

THE PRIOR KNOWLEDGE EXCLUSION IN CLAIMS-MADE POLICIES: OBJECTIVE OR SUBJECTIVE STANDARD?

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Virtually every professional (lawyers, doctors, architects, etc.) who is insured under a “claims-made” policy is familiar with the following scenario: After performing a professional service for its client, the client contacts the insured and expresses unhappiness or dissatisfaction over the services provided by the insured. The client does not file a formal claim or lawsuit against the professional, and perhaps does not even threaten to file a claim or lawsuit in the future, but merely expresses grave dissatisfaction with the services rendered. Weeks, months, or even years later, the professional becomes insured under a claims-made policy, covering it for claims that are first made against it during the policy period. Subsequent thereto, the “unhappy client” files a formal claim or lawsuit against the professional.

Even though, technically speaking, that claim was “first made” against the insured during the policy period, thereby satisfying the requirements of the claims-made policy, what is the impact of the prior series of communications in which the client expressed dissatisfaction with the services provided? Do those conversations, while perhaps falling short of constituting a formal “claim” as defined by the policy, nevertheless operate to preclude coverage for the formal claim made during the policy period?

Most claims-made policies contain language barring coverage for claims first made against the insured during the policy period where the insured had a “reasonable belief,” prior to the policy period, that a claim might be made against it in the future. For example:

“This policy does not apply to any claim arising out of a wrongful act occurring prior to the policy period if, prior to the effective date of the [policy]: ...

b. you had a reasonable basis to ... foresee that a claim would be made against you; ...”

Would this type of exclusionary language bar the sort of pre-policy expressions of dissatisfaction described above? Courts use a mixed subjective-objective test in answering that question, ultimately asking what a “reasonable” insured possessed of the knowledge of those facts would believe, as opposed to what that particular insured actually believed.

It is important to put this issue into its proper perspective in the context of claims-made policies. Under a “claims made” pol-

icy, coverage is triggered by the making of the claim against the insured, and the reporting of that claim to the insurer, during the policy period. By utilizing claims-made policies, insurers are able to confine the risks that are covered to only those claims that are made and reported during a specified time, thus enabling the insurers to more accurately predict risks and price coverage. The risk that is insured is the risk of claims reported during the current policy period, and the coverage is priced based on current market conditions.

As such, the notice requirements attendant to claims-made policies are of paramount importance. As a New Jersey court commented, “an extension of the notice period in a ‘claims made’ policy constitutes an unbargained-for expansion of coverage, gratis, resulting in the insurance company’s exposure to a risk substantially broader than that expressly insured against in the policy.” (*Zuckerman v. National Union Fire Ins. Co.*, 100 N.J. 304 (1985)). This interest in containing risks to those made against the insured during the policy period is equally true with respect to the insured’s knowledge of a potential claim prior to the policy period where that potentiality blossoms into an actual claim during the policy period. For that reason, many claims-made policies contain language that bars coverage for such claims, under similar language noted above.

Thus, where an insured, prior to the policy, had reason to believe that something it did would result in a claim being filed against it, many claims-made policies operate to preclude coverage for that claim when it is actually made against the insured, even during the policy period. The difficult question to ask, and the issue explored in this article, is exactly what constitutes “reasonable belief?” Certainly, most insureds, in the interests of preserving coverage, would assert that while yes, they were aware of certain circumstances, they never “in their wildest dreams” imagined that there would actually be a claim filed against them.

