

RECENT DEVELOPMENTS IN INSURANCE
COVERAGE LAW

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**I. COMMERCIAL GENERAL LIABILITY COVERAGE FOR CLAIMS
OF INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS:
CLAIMS ARISING FROM EMPLOYER-EMPLOYEE RELATIONSHIPS**

The common law has handed down to us the well-established doctrine that the principal is liable for the actions of its agents, assuming that

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the actions giving rise to liability arise within the scope of the agent's authority. This rule has been carried over to modern-day vicarious liability claims arising from the relationships between employers and employees. However, a frequently litigated question is the degree and extent to which an employer's insurance provider is obligated, typically pursuant to a commercial general liability (CGL) policy, to defend and indemnify employers and their employees. In addressing the scope of coverage, if any, the inquiry under CGL policies is generally undertaken in a two-step process: (1) whether the alleged actions of the defendant-insured constitute an "occurrence" under the policy and (2) assuming arguendo that an "occurrence" has been alleged, whether the relevant policy contains applicable exclusionary language.

This analysis usually yields coverage when the agent's actions were negligent, but what is the application of CGL language to cases involving intentional conduct? Particularly, how do courts interpret "occurrence" and apply the "expected or intended injury" exclusion to allegations of intentional conduct? Courts generally conduct such an analysis by looking to the allegations as opposed to the labels set forth in a complaint.¹ This method has led to a seeming consensus that certain intentional torts such as assault and battery do not trigger coverage or are excluded under CGL policies.² But what about more amorphous intentional tort claims, such as claims for intentional infliction of emotional distress (IIED)? A quick, initial assumption suggests that claims for IIED would be predicated on allegations of intentional conduct, which would presumably fall outside the definition of "occurrence"³ and trigger the "expected and intended injury" exclusion. This assumption appears to have received support from recent federal court decisions addressing individual claims for IIED.

In *Grace v. ISI Alarms NC, Inc.*, Scottsdale Insurance Co. insured ISI Alarms NC, Inc., which installed an alarm system in a residence owned

1. See, e.g., *Bertagnolli v. Ass'n of Trial Lawyers Assurance*, 934 P.2d 916, 918-19 (Colo. Ct. App. 1997) ("[R]egardless how the claims against an insured are denominated, a court looks to the essence of the claim rather than how it is characterized in the pleadings."); see also *State Farm Fire & Cas. Co. v. Watters*, 644 N.E.2d 492, 498 (Ill. App. Ct. 1994) (concluding that "allegations of negligent infliction of emotional distress [wer]e a transparent attempt to trigger insurance coverage . . . [because] [t]he facts alleged as the basis of th[e] tort [wer]e still [the insured's] intentional acts of molestation").

2. See, e.g., *Mountain States Mut. Cas. Co. v. Hauser*, 221 P.3d 56, 58-62 (Colo. Ct. App. 2009); see also *Essex Ins. Co. v. Rizqallah Invs., Inc.*, 394 F. Supp. 2d 1002, 1005-07 (W.D. Mich. 2005); but see *RJC Realty Holding Corp. v. Republic Franklin Ins. Co.*, 808 N.E.2d 1263, 1265-66 (N.Y. 2004) (holding that the actions of the agent were "unexpected, unusual and unforeseen" from the employer's perspective; therefore, they were an "accident" within the meaning of the policy and not excluded by the "expected or intended" clause).

3. As reflected by the cases addressed in this piece, "occurrence" is typically defined in CGL policies as an accident.

by the plaintiff where the plaintiff's father resided.⁴ Following the installation, the ISI technician allegedly obtained the plaintiff's credit report through her father, which included her Social Security number.⁵ Afterward, ISI allegedly applied for credit cards using the plaintiff's SSN and a fake e-mail address.⁶ Among other things, the plaintiff sued ISI for intentional infliction of emotional distress.⁷ In her second amended complaint, the plaintiff alleged a direct claim against Scottsdale, and the two parties filed cross-motions for summary judgment on the issue of insurance coverage.⁸

Prior to addressing the exclusionary language, the court analyzed whether the plaintiff's complaint had alleged an "occurrence" within the meaning of Scottsdale's policy.⁹ The court's determination of whether an "occurrence" was pleaded relied upon whether the injuries claimed by the plaintiff were substantially certain to be caused by ISI's behavior.¹⁰ The court noted that the plaintiff alleged that ISI "obtained her credit report without her knowledge or permission and then used that report to apply for credit in [the plaintiff's] name. . . . [And the] alleged conduct was substantially certain, if not intended, to cause the injuries that [the plaintiff] suffered."¹¹ Therefore, the court held that the plaintiff had not alleged an "occurrence."¹² Having determined that the plaintiff did not allege an "occurrence" under Coverage A,¹³ the court did not address whether the "expected or intended injury" exclusion applied.¹⁴

A similar result was reached by the U.S. District Court for the Middle District of Florida in *Chestnut Associates, Inc. v. Assurance Co. of America*.¹⁵ The underlying plaintiffs, two homeowners, brought suit against Chestnut Associates, Inc., alleging claims for intentional infliction of emotional

4. 2014 WL 1600396, at *1 (E.D. La. Apr. 21, 2014).

5. *Id.*

6. *Id.*

7. *Id.* The plaintiff also alleged claims for fraud; invasion of privacy; and knowingly, willfully, and/or negligently failing to comply with the requirements of the Fair Credit Reporting Act. *Id.*

8. Prior to reaching the substantive issues, the court conducted a choice-of-law analysis between the application of Louisiana and North Carolina law. *Id.* at *4. Ultimately, the court ruled that North Carolina law applied to the case. *Id.*

9. *Id.* at *7. The court first addressed whether emotional distress can constitute "bodily injury" as defined by the relevant policy. *Id.* at *6-7. Ultimately, it noted that North Carolina law was unsettled on the question; however, the inquiry was unnecessary given the court's disposition on the issues of "occurrence" and exclusionary language. *Id.* at *7.

10. *Id.* at *7.

11. *Id.*

12. *Id.*

13. Coverage A under the Scottsdale policy covered damages for "bodily injury" and "property damage." *Id.* at *5.

14. *See id.*

15. 17 F. Supp. 3d 1203 (M.D. Fla. 2014).

distress as a result of a Chestnut employee's actions on the their property.¹⁶ Chestnut's insurer, Assurance Company of America, refused to defend Chestnut in the underlying litigation, prompting Chestnut to file a declaratory relief action.¹⁷ For the purposes of the declaratory relief action, the parties stipulated to the following pertinent facts:

- (1) In the complaint, [the underlying plaintiff] alleges that Chestnut's pool service technician came to his house in Holiday, Florida, to service the swimming pool.
- (2) [The underlying plaintiff] alleges that "the pool service technician removed all of his clothes and entered the pool naked." The technician then "sexually pleased himself in the pool" and "brought this sexual behavior to conclusion by casting ejaculate into [[the underlying plaintiff]'s] pool."
- (3) [The underlying plaintiff] alleges that Chestnut's "pool service technician intended and knew or should have known that emotional distress would likely result of [[the underlying plaintiff]] as a result of this subject behavior."
- (4) [The underlying plaintiff] seeks damages for emotional distress, mental anguish, embarrassment, humiliation, loss of dignity and diminution of the value of his house.
- (5) The only cause of action alleged in the underlying complaint is for intentional infliction of emotional distress.¹⁸

The court highlighted that the allegations stated that the pool service technician "intended and knew or should have known that emotional distress" would be the likely outcome of his actions.¹⁹ The insured, however:

relie[d] on the absence of factual allegations that anyone was at home at the time of the alleged incident, or that the pool service technician intended to be or that he was being watched while he engaged in the purported conduct, or that the pool service technician knew that security cameras were recording his alleged conduct.²⁰

In response to the insured's position, the court noted that "it is irrelevant to the determination of coverage whether the pool service technician or Chestnut Associates in fact had knowledge of and intended to cause harm to the [underlying plaintiff]. It is the conduct which must be intentional or reckless, not the emotional distress which resulted."²¹

16. *Id.* at 1207–08.

17. *Id.* at 1207.

18. *Id.* at 1207–08.

19. *Id.* at 1213.

20. *Id.*

21. *Id.* (citing *Dominguez v. Equitable Life Assurance Soc'y*, 438 So. 2d 58, 59 (Fla. Dist. Ct. App. 1983)).

