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Six Insurance Coverage Lessons from 2016

By Robert D. Chesler and Christina Yousef

The year 2016 saw a number of decisions that are important to every risk manager and insurance professional, and should influence the way they conduct business. This article discusses six decisions that address key issues in the policy application, policy drafting and notice that are essential reading for anyone in the insurance business.

Give Notice Immediately

Templo Fuente De Vida Corp. v. National Union Fire Ins. Co. of Pittsburgh concerned a claims-made insurance policy. 224 N.J. 189 (2016). Most specialty insurance policies are claims made. As a general rule, notice of a claim outside the claims-made policy period is fatal. In *Templo Fuente*, though, the policy also contained a requirement that the policyholder provide notice "as soon as practicable." Templo Fuente gave notice six months after it received notice of a complaint, within the policy period, but without an explanation for its six-month delay.

The New Jersey Supreme Court held that an unexplained delay of six months was not "as soon as practicable," and denied coverage. When a company receives a complaint, it may not immediately think of notice; the company's first concern is defending against the claim. Delay in giving notice to the insurance company is not unusual. Now, notice must be a priority. While notice law differs dramatically among jurisdictions, late notice is always a danger.

Give Notice of Anything That Even Resembles a Claim

In *S.M. Electric Company, Inc. v. Torcon, Inc.*, SME, a contractor, sent Torcon, the construction manager, a letter in August 2008 entitled "A Request for Equitable Adjustment," which sought $15,337,068 "as compensation for the additional cost of performing the work." 2016 N.J. Super. Unpub. LEXIS 2289, *4 (N.J. App. Div. Oct. 19, 2016). Torcon did not provide notice of this letter to its insurance company. SME sued Torcon in 2010, and Torcon at that point gave notice.

Torcon's insurance company denied coverage. It argued that the August 2008 letter constituted a claim, and that the SME complaint was simply a continuation of that claim. As a result, the insurance company asserted that late notice

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barred the claim. The court agreed, and upheld the insurance company's disclaimer.

Many companies hesitate to give notice of pre-litigation claims to their insurance companies, and indeed, many companies do not recognize that a pre-litigation notice can be a claim. S.M. Electric underscores that a company must give notice to its insurance company of anything that even smells like a claim.

Read the Policy Application

An insurance company can rescind an insurance policy because of an error in the application — and a number of insurance companies did so in 2016. No case was as notorious as *H.J. Heinz Co. v. Starr Surplus Lines Ins. Co.*, 2016 U.S. Dist. LEXIS 11737 (W.D. Pa. Feb. 1, 2016). In *Heinz*, the advisory jury found that Heinz's risk manager had deliberately failed to report on the application certain prior losses in order to obtain a lower premium or self-insured retention. The court agreed and rescinded the policy. The Third Circuit recently affirmed. *H.J. Heinz Co. v. Starr Surplus Lines Ins. Co.*, 2017 U.S. App. LEXIS 510 (3d Cir. Jan. 11, 2017).

Rarely will misrepresentations be as egregious as in *Heinz*. However, an insurance company can usually rescind a policy for even negligent misrepresentations. Many companies simply do not expend enough due diligence when filling out an application for insurance coverage. Such a failure can result in rescission of the policy should a claim arise. Insurance companies will scrutinize the application to see if a mistake exists that could be the basis for rescission.

Customize Your Cyber Policy

P.F. Chang's v. Federal Insurance Co. was the first substantive decision on a so-called cyber policy, and it should serve as a wake-up call on the necessity of carefully drafting these policies. 2016 U.S. Dist. LEXIS 70749 (D. Ariz. May 26, 2016). P.F. Chang's, a restaurant chain, had a contract with a third-party servicer to manage its credit card transactions, and that company had a separate contract with a bank. The bank incurred various charges as the result of a data breach at P.F. Chang's and passed those charges onto the servicer, which passed them back to P.F. Chang's. P.F. Chang's sought reimbursement from its cyber insurance company, Federal Insurance Company. Federal had advertised its cyber policy as a "flexible insurance solution designed by cyber risk experts to address the full breadth of risks associated with doing business in today's technology-dependent world." Federal denied coverage on the basis of a contract exclusion in the policy — P.F. Chang's was contractually obligated to pay the servicer.

P.F. Chang's might have been able to avoid this result with careful policy drafting. The cyber insurance world does not have a single standardized insurance policy; rather, insurance brokers can manuscript policies. A careful review of P. F. Chang's operations may have captured this risk, and the insurance professional could have crafted a solution. Do not buy a cyber policy off the shelf. Know your operations and risks, and make sure that they are covered.

Are You a Professional?

A number of cases in 2016 concerned the extent of the professional services exclusion. In *Educ. Affiliates, Inc. v. Fed. Ins. Co.*, former students sued a for-profit educational institution company for misrepresentations in advertising the schools. 2016 U.S. Dist. LEXIS 99137, *2-3 (D. Md. July 28, 2016). The insurance company, which had issued a directors and officers policy, denied coverage on the basis of the professional services exclusions. The exclusion applied to "the rendering of . . . any professional services . . . for others." Apparently, "professional services" was not defined. The court found that the exclusion did not apply — the policyholder was marketing professional services, not rendering them. The court further found that to read the exclusion as broadly as the insurance company contended would "eviscerate" coverage.

The line between professional and ordinary services is a fine one, a gray area that can become a quagmire. Case law from different jurisdictions is difficult to reconcile. Companies must, therefore, carefully review their operations to determine if they have a professional services exposure.

Counting the Occurrences

Counting the number of occurrences may seem like counting the number of angels on the head of a pin, except that there are real-world consequences.

Selective Ins. Co. of Am. v. County of Rensselaer, concerned a class action by people who had been jailed and strip-searched. 26 N.Y.3d 649 (App. Ct. 2016). The county paid $5,000 to the lead plaintiff and $1,000 to the other members of the class, and incurred attorneys' fees of $442,701.74. The implicated insurance policies had annual per occurrence deductibles of $10,000 or $15,000.The county argued that each claim by each class member constituted one occurrence, and that a single deductible applied. The New York Court of Appeals disagreed, and held that each individual class member constituted a separate occurrence to which a separate deductible applied. As a result, when the damages were prorated across the number of class members, each member's allocated damages fell within the per-occurrence deductible, and the county obtained no recovery.

There are ways to avoid this result. For some companies, a "batch clause" may be effective. In some instances, the policyholder may be able to obtain an "aggregation clause," which states that all claims arising from a single product line or process will be deemed one occurrence. An aggregate limit on the deductible may be available. Insurance professionals must address this issue.

Conclusion

Insurance coverage law is constantly evolving, and each turn of the wheel can have direct ramifications on policyholders. Companies must not only be aware of their rights vis-à-vis their insurance companies, but must also be attuned to the pitfalls on the road to coverage.