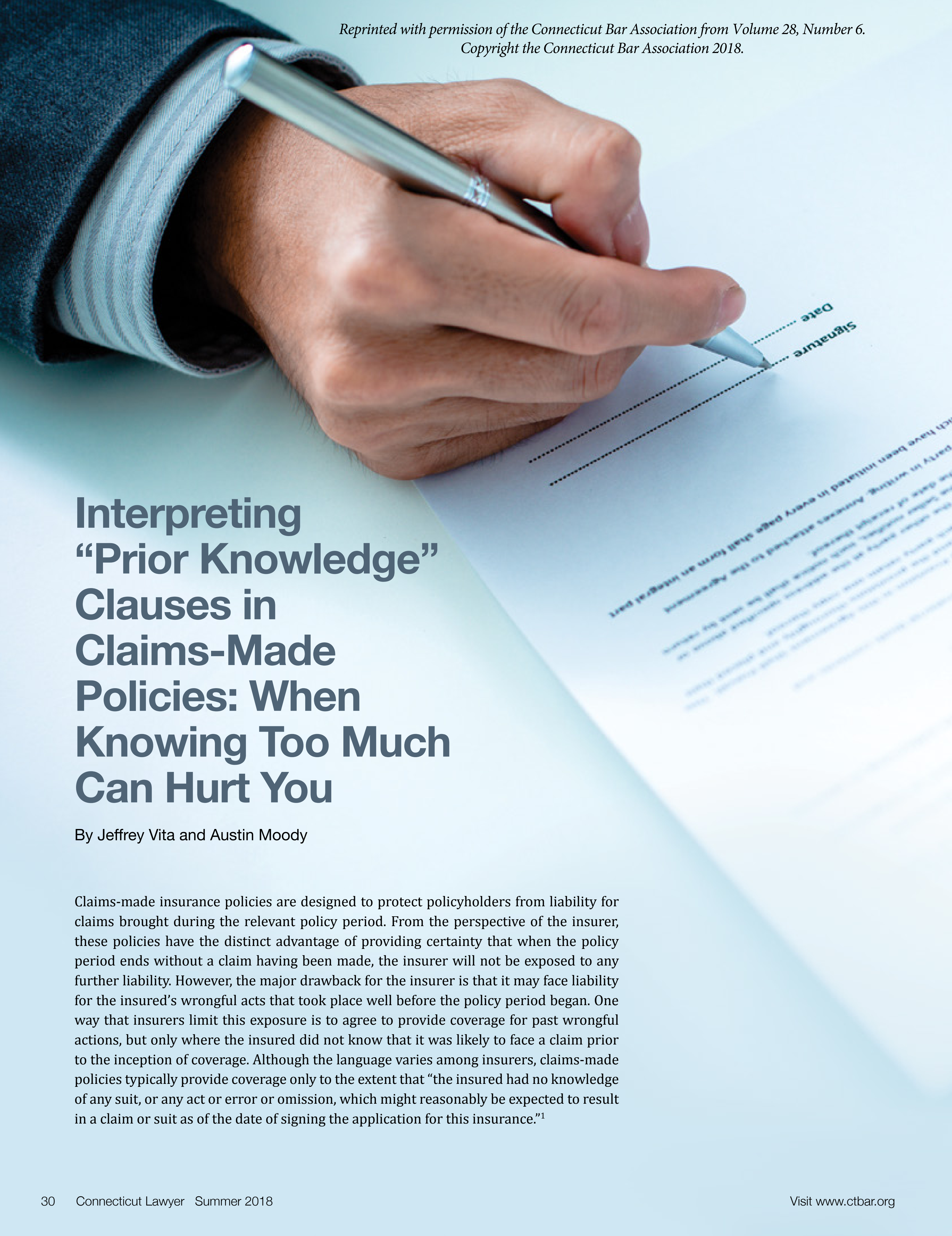

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Interpreting "Prior Knowledge" Clauses in Claims-Made Policies: When Knowing Too Much Can Hurt You

By Jeffrey Vita and Austin Moody

Claims-made insurance policies are designed to protect policyholders from liability for claims brought during the relevant policy period. From the perspective of the insurer, these policies have the distinct advantage of providing certainty that when the policy period ends without a claim having been made, the insurer will not be exposed to any further liability. However, the major drawback for the insurer is that it may face liability for the insured's wrongful acts that took place well before the policy period began. One way that insurers limit this exposure is to agree to provide coverage for past wrongful actions, but only where the insured did not know that it was likely to face a claim prior to the inception of coverage. Although the language varies among insurers, claims-made policies typically provide coverage only to the extent that "the insured had no knowledge of any suit, or any act or error or omission, which might reasonably be expected to result in a claim or suit as of the date of signing the application for this insurance."[1]

This seemingly simple language has been the subject of extensive litigation. Courts across the country frequently wrestle with the question of whether the insured had knowledge of any wrongful acts that were reasonably likely to result in a claim. As part of this determination, courts also must decide whether the relevant language excludes acts that the insured should have known would result in a claim or only those acts that the insured subjectively thought were likely to result in a claim. To help interpret this "prior knowledge" language, courts traditionally have applied one of two tests: 1) the subjective standard or 2) the objective standard. More recently, a growing number of jurisdictions, including Connecticut, have applied a new hybrid subjective-objective standard. This novel approach attempts to avoid the pitfalls of the other two tests and create a result that is fair to both the insured and the insurer.