Is that subjective belief of the insured enough to shield it from the “reasonable belief” limitation in coverage? The answer is probably not. Courts across the country have employed a two-part test, applying both an objective and a subjective standard. Under this test:

“...the court first asks the subjective question of whether the insured knew of certain facts and then asks the objective question of whether such facts could reasonably have been expected to give rise to a claim. The reasoning behind the application of this standard is based upon the

plain language of the insurance policy—the use of both subjective and objective elements in the critical language of the policy is deemed to clearly express the parties’ intent to incorporate both components.” (*Am. Special Risk Mgmt. Corp. v. Cahow*, 286 Kan. 1134 (Kan. 2008))

In other words, under the subjective component of the test, the court will first ask whether or not the insured was actually aware of the facts or circumstances. A court will not presume that the insured must have known of the facts, or assume that because of the surrounding circumstances, the insured is deemed to have been aware. There must be actual, subjective awareness. In the hypothetical situation noted at the beginning of this Article, an actual communication between the insured and its client in which the insured expressed dissatisfaction with the services rendered would likely satisfy this subjective element. On the other hand, an insured that has no actual knowledge that it performed its services deficiently might be justified in believing that a client’s complaints are just “mere mutterings” (*General Ins. Co. v. Rhoades*, 196 F.R.D. 620 (D.N.Mex. 2000)).

Once it is established that the insured was subjectively aware of the facts giving rise to a potential claim, the test then becomes an objective one, asking whether a reasonable attorney possessed of those facts would reasonably expect those facts to result in a claim or suit (see, e.g., *Colliers Lanard & Axilbund v. Lloyds of London*, 458 F.3d 231 (3d Cir. N.J. 2006); *Selko v. Home Ins. Co.*, 139 F.3d 146 (3d Cir. Pa. 1998); *Am. Special Risk Mgmt. Corp. v. Cahow*, 286 Kan. 1134 (Kan. 2008); *Maynard v. Westport Ins. Corp.*, 208 F. Supp. 2d 568, 576 (D. Md. 2002); *Nat’l Union Ins. Co. v. Holmes & Graven*, 23 F. Supp. 2d 1057, 1066 n.7 (D. Minn. 1998); *Home Indem. Co. Manchester, N.H. v. Toombs*, 910 F. Supp. 1569, 1574 (N.D. Ga. 1995); *Smith v. Neumann*, 289 Ill. App. 3d 1056, 682 N.E.2d 1245, 225 Ill. Dec. 168 (1997); *Wittner, Poger, Etc. v. Bar Plan Mut.*, 969 S.W.2d 749, 754 (Mo. 1998) (entry of default against client together with client’s letters of complaint “was sufficient to establish a ‘basis to believe that the insured committed such act or omission’” regardless of the subjective belief of the lawyers involved).

Under this test, courts will essentially ignore the insured’s plea that although it was aware of the client’s dissatisfaction and unhappiness, it never “in its wildest dreams” believed that the client would actually file a claim or suit. The insured’s own belief that the claim lacks merit also makes no difference. Once there is a reasonable belief that

there could be a claim, the insured cannot unilaterally conclude that a claim will not be brought simply because the insured believes it lacks merit or that the client will not pursue a claim. This approach is consistent with the purpose behind claims-made policies - a subjective standard by itself could “defeat the ability of an insurance company to assess risk prior to issuing insurance” because the insured would be permitted to determine “unilaterally whether the risk is material and accordingly, whether it should be reported.” (*Mt. Airy Ins. Co. v. Thomas*, 954 F. Supp. 1073, 1079 (W.D. Pa. 1997)).

This quote from the *Colliers* case perhaps sums it up best:

“It is reasonable for the insurer to refuse coverage for claims based on preexisting but undisclosed misconduct by an insured attorney. Nor is it unreasonable to tie such an exclusion to an even-handed ‘reasonable attorney’ assessment, rather than to speculation concerning the individual attorney’s subjective understanding. The latter approach, by rewarding the attorney who is ignorant of the law, or by encouraging disingenuous, after-the-fact justifications, could result in totally capricious and unpredictable outcomes. Under the mixed standard...coverage does not turn on psychoanalysis, yet the attorney is not made accountable for matters he did not know about, nor for known matters that would not cause a reasonable attorney to foresee a claim.”

Naturally, this is a factually-specific issue rendering it difficult to apply a “cookie cutter” answer. What is clear, however, is that courts do not permit the insured to perform its own risk analysis in lieu of the insurer.



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