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A TRAP FOR THE UNWARY

NAVIGATING TRICKY CLAIM NOTICE ISSUES UNDER CLAIMS-MADE INSURANCE POLICIES

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In an insurance claim context, one of the worst things an insured can do is give the insurer a strong late notice defense. In certain situations, late notice can doom an insurance claim, even if the insurer has no other coverage defense. Worse yet, because late notice issues frequently turn on undisputed facts, they often can be teed up for a decisive court ruling early and inexpensively in coverage litigation. Put simply, insureds who put themselves in a late notice position gravely undermine their leverage against their insurers. Indeed, if insurers are bullish on their chances of inexpensively prevailing in coverage litigation on late notice, they won't be willing to pay significant coverage dollars in a settlement. Clearly, late notice issues should be avoided. But as the cautionary tales below demonstrate, this is sometimes easier said than done.

Notice standards under claims-made and occurrence policies

To frame our cautionary tales in their proper context, understand that business insurance policies insure risks on one of two bases: (1) claims-made; or (2) occurrence. Given the differences between these two types of policies, the standards and risks of late notice drastically vary between them.

Claims-made policies only cover claims that are first made against the insured during the policy period, even if the allegations underlying the claim pre-date the policy. Most claims-made policies also require insureds to report claims to insurers during the policy period or a fairly short time after expiration (to be precise, these are called "claims-made and reported" policies). In many jurisdictions, if the insured fails to give notice within the defined timeframe, the insurer may be able to deny coverage, even if it suffered no real prejudice. Notably, many key business insurance policies, including directors & officers, employment practices liability, and errors & omissions, are usually written on claims-made forms.

By contrast, occurrence policies cover loss if the alleged accident occurred during the policy period, even if the claim itself is first asserted after the policy period. Because claims based on facts occurring during a policy period can be asserted long after the policy period ends, occurrence policies cannot and do not impose the same strict timing requirements. Instead, notice only need be given "as soon as practicable" — an ever-moving target in the occurrence policy context. In Ohio, an occurrence policy insurer can only prevail on late notice by proving that notice was late under the circumstances and that the insurer was actually prejudiced. This is a much tougher burden for insurers to meet.

The dangers of claims-made policy provisions

Clearly, late notice landmines are much more dangerous in the claims-made context. The basic "claims-made and reported" requirement means not only that the claim must be first made during the policy period, but also reported during that period or a set period of time after the period ends (typically 30-90 days unless the insured buys a longer post-policy reporting period).

On top of that, many claims-made policies contain other provisions that make it more difficult for an insured to establish that a claim really was "first made" during the policy period:

- **"Related claims" provisions.** Broadly worded "related claim provisions" provide that if an earlier claim and a later claim arise from the same or related facts, transactions, etc., then the later claim will be deemed to have been made when the earlier claim was made. If the earlier claim was asserted before the operative policy period began, insurers will argue that the later-in-time, purportedly related claim was not "first made during the policy period," as required to trigger the insuring agreement.
- **"Prior knowledge" exclusions.** A typical "prior knowledge" exclusion excludes claims "arising out of or resulting from any actual or alleged act, error or omission" committed before the policy began if designated senior management (*e.g.*, CEO, General Counsel, CFO, etc.) "knew or could have reasonably foreseen that such act, error or omission… might be expected to be the basis of a Claim" before the policy began. This exclusion can have especially harsh effects when senior management might have at

least some general awareness of the underlying facts, even if they did not subjectively foresee the possibility of a lawsuit.

Unfortunately, these provisions have trapped many an unsuspecting insured in the unenviable negotiating and litigating position associated with late notice. Consider the following cautionary tales:

Tale #1: If they reserve rights, you better preserve insurance rights

The insured's CEO receives a letter from a customer that says, "There may be a problem with your professional services on the project, we're investigating, and we reserve our rights." The letter doesn't come from a lawyer, doesn't threaten litigation, and doesn't demand money. In fact, this letter alone may not even trigger the insurer's coverage obligations. Generally, coverage under most claims-made policies is only triggered when the insured receives a lawsuit or written demand for money or other legal relief. So, understandably, but regrettably, the insured does not send the letter to its errors & omissions policy then in effect.