The Subjective Standard

Under the subjective standard, the court examines what the insured actually knew at the time that it entered into the insurance contract. This standard is applied in a minority of jurisdictions and is most frequently employed when the policy does not contain the word "reasonably."[2]

For example, in *Estate of Logan by Fink v. Northwestern Nat. Cas. Co.,* the Wisconsin Supreme Court interpreted a professional liability policy that contained the following provisions:

> "1. Professional Liability and Claims Made Clause: To pay on behalf of the Insured all sums in excess of the deductible amount stated in the Declarations which the Insured shall become legally obligated to pay as damages as a result of CLAIMS *331 FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD:
> "(a) by reason of any act, error or omission in professional services....
> "PROVIDED ALWAYS THAT such act, error or omission or such personal injury happens:
> "(aa) during the policy period, or
> "(bb) prior to the policy period, provided that prior to the effective date of this policy:
> "(2) the Insured had no basis to believe that the Insured had breached a professional duty or committed a personal injury."[3]

In *Logan,* the court addressed whether the policy applied to a legal malpractice claim where an attorney failed to timely file tax returns for the estate. The attorney argued that he did not have the subjective belief that a claim would result from this failure while the insurer argued that this was irrelevant because an objective standard should apply. Despite explicitly rejecting the objective standard and applying the subjective standard, the court ruled in the insurer's favor, finding that the insured had a subjective belief that a claim was likely.[4] Notably, the policy in *Logan* did not include acts that might *reasonably* be expected to result in a claim. However, even this seemingly objective language has not prevented a minority of courts from applying a subjective standard. For example, in *Liebling v. Garden State Indem.,* the court applied the subjective standard even where the policy excluded coverage when the insured "reasonably could have foreseen" that any act, error, or omission would give rise to a claim.[5] The court held that even though the policy contained objective language, the parties must have intended for a subjective standard to apply: "[T]he 'reasonably could have foreseen' exclusion in Garden State's policy shall be deemed to mean that coverage may be denied only if the insured knew or believed that there had been a deviation from professional standards and that based on all the known circumstances it was likely that a malpractice claim would be made."[6]

The subjective standard is the most policyholder friendly test but represents the minority approach. This is likely due to the fact that the test suffers from two key deficiencies. First, as noted in *Liebling,* this standard frequently goes against the plain language of the policy. The words "reasonably could have foreseen" suggest an objective test. Secondly, it is often difficult to determine what the insured actually knew. It is much easier for the trier of fact to determine what a reasonable insured should have known in a certain situation.

The Objective Standard

The objective standard has been applied by a clear majority of courts that have considered the issue. Under the objective standard, courts will look to what a reasonable insured should have known in a given situation. They will also consider whether, given the insured's knowledge of the facts, the insured should have reasonably expected a claim to result.[7]

Courts generally apply this standard where the relevant language at issue includes the words "reasonably foreseeable," "reasonably believe," or similar language.[8] However, some courts have applied this standard even in the absence of this key policy language. Just as in the case of the subjective standard, the policy language is often instructive but it does not always dictate which standard the court will apply. For example, in *Ratcliffe v. Int'l Surplus Lines Ins. Co.,* the court held that an objective standard should apply where the policy did not provide coverage when the insured was aware of "any circumstances which might give rise to a claim being made..."[9] Even though the policy language seemed to suggest a subjective analysis, the court nevertheless refused to consider the subjective beliefs of the insured.[10]

The most common justification for the use of the objective standard is that the insured should not be given the unilateral power to decide whether a particular set of circumstances present a material risk of a claim. Instead, in order to properly manage risks, the insurer should be made aware of all circumstances that could objectively lead to a claim.[11]

Subjective-objective Standard

While the objective standard remains the majority position, in recent years, many courts, including Connecticut courts, have applied a hybrid two-pronged subjective-objective standard. Under this approach, 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."[12] Courts that have adopted this approach argue that it represents the cor-

rect interpretation of the plain language of most prior knowledge exclusions and that it avoids some of the problems caused by the other two standards.

