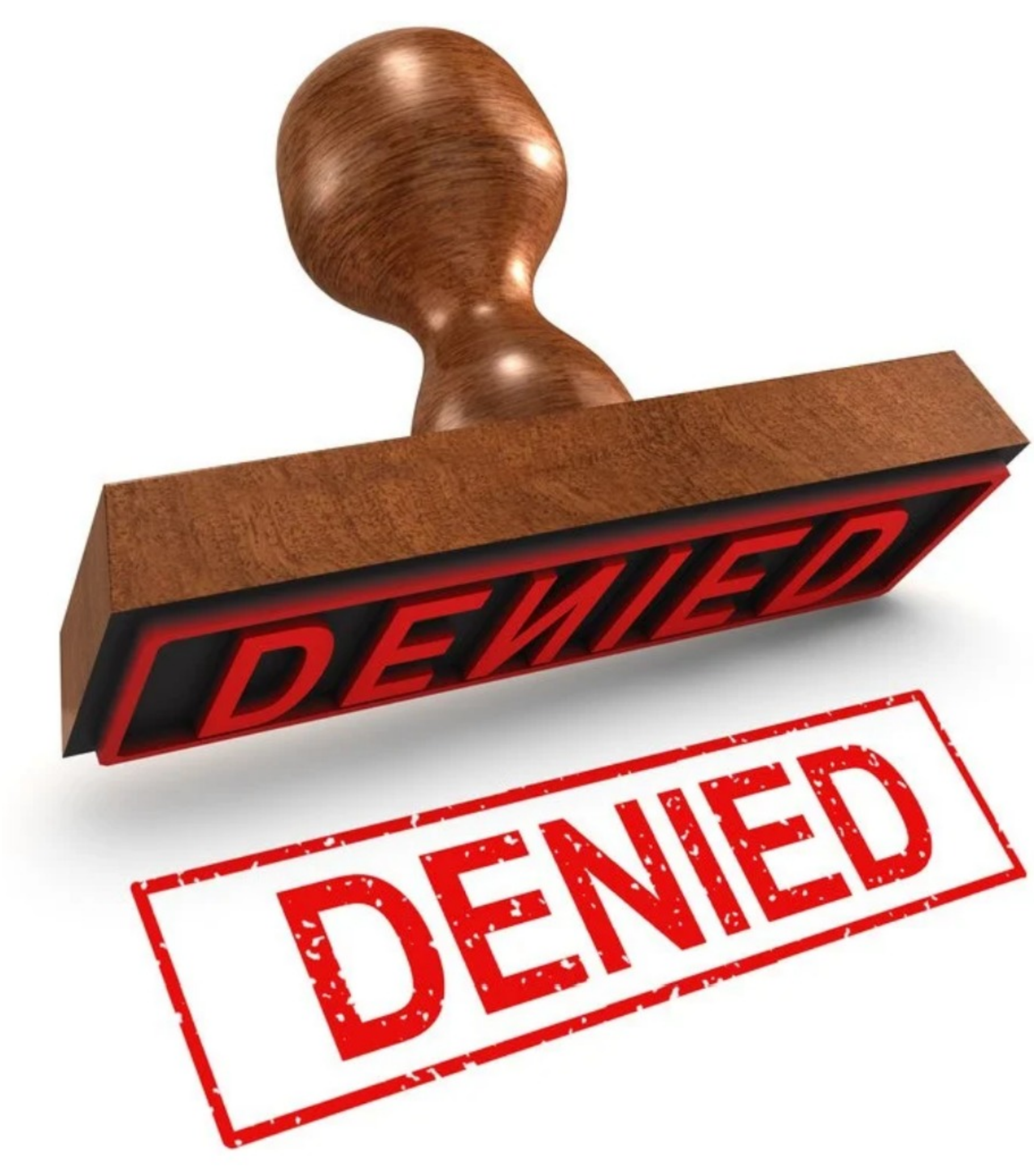
Justifiable Denial of Claims-Made-and-Reported Losses



Claims-made insurance policies have existed since at least 1964. They were designed, in part, to solve the problem of a lag between the wrongful or erroneous act of a professional, the discovery of the loss, and the time that loss is reported to the insurer.

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Claims-made policies were created to avoid the actuarial uncertainty of a claim occurring in one policy period being reported in a subsequent policy period. In essence, they provided indemnity for claims first made against the insured during the policy period.

The following quotes a five-part series I authored over a decade ago examining the history and latest developments of the claims-made form in the *Insurance Journal*.

> Yet the concept, as simple as it may seem, is in fact rather complicated, especially at or around renewal. This is because the above is consistent with a "Pure Claims Made Policy" form which, over the past 45 years, has morphed into a form that is a "Claims First Made and Reported to the Company form," possibly with Prior act limitations, and/or Prior-Pending Date limitations and many varieties of "extended reporting" extensions.[1]

Issues with Occurrence Forms and Benefits of Claims-Made Forms

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. Avoiding this necessity was one of many benefits of the claims-made forms.

Interestingly enough, and unlike more modern forms to come, the word "claim" was undefined in policies at that time. Thus, "claim" was usually judicially defined as a "demand for money or services." "Claim" definitions began to become much more prominent in the 1980s.

Applications for coverage also asked the question (in several different ways) as to whether the insured or any member of the insured's firm was aware of any act, error, or omission that might result in a claim or suit. A "yes" answer would give rise to several underwriter responses. The first would be to accept the application and do nothing further and give a quote. Such a response is highly unlikely. The second and more likely option would be for the underwriter to issue an endorsement excluding from coverage any claim arising from the incident that had just been disclosed on the application. Finally, the underwriter could elect to decline to write the account.