With respect to whether the underlying complaint stated allegations giving rise to an “occurrence,” the court explained that Florida law broadly construes the term “accident” to include “accidental events” and “injuries or damage neither expected nor intended from the standpoint of the insured.”²² Based on this definition, the court held that “[t]he everyday meaning of this clause is that the policy does not insure against damages that an insured intentionally inflicts or that are expected to result from an insured’s intentional acts”²³; thus, the underlying complaint did not set forth an “occurrence.”²⁴ In summary fashion, likely as a result of holding that the technician’s actions were intentional, the court held that the “alleged wrongful acts are excluded from coverage by the intended or expected injury exclusion.”²⁵

The plaintiff in *Harn v. Scottsdale Insurance Co.* was the victim of a motor vehicle accident caused by a drunk driver.²⁶ The accident left her “paralyzed, confined to a reclining wheelchair/gurney,” and she was “unable to speak or move her body, but underst[ood] conversation and communicate[d] by blinking her eyes.”²⁷ Since the accident, the plaintiff had voluntarily attended public events in order to “dramatize for the public, in first hand fashion, the dangers and consequences of driving while under the influence of alcohol.”²⁸

The circumstances of this coverage case arose from the plaintiff’s attendance at the Western Idaho State Fair in 2008.²⁹ The plaintiff and her husband had volunteered with Mothers Against Drunk Driving (MADD), and the plaintiff was stationed at its booth during the state fair, which had been leased to MADD by Spectra Productions, Inc.³⁰ Spectra was insured by Scottsdale.³¹

According to the plaintiff, a Spectra supervisor approached the MADD booth and confronted the plaintiff and her husband, asking them both to leave the fair. The supervisor explained that she was asking the plaintiff to leave “[b]ecause [the plaintiff] . . . [wa]s too graphic and other customers [we]re complaining.”³² Although initially refusing to leave the fair, the

22. *Id.* (quoting *State Farm Fire & Cas. Co. v. CTC Dev. Corp.*, 720 So. 2d 1072, 1076 (Fla. 1998)).

23. *Id.* (citation omitted).

24. *Id.*

25. *Id.* at 1214.

26. 2014 WL 4702235, at *1 (D. Idaho Sept. 22, 2014).

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

plaintiff and her husband eventually left because “they did not feel welcome there.”³³

On October 19, 2009, the plaintiff filed suit against Spectra in state court, alleging two claims: (1) discrimination/loss of civil rights and (2) intentional infliction of emotional distress.³⁴ Following the complaint, Spectra tendered defense to Scottsdale, but Scottsdale reaffirmed an earlier denial of defense in this matter, denying coverage for the underlying actions of the insured and its employee.³⁵ On December 2, 2011, Spectra and the plaintiff reached a settlement agreement whereby Spectra would consent to a stipulated judgment, which would not be executed by the plaintiff, and Spectra would assign its rights under the Scottsdale policy to the plaintiff.³⁶ Thereafter, the plaintiff filed a declaratory judgment action that Scottsdale removed to the U.S. District Court for the District of Idaho; both parties moved for summary judgment on the issue of coverage.³⁷ The two dispositive issues presented to the court on summary judgment³⁸ were in pertinent part (1) whether intentional infliction of emotional distress constituted an “occurrence” under the Scottsdale policy and (2) whether the expected or intended injury exclusion applied.³⁹

Scottsdale argued that emotional distress did not constitute “bodily injury” as defined under the policy;⁴⁰ however, the court determined that the definition of “bodily injury” as applied to emotional distress was ambiguous and, thus, construed it against Scottsdale.⁴¹ Therefore, the court turned to whether the facts of the plaintiff’s underlying complaint set forth an “occurrence.”⁴²

33. *Id.*

34. *Id.* at *2. Prior to filing her state court complaint, the plaintiff had lodged a complaint against Spectra with the Idaho Human Rights Commission. *Id.* at *1–2. Spectra had tendered its defense to Scottsdale in response to this complaint; however, Scottsdale denied the tender. *Id.*

35. *Id.* at *1–2.

36. *Id.* at *3.

37. *Id.* Scottsdale moved for summary judgment in toto, asking the court to determine that the plaintiff’s allegations did not allege “any ‘bodily injury’ resulting from an ‘occurrence’ under the Coverage A section of the [p]olicy; and, second, that [p]laintiff’s allegations did not fall within the Coverage B ‘personal and advertising’ section of the [p]olicy.” *Id.* Conversely, the plaintiff moved for partial summary judgment, seeking a declaration that Scottsdale owed Spectra a duty to defend under the allegations of the underlying complaint. *Id.*

38. As noted in a prior footnote, in addition to analyzing Coverage A under the Scottsdale policy, the court reviewed, interpreted, and applied the language of Coverage B, which addressed “personal injury” and “advertising injury.” See *supra* note 37. However, this article addresses the application of Coverage A to these circumstances and not the court’s analysis regarding Coverage B.

39. *Harm*, 2014 WL 4702235, at *3.

40. The policy defined “bodily injury” to mean “bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.” *Id.* at *6.

41. *Id.* at *7–8.

42. *Id.* at *9.

Scottsdale argued that the complaint set forth a claim for intentional infliction of emotional distress that “by its very terms could not involve accidental conduct.”⁴³ The court noted that Scottsdale’s argument followed a logical path; however, it explained that “the fact that certain conduct may have been allegedly intentional . . . does not *ipso facto* mean that a related accident could not have taken place, owing to such conduct.”⁴⁴ In reaching its conclusion, the court adopted the definition of “accident” set forth by the Idaho Supreme Court, which defined “accident” as “‘an unexpected event which is the result of unintentional conduct or an intentional act which results in unexpected consequences.’”⁴⁵ While the court did not comment on whether the plaintiff’s allegations meant, as a matter of law, that the injury was the result of an accident, it explained that “the record [wa]s uncertain as to what the Spectra employees intended to accomplish from their conduct.”⁴⁶ For the foregoing reasons, the court held that “it [wa]s unclear whether or not the conduct leading up to [p]laintiff’s alleged injury was an accident and, thus, an ‘occurrence’ under the [p]olicy.”⁴⁷ Therefore, Scottsdale’s request for summary judgment was denied.⁴⁸

After determining that the record did not allow it to conclude whether the employees’ actions constituted an “occurrence,” the court addressed whether the “expected or intended injury” exclusion applied.⁴⁹ The court explained that a ruling in Scottsdale’s favor meant that the court had to “be convinced that, in insisting that [p]laintiff leave the Expo Building, Spectra’s employees expected or intended for [p]laintiff to suffer emotional distress.”⁵⁰ However, the court noted that “[t]he record does not permit that ultimate conclusion as a matter of law because questions of fact preclude a finding that Spectra’s employees—even if acting either intentionally or recklessly as [p]laintiff alleges—had any particular expectations . . . by way of [p]laintiff’s physical/emotional reaction.”⁵¹ Consequently, the court held that “it is unclear whether [p]laintiff’s alleged

43. *Id.*

44. *Id.*

45. *Id.* (quoting *State Farm Fire & Cas. Co. v. Doe*, 946 P.2d 1333, 1336 (Idaho 1997)).

46. *Id.* Scottsdale cited *Blue Cross of Idaho Health Services, Inc. v. Atlantic Mutual Insurance Co.*, in which the court held that a claim for IIED was not covered by the relevant insurance policy. 2011 WL 162283, at *17 (D. Idaho Jan. 19, 2011). The *Harn* court dismissed this case as inapposite because the court in *Blue Cross of Idaho Health Services, Inc.* addressed a claim for IIED in the context of coverage, whereas the *Harn* court was asked to address whether Scottsdale had a duty to defend its insured, noting that the distinction was dispositive. *Harn*, 2014 WL 4702235, at *9 n.5.

47. *Harn*, 2014 WL 4702235, at *9.

48. *Id.*

49. *Id.* Notably, the court analyzed this exclusion from the standpoint of the insured. *Id.*

50. *Id.* at *10.

51. *Id.*

emotional distress was either expected or intended and, likewise, whether the [p]olicy's 'Expected or Intended Injury' exclusion applie[d] to exclude [p]laintiff's claims."⁵²

Based upon the foregoing rationale, the court determined that the policy was ambiguous on each of the three prongs that Scottsdale asserted to challenge its obligations to defend the underlying case.⁵³ Therefore, it ruled that the underlying complaint against Spectra, the insured, gave rise to a duty to defend Spectra.⁵⁴

Claims under CGL policies predicated on vicarious liability frequently present difficult coverage issues, especially when the alleged wrongful conduct takes the form of an intentional tort. Most often in these circumstances, plaintiffs attempt to trigger coverage and escape relevant exclusionary language by alleging claims for negligent hiring, training, and supervision against the employer, arguing that the employer's negligence is separate and distinct from the employee's intentional conduct.⁵⁵ Such arguments often arise in cases where the employer's liability arises from an employee's assault and battery, which typically leads to ancillary claims for relief such as IIED. The claim for IIED is an alleged consequence of the underlying assault and battery.

