
Claims-Made Coverage

Claims-Made Errors and Omissions Policy's Coverage for Claims Based on "Prior Acts" the Insured Did Not Know Would Result in a Claim Does Not Apply to Class Actions Filed during Policy Period If Other Class Actions Containing Similar Allegations Predate Policy

Applicability of Prior Acts Coverage to Class Actions Was Question of First Impression

H & R Block v. American International Speciality Lines Insurance Company, 546 F.3d 937 (8th Cir. 2008)

Case at a Glance

Under Missouri law, class actions filed against nationwide tax preparer H & R Block ("Block") asserting a variety of statutory and common law claims arising out of Block's Refund Anticipation Loan ("RAL") program are excluded from "prior acts" coverage under professional liability "claims made" insurance policies because other class actions asserting similar claims were filed prior to the policy periods. The policy's requirement that the insured have "no knowledge of the prior wrongful act" or no "reasonable way to foresee that a claim might be brought" precludes coverage when the insured has enough knowledge of prior acts to foresee the coming claims. The insured need not know the specifics of the claim, i.e., who would bring the claim, when the when the act on which the claim is based took place, the specific act on which the claim is based.

Summary of Decision

Professional liability or errors and omissions insurance uniformly covers claims made during the policy period and often also requires that the claim be reported to the insurer during the policy period. To ensure against adverse selection by insureds, policies limit coverage for claims based on "Prior Acts"—claims based on wrongful acts that occurred before the policy's effective date—to claims that were not

anticipated or foreseen on the policy's effective date. Typically, the policy will cover claims based on prior wrongful acts only if the insured both (1) "had no knowledge of the prior wrongful act on the effective date of this Policy," and (2) lacked "any reasonable way to foresee that a claim might be brought." In the context of a garden variety professional claim, in which the particular claim to be anticipated by the insured is not in dispute, application of the prior knowledge/foreseeability requirement is simple and straight forward. When claims are brought in a representative capacity on behalf of an entire class, however, the requirement's application is less clear: Must the insured anticipate a specific claimant making a claim based on a specific wrongful act? Or, must insured merely anticipate that a type of wrongful conduct affecting an entire class of claimants would result in additional claims during the policy period? This was the question—a question the court said no court had addressed previously—that was before the court in the *H & R Block* case.

Factual Background. Block launched its RAL program, which provided short term loans to taxpayers who did not want to wait for their tax refunds, in the late 1980s. Between 1990 and May 1996, when Block purchased the professional liability insurance at issue, Block was named in 11 federal and state class actions arising out of the RAL program. The complaints in these cases asserted a variety of statutory and common law damage claims based on allegations that Block failed adequately to disclose finance charges, charged usurious and unconscionable interest rates, failed to disclose it received "kickbacks" from the lending banks, misled clients as to the nature of the RAL loans, and breached a fiduciary duty to its clients by peddling imprudent, high-interest loans.

Block disclosed all this litigation when in applied for and purchased second- and third-level excess policies from American International Speciality Lines Insurance Company and Lexington Insurance Company ("the excess insurers") in May 1996. Both excess insurers' policies were "follow form" policies that incorporated the coverage provisions of the underlying primary policies. The primary policies, and thus the excess policies, all contained the Prior Acts coverage language with the prior knowledge limitation typically found in claims made professional liability policies.

Eleven more class actions were filed in federal and state courts between May 1996 and August 1998, when the excess policies were in effect. The fact allegations and legal theories in these suits mirrored those of the prior class action suits. The excess insurers therefore denied coverage based on their policies' prior knowledge limitation. They did so even though the underlying primary insurers accepted coverage under the same policy provisions and paid \$1 million for each annual policy period to help settle the second wave of class actions.

Procedural History. Block sought a declaratory judgment that the excess insurers were obligated to contribute to the settlements. The trial court entered summary judgment for the excess insurers. In so ruling, the trial court adopted the excess insurers' interpretation of the prior acts language, explaining: The clause does not require [Block] to know the identity of the person(s) presenting the claim. On this record [Block] had reason to know that additional claims would be filed by *somebody* when it obtained coverage." Block appealed to the Eighth Circuit.

