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Maximize recovery under your claims-made insurance policy by determining what constitutes a "related claim."

The Claim Game

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It's all part and parcel of being a risk manager. At five o'clock on a Friday, all of a sudden, a fax rolls in or an e-mail pops up on the computer screen: Somebody, somewhere, has initiated litigation against your company. In a flash, dinner reservations are rescheduled and plans pushed back so that you can review the correspondence and put your insurance company on notice of the claim. And then … you wait, secure in the knowledge that your insurance company will step in to provide a defense and, if necessary, indemnification.

All too often, however, risk managers are shocked to learn that they don't have the coverage they think they do, particularly when the policy in question is "claims-made" — providing coverage for acts that both *occur* and are *reported* to the insurance company during the time the policy is in force.

Indeed, claims-made policies, such as directors and officers (D&O) and errors and omissions (E&O) liability policies, are rife with exclusions, provisions, and conditions that can make it nearly impossible to determine which insurance policy provides coverage for a given claim and which may even provide the insurance company with an argument that there is no coverage for a given claim at all — premium payments and signed insurance policies notwithstanding.

As such, policyholders must be sure to carefully analyze their insurance policies and all available

coverage to ensure that they maximize recovery.

A Claim by Any Other Name

Claims-made policies are triggered when the policyholder (a) becomes aware of the possibility of a claim or a claim is actually brought against the policyholder; and (b) the policyholder notifies the insurance company of the claim or potential claim. Most claims-made insurance policies also contain a variation of a provision holding that once written notice of a claim has been given to the insurance company, then any claim that is subsequently made against the policyholder and reported to the insurance company that *alleges, arises out of, is based upon, is related to, or references the facts alleged in the original claim* shall be considered to be *made at the time the initial notice was given*.

When dealing with claims-made policies, policyholders must take an extremely close look at all potentially available insurance policies.

Straightforward Provisions? A Real-Life Example

At first glance, these provisions seem fairly straightforward. On January 1, 2005, the human resources manager at a large company is made aware that an employee has complained that she is being sexually harassed by a supervisor and is threatening to file suit. The company's risk manager gives notice to its employment practices liability insurance (EPLI) insurer the next day. Whether the employee files suit on January 3, 2005, or January 3, 2010, doesn't matter — the policy that was in place on the day the insurance company received notice of the sexual harassment must cover the claim.

But imagine that two more claims are leveled against the same supervisor in 2005. Another is raised in 2006. And then, on January 1, 2008, a lawsuit is filed against the company — by the supervisor, claiming that the company failed to properly investigate the claims against him and improperly denied him several promotions and pay raises based on unsubstantiated rumors. Assuming the company provides timely notice of the supervisor's claim to the insurance company, which policy will be triggered — the one in place on January 1, 2005, or the one covering January 1, 2008? And just as importantly, does it matter?

Which Policy Responds Does Matter

To answer the second question first — yes, it matters, unless the two existing policies are absolutely identical. More often than not, this will not be the case. Perhaps the 2005 policy has only $500,000 in remaining limits of liability, while the 2008 policy has $10 million in remaining limits. The policyholder may have an interest in seeing the 2008 policy triggered. On the other hand, perhaps the policyholder has already met its deductible on the 2005 policy, which means all available limits will be available to settle the supervisor's claim, whereas the 2008 policy may require the policyholder to "spend down" the deductible before a dollar of coverage is made available. Or perhaps one policy contains an endorsement that either increases or vitiates coverage.

When dealing with claims-made policies, policyholders must take an extremely close look at all potentially available insurance policies to determine which policy has the highest available limits, the best terms, and the least restrictions. You can bet your insurance company will be doing the same thing.

Which Policy Properly Applies?

Which leads us back to the first question — which policy properly applies? The answer to this question will depend upon the facts of the underlying case as well as the language of the specific "related act" provision. Generally speaking, however, most state courts have held that where actions allege *different wrongs to different parties*, arising out of *different alleged duties*, they shall not be deemed to arise out of the same acts or circumstances.

