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The Inapplicability of the Notice-Prejudice Rule to Pure Claims-Made Insurance Policies Note

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Note

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JEFFREY P. GRIFFIN

The claims-made insurance policy has become the dominant form of liability insurance, overtaking the once-popular occurrence policy. Due in part to an easily identifiable coverage trigger and affordable premiums, the benefits of a claims-made insurance policy are enjoyed by both the insured and the insurer. A unique type of claims-made policy—the pure claims-made policy—developed to protect an insured against claims made during the policy period or soon thereafter, ensuring that coverage is provided if a claim is made during the final hours of an insured’s policy period even if it is reported after the expiration of the policy.

As claims-made insurance policies became more prevalent, so did litigation involving coverage disputes. The typical case involved an insurer’s denial of coverage following an insured’s unreasonably late notice of a claim. In deciding some of these late notice cases, courts applied the notice-prejudice rule—a rule traditionally used in the occurrence policy context—to pure claims-made policies. When applied, the rule prohibits an insurer from denying coverage due to unreasonably late notice unless it can show it was prejudiced by the delay. This Note argues that application of such a rule undermines the pure claims-made insurance form, as such policies are priced based on an insurer’s knowledge that claims will be made and reported within the policy period or soon thereafter. If unable to rely on this basic assumption, the insurer will be unable to sell such policies, and insureds will no longer benefit from this insured-friendly insurance format.

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THE INAPPLICABILITY OF THE NOTICE-PREJUDICE RULE TO PURE CLAIMS-MADE INSURANCE POLICIES

JEFFREY P. GRIFFIN*

I. INTRODUCTION

Suppose that on February 1, 2007, a California company purchased an errors and omissions insurance policy from a national insurance carrier, set to expire on February 1, 2008. This hypothetical policy provides that any claims made against this California company must be reported to the insurer “as soon as practicable.” Unfortunately for the company, an error or omission led to a claim made against it on October 15, 2007. The company knew that in California, an insurer requiring notice of a claim “as soon as practicable” cannot deny coverage for late reporting of claims—no matter how late—unless it can show it was prejudiced by the delay. In fear that its premiums may go up if it reported the claim, the company decided to wait to report anything to the carrier in case the litigation proved frivolous.

Meanwhile, the insurer’s actuaries are at the home office, attempting to set rates for other insureds. In doing so, the actuaries and underwriters rely on the fact that in most states, it will not have to provide coverage for claims reported outside the policy period and not “as soon as practicable.” The insurer knows that when it is able to confidently close its books on a policy soon after the end of the policy period, it may calculate increasingly accurate rates for policyholders while maintaining its own profit. In March of 2009, the hypothetical California company discovered that its error was worse than it thought, only then finding itself ready to turn to its insurer for coverage. Because California courts decided that an insurer is not harmed by delay of notice even if its actuarial basis for calculating risks is undermined, the carrier will be required to provide coverage even though the insured failed to comply with the requirements of its policy.¹ This Note will examine various jurisdictions’ reactions to similar fact patterns, and will argue that the law should not force an insurer to provide coverage

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¹ See *Pension Trust Fund for Operating Eng’rs v. Federal Ins. Co.*, 307 F.3d 944, 955–57 (9th Cir. 2002) (holding that an insurer requiring notice of a claim “as soon as practicable” must show it was prejudiced by late notice of a claim in order to deny coverage).

when notice is outside the policy period and not “as soon as practicable.”

Professional liability insurance comes in two general forms: occurrence and claims-made.² Claims-made coverage is relatively new to insurance markets; it was developed in part to limit insurer’s exposure to claims that are reported significantly after the end of a policy period. An insurance format that limits such late reports allows for less expensive insurance policies, a benefit that is passed on to policyholders in the form of lower premiums.³ Perhaps unsurprisingly, as claims-made insurance policies became more prevalent, so did litigation involving such policies. One of the most frequently litigated issues in the claims-made context involves the problem of an insured’s late reporting of a claim, and courts are often asked whether an insurer can properly deny coverage based on failure to provide timely notice as required by the policy.⁴ Possibly due to the complexity of such policies, some courts began applying the older, common law notice-prejudice rule to some types of claims-made policies without considering the propriety of the rule in such a context.⁵ The rule effectively allows an insured to provide its insurer with late notice of a claim and still obtain coverage, so long as the late notice does not “prejudice” the insurer.⁶ Unfortunately, the application of such a rule undermines the basic underpinnings of claims-made coverage,⁷ potentially eliminating the benefits such policies provide to both the insured and insurer.

This Note focuses on a particular type of claims-made policy—the pure claims-made policy—and argues that the notice-prejudice rule should not be applied to such policies. Part II of this Note discusses common types of liability insurance forms, and explores various types of claims-made policies. This section also introduces claims-made notice provisions, the element of the policy that is at the heart of a discussion involving late notice and the notice-prejudice rule. Part III explores current case law involving claims-made insurance policies and late notice of claims. The first section discusses the inapplicability of the notice-prejudice rule to

² See Bob Works, *Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case*, 5 CONN. INS. L.J. 505, 518 (1999) (noting that “liability insurance comes in two flavors: occurrence and claims-made”).

³ *Id.* at 516–17.

⁴ See TOM BAKER, *INSURANCE LAW AND POLICY: CASES, MATERIALS, AND PROBLEMS* 504 (2008) (noting that “[t]he notice provision is one of the most litigated conditions in liability insurance policies of all kinds”).

⁵ See *Pension Trust Fund for Operating Eng’rs*, 307 F.3d at 956–57 (holding that the notice-prejudice rule applies to pure claims-made policies but not claims-made and reported policies).

⁶ See, e.g., *Brakeman v. Potomac Ins. Co.*, 371 A.2d 193, 198 (Pa. 1977) (holding “that where an insurance company seeks to be relieved of its obligations under a liability insurance policy on the grounds of late notice, the insurance company will be required to prove that the notice provision was in fact breached and that the breach resulted in prejudice to its position”).

⁷ Specifically, by requiring notice to be within the policy period or within a reasonable time thereafter, an insurer can easily identify its risk and thereby accurately price its policies.

claims-made and reported policies.⁸ The second section explores case law involving the applicability of the notice-prejudice rule to pure claims-made policies. Recently, a court applying California law has held that the notice-prejudice rule is not applicable to some types of claims-made policies, but is applicable to pure claims-made policies.⁹ On the other hand, courts in Texas, Pennsylvania, and Massachusetts have held that the rule is not applicable to pure claims-made policies.¹⁰ Finally, this Note argues that courts deciding similar issues in the future should look to Texas, Pennsylvania, and Massachusetts when making their conclusions, thereby preserving the benefits offered by pure claims-made insurance policies.

II. COMMON LIABILITY INSURANCE FORMS: OCCURRENCE POLICIES AND CLAIMS-MADE POLICIES

A. Occurrence Policies

Before one scrutinizes claims-made insurance policies in light of the notice-prejudice rule, it is important to understand the nature of the claims-made insurance policy itself, specifically focusing on the elements of claims-made policies and the triggers that provide coverage. Interestingly, an initial examination of occurrence policies—the alternative form of liability insurance¹¹ and the predecessor to claims-made coverage¹²—aids in this analysis by offering a view into the rationale for the development of claims-made policies.¹³ The Florida Supreme Court defined an occurrence policy as one “in which the coverage is effective if the negligent act or omission occurs within the policy period, regardless of the date of discovery or the date the claim is made or asserted.”¹⁴ Automobile policies

⁸ The term “claims-made and reported” is the specific name of the type of claims-made policy that dominates late notice case law in the liability insurance context. As will be discussed, the tendency of courts to simply call these policies “claims-made policies” has led to confusion among commentators and courts alike, as the particular reporting requirement goes unknown to the reader of the case.

⁹ See *infra* text accompanying notes 150–60 (discussing the application of the notice-prejudice rule to pure claims-made policies in California).

¹⁰ See *infra* notes 161–225 and accompanying text (discussing rejection of the notice-prejudice rule to pure claims-made policies in Pennsylvania, Massachusetts, and Texas).

¹¹ See Works, *supra* note 2, at 518 (noting that liability insurance “comes in two flavors: occurrence and claims-made”).

¹² See *id.* at 515 n.12 (noting that claims-made policies made occurrence policies obsolete). It has been suggested that the occurrence policy has its origins in insuring against shipping losses at sea. See, e.g., *Zuckerman v. Nat. Union Fire Ins. Co.*, 495 A.2d 395, 398 (N.J. 1985) (providing that occurrence policies originated when insurance was primarily used to insure against property loss at sea).

¹³ See John K. Parker, *The Untimely Demise of the “Claims Made” Insurance Form? A Critique of Stine v. Continental Cas. Co.*, 1983 DET. C.L. REV. 25, 27 (1983) (“Definitions of ‘occurrence’ policies universally accompany ‘claims made’ definitions because they are best understood when contrasted one to the other. In a sense, these two forms of insurance are opposites.”).

¹⁴ *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512, 514 (Fla. 1983).

are common examples of occurrence policies that are still available;¹⁵ the automobile policy is triggered the moment an accident occurs, and the insurer will be required to pay claims whenever they might be made—be it within the policy period or years later.

In the context of professional liability insurance policies, occurrence policies have not been a viable option ever since the introduction of claims-made policies to the insurance market.¹⁶ Unlike with automobile policies, a negligent act in an occurrence professional liability policy might not cause an injury until years after the policy has expired.¹⁷ While it is likely that the entire claim in an automobile policy will be resolved within the policy period given the nature of automobile claims, an occurrence policy in the professional liability context is more susceptible to claims materializing years after the expiration of the particular occurrence policy that was in effect when the injurious act occurred.¹⁸ In *Zuckerman v. National Union Fire Insurance Co.*, the New Jersey Supreme Court highlighted the difference between an automobile occurrence policy and a professional liability occurrence policy:

In the context of professional malpractice or long-term exposure to hazardous environmental conditions, however, the injury and the negligence that cause it are often not discoverable until years after the delictual act or omission. Consequently, with these types of perils, claims will frequently be made years after the insured event, and long tail exposure becomes a significant problem.¹⁹

In fact, in 1988, an insurer was required to tender a defense of claims that arose from activities occurring between 1924 and 1969.²⁰

¹⁵ See Works, *supra* note 2, at 514 (noting that automobile policies are occurrence policies).

¹⁶ See *id.* at 515 n.12 (noting that “[b]efore the advent of claims-made policies made them obsolete, ‘occurrence’ professional liability policies often were triggered when the professional services were rendered—and the negligent act or omission allegedly occurred—rather than when the client was injured”).

¹⁷ See *id.* at 514 (noting that “everything we would consider an element of [a car] accident, from [the damage] to the insurer’s payments to the [victims], seems likely to be conveniently packed within a single policy period”); Parker, *supra* note 13, at 30 (“Modernly there are events whose ‘occurrence’ is still easily and readily ascertained and, therefore, still universally insured on an ‘occurrence’ basis. Automobile coverage is an example of this.”). Parker also noted that such occurrence policies are not as suited to the professional liability context: “Of course, in the professional or product liability areas, negligent errors, omissions or product defects can remain latent and undiscovered for literally scores of years before becoming actionable. The ‘occurrence’ of the event insured is often unclear in these contexts.” *Id.* at 31.

¹⁸ See *Zuckerman v. Nat. Union Fire Ins.*, 495 A.2d 395, 399 (N.J. 1985) (“The long tail exposure inherent in ‘occurrence’ policies is less likely to be a problem in the context of certain more familiar perils, such as automobile accidents, where the insured event is easy to identify in terms of time and place, the resulting injury is immediately perceived, and a claim is typically asserted soon after the occurrence.”).

