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**Practical Issues in Enforcement of
Claims-Made Policies:
Timing is Everything**

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Welcome to the 80's



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**Courts Generally Enforce
Claims-Made Coverage.**

- Courts specified their concerns, and the insurance industry responded.
- Problem is the tension between insureds "stuck in the 80s" as to their expectation of coverage, and the policy language.
- Insurers have the right to enforce clear policy language, and this principle allows insurers to stand firm on the timing parameters/rules characteristic of claims made coverage.
- The issue is timing.

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Timing: Four Claims-Made Issues

- 1. What if the policyholder missed the deadline by just a few weeks, or a few days?
- 2. To whom must the insured report the claim?
- 3. Is the reporting requirement enforced if the policyholder maintained consecutive claims-made coverage?
- 4. Is the "reporting during the policy period" requirement rendered ambiguous/unenforceable by the "notice as soon as possible" condition?



Vocabulary – Use the Right Words

- **"Claim"** A claim is a demand for damages. Compare "The surgery didn't work and I'm really mad" with "The surgery didn't work and you owe me a million bucks."
- **ISO Definition for Physicians, Surgeons and Dentists:** "'Claim' means a 'suit' or demand made by or for the injured person for monetary damages because of alleged injury to which this insurance applies."




More Definitions

- **"Claims-made and reported."**
 - A "claims-made" policy requires only that the claim be made in the policy period.
 - A "claims-made and reported" policy requires that both the claim and the report take place during the policy period, or *extended reporting period*.
- **ISO Language**
 - A "claim" received by the insured during the policy period and reported to us within 30 days after the end of the policy period will be considered to have been reported within the policy period.




More Vocabulary: "Report" vs. "Notice"

- Use the words as they are used in the policy.
- If you start talking about "notice" when you mean "report," *most* courts will begin thinking about "prejudice."




More Vocabulary: "Report" vs. "Notice"

- The difference between "report" and "notice" is a difference with consequences.
 - In the claims-made context, the reporting requirement is an *element* of coverage, stated in the insuring agreement. As an element of coverage, the insured has the burden to prove that it reported the claim within the time specified by the policy.
 - In the occurrence context, the notice issue is a condition to coverage. In most jurisdictions, the insurer cannot prevail on a disclaimer of coverage based on late notice unless the insurer proves prejudice.



Issue 1: "But under my occurrence policy, a week wouldn't matter."

- The biggest litigation issue is the "Oops, I missed the deadline" issue.
- Typical scenario: The insured reports the claim a few weeks too late.
- Remember the differences: Unlike in the "occurrence" context, *most* courts do not apply proof of prejudice to the reporting requirement in a claims-made policy.



Issue 1: Proof of Prejudice Required?

- While the result may be harsh, the general rule is that enforcement of claims-made policies' reporting requirements do not require proof of prejudice. See e.g., *ACE Am. Ins. Co. v. Underwriters at Lloyds*, 939 A. 2d 935 (Pa. Super. 2007), *aff'd* 601 Pa. 95 (Pa. 2009): “[I]n the claims made context, if an insured has clearly breached the notice requirement, an insurer need not show prejudice to deny coverage.”



Issue 1, continued: “But it’s only a little bit late; what’s the big deal?”

- All decisions driven by facts:
 - Direct Action States: Historically reluctant to enforce a reporting requirement if it precludes the claimant from having a year to file suit against the insurer.
 - Root v. American Equity Specialty Ins. Co., 130 Cal. App. 4th 926 (2005): Unique situations may warrant departure from the general rule.
 - Southern New Jersey Rail Group v. Lumbermens Mut. Cas. Co., 2007 U.S. Dist. LEXIS 58510 (S.D.N.Y. August 13, 2007): Courts will not disregard policy language in favor of an insured who did not follow the rules.



Direct Action States – Different But Similar Analysis

- Historical reluctance to enforce reporting requirements. Hedgepath v. Guerein, 691 So. 2d 1355 (La. Ap. 1997). The claims-made policy required the occurrence *and claim* during the policy period.
 - Court found that the policy violated Louisiana statute because it limited the claimant’s right of action against the insurer to a period of less than one year from the time when the cause of action accrues. *Id.*
- More recently, courts have held that because claims-made policies do not limit the amount of time in which an insured can file suit against its insurer, but instead limit the risk insured by the policy, claims-made policies are not void as contrary to the statute. Guthrie, et al. v. La. Medical Mut. Ins. Co., et al., 975 So. 2d 804 (La. Ct. App. 2008).
 - Claimant filed a claim against insurer within a year of the occurrence, at a time when the claims-made coverage had terminated, and been followed by occurrence coverage. Because neither policy provided coverage, the claimants argued that the claims-made coverage violated statutes, and therefore was against public policy. *Id.* The Court disagreed, finding that claims-made policies are not void as contrary to the applicable statutes. *Id.*



Issue 1, continued: "But it's only a little bit late; what's the big deal?"