Different Wrongs, Different Victims, Different Duties = Different Claims

For example, in *Lehigh Valley Health Network v. Executive Risk Indem., Inc.*,[1] three insurance companies sought to disclaim coverage for a lawsuit against the policyholder under a claims-made policy, based, in part, on the argument that certain claims in the lawsuit had been raised in prior lawsuits.

In the first underlying claim, a surgeon (Dr. Toonder) brought suit against Lehigh Valley and sought to have another surgeon (Dr. Angelico) considered for a position at the hospital. In the second underlying claim, Dr. Angelico, having had a request for privileges declined, brought suit against the hospital and others on a variety of theories, including conspiracy.

While the underlying claims had some connection, the court held that the fact that the actions were brought by *different plaintiffs and on different theories was sufficient to create two different claims for coverage purposes*.[2]

On the Other Hand …

On the other hand, if the policy language provides a very broad definition of the term "claim," and/or the two sets of circumstances truly overlap, courts will find that the claims are interrelated. For example, in *National Union Fire Insurance Co. of Pittsburgh v. Willis*,[3] the court focused on the definition of "claim" in order to combine allegations in an original complaint and amended complaint as one "claim." In addition, the court relied on its determination that a separate underlying claim at issue in the amended complaint was "based on identical facts as those used in the original petition."[4]

Likewise, in *Continental Casualty Co. v. Cuda*,[5] the court determined that allegations against the policyholder in the amended complaint were based on facts that had been *specifically alleged in the original complaint*.[6]

Thus, in the EPLI scenario described above, a policyholder could logically argue that because the supervisor's lawsuit alleges *different wrongs to different parties*, arising out of *different alleged duties*, they should not be deemed "related." As such, the policy in place when the claim was made — the 2008 policy — would likely apply. It is conceivable, however, that the policyholder would prefer to obtain coverage under the 2005 policy, in which case, it could also argue that the underlying claims are related.

Ambiguity Must Be Construed in Favor of the Policyholder

Some risk managers express discomfort at using strategy to determine the policy from which they should seek coverage. "Shouldn't it be obvious?" they ask. "Using strategy feels like cheating." More often than not, however, it is anything but obvious whether claims are "related" or have "arisen" from the same set of facts. And if any ambiguity exists regarding the interpretation of an insurance policy, that ambiguity must be construed in favor of the policyholder pursuant to the principle of *contra proferentem*, which holds that ambiguities in a contract or an insurance policy are to be construed against the drafter.[7] Indeed, "[t]he true test is not what the parties to the [policy] intended it to mean, but what a reasonable person in the position of the parties would have thought it meant."[8]

Unfortunately, insurance companies often forget that it is their obligation to look for coverage for their policyholders, rather than to seek a reason to deny or truncate coverage. Risk managers should never make the same mistake.

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When Having Multiple Insurance Policies Equals No Coverage

A policyholder that has purchased multiple insurance policies from one insurance company will have to analyze the facts underlying the claim as well as the policies to determine which policy provides coverage for the claim. But what if the policyholder does not have continuous coverage with one insurance company? Under these circumstances, companies frequently find they are not simply fighting for the best coverage available — they are fighting for any coverage at all.

Returning to our previous scenario, imagine that on January 1, 2005, a company's human resources manager receives a letter from an employee informing the human resources department that she is being sexually harassed by a male supervisor. The employee asks for a transfer to another department, but does not threaten or otherwise reference litigation. Recognizing the potential for a future claim, the company's risk manager notifies its employment practices liability insurance (EPLI) insurer of this

potential future claim. In January 2006, the company decides it needs to cut corners and switches to a new EPLI insurer with lower premiums. In January 2008, the supervisor files his lawsuit.

In this scenario, a diligent risk manager would likely provide notice to both insurance companies — the company providing coverage when it received notice of the potential claim and the company providing coverage when the claim actually arose — feeling confident that one, if not both, policies would provide a defense and indemnity for the sexual harassment claim. That diligent risk manager, however, may be startled to learn that both insurance companies are denying coverage for the claim.