The Eighth Circuit's Reasoning. On appeal, Block argued that the Prior Acts coverage provision applies unless the policyholder could reasonably foresee "a specific claimant making a claim based on a specific alleged wrongful known to [the policyholder] before the inception of the policy." In order to bar an extension of coverage under the Prior Act provision, Block argued, an insurer would have to be proved to know "(a) the identity of the plaintiffs in the [various class actions], (b) the specific 'wrongful acts' upon which those plaintiffs based their claims, (c) which tax season was involved, or (d) at which facilities or in which jurisdiction the alleged wrongdoing took place." The excess insurers maintained that the RAL class actions suits filed before May 1996 gave Block both knowledge of the wrongful acts and enough knowledge to predict that additional class action claims might be filed.

In adopting excess insurer's view and affirming the trial court, the circuit court surveyed case law analyzing the prior knowledge limitation on Prior Acts coverage. Most of the case law involved particular claims and hence specific knowledge or a specific reason to predict claims. The principle guiding courts in making coverage determinations in these cases is that "the very purpose of insurance is to protect against risk of unknown but unexpected loss."

Applying this principle to determine Prior Acts coverage for a claim that a Block agent negligently prepared a particular client's tax return would have been uncontroversial. Prior Acts coverage would apply unless Block had reason to anticipate a claim by that particular client; the fact that Block had been sued for the same type of negligence by other client's prior to the policy's inception would not affect coverage. The "difficult question," noted the court, "is how to apply this principle to class actions." In deciding that the pre-policy class actions gave Block reason to foresee later similar class actions, the court looked to "the realities of the modern consumer class action" in which "class action plaintiffs must allege and undertake to prove that each class member was injured by the same wrongful act or acts." The court reasoned that, when an insured sells a product or services, such as the RAL program, nationwide, class action claims based on "uniform aspects" of the product or service and on "causes of action recognized in most or all jurisdictions" put the insured on notice that other contemporaneous clients are likely to assert similar claims alleging the same wrongful acts. The court rejected Block's contention that interpreting the Prior Acts provision "illusory." The court explained that the "doctrine of illusory coverage applies only when part of the premium is specifically allocated to a particular type or period of coverage and that coverage turns out to be functionally nonexistent." *United Fire & Casualty Co. v. Fed Title Ins. Co.* 258 F3d 714, 719 (8th Cir. 2001).

The court also rejected Block's contention that denying Prior Acts coverage for claims for which it could not have obtained Reported Acts Coverage in an earlier policy period "created and unconscionable coverage gap." Generally, Prior Act coverage goes along with "Reported Act" coverage extensions. The latter affords coverage for claims made after the policy period if an insured, during the policy, reasonably believes that a wrongful act has occurred and will result in a claim, and reports it to the carrier during the policy period. Block argued that these two policy extensions go together so that if a Reported Act Coverage Extension cannot be obtained for a policy in Year One, the insurer in Year One-Plus-One, having issued coverage of (roughly) the same coverage, should not be able to deny coverage under the Prior Act Coverage Extension. The court agreed and stated

that the two extensions “should be read together, perhaps even *in pari materia*.” While expressing some sympathy for this argument, the court found that the argument failed for lack of evidence: Block offered no evidence that the Reported Act Coverage Extension *could not* have been applied in one or more previous policy periods. Indeed, Block had failed to report the earlier class actions under its then current policies. Such evidence is an integral part of this kind of argument, in part at least, since a policyholder may not voluntarily put off reporting until a next-policy period in order to serve some purpose of its own.