- Unique situations may warrant departure from the general rule.
- Root v. American Equity Specialty Ins. Co., 130 Cal. App. 4th 926 (2005).
- Suit filed days before policy period ended. When read about the suit in a legal paper a few days later (after policy ended), the insured reported the article to his insurer.
- Insurer denied coverage on basis that policy terminated before report of claim. Note that policy did not have a grace period.
- Court did not apply the notice-prejudice rule.
- The court instead applied its equitable powers because the insured did all it could do, but still could not access coverage.
- Lesson: Root does not apply if the policy has a grace period.



Issue 1, continued: "But it's only a little bit late; what's the big deal?"

- Courts will not disregard policy language in favor of an insured who did not follow the rules. Southern New Jersey Rail Group v. Lumbermens Mut. Cas. Co., 2007 U.S. Dist. LEXIS 58510 (S.D.N.Y. August 13, 2007).
- Contrast to Root: Proves that you need a blame-free insured to set aside policy language.
- Insured received claim during the policy period but waited until very end of grace period to report to broker. Broker faxed three days later, and sent also by overnight mail.
- The insurer receive the written report days after the grace period ended. The insurer denied, stood firm on its denial, and the court agreed.



When Will a Denial Based on Post-Policy Reporting "Stick"?


1. Jurisdiction that follows the majority rule.
2. A claims-made and reported policy that is not uniquely narrow.
3. A clearly written denial letter.
4. Courage.

If the first three factors are in place, courts are willing to enforce policy language.



Issue 2: "But I reported the claim on time to my broker. What's the problem?"


- The policy language: the insured must report the claim to the insurer from whom the insured wants coverage.
 - A report to the insured's broker does not qualify as a report to the insurer.
- Southern N.J. Rail Group v. Lumbermen's Mut. Cas., supra. Insured reported the claim to its *broker* during the policy period, but the broker didn't report it to the insurer until days later. The court rejected the insured's "custom and industry" argument, holding the claim had to be reported to the *insurer* itself during the time specified by the policy.



Issue 2: "But I reported the claim on time to my broker. What's the problem?"


Close Does Not Count

- Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co., et al., No. 07-0958, 2010 Iowa Sup. LEXIS 27 (Iowa April 9, 2010). Insured reported to broker within grace period, but broker delayed.
- Countryside Cooperative, et al. v. Harry A. Koch Co., 280 Neb. 795 (2010). Insured reported to broker, but broker delayed report to insurer until **3 days** after the extended reporting period concluded.



Issue 2: "But I reported the claim on time to my primary insurer. What's the problem?"

- A report to primary does not qualify as a report to the excess.
- If an insured wants coverage under an excess claims made policy, it must report the claim directly to the excess carrier in the time specified in the excess policy. Lexington Ins. Co. v. Western Pennsylvania Hospital, 423 F.3d 318 (3rd Cir. 2005).



Issue 2: "But I reported the claim on time to my primary insurer. What's the problem?"

- Excess insurers cannot require *more* than the policy terms. An insured sufficiently reported a claim because the policy only required notice of a "wrongful act" that could give rise to a claim under the policy, with no additional details. JPMorgan Chase and Co., et al. v. Travelers Indem. Co., et al., 2010 N.Y. App. Div. LEXIS 2006 (N.Y. App. Div. March 18, 2010).
- Courts are willing to enforce policies as written. If an excess policy requires that the claim be reported to the excess insurer during the policy period, the court would have to re-write the policy language to avoid that requirement.



Issue 3: I paid my premiums; how can I have a gap in coverage? Do Successive Policies Create Seamless Coverage?

- A renewal does not create a single, seamless policy, nor extend the reporting requirement of the first policy. Each policy stands on its own terms.
- For the first policy, although the claim was made against the insured in that policy period, it was not reported in that policy period.
- And as for the second policy, that policy does not provide coverage for claims made against the insured in an earlier policy period.



As a Matter of Law, Successive Policies Do Not Create Seamless Coverage

- Pizzini v. American International Specialty Lines, 210 F. Supp. 2d 658, 666 (E.D. Pa. 2002).
- Claim made against insured in 1995; insured reported in 1996.
- "I find that ALSIC is entitled to summary judgment on the ground that plaintiff's claims against [the insured] were not covered under either the 1995 or 1996 policy because they were not "first made and reported" during a single policy period."
- Summary-judgment appropriate.



As a Matter of Law, Successive Policies Do Not Create Seamless Coverage

- Checkrite Limited v. Illinois National, 95 F. Supp. 2d 180, 193 (S.D.N.Y. 2000): “Nowhere in the contract does it say that renewal creates a continuing period of coverage during which the insured may report claims without regard to the policy period in which they were first made.”
- For cases reaching similar results, see:
 - Pizzini v. American International Specialty Lines, 210 F. Supp. 2d 658, 666 (E.D. Pa. 2002).
 - Westport Ins. Co. v. Mirsky, 2002 U.S. Dist. LEXIS 16967, *31 (E.D. Pa. 2002).
 - Quinones v. Jimenez & Ruiz, S.E., 261 F. Supp. 2d 87, 91 (D.P.R. 2003).