Application of Prior Notice Provision

Most claims-made policies include a "prior notice provision." A typical prior-notice provision will state that:

> The Company shall not be liable for Loss on account of any Claim *based upon, arising from, or in consequence of* any fact, circumstance, situation, transaction, event or Wrongful Act that, *before the inception date of the Policy*, was the subject of any notice given under *any policy or coverage section of which this Coverage Section is a direct or indirect renewal or replacement.*

Thus, under our scenario, the 2008 insurance company may rely on this provision to say that because the risk manager gave notice of the initial sexual harassment claim to its insurance company in 2005, there is no coverage for the supervisor's lawsuit under the 2008 EPLI policy.

The 2005 insurance company will likely argue that the two claims are separate, and in any case, the policyholder gave notice only of a potential future claim, which is not sufficient to trigger coverage under a policy that requires an event to occur and a claim to be made during the course of the policy period in order to trigger coverage. (Of course, if the policyholder had failed immediately to report the "potential future claim" to its insurance company, it would probably be barred from pursuing coverage due to late notice, but that is a topic for another article.)

Under this scenario, the company will need to demonstrate that the acts at issue are not "interrelated" and that two separate claims have been made in order to secure coverage. Careful analysis and strategy could be the difference between using or losing your company's insurance coverage.

Policyholder Must Be Proactive to Obtain Coverage

Claims, like insurance policies, can be complicated and ambiguous. Whether two alleged incidents constitute "interrelated acts" or separate incidents is often subject to opinion — and insurance companies are usually of whatever opinion saves them money. It is, therefore, crucial that companies take the time to analyze their insurance policies and the claims pending against their companies in order to determine which policy or policies will provide the maximum insurance recovery possible and how best to present the facts at issue in order to obtain this coverage. The rules of policy interpretation are in the policyholder's favor, but it is up to the policyholder to make sure these rules are acknowledged and enforced.

Endnotes

1. Civ. A. No. 1999-cv-5916, 2001 WL 21505 (E.D. Pa. Jan. 10, 2001).
2. Ibid., 2001 WL 21505, at *9. See also *National Union Fire Ins. Co. of Pittsburgh, PA v. Ambassador Group, Inc.*, 691 F. Supp. 618, 623 (E.D.N.Y. 1988) (noting that, while claims were "interrelated to the extent that they all involve[d] allegations of wrongdoing of one sort or another and relate[d], in some way" to the demise of the same company, four claims alleged against one company were legally distinct, for purposes of determining whether prior notice had been given to the company's insurance company, as they "allege[d] different wrongs to different people"); *Home Ins. Co. v. Spectrum Information Tech., Inc.*, 930 F. Supp. 825, 848 (E.D.N.Y. 1996) (finding against insurance company, which argued that three claims reported by same company arose from the "interrelated, repeated or continuous wrongful acts," and holding that various claims reported to the insurance company were factually distinct: The first claim related to alleged misstatements regarding the company's licensing agreement, the second claim related to alleged insider trading claims made by the company, and the third claim related to trading based on material nonpublic information); *Brown v. National Union Ins. Co. of Pitts., Pa.*, No. Civ. 02-4724DWFSRN, 2004 WL 292158, at *2 (D. Minn. Feb. 11, 2004) (explaining that term "related" does

not "encompass every conceivable logical relationship," because underlying claims might be "so attenuated or unusual that an objectively reasonable insured could not have expected that they would be treated as a single claim under the policy") (quoting *American Commerce Ins. Brokers, Inc. v. Minnesota Mut. Fire & Cas. Co.*, 551 N.W.2d 224, 228 [Minn. 1996]).

3. 296 F.3d 336, 342–43 (5th Cir. 2002).
4. Id. at 342 (emphasis added).
5. 715 N.E.2d 663 (Ill. App. Ct. 1999).
6. Ibid., 715 N.E.2d at 668–69.
7. See *Tolifson v. Globe Am. Cas. Co.*, 672 P.2d 983, 985 (Ariz. Ct. App. 1983).
8. See *Rhone-Poulenc Basis Chem. Co. v. American Motorists Ins. Co.*, 616 A.2d 1192, 1196 (Del. 1992) (internal citation omitted); see also *Samsel v. Allstate Ins. Co.*, 59 P.3d 281, 284 (Ariz. 2002) (stating insurance policies "may not be interpreted so as to defeat the reasonable expectations of the insured") (internal citation omitted).

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