained when a business is not in operation as well as hardware and software issues. This remains an emerging area, which on this basis alone could create coverage gaps regarding which an insurance broker could face liability.

A key case which illustrates this issue is *P.F. Chang China Bistro Inv. v. Federal Insurance Company*, 2016 WL 3055111 (D. Ariz. May 31, 2016). In this case, Federal Insurance Company issued a Cyber Security Policy, as the restaurant was concerned regarding the protection of credit card charges and had entered into a services contract with Bank of America, which was a standard industry practice to contract with a third party services company. Notably, this agreement obligated P.F. Chang to indemnify Bank of America for any fines or penalties imposed upon it by the various credit card companies. For a broker, this is an important consideration as the coverage needs to meet the specific requirements of the client. In June 2014, computer hackers obtained approximately 60,000 credit card numbers belonging to the restaurant's customers. As a result, Bank of America became liable to the various credit card companies for $1,929,921.57, which it demanded from the restaurant chain. After a claim was reported, Federal Insurance Company denied coverage, asserting that Bank of America did not sustain a "Primary Injury" as that term was defined in the policy. The court agreed, granting summary judgment in favor or the insurer and stating:

> Here, because the customer's information that is the subject of the data breach was not part of (Bank of America's) Record, but rather the Record of the issuing banks, (Bank of America) did not sustain a Privacy Injury. This (Bank of America) did not make a valid claim….

It is important to note that, in this type of breach, a loss of this nature—customer date—should be anticipated by the broker, based upon the nature of the client's business. It is also worth noting that the court additionally found that there was no coverage for liability which the restaurant chain had assumed from Bank of America "under any contract or agreement" as well as for any "costs or expenses incurred to form any obligation" by the restaurant chain. In light of the foregoing, when defending an insurance broker in such matters, you should consider the client's agreements and commitments to any third parties and whether there would be coverage for any responsive measures in the event of a

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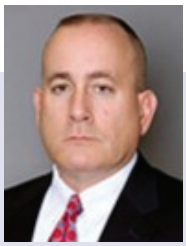

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breach, such as investigators, consultants, regulators as well as public relations firms.

Mississippi Silicon Holdings, LLC v. Axis Insurance Company, No. 20-60215 (5th Cir. Feb. 4, 2021) presents yet another example of the limitations of Cyber coverage which may not be considered by an insurance broker at the time that the policy is procured. This case involved a silicon metal manufacturing company which provided a purported vendor with a contract containing modified banking information. Notwithstanding the fact that the company utilized a verification process to determine the propriety of the request, it was later determined that a third party had breached its system, but only after over $1,000,000.00 had been paid by the company. After a resulting claim was reported, the insurance company concluded that the claim was covered, however was subject to its Social Engineering Fraud provision which only provided coverage up to a $100,000.00 sublimit and limited coverage for a loss sustained as a result of any employee of the Insured "acting in good faith and reliance" processes a transfer of funds based upon an unauthorized instruction.

For our purposes, one should recognize that this coverage award was a limited victory as the insured had asserted that the subject loss was to be covered at the full $1,000,000.00 policy limit pursuant to the Computer Transfer Fraud or the Funds Transfer Fraud provisions. The court, however, disagreed noting that the Computer Transfer Fraud provision requires that the subject loss occurs "without the Insured Entity's knowledge or consent." In this case, regrettably the insured provided its consent although under false pretenses. This factor was not enough for the court to grant the full coverage. Additionally, the Computer Transfer Fraud provision also required that the loss was created through the fraudulent entry of "information into a computer system" which the court conclude did not factually occur in these circumstances. As respects the Funds Transfer Fraud provision, the court was equally dismayed by the fact that the company's employees had authorized the disbursements which it held was dispositive of this issue and did not constitute a fraudulent transfer. In light of the foregoing, the message to be learned from this case, and therefore important for an insurance broker to consider, is that even if a client is careful and diligent, they may nonetheless be faced with limited coverage due to an applicable sublimit.

As part of this analysis, it is also worth noting that the court's recent decision in *RealPage, Inc. v. National Union Fire Insurance Company of Pittsburgh, PA and Beazley Insurance Company, Inc.*, case no. 3:19-cv-01350-B (N.D. Texas 2021) further illustrates the limitations of Cyber coverage, in this case regarding commercial crime coverage, which insur-

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ance brokers need to address with their clients. This case involved a "phishing" scam-related loss sustained by RealPage, a real estate software developer, which provided payment collection services for property managers. RealPage subsequently contracted with Stripe, Inc. to provide "software services that enable payment processing and related functions" which, in turn, would place funds in its own account prior to disbursement to the property owners.

In May 2018, certain individuals targeted a RealPage employee, altered his online credentials, and gained access to key accounts, diverting over $10,000,000.00 which was pending disbursement. After this was discovered and significant efforts undertaken to recover the stolen funds, approximately $6,000,000.00 was never recovered. RealPage thereafter filed a claim with both National Union and Beazley, its primary and excess insurers, which denied coverage on the basis that RealPage, the Named Insured on the policies, "did not own or hold" the subject funds at the time of the loss as required. Based upon this coverage determination, RealPage filed suit for declaratory judgment. The court, in applying Texas law, on summary judgment, found in favor of the insurers, ruling that RealPage did not sustain a direct loss as required pursuant to the policy terms as it was not, as Named Insured, in possession of the funds at the time. In its ruling, the court expressly stated that the "central issue to the coverage determination is whether RealPage held these funds despite its use of a third-party payment processor, Stripe, Inc." *Id*. at 1. The court continued:

> In sum, the definition of "hold" as used in the Policy cannot be reduced to an ability to direct—it requires some sort of possession of property.

