CONTINUITY AND PRIOR/PENDING LITIGATION EXCLUSIONS IN THE CLAIMS-MADE POLICY FORM

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The 35-year history of the claims-made policy form has not brought it stability or standardization. In fact, claims-made forms have begun to incorporate with increasing frequency additional and exclusionary language that is unfavorable to the policyholder.

The current claims-made form is used for both professional liability (errors and omissions) and directors and officers (D&O) liability policies (in addition to others). This version of the policy evolved from two different "tracks" that are now converging with subtle yet dangerous results for insureds as well as for those who sell these forms.

Evolution of Claims-Made Provisions in D&O Forms

Directors and officers liability policies have long been issued on a "pure claims-made" basis (a phrase this writer first coined in 1990). That is, they were written with no prior act date (also known as a retroactive date). As a result, wrongful acts of the directors and officers dating back to corporate formation were covered as long as the claim was first made against the insured during the policy term. To minimize the singular risk D&O insurers were taking (i.e., “what probability exists that a claim will be first made against the insured during the policy term?”), they began using a "continuity date" and/or a "prior/pending litigation exclusionary” date that was the same as the inception date of the first policy issued. The date the insured first obtained coverage thus became known as the "first coverage date” so the "continuity date" could be honored at renewal. This was reinforced by a

warranty within the application for coverage stating that the insured was or was not aware of facts, incidents, or circumstances that could give rise to a claim in the future.

Renewal applications did not contain such warranties so as not to "break the chain of continuity," even after several years. The continuity date would often be "backdated" to the "first coverage date." Given policy language changes requiring claims be reported to the insurer during the policy term, one does have trouble reconciling the lack of a warranty statement on renewal with the requirement that claims be reported during the policy term. Solving the problem that arises if a known claim is "reported" after renewal with the chain of continuity dating back to the original application of years ago is also a problem. Worse, perhaps, was if the insured elected to move to another insurer that was willing to accept a renewal application without warranties so as not to break the chain of continuity. Simply stated, this appears absurd, given that many such policies do not define the term "continuity date" other than being the "continuity date" that appears on the declarations page!

The Continuity Date

There are numerous D&O policy forms for the privately held for-profit corporation. These policies make reference to a “continuity date," yet the definitions section of the policy form simply defines this date as “the date specified in Item XXX of the declarations page.” Without further clarification, what does that mean? And how can the chain of continuity be broken when one does not define what is meant by “continuity date” in the first place? Why would an underwriter not want new warranties every year when the policy requires claims be reported during the policy term or automatic extended reporting period (often 30 to 60 days depending on insurer)?

Only one policy found actually defines “continuity.” It is quoted in Figure 1.

FIGURE 1
"CONTINUITY" DEFINITION

The following appears in the "Exclusions" section of the policy (emphasis added).

> **4. EXCLUSIONS**
>
> The Insurer shall not be liable to make any payment for Loss in connection with any Claim made against an Insured:
> . . .
>
> (c) alleging, arising out of, based upon or attributable to as of the **Continuity Date**, any pending or prior: (1) litigation; or (2) administrative or regulatory proceeding or investigation of which an Insured had notice, or alleging any Wrongful Act which is the same or Related Wrongful Act to that alleged in such pending or prior litigation or administrative or regulatory proceeding or investigation; . . .

The following appears in the "Definitions" section of the policy (emphasis added).

> (d) "**Continuity Date**" means the date set forth in Item 6 of the Declarations with respect to each coverage.

Source: AIG Insurance Company, Private Collection policy, 76174 (6/00)

That is an understandable intent given these policies are often issued covering “wrongful acts” dating back to corporate or entity formation.