Minority Rule: Seamless Coverage

- Consecutive Policies Create “Seamless” Coverage
- Some courts are uncomfortable with the idea that insureds with consecutive, claims-based policies may not have coverage if a claim occurs in policy period 1, and is not reported until policy period 2.
- Courts may find seamless coverage, even though the insured could have purchased an extended reporting period.




Minority Rule: Seamless Coverage

- Some courts reason that when the policy language specifies that the purchase of an extended reporting period is necessary *only* in instances of cancellation or non-renewal, the renewal of a policy does not require the purchase of an extended reporting period to result in seamless coverage.
 - See Helberg v. National Union Fire Ins. Co., 102 Ohio App. 3d 679 (1995).
 - See also New England Environmental Technologies v. American Safety Risk Retention Group, Inc., et al., 738 F. Supp. 2d 249, 257 (D. Mass. 2010) (noting that the renewal of the claims-made policy was “intended to provide seamless, identical coverage from one year to the next”).




Minority Rule: Seamless Coverage

- Cast Steel Prods., Inc. v. Admiral Ins. Co., 348 F.3d 1298 (11th Cir. 2003).
 - A claim was made during the first policy period was not reported by broker until hours after the first policy term expired.
 - The Eleventh Circuit was faced with the “alarming scenario” of an insured that could not recover under either policy.
 - The policies did not have a grace period, and the extended reporting period only applied to cancellations or non-renewals.
 - The court found that because the extended reporting provision was silent as to renewals, the provision was ambiguous, and construed the policy in favor of coverage for the insured.




Issue 4: The policy says “as soon as practicable.” Doesn’t that language require proof of prejudice?

- Three approaches:
- Insureds will argue that “as soon as practicable” language invokes the notice/prejudice rule to the *entire* claims-made policy, including the reporting requirement.
- Some/few courts hold that the “as soon as practicable” language in a claims-made policy does not invoke the “notice/prejudice rule” because that rule is reserved for “occurrence” policies.
- Most courts rule that even if the notice requirement requires proof of prejudice, the reporting requirement does not. The two provisions have different purposes.



“As Soon as Practicable” & Prejudice

- If the claim is not reported “as soon as practicable” but is still reported within the policy period, the insurer must show prejudice in order to deny. See e.g., Prodigy Communications Corp. v. Agricultural Excess and Surplus Ins. Co., 288 S.W. 3d 374 (Tx. 2009); Financial Indust. Corp. v. XL Specialty Inc. Co., 285 S.W.3d 877 (Tx. 2009); Fulton Bellows, LLC v. Federal Ins. Co., 662 F. Supp. 2d 976 (E.D. Tenn. 2009).



“As Soon as Practicable” & Prejudice

- The Texas Supreme Court issued two opinions addressing the notice-prejudice rule as it applies to claims-made policies.
- In Prodigy Communications, the insured purchased a claims-made and reported policy which required notice of a claim to be given “as soon as practicable.”
- The insured provided notice approximately a year after the underlying lawsuit was filed, but within the policy’s 90-day extended reporting period.
- The Court disagreed with the insurer’s denial of coverage, holding that “when an insured gives notice of a claim within the policy period or other specified reporting period, the insurer must show that the insured’s non-compliance with the policy’s ‘as soon as practicable’ notice provision prejudiced the insurer before it may deny coverage.”



**Issue 4: The policy says “as soon as practicable.”
Doesn’t that make “during the policy period” ambiguous?**

- This is the standard “ambiguity” argument, but courts recognize the difference between reporting requirements and notice conditions.
- A policy’s notice condition does not render the reporting requirement unenforceable.
- In United States of America v. A.C. Strip, 868 F.2d 181 (1989), the Sixth Circuit explained:
 - The “as soon as practicable” language is intended to preclude an insured who has knowledge of a claim near the beginning of the policy period, from waiting many months until near the end of the policy period to notify the insurer of the existence of the claim, when such delay would cause prejudice to the insurer. It does not excuse, modify, or render ambiguous the claim reporting requirement that is recited in paragraph 1 as a condition of coverage.
- In Prodigy Comms. Corp. v. Agricultural Excess and Surplus Ins. Co., 288 S.W.3d 374 (Tex. 2009), the Texas Supreme Court found:
 - If notice is not “as soon as practicable” but still occurs within the claims-made policy period, the insurer must demonstrate prejudice in order to deny coverage.



**Enforcement of Claims-Made Policies:
Timing is Everything.**

- Courts enforce policy language.
- Check that the insured complied with its timing requirements.
- Courts are not inclined to rewrite policies, and generally will *not* come to the aid of an insured who did not comply with the policy’s timing requirements.