Accordingly, the court found the fact that the subject funds were in a third-party account in a third-party bank which the insured could not access was dispositive of this issue. An insurance broker should therefore remain cognizant of these issues when addressing Cyber coverage with clients. ■

LGBT v. Religion: Tough Questions Ahead for the Supreme Court

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For some time, a conflict has been brewing between religious traditionalists and LGBT advocates. As more LGBT individuals have opened up about their orientations and identities, religious traditionalists have become more vocal about their beliefs regarding gender and sexuality.

Predictably, this conflict has spilled into the courts. The following is a sampling of some of these disputes:

- A funeral employee was terminated after transitioning from male to female. The funeral home owner "sincerely believed that the Bible teaches that a person's sex is an immutable God-given gift," and that he would be "violating God's commands if [he] were to permit one of [the funeral home's] funeral directors to deny their sex while acting as a representative of [the] organization" or if he were to "permit one of [the funeral home's] male funeral directors to wear the uniform for female funeral directors while at work." *EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560 (6th Cir. 2018).
- Citing his Christian beliefs, an employee refused to answer transgender-related questions in his employer's Ethics Compliance course and was terminated. *Brennan v. Deluxe Corp.*, 361 F.Supp.3d 494 (D.Md. 2019).
- An Employee Assistance Program counselor was terminated after refusing to counsel LGBT co-workers due to her religious beliefs. *Walden v. Center for Disease Control & Prevention*, 669 F.3d 1277 (11th Cir. 2012).
- An employee was terminated by his employer for refusing to sign a certification agreeing to "fully recognize, respect and value the differences among all of us." Citing his Christian beliefs, the employee believed some behavior and beliefs were deemed sinful by Scripture, and thus, he could not "value" such behavior or beliefs without compromising his own religious beliefs. *Buonanno v. AT&T Broadband, LLC,* 313 F.Supp.2d 1069 (D.Colo. 2004).
- An employee was terminated for refusing to stop displaying Bible verses condemning sodomy in response to an employer's diversity campaign posters, which featured gay employees. *Peterson v. Hewlett-Packard Co*., 358 F.3d 599 (9th Cir. 2004).

In 2020, the Supreme Court in *Bostock v. Clayton County,* 140 S.Ct. 1731 (2020) added a new wrinkle to this conflict. In a 6-3 opinion, the Court held Title VII of the Civil Rights Act of 1964 ("Title

As with many opinions, the Court answered one question only to raise new ones. In his dissent, Justice Samuel Alito warned: "The entire Federal Judiciary will be mired for years in disputes about the reach of the Court's reasoning."

VII") protects applicants and employees against discrimination because of their sexual orientation and gender identity.

As with many opinions, the Court answered one question only to raise new ones. In his dissent, Justice Samuel Alito warned: "The entire Federal Judiciary will be mired for years in disputes about the reach of the Court's reasoning." Among the new questions raised by *Bostick* are those that frequently arise from workplace disputes pitting religious freedom against LGBT rights. Indeed, it is likely the Supreme Court face two such questions sooner rather than later.

Can an Employer Legally Refuse to Hire or Retain a Gay or Transgender Individual if to do so Would Violate the Employer's Religious Beliefs?

Predictably, many would presume the answer to this question to be no, citing the 1990 Supreme Court opinion in *Employment Div. of Human Resources of Oregon v. Smith,* 485 U.S. 660 (1988). There, the Court framed the reach of the First Amendment bar against laws prohibiting the free exercise of religion. Writing for the 6-3 majority, Justice Antonin Scalia stated: "The right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes).'"

Since Title VII is a valid and neutral law of general applicability, *Smith* supports the argument that an employer's religious beliefs do not excuse compliance with the Act. Several events since *Smith* nevertheless make the continued viability of this argument far from certain.

Religious Freedom Restoration Act

In 1993, the Religious Freedom Restoration Act ("RFRA") was enacted. This Act bars the government from "substantially burden[ing] a person's exercise of religion even if the burden results from a rule of general applicability" unless the Government "demonstrates that application of the burden to the person—(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U. S. C. §§ 2000bb–1(a), (b).

Burwell v. Hobby Lobby Stores, Inc.

In 2014, the RFRA was put to the test in *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014). The owners of three closely held for-profit corporations had sincere Christian beliefs that life begins at conception and that it would violate their religion to facilitate access to contraceptive drugs or devices that operate after that point. In separate actions, they sued HHS and other federal officials and agencies under the RFRA seeking to enjoin application of the contraceptive mandate of the Affordable Care Act insofar as it required them to provide health coverage for four objectionable contraceptives.

Writing for a 5-4 majority, Justice Samuel Alito issued two consequential opinions. First, he confirmed the application of the RFRA to the owners of closely held corporations. He concluded that nothing in the language of the RFRA precluded such application.

Second, he found the contraception mandate was violative of the RFRA. He noted a less restrictive means of providing access to contraceptive drugs or devices "would be for the Government to assume the cost of providing the four contraceptives at issue to any women who are unable to obtain them under their health-insurance policies due to their employers' religious objections."

Bostick v. Clayton County

In June 2020, the majority opinion in *Bostick* left the door open to challenges to the decision based upon religious freedom. It is perhaps no accident that this opinion was written by Justice Neil Gorsuch, a staunch defender of religious freedom. Even as he was writing that Title VII's protections extended to sexual orientation and gender identity, he addressed the religious implications of the decision:

> "Separately, the employers fear that complying with Title VII's requirement in cases like ours may require some employers to violate their religious convictions. We are also deeply concerned with preserving the promise of the free exercise of religion enshrined in our Constitution; that guarantee lies at the heart of our pluralistic society."

Much of his opinion, in fact, provides a road map for future religious chal-

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