Of course, this begs the question, how can an insured still be protected if they know of an error that might later give rise to a claim?

The Safety Net for Insureds

One of the features of policies as early as 1972, and a feature that exists even today, is often referred to as the "incident reporting provision." In other words, no claims were made against the insured, but they believe that one could be made against them due to an error or possible error (now universally referred to as a wrongful act) that would lead any reasonable person to believe will later result in a claim or lawsuit.

Since that would have to be disclosed on an application, how does one cover oneself when they are disclosing something that hasn't 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.

The following typical language was then used.

> If, during the term of this certificate, the insured shall become aware of any occurrence which may subsequently result in a claim or suit and give notice thereof to the company, such claim or suit subsequently arising therefrom shall be covered under this certificate.

Note the lack of required items as typically specified in today's forms. This safety net feature still exists today, yet significantly evolved. The provision, nonetheless, allowed an insured, who may be aware of an error or potential claim that could be made against them later, to report that incident to an insurance company at that point in time. If a claim would later be made against the insured, even after the policy expires, the policy would still respond because the potential claim was reported during that policy term.

Obviously, the incident reporting provision has seen some evolution and was strengthened in the 1980s. Up until that time, policyholders were submitting "laundry lists" of potential claims to insurance companies. For example, a real estate broker might send a list of every transaction conducted that year as a potential claim. This was not deemed to be in "good faith" and resulted in the evolution of that specific provision. As a result, since the 1980s, to report a potential claim that may take place in the future, most incident reporting provisions of policies began requiring that several items be enumerated, such as the nature of the error, the identity of the claimant(s), how much money may be at issue, and what would be the nature of the allegations against the insured. These may vary between insurers, but in essence, these changes fortify the specific items that must be submitted with the notice-of-incident report to trigger the policy.

These additional requirements limited the ability of an insured to trigger the expiring policy and cover all potential matters they handled that year. The more limited incident reporting language appears consistently in more modern policies to this very day. One policy, however, has taken the requirements to an unusual and substandard extreme.

> The Company will determine, *in its sole discretion*, whether the NAMED INSURED's written notice satisfies the condition precedent above [emphasis added].

Claims-Made-and-Reported Forms

By 1990, policies commonly defined the word "claim" in their definitions sections. Given the many differences in definitions being used, still true today, other problems arose. Many policyholders were not reporting their claims in a timely matter. Sometimes, they did not report their claims until after a trial when a verdict had already been rendered. Occasionally, the insurance company that issued the policy that was "at risk" when the claim was first made may not have been on the risk at the time of trial, with the insured having moved coverage to another insurer. At that point in time, however, the notice prejudice role still prevailed, and the insurance company would have to show prejudice to deny coverage. In some states, to show prejudice, the insurance company would have to have shown that a different result might likely have occurred had they been notified in a timelier manner. That was a difficult burden for the insurer to overcome.

Thus, policies began moving the reporting requirement from the conditions section and included the reporting language as part of the insuring agreement. The language in the insuring agreement required that a claim "be first made against the insured" and that the claim must "be reported to the Company during the policy term." Thus, since 1981, policies began being written on a claims-made-and-reported basis, requiring that the claim be reported to the insurer during the policy term or during some short automatic reporting period of 30–60 days after policy expiration. Because the claim reporting requirement was moved from the conditions section of the policy and became part of the insuring agreement, courts started ruling that the failure to report a claim during the policy term was enforceable. As that rationale took hold, more insurers slowly followed the trend.

In the late 1980s and continuing into the 1990s, the reporting requirement was tested in the courts. States ruled that it was enforceable. Thus, to be covered under such a policy, the claim must be first made against the policy term *and be reported to the company during the policy term* in order to trigger the policy. This ultimately led to the notice prejudice rule being eliminated in a majority of states by 2020.

Another aspect of this trend was a newer condition that the "Insured must report all Claims or Lawsuits as soon as Practicable...." The term "as soon as Practicable" was interpreted as being "as soon as possible and without any inexcusable delay." Thus, a lawsuit served on an insured within a month of the policy inception yet not reported to the insurer until 8 months later might be deemed a late report if there was no reasonable basis for waiting 8 months.

Claims-Made Trigger Denials Continue

Obviously, claims-made forms have been around quite a while, and despite the evolution described above, they are the standard in the specialty and professional lines industry. Yet, it is incredible that claims continue to be denied for either late reporting, failing to disclose facts or circumstances that a claim might be made on a new or renewal application (i.e., known claims or knowledge of circumstances of a claim that could later be made), as well as ignoring the important safety net provision in every claims-made policy that has existed since at least 1972.

Obviously, there is a failure to communicate with respect to policyholders who failed to timely report a claim, failed to report a notice of circumstance, and/or failed to disclose knowledge of facts or circumstances that any reasonable person would believe would give rise to a claim. Yet, so many are shocked to find that their claim will be denied and that the denial will be upheld. This is not exactly what insurance should be about. Insurance should be a tool to place the insured back into the financial position that they were in before the loss. With some of these evolutions, insureds are instead finding that they are on their own. Yet, it is so easy to report a claim and/or a potential claim, and such situations can often be avoided.

An upcoming white paper will examine all the various claims and 140 denials that have been upheld, especially 70 of those involving lawyers. It will be a much-expanded version of this article, addressing underwriting considerations, issues with the application, and initial claims analysis. It will further provide links to summaries of court cases dealing with this topic.

Stay tuned!

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[1]Frederick Fisher, *Insurance Journal,* MyNewMarkets e-newsletter, 2009, republished in 2010.

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