¹⁹ *Id.*

²⁰ Works, *supra* note 2, at 516 n.17.

Commentators have been quick to highlight the problems with an insurer that finds itself required to defend claims arising out of activities that occurred over sixty years earlier. For one, the complicated nature of occurrence policies makes them difficult to price, and underwriting such policies becomes an increased gamble for an insurer. Because the insurer must wait years before it can accurately calculate its loss data, it would be increasingly difficult to accurately price newly underwritten occurrence policies.²¹ Indeed, the Supreme Court of New Jersey noted that “[t]his time lapse prevents insurers from making a precise calculation of premiums based upon the cost of the risks assumed. Not uncommonly, ‘occurrence’ policy premiums have proven to be grossly inadequate to cover the inflationary increase in the cost of settling claims asserted years later.”²²

The New Jersey Supreme Court noted that occurrence policies pose more problems than merely the difficulty in accurately calculating a particular risk. Specifically, the court provided that “new theories of recovery in tort law and increased consumer awareness have contributed to an increase in the number of claims that undermines the actuarial basis for premiums on occurrence policies issued years earlier.”²³ Moreover, occurrence policies are ill suited for insuring against risks in which a potentially injurious act will be difficult to recognize. Unlike an accident in an automobile policy, an injurious event in a professional liability occurrence policy may be hard to identify, contributing to disputes and further pricing difficulties.²⁴ Likewise, there may be times when a claim is made so long after the expiration of an occurrence policy that the underwriter or insurance company originally providing the policy is no longer in existence.²⁵ Finally, occurrence policies issued many years

²¹ See *id.* at 516 (“Consequently, the longer the period for which one must ‘develop’ immature historical loss data in order to estimate ultimate loss costs for policies written in the past, and the longer into the future one must peer in an effort to trend those estimates of past loss costs in order to make predictions about future loss costs for new policies, the greater the likelihood for error.”).

²² *Zuckerman*, 495 A.2d at 399.

²³ *Id.*

²⁴ *Id.* (“An additional shortcoming associated with the use of ‘occurrence’ policies for perils that can cause latent injuries over an extended period of time is the difficulty in determining precisely when the essential causal event occurred. This is particularly true in products liability, professional malpractice, and environmental litigation.”). John Parker made a similar observation:

Increased social and industrial complexity . . . as well as expanded tort notions, have made pinpointing the occurrence of many fortuitous events very difficult. For example, in the relatively new area of asbestos and other environmental exposure litigation, courts, legislatures, and even scholars are confused about, or disagree as to when the insured event ‘occurs.’ The difficulty arises because of the latent and continuing nature of the ‘injury’ and the long term exposure precipitating it.

Parker, *supra* note 13, at 30–31.

²⁵ See *Zuckerman*, 495 A.2d at 399 (“A further disadvantage of ‘occurrence’ policies is that their long tail exposure can lead to situations in which the policy underwriter is no longer in existence at the time a claim is finally made.”). Another related problem arises when allegedly injurious acts might have occurred over a period of years, and the insured switches from one occurrence insurance carrier to

before an injury becomes apparent may be wholly inadequate to cover a claim. That is, it is likely that the policy limits of the original occurrence policy are far smaller than what would be necessary to provide adequate coverage in present day terms.²⁶ In addition to the insured's frustration with the potential for inadequate coverage, the insurer may also find that the premium it collected years earlier related to a risk that, at the time, would result in far less exposure than that same risk in current terms.²⁷

B. *Development of Claims-Made Policies*

Due in large part to the problematic nature of occurrence policies, the insurance industry sought an alternative form of insurance to provide adequate protection to insureds while avoiding the issues inherent in occurrence policies. Without the development of an alternative, commentators predicted that some types of professional liability insurance markets would completely dissolve. For instance, John Parker suggested that:

[D]ue to the actuarial difficulty of dealing with [occurrence policy problems], the "occurrence" form necessarily makes insurers dependent on their financial reserves in underwriting that type of insurance. Correspondingly, the "occurrence" form has greatly contributed to the volatility of premiums and the unavailability of any insurance whatsoever in some professions. This, of course, is detrimental to the insured's interests because it threatens his very status as an insured, and again, the public ultimately bears the adverse consequences. The 'claims made' form, at least for the present and near future, precludes this highly undesirable result.²⁸

the other. Not only is the particular "occurrence" that led to the injury difficult to identify, but litigation is likely to ensue between insurers in order to determine who is liable for the claims. *See Thoracic Cardio. Assocs. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 919 (Ariz. App. Ct. 1994) ("Another difficulty with occurrence policies is that when professional negligence continues over a period of time, and an insured changes from one occurrence carrier to another, uncertainty exists about which insurer will provide coverage.").

²⁶ *See* Parker, *supra* note 13, at 75 ("Along the same lines, it has been mentioned that even the professional or business that had 'occurrence' insurance is not properly protected from the 'long tail' problem because of the gross inadequacy of formerly acceptable coverage limits.").

²⁷ *See, e.g., Thoracic Cardio. Assocs.*, 891 P.2d at 919 ("One problem with occurrence policies is that the insurer cannot calculate the premium for the risk with any certainty. The insurer must compute premiums for occurrence professional liability policies at current rates while claims must be resolved at market rates, sometimes long after the premiums have been paid.").

²⁸ Parker, *supra* note 13, at 77. Because of the "highly undesirable results" resulting from occurrence policies, Parker notes that the claims-made policy "is a natural and essential response to the legitimate needs of both the insurance consumer and supplier, without which the insurance market would be a crippled anachronism." *Id.* at 32, 77.

The advent of claims-made policies was therefore a necessary response to the increasing problems with occurrence insurance policies. As Professor Works suggests:

[It would be better] if a claim made against an insured in 1985 based upon a latent injury that ‘occurred’ in 1945 could have been treated as triggering the 1985 policy rather than the 1945 policy; with the benefit of forty additional years of experience to reflect the correlated changes in inflation, loss frequency, legal doctrine, medical technology and jury attitudes over that period, the best pricing guesses for 1985 must necessarily be superior to the best pricing guesses for 1945.²⁹

In this way, Professor Works notes that in place of occurrence policy triggers, an insurer would rather “employ a policy trigger that falls later in the sequence rather than earlier, in order to shorten the time between when a policy obligation is priced and when the extent of that obligation is determined.”³⁰

Insurers did in fact respond by creating an insurance policy with a new trigger; claims-made policies would be triggered not by the insured’s injurious act, but rather by when a claim is made on the policy.³¹ The types of claims-made triggers vary (and will be explored in detail in the forthcoming discussion of the notice-prejudice rule), but the general identifying element of a claims-made policy is that the risk being insured against is the claim on the policy, rather than the occurrence of a peril as insured against in occurrence policies. The *Zuckerman* court succinctly noted the difference between occurrence and claims-made policies:

In the ‘occurrence’ policy, the peril insured is the ‘occurrence’ itself. Once the occurrence takes place, coverage attaches even though the claim may not be made for some time thereafter. While in the ‘claims made’ policy, it is the making of the claim which is the event and the peril being insured and, subject to policy language, regardless of when the occurrence took place.³²

By moving the trigger to the claim rather than the occurrence, it would seem that the insurers found a policy that would reduce some of the issues

²⁹ Works, *supra* note 2, at 516–17.

³⁰ *Id.* at 516.

³¹ *See id.* at 517 (“If the policy trigger no longer must be the injury, but instead could be the claim, many of the nasty . . . problems involved in determining when an occurrence occurred disappear, and the guesswork involved in determining a price for future liability coverage can be made less daunting.”).

³² *Zuckerman v. Nat. Union Fire Ins. Co.*, 495 A.2d 395, 398 (N.J. 1985) (internal citation omitted).

associated with the problematic occurrence policies.

Courts and commentators agree that the adoption of claims-made policies remedied many of the problems associated with occurrence policies. Importantly, an insurer could now significantly reduce the long tail exposure once associated with occurrence policies since claims-made policies will allow an insurer to be aware of its exposure soon after the end of a policy period.³³ Since claims-made policies are triggered by a claim rather than an act that leads to an injury, the insurer will know that it will not have to cover claims after the expiration of the policy.³⁴ This knowledge will benefit the parties to the insurance contract, as the insurer will be able to calculate the premium on future policies with increased precision and confidence.³⁵

Because claims-made policies insure risks over a shorter period, an insurer can also more precisely calculate both premiums and the reserves it must keep since it will no longer be concerned with inflationary changes that plagued insurers offering occurrence policies.³⁶ Likewise, the shortened tail exposure will allow an insurer to price its policies based on current law and jury award trends, and it need not worry about the effect of evolving legal doctrine in future years.³⁷ The insurer's ability to precisely calculate premiums also benefits the insured; the shortened tail of exposure leads not only to an increasingly accurate calculation of insurance premiums, but it also leads to far lower premium costs when compared to

³³ See *Thoracic Cardio. Assocs. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 920 (Ariz. App. Ct. 1994) (noting that insurers switched to employing claims-made policies so as to “reduce exposure to an unpredictable and lengthy ‘tail’ of lawsuits filed years after the occurrence they agreed to protect against”).

³⁴ See *id.* (noting that claims-made policies allow an insurer to be confident that claims will not arise under the policy following its expiration). This is a simplified view, however. The pure claims-made policy requires the insured to report a claim “as soon as practicable,” which may very well be soon after the end of the policy period in the event of an eleventh hour claim. Nevertheless, the distinction is small—a pure claims-made insurer will still benefit from the claims-made policy in that it will know of its exposure soon after the end of the policy. See *infra* notes 36–39 and accompanying text (discussing the benefits of pure claims-made policies).

³⁵ See *Zuckerman*, 495 A.2d at 400 (“The obvious advantage to the underwriter issuing ‘claims made’ policies is the ability to calculate risks and premiums with greater exactitude since the insurer’s exposure ends at a fixed point, usually the policy termination date.”); *Thoracic Cardio. Assocs.*, 891 P.2d at 920 (“An insurer who knows that claims will not arise under the policy after its expiration can underwrite a risk and calculate premiums with greater certainty.”); see also *Parker*, *supra* note 13, at 77 (noting that claims-made insurance policies prevent the insurer from being subject to long tail exposure associated with occurrence policies).

³⁶ See *Thoracic Cardio. Assocs.*, 891 P.2d at 920 (noting that claims-made policies alleviate concerns of inflation after the end of the policy period since an insurer will know when its exposure ends). This benefit also reaches the insured. In *Zuckerman*, the New Jersey Supreme Court noted that “[a] corollary benefit to the insured is that since liability coverage is purchased on a contemporary basis, it can afford protection in current dollars for liability that may be based on negligence that occurred years earlier.” *Zuckerman*, 495 A.2d at 400.