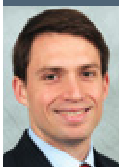
First, most prior knowledge exclusions are worded similarly to the following: the insurance coverage applies, provided that "the insured had no knowledge of any suit, or any act or error or omission, which might reasonably be expected to result in a claim or suit as of the date of signing the application for this insurance."[13] Courts that apply the subjective-objective standard divide this language into two separate clauses. The first condition in the exclusion is satisfied if the insured had actual knowledge of the relevant suit, act, error, or omission.[14] This is a purely subjective test that measures what the insured actually knew at the time that it completed the insurance application. If the insured had no subjective knowledge of the facts leading to the claim, coverage will not be excluded. However, if the insured did have subjective knowledge of these facts, the court will then consider the second condition. The second condition is satisfied if "the suit, act, error, or omission *might reasonably be expected* to result in a claim or suit."[15] This is purely an objective standard. It does not require that the insured actually expected a claim or suit. It only asks whether a reasonable professional in the insured's position might expect a claim or suit to result. This two-pronged analysis is purported to be a more accurate interpretation of the plain language of the policy. However, it is also applied in situations where the language does not clearly call for such an approach.[16]

Although Connecticut appellate courts have yet to weigh in on the issue, multiple superior courts and the United States District Court for the District of Connecticut have applied the subjective-objective standard.[17] These courts have touted the two-pronged approach as avoiding the pitfalls of the other two approaches: "the subjective-objective approach is sensible because it avoids the problems that might result from applying a purely subjective approach (e.g., 'encouraging disingenuous, after-the-fact justifications') or a purely objective approach (e.g., making a policyholder 'accountable for matters he did not know about')."[18] This "balanced" approach appears to be the real reason that the subjective-objective standard has been gaining traction in recent years. It is the only approach that considers the interests of both parties. The insured is not allowed to unjustifiably claim ignorance, but is held to a reasonable person standard when it comes to anticipating a claim. As a result, it would not be surprising to see the subjective-objective approach continue to gain traction and eventually become the majority position.

Conclusion

Whether an insured is held to have prior knowledge of a likely claim or suit in a claims-made policy setting can be largely influenced by the law of the relevant jurisdiction and the precise wording of the policy at issue. Although Connecticut insureds can expect the subjective-objective approach to continue to gain momentum in the state, they should endeavor to secure a policy that avoids words such as "reasonably" or, at the very least, establishes a clear two-pronged approach. However, regardless of the language of their policies, policyholders should proactively report all potential claims as soon they become aware of any actions, errors, or omissions that could potentially lead to covered liabilities. **CL**

Jeffrey Vita is a founding Partner of Saxe Doernberger & Vita PC, and has more than two decades of experience in pursuing insurance recoveries and crafting creative risk transfer solutions for his policyholder clients, both corporate and individuals. He routinely counsels clients on insurance and risk management issues related to the construction, manufacturing, power and energy, transportation, financial, healthcare, and real estate industries, as well as the municipal sector.



Austin D. Moody began his career as a Summer Associate with SDV and currently focuses his practice on complex litigation, with a concentration in life insurance coverage matters.

Notes

1. *See, e.g., Colliers Lanard & Axilbund v. 1 Lloyds of London,* 458 F.3d 231, 234 (3d Cir. 2006).
2. *Am. Special Risk Mgmt. Corp. v. Cahow,* 286 Kan. 1134, 1147, 192 P.3d 614, 623 (2008).
3. 144 Wis. 2d 318, 337, 424 N.W.2d 179, 185 (1988).
4. *Id.* at 338.
5. 337 N.J. Super. 447, 462-63, 767 A.2d 515, 523 (App. Div. 2001).
6. *Id.* at 462.
7. *See, e.g., Nat'l Union Ins. Co. of Pittsburgh, Pennsylvania v. Holmes & Graven,* 23 F. Supp. 2d 1057, 1066 n.7 (D. Minn. 1998).
8. *Cahow,* 286 Kan. at 1149.
9. 194 Ill. App. 3d 18, 26, 550 N.E.2d 1052, 1057 (1990).
10. *Id. See also International Ins. Co. v. Peabody Intern. Corp.,* 747 F.Supp. 477, 482 (N.D.Ill.1990) (question on insurance application asking whether insured was " 'aware of any circumstances, occurrence or condition ... which may result in the ... assertion of a claim' " was deemed to be objective, not subjective).
11. *Mt. Airy Ins. Co. v. Thomas,* 954 F.Supp. 1073, 1079 (W.D. Pa.1997).
12. *Philadelphia Indem. Ins. Co. v. Atl. Risk Mgmt., Inc.,* No. CV064018752, 2009 WL 2783073, at *6 (Conn. Super. Ct. July 30, 2009)
13. *See, e.g., Colliers Lanard & Axilbund v. Lloyds of London,* 458 F.3d 231, 233 (3d Cir. 2006).
14. *Id.* at 237.
15. *Id.*
16. *See, e.g., Selko v. Home Ins. Co.,* 139 F.3d 146, 151 (3d Cir. 1998) ("provided ... the insured neither knew nor believed that the insured had breached a professional duty").
17. *Philadelphia Indem. Ins. Co,* No. CV064018752, 2009 WL 2783073, at *6-7; *Vertrue, LLC v. Hiscox, Inc.,* No. FSTCV136019949S, 2015 WL 6405812, at *18 (Conn. Super. Ct. Sept. 17, 2015); *Maher & Williams v. ACE Am. Ins. Co.,* No. 3:08CV1191 JBA, 2010 WL 3546234, at *11 (D. Conn. Sept. 3, 2010).
18. *Philadelphia Indem. Ins. Co.,* No. CV064018752, 2009 WL 2783073, at *7 (quoting Selko at 152).

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