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Be Aware Of Risk When Providing Notice To Multiple Insurers

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In providing notice to insurers, policyholders commonly place all potential insurers on notice without consideration as to any potential downside to doing so. A recent decision by the U.S. Court of Appeals for the Seventh Circuit serves as a stark reminder that this time-honored approach is not without risk.

In Emmis Communications Corp. v. Illinois National Insurance Co.,[1] the policyholder gave notice under both a current directors and officers policy as well as a prior-year D&O policy. The Seventh Circuit concluded, based on an exclusion in the current policy for claims "as reported" under another policy, that the policyholder's provision of notice under the prior policy in and of itself barred coverage under the current policy.

Particularly in light of this ruling, we suggest that policyholders be wary of and seek to negotiate changes to similar exclusions in advance of any claim and, in the event of a claim, we stress the importance of evaluating whether there might be an adverse impact to providing cautionary notice under multiple insurance policies and programs.

The scenario is all too familiar to policyholders. A claim is made. It potentially could be covered under insurance policies issued over more than one policy period, or under more than one type of insurance. The policyholder takes a "better safe than sorry" approach and provides notice under all potentially responsive policy periods and policy types, thinking (without evaluating pertinent policy language) that there can be no downside to doing so.

But there can be a downside — a significant one. The United States Court of Appeals for the Seventh Circuit's decision in Emmis Communications Corp. v. Illinois National Insurance Co. demonstrates the potentially significant adverse consequences that can arise for a policyholder under an inartfully drafted exclusion for claims reported under other policies of insurance. In Emmis, the policyholder's cautionary, "better safe than sorry," claims reporting strategy resulted in the unanticipated exclusion of coverage as a result of "complex" and "Byzantine" policy language.

The facts leading to the coverage dispute appear in the district court's summary judgment order.[2] The policyholder, Emmis Communications Corp., attempted a "go-private" transaction that resulted in several securities lawsuits filed in 2010. Emmis reported these lawsuits to Chubb Insurance Co., the

issuer of Emmis' directors and officers and entity liability policy for claims first made from Oct. 1, 2009 through Oct. 1, 2010, and Chubb accepted coverage under a reservation of rights.

An additional lawsuit related to the transaction was filed in February of 2011. Emmis reported the 2011 suit to its D&O insurers for the Oct. 1, 2010, through Oct. 1, 2011, policy period, including Chubb, and Chubb ultimately accepted coverage of the 2011 suit on the grounds that it was a "related claim" to the 2010 litigation.

For the policy period of Oct. 1, 2011, through Oct. 1, 2012, Emmis purchased D&O and entity liability coverage from an American International Group affiliate, Illinois National Insurance Company. The AIG policy contained an exclusion for specific events, with "Events" defined to include claims "as reported" under the Chubb policy.

While it is not uncommon for a liability policy to contain exclusions for specific events or reported claims, the definition of "Events" in the AIG policy was not tied to an explicit date cut-off. The exclusion also lacked any requirement that the "as reported" claim actually be covered by the other insurer; simply reporting the claim under another policy was argued (successfully) to be sufficient to exclude coverage under the AIG policy.

We caution against both of these omissions in the wording of a policy exclusion and underlying definition, as in this instance they opened the door to the possibility of a future claim being reported to both Chubb and AIG but accepted by neither.

In April of 2012, Emmis, its directors and officers faced a new legal challenge brought by shareholders. This 2012 litigation arose out of transactions that occurred in 2011, including one entered into as part of the settlement of the 2011 litigation. The shareholder plaintiffs alleged these 2011 transactions had the effect of Emmis gaining control of the voting rights of a majority of its preferred stock, thereby "paving the way" for another go-private attempt.

The shareholder plaintiffs further alleged these 2011 transactions were part of a scheme that was concocted and set into motion to achieve the same goals as the failed "go-private" transaction that was the subject of the 2010 and 2011 litigation.

Emmis promptly notified its broker, who in turn submitted the 2012 lawsuit to AIG and the insurers who had provided D&O and entity liability coverage in the previous two policy periods. This included Chubb, which denied coverage on the grounds that the 2012 lawsuit was not a "related claim," as defined in the Chubb policy, to the 2010 litigation.

The decision to notify Chubb, particularly in light of its previous coverage position that the 2011 litigation related to the 2010 litigation, adheres to the standard view among policyholders and legal practitioners alike that it is often "better to be safe than sorry" concerning notice.[3] Virtually all insurance policies will contain notice requirements that threaten to absolve the insurer of responsibility for any claim not tendered in a timely manner. When a loss or claim arises, policyholders typically, and understandably, take a broad position on notice to avoid having a potentially viable claim denied over a defect in notice.