³⁷ See *Thoracic Cardio. Assocs.*, 891 P.2d at 920 (“The insurer can establish its reserves without having to consider the possibilities of inflation beyond the policy period, upward spiraling jury awards, or later changes in the definition and application of negligence.”).

occurrence policies.³⁸ Similarly, by utilizing an insurance policy that insures against claims rather than occurrences, the insured will benefit from knowing that the policy limits will not be too little to cover claims.³⁹

An insurer also benefits from a decrease in costs associated with coverage analyses, since the event that triggers a claims-made policy is far easier to ascertain than many events that trigger an occurrence policy. One commentator suggests that this simpler trigger is just as beneficial to the insurer as it is to the insured:

Additionally, with the “claims made” policy, there is no need to ascertain when an ‘occurrence’ ‘occurred,’ especially problematic in long term exposure cases. More than once an insured has been left without coverage due to a court’s adverse understanding of “occurrence.” Although there have been a few cases litigating the issue of when a “claim is made,” usually its happening is indisputable.⁴⁰

This analysis makes sense. When an individual is diagnosed with a disease (asbestosis, for instance) and that individual subsequently files suit against the asbestos manufacturer, it is easy to determine when the suit was filed. With that easily-ascertainable information, the insurer will know that the claims-made policy has been triggered. However, it is more difficult to determine when the initial injury took place that led to the asbestosis diagnosis years later. Due in part to the cost of settlement and the increasing size of jury awards, the various occurrence carriers that insured the asbestos manufacturer will likely pursue litigation to attempt to point to each other’s particular policy as the one in effect on the particular date of “injury.”⁴¹ With the claims-made policy and its easily identifiable triggers, the costs of such litigation need not be built into the price of the premium.

Some commentators have gone so far as to suggest that claims-made policies are not only cheaper, but provide greater coverage than their occurrence counterparts. For instance, John Parker suggests that “[t]he

³⁸ See Parker, *supra* note 13, at 73 (“[I]t has been clearly established that ‘claims made’ insurance, at least initially, is vastly cheaper than the ‘occurrence’ variety. Of course this results from the relative ease of actuarially assessing risks and premiums. Consequently, because the underwriter can more accurately assess the risk, the insurer pays a lower premium.”).

³⁹ In the occurrence policy context, the insured may slowly become uncomfortable with its policy limits on old occurrence policies, as inflation and larger jury awards will likely bring some claims far outside of the policy limits. Of course, claims-made policy limits may be met fairly easily; large jury awards in the medical malpractice context routinely exhaust policy limits.

⁴⁰ Parker, *supra* note 13, at 75.

⁴¹ See Works, *supra* note 2, at 515–16 (using the asbestos example to demonstrate the difficulty of determining when an injury took place); see also Parker, *supra* note 13, at 30–31 (utilizing the asbestos example as illustrative of the difficulty in determining when the event causing the latent injury took place). It should be noted that in the unlikely event this hypothetical asbestos manufacturer had only one occurrence carrier throughout its early years of business, the policy period in which the latent injury occurred would be irrelevant; coverage would attach regardless, and there would be no other carrier to implicate as insuring during the injurious policy period.

‘claims made’ form also arguably provides broader coverage [than occurrence policies]. When it is not subject to specific limitation, it is completely retrospective, covering all errors or omissions or other insurable events irrespective of when each occurred.”⁴² The retrospective nature of claims-made policies allows an insured who failed to (or was otherwise unable to) procure insurance during the early years of a business to purchase claims-made coverage and enjoy protection for negligent acts that may have occurred in the past that might not yet have given rise to a claim.⁴³ Without the development of claims-made policies, those businesses that did not purchase occurrence coverage would be fully exposed to liability for those years it went unprotected. Likewise, even if an insured purchased occurrence policies in the early years of its business, its current claims-made policy could provide additional coverage for claims that might arise out of injurious acts that took place when the occurrence policy was in effect. This may be particularly useful when the occurrence policy limit proves to be far too small to cover the cost of the injury in present day terms; now, the claims-made policy could make up the difference.⁴⁴

C. Elements of Claims-Made Policies

The forthcoming analysis of the notice-prejudice rule will generally focus on two versions of claims-made policies: the “pure claims-made” policy (which is the heart of this Note’s thesis), and the older, more common “claims-made and reported” policy.⁴⁵ The claims-made and reported policy is relatively self-explanatory; it contains a two-part trigger—the first that a claim is made against the insureds during the policy

⁴² Parker, *supra* note 13, at 75. It should be noted that many claims-made policies contain retroactive (“retro”) dates, which afford coverage only for claims arising out of acts or occurrences after the retro date. See *infra* note 50 and accompanying text (discussing retro dates in context).

⁴³ Parker, *supra* note 13, at 75 (“Insureds who could not afford insurance earlier in their professional careers or business can obtain protection against long term exposure or “long tail” liabilities arising from events transpiring when they had no insurance.”).

⁴⁴ *Id.* Parker notes that:

Along the same lines, it has been mentioned that even the professional or business that had “occurrence” insurance is not properly protected from the “long tail” problem because of the gross inadequacy of formerly acceptable coverage limits. Under such circumstances an insured having a currently operative “claims made” policy can utilize such as an “excess” policy, due to its retrospective application, and assure against personal exposure.

Id. Of course, this assumes that the policy at issue does not contain a retro provision for which coverage exists only for claims arising out of acts or omissions that occur after the specified retro date.

⁴⁵ See Works, *supra* note 2, at 525 (noting that “many ‘claims-made’ forms” are claims-made and reported policies). The majority of claims-made litigation involves claims-made and reported cases; only a small number of courts address what appear to be pure claims-made policies, and even fewer courts clearly address pure claims-made policies. The following section will provide analysis of some of those cases and the reader will notice the high number of courts contemplating claims-made and reported policies and the correspondingly lower number of courts examining pure claims-made policies.

period; and second, that the insureds report the claim to the insurer within the policy period.⁴⁶ The insuring agreements in such policies typically state that “the insured shall, as a condition precedent to their rights under this policy, give written notice as soon as practicable to the company of a claim made against the insured, provided that . . . this *notice must be during this policy period*.”⁴⁷ On the other hand, a pure claims-made policy provides that claims must be made against the insured within the policy period and reported to the insurer “as soon as practicable.”⁴⁸

In theory, there should be little difference between the effect of a claims-made and reported policy on an insured’s coverage, and the effect of a pure claims-made policy on the insured’s coverage. In the pure claims-made context, like in the claims-made and reported context, a claim must be made against the insured, and the insured should then notify the insurer. The difference is that in pure claims-made policies, the notification to the insured does not necessarily have to be within the policy period (although in most circumstances, it still should be within the policy period), so long as the reporting is done in a manner that is “as soon as practicable.” The time in which such a difference may be particularly relevant is when a claim is made against an insured on the last day of his or

⁴⁶ See, e.g., *id.* (noting that a claims-made and reported policy “require[s] that at least two things happen during a particular policy period in order to trigger the policy: with a ‘claims-made-and-reported’ format, the injured party must assert a claim against the insured during the policy period, and the insured must report that claim to the insurer during the policy period”). Works also provides an example of a claims-made and reported policy’s insuring agreement:

To pay on behalf of the Insured all sums in excess of the deductible amount . . . which the insured shall become legally obligated to pay as damages as a result of CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED TO THE COMPANY DURING THE POLICY PERIOD caused by any act, error or omission for which the insured is legally responsible, and arising out of the rendering or failure to render professional services for others in the insured’s capacity as a lawyer or notary public.

Id. at 525 n.31.

⁴⁷ Cont’l Cas. Co. v. Maxwell, 799 S.W.2d 882, 884 (Mo. Ct. App. 1990).

⁴⁸ This is the policy language in Travelers’ HOA/Condo Directors and Officers liability policy, as amended by its Non-Profit Change Endorsement. Kevin Davis Policy Specimen, http://www.kdis.com/online.com/specimen_policies/do_country_specimen_0704.pdf (last visited July 24, 2009). This same pure claims-made Travelers policy has an insuring agreement that defines a “Claim” in the following manner:

Claim means:

- 1) a written demand for monetary or non-monetary relief;
- 2) a civil proceeding commenced by the service of a complaint or similar pleading;
- 3) a criminal proceeding commenced by a return of an indictment; or
- 4) a formal administrative or regulatory proceeding commenced by the filing of a notice of charges, formal investigative order or similar document, against an insured for a Wrongful Act, including an appeal therefrom.

Id. Section II.S of the Travelers HOA/Condo Directors and Officers policy defines a “Wrongful Act” as “any error, misstatement, misleading statement, act, omission, neglect, or breach of duty committed or attempted, or allegedly committed or attempted, by the Insured Organization or by one or more Insured Persons, individually or collectively, in their respective capacities as such, including but not limited to any Wrongful Employment Practices.” *Id.*

her policy period, and the insured is unable to report the claim to the insurer on that same day. Following a strict approach to the claims-made and reported policy, there would be no coverage. With a pure claims-made policy, a report on the following day (albeit after the expiration of the policy period) would still likely be “as soon as practicable,” and the policy will likely afford coverage.

While this Note only critically examines these two overarching types of claims-made policies in light of the notice-prejudice rule, a brief account of the numerous varieties of these claims-made policies will be useful in providing background for the types of risks generally insured against. Prior to engaging in the analysis, it is important to note that commentators and courts often use varying terms to describe the same policy, and some of these terms do not accurately describe the policy at issue. For instance, in the early days of claims-made insurance, the policies were often called “discovery policies” or “reporting policies.”⁴⁹ Although use of varied and vague terms in describing a particular type of claims-made policy may seem innocuous at first blush, it is a major factor in courts’ misapplication of legal rules in the claims-made context.

Professor Works highlights the numerous types of claims-made triggers and the resulting breadth of the types of claims-made policies on the market. In addition to the basic triggers found within pure claims-made policies and claims-made and reported policies, some claims-made policies also include a “retro date.” A policy with a retro date is one in which coverage is afforded only if the underlying act or injurious activity that led to the claim occurred after the retro date.⁵⁰ This effectively limits the insurer’s exposure, as it will not have to be concerned with defending claims arising from acts occurring years earlier. An insuring agreement for a claims-made and reported policy with a retro date may provide the following:

A policy is triggered if:

- 1) the [allegedly tortious act, error or omission] [injury to the victim] took place after the applicable retro date; and
- 2) during the policy period,

⁴⁹ See, e.g., Works, *supra* note 2, at 521 (noting that claims-made policies have been characterized as “discovery policies” ever since a federal district court described the policies as such). Such a characterization may be problematic when discussing some types of claims-made policies with reporting requirements that may appear less onerous.

⁵⁰ See *id.* at 529 (noting that an insured must “determine not only whether the claim was first made during the policy period, but also whether the allegedly negligent act or omission that prompted the claim (or, in some policies, the injury to the victim) occurred after the retro date”). A retro date typically corresponds with the date the insured switched from an occurrence policy to a claims-made policy. This provides the insured with coverage for claims arising out of occurrences before the retro date by way of the insured’s old occurrence policies, and after the retro date through the insured’s new claims-made policies.

- a) the victim made a claim against the insured; and
- b) the insured reported the claim to the insurer.⁵¹

Likewise, some claims-made policies allow an insured to notify the insurer of acts that occurred during the policy period that may eventually give rise to a claim. Once the insurer is notified of these acts, the insurer will provide coverage should a claim materialize, even if that claim falls outside the policy period.⁵² Most claims-made policies also allow an insured to purchase “extended reporting periods” that provide an extension of insurance coverage for claims that arise out of acts occurring within the policy period but evolve into claims after the period ends.⁵³ This type of “tail coverage” can come in two forms. The first form only allows an insured to purchase such coverage if the insurer cancels or non-renews the policy.⁵⁴ The second form allows the insured to purchase such coverage either if the insurer cancels or non-renews, or if the insured decides not to renew his or her policy.⁵⁵ As can be seen, there are numerous variations of claims-made policies and triggers, and consideration of such variations is important as they are often at issue in late-notice cases.

III. LATE NOTICE AND THE NOTICE-PREJUDICE RULE

As mentioned above, the forthcoming analysis of the notice-prejudice rule focuses on pure claims-made and claims-made and reported policies. Again, the traditional claims-made and reported policy contains a two-part trigger—the first that a claim is made against the insured during the policy

⁵¹ *Id.* at 530 exhibit 7.