Yet, some cases present independent claims for intentional IIED; such claims are decoupled from other underlying intentional torts. When addressing such a claim, how have courts interpreted and applied CGL language? As reviewed herein, the Eastern District of Louisiana and the Middle District of Florida held that such claims do not constitute an "occurrence" and even in the event such allegations gave rise to an "occurrence," the "expected or intended injury" exclusion applies. Notably, as the *Chestnut Associates* court explained, the application of CGL language, at least under Florida law, looks to the act rather than the emotional distress. On the other hand, the *Harn* court determined that a claim for IIED did, in fact, give rise to an "occurrence" and the "expected or intended injury" exclusion did not apply.⁵⁶ In reaching this decision, the court appeared to analyze whether the emotional distress was intended rather

52. *Id.* For factual support of its holding, the court noted that "[a]mong other things, the record does not contain information about what the Spectra employees may have understood about the nature (and extent) of [the plaintiff's] cognitive limitations and other disabilities." *Id.*

53. *Id.*

54. *Id.* at *13.

55. See *Mountain States Mut. Cas. Co. v. Hauser*, 221 P.3d 56, 58–62 (Colo. Ct. App. 2009); see also *Essex Ins. Co. v. Rizqallah Invs., Inc.*, 394 F. Supp. 2d 1002, 1005–07 (W.D. Mich. 2005); but see *RJC Realty Holding Corp. v. Republic Franklin Ins. Co.*, 808 N.E.2d 1263, 1265–66 (N.Y. 2004) (holding that the actions of the agent were "unexpected, unusual and unforeseen" from the employer's perspective, therefore, they were an "accident" within the meaning of the policy and not excluded by the "expected or intended" clause).

56. In essence, the *Harn* court explained that the language defining "occurrence" and the exclusion was ambiguous on the record before the court. 2014 WL 4702235, at *7–10.

than analyzing whether the alleged conduct was intentional. As is evident from the holdings of these cases, the distinction is one with a significant difference. Is the reasoning of the *Harn* court an outlier in this area of the law, or does it provide a framework by which plaintiffs can craft complaints that set forth an “occurrence” that falls within the coverage of a CGL policy? Perhaps the answer is to be found in perspective; that is, whether the expectation or intention language is to be tethered to the act itself or whether expectations and intentions are interpreted through the prism of the alleged consequences of a particular action.

II. RECENT DEVELOPMENTS IN INDEMNIFICATION LAW

A. Introduction

Indemnity clauses have been a tried and true method for shifting the risk of economic loss associated with contracts, typically downstream to parties with less bargaining power, such as subcontractors. However, the last several years have seen the proliferation of anti-indemnity statutes in the construction context that, in one form or another, limit the ability of parties to seek indemnification for their own negligence.⁵⁷ At least forty-four states have now adopted some form of an anti-indemnity statute.⁵⁸

Given the wave of anti-indemnity legislation, upper-tier parties, such as owners or general contractors, have relied more heavily on contractual requirements that they be named as additional insureds on lower-tier parties’ liability policies. By using this additional insured status, upper-tier parties procure broad coverage from insurance carriers, including coverage for the additional insured’s own negligence. However, some states (Arizona, California, Minnesota, and Texas) are now addressing the permissibility of an upper-tier party using additional insured status to insure against its own negligence when that same party could not be indemnified for its own negligence under the applicable anti-indemnity legislation.⁵⁹

57. Traditionally there are three types of indemnity clauses: (1) broad form indemnity under which an indemnitor (the party giving indemnification) assumes the obligation to indemnify the indemnitee (the party seeking indemnification) regardless of which party is at fault; (2) intermediate form indemnity under which an indemnitor assumes the obligation to indemnify the indemnitee as long as *any* fault rests with the indemnitor; and (3) limited form indemnity that requires the indemnitor to assume the obligation to indemnify only to the extent of its own fault in contributing to any loss.

58. See Donald W. Gregory, *Anti-Indemnity Statutes in the 50 States* (2013), <http://www.keglerbrown.com/content/uploads/2013/10/ASA-Anti-Indemnity-Chart-2013.pdf> (last visited Jan. 20, 2015). Alabama, Maine, Nevada, North Dakota, Vermont, Wyoming, and the District of Columbia have yet to enact anti-indemnity legislation.

59. This article focuses on recent legislative changes with regards to the ability to obtain additional insured coverage for a party’s own negligence. However, although not within the

B. Legislative Changes

1. Arizona

Effective September 13, 2013, Arizona amended its anti-indemnity statutes that apply to contractors, subcontractors, and design professionals performing work in connection with a public works project.⁶⁰ The revised statute permits additional insured coverage only to the extent “it complies with this section.”⁶¹ In essence, the Arizona legislature is now preventing additional insured coverage that would provide coverage for a party’s own “negligence, recklessness, or intentional wrongful conduct.”⁶²

2. California

While California has had some form of anti-indemnity legislation since 1967, California expanded the scope of the law.⁶³ In particular, the revised

primary scope of this article, Florida, Michigan, and Washington have also recently enacted changes to their anti-indemnity statutes, which bear mention.

Effective July 1, 2013, Florida enacted a statute that places the contractual ability to limit a design professional’s liability within the purview of the design professional’s employer. FLA. STAT. § 558.0035 (2014). Specifically, the statute grants individual design professionals employed by a business entity or an agent of the entity immunity from liability for economic damages resulting from negligence occurring within the course and scope of a professional services contract under the following conditions: (a) the contract is made between the business entity and a claimant or another entity for the provision of services to the claimant; (b) the contract does not name an individual employee or agent as a party to the contract; (c) the contract prominently states in an uppercase font that is at least five font sizes larger than the other text that an individual employee or agent may not be held individually liable for negligence; (d) the business entity maintains any professional liability insurance required under the contract; and (e) any damages are solely economic in nature and do not extend to persons or property not subject to the contract. *Id.*

Effective March 1, 2013, Michigan expanded its anti-indemnity act to apply to not only “buildings and structures,” but also “highway, road, bridge, water line, sewer line, or other infrastructure, or any other improvement to real property.” MICH. COMP. LAWS SERV. §§ 691.991(1) & (2) (LexisNexis 2014). Michigan also clarified that “design” work was covered by the statute. *Id.* at (1). Finally, the Michigan legislature also specified that public entities may not require a “Michigan-licensed architect, professional engineer, landscape architect, or professional surveyor . . . to defend the public entity or any other party from claims, or to assume any liability or indemnify the public entity or any other party for any amount greater than the degree of fault of the . . . architect, professional engineer, landscape architect, or professional surveyor.” *Id.* at (2).

Effective June 7, 2012, the Washington legislature made two significant modifications of its anti-indemnity statute. WASH. REV. CODE ANN. § 4.24.115 (2014). First, Washington expanded its act to preclude requiring the “duty and cost to defend” arising out of another party’s negligence. *Id.* at (1). The second significant change is the Washington statute was revised to apply to “architectural, landscape architectural, engineering, or land surveying services,” including “liability for damages arising out of such services.” *Id.* This change would seem to include design professionals among those now protected by Washington’s anti-indemnity statute.

60. ARIZ. REV. STAT. §§ 34-226, 41-2586.

61. ARIZ. REV. STAT. §§ 34-226(B), 41-2586(C).

62. ARIZ. REV. STAT. §§ 34-226(B), 41-2586(C).

63. See CAL. CIV. CODE § 2782.05 (Deering 2014).

statute now protects certain subcontractors and suppliers (in addition to contractors), as well as certain private owners (in addition to public entities) from being indemnified for their own “active negligence.”⁶⁴ The revised statute reads:

[P]rovisions, clauses, covenants, and agreements contained in, collateral to, or affecting any construction contract and amendments thereto entered into on or after January 1, 2013, that purport to insure or indemnify, including the cost to defend, a general contractor, construction manager, or other subcontractor, by a subcontractor against liability for claims of death or bodily injury to persons, injury to property, or any other loss, damage, or expense are void and unenforceable to the extent the claims arise out of, pertain to, or relate to the active negligence or willful misconduct of that general contractor, construction manager, or other subcontractor, or their other agents, other servants, or other independent contractors who are responsible to the general contractor, construction manager, or other subcontractor, or for defects in design furnished by those persons, or to the extent the claims do not arise out of the scope of work of the subcontractor pursuant to the construction contract.⁶⁵

Thirteen enumerated exceptions apply to this new section, including certain residential contracts, direct contracts with owners, breach of contract or warranty obligations that are independent of the indemnity obligation, and contracts with design professionals.⁶⁶

Importantly, the California legislature expressly adopted a statutory provision that provides that nothing in § 2782.05 would affect “the obligation, if any, of either a contractor or a construction manager to provide or maintain insurance covering the acts or omissions of the promisor, including additional insurance endorsements.”⁶⁷ As reflected in this article, California’s approach of allowing additional insured coverage for one’s own negligence is contrary to the current statutory trend.⁶⁸

64. *Id.* The California Supreme Court has explained that “active negligence,” which is determined on a case-by-case basis, occurs when an indemnitee has “personally participated in an affirmative act of negligence, was connected with negligent acts or omissions by knowledge or acquiescence, or has failed to perform a precise duty which the indemnitee had agreed to perform.” *Rossmoor Sanitation, Inc. v. Pylon, Inc.*, 532 P.2d 97, 101 (Cal. 1975) (citations omitted).