15 months later — into the next E&O policy period — the customer files a $10 million lawsuit. The insured promptly tenders the lawsuit to its E&O carrier. To the insured's shock, the insurer denies coverage under the prior knowledge exclusion. Citing the customer's generic letter from the prior policy period, the insurer argues that the CEO should have foreseen that a claim might someday materialize and should have reported it under the prior policy. The insured may well lose this one.

In this scenario, the insured's safest play would have been to give immediate notice of the reservation of rights letter under the policy in effect when the letter was received. Claims-made policies allow insureds to give "notice of circumstances" (a/k/a "notice of potential claim") in situations where they learn of facts that could later lead to a claim. The policy will provide that if a notice of potential claim is given during the policy period, any later-asserted claim will "relate back" and be deemed timely reported under that policy, even if it is asserted after the policy ends.

Tale #2: No crime in asking

An insured receives a grand jury subpoena and fears that indictments might someday follow. Many D&O insurers assert that their policies only cover the costs of a criminal defense after an insured is indicted and refuse to cover pre-indictment costs. While that is a coverage topic for another article, assume that the insured anticipates the insurer's position and prefers not to push this issue and create adversity with its insurer while dealing with the burdens of a criminal investigation. In what the insured thinks is an exercise in expediency, it decides not to submit the subpoena to the insurer. Big mistake. Months after expiration of the policy in effect when the subpoena was served, the insured's CEO is indicted. Because the insured received the subpoena in the prior policy period, the D&O insurer denies coverage for the CEO's post-indictment defense costs under the prior knowledge and related claim provisions. The insured company is left advancing — from its own funds — the substantial and otherwise insurable criminal defense costs to its CEO.

Even if the insured did not want to fight the insurer's position on coverage for the subpoena, the insured should have given prompt notice of the subpoena. No sense in being bashful about submitting a claim in this situation. The worst the insurer can say is "no" and accept it as a notice of circumstances, leaving the insured free to push coverage for these proceedings (including future charges) in the future without late notice problems.

Tale #3: Hoodwinked by vague demands

An executive at the insured's outside marketing company emails the insured's management team to renegotiate the terms of their agreement. The marketing executive complains in the same email that the insured's president sexually harassed her and says that the issue "needs to be settled" in the "high seven figures." During a subsequent policy period, the complainant sues the insured. The insured tenders the lawsuit to its employment practices liability insurer. The insurer uncovers the claimant's pre-suit, pre-policy period email. Predictably, the insurer concludes that the pre-policy email and the later lawsuit are "related claims" under the related claims provision. This means the claims in the lawsuit were not "first made" during the policy period, as required to trigger the insuring agreement. The insurer denies coverage, and a federal district court sides with the insurer.

Often, but not always, pre-suit monetary demands arrive in a formal demand letter from the claimant's lawyer. Certainly, assessing insurance coverage should be top of mind whenever one gets a demand letter from a lawyer. But insureds also should think of insurance anytime a claimant threatens litigation or demands money, even if he or she is unrepresented at the time. The insured in this case simply did not make the connection because of the less formal presentation of the "claim." The insured argued in coverage litigation that the original email essentially was a business negotiation about the contract, not a demand for money that would have been a reportable claim. But the court rejected that argument, concluding instead that the reference to settling in the "high seven figures" was a written demand for money — the classic hallmark of a reportable claim.

The moral of the story

"Better late than never" might be true in many facets of life. But not so much when it comes to claims-made insurance. Because claims-made policies are so prevalent in the world of business insurance, always think proactively about notifying insurers whenever there are makings of a possible claim, even if full-blown litigation seems unlikely.

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