⁵² *See id.* at 527 (discussing provisions that provide coverage for claims arising out of acts occurring within the policy period that mature into a claim outside the policy period). A policy provision that allows for such coverage may provide:

If, during the policy [or any tail coverage] . . . the insured first becomes aware that an insured has committed a specific act, error or omission in professional services for which coverage is otherwise provided hereunder, and if the insured shall during the [policy period or tail period] . . . give notice to the Company of:

- (a) the specific act, error or omission; and
- (b) the injury or damage which has or may result from such act, error or omission; and
- (c) the circumstances by which the insured first becomes aware of such act, error or omission then any claim that may subsequently be made against the insured arising out of such act or omission shall be deemed for the purpose of this insurance to have been made within [the coverage period].

Id. at 527–28 n.35.

⁵³ *See id.* at 528 n.36 (providing that “[s]ome ‘claims-made’ policies contain ‘extended reporting’ or ‘tail’ coverage provisions that guarantee a right to purchase (for an additional premium) a limited extension of the coverage for future claims arising out of acts or omissions committed prior to the termination of the coverage”).

⁵⁴ *See id.* (noting that these types of extended reporting provisions are often “one way,” which is only available when the insurer decides to end the insuring relationship; if the insured cancels or non-renews, the option is unavailable).

⁵⁵ *See id.* (noting that this type of provision is less common and can vary depending on the type of professional liability that is insured against).

period—and second, that the insured report the claim to the insurer within the policy period.⁵⁶ The insuring agreement in a claims-made and reported policy may state that “the insured shall, as a condition precedent to their rights under this policy, give written notice as soon as practicable to the company of a claim made against the insured, provided that . . . this *notice must be during this policy period*.”⁵⁷ On the other hand, a pure claims-made policy provides that claims must be made against the insured within the policy period and reported to the insurer “as soon as practicable.”⁵⁸ Notice of a claim to the insurer in claims-made policies is often a condition precedent to coverage,⁵⁹ and the common law of conditions would suggest that if the insured fails to provide timely notice, then there will simply be no coverage.⁶⁰ However, in many jurisdictions the notice-prejudice rule may save an insured by providing coverage notwithstanding late notice of a claim, so long as a court determines that the insurer is otherwise unaffected (or, more specifically, unprejudiced) by the tardy notice.⁶¹

There are a significant number of situations in which an insured fails to give prompt notice of a claim to the insurer, thereby sparking litigation as to whether the late notice should be excused and if coverage should therefore be afforded under the policy. The reasons for late notice vary; and as Professor Works suggests, there are a “range of snares” that may cause late notice.⁶² In his article, Professor Works highlights the following cases to illustrate the range of such explanations.⁶³ In *Zuckerman v. National Union Fire Insurance Co.*, the insured thought that the claim would be within the policy deductible and therefore did not anticipate the

⁵⁶ See *id.* at 525 (noting that a claims-made and reported policy “require[s] that at least two things happen during a particular policy period in order to trigger the policy: with a ‘claims-made-and-reported’ format, the injured party must assert a claim against the insured during the policy period, and the insured must report that claim to the insurer during the policy period”).

⁵⁷ Cont’l Cas. Co. v. Maxwell, 799 S.W.2d 882, 884 (Mo. Ct. App. 1990).

⁵⁸ This is the policy language in Travelers Indemnity Company’s HOA/Condo Directors and Officers liability policy, as amended by its Non-Profit Change Endorsement, CIRC 70004 (04-00).

⁵⁹ See, e.g., Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So. 2d 512, 515 (Fla. 1983) (noting that “[b]oth claims-made and occurrence policies generally have provisions written into the contract that require, as a condition of the policy, that the insured give notice of the claim to the insurance carrier ‘immediately,’ ‘promptly,’ ‘as soon as practicable,’ or ‘within a reasonable time’”).

⁶⁰ See Works, *supra* note 2, at 544–45 (noting that under “the strict common law of conditions,” late notice of a claim would foreclose insurance coverage). In jurisdictions requiring a showing of prejudice, there are different rules regarding which party has the burden of proof. In some states, when an insured breaches the notice provision of a policy, coverage exists until the insurer can prove it was prejudiced by the breach. See, e.g., Weaver v. State Farm Mut. Auto Ins. Co., 936 S.W.2d 818, 821 (Mo. 1997) (requiring the insurer to prove prejudice before it will be relieved from providing coverage). However, in other states, late notice creates a rebuttable presumption of prejudice that the insured has the burden to disprove. See, e.g., Alcazar v. Hayes, 982 S.W.2d 845, 856 (Tenn. 1998) (holding that when an insured breaches the notice provision of an occurrence policy, a rebuttable presumption of prejudice arises that the policyholder must disprove to avoid liability).

⁶¹ See Works, *supra* note 2, at 538–39 (discussing the states that have adopted the notice-prejudice rule).

⁶² *Id.* at 544.

⁶³ See *id.* (providing a list of cases that highlight common excuses by an insured for late notice).

need to report the claim.⁶⁴ In *Chas. T. Main, Inc. v. Fireman's Fund Insurance Co.*, the insured reported a claim in a timely manner to the primary insurer, but failed to provide timely notice to the excess insurer.⁶⁵ In *Thoracic Cardiovascular Associates, Ltd. v. St. Paul Fire & Marine Insurance Co.*, suit was filed against the insured during the policy period (thereby constituting a claim), but the insured was unaware that suit was filed until service was made on the insured after the policy had expired.⁶⁶ Finally, in *Home Insurance Co. of Illinois v. Adco Oil Co.*, the insured thought that a claim was without merit and thought that it could be resolved without involving the insurer and risking an increase in premium.⁶⁷

In jurisdictions that have adopted the notice-prejudice rule, an insurer must show that it was prejudiced by the insured's late notice of a claim in order to disclaim liability under the policy.⁶⁸ While some states have created a statutory notice-prejudice rule, the vast majority have implemented the notice-prejudice rule through the common law.

A. Notice-Prejudice Rule in Claims-Made and Reported Policies

Few courts have considered whether the notice-prejudice rule should apply to pure claims-made policies (and the aim of this Note is to articulate why courts should conclude that it does not apply).⁶⁹ However, there is an abundance of case law addressing whether the rule should apply to claims-made and reported policies, and consideration of the major cases discussing this issue is necessary prior to engaging in a similar analysis with respect to pure claims-made policies.

1. Gulf Insurance Co. v. Dolan, Fertig & Curtis

In what has become a landmark case in the area of claims-made insurance litigation, *Gulf Insurance Co. v. Dolan, Fertig & Curtis* was one of the first cases in which a state supreme court concluded that the notice-prejudice rule should not apply to claims-made and reported insurance

⁶⁴ See *id.* at 544 (citing *Zuckerman v. Nat. Union Fire Ins. Co.*, 495 A.2d 395, 396 (N.J. 1985)).

⁶⁵ See *id.* (citing *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28, 29 (Mass. 1990)).

⁶⁶ See *id.* (citing *Thoracic Cardio. Assocs. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 919 (Ariz. App. Ct. 1994)).

⁶⁷ See *id.* (citing *Home Ins. Co. of Illinois v. Adco Oil Co.*, 987 F. Supp. 1057, 1059 (N.D. Ill. 1997)).

⁶⁸ See *Brakeman v. Potomac Ins. Co.*, 371 A.2d 193, 198 (Pa. 1977) (discussing the notice-prejudice rule). In *Brakeman*, the Supreme Court of Pennsylvania held "that where an insurance company seeks to be relieved of its obligations under a liability insurance policy on the ground of late notice, the insurance company will be required to prove that the notice provision was in fact breached and that the breach resulted in prejudice to its position." *Id.* Thus, in order to disclaim liability, the insurer must first show the breach of the notice provision and then show that the breach was actually prejudicial.

⁶⁹ See *infra* notes 161–226 and accompanying text.

policies.⁷⁰ In *Gulf*, the law firm of Dolan, Fertig & Curtis obtained a claims-made and reported policy from the Gulf Insurance Company.⁷¹ The insurance policy was in effect from November 20, 1978, through November 20, 1979, and required Gulf to pay all damages for claims arising out of professional legal services offered by the law firm.⁷² The policy required three things: first, that the claim must arise out of services performed during the policy period; second, that the claim must be made against the insured during the policy period; and third, that the claim must be reported to the insurer during the policy period.⁷³

Dolan, Fertig & Curtis decided to obtain new claims-made coverage from another carrier, and that coverage was to become effective on November 20, 1979.⁷⁴ While the new policy contained a retroactive provision that dated back to 1977, it expressly disclaimed liability for “claims arising out of any occurrence prior to the effective date of the policy if the insured knew of it prior to the policy period.”⁷⁵ On November 19, 1979, the last day of the Gulf policy, the law firm received a letter from a client indicating that the client no longer desired representation from Dolan, Fertig & Curtis, that the firm was grossly negligent in performing its legal services, and that the firm should put its malpractice insurance carrier on notice of the allegations.⁷⁶

On or about December 6, 1979, Dolan, Fertig & Curtis notified its new insurance carrier of the claim.⁷⁷ However, the new carrier disclaimed liability since the firm was aware of the claim prior to the inception of the insurance policy on November 20, 1979.⁷⁸ After its lack of success with the new insurance carrier, Dolan, Fertig & Curtis notified Gulf of the claim on or about February 12, 1980.⁷⁹ Gulf also denied the claim, noting that there would be no coverage since the claim was reported to Gulf outside the policy period, and the insurance contract expressly required that notice be provided during the policy period.⁸⁰

During the time the law firm sought coverage from one of its two carriers, the firm received a judgment against it for over \$50,000.⁸¹ The

⁷⁰ *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512, 516 (Fla. 1983). As will be discussed, the court was construing a claims-made and reported policy, and while it is a type of claims-made policy, this holding does not expressly include pure claims-made policies. This Note argues that such a holding does implicitly include pure claims-made policies.

⁷¹ *Id.* at 513.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at 513–14.

⁷⁹ *Id.* at 514.

⁸⁰ *Id.*

⁸¹ *Id.*

firm then initiated suit seeking a declaratory judgment that either Gulf or the new carrier was liable for the damages award against it.⁸² Initially, both insurance companies' motions for summary judgment were granted; however, Dolan, Fertig & Curtis appealed the granting of Gulf's motion for summary judgment.⁸³ The appellate court reversed summary judgment, as it held that the contract was not ambiguous and that claims-made policies were not against public policy.⁸⁴ However, the court held that in order to make the insurance policy "fair," there should be a reasonable time after the expiration of a policy for an insured to report claims that are discovered late in the policy period, notwithstanding the fact that such reporting would extend beyond the policy period.⁸⁵ On the petition for rehearing, the court certified the following question to the Supreme Court of Florida: "As a matter of policy may the court require that 'claims made' professional liability policies should [sic] be subjected to a reasonable additional period beyond the termination date of the policy for reporting claims that arise late in the contract term?"⁸⁶

The court answered the preceding question in the negative, and began its discussion by referring to the distinction between claims-made and occurrence policies.⁸⁷ Prior to this case, the general rule in Florida was that when an insured provides late notice of a claim in the occurrence context, a presumption of prejudice was created against the insured.⁸⁸ However, although prejudice is presumed, "recovery is not precluded if the insured can demonstrate lack of actual prejudice."⁸⁹ Therefore, the insurer has no burden to show that it was prejudiced by the insured's delay in giving notice pursuant to the policy; rather, "the burden rests upon the one seeking to impose liability to show that no prejudice did, in fact, occur."⁹⁰

The court differentiated claims-made policies from occurrence policies, noting that the event that triggers coverage is different. In claims-made policies, the trigger is when a claim is made against an insured and the insurer is notified of such a claim; in occurrence policies, the trigger is when an injurious act occurs.⁹¹ The court then emphasized that claims-

⁸² *Id.*

⁸³ Dolan, Fertig & Curtis v. Gulf Ins. Co., 419 So. 2d 1108, 1111 (Fla. 1982), *rev'd*, 433 So. 2d 512, 516 (Fla. 1983).

