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NEWSLETTER

Nationwide Litigation Over “Tier Rating” Constitutes One Claim; Court Also Addresses Other Common Professional Liability Issues

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The United States District Court for the Eastern District of Wisconsin, applying Wisconsin law, has recently addressed several professional liability coverage issues in granting in part and denying in part cross summary judgment motions of a professional liability insurer and insured. *Am. Med. Security, Inc. v. Exec. Risk Specialty Ins. Co.*, 2005 WL 2449691 (E.D. Wis. Sept. 30, 2005). The district court held that nationwide litigation over the insured's use of "tier rating" when renewing group health insurance policies constituted a single claim under a series of professional liability policies, triggering only one policy period. Wiley Rein & Fielding LLP represented the insurer in the case.

The court also held:

- The policies' retroactive dates did not trump the Inception Dates in the "prior and pending litigation" exclusions;
- A prior administrative proceeding involving "similar" types of, but not "the same," issues did not bar coverage under the "prior and pending litigation" exclusions;
- No coverage existed for benefits due under an insurance policy for costs of complying with non-monetary/injunctive relief because those costs were not covered "Loss;"
- The "profit, remuneration or advantage" exclusion precluded coverage for premiums the insured was required to return to its present and former group policyholders; and
- The liability insurer did not waive its right to recover non-covered portions of the defense expenses it had paid to the insured simply because it had not required a written undertaking at the time when defense costs were first advanced.

The insurer issued a series of claims-made managed care E&O policies to a health insurance plan underwriter effective between 1998 and 2002. The retroactive date of the 1999-2002 policies was amended to January 1, 1983. The policies contained "prior and pending litigation" exclusions barring coverage for "Loss, including Defense Expenses . . . based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving" facts, circumstances or Wrongful Acts "underlying or alleged in any litigation or

administrative or regulatory proceeding brought prior to and/or pending as of the Inception Date." The "Inception Date" under the policies was September 25, 1998.

The policies also provided that "Related Claims . . . shall be deemed to be a single Claim . . . first made on . . . the date on which the earliest Claim within such Related Claims was received by an Insured." Under the policies, "Related Claims" were defined as claims "based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related" facts, circumstances or events "whether related logically, causally, or in any other way." The policy defined "Loss" to exclude: (1) "benefits or coverage owed under any contract, health care plan or trust, [or] insurance . . . plan" and (2) "non-monetary relief or redress in any form, including . . . the cost of complying with any injunctive, declaratory or administrative relief. "

In 2000, the health care underwriter was sued in a class action in Florida by certain of its present and former group health plan insureds who alleged that the insured had impermissibly engaged in "tier rating" of the group by "re-underwriting" individuals every year—canceling the policies of high-risk subscribers and forcing them to accept alternative policies with higher premiums. The plaintiffs sought damages for breach of contract and equitable relief. The policyholder also faced 38 similar lawsuits in four other states. In 2002, the Florida state court found that the tier rating violated state statutes and noted that the Florida Department of Insurance (DOI) had denied a 1996 rate filing by the underwriter that proposed to base renewal premiums for individual group members on a "health risk assessment" and has ordered it to "cease and desist from such conduct." The insured then reached a settlement with the class action plaintiffs. Upon learning of the DOI proceeding, the professional liability insurer, which had been advancing defense costs to the insured under a reservation of rights, declined coverage for the lawsuits and sought reimbursement for $797,000 in defense expenses. The insurer argued that the DOI proceeding was an "administrative or regulatory proceeding brought prior to and/or pending as of the Inception Date" that barred coverage for the Florida class action as well as the other 38 lawsuits.

The court first rejected the insured's contention that the prior and pending litigation exclusion was inapplicable because the Inception Date had been modified by the change in the retroactive date. Despite suggesting that the policies were "vague" as to the application of the retroactive date, the court stated that it was "quite clear" that the operable date for the exclusion was the Inception Date, as "[n]othing in the policies indicates that the Retroactive Date modifies the Inception Date." The court cited favorably to *ML Direct, Inc. v. TIG Specialty Ins. Co.*, 93 Cal. Rptr. 2d 846 (Cal. Ct. App. 2000), in which the California intermediate appellate court held that "the policy's retroactive date meant that it provided coverage for acts occurring after [the retroactive date], provided no proceedings arising out of those acts were initiated prior to [the Inception Date]."