65. CAL. CIV. CODE § 2782.05(a) (Deering 2014).

66. CAL. CIV. CODE § 2782.05(b).

67. CAL. CIV. CODE § 2782.05(n).

68. California also amended its Public Contract Code, effective October 3, 2013, to permit counties to utilize construction manager at-risk contracts for projects in excess of \$1 million. CAL. PUB. CONT. CODE § 20146 (Deering 2014). The revised statute explicitly stated that the anti-indemnification provisions of Chapter 2782 of the California Civil Code were applicable to these construction manager at-risk contracts. *Id.* § 20146(f).

3. Minnesota

Minnesota revised its anti-indemnity statute, which applies to “building and construction contracts.”⁶⁹ In relevant part the Minnesota statute added the following language: “A provision that requires a party to provide insurance coverage to one or more other parties, including third parties, for the negligence or intentional acts or omissions of any of those other parties, including third parties, is against public policy and is void and unenforceable.”⁷⁰ This new subsection (b) appears to be aimed at stemming efforts by contractors to require subcontractors to name them as additional insureds on the subcontractor’s policy. However, additional ambiguity is created by the next subsection, which reads:

Paragraph (b) does not affect the validity of a provision that requires a party to provide or obtain workers’ compensation insurance, construction performance or payment bonds, or project-specific insurance, including, without limitation, builder’s risk policies or owner or contractor-controlled insurance programs or policies.⁷¹

Subsection (c), by allowing additional insured coverage for the undefined term “project-specific insurance,” potentially creates an exception that swallows the rule. “Project-specific insurance” will assuredly be the subject of future litigation as, interpreted broadly, broad-form indemnity provisions could be valid and enforceable as long as a policy is tied to a specific project.

4. Texas

Joining the throng of other states with anti-indemnity legislation, the Texas Anti-Indemnity Act became effective January 1, 2012.⁷² The Act prohibits “construction contract[s]” or agreements “collateral to or affecting a construction contract” from containing broad-form or intermediate-form indemnity clauses.⁷³ More specifically, the statute applies to a “construction contract for a construction project.”⁷⁴ A “construction project” is defined as:

[C]onstruction, remodeling, maintenance, or repair of improvements to real property. The term includes the immediate construction location and areas incidental and necessary to the work as defined in the construction contract documents. A construction project under this chapter does not include a sin-

69. See MINN. STAT. ANN. § 337.01–10 (2014). Minnesota’s original anti-indemnity statute became effective in 1984.

70. MINN. STAT. ANN. § 337.05(b).

71. MINN. STAT. ANN. § 337.05(c).

72. TEX. INS. CODE § 151.001–151 (2014).

73. TEX. INS. CODE § 151.102.

74. TEX. INS. CODE § 151.101(a).

gle family house, townhouse, duplex, or land development directly related thereto.⁷⁵

Importantly, the Texas Anti-Indemnity Act also contains certain exceptions.⁷⁶ For example, § 151.103 states that the Act

does not apply to a provision in a construction contract that requires a person to indemnify, hold harmless, or defend another party to the construction contract or a third party against a claim for the bodily injury or death of an employee of the indemnitor, its agent, or its subcontractor of any tier.

Notably, seeing the trend toward circumventing anti-indemnity acts via additional insured endorsements, in § 151.104(a), the Texas legislature expressly prohibited any additional insured coverage “to the extent” it provides coverage for the indemnitee’s own negligence. Specifically, the Texas statute provides:

[A] provision in a construction contract that requires the purchase of additional insured coverage, or any coverage endorsement, or provision within an insurance policy providing additional insured coverage, is void and unenforceable to the extent that it requires or provides coverage the scope of which is prohibited under this subchapter for an agreement to indemnify, hold harmless, or defend.⁷⁷

Consequently, in Texas, an additional insured provision is unenforceable “to the extent” the coverage is prohibited by the anti-indemnity act under the indemnity provisions.

C. Conclusion

The current statutory trend is toward prohibiting the use of additional insured coverage to insure against a party’s own negligence when that same party could not be indemnified for its own negligence under the relevant anti-indemnity legislation. It is anticipated that other states will adopt similar legislation, and any party that currently relies on additional in-

75. TEX. INS. CODE § 151.001(2). This definition under the Texas Anti-Indemnity Act is not groundbreaking, but neither is it devoid of ambiguities. For example, determining the meaning of “areas incidental and necessary to the work as defined in the construction contract documents” could easily be subject to different but reasonable interpretations. Would paving contractors performing work on roads leading to a project site fall within the Act’s scope? Would environmental remediation activities occurring in areas near the work site be “incidental and necessary to the work”? Depending on the language in the contract, it could very well be the case that such projects are now covered by this Act. However, the statute itself provides little guidance and, as of the time this article was drafted, there has been no clarification from Texas courts or the Texas Department of Insurance.

76. TEX. INS. CODE § 151.105 (listing twelve statutory exceptions, including public works projects, breach of contract or warranty actions, and construction contracts pertaining to single-family homes, townhouses, and duplexes).

77. *Id.*

sured coverage for protection against harm caused by its own negligence should not assume it will be able to use this approach in the future.

III. NEW YORK COURT OF APPEALS REINFORCES THE STATUS QUO IN 2014

In 2014, the New York Court of Appeals, New York's highest court, decided a number of cases involving insurance coverage disputes or involving the manner in which insurance claims are handled and resolved. Although these cases have the potential to drastically alter the landscape of New York insurance law and have garnered significant attention within the insurance community, they are marked by their reinforcement of the status quo.

Perhaps the most significant and widely anticipated of these decisions was the court's February 2014 decision in *K2 Investment Group, LLC v. American Guarantee & Liability Insurance Co.*,⁷⁸ which marked the court's return to its June 2013 decision in which it seemingly articulated a new rule regarding the consequences of an insurer's breach of its duty to defend.⁷⁹ In *K2-I*, the court held that by having wrongfully denied a defense to its insured under a professional liability policy, the insurer lost its right to subsequently rely on certain policy exclusions for indemnification purposes.⁸⁰ Relying on its decision in *Lang v. Hanover Insurance Co.*⁸¹—a case involving the insurer's right to contest the insured's liability for an underlying loss after breaching the duty to defend—the court explained the new rule as follows:

[W]e now make clear that *Lang*, at least as it applies to such situations, means what it says: an insurance company that has disclaimed its duty to defend “may litigate only the validity of its disclaimer.” If the disclaimer is found bad, the insurance company must indemnify its insured for the resulting judgment, even if policy exclusions would otherwise have negated the duty to indemnify.⁸²

The court justified this rule on grounds of fairness, explaining that it would promote unnecessary and wasteful litigation if an insurer, having wrongfully denied a duty to defend, could then force its insured to litigate the effect of policy exclusions on the duty to defend.⁸³ In so ruling, the court notably did not cite to its prior decision in *Servidone Construction Corp. v. Security Insurance Co.*, wherein the court had held that an insurer's

78. 6 N.E.3d 1117 (N.Y. 2014) [*K2-II*].

79. *K2 Inv. Grp., LLC v. Am. Guar. & Liab. Ins. Co.*, 993 N.E.2d 1249 (N.Y. 2013) [*K2-I*].
80. *Id.* at 1254.

81. 820 N.E.2d 855 (N.Y. 2004).

82. *K2-I*, 993 N.E.2d at 1253–54.

83. *Id.* at 1254.

breach of its duty to defend cannot operate to enlarge a policy's coverage, i.e., that a wrongful disclaimer of coverage does not preclude an insurer from later relying on policy exclusions to avoid an indemnity obligation.⁸⁴ Thus, the decision in *K2-I* stood in direct conflict with *Servidone*.

