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NEWSLETTER

Court Applies Related Claims Language and Contract Exclusion to Preclude Coverage

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A Pennsylvania trial court has granted summary judgment in favor of several professional liability insurers, holding that claims filed against the policyholder during the relevant policy periods were related to pre-policy period claims and that, for the sole claim not related to the pre-policy period claims, an exclusion for obligations assumed under contract barred coverage. *Aetna, Inc. v. Lexington Ins. Co.*, 2006 WL 1462926 (Pa. Ct. Com. Pl. May 2, 2006).

The policyholder was an insurance company that operated, *inter alia*, healthcare insurance plans. The insurers issued excess professional liability insurance policies to the policyholder for the years 1999 and 2000. The 1999 and 2000 primary policies were claims-made-and-reported policies that contain similar definitions of "claim" and reporting requirements. The 1999 primary policy stated that "[a]ll claims of all persons arising out of the same act, error or omission or series of acts, errors or omissions shall be one claim and shall be deemed to have been made at the time the first of those claims is made against any insured." Similarly, the 2000 primary policy provided that "[a]ll claims of all persons arising out of the same act, error or omission or series of related acts, errors or omissions resulting from the same loss shall be one claim and shall be deemed to have been made at the time the first of those claims is made against any insured."

Numerous healthcare providers filed actions against the policyholder for improper claims handling and denial of benefits under healthcare insurance plans. The suits were consolidated in a multi-district litigation referred to as the "Provider MDL" with an action filed in 2000 as the lead case. The policyholder ultimately settled the Provider MDL in 2003 and sought reimbursement from the insurers under either the 1999 or 2000 policies for the costs it incurred in connection with the Provider MDL. The insurers denied coverage and filed summary judgment motions on the grounds that the Provider MDL claim was related to claims filed against the policyholder by other healthcare providers prior to the 1999 policy period and thus did not fall within the coverage of the 1999 or 2000 policies.

The court first held that none of the applicable policy language was ambiguous based on its review of dictionary definitions and prior judicial constructions of the undefined terms "series" and "related." The court specifically adopted the dictionary definitions of "series" as "like, related or identical things arranged or occurring in order" and "related" as "being connected; associated" or "standing in relation; connected; allied; akin." It also endorsed the judicial constructions of the same terms in *Highwoods Properties, Inc. v. Executive*

Risk Indemnity, Inc., 407 F.3d 917, 924 (8th Cir. 2005) ("A 'series' is 'a number of things or events of the same class coming one after another in special or temporal succession.'"), and *Continental Casualty Co. v. Wendt*, 205 F.3d 1258, 1263 (11th Cir. 2000). ("The plain meaning of the word 'relate' is 'to show or establish a logical or causal connection between.'")

The court next compared the allegations in the actions filed in 1999 and 2000 in the Provider MDL with the allegations in other actions filed against the policyholder in 1996 and 1998. After reviewing the allegations in the prior actions and comparing them to the allegations in the Provider MDL, the court concluded that "it is clear that all but a few of the acts complained of in the Provider MDL were the subject of" prior actions. The court held that the bulk of the allegations in the Provider MDL related back to the same wrongful acts alleged in the prior actions and, accordingly, that neither the 1999 nor the 2000 policies provided coverage for the Provider MDL.

With respect to the single category of claims against the policyholder in the Provider MDL that the court concluded was not based on acts that served as the basis for the prior actions, the court held that coverage under the 2000 Policy would be available unless an exclusion applied. The court held that the exclusion in the 2000 Policy for "liability arising out of . . . payment obligations imposed or assumed by the insured as a carrier, insurer, reinsurer, benefit plan, third party payor or under a service agreement, provider contract or purchase agreement" applied to preclude coverage. The court reasoned that the only new claims in the Provider MDL "concern its failure to pay amounts that it was required to pay to the [providers] under their Capitation Agreements" and that such claims "clearly constitute an attempt to impose liability on Aetna based on payment obligations that Aetna assumed under provider contracts," and were thus within the scope of the exclusion.

The court also rejected the policyholder's argument that, even if it was not entitled to indemnity, it should receive reimbursement for the costs it incurred in defending the Provider MDL. The court noted that both the 1999 and 2000 policies expressly state that the insurers "shall not be called upon to assume charge of the settlement or defense of any claim or suit brought, or proceeding instituted against the insured." The court reasoned that these provisions were negotiated by the parties and that, as a sophisticated insurer itself, the policyholder "may be presumed to understand the import of the defense rights its retained for itself." The court also noted that retention of the defense rights by the policyholder made sense because of the policyholder's significant self-insured retentions and primary coverage through captive subsidiaries.

The court also held that the insurer's indemnity obligations only extended to defense costs as a portion of "loss" that resulted from a covered claim. Accordingly, because there were no covered claims under the 1999 or 2000 policies, the court held that the insurers "need not pay the defense costs associated with such non-covered claims."

Finally, the court opined that, although the result seemed harsh, it was "dictated by the unambiguous terms of the Policies" and "furthers the purpose for which liability insurance exists." The court reasoned that "[l]iability insurance is intended to spread an individual's unforeseen (or at least unpreventable) risk among a pool of willing participants; it is not intended to alleviate the individual's obligation to behave rationally and to be risk

averse" and that "[o]nce an insured becomes aware that it is engaging in behavior that may result in a loss, it should adjust its behavior to avoid the loss." Applying this reasoning, the court concluded that the policyholder should have modified its behavior after the prior actions were filed and that "[i]t should not have waited to get caught in the Provider MDL and then try to make its insurers share in its (by then) foreseeable and preventable loss."