⁸⁴ *Gulf*, 433 So. 2d at 514.

⁸⁵ *Id.* (quoting *Dolan, Fertig & Curtis*, 419 So. 2d at 1110).

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ National Gypsum Co. v. Travelers Ins. Co., 417 So. 2d 254, 256 (Fla. 1982).

⁸⁹ *Id.*

⁹⁰ *Deese v. Hartford Accident & Indem. Co.*, 205 So. 2d 328, 332 (Fla. App. 1967) (noting that "no burden rests on the insurer to show that it was prejudiced by the insured's delay in giving the notice as required by the terms of the policy").

⁹¹ *Gulf*, 433 So. 2d at 514 ("An occurrence policy is a policy in which the coverage is effective if the negligent act or omission occurs within the policy period, regardless of the date of discovery or the date the claim is made or asserted A claims made policy is a policy wherein the coverage is

made policies are designed in part to limit the tail exposure of a liability policy, a problem that plagued occurrence policy providers and led, in part, to the introduction of claims-made policies.⁹² The court noted that “[n]otice within an occurrence policy is not the critical and distinguishing feature of that policy type,” and that such policies are “built around an insurer who is liable for the insured’s malpractice, no matter when discovered, so long as the malpractice occurred within the time confines of the policy period.”⁹³ As such, the “occurrence insurer . . . is faced with a ‘tail’ that extends beyond the policy period itself.”⁹⁴ The “‘tail’ is the lapse of time between the date of the error (within the policy period) and the time when a claim is made against the insured.”⁹⁵ The court then noted that because claims-made policies require that the notice be given as soon as practicable as well as within the policy period, there is significantly less tail exposure than that of an occurrence policy.⁹⁶ For that reason, requiring an insurer to allow extra reporting time after the end of the policy period “negates the inherent difference between the two contract types,” and “[i]f a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an *extension of coverage* to the insured gratis, something for which the insurer has not bargained.”⁹⁷ To permit this extension of coverage would “in effect rewrite[] the contract between the two parties,” something that the court “cannot and will not do.”⁹⁸

While the *Gulf* court did not expressly provide that the notice-prejudice rule does not apply to claims-made and reported policies when notice is given outside the policy period, the effect of the decision reflects that position. Because the court held that an insurer need not provide an “extension of reporting time” after the expiration of a claims-made and reported policy, regardless of whether late notice injured the insurer or not, the court, in so many words, rejected application of the notice-prejudice rule in claims-made (and reported) policies.⁹⁹ Indeed, other Florida courts have agreed that *Gulf* stands for the proposition that an insurer need not

effective if the negligent or omitted act is discovered and brought to the attention of the insurer within the policy term.” (internal quotation marks omitted)). The court quickly dispensed with the law firm’s argument that claims-made policies were in violation of public policy—the court found that such policies were not “patently offensive,” “inimical to the public welfare,” or encouraging conduct that is “deleterious, anti-social or unlawful.” *Id.* (internal quotation marks omitted).

⁹² *Id.* Of course, an insured who previously obtained an occurrence policy would still have coverage for claims arising out of occurrences during those policy years. *See supra* notes 28–44 and accompanying text (describing the development of the claims-made policy).

⁹³ *Gulf*, 433 So. 2d at 515.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.* (“Coverage depends on the claim being made and reported to the insurer during the policy period. . . . If the claim is reported to the insurer during the policy period, then the carrier is legally obligated to pay; if the claim is not reported during the policy period, no liability attaches.”).

⁹⁷ *Id.*

⁹⁸ *Id.* at 515–16.

⁹⁹ *Id.* at 515.

show prejudice in order to disclaim liability after notice is given outside the policy period in claims-made and reported policies.

In *Pantropic Power Products, Inc. v. Fireman's Fund Insurance Co.*, a Florida court noted that "the [Florida] supreme court has rejected applicability of the rule to claims-made policies," referring to the decision in *Gulf*.¹⁰⁰ Likewise, a Florida court in *The Doctors Co. v. Health Management Associates* provided that:

[A] prejudice analysis is not reached under [a claims-made and reported policy]. We are guided in our holding by *Gulf* . . . which denied claims-made coverage for a claim alleged to have occurred during the policy period but not reported to the insurer until after the policy expired. . . . Thus, prejudice is not a factor here that can extend coverage that has expired.¹⁰¹

While the majority of the fifty states have held that the notice-prejudice rule applies to late notice in occurrence policies, no state has expressly held that the notice-prejudice rule should apply to claims-made and reported policies when notice is given outside the policy period.¹⁰² Some states have not decided whether the rule should apply, while others have expressly held that an insurer need not show prejudice in order to deny coverage based on late notice under claims-made and reported policies.¹⁰³

B. Notice-Prejudice Rule in Pure Claims-Made Policies

Only four states—California,¹⁰⁴ Texas,¹⁰⁵ Pennsylvania,¹⁰⁶ and

¹⁰⁰ *Pantropic Power Prods., Inc. v. Fireman's Fund Ins. Co.*, 141 F. Supp. 2d 1366, 1369 (S.D. Fla. 2001).

¹⁰¹ *The Doctors Co. v. Health Mgmt. Assocs., Inc.*, 943 So. 2d 807, 810 (Fla. App. 2d Dist. 2006).

¹⁰² Covington & Burling, Application of Notice-Prejudice Rule ("N-P") by State (2008), http://www.abanet.org/litigation/prog_materials/2008_sectionannual/010.pdf. This analysis does not consider the jurisdictions in which failure to comply with a condition precedent to coverage is a bar to recovery under the policy.

¹⁰³ *Id.*

¹⁰⁴ See *Pacific Employers Ins. Co. v. Rausch*, 221 Cal. App. 3d 1348, 1358–59 (1990) (holding that the notice-prejudice rule does not apply to claims-made and reported policies); *Pension Trust Fund for Operating Eng'rs v. Federal Ins. Co.*, 307 F.3d 944, 956 (9th Cir. 2002) (agreeing that the notice-prejudice rule applies to pure claims-made policies but not claims-made and reported policies).

¹⁰⁵ See *East Tex. Med. Ctr. v. Lexington Ins. Co.*, No. 6:04-CV-165, 2007 WL 2048660, at *9 (E.D. Tex. July 12, 2007) (mem.) (holding that the notice-prejudice rule does not apply to pure claims-made policies); *Chicago Ins. Co. v. Western World Ins. Co.*, No. Civ.A. 3-96-CV-3179R, 1998 WL 51363, at *3 (N.D. Tex. Jan. 23, 1998) (mem.) (holding that the notice-prejudice rule does not apply to pure claims-made policies).

¹⁰⁶ See *Coregis Ins. Co. v. Caruso*, No. 06-2189, 2006 WL 3762026, at *1 (E.D. Pa. Dec. 19, 2006) (mem.) (holding that the notice-prejudice rule does not apply to pure claims-made policies); *4th Street Investors v. Dowdell*, No. 06-0536, 2008 WL 163052, at *10 (W.D. Pa. Jan. 15, 2008) (mem.) (holding that the notice-prejudice rule does not apply to pure claims-made policies).

Massachusetts¹⁰⁷—have truly addressed the question of whether the notice-prejudice rule should apply to pure claims-made policies.¹⁰⁸ While courts applying Texas, Pennsylvania, and Massachusetts law have held that the notice-prejudice rule does not apply to pure claims-made policies,¹⁰⁹ California courts (and federal courts applying California law) have held that the notice-prejudice rule applies to pure claims-made policies but not claims-made and reported policies.¹¹⁰

1. *California*

In 1970, a California court was first presented with the question of whether the notice-prejudice rule applied to claims-made policies.¹¹¹ In *Northwestern Title v. Flack*, a California court of appeals for the first district decided that the notice-prejudice rule applied to claims-made policies, though the court failed to distinguish the type of claims-made policy that was at issue in the case.¹¹² In 1964, Albert and Melanie Arens decided to purchase a parcel of land in order to subdivide the property.¹¹³ The couple employed Northwestern Title to draft a title report that would reflect easements and limitations on the property.¹¹⁴ Northwestern completed its title search, though it failed to discover that there were limitations on the land that restricted development to only one dwelling.¹¹⁵ After realizing its error, Northwestern attempted to purchase additional easements to remedy the issue, though it proved unsuccessful.¹¹⁶ In

¹⁰⁷ See *Tenovsky v. Alliance Syndicate, Inc.*, 677 N.E.2d 1144, 1146 (Mass. 1997) (holding that the notice-prejudice rule does not apply to pure claims-made policies).

¹⁰⁸ Other states may have addressed late notice in the pure claims-made context, though it is difficult to ascertain whether the policies at issue are, in fact, pure claims-made policies. Courts tend to omit portions of the insuring agreement at issue, leaving the reader without a complete view of the policy contemplated by the court. For instance, a federal court applying Louisiana law held that the notice-prejudice rule does not apply to claims-made policy that could, based on the quoted language, be a pure claims-made policy. See *Williams v. Synergy Care, Inc.*, No. 07–0137, 2008 WL 2945918, at *4 (W.D. La. Jul. 29, 2008) (unreported) (providing that the notice-prejudice rule does not apply to claims-made policies). In *Williams*, the court did not specifically call the policy a “pure claims-made” policy, though the notice provision in the policy provided that “[a]s a condition precedent to any right to payment in respect of any Claim . . . the Insureds must give the underwriter [sic] written notice of such Claim, with full details, as soon as practicable after it is first made.” *Id.* at *2. The opinion did not reference any more of the policy language; as such, a reader would have a good faith basis for taking the position that in Louisiana, the notice-prejudice rule does not apply to pure claims-made policies. However, one could not be completely certain that other courts would follow that reasoning, as it is not completely clear that the *Williams* court actually construed a pure claims-made policy.

¹⁰⁹ See *infra* notes 161–225 and accompanying text.

¹¹⁰ See *Pension Trust Fund for Operating Eng’rs v. Federal Ins. Co.*, 307 F.3d 944, 957 (9th Cir. 2002) (holding that the notice-prejudice rule applies to pure claims-made but not claims-made and reported policies).

¹¹¹ *Nw. Title Sec. Co. v. Flack*, 6 Cal. App. 3d 134, 140 (1970).

¹¹² *Id.* at 144.

¹¹³ *Id.* at 139.

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

August of 1965, the Arenses instituted an action against Northwestern for damages incurred as a result of the defective title report.¹¹⁷

Northwestern notified its professional liability carrier—Underwriters at Lloyds, London—of its error, though Lloyds denied the claim due to Northwestern’s late notice of the claim.¹¹⁸ After Lloyds denied the claim, Northwestern settled the dispute for \$5500, and sought reimbursement from Lloyds.¹¹⁹ The trial court determined that Lloyds was not substantially prejudiced by the delay, and a judgment was entered against the insurer for \$8,613.55—the sum of the settlement, attorneys fees, cost, and interest.¹²⁰ Lloyds appealed the judgment, arguing in part that the court should strictly enforce conditions precedent to coverage and reject the application of the notice-prejudice rule to claims-made policies.¹²¹

Before making its decision, the court turned to *Campbell v. Allstate Insurance Co.*, an earlier California decision in which the notice-prejudice rule was applied to late notice in the occurrence policy context.¹²² In that case, the California Supreme Court considered late notice in an automobile policy and broadly held that “prejudice must be shown with respect to breach of a notice clause.”¹²³ The *Flack* court concluded that because *Campbell* did not expressly exclude claims-made policies from its holding, the notice-prejudice rule applied to both claims-made policies as well as occurrence policies.¹²⁴ The court noted that with late notice in either occurrence policies or claims-made policies, “the crucial question in each instance is not the possibility of prejudice but rather whether there was

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 140.