Following the court's June 2013 decision in *K2-I*, the insurer, American Guarantee, moved for reargument, primarily on the basis that the court had failed to address the decision in *Servidone* and thus created an inconsistency in the case law.⁸⁵ The court granted American Guarantee's motion for reargument—relief that it affords on very rare occasions—and a second round of oral argument was held in January 2014.⁸⁶

In the February 2014 decision, Judge Robert Smith, writing for a four-judge majority (two judges dissented and one judge abstained), acknowledged that the court's June 2013 holding was irreconcilable with its prior decision in *Servidone*.⁸⁷ While the court reaffirmed its prior holding in *Lang* that an insurer is not permitted to relitigate issues in the underlying case if it breaches its duty to defend, the court recognized that this issue is distinct from whether an insurer is permitted to litigate its indemnity obligation subsequent to a wrongful denial of its duty to defend.⁸⁸

In so holding, the court noted that “[t]here is much to be said for the rule” it articulated in its 2013 decision.⁸⁹ The court nevertheless acknowledged that the majority of jurisdictions follow the *Servidone* rule, with the main exceptions being Illinois and Connecticut.⁹⁰ The court further observed that K2 Investment Group had failed to present “any indication that the *Servidone* rule has proved unworkable, or caused significant injustice or hardship, since it was adopted in 1985.”⁹¹ Under the circumstances, the court found it preferable to follow its prior holding in *Servidone*, explaining:

When our Court decides a question of insurance law, insurers and insureds alike should ordinarily be entitled to assume that the decision will remain unchanged unless or until the Legislature decides otherwise. In other words, the rule of stare decisis, while it is not inexorable, is strong enough to govern this case.⁹²

With the court's decision to vacate its earlier ruling in *K2-I*, New York returned comfortably to the majority rule that an insurer's right to contest

84. 477 N.E.2d 441, 445 (N.Y. 1985).

85. *K2-II*, 6 N.E.3d 1117, 1118 (N.Y. 2014).

86. *Id.*

87. *Id.* at 1120.

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

its indemnity obligation does not hinge on whether it wrongfully denied a duty to defend.

Also decided in February 2014 was the court's decision in *Country-Wide Insurance Co. v. Preferred Trucking Services Corp.*, a case involving the time and manner in which an insurer must disclaim coverage for matters implicating New York Insurance Law § 3420(d), particularly those involving an insured's breach of the duty to cooperate.⁹³

New York Insurance Law § 3420 is one of the cornerstones of New York insurance law, governing issues such as late notice and direct actions against insurers. Section 3420(d) concerns the timing and notice requirements that must be followed by an insurer when disclaiming coverage for a claim involving bodily injury or death on the basis of a policy exclusion or condition.⁹⁴ Specifically, the statute provides that if

an insurer shall disclaim liability or deny coverage for death or bodily injury arising out of a motor vehicle accident or any other type of accident occurring within this state, it shall give written notice *as soon as is reasonably possible* of such disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant.⁹⁵

For decades, New York courts have construed this statute as affording only a very limited period of time for an insurer to issue a written disclaimer of coverage upon learning of a basis on which to do so. Failure to comply with the statute results in the insurer subsequently being estopped from relying on the coverage defense.

The *Country-Wide* decision addressed the timing requirement under § 3420(d), namely, what constitutes "as soon as is reasonably possible" and when an insurer has a sufficient basis upon which to issue a disclaimer of coverage.⁹⁶ The underlying suit involved injuries sustained by an individual when he was unloading a truck owned by Preferred Trucking Services, which was insured under a business auto policy issued by Country-Wide Insurance Co.⁹⁷ Country-Wide received notice of the accident from its insured and immediately made several unsuccessful attempts to contact the president of Preferred as well as the driver.⁹⁸ Country-Wide was not given notice of the ensuing lawsuit until after the plaintiff moved for default against both Preferred and the individual driver.⁹⁹ At that point, Country-Wide issued a letter disclaiming any indemnity obligation in connection with the underlying suit on the basis of the insureds'

93. 6 N.E.3d 578 (N.Y. 2014).

94. N.Y. INS. LAW § 3420(d) (McKinney 2014).

95. N.Y. INS. LAW § 3420(d)(2) (emphasis added).

96. 6 N.E.2d at 581–82.

97. *Id.* at 579.

98. *Id.*

99. *Id.* at 580.

failure to cooperate.¹⁰⁰ The letter did not disclaim a duty to defend, but instead reserved the company's right to do so should circumstances warrant.¹⁰¹

Upon receiving the letter, the president of Preferred expressed his willingness to assist Country-Wide in its defense of the underlying suit, but he subsequently proved impossible to reach.¹⁰² For the next year, Country-Wide paid for Preferred's defense in the underlying suit, but this defense was frustrated as a result of the failure of any individual Preferred employee, including the alleged tortfeasor driver, to assist in the defense or appear for deposition.¹⁰³ Notably, the relevant Preferred employees occasionally indicated that they would assist in the defense, but in all instances, failed to do so.¹⁰⁴ Country-Wide even hired an investigator to locate the driver, but his efforts were rebuffed.¹⁰⁵ After several months of repeated attempts to secure the cooperation of these individuals' participation in the defense of the underlying suit, all of which ultimately proved fruitless, Country-Wide issued a second disclaimer letter, this time denying both a defense and indemnity obligation as a result of the individuals' refusal to cooperate in the underlying defense.¹⁰⁶

Country-Wide subsequently brought a coverage action against Preferred, certain Preferred employees, and the underlying plaintiff, seeking a declaration that it had no duty to defend or indemnify as a result of the insureds' breach of the duty to cooperate.¹⁰⁷ The underlying plaintiff moved for summary judgment, arguing that Preferred failed to timely disclaim coverage under § 3420(d), and that as such, its disclaimer of coverage was ineffective.¹⁰⁸ The trial court held that while Country-Wide's disclaimer of coverage was effective as to the Preferred driver, it was untimely as to Preferred and, as such, its disclaimer was invalid, thus obligating Country-Wide to indemnify any underlying judgment.¹⁰⁹ Specifically, the trial court agreed that Country-Wide's time in which to issue a disclaimer began running from one of the earliest unsuccessful attempts to secure Preferred's cooperation and was not in any way tolled or forgiven by the insurer's subsequent attempts to secure this cooperation or the insureds' subsequent indications that it would cooperate. An intermediate

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.* at 580-81.

court affirmed the judgment, and the case was then certified to the Court of Appeals.¹¹⁰

In considering application of § 3420(d) to the underlying facts, the court explained that the timing mechanism of the statute is triggered “once the insurer has sufficient knowledge of facts entitling it to disclaim.”¹¹¹ At that time, the insurer must issue the disclaimer letter as soon “as is reasonably possible,” which is necessarily a case-specific inquiry.¹¹² The court explained that determining the trigger, i.e., knowledge of facts sufficient to issue a disclaimer, in the context of a breach of the duty to cooperate is complicated since an insured’s “noncooperative attitude is often not readily apparent,” and because the courts prefer that an insurer make several attempts to secure an insured’s cooperation before making a final coverage determination.¹¹³ Looking at the facts on the record, the court found compelling several vague statements by Preferred’s president over a period of several months that he *might* assist in the defense of the underlying suit.¹¹⁴ These statements, which the court characterized as “punctuated periods of noncompliance with sporadic cooperation or promises to cooperate,” justified Country-Wide’s decision to refrain from an earlier disclaimer of coverage and prevented the “3420(d) clock” from running at the time of the insureds’ earliest indication of noncooperation.¹¹⁵

Also decided on the same day as *K2-II* and *Country-Wide* was the Court of Appeals’ decision in *QBE Insurance Corp. v. Jinx-Proof Inc.*, a decision concerning the effectiveness of an insurer’s coverage communications to its insured.¹¹⁶ The underlying matter arose out of an assault and battery committed by an employee of the insured.¹¹⁷ QBE had issued a general liability and liquor liability policy to Jinx-Proof that contained an assault and battery exclusion.¹¹⁸ The eventual lawsuit alleged theories of liability escaping the policy’s assault and battery exclusion, including negligence and dram shop liability.¹¹⁹ QBE issued two coverage letters to Jinx-Proof.¹²⁰ The first stated that QBE would not cover any liability under the general liability policy arising out of the assault and battery; the letter mistakenly stated that Jinx-Proof did not have liquor liability coverage.¹²¹

110. *Id.* at 581.

111. *Id.* at 575–76 (quoting *First Fin. Ins. Co. v. Jetco Contr. Corp.*, 801 N.E.2d 835, 837 (N.Y. 2003)).

112. *Id.*

113. *Id.* (quoting *Cont’l Cas. Co. v. Stradford*, 900 N.E.2d 144, 148 (N.Y. 2008)).

114. *Id.* at 582.

115. *Id.* (citation omitted).

116. 6 N.E.3d 583 (N.Y. 2014).

117. *Id.*

118. *Id.*

119. *Id.*

120. *Id.*

121. *Id.* at 584.