Comment

There is a clearer way to distinguish the Prior Acts jurisprudence. The factual contexts of the specific knowledge or specific predictability in the cases Block cites and relies upon are not necessary conditions for justifying the applications of the principles courts utilized in those cases. They are simply patterns of facts; they are simply the factual examples in which those cases arose. There is nothing about them which entails or even suggests that relevant problems arise only in or from those fact configurations. General legal principles are not restricted to the fact typologies to which they have been usually applied. Had the general principles of product liability law first been applied to a series of blown tire cases, that fact would not restrict its subsequent application to tire cases or even to auto cases. The meanings and hence the ranges or extents of legal principles are determined by the principles themselves. // Quinn

Directors & Officers Insurance

Insured vs. Insured Exclusion in D & O Policy Is Unambiguous

Court Takes Broad View of Exclusion

Macey v. Carolina Casualty Insurance Co., __ F.Supp.2d __, 2008 WL 4906161 (D. Conn., Nov. 14, 2008)

Case at a Glance

The “insured vs. insured” exclusion is unambiguous and applies to defeat coverage for breach of fiduciary duty claims brought by former directors and officers against subsequent directors of the insured company.

Summary of Decision

An Illinois company named Community Research Associates (“CRA-Illinois”) undertook a major reorganization of its operations. This reorganization included (1) changing its state of incorporation from Illinois to Delaware and (2) effectuating a share purchase agreement with another company named Sterling Investment Partners (“Sterling”). Sterling then became the majority shareholder of the newly incorporated CRA-Delaware. During the course of the reorganization, three of the former majority shareholders of CRA-Illinois, who were also former directors and officers of CRA-Illinois, each briefly assumed a position of either director and/or officer of CRA-Delaware, in order to effectuate the reorganization plan. Once the reorganization was complete, these three persons (together “Legacy Shareholders”) became minority shareholders in CRA-Delaware and were replaced by a new set of directors (together “Plaintiffs”).

Over a year after the reorganization, the Plaintiffs approved a merger by means of which all of CRA-Delaware’s stock was sold to a third party. After the merger, neither the Plaintiffs nor the Legacy Shareholders were left with any ownership interest or management role in CRA-Delaware. The Legacy

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disclaiming, measured from the date its final letters were returned unclaimed, was unreasonable as a matter of law. The dissent disagreed, reasoning that Continental's need to carefully analyze Stradford's conduct and to consult with counsel to ensure that the company had discharged its "heavy burden" of attempting to bring about his cooperation prior to disclaiming, supported the conclusion that Continental's delay was "explained and ... reasonable under the circumstances"

The New York Court of Appeals determined that the Appellate Division's order should be modified by denying the defendants' cross motion for summary judgment. The state high court concluded that a question of fact remained regarding the amount of time required for Continental to complete its evaluation of Stradford's conduct in the two underlying actions. The court observed that in some cases, such as where an insured openly disavows its duty to cooperate, little time is needed to evaluate the relevant noncooperative conduct before disclaiming. But where the insured has punctuated periods of non-compliance with sporadic cooperation or promises to cooperate, some reasonably longer period for analysis may be warranted. In Stradford's case the reasonableness of an approximately two-month delay to analyze the pattern of obstructive conduct that permeated the insurer's relationship with its insured for almost six years presented a question of fact that precluded entry of summary judgment for either plaintiff or for defendants. // Holt

Reformation

No Insurance Policy Can Be Reformed under Rhode Island Law without Proof by Clear and Convincing Evidence of a Mutual Mistake

Rhode Island Supreme Court Rejects Trial Court's Finding of Mutual Mistake Based on Concept of "Vicarious Mistake"—Insurer's Unwillingness to Provide Coverage Insured Did Not Intend to Purchase

Merrimack Mutual Fire Insurance Co. v. Dufault, 958 A.2d 620 (R.I. 2008)

Case at a Glance

Insurer may not reform liability policy to exclude named insured's resident son on ground that named insured did not intend to purchase coverage for his son and insurer would not provide such coverage had it known the named insured's true intent. Reformation of an insurance policy is permissible under Rhode Island law only upon clear and convincing evidence of mutual mistake. If a policy provides more coverage than the insured intended to purchase, and the insurer would have issued an endorsement restricting coverage had it known of the insured's intention, the policy is not the product of "mutual" mistake. The mistake is unilateral—by the insured—and the insurer may not "vicariously" rely on the insured's mistake to argue that the policy it intended to issue would have been different had it known of the insured's mistake.