¹²⁰ *Id.*

¹²¹ *Id.* at 143. The court noted that:

[The defendant] argues that the cases which hold that an insurer may assert defenses based upon a breach by the insured of a policy condition only where the insurer was substantially prejudiced thereby, have been enunciated in ‘occurrence-type’ policies where the obligation of the insurer is fixed in time by reference to the happening of an occurrence occasioning loss, such as an automobile accident. In the ‘occurrence-type’ cases, . . . the damages are fixed once the event has happened. Thus, since there is little danger of an expansion of the liability, the need for prompt notification is reduced. Defendant contends that irrespective of the date of the insured’s tort and the date of loss in a ‘claims-type’ policy insuring against claims for errors and omissions, the obligation of the insurer dates in point of time from the time when the third party claim is made against the insured. Accordingly, defendant argues that in a ‘claims-type’ policy the possibility of prejudice resulting from late notice is greater than in ‘occurrence-type’ policies.

Id.

¹²² *Id.* at 143–44 (referring to *Campbell v. Allstate Ins. Co.*, 384 P.2d 155 (Cal. 1963)).

¹²³ *Campbell*, 384 P.2d at 156.

¹²⁴ *Nw. Title Sec. Co.*, 6 Cal App. 3d at 143–44. The court broadly concluded that “notwithstanding the generic differences between [claims-made and occurrence] policies, there is no indication in *Campbell* . . . that a different rule can apply in ‘claims-type’ policies. The cases make it clear that the subject rule applies to all cases in which the insurer asserts a defense based upon a breach by the insured of a cooperation or notice clause.” *Id.*

actual prejudice to the insurer.”¹²⁵

It was not until 1990 that a California court reconsidered the rather austere holding of *Flack*.¹²⁶ In *Pacific Employers Insurance Co. v. Rausch*, a California court of appeals for the second district determined that the notice-prejudice rule did not apply to claims-made and reported policies.¹²⁷ Pacific Employers Insurance issued Rausch, an insurance salesman, a claims-made and reported liability policy in effect from March 15, 1981, through March 15, 1983.¹²⁸ On November 2, 1982, Rausch died.¹²⁹ Rausch’s widow tendered the policy to the law firm handling her husband’s estate, though the law firm failed to notify Pacific Employers of claims that were made soon after.¹³⁰ When notice was eventually provided to Pacific Employers, the company denied coverage because notice was not provided during the policy period as required by the claims-made and reported policy.¹³¹

Rausch brought suit, and the trial court held that Pacific Employers would need to show actual prejudice in order to deny the claim.¹³² Pacific Employers appealed, and Rausch first maintained that the notice-prejudice rule is applicable to claims-made and reported policies, and that because Pacific Employers could not show prejudice, the insurer should be liable for the claim.¹³³ The *Pacific Employers* court declined to follow *Flack* in its application of the notice-prejudice rule to both claims-made and occurrence policies, noting that:

We recognize that the “notice prejudice” rule has been applied to a “claims made” professional errors and omissions policy In applying the rule, however, the *Flack* court relied solely on *Campbell* finding, without discussion, that the distinction between a “claims made” insurance policy and an “occurrence” policy did not require a departure from the ordinary application of the notice-prejudice rule. In our opinion, this distinction is critical.¹³⁴

The *Pacific Employers* court engaged in an analysis that contrasted claims-made policies and occurrence policies.¹³⁵ In a discussion that closely resembled that of the Florida Supreme Court in *Gulf*—the *Pacific*

¹²⁵ *Id.* at 144.

¹²⁶ *Pacific Employers Ins. Co. v. Rausch*, 221 Cal. App. 3d 1348 (1990).

¹²⁷ *Id.* at 1359.

¹²⁸ *Id.* at 1352–53.

¹²⁹ *Id.* at 1353.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.* at 1353–54.

¹³³ *Id.* at 1354.

¹³⁴ *Id.* at 1357.

¹³⁵ *Id.* at 1358.

Employers court noted that while notice provisions in occurrence policies were designed to aid the insurer in investigating and defending claims, notice provisions in claims-made policies were designed to curtail the “unpredictable and lengthy ‘tail’ of lawsuits filed years after the occurrence.”¹³⁶ Because occurrence policies created lengthy and expensive “tails,” the court reasoned that claims-made policies—and their notice provisions—were materially different from occurrence policies.¹³⁷ As such, the California court held that the notice-prejudice rule does not apply to claims-made and reported policies.¹³⁸

The *Pacific Employers* decision created a split in California courts; while *Flack* stood for the proposition that the notice-prejudice rule applied to both occurrence and claims-made policies,¹³⁹ *Pacific Employers* stood for the proposition that the rule applies to occurrence policies but not claims-made and reported policies.¹⁴⁰ Because the decisions were from appellate courts in different districts, neither decision could control the other.¹⁴¹

One year later, a federal court applying California law was asked to determine whether the notice-prejudice rule should apply to claims-made and reported policies.¹⁴² In *Burns v. International Insurance Co.*, the court considered a claims-made and reported policy requiring that claims be made within the policy period and reported to the insurer within the policy period or sixty days thereafter.¹⁴³ The insureds—officers and directors of a bank—were sued following allegations of professional misconduct and did not notify International Insurance until five months after the expiration of the policy period.¹⁴⁴ The policy holders sued after coverage was denied, and International Insurance was granted summary judgment at the trial court level.¹⁴⁵ The insureds appealed, claiming that the notice-prejudice rule applies to claims-made policies in California.¹⁴⁶

The *Burns* court noted that because the California Supreme Court had not decided whether the notice-prejudice rule applied to claims-made

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.* at 1358–59.

¹³⁹ See *Nw. Title Sec. Co. v. Flack*, 6 Cal App. 3d 134, 144 (1970) (holding that the notice-prejudice rule applies to both occurrence and claims-made insurance policies).

¹⁴⁰ See *Pacific Employers Ins. Co.*, 221 Cal. App. 3d at 1358–59 (holding that the notice-prejudice rule does not apply to claims-made and reported policies).

¹⁴¹ See *Burns v. Int’l Ins. Co.*, 929 F.2d 1422, 1425 (9th Cir. 1991) (noting that “[b]ecause [the *Flack* and *Pacific Employers*] decisions are from different districts of the Court of Appeal, neither is binding on the other”).

¹⁴² *Id.* at 1423.

¹⁴³ *Id.* at 1424.

¹⁴⁴ *Id.* at 1423. Because the insureds had sixty additional days after the policy expiration to report the claim, notice of their claim was over three months late. *Id.*

¹⁴⁵ *Id.* at 1423–24.

¹⁴⁶ *Id.* at 1424.

insurance policies, it would look to other authority in determining how that court would resolve the question.¹⁴⁷ The court found the *Pacific Employers* decision convincing, first noting that because the California Supreme Court denied a request to review the case, “the denial provides some indication that *Pacific Employers* was decided correctly.”¹⁴⁸ Further, the *Burns* court agreed that the distinction between claims-made policies and occurrence policies “is critical,” and that “[t]o apply the notice prejudice rule to a claims-made policy would be to rewrite the policy, extending the policy’s coverage at no cost to the insured.”¹⁴⁹

In 2002, the Ninth Circuit, applying California law, determined that while the notice-prejudice rule did not apply to claims-made and reported policies, it did apply to pure claims-made policies.¹⁵⁰ The case was relatively complicated; the insured—Pension Trust Fund—was named in a third-party action after it engaged in a series of unsuccessful investments.¹⁵¹ Pension Trust tendered its claim to Federal Insurance Company with whom it had a fiduciary responsibility insurance policy.¹⁵² However, Pension Trust failed to provide timely notice of one of its claims to the insurer.¹⁵³ Federal denied coverage based on this late notice, and Pension Trust argued that Federal would need to show prejudice in order to properly deny the claim.¹⁵⁴

The policy at issue was a pure claims-made policy with a notice provision that provided that “The insured shall, as a condition precedent to its right to be indemnified under this policy, give the Company notice as soon as practicable in writing of any claim made against it.”¹⁵⁵ The court identified the existence of pure claims-made policies as distinct from claims-made and reported policy, noting that “[c]laims-made policies can be further classified as either *claims-made-and-reported* policies, which require that claims be reported within the policy period, or general claims-made policies, which contain no such reporting requirement.”¹⁵⁶ While the former distinction was technically accurate, the court went on to note that “[t]he Federal policy was a claims-made policy with no reporting requirement. The policy language required that [Pension Trust] provide notice of claims ‘as soon as practicable.’ It did not require that the claims be reported within the policy period or even within a specific number of

¹⁴⁷ *Id.*

¹⁴⁸ *Id.* at 1425.

¹⁴⁹ *Id.*

¹⁵⁰ *Pension Trust Fund for Operating Eng’rs v. Federal Ins. Co.*, 307 F.3d 944, 957 (9th Cir. 2002).

¹⁵¹ *Id.* at 947–48.

¹⁵² *Id.* at 947.

¹⁵³ *Id.* at 955.

¹⁵⁴ *Id.* at 955–56.

¹⁵⁵ *Id.* at 956 n.6.

¹⁵⁶ *Id.* at 955.

days thereafter.”¹⁵⁷ By convincing itself that the pure claims-made policy at issue contained no reporting requirement, the court held that:

It is reasonable to conclude that a claims-made-and-reported policy differs from a general claims-made policy containing no requirement that the claim be reported within the policy period. . . . [T]he reporting requirement serves two different purposes in the two policies. The notice provision in a general claims made policy, as in an occurrence policy, often requires notice ‘as soon as practicable.’ This serves to ‘facilitate the timely investigation of claims by bringing an event to the attention of the insurer and allows an inquiry ‘before the scent of factual investigation grows cold.’ In contrast, in a claims-made-and-reported policy, notice is the event that actually triggers coverage. Because [the insured’s] policy did not contain a reporting requirement, the notice prejudice rule applies.¹⁵⁸

Once the court determined that Federal needed to show prejudice, it remanded for further proceedings to determine if such prejudice could be shown.¹⁵⁹

By conflating the notice provisions in occurrence and pure claims-made policies, the *Pension Trust* court managed to persuade itself that pure claims-made policies were akin to occurrence policies merely due to the fact that both require notice “as soon as practicable.” Perhaps because the phrasing of the notice provisions in both types of policies was identical, the court concluded that the rationale for requiring notice “as soon as practicable” in pure claims-made policies is to provide the insurer with ample time to investigate the claim. While ensuring that a policy holder provides adequate time for an insurer to investigate claims is one reason that notice is required “as soon as practicable,” pure claims-made policies are less expensive than occurrence policies for the same reason claims-made and reported policies are less expensive; the policies are designed to curb the problem of long “tail coverage,” reduce insurer liability, and consequently reduce the cost of premiums. While the *Pension Trust* court was correct to identify that two types of claims-made policies exist—pure claims-made and claims-made and reported—the court unfortunately undermined one of the central reasons for the creation of pure claims-made policies.¹⁶⁰

¹⁵⁷ *Id.* at 956.