One month later, QBE issued a second letter stating that Jinx-Proof did, in fact, have a liquor liability policy but that the policy had an assault and battery exclusion.¹²² The second letter contained the somewhat confusing statement that

we are defending this matter under the Liquor Liability portion of the [general commercial liability] coverage, and under strict reservation of rights for allegations of Assault and Battery. Your policy excludes coverage for assault and battery claims. . . . Therefore, should this matter proceed to verdict, any awards by the Court stemming from allegations of Assault and Battery will not be covered under your Commercial General Liability policy.¹²³

When the remaining claims were dismissed from the underlying suit, QBE brought a declaratory judgment action on the basis of the policy's assault and battery exclusion.¹²⁴ Jinx-Proof argued that QBE's second coverage letter was invalid since it was confusing as to whether QBE was disclaiming coverage or reserving rights. The Court of Appeals rejected this assertion, noting that while QBE's letters contained some "contradictory and confusing" language, the letters did effectively communicate the policy's assault and battery exclusion and the effect that the exclusion had on Jinx-Proof's right to coverage.¹²⁵ As the court explained, the letters "were sufficient to apprise Jinx-Proof that QBE was disclaiming coverage on the ground of the exclusion for assault and battery, and this disclaimer was effective even though the letters also contained 'reservation of rights' language."¹²⁶ Thus, the *Jinx-Proof* decision demonstrates that while coverage correspondence must communicate the insurer's coverage position in an unequivocal and unmistakable fashion, minor errors will not necessarily render it invalid.

Perhaps more notable than the majority's decision in *Jinx-Proof* is the dissent. In addition to reasoning that QBE did not effectively and timely communicate a disclaimer of coverage, the dissent raised an issue as to QBE's failure to have offered independent counsel to Jinx-Proof to defend the underlying suit.¹²⁷ The New York Court of Appeals, in *Public Service Mutual Insurance Co. v. Goldfarb*, long ago established the rule that when an insurer is providing a defense under a reservation of rights on grounds that are at issue in the underlying litigation, the insured is free to select counsel of its own choosing.¹²⁸ The *Goldfarb* decision, however, provides no instruction as to whether the insurer must affirmatively offer

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 585–86.

128. 425 N.E.2d 810 (N.Y. 1981).

independent counsel to the insured. This has generated some uncertainty in the lower courts, although New York's appellate court, in *Elaqua v. Physicians' Reciprocal Insurers*, held that an insurer not only has an affirmative obligation to advise of the right to independent counsel, but failure to do so is a deceptive business practice.¹²⁹

The QBE dissent observed that QBE's reservation of rights on the assault and battery exclusions created a conflict situation under *Goldfarb*.¹³⁰ More notably, the dissent, citing to the lower court decision in *Elaqua*, concluded that QBE had a duty to advise Jinx-Proof of the conflict and its right to independent counsel, and that its failure to have done so precluded its right to disclaim coverage:

Here, by failing to communicate to Jinx-Proof that it was entitled to an attorney of its own choosing paid for by the insurer, QBE breached its duty to its insured in such a way as to estop it from disclaiming. An insurer that arranges matters so that it exclusively controls its insured's defense, preventing the defense from retaining its own counsel at insurer's expense, and possibly acting directly against the interests of the insured, cannot now assert that the policy does not cover the claim.¹³¹

Because the independent counsel issue was only raised in dissent and not addressed in the majority's holding, the rule articulated in *Elaqua* was not adopted by the Court of Appeals and thus is not necessarily the law of New York. Insurers and practitioners should take note, however, that the question of whether an insurer has an affirmative obligation to advise its insured of the right to independent counsel remains open and that the dissent's reasoning as to this issue could be adopted by the court in the future.

The court's fourth major decision was its June 2014 decision in *KeySpan Gas East Corp. v. Munich Reinsurance America, Inc.*, another case addressing an insurer's obligations when issuing disclaimers of coverage in New York.¹³² New York Insurance Law § 3420(d), as discussed above, pertains to an insurer's obligation to issue a disclaimer of coverage within a reasonable period of time for matters involving death or bodily injury when the disclaimer is based on an exclusion or condition.¹³³ By its express terms, the statute does not apply to claims involving property damage, and New York courts have long recognized this distinction.¹³⁴ In *KeySpan*, however, the insured argued that courts *should* impose a similar

129. 860 N.Y.S.2d 229, 232 (N.Y. App. Div. 2008).

130. *Jinx-Proof, Inc.*, 6 N.E.3d at 585–86.

131. *Id.* at 586.

132. 23 N.Y.3d 583, 589 (N.Y. 2014).

133. See *supra* notes 93–113 and accompanying text.

134. *KeySpan*, 23 N.Y.3d at 590–91.

timing requirement on disclaimers of coverage in the property damage context.¹³⁵

KeySpan involved Long Island Lighting Co.'s (LILCO) right to coverage under a series of older general liability policies without pollution exclusions for environmental liabilities arising from manufactured gas plants in Long Island, New York.¹³⁶ Notice was first given by LILCO to its insurers in late 1994, at a time when no formal regulatory proceeding or investigation had been commenced, but when a neighboring property owner had asserted a claim for property damage.¹³⁷ The insurers issued reservation of rights letters that, among other things, reserved the insurers' rights to disclaim coverage on the basis of late notice.¹³⁸ Over the next several years, the insurers investigated LILCO's right to coverage, until 1997, when LILCO commenced a declaratory judgment action against its insurers.¹³⁹ At that time, the insurers asserted late notice as an affirmative defense.¹⁴⁰ Several years of litigation ensued, and while the trial court ultimately held that a question of fact was raised as to whether LILCO's delay in providing notice was reasonable under the circumstances, the court rejected LILCO's assertion that the insurers waived their rights to assert late notice as a coverage defense by not having asserted it sooner.¹⁴¹

On appeal, however, the New York Appellate Division agreed that LILCO failed to provide timely notice with respect to certain of the MGP sites, but further held that summary judgment was inappropriate as questions of fact were raised "as to whether defendants waived their right to disclaim coverage based on late notice" by "fail[ing] to timely issue a disclaimer."¹⁴² More specifically, the court concluded that a jury question was raised as to whether the insurers satisfied "the obligation to issue a written notice of disclaimer on the ground of late notice *as soon as reasonably possible* after first learning of the accident or of grounds for disclaimer of liability."¹⁴³

The court's rationale was notable since the "as soon as reasonably possible" language employed by the court is language unique to New York Insurance Law § 3420(d) and has been limited to the context of disclaimers involving death or bodily injury.¹⁴⁴ Thus, the court's decision

135. *Id.*

136. *Id.* at 587.

137. *Id.* at 587–88.

138. *Id.* at 588.

139. *Id.*

140. *Id.*

141. *Id.* at 588–89.

142. *Id.* at 589.

143. *Id.* (emphasis added).

144. *Id.* at 589–90.

suggested that it was either attempting to apply § 3420(d) to property damage claims, or that it was fashioning a new standard altogether for the timeliness of disclaimers involving property damage claims. This new standard would be governed in the same manner as claims subject to § 3420(d), meaning that an insurer would have only a relatively small window of time in which to issue a disclaimer on the basis of a policy exclusion or condition. The Court of Appeals' decision to take the *KeySpan* appeal, therefore, presented a major opportunity for the court to greatly impact the landscape of claims handling practice in New York.

In its June 2014 decision, the Court of Appeals reaffirmed the long-standing rule that disclaimers of coverage for property damage claims are not governed by the same standard applying to bodily injury claims.¹⁴⁵ In doing so, the court focused on the history and intent of § 3420(d), which it observed was to encourage expeditious resolution of liability claims.¹⁴⁶ The statute, explained the court, “creates a heightened standard for disclaimer that ‘depends merely on the passage of time rather than on the insurer’s manifested intention to release a right as in waiver, or on prejudice to the insured as in estoppel.’”¹⁴⁷ The court expressly rejected LILCO’s argument that a similar standard should govern property damage disclaimers, noting that the New York legislature “chose to limit [application of § 3420(d)] to accidental death and bodily injury claims, and it is not for the courts to extend the statute’s prompt disclaimer requirement beyond its intended bounds.”¹⁴⁸ Rather, for property damage claims such as the underlying suit, the guiding principle is whether the insurers’ delay in disclaiming coverage “manifested an intent to abandon their late-notice defense” under common law principles of waiver and estoppel.¹⁴⁹

Thus, with its decision in *KeySpan*, along with its decisions in *K2-II*, *Country-Wide*, and *Jinx-Proof*, the Court of Appeals reestablished and reaffirmed New York insurance law concerning the consequences of breaching the duty to defend, the timing of disclaimers for matters implicating or not implicating § 3420(d), and the manner in which those disclaimers must be communicated.

IV. CLAIMS-MADE-AND-REPORTED INSURANCE POLICIES

There are many types of insurance policies and many avenues through which an insured is allowed to present the insurer with a claim. On

145. *Id.* at 590–91.

146. *Id.*

147. *Id.* at 590 (quoting *Allstate Ins. Co. v. Gross*, 27 N.E.2d 263, 269 (N.Y. 1970)).

148. *Id.* at 591.

