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6th Circ. Encourages Insureds To Be Open With Insurers

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A recent ruling by the U.S. Court of Appeals for the Sixth Circuit reinforces the importance of providing timely and complete notice to insurance carriers. In First Horizon Nat'l Corp. v. Houston Cas. Co.,[1] the court held that coverage was unavailable to a bank that provided a notice of a potential claim despite having received an actual claim (as defined by the claims-made policies at issue) less than a month earlier.

In 2012, the U.S. Department of Justice and other federal law-enforcement agencies commenced an investigation under the federal False Claims Act based upon allegations that the bank had submitted false claims for FHA mortgage insurance. By 2013, the DOJ had concluded that the bank had violated the False Claims Act. In 2014, the bank received an offer from the DOJ to settle the matter for $610 million. The settlement offer was conveyed via telephone and confirmed in writing in an email. About a month later, the bank provided a notice of a potential claim to its E&O insurance carriers. Under the notice provisions of those policies, notice of an actual claim had to be provided within 90 days of the expiration of the policy period. The bank's notice omitted any mention of the $610 million settlement offer or that the government had concluded that the bank had violated the False Claims Act. Instead, the notice stated that a claim or demand merely "could" result in the future. The notice emphasized the purportedly inchoate nature of the investigation, asserting that the bank was "not able to predict the eventual outcome of [the] matter," had "established no liability for [the] matter," and was "not able to estimate a range of reasonably possible loss due to significant uncertainties."

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After the applicable notice period of the policies had expired, the bank provided notice of a claim to its insurance carriers. The insurers eventually denied coverage, asserting that the 2014 email constituted a "claim" under the subject policies that was not timely reported to the insurers, because the term "claim" included "any written demand for monetary ... relief." In the coverage litigation that ensued, the Sixth Circuit affirmed the trial court's grant of summary judgment to the insurance carriers, holding that no coverage was available under the policies at issue.

The court of appeals rejected the bank's argument that the 2014 email was not a monetary demand because it did not have a forceful, threatening statement seeking money. Rather, the court held that a "demand" "need not expressly demand payment if by implication its meaning is clear." And, the court held that the 2014 notice of potential claim could not be construed as a "notice of claim." The court found "persuasive[]" the insurers' argument that "a reference to a potential 'demand or claim' conveys to any reasonable reader that no actual 'demand' or 'claim' exists." The court also rejected the bank's argument that the insurers waived the late notice defense. In that regard, the court noted that the bank had assured the insurers that no demand existed, and that the insurers could not "waive anything that [the bank] had concealed from them."

Brokers and insurance carriers often emphasize to policyholders the importance of providing timely and adequate notice. This is because a failure to provide timely notice may result in a forfeiture of coverage. This is particularly so for "claims-made-and-reported" policies with strict reporting requirements, which are common in the professional liability markets. Nearly all states that have considered the issue have determined that a failure to provide timely notice under a claims-made-and-reported policy vitiates coverage, regardless of whether an insurance carrier is "prejudiced" by the late reporting. This is distinct from "occurrence"-based insurance policies — common in the general liability markets — for which many states impose a requirement that the insurance carrier be "prejudiced" by the denial of coverage.

Nevertheless, some policyholders may be of the view that they should limit the number and content of notices provided to insurance carriers in the hopes that doing so will enable them to secure lower premiums on renewal policies. In so doing, policyholders may attempt to submit notices containing "broadly phrased, innocuous, or nonspecific statements," in order to "disguise potential claims so that they would be covered by insurance well into the future while not drawing attention to conduct that might increase future premiums, or terminate coverage altogether."[2]

The First Horizon case demonstrates the perils of such an approach. In the short-term, the bank in First Horizon may have avoided an increase in premiums in its renewal policies by downplaying the significance of the DOJ's investigation at the time it submitted the notice. As demonstrated by the First Horizon case, that view would have been a myopic one. In actuality, the bank would have been better served if it had submitted a notice of the $610 million settlement offer. Had the insurers agreed with the bank's apparent conclusion that the offer did not constitute a monetary demand, the policyholder would have been no worse off from a coverage perspective. Instead, the bank chose to submit only a notice of a potential claim, which in fact emphasized that no claim had been made. As the First Horizon court put it, the insurers could not be held responsible for failing to learn information that the bank had "concealed from them." Although the First Horizon court did not decide whether the insured in fact was subjectively motivated to omit crucial information

in the attempts of securing a lower renewal premium, if that were so, the bank's plan clearly backfired.

Policyholders, insurers, and brokers do not benefit from an approach that incentivizes insureds to disguise crucial facts about claims that may be covered under insurance policies. The First Horizon court's approach will incentivize insureds to take a more practical, constructive approach: open communication with their insurance carriers, and good-faith attempts to resolve disputed issues of liability and coverage. Such an approach helps both insureds and insurers, and has the added benefit of being the right thing to do.

[1] First Horizon Nat'l Corp. v. Houston Cas. Co., — Fed. App'x —, No. 17-5767/5844, 2018 WL 3359555 (6th Cir. July 10, 2018)

[2] Sigma Fin. Corp. v. Am. Int'l Specialty Ins. Co., 200 F. Supp. 2d 710, 718-20 (E.D. Mich. 2002).