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NEWSLETTER

Claims-Made Professional Liability Policy Enforceable under Nevada Law

March 2007

The United States District Court for Nevada has held that claims-made professional liability policies are enforceable under Nevada law. *Prime Ins. Syndicate v. Damaso*, 2007 WL 174669 (D. Nev., Jan 19, 2007).

The insurer issued two consecutive one-year claims-made healthcare services professional liability policies to a company. The policies provided coverage only for claims:

1. Which are first made against you during the policy period; and
2. Which result from wrongful acts during the policy period.

The policies also included a warning that the policies "differ[] significantly from claims made or occurrence-type general liability policies offered by other insurance companies . . . [and include] very strict reporting requirements...."

During the first policy period, a woman died while in the care of the healthcare provider. The woman's family did not file suit against the healthcare provider until after the expiration of the second policy. The policyholder promptly reported the suit to the insurer after receiving the complaint. The insurer denied coverage and brought the instant declaratory judgment. The day after filing suit, the insurer sent the healthcare provider a check covering its defense costs to date.

The healthcare provider argued on summary judgement that claims-made policies were "'patently unfair' and contrary to the reasonable expectations of a person seeking liability insurance." The court disagreed and concluded that the policies were "clear and unambiguous" and did not "violate Nevada public policy because no prohibition against claims-made policies exists in Nevada and Nevada law specifically recognizes and defines 'claims-made' policies." In holding that the policies were unambiguous and enforceable, the court cited the warning in the policies that they provided coverage that was different from other insurance policies and required strict reporting requirements.

As to coverage for the occurrence in question, the court concluded that coverage was not available under either policy. Regarding the first policy, the court determined that there was no coverage for the incident because, although it occurred during the policy period, it was not reported to the insurer during the first policy period. The court was unmoved by the healthcare provider's argument that it could not have possibly reported

the claim during the policy period because it was not aware of the claim at the time. The court stated that "[w]hile such a requirement may seem unduly restrictive, [the policyholder] was on notice of the coverage terms and agreed to enter into the insurance contract." As to the second policy, the court held that there was no coverage because the incident neither occurred nor was reported during the policy period.

The court rejected a trio of arguments asserted by the healthcare provider based on estoppel, ratification and waiver. The healthcare provider argued that the payment of defense expenses was a concession that there was coverage. The court rejected the estoppel argument because there was no evidence that the payment was intended to induce the healthcare provider into changing its position to its detriment. Ratification was inapplicable because the healthcare provider could not show that the policies were once void and that the payment for defense costs constituted an adoption of previously void insurance policies. Regarding waiver, the court ruled that waiver only applies in the insurance context where an "insurer engages in misconduct, ... or where the insured relied on an insurer's misrepresentation." The court concluded that there was no evidence of misconduct and rejected the healthcare provider's attempt to "extend coverage over a claim the policy expressly and unambiguously excludes."