149. *Id.*

one hand, there are the standard “occurrence” policies where the insured is permitted to submit a claim under a long-expired policy for an alleged wrongdoing that may have “occurred” a number of years ago.¹⁵⁰ Conversely, there are “claims-made” policies that require the insured to make the claim within a specific period of time or forever lose the right to do so.¹⁵¹ One noted authority has stated that, generally speaking, “[a]n ‘occurrence’ policy protects a policyholder from liability for any act done while the policy is in effect, whereas a ‘claims-made’ policy protects the holder only against claims-made during the life of the policy.”¹⁵²

A specific subset of claims-made policies are known as “claims-made-and-reported” policies. It is a variation of a straight “claims-made policy” and is very different from an occurrence policy. These policies generally are issued to professionals as malpractice liability coverage.

For example, Steadfast Insurance Company, a member of the Zurich group of insurance companies, provides malpractice coverage to professionals. A typical policy in this class provides, at the outset, the following prefatory notice language to the insured regarding the timing of the insured’s notice to the insurer of a claim:

This is a claims-made-and-reported policy. Notice of a potential “claim” is not a “claim” and does not trigger coverage under this policy. This policy

150. In *Sherwood Brands, Inc. v. Great American Insurance Co.*, the Maryland Court of Appeals noted:

Coverage in an “occurrence” policy is provided no matter when the claim is made, subject, of course, to contractual and statutory notice and limitations of actions provisions, providing the act complained of occurred during the policy period. Because the insurer’s liability in such policies ordinarily relates to a definite, easily identifiable and notorious event such as an automobile accident, a fire, a slip and fall injury, or a ship collision, the insurer is ordinarily able to conduct a prompt investigation of the incident and make an early assessment of related injuries and damages with the result that actuarial considerations permit relative certainty in estimating loss ratios, establishing reserves, and fixing premium rates.

13 A.3d 1268, 1277 (Md. 2011) (citing *St. Paul Fire & Marine Ins. Co. v. House*, 554 A.2d 404, 414 (Md. 1989) (quoting *Stine v. Cont’l Cas. Co.*, 349 N.W.2d 127, 131 (Mich. 1984))).

151. In *Financial Industry Regulatory Authority v. Axis Insurance Co.*, the U.S. District Court for the District of Maryland stated: “A claims-made policy is one in which ‘a claim must be made against the insured during the policy period, but need only be reported to the insurer ‘promptly,’ or ‘as soon as practicable,’ but not necessarily during the policy period.’” 951 F. Supp. 2d 826, 836 (D. Md. 2013) (quoting *Sherwood Brands*, 13 A.3d at 1282); see also *Lindsay v. Att’y’s Liab. Prot. Soc’y, Inc.*, 2013 WL 1776465, at *1 n.2 (W. Va. Apr. 25, 2013) (quoting 1 ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSURED § 1:7 (5th ed. 2007)) (“Under a claims-made insurance policy, ‘coverage is provided based on when a claim is made as opposed to when the circumstances giving rise to the claim came into existence.’”).

152. See *id.* (quoting 7A J. APPLEMAN, INSURANCE LAW AND PRACTICE § 4503 (Berdal ed., 1979; Supp. 1995)).

has certain provisions and requirements unique to it and may be different from other policies an “insured” may have purchased. Read the entire policy carefully to determine rights, duties[,] and what is and is not covered. Throughout this policy the words “you” and “your” refer to the Named Insured shown in the Declarations, and any other person or organization qualifying as a Named Insured under this policy. The words “we”, “us”[,] and “our” refer to the Company providing this insurance. Words and phrases that appear in quotations have special meaning. Refer to DEFINITIONS (Section VIII).

“Claims” must first be made against the “insured” during the “policy period” and “claims” must be reported, in writing, to us during the “policy period”, the automatic extended reporting period[,] or the extended reporting period, if applicable.¹⁵³

Consequently, as noted in *Dilmar Oil Co., Inc. v. Federated Mutual Insurance Co.*, the “focus under a claims-made policy is the type of claim and the date it was asserted.”¹⁵⁴ The Fifth Circuit in *First American Title Insurance Co. v. Continental Casualty Co.* acknowledged that “a claims-made-and-reported policy establishe[d] certain conditions precedent to coverage.”¹⁵⁵ The court recognized:

Claim-triggering reporting is one of these conditions [and] [b]y serving as a required element for establishing a claim under a claims-made-and-reported policy’s insuring clause, claim-triggering reporting “allow[s] the insurer to

153. In *Lindsay v. Attorneys Liability Protection Society, Inc.*, 2013 WL 1776465 (W. Va. Apr. 25, 2013), the Supreme Court of Appeals of West Virginia noted that the professional liability policy issued by Attorneys Liability Protection Society, Inc. (ALPS) provided similar prefatory and, more importantly, cautionary language:

This policy is a “Claims-made and Reported” policy. Therefore, the **Insured** must immediately report any **claim** to ALPS during the **policy period** or during any applicable **extended reporting period**. No coverage exists under this policy for a **claim** which is first made against the **Insured** or first reported to ALPS after the **policy period** or any applicable **extended reporting period**. If the **Insured** receives notice of a **claim**, or becomes aware of an act, error or omission or **personal injury** that could reasonably be expected to be the basis of a **claim**, the **Insured** must immediately deliver a written notice of the **claim** directly to ALPS. . . .

Id. at *12 (emphasis in original).

154. 986 F. Supp. 959, 978 (D.S.C. 1997); *see also* Med. Protective Co. of Ft. Wayne, Ind. v. S.C. Med. Malpractice Liab. Ins. JUA, 648 F. Supp. 2d 753, 760 n.14 (D.S.C. 2009) (citing Truck Ins. Exch. v. Ashland Oil, Inc., 951 F.2d 787 (7th Cir. 1992); Nat’l Cycle, Inc. v. Savoy Reins. Co. Ltd., 938 F.2d 61, 62 (7th Cir. 1991)); *see also* St. Paul Fire & Marine Co. v. Barry, 438 U.S. 531, 535 n.3 (1978).

155. *First Am. Title Ins. Co. v. Cont’l Cas. Co.*, 709 F.3d 1170, 1174 (5th Cir. 2013) (“Under claims-made policies, the mere fact that an ‘act, error, or omission’ occurs during the policy period is not sufficient to trigger insurance coverage.”) (quoting Resolution Trust Corp. v. Ayo, 31 F.3d 285, 288 (5th Cir. 1994)).

‘close its books’ on a policy at its expiration and therefore ‘attain a level of predictability unattainable under standard occurrence policies.’¹⁵⁶

In *PCCP, LLC v. Endurance American Specialty Insurance Co.*, the U.S. District Court for the Northern District of California recognized that

claims-made-and-reported policies do not countenance extensions for last-minute claims, but that such policies are valid as a matter of public policy because they allow insurers to offer low premiums; also noting that “insureds may protect themselves [against last-minute claims] by purchasing so-called ‘tail coverage’ or extended reporting coverage.”¹⁵⁷

Furthermore, the U.S. District Court for the Southern District of Mississippi, in *Sollek v. Westport Insurance Corp.*, noted a “‘claims-made’ policy . . . protects the insured against claims-made during the term of the policy.”¹⁵⁸ The court further recognized that “[a]lthough similar in many respects to a claims-made policy, a claims-made-and-reported policy differs in that it ‘also requires that the claim be reported to the insurance company within the policy period.’”¹⁵⁹ Importantly, “it is generally

156. *Id.* at 1175 (quoting *Resolution Trust Corp. v. Ayo*, 31 F.3d 285, 289 (5th Cir. 1994) (quoting *FDIC v. Mijalis*, 15 F.3d 1314, 1330 (5th Cir. 1994))). In a “claims-made-and-reported” policy, an insurance company “[i]n exchange for the assurance that it will be liable for only those claims that are made and reported to it during the policy’s effective term, . . . may make certain concessions, such as accepting a lower policy premium.” *See id.* at 1175–76; *see also Simpson & Creasy, P.C. v. Cont’l Cas. Co.*, 770 F. Supp. 2d 1351, 1355 (S.D. Ga. 2011) (citing GERALD P. DWYER, JR., APPLEMAN ON INSURANCE LAW AND PRACTICE, § 4.04 [4][d][1] (2010)); *see also Textron, Inc. v. Liberty Mut. Ins. Co.*, 639 A.2d 1358, 1365 n.7 (R.I. 1994) (citing *Burns v. Int’l Ins. Co.*, 929 F.2d 1422, 1425 (9th Cir. 1991) (“[a] claims-made policy reduces the potential exposure of the insurer and is therefore less expensive to the insured”); *see also City of Harrisburg v. Int’l Surplus Lines Ins. Co.*, 596 F. Supp. 954, 961 (M.D. Pa. 1984), *affirmed*, 770 F.2d 1067 (3d Cir. 1985) (because an insurer’s liability under a claims-made policy “does not extend beyond the end of a specific term . . . an insured pays a lesser premium”); *see also Gulf Ins. Co. v. Dolan Fertig & Curtis*, 433 So. 2d 512, 516 (Fla. 1983) (lower premiums are charged because “there is no open-ended ‘tail’ after the expiration date of the policy”); *see also Esmailzadeh v. Johnson & Speakman*, 869 F.2d 422, 425 (8th Cir. 1989)).