Summary of Decision

Merrimack Mutual Fire Insurance Company issued a personal umbrella policy to Ronald H. Dufault and with wife Pauline Dufault. The policy covered auto-related liability in excess of the minimum required by the Rhode Island financial responsibility law. The policy unambiguously covered the named insured's resident relatives. Since the Dufault's son, Ronald Dufault, Jr., lived with them, he unquestionably qualified as an insured under the

policy. Ronald Jr. sought coverage as a resident relative when, while driving his own vehicle, he allegedly injured one Frank Beauparlant in an automobile accident.

The issue in the ensuing coverage litigation was whether Merrimack could reform the policy to exclude Ronald, Jr., or rescind the policy as to Ronald, Jr., on the ground that the policy's extension of coverage to him was the result of a mutual mistake between the contracting parties. The trial court decided in favor of the insurer based on an agreed statement of facts suggesting that the named insureds, Ronald's parents, intended to exclude his vehicle from coverage, and Merrimack would have done so if it had known of the Dufault's intent. According to the agreed statement of facts, Merrimack biannually sent renewal questionnaires to the Dufaults, who were asked to list the members of their household and the operators of any vehicles. In the renewal questionnaire in effect at the time of the alleged injury to defendant, neither Ronald Jr. nor his vehicle was listed; instead, only the Dufaults and their two vehicles were included in the response. The parties also agreed that Ronald Jr. was not included because Ronald Sr. "intended that the personal umbrella liability [policy] only appl[y] to his own vehicles." Furthermore, the parties agreed that, if Merrimack knew that Ronald Jr. was a member of the household and owned a motor vehicle that fell short of the minimum coverage required by the policy and that Ronald Sr. did not intend to provide his son with umbrella insurance, the carrier would have issued a restricted endorsement that would have excluded Ronald Jr.

The Rhode Island Supreme Court reversed, holding that Merrimack failed to meet its burden of proving by clear and convincing evidence the existence of a mutual mistake sufficient to warrant reformation of the insurance policy and thus the trial justice's finding of mutual mistake was wrong. Initially, the supreme court explained that evidence extrinsic to the insurance policy is inadmissible in the absence of a finding by the trial court that the policy is ambiguous. Here, there was no such finding, and the supreme court found the policy clearly and unambiguously covered Ronald, Jr. Thus, the trial court improperly based its finding of mutual mistake on extrinsic evidence.

The court further noted that the evidence the

court considered did not support a finding of mutual mistake sufficient to support rescission. In order to obtain reformation, the party seeking it must prove that there was a common and mutual mistake between the two parties, "manifest in the agreement at the time it was entered into," so that the agreement itself "fails in a material respect to reflect the understanding of both parties." In addition, the party seeking reformation must prove mutual mistake by clear and convincing evidence.

Any mistake in appreciating the terms of the policy here was, in the court's view, unilateral—the Dufaults' lack of intention to cover their son's vehicle. The record contained no evidence that Merrimack intended, at the time it sold the policy to the Dufaults, to insure some, but not all of the named insured's relatives who were living in the household. To the contrary, the plain language of the policy extended coverage to relatives of the named insured who reside in the same household. Ronald Jr. squarely fell within that language, and the court refused to allow Merrimack to "retreat from the terms of the policy based on what the named insured may have intended when the policy was purchased or renewed."

