Claims Made and Reported Error and Omissions Policies: The Basics

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A professional needs insurance coverage for malpractice liability. While a commercial general liability (CGL) policy provides coverage for liability for bodily injury and property damage caused by an accident, it excludes coverage for liability for professional services. This is an occurrence policy.

Another option is the errors and omissions (E&O) policy, which provides coverage for malpractice and related alleged wrongdoing. E&O policies for professionals usually are sold as claims made and reported policies. At one time, some claims made policies required only that a claim be made against the insured in the policy year; there was no requirement that the claim be reported to the carrier in that year. *(Homestead Ins.* Co. *v. American Empire Surplus Lines Ins. Co.*, 44 Cal.App.3d 1297 (1996).) Now, most, if not all E&O carriers issue only claims made and reported policies.

There is a fundamental difference between a claims made and reported policy and an occurrence policy. Under a claims made and reported policy, only claims made to an insured and reported to the insured's insurance carrier during the policy period and any extended reporting period has liability coverage. In addition, the allegedly wrongful act must have taken place during the policy period or during the "prior acts" coverage period provided for in the policy. Under a CGL or other occurrence policy, there is liability coverage for bodily injury or property damage caused by an accident that results in harm to the claimant dUling the policy period, regardless of when the claim is made against the insured, reported to the carrier or when the allegedly wrongful act took place. *(Helfand v. National Union Fire Ins. Co.*, 10 Cal.App.4th 869, 888 (1992).)

The hallmark of a claims made and reported policy is that the insurance carrier's exposure ends when the policy term and any extended reporting period end, thereby providing certainty as to the insurance carrier's potential liability. If a claim is reported to an insurance carrier after the policy has expired and after any extended reporting period, the carrier can deny coverage whether or not it is prejudiced. *(Industrial Indemn. v. Superior Court,* 224 Cal.App.3d 828 (1990).) This is in contrast to CGL and other occurrence policies, in which carriers cannot defeat coverage based on a late tender or other breach of the cooperation clause, unless the carrier can show that it has been substantially prejudiced. *(Truck Ins. Exch. v.Unigard Ins. Co.*, 79 Cal.App.4th 966, 975-976 (2000).)

There are two ways insureds can protect themselves in advance: First, they can and should purchase prior acts coverage to be protected in case of a claim from work done before the policy goes into effect. Second, they can obtain coverage permitting them to report claims after the policy has expired, called an extended reporting period (ERP). Some policies include a 30 or 60 day ERP as part of the basic coverage. For an additional premium, an insured usually can purchase optional coverage allowing an ERP for up to a few years.

The reporting requirements of a claims made and reported policy can create problems for insureds and their counsel. First, at what point does a communication from an unhappy client or a third party amount to a "claim?" Policies typically define "claim." One such definition is "a written demand for civil damages or other relief." *(Westrec Marina Management, Inc. v. Arrowood Indemn. Co.,* 163 Cal.App.4th 1387, 1389 (2008).) Further, "[a] mere request for an explanation, expression of dissatisfaction, or lodging of a grievance...is not a demand." *(Westrec Marina v. Arrowood,* supra, 163 Cal.App.4th at 1392.) If the term "claim" is not defined in the policy, it is deemed to be a demand for money or services as a matter of right. *(Safeco Surplus Lines Co. v. Employer's Reinsurance Corp.,* 11 Cal.App.4th 1403, 1407 (1992).) A claim is first made against an insured when the insured receives it or has notice of it, not when the notice is transmitted to the insured.

Second, what if an insured receives a claim against it just as its policy is about to expire? Even if the insured has renewed coverage with the same carrier, in order to have coverage, the insured is required to report the claim to the carrier during the policy period in which the claim is made to the insured and any ERP.One published opinion applied a limited exception against the consequences of not reporting a claim during the policy period. In *Root v. American Equity Specialty Insurance Co.,* 130 Cal.App.4th 926 *(2005),* an attorney, unbeknownst to him, was sued by his former client two business days before the end of the policy period. The attorney had no reason to expect to be sued - he had recovered a huge settlement for his client. That day, the attorney received a call from someone claiming to be an employee of a legal journal. The attorney thought that the call was perhaps a prank or only hearsay regarding a potential claim.

A few days later, after the policy expired, the attorney read an article about the case against him in the same legal journal. The attorney then promptly reported the claim to his insurance carrier. The Court of Appeal held that there was coverage. It pointed out that the initial communication of the claim to the insured was ambiguous; the claim came at the very end of the policy period; and the insured promptly reported the lawsuit once he confirmed it by reading the article. Because of that, the court equitably excused the attorney's failure to report the claim during the policy period.

But the *Root* court emphasized "the narrowness" of its decision and that it was not adopting a requirement that the carrier be prejudiced. Because *Root* was a limited exception to the rule that a claim must be reported during the policy period, insureds should not rely on this case to report a claim late. Rather, as the policy is about to expire, report a possible claim. It is far

better to withdraw the reporting of a claim than to hope that the potential claimant's communication is not deemed to be a "claim."

Among the common exclusions are: Liability based on a dishonest, intentional, criminal, or malicious act or omission. Claims for bodily injury and property damage, unless the liability was caused by the performance of a professional service. Claims for "personal injury" are sometimes also excluded. "Personal injury" is an insurance term of art - arguably a misnomer - for torts including false arrest, defamation, invasion of the light of privacy, and discrimination. To be covered for bodily injury, property damage, and "personal injury," a professional must obtain a CGL policy. A professional also needs CGL coverage for liability stemming from non-professional activities at the premises and for such optional coverage as liability stemming from employees' use of their motor vehicles for business purposes. Claims for the return of fees. Claims for wrongful termination or other employment-related practices. CGL policies also have this exclusion. But in order to have employment-related practices coverage, a professional needs a separate employment-practices liability policy.

Additionally, the policy limits usually are reduced by defense expenses ("burning limits" policies).

Also, if a professional retires, he or she has no future coverage unless the professional purchases "tail coverage." Because retirement does not end one's exposure to malpractice claims, a professional should consider such coverage, especially if the business closes with the professional's retirement.

Many policies require that the insured consent to settle. But the carriers protect themselves with a "hammer clause." If the insured has an opportunity to settle but refuses, the carrier's liability, including defense expenses, is capped at the settlement amount.

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