The Emmis case, however, illustrates the somewhat unusual situation in which "notice" can be too much of a good thing and actually imperil coverage that would otherwise be available. Here, the decision to

notify Chubb resulted in AIG denying coverage based on the exclusion for certain claims "as reported" to Chubb.

Emmis successfully defended itself in the 2012 litigation, but in so doing incurred more than $4.1 million in defense costs. Emmis then sued AIG in the United States District Court for the Southern District of Indiana. Emmis brought claims for breach of contract and breach of the duty of good faith and fair dealing, seeking recovery of its defense costs subject to a $1 million retention. The parties subsequently filed cross-motions for summary judgment on Emmis' breach of contract claim.

The district court opinion — had it survived appellate review — would have stood as a reassuring decision for policyholders in a similar predicament as Emmis. The district court methodically compared arguments advanced by both parties about various phrasing found in the policy, often using hypotheticals to find potentially absurd results stemming from the insurer's position. Although the district court decision was overturned in the Seventh Circuit, the analysis undertaken in the lower court may provide guidance to advance similar arguments to the extent compatible with precedent in other jurisdictions.

The district court examined Indiana law regarding principles of insurance policy and general contract interpretation, and applied those principles to each of the AIG policy exclusion's three subparagraphs separately. Importantly, all three subparagraphs of the exclusion referred back to the meaning of "Events[,]" which was defined in the policy to include "[a]ll notices of claim or circumstances as reported under [the policy Chubb issued to Emmis]."

The district court started with subparagraph (1), which excluded "any payment for Loss in connection with: (1) any of the Claim(s), notices, events, investigations or actions listed under EVENT(S) below[.]" The district court decided subparagraph (1) did not apply because the definition of "Events" — specifically, the language "as reported under [the Chubb policy]" — was ambiguous and could be read in either of two ways: (1) as argued by AIG, to exclude any claim reported under the Chubb policy at any point in time or (2) as argued by Emmis, to only exclude claims that had been reported under the Chubb policy as of Oct. 1, 2011, when the AIG policy went into effect.

Agreeing with Emmis, the district court concluded that the past tense of the term indicated it referred to events that had already occurred. In addition, the district court found that AIG's position was unreasonable because it could extend to any report made by any person to Chubb at any time — including a report made by accident or made by someone other than Emmis or its agent. According to the district court, there was "simply no rational basis" for interpreting the policy so that its coverage was that precarious. Finally, the district court applied the principle that an insurance policy's terms, particularly its exclusions, that are ambiguous must be constructed strictly against the insurer.

The district court similarly interpreted the other two subparagraphs in the exclusion in favor of Emmis. The district court reiterated its findings regarding the meaning of "Events" in concluding that subparagraph (2) of the AIG policy exclusion ("any payment for Loss in connection with: […] (ii) the prosecution, adjudication, settlement, disposition, resolution or defense of: (a) Event(s); or (b) any Claim(s) arising from the Event(s)") did not apply.

The district court further construed "arising out of" in insurance policies to mean the "efficient and predominating" cause, and concluded that the existence of certain overlapping factual allegations among the three years' litigation did not mean that the 2010 and 2011 cases were the "cause" of the 2012 litigation. Regarding subparagraph (3) of the AIG policy exclusion ("any payment for Loss in

connection with: […] (iii) any Claim alleging, arising out of, based upon, attributable to or in any way related directly or indirectly, in part or in whole, to an Interrelated Wrongful Act (as that term is defined below)"), the district court parsed the AIG policy's definition of "Interrelated Wrongful Act," which included facts and wrongful acts that were "related" to "Events."

The district court acknowledged that a literal reading would exclude the 2012 litigation from coverage, but a literal reading would also cover allegations of Emmis' status as a publicly traded corporation that conducted business in Indiana. Applying similar reasoning as it had in the analysis of subparagraph (1), the district court found that it would be "nonsensical" to read subparagraph (3) so literally as to render the policy's coverage that precarious.

Having combed through the history of the various lawsuits against Emmis from 2010 through 2012, the three subparagraphs of the exclusion and the underlying policy definitions incorporated therein, and prior case law construing certain terms, the district court granted summary judgment in favor of Emmis on its breach of contract claim.[4]

AIG appealed the summary judgment ruling to the Seventh Circuit. On appeal, the parties briefed the many legal issues decided by the district court. Although the Seventh Circuit did not delve into these multiple legal issues, it characterized the exclusion's language as both "complex" and "Byzantine." Sometimes, when a court depicts insurance policy language as excessively complicated, the language at issue is held to be "ambiguous."

This determination is of particular significance in the insurance context, as courts — such as the district court in Emmis when interpreting the "as reported" term — generally apply the maxim that ambiguous insurance policy terms that could have the effect of narrowing coverage shall be construed against the insurer, as the insurer typically holds the greater bargaining power when drafting and negotiating coverage terms.