Application to Professional Liability and Convergence of the Continuity Date Concept

Now, however, we are seeing a new twist in professional liability terms and conditions. It takes the form of a prior and pending litigation exclusion that applies beginning on the inception date of the policy even where the insured has maintained prior and continuous coverage with one or more other insurers. The prior/pending concept originated with the D&O market, where—unlike the errors and omissions (E&O) market—full prior acts coverage beginning on the date of corporate formation was and is the norm. Yet this concept differs dramatically from professional liability policies. Since 1976, these policies have required evidence of prior coverage in order to obtain coverage for "wrongful acts" that took place prior to the inception date of the new policy. The "first coverage date" in professional liability policies became synonymous with the "prior act date," i.e., the date of the wrongful act. However, in D&O policies, the "first coverage date" is used for the prior and pending/continuity date, which refers to a different matter, i.e ., the date a suit is filed. It therefore seems inconsistent to use a prior/pending litigation exclusion in E&O forms since the history and approach to prior acts and "first coverage date(s)" were so different between D&O and E&O policy forms.

The Prior/Pending Date Dilemma

The usage of a prior and pending litigation exclusionary date that is the same as the inception date of an E&O policy is creating a serious, and perhaps unintended, coverage gap. This is very subtle. More and more insurers are using this exclusion when quoting and insuring professional liability/E&O liability policies as if the "first coverage date" should be used when it is the "first coverage date" for that insurer even though an earlier "prior act date” is being

honored. These insureds have not seen full prior acts coverage from date of entity formation since the mid-1970s when retroactive dates (or prior act dates) became the norm. The rationale for using one in the D&O form does not seem to justify using one in professional liability policies. The purpose of the "retro date" exclusion was and is to exclude from coverage any claim arising from a wrongful act prior to the “retro date.” It was justified as a reward for the insured who bought coverage year after year and as a penalty for those that did not.

Worse, some insurers may write a policy with the retroactive date disclosed, while others may refer to an endorsement with an absolute exclusion “buried” in what at first blush looks like a coverage enhancement endorsement. Yet the inception date of the exclusion remains undisclosed. This is an evolutionary step in the development of the claims-made form that is potentially fraught with peril for both the insurer and the insurance industry.

New Coverage Trigger Requirements

Given this new trend, determining exactly what losses a claims-made policy will respond to has become a minefield for the unwary and uninformed.

With the inclusion of prior and pending litigation exclusions (also known as P/P dates), there are now four potential conditions to trigger the claims-made provision of any policy.

1. The claim must be first made against the insured during the policy term (an act by the claimant against the insured).

2. The wrongful act must take place subsequent to any retro/prior act date (action by the insured causing injury to the claimant).

3. The claim must be reported to the insurer during the policy term or any automatic extended reporting period (a necessary item created after the insurance industry recognized the need to deal with claims that were reported late, although in good faith).

4. Prior/Pending inception date. This requires that if the claim was first made against the insured on the date a lawsuit was served (and the insured had no prior inkling that anything was awry), that lawsuit must be filed after the prior/pending date. If that date is the inception date of the policy, even with prior and continuous coverage, as well as a retroactive date of 10 years ago, there is a potential gap in coverage. This is because the prior/pending exclusionary date is absolute and does not require that the insured have actual knowledge of the suit prior to inception of the policy.

An Example

ABC Company has coverage effective January 1, 2004, and a retroactive date of January 1, 1994, but moved to a new insurer on January 1, 2004, with a prior/pending date of inception (January 1, 2004).

A suit is filed December 1, 2003, but not served until January 10, 2004. The insured had no knowledge of any error nor had the claimant or his attorney made a prior written or oral demand. In effect, a “blind” lawsuit had been filed against the insured.

There is no coverage with the new insurer due to the absolute nature of the prior/pending exclusion, thus creating a gap in coverage that is *not* supposed to happen when an insured has maintained continuous coverage for a decade!

Nor is there coverage with the insured’s prior insurer (i.e., prior to January 1, 2004), even if the lawsuit is reported to the prior insurer during their 30/60-day automatic reporting tail. This is because the

claim was *not* first made during the policy term since “claim” is often defined as a **“**written demand for money or services *received* by the insured prior to policy expiration.”

To prevent a gap of this kind, an insured could ask his corporate counsel to use the Lexis/Nexis system to do a last-minute courthouse check, just prior to expiration of the current policy. Unfortunately, such searches are not always accurate because some counties are days or even weeks behind in updating their systems. In addition, the problem is even greater if the insured has a multistate lawsuit exposure.