¹⁵⁸ *Id.* at 956–57 (internal citations omitted).

¹⁵⁹ *Id.* at 957.

¹⁶⁰ Of course, the *Pension Trust* holding is favorable to the insured and/or the injured party. While the court’s holding does not focus exclusively on a public policy rationale for assuring coverage,

2. Pennsylvania

Before the 2006 decision in *Coregis Insurance Co. v. Caruso*,¹⁶¹ the law regarding late notice and the notice-prejudice rule in Pennsylvania was very similar to that of Florida.¹⁶² In *City of Harrisburg v. International Surplus Lines Insurance Co.*, a federal court applying Pennsylvania law concluded that the notice-prejudice rule should not apply to claims-made (and reported) policies.¹⁶³ Like *Gulf*, the *City of Harrisburg* court found the differences between occurrence policies and claims-made and reported policies persuasive in determining that the notice-prejudice rule should not apply to claims-made and reported policies.¹⁶⁴ The court provided three policy reasons for not extending the notice-prejudice rule to claims-made policies. First, the court noted that while those purchasing occurrence policies are generally unable to bargain over the notice provision, those purchasing claims-made policies could bargain for an extended discovery period.¹⁶⁵ Second, the court suggested that to apply the notice-prejudice rule to claims-made policies would effectively provide the insured with free coverage.¹⁶⁶ Finally, the court concluded that “[i]n a claims-made policy, the provision requiring notice before the end of the policy period serves a different purpose” than that in an occurrence policy.¹⁶⁷ Notably, the notice provision in claims-made policies “provides a certain date after which an insurer knows that it no longer is liable under the policy, and accordingly, allows the insurer to more accurately fix its reserves for future liabilities and compute premiums with greater certainty.”¹⁶⁸

In *Coregis Insurance Co. v. Caruso*, a federal court applying Pennsylvania law held that the notice-prejudice rule did not apply to claims-made policies requiring notice “as soon as practicable.”¹⁶⁹ While

one may argue that this holding is desirable given that the party who might be hurt in the third-party insurance context tends to be the injured party rather than the insured.

¹⁶¹ *Coregis Ins. Co. v. Caruso*, No. 06-2189, 2006 WL 3762026, at *1 (E.D. Pa. Dec. 19, 2006) (mem.).

¹⁶² During this time, Pennsylvania courts held that the notice-prejudice rule applied to late notice in occurrence policies, but not in claims-made and reported policies, which was the law in Florida following the decision in *Gulf Insurance Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512, 516 (Fla. 1983).

¹⁶³ *City of Harrisburg v. Int’l Surplus Lines Ins. Co.*, 596 F. Supp. 954, 961 (M.D. Pa. 1984) (mem.). This court’s opinion, like many other opinions referring to the notice-prejudice rule, merely called the policy at issue a “claims-made” policy. *Id.* However, the court was construing a claims-made and reported policy. *Id.* The failure of courts to specify which type of claims-made policy is at hand in a particular case may have led to some of the confusion in articulating whether the notice-prejudice rule should apply to pure claims-made policies.

¹⁶⁴ *City of Harrisburg*, 596 F. Supp. at 961.

¹⁶⁵ *Id.* at 962.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Coregis Ins. Co. v. Caruso*, No. 06-2189, 2006 WL 3762026, at *1 (E.D. Pa. Dec. 19, 2006) (mem.).

the *Coregis* court did not specifically indicate that it was construing a pure claims-made policy, the notice provision provided by the court is that of pure claims-made policies.¹⁷⁰ In the case, the insured was an attorney who handled disability claims.¹⁷¹ After failing to properly file the defendant's disability claim, the defendant brought suit against the attorney.¹⁷² While suit was filed and the attorney was served, Coregis Insurance was not notified of the claim until four years after the claim was made, and it subsequently denied coverage upon notification.¹⁷³ The attorney's former client brought suit against Coregis seeking payment for the default judgment that was subsequently entered against the attorney.¹⁷⁴ Without any significant analysis, the court declared that because "the notice-prejudice rule does not apply to claims-made policies," coverage was properly declined.¹⁷⁵ Because the court did not provide the rationale behind its holding, the holding may arguably be due to the court's failure to distinguish between pure claims-made and claims-made and reported policies. However, the court may very well have identified the similarities between pure claims-made and claims-made and reported policies and decided that the same rationale for not applying the notice-prejudice rule to claims-made and reported policies extends to pure claims-made policies.¹⁷⁶

The plaintiffs in *4th Street Investors v. Dowdell* sued for garnishment under a Directors and Officers liability policy after the insured allegedly misrepresented the health of his company.¹⁷⁷ When the claim was initially brought, Dowdell, the insured, failed to notify Federal Insurance of the claim.¹⁷⁸ During the subsequent garnishment proceedings, Federal claimed that Dowdell's lack of notice precluded coverage under the policy.¹⁷⁹ In response, the plaintiffs argued that first, the policy was pure claims-made; second, that pure claims-made policies have no reporting requirement; and third, that the insurer should have to show prejudice to disclaim liability due to lack of notice in such policies.¹⁸⁰

While only portions of the Federal insurance policy are quoted in the case, the language suggests that it is a pure claims-made policy. The reporting requirement provides that "[a]ny insured shall, as a condition precedent to exercising their rights under any Liability Coverage Section,

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *4th Street Investors v. Dowdell*, No. 06-0536, 2008 WL 163052, at *2 (W.D. Pa. Jan. 15, 2008) (mem.).

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at *3.

¹⁸⁰ *Id.* at *7.

give to the Company written notice as soon as practicable of any Claim.”¹⁸¹ The plaintiffs insisted that this language was indicative of a pure claims-made policy and that the “rejection of the notice prejudice rule h[as] developed in cases that, in reality, involved claims-made-and-reported policies—not those written on a pure claims-made basis.”¹⁸² Further, the plaintiffs argued that the language in the declarations page of the policy suggests that the policy contains no reporting requirement.¹⁸³ However, the court rejected the plaintiff’s argument, and it instead read the declarations in conjunction with the rest of the policy.¹⁸⁴ The court noted that “ignoring [the policy’s] reporting requirements does greater damage to fundamental contract principles than reading them as integral to the contract as a whole.”¹⁸⁵ In dismissing the plaintiffs’ argument, the court characterized the pure claims-made policy as a claims-made and reported policy based on the reporting requirement that the insurer be notified “as soon as practicable.”¹⁸⁶

The court went on to hold that Federal need not show prejudice to disclaim liability due to the insured’s lack of notice.¹⁸⁷ By following the court’s logic, the holding appears to apply to late notice in a pure claims-made context. First, the court initially provided that “lack of notice or late notice under a claims-made policy precludes coverage.”¹⁸⁸ Then, the court noted that “[t]his rule, however, does not precisely cover the situation presented by . . . Federal’s Motion for Summary Judgment” since the plaintiff argued that in a *pure* claims-made context, the notice-prejudice rule should apply.¹⁸⁹ The court dismissed the plaintiff’s argument partly due to its “reporting requirement” in the policy (that claims be reported “as soon as practicable”).¹⁹⁰ While the court categorized the pure claims-made policy as a type of a claims-made and reported policy, this categorization was merely due to the fact that the policy had a reporting requirement—the insurer was to be notified as soon as practicable.

Like the other courts declining to extend the notice-prejudice rule to claims-made policies, the *4th Street Investors* court indicated that the rule should not apply since “[t]he risk to an insurer writing a claims-made policy is narrowly circumscribed.”¹⁹¹ Further, the court noted that:

¹⁸¹ *Id.* at *6.

¹⁸² *Id.*

¹⁸³ *Id.* at *6–7. The declarations provide: “The liability coverage sections (whichever are purchased) [sic] provide claims made coverage which applies only to ‘claims’ first made during the ‘policy period’ or to any extended reporting period.” *Id.* at *7.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at *6, *8.

¹⁸⁷ *Id.* at *9.

¹⁸⁸ *Id.* at *5, *7.

¹⁸⁹ *Id.* at *5.

¹⁹⁰ *Id.* at *6–7.

¹⁹¹ *Id.* at *9.

Coverage [in the claims-made context] is triggered by notice from the insured and ends at a point at which the insurer knows that it will have no further liability under the policy. This benefits the insurer who is able more precisely to calculate risk, and the insured, who pays a significantly lower premium than is available under an occurrence-based policy.¹⁹²

Unlike the court in *Pension Trust*,¹⁹³ the *4th Street Investors* court aptly concluded that the risk-calculating considerations applicable to claims-made and reported policies are just as applicable to pure claims-made policies. While the issue in *4th Street Investors* involved lack of notice, the case is applicable to late-notice situations. Specifically, the court held that when a claims-made policy requires reporting “as soon as practicable,” an insurer need not show prejudice to disclaim coverage when notice was not as soon as practicable.¹⁹⁴

3. Massachusetts

Similar to the court in *4th Street Investors*, the Massachusetts Supreme Judicial Court concluded that the notice-prejudice rule does not apply to pure claims-made policies.¹⁹⁵ In *Tenovsky v. Alliance Syndicate, Inc.*, the plaintiff and his wife brought a tort action against the plaintiff’s employer for personal injury and loss of consortium.¹⁹⁶ The Tenovskys sought a declaratory judgment that Alliance, the employer’s insurer, must defend the employer in the tort action and pay any judgment up to the policy limit.¹⁹⁷ The court noted that the Alliance policy included a clause providing that “in the event that a claim is made against the insured, the insured must ensure that the insurer receives ‘prompt written notice’ of the claim.”¹⁹⁸ Although Tenovsky’s employer was aware of the claim, the employer failed to notify Alliance of the suit.¹⁹⁹ Alliance was unaware of the claim until it received copies of the Tenovskys’ complaint and summons two and one half years after the suit was filed.²⁰⁰ Based on the insured’s failure to provide notice of the claim, Alliance denied coverage.²⁰¹

¹⁹² *Id.* (internal citations omitted).

¹⁹³ *Pension Trust Fund for Operating Eng’rs v. Federal Ins. Co.*, 307 F.3d 944, 957 (9th Cir. 2002).

¹⁹⁴ *4th Street Investors*, 2008 WL 163052, at *6, *10.

¹⁹⁵ See *Tenovsky v. Alliance Syndicate, Inc.*, 677 N.E.2d 1144, 1146 (Mass. 1997) (holding that the notice-prejudice rule does not apply to pure claims-made policies).

¹⁹⁶ *Id.* at 1145.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.*

In holding that the notice-prejudice rule does not apply to pure claims-made policies, the Massachusetts Supreme Judicial Court relied on the same policy rationale for not applying the notice-prejudice rule to claims-made and reported policies. Specifically, the court noted that the requirement that notice of a claim must be made during the policy period or soon thereafter provides fairness in rate setting.²⁰² Likewise, the court provided that:

The closer in time that the insured event and the insurer's payoff are, the more predictable the amount of the payment will be, and the more likely it is that rates will fairly reflect the risks taken by the insurer If a claim is made against an insured, but the insurer does not know about it until years later, the primary purpose of insuring claims rather than occurrences is frustrated.²⁰³

While the *Tenovsky* case may be distinguished on the facts (notice was not merely late, but it was absent), the court's basis for refusing to apply the notice-prejudice rule to pure claims-made policies is still applicable. Because pure claims-made policies were designed to provide cheaper coverage and more accurate rates, application of the notice-prejudice rule would extend coverage and subvert the rationale behind claims-made policies.