However, in this instance, the Seventh Circuit concluded that the language was neither "complex" nor "Byzantine" enough to render it ambiguous. The appellate court reversed the district court's approximately 9,000-word opinion in fewer than 500 words. Instead of enumerating the multiple arguments over interpretation raised by AIG and analyzed by the district court, the Seventh Circuit stated it could "resolve this case on a single issue: the meaning of 'as reported.'"

The Seventh Circuit held that AIG's proposed interpretation — that "as reported" excluded all notices reported to Chubb at any time — was "correct" because the phrase contained "no discernable temporal limitations." Notably, while the Seventh Circuit declined to read in a limitation as to when the claim was reported, it did effectively read in a limitation as to who reported the claim. The district court had extrapolated that a literal reading of the exclusion would subsume even claims "as reported" by a person who is neither the policyholder nor its agent.

While not explicitly referring to the district court's reasoning on this point, the Seventh Circuit's construction incorporated a requirement that the report come from the policyholder or its agent: "Once Emmis or one of its agents reports a claim to Chubb, at any time, then that claim is 'reported' — and so is excluded.... Emmis acknowledged in its brief that it did in fact report its claim to Chubb. That resolves our inquiry."

Both the painstaking analysis by the district court and the concise opinion of the Seventh Circuit offer valuable insight into the different approaches a court may take in interpreting insurance policy

language. From the perspective of a policyholder, the Seventh Circuit's decision in Emmis underscores the importance of crafting and agreeing to terms that advance the policyholder's interests. The focus on the temporal element of the past-tense phrase "as reported" suggests that Emmis may have been better served by explicitly inserting a date cut-off, such as claims "as reported by the start of the policy period."

Another approach to protect the policyholder would be to require that excluded claims be both reported to and actually covered by the other carrier. This would obviate the need to choose between two potential avenues of coverage. Neither the district court nor appellate court opinion indicate that the earlier Chubb policy offered greater coverage limits or otherwise superior terms compared to the AIG policy. It is easy, however, to imagine other scenarios in which a policyholder would prefer to seek coverage that may be less assured but otherwise more favorable.

In light of the Emmis decision, we recommend that policyholders review their liability policies to ascertain whether they contain an exclusion for reported claims that is not tied to either a specific reporting date or acceptance of coverage by the other carrier. A policyholders' outside counsel or insurance broker may be able to assist with this review and any ensuing negotiations.

Furthermore, in the event that a claim is made, we suggest prompt and attentive scrutiny to exclusions for reported claims. As demonstrated by Emmis, where an exclusion for reported claims is involved, it may jeopardize a more easily attainable source of coverage in favor of notifying insurers with a less direct path to coverage.

A policyholder in this situation may consider notifying the insurer whose policy contains the exclusion first, but hold off on notifying other carriers until or unless the first insurer denies coverage. This is a difficult situation and any action would need to take into account the interplay of the various policies' language (including their coverages, notice requirements and exclusions) as well as the circumstances of the claim that has arisen.

Again, outside counsel and insurance brokers may provide guidance in creating the appropriate strategy for a particular claim by assessing and comparing the relative likelihood and benefit of potentially available sources of coverage.

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[1] Emmis Communications Corp. v. Illinois National Insurance Co., No. 18-3392, 2019 WL 2754188 (7th Cir. July 2, 2019)

[2] 323 F. Supp. 3d 1012 (S.D. Ind. 2018)

[3] It is also plausible that the policyholder expected the use of the past tense "as reported" to refer, with sufficient clarity, to earlier claims that had already been tendered to and accepted by Chubb. After all, at least some courts have historically taken into account the tense selected in insurance policy terms in order to determine whether such terms encompassed future events. Compare Harter v. Reliance Ins.

Co., 562 A.2d 330, 337 (Pa. Super. Ct. 1989) (holding, based on use of past tense, that fraud occurring after issuance would not void policy containing language that it "is void if any insured has intentionally concealed or misrepresented any material fact or circumstance relating to this insurance"), with Tempelis v. Aetna Cas. & Sur. Co., 485 N.W.2d 217, 220-21 (Wis. 1992) (holding, despite use of past tense, that intentional concealment, misrepresentation, or false statements made after issuance would void policy that stated, "WE DO NOT PROVIDE COVERAGE FOR ANY INSURED WHO HAS: a. INTENTIONALLY CONCEALED OR MISREPRESENTED ANY MATERIAL FACT OR CIRCUMSTANCE; [or] b. MADE FALSE STATEMENTS OR ENGAGED IN FRAUDULENT CONDUCT; RELATING TO THIS INSURANCE").

[4] AIG also moved for summary judgment — successfully — on Emmis' tort claim. Although the district court sided with Emmis on the interpretation of the exclusion, it found Emmis failed to establish AIG's denial had been made in bad faith.