The court then determined, however, that the claims against the insured in Florida were not based on any fact, circumstance or Wrongful Act alleged in a prior judicial, administrative or regulatory proceeding. Although the insured admitted that the DOI disapproved its 1996 rate filing because of the proposed "'tier rating' renewal process" and that the Florida action "involve[d] re-underwriting and/or tier rating," the court did not find that

the action involved "the same" Wrongful Acts at issue in the DOI proceeding. Instead, the court concluded that these were "two different 'facts, circumstances, situations, transactions, events or Wrongful Acts'" that involved similar "type[s]" of practices but not "the same" practices. In reaching this conclusion, the court indicated that the language of the prior and pending litigation exclusion was "extremely broad," to the point of being "ambiguous," because the phrase "in any way involving" conceivably could apply to any prior proceeding that "'involve[d]' the 'fact' that [the insured] sold insurance." Choosing instead to apply the exclusion narrowly, the court noted that the exclusion could apply where a second proceeding alleged "different consequences of the Wrongful Acts involved in the first proceeding" or "different legal theories or prayers for relief" with respect to the same Wrongful Acts. The court then concluded that coverage for the other 38 lawsuits also was not precluded by the exclusion for similar "but more emphatic reasons"—as those plaintiffs may not have been insured under the same type of policy at issue in the 1996 DOI proceeding.

Next, the court concluded that all 39 lawsuits were "Related Claims" such that they implicated only the 1999-2000 policy and were subject to one aggregate limit. Noting that the language of the "Related Claims" provision was broader than that in the prior and pending litigation exclusion, the court concluded that "cases arising out of different Wrongful Acts can be related claims." Again, the court sought to apply the "reasonable expectations" of the insured with respect to the provision, after concluding that the phrase "related . . . in any . . . way" clause was so broad as to be "ambiguous." The court found, however, that the "common understanding of the word "Related" covers a very broad range of connections, both causal and logical" and that the lawsuits against the insured were "clearly 'related' in any meaningful sense of the word" as they related "both causally and logically" to the insured's re-underwriting of group insurance policies at renewal.

The court then addressed whether some or all of the damages sought by the insured fell outside covered "Loss" under the policy. The court first held that, to the extent that the underlying plaintiffs in Florida sought recovery of unpaid insurance benefits due at the time of the claim, these damages were not covered "Loss." The court noted, however, that this was the case for only a small portion of the claimed damages.The court then held that the definition of "Loss" unambiguously precluded coverage for costs associated with eliminating tier rating or providing the underlying plaintiffs with the opportunity to purchase policies at group rates. While the insured argued that these costs were a part of the settlement and not injunctive relief ordered by a court, the court found that the policy clearly did not cover any "non-monetary relief" not just injunctive relief.

After noting that the policy definition of "Loss" might not include coverage for the insured's restitutionary payments (*e.g.*, such as the return of excessive premiums or payment of the medical care expenses to plaintiffs who were unable to locate other health insurance coverage), the court found the "profit, remuneration or advantage" exclusion to "specifically" bar coverage for a substantial portion of the damages. According to the court, the exclusion, which provided that the insurer would not pay loss "[e]xcept for Defense Expenses . . . brought about or contributed to in fact by . . . any Insured gaining any Profit, Remuneration or Advantage to which such Insured was not legally entitled," served to prevent the insured from being reimbursed for expenses that it should have paid from the outset. The court declined to address whether the insured's payment of the underlying plaintiffs' attorneys' fees was covered under the policy but opined that payments for other damages asserted, such as mental anguish and punitive damages, would be covered by

the policy.

Finally, the court rejected the insured's assertion that the insurer had waived its right to recover some or all of the $797,000 in defense expenses it had advanced for the defense of the Florida action by failing to request a written undertaking as a condition to making payment. Under the policy, the insured agreed to pay defense expenses but that "[a]s a condition of any payment of Defense Expenses before final disposition of a Claim, the Underwriter may require a written undertaking . . . guaranteeing the repayment of any Defense Expenses paid" if there is no coverage under the policy or a "fair and appropriate allocation of any fees, costs and expenses and settlement amounts" if only certain underlying allegations give rise to "Loss" under the policy. According to the court, the insurer had not waived its rights to repayment because it was not required to demand an undertaking under the policy and it had "consistently reserved its rights under the policy." Moreover, the court noted that these expenses might be recoverable under a theory of unjust enrichment. The court, however, rejected the insurer's argument that it was entitled to repayment of all defense costs advanced because some of the allegations in the lawsuits gave rise to covered losses and the "profit, remuneration and advantage" exclusion did not encompass defense expenses.

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