The court rejected Merrimack's "endeavors to invoke a novel theory of 'vicarious mistake.'" Merrimack maintained that if it knew that Ronald Sr. did not intend for his son to be covered by the policy, then it would have issued the Dufaults a restricted endorsement that excluded Ronald Jr. from its terms. The court said "[t]his assertion evades the basic premise of mutual mistake. Merrimack may not rely on the insured's alleged mistake (or the insured's intent when buying the policy or answering a questionnaire) to modify the agreement in its favor. Rather, the parties to the contract must both be laboring under the same mutual mistake of fact at the time the agreement was made"

Comment

The Supreme Court vacated and remanded the final judgment. The trial court had actually tried the case, and the holding in the appellate court was that the insurer did not prove its case by clear and convincing evidence, once the extrinsic evidence was gone. Since mutual mistake is an issue of fact, presumably the insurer gets a new trial, if it wants it, and if the plaintiff cannot succeed on summary

judgment. Of course, the Supreme Court seems to hint that such a motion should be granted, at least on the evidence it has seen. // Quinn

UM/UIM

Guest Passenger May Stack Underinsured Motorist Benefits Available Under Her Own Policy After Recovering Such Benefits from Driver's Insurer

"Other Insurance" Provision Violates Public Policy

Generette v. Donegal Mutual Insurance Company, 957 A.2d 1180 (Pa. 2008)

Case at a Glance

An insured's waiver of the right to stack underinsured motorist benefits did not apply where she recovered first priority benefits under a policy issued to the owner of a vehicle in which she was injured while riding as a guest passenger.

An "other insurance" provision that prevented stacking of underinsured motorist benefits violated public policy and therefore was unenforceable.

Summary of Decision

Plaintiff was injured while riding as a passenger in an automobile that was struck by another vehicle. Plaintiff obtained the \$25,000 limit that was available under the third-party tortfeasor's automobile liability insurance policy. She then recovered an additional \$50,000 that was available under the underinsured motorist coverage of the policy that covered the driver of the vehicle in which she was riding. These payments did not fully compensate plaintiff for her injuries, and she sought additional benefits under the underinsured motorist coverage provided by her own automobile insurance policy. That policy contained a liability limit of \$35,000. The insurer denied coverage, asserting that plaintiff had waived the right to stack underinsured motorist benefits in exchange for a lower premium. The insurer invoked an "other insurance" clause that was included in plaintiff's

policy providing that when other insurance was available, (a) a policy providing underinsured motorist coverage for the vehicle the "insured" was occupying at the time of the injury would apply first; and (b) the maximum recovery under plaintiff's policy would not exceed the amount by which her underinsured motorist coverage limit exceeded the amount of similar coverage provided by the first-priority insurance covering the vehicle she was occupying. The insurer took the position that no underinsured motorist coverage was available under plaintiff's policy because she had already recovered \$50,000 in underinsured motorist benefits under the policy covering the vehicle in which she was riding, and that amount exceeded the limit of her own underinsured motorist coverage.

Plaintiff filed an action for declaratory relief, seeking a determination that she was entitled to recover underinsured motorist benefits under her own policy. The trial court rendered summary judgment favor of the insurer, rejecting plaintiff's argument that the "other insurance" provision and the waiver of her right to stack underinsured motorist benefits violated public policy. A state intermediate court affirmed that result.

The Pennsylvania Supreme Court reversed. Initially, the court observed that Pennsylvania's statute governing uninsured and underinsured motorist benefits expressly allows an "insured" to waive stacking of benefits. The court then determined, however, that this statutory waiver provision applied only to multiple policies held by the insured and did not extend to cases where the insured was entitled to recover benefits as a guest passenger under a policy covering a vehicle owned by another. In so ruling, the court interpreted the policy term "insured" in conformity with the statutory definition that applies generally in Pennsylvania with respect to uninsured and underinsured motorist benefits. That definition limits the scope of an "insured" to the named insured relatives of the named insured, and members of the named insured's household. The court rejected the insurer's attempt to invoke a broader statutory definition of "insured" that applies in bad faith litigation. Because the policy under which plaintiff had recovered 50,000 in underinsured motorist benefits was held by an unrelated individual and covered a vehicle that was not owned by plaintiff or her family, the court concluded that recovery of