Turning Back the Clock

In 1975, the "prior act date" first appeared in professional liability policies. The rationale of rewarding an insured who bought continuous coverage quickly caught on and most insurers adopted this practice. Unfortunately, many would not “honor" the prior act date of another insurer. Those insurers seeking to sway insureds to move their coverage quickly found that was not going to happen unless they matched the expiring prior act date of the current insurer. Therefore, it did not take long for the industry to adopt the standard of honoring an expiring insurer’s prior act date unless there was a compelling reason, such as poor loss history, to do otherwise.

Thirty years down the road, the question now is whether market demand will create the same situation with respect to prior/pending litigation dates. The answer is maybe and maybe not. The concept of a retro date, and the manner in which it limits coverage, is relatively simple to grasp, even for insurance industry neophytes. Coupled with the requirement that a claim be made against the insured during the policy term, these two provisions give rise to only two conditions to trigger coverage. Yet, understanding the “gap” created for an unknown or “blind” lawsuit is very subtle and

only the most experienced practitioners would recognize the danger. This danger is magnified when some insurers are not even disclosing the prior/pending exclusion provision when quoting coverage for a prospective insured. It may be that only bad faith and declaratory lawsuits will force a change in industry practices, an expensive and disheartening series of events at best.

Consumer Expectations

Many consumers have long had unrealistic expectations of what is or can be covered. Striking a balance between what the consumer wants and what the insurance industry is willing to deliver has never been easy. There have, however, been many successes. For example, when entity coverage was added to a private company D&O form in 1995, it spurred the industry to eventually provide entity coverage for privately held companies and sometimes for publicly traded companies when dealing with SEC-related claims.

Perhaps the same will occur here. The solution is simple. One possibility is to add the word “known” to the prior/pending language, an approach that is consistent with the insured’s claim warranties provided within the application for coverage. The other potential solution is to backdate the prior/pending exclusionary date to one that makes sense, such as 1 year prior to the inception of the new policy. After all, how likely is it that an insured will have a claim made against it based on an unknown lawsuit filed more than 1 year from the date on which it is originally served?

The Potential “Backlash”

Absent such changes, an insured could be “bare” or devoid of coverage, when, as in the example above, they have purchased coverage for 10 years, only to be without coverage because suit was filed weeks before the policy anniversary date and served soon

thereafter. This actually happened when two such suits were *filed* before the anniversary of the policy and both *served* thereafter.

No doubt, declaratory lawsuits will be filed if such occurrences become frequent. The outcome will not be good for the industry. An appellate court could easily hold that the filing of the suit is constructive notice if it exists and therefore constitutes constructive receipt of a “written demand.” If so, the expiring insurer may be held responsible for providing coverage. On the other hand, a court could also rule that a “prior and pending" litigation exclusion violates public policy since the word “known” is absent from the policy and therefore places an unreasonable burden on the insured to search court records at the last minute, a feat impossible to accomplish even by the most diligent.

And what if a court upholds the exclusion? That spells bad news for the brokers who sold the coverage and could seriously undermine a relationship between broker and an insurer for not disclosing the problem prior to binding the policy. This is especially true for those insurers that do not disclose the exclusion in their quotes *or* the consequences of the exclusion for the unwary insured or broker. More importantly, it is often difficult enough for an insurer to make a profit on its underwriting, given claims frequency and severity suffered by its policyholders. Declaratory suits would compound the problem by adding unnecessary costs and monetary damages and ultimately reduce insurers’ bottom lines.

The Need for Better Education

A number of underwriters have recently stated to me that no one is questioning the potential adverse consequences of this practice. If true, what does that say about the average broker who provides coverage to consumers? Most professional liability policies are *not* placed by retail brokers that specialize in professional liability.

Rather, they are placed by generalists using a wholesale intermediary or by accessing a market directly. In either scenario, there is a distinct lack of awareness of the issue, which reflects a sad lack of knowledge regarding even the basics of professional liability coverage, i.e., the claims-made coverage trigger. Even specialists seem to be silent on the issue, a situation reflecting an even more troubling lack of understanding. If it takes litigation and deteriorating broker-insurer relationships in which neither can rely upon the other, than indeed we will hoist ourselves on our own petards.

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