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NEWSLETTER

Under New Jersey Law, “Reasonable Expectations” of the Parties May Operate to Void Policy Language

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A federal district court in Minnesota, applying New Jersey law, has held that the reasonable expectations of the insured may operate to void policy provisions governing the assignment of a claim to a particular policy period. *See St. Paul Mercury Ins. Co. v. JBA Int'l, Inc.*, 2003 WL 22272120 (D. Minn. Sept. 30, 2003). The court also made rulings on motions for summary judgment concerning the alleged bad faith refusal to settle on the part of the insurer.

Beginning on June 30, 1997, the insurer issued three consecutive one-year errors and omissions policies to a computer software company. The policies provided coverage for "claims or suits for covered loss...first made or brought while this agreement is in effect." The policies contained a retroactive date of October 31, 1994. The policies further provided that the insurer would deem a claim to be first made or brought on the earliest of the following dates: the date the insured received written notice of suit; the date the insured provided a notice of potential claim stemming from its error; or the date the insured could reasonably foresee that a claim or suit would be brought. The policies also contained an excess insurance clause stating that "[w]hen this agreement is excess insurance, we'll have no duty to defend any claim or suit that any other insurer has a duty to defend. However we'll defend a claim or suit for covered loss if the other insurers won't."

The company sought coverage from the insurer for three lawsuits. The first lawsuit was brought against the company in December 1997. The insurer deemed the claim to have first been made prior to June 30, 1997 and denied coverage. A second lawsuit was brought against the company in June 1999. After investigation, the insurer deemed the claim to have first been made in the 1997-1998 policy period and denied coverage because the applicable limits for that policy period had been exhausted. A third lawsuit was brought after the third policy had expired, during the extended reporting period, and the insurer refused to contribute to a settlement within the deductible of the policy being provided by a second insurer. The company sued the insurer, contesting the insurer's determinations as to when the first two claims had first been made and alleging a bad faith refusal to settle in connection with the second and third lawsuits. The insurer moved for summary judgment on a number of issues.

The district court denied the insurer's motion for summary judgment that its determination as to when the claims were made was correct. Although the court agreed that the language of the policy unambiguously supported the insurer's position and although the court rejected the company's argument that the insurer had made misrepresentations that estopped it from denying coverage, the court held that the company had raised an issue of fact as to whether applicable policy terms were inconsistent with its reasonable expectations in light of the October 31, 1994 retroactive date. The court based its holding on a decision by the New Jersey Supreme Court finding that the absence of retroactive coverage in a claims-made policy does not comport with the reasonable expectations of a policyholder. *See Sparks v. St. Paul Ins. Co.*, 495 A.2d 406 (N.J. 1985). The district court reasoned that because the policy defined "Claim" to preclude coverage for a claim or suit that was resonably forseeable prior to the inception of the policy, "the policy's definition of when a claim is first made effectively eliminates retroactive coverage." However, the court also declined to rule at the summary judgment stage of the case whether the elimination of retroactive coverage was reasonable and expected when the company purchased the policy. The court also rejected the insurer's argument that the fact that the company purchased the policy through a broker precluded reliance on the reasonable expectations defense, explaining that such an argument would hold sway only if the policy was "actually negotiated or jointly drafted."

The district court granted the insurer's motion for summary judgment as to violations of the New Jersey Consumer Fraud Act in connection with the negotiation of the initial policy based on alleged misrepresentations concerning the scope of coverage. The court explained that the Consumer Fraud Act allows a plaintiff to recover "any ascertainable loss of money." Here, since the insurer had paid out the entire limits under the first policy and there was no allegation concerning misrepresentations about the amount of coverage available under that Policy, the court concluded that there was no ascertainable loss.

The court also made rulings on the insurer's motion for summary judgment with respect to the bad faith claims made by the company based on the insurer's failure to settle the second and third lawsuits. The company alleged that at two points in time the insurer had failed to settle the second lawsuit. The court declined to rule on the argument with respect to the first opportunity to settle, reasoning that it could not determine on the existing record whether the refusal to settle "was thoroughly honest, intelligent, and objective." With respect to the second opportunity to settle that case, the court noted that it came after the insurer had placed that claim in the 1997-1998 policy period at a point when coverage was exhausted. Accordingly, since the refusal to settle was based on a denial of coverage, the court reasoned that the refusal should be evaluated based on whether the insurer's decision to deny coverage was "fairly debatable," which the court held that it was. The court therefore granted the insurer summary judgment with respect to the second opportunity to settle.

The court also granted the insurer's motion for summary judgment concerning its refusal to settle the third case, which settled within the deductible of a second insurer's policy. The court rejected the company's argument that the amount not paid by the other insurer should have been funded, reasoning that the plain language of the other insurance clause supported the insurer's conclusion that it had no obligation to pay the deductible of another insurer's policy.

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