4. *Texas*

Texas has taken a narrow—and for the purposes of this Note—appropriate position with regard to the applicability of the notice-prejudice rule in pure claims-made policies. Unfortunately, like the courts in Pennsylvania, two of the noteworthy Texas opinions are memorandum opinions.²⁰⁴ That in itself is interesting, and perhaps suggests that Texas courts find such little merit in the distinctions that are often drawn between pure claims-made and claims-made and reported policies that the courts found their conclusions biting obvious, neglecting to publish their opinions and establish precedent. Nevertheless, consideration of these Texas opinions is important, particularly so that courts in other jurisdictions may follow Texas's lead.

In *Chicago Insurance Co. v. Western World Insurance Co.*, a federal court applying Texas law held that the notice-prejudice rule should apply

²⁰² *Id.* at 1146.

²⁰³ *Id.* (quoting *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28, 30 (Mass. 1990)).

²⁰⁴ See *Chicago Ins. Co. v. W. World Ins. Co.*, No. Civ.A. 3-96-CV-3179R, 1998 WL 51363, at *2-3 (N. D. Tex. Jan. 23, 1998) (mem.) (holding that the notice-prejudice rule does not apply to pure claims-made policies); *East Tex. Med. Ctr. v. Lexington Ins. Co.*, No. 6:04-CV-165, 2007 WL 2048660, at *7 (E.D. Tex. July 12, 2007) (mem.) (holding that the notice-prejudice rule does not apply to pure claims-made policies).

to neither claims-made and reported policies nor pure claims-made policies.²⁰⁵ The case was relatively complicated, as it involved a disagreement between two separate insurance companies providing two different insurance policies.²⁰⁶ Chicago Insurance Company provided the insured with an occurrence policy, and Western World Insurance Company provided a pure claims-made policy.²⁰⁷ A claim was brought against the insured, and while both insurers disclaimed liability, they settled the case on behalf of the insured and agreed to litigate between themselves.²⁰⁸ Chicago Insurance took the position that Western World was responsible for the claim since it contended that an insurer must show prejudice to deny a claim following late notice in the pure claims-made context.²⁰⁹ Chicago Insurance argued that the difference between a pure claims-made and a claims-made and reported policy is that a pure claims-made policy has no reporting requirement, thereby making it subject to the notice-prejudice rule.²¹⁰ The court swiftly rejected the argument, noting that it was a “bizarre” interpretation of the phrase “as soon as practicable” and that such language was an “explicit” reporting requirement.²¹¹ Next, Chicago Insurance argued that Western World should be required to show prejudice to disclaim liability since the policy was pure claims-made rather than a claims-made and reported policy.²¹² The court noted that Chicago Insurance provided no authority to support its argument, and concluded that the court would not apply the notice-prejudice rule to pure claims-made policies.²¹³

In *East Texas Medical Center v. Lexington Insurance Co.*, another federal court applying Texas law expanded on the court’s holding in *Chicago Insurance* and held that “[c]onsistent with Texas and Fifth Circuit law governing claims-made policies, the court declines to impose a duty on [the Insurer] to show prejudice for untimely notice” in the pure claims-made context.²¹⁴ In *East Texas Medical Center*, the court considered a pure claims-made medical malpractice liability policy requiring notice “as soon as practicable.”²¹⁵ Lexington denied coverage on the claim due to late notice after the insured failed to provide notice of a claim for seven months, which also happened to be seven months after the expiration of the

²⁰⁵ *Chicago Ins. Co.*, 1998 WL 51363, at *1.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.* at *2.

²⁰⁹ *Id.* at *3.

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *East Texas Med. Ctr. v. Lexington Ins. Co.*, No. 6:04-CV-165, 2007 WL 2048660, at *9 (E.D. Tex. July 12, 2007).

²¹⁵ *Id.* at *7.

policy period.²¹⁶ The insured claimed that Lexington should be required to show prejudice to deny coverage, arguing that a pure claims-made policy:

[R]equires only that a claim be made during the policy period, and leaves open the possibility that notice may be sent after the expiration of the policy period. . . . [T]herefore, . . . the notice provision in the Lexington policy is not an element of the covered risk and should not be treated as such.²¹⁷

The court summarily dismissed the insured's argument, noting that "[a] review of Texas and Fifth Circuit cases applying Texas law . . . reveals no indication that Texas courts have recognized or are likely to recognize [the Insured's] suggested distinction."²¹⁸ The court noted that rejecting the notice-prejudice rule in the claims-made context is in "congruence with" the rationale for applying the rule to claims-made and reported policies.²¹⁹ Further, the court held that "[t]o require coverage under a claims-made policy where the insurer is not notified of a lawsuit until over seven months after the policy expires would unquestionably expand the risks covered and undermine or destroy the benefits of the claims-made coverage."²²⁰ While this court—like many courts before it—failed to specifically call the policy at issue a pure claims-made policy, it noted that a "distinction" exists between the types of claims-made policies, yet nevertheless aptly held that the notice-prejudice rule applies to neither.²²¹

On March 27, 2009, the Texas Supreme Court endorsed the current no-prejudice trend for late notice in pure claims-made policies. The Fifth Circuit recently certified the question of whether "an insurer [must] show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is nevertheless given within the policy's coverage period."²²² Although the Texas Supreme Court answered this question in the affirmative,²²³ the rationale makes sense. The court reasoned that an insurer should be required to prove prejudice when notice was not provided as soon as practicable *within* the policy period since the insurer

²¹⁶ *Id.* at *2.

²¹⁷ *Id.* at *8.

²¹⁸ *Id.*

²¹⁹ *Id.* (noting that "the Lexington 'claims-made' policy enables Lexington to know its potential costs and liabilities within a short period of time after the policy period has expired").

²²⁰ *Id.*

²²¹ *Id.* at *8–9.

²²² *XL Specialty Ins. Co., v. Fin. Indust. Corp.*, 259 F. App'x. 675, 678 (5th Cir. 2007) (emphasis added).

²²³ *See Fin. Indust. Corp. v. XL Specialty Ins. Co.*, No. 07-1059, WL 795529, at *2 (Tex. Mar. 27, 2009).

had not yet “closed its books” on the policy.²²⁴ The Texas Supreme Court further noted that “for the insurer, the inherent benefit of a claims-made policy is the insurer’s ability to close its books on a policy at its expiration and thus to attain a level of predictability unattainable under standard occurrence policies.”²²⁵ Given this language, it appears to be well-settled law in Texas that when an insured provides notice of a claim that is not as soon as practicable and outside the pure claims-made policy period, an insurer will be allowed to disclaim coverage without showing prejudice.

C. *Going Forward: Handling the Notice-Prejudice Rule and Pure Claims-Made Policies in the Future*

Texas, Massachusetts, and Pennsylvania have appropriately concluded that the notice-prejudice rule should not apply to pure claims-made policies. Unlike California,²²⁶ future courts addressing late notice in the pure claims-made context should follow the current trend and similarly reject the application of the notice-prejudice rule to any type of claims-made policy—be it pure claims-made or claims-made and reported.²²⁷ While the requirement that notice be given “as soon as practicable” does help the insurer adequately investigate claims (as it does in an occurrence policy), the provision also does much more. Such notice requirements help reduce the insurer’s long tail exposure while simultaneously providing the insured with claims-made coverage that is far more affordable than occurrence coverage.²²⁸ In order to provide such affordable coverage, it is imperative that the insurer know its exposure for claims soon after a policy period ends; otherwise, the underwriters’ ability to accurately underwrite policies diminishes.²²⁹ While the notice-prejudice rule may initially appear insured-friendly in purporting to provide coverage only when the insurer is not “prejudiced” by the late notice in the traditional sense (such as being

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ See *Pension Trust Fund for Operating Eng’rs v. Fed. Ins. Co.*, 307 F.3d 944, 956–57 (9th Cir. 2002) (holding that the notice-prejudice rule applies to pure claims-made policies but not claims-made and reported policies).

²²⁷ It should be mentioned that New York recently passed legislation applying the notice-prejudice rule to some types of liability policies. N.Y. INS. LAW § 3420 (McKinney 2009). While the statute appears to provide an escape hatch for claims-made and reported policies, it is unclear whether the exception will also apply to pure claims-made policies. For the same reasons this Note argues that courts should not apply the common law notice-prejudice rule to pure claims-made policies, the statutory escape hatch should be interpreted broadly to prevent application of the notice-prejudice rule to pure claims-made policies in New York.

²²⁸ See Works, *supra* note 2, at 510 (providing that “[a]fter all, as Judge Richard Posner recently assured us, with claims-made formats ‘the coverage is less, but so, therefore, is the cost’”).

²²⁹ See, e.g., *4th Street Investors v. Dowdell*, No. 06-0536, 2008 WL 163052, at *9 (W.D. Pa. Jan. 15, 2008) (mem.) (“Coverage [in the claims-made context] is triggered by notice from the insured and ends at a point at which the insurer knows that it will have no further liability under the policy. This benefits the insurer who is able more precisely to calculate risk, and the insured, who pays a significantly lower premium than is available under an occurrence-based policy.”).

denied the ability to investigate the claim, choose the defense attorney, or participate in settlement discussions), the late notice itself is prejudicial in that it alters the ability of the underwriter to calculate its risk relatively soon after the end of the policy period. The costs of such underwriter uncertainty will likely be passed on to the insured, thereby spreading the cost of excusing insureds' late notice across the entire group of policyholders. As such, application of the notice-prejudice rule to pure claims-made policies harm both the insurer and insured, and the availability of affordable insurance coverage should be preserved by rejecting the notice-prejudice rule in the pure claims-made context.

Of course, any discussion of coverage issues in the third party insurance context involves more individuals than just the insurer and the insured—there is necessarily a third party bringing suit against an insured. When an insurer denies coverage based on late notice, it may very well be that the party that subsequently suffers is not a careless insured, but rather the injured plaintiff who was never a party to the insurance contract to begin with. To make matters worse, if the insured happens to be judgment-proof, the injured party is wholly out of luck and will go uncompensated for the injuries caused by the insured. One may take the position that the law should require the insurer to pay for this loss (even if it would otherwise not be obligated to do so following the insured's late notice) rather than leave the burden of loss on the injured without any hope for compensation.

However, the ideal solution to this problem need not be the extension of coverage in situations in which it never existed. If the notice-prejudice rule were employed to ensure that injured third-parties receive some compensation, a series of other concerns will arise, including the fear that insureds will not comply with notice provisions since they will know coverage will be afforded in such situations. Further, only plaintiffs injured by insured defendants would benefit from this scheme. Instead, the legislature should consider other options—perhaps a fund to which insurers contribute—to ensure that those injured by defendants who fail to comply with their policy provisions (or uninsured defendants, for that matter) will not go uncompensated.

IV. CONCLUSION

The relative lack of case law involving the applicability of the notice-prejudice rule in the pure claims-made context should not motivate courts to blindly follow the old rules imposing the notice-prejudice rule in occurrence policies. Instead, courts should consider the recent opinions in Pennsylvania, Texas, and Massachusetts and similarly hold that the notice-prejudice rule does not apply to pure claims-made policies. To do so will

preserve the benefits of pure claims-made policies,²³⁰ allowing the savings to be passed on to the insured. Likewise, New York courts that are called on to interpret the recent legislation imposing a statutory notice-prejudice rule to insurance policies should interpret the statutory exclusion to prevent application of the notice-prejudice rule to pure claims-made policies. While the statutory language may suggest that pure claims-made policies are exempt from the rule, courts interpreting the statute should ensure that such a position is taken and the benefits of pure claims-made policies are preserved.

²³⁰ One of the benefits includes an insurer's ability to accurately price premiums due to its awareness of exposure soon after the end of a policy period, causing a lower cost of premium.