157. 2013 WL 4384245, at *6 (N.D. Cal. Aug. 13, 2013) (citing CALIFORNIA PRACTICE GUIDE INSURANCE LITIGATION §§ 7:103-7 through 7:104.1); *see also D&M Screw Mach. Prods., LLC v. Tabellione*, 2014 WL 1187893, at *3 (Conn. Super. Ct. 2014).

158. 2012 WL 5835535, at *3 (S.D. Miss. Nov. 2, 2012) (quoting *Titan Indem. Co. v. Williams*, 743 So. 2d 1020, 1024 (Miss. Ct. App. 1999)); *see also Moody v. Am. Guar. & Liab. Ins. Co.*, 804 F. Supp. 2d 1123 (W.D. Wash. 2011) (quoting *Safeco Title Ins. Co. v. Gannon*, 774 P.2d 30, 35 (Wash. Ct. App. 1989)); *see also In re McCarthy*, 473 B.R. 485 (D. Mass. Bankr. 2012). The court in *In re McCarthy* noted: “Under a claims-made-and-reported insurance policy, the date of the event giving rise to the claim does not control the availability of coverage. Instead, under this type of policy, the claim must both be made to the insured and reported to the insurer within the policy period.” *Id.* at 489 n.4 (citing *Edwards v. Lexington Ins. Co.*, 507 F.3d 35, 38 n.2 (1st Cir. 2007)); *see Fin. Res. Network, Inc. v. Brown & Brown, Inc.*, 867 F. Supp. 2d 153, 178 (D. Mass. 2012); *see also Jennings Constr. Servs. Corp. v. ACE Am. Ins. Co.*, 783 F. Supp. 2d 1209, 1212 (M.D. Fla. 2011).

159. *Sollek*, 2012 WL 5835535, at *3 (quoting *Jones v. Lexington Manor Nursing Ctr., L.L.C.*, 480 F. Supp. 2d 865, 868 (S.D. Miss. 2006)). One of the noted authorities, *New*

held that [claims-made-and-reported] policies require both the making and reporting of the claim within the specified period [because] “[b]oth reports are “considered essential to coverage”. . . .”¹⁶⁰ Moreover, “[s]uch a [notice requirement] provision defines the scope of coverage by providing a certain date after which an insurer knows it is no longer liable under the policy.”¹⁶¹ Importantly, under a claims-made-and-reported policy, “the risk of a claim incurred but not made, as well as a claim made but not reported, is shifted to the insured.”¹⁶² Therefore, the “purpose of the reporting requirement [in a claims-made policy] is to define the scope of coverage [purchased by the insured] by providing a certain date after which an insurer knows it is no longer liable under the policy.”¹⁶³

In *Murray Architects, Inc. v. Scottsdale Insurance Co.*, the Eastern District of Louisiana concluded that “claims-made-and-reported policies shift

Appleman on Insurance Law, describes these types of insurance policies, as well as the insured’s rights, duties, and responsibilities, as follows:

Under claims-made-and-reported policies, the insured’s duty to provide notice is part of the insuring agreement; that is, providing notice to the insurer is a contractual covenant of the insured and not, as with occurrence-based or claims-made coverage, a mere condition to coverage. Thus, in claims-made-and-reported policies, coverage is triggered only where the third-party claim is asserted against the policyholder during the policy period and the policyholder notifies the carrier of the claim during the policy period.

FRANKLIN D. CORDELL, 3 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 20.01[7][b] (2011); see also *Jennings Constr. Servs Corp. v. ACE Am. Ins. Co.*, 2012 WL 851180, at *2 (M.D. Fla. Jan. 11, 2012).

160. *Sollek*, 2012 WL 5835535, at *3 (quoting *E. Tex. Med. Ctr. Reg’l Healthcare Sys. v. Lexington Ins. Co.*, 575 F.3d 520, 528 (5th Cir. 2009)); see also *Jones v. Lexington Manor Nursing Ctr.*, 480 F. Supp. 2d 865, 868–69 (collecting cases); 7 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 102:20 n. 65 (2011).

161. *Id.* at *8 (quoting *E. Tex. Med. Ctr.*, 575 F.3d at 528); see also *Jones*, 480 F. Supp. 2d at 868; see also *Pension Trust Fund for Operating Eng’rs v. Fed. Ins. Co.*, 307 F.3d 944, 956 (9th Cir. 2002); *Doctors’ Co. v. Ins. Corp. of Am.*, 864 P.2d 1018, 1025 (Wyo. 1993); see also *Textron*, 639 A.2d at 1363 n.2 (quoting ROLAND W. LONG, *THE LAW OF LIABILITY INSURANCE* § 12A.05[3A] (Supp. 1991)). “‘An underwriter who is secure that claims will not arise under the subject policy . . . after its termination or expiration [date] can underwrite a risk and compute premiums with greater certainty’ [and] [t]he insurer [is able to] establish lower reserves and lower premiums because of [the] reduced risk resulting from not having to calculate for inflation or other future material risks.” *New England Reins. Corp. v. Nat’l Union Fire Ins. Co.*, 654 F. Supp. 742, 745 (C.D. Cal. 1986), *vacated on other grounds*, 829 F.2d 840 (9th Cir. 1987) (quoting Comment, *The “Claims-Made” Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. REV. 925 (1975), and citing *Zuckerman v. Nat’l Union Fire Ins. Co.*, 495 A.2d 395, 399 (N.J. 1985)).

162. *Gorman v. City of Opelousas*, 148 So. 3d 888, 893 (La. 2014) (citing *Anderson v. Ichinose*, 760 So. 2d 302, 306 n.6 (La. 1999) (citing *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, 546 (1999))).

163. *Id.* at 893 (quoting *Resolution Trust Corp. v. Ayo*, 31 F.3d 285, 289 (5th Cir. 1994)).

the risks both of claims incurred but not made and of claims-made but not reported.”¹⁶⁴ Moreover, the court recognized that the undeniable “purpose of a claims-made-and-reported policy is to alleviate problems in determining when a claim was made or whether an insured should have known a claim was going to be made.”¹⁶⁵ Finally, the court noted “the plain intent of the language in [a claims-made-and-reported] policy is to restrict . . . liability to those claims discovered and reported during the policy period.”¹⁶⁶

The Southern District of Georgia, in *Simpson & Creasy, P.C. v. Continental Casualty Co.*, acknowledged “coverage [under a ‘claims-made and reported’ policy] is contingent on ‘the claim being made and reported to the insurer during the policy period.’”¹⁶⁷ Furthermore, the district court recognized an important consideration when a court interprets a claims-made-and-reported policy as opposed to some other type of policy, noting that

if a court were to excuse the insured from the reporting requirement or to allow an extension of reporting time after the end of the policy period and any extended reporting period, such is tantamount to an extension of coverage to the insured gratis, something for which the insurer has not bargained. This extension of coverage, by the court, so very different from a mere condition of the policy, in effect rewrites the contract between the two parties.¹⁶⁸

164. 2011 WL 5878148, at *4 (quoting *Regions Bank v. Kountz*, 931 So. 2d 506, 510–11 (La. Ct. App. 2006) (citing *Anderson v. Ichinose*, 760 So. 2d 302 (La. 1999))); see also *Simpson & Creasy, P.C. v. Cont’l Cas. Co.*, 770 F. Supp. 2d 1351, 1354 (S.D. Ga. 2011) (“[U]nder a claims-made and reported policy, ‘a claim notified to the insured during a policy period must be reported to its insurer during the same policy period or an Extended Reporting Period before the policy will provide coverage.’”) (quoting ROBERT D. GOODMAN ET AL., *NEW APPLEMAN LAW OF LIABILITY INSURANCE* § 1.07 (Lexis/Nexis 2010)).

165. *Murray Architects*, 2011 WL 5878148, at *4 (quoting *Regions Bank*, 931 So. 2d at 510–11 (citing *Anderson*, 760 So. 2d 302)).

166. *Id.* (quoting *Poirier v. Nat’l Union Fire Ins. Co.*, 517 So. 2d 225, 227 (La. Ct. App. 1987)); see also *Gargano v. Liberty Int’l Underwriters, Inc.*, 575 F. Supp. 2d 300, 309 (D. Mass. 2008) (in a “claims-made-and-reported” policy, an insured’s failure to report the claim during the policy term is sufficient, standing alone, to permit the insurer to deny coverage”) (citations omitted); see also *ACE Capital Ltd. v. ePlanning, Inc.*, 2013 WL 927084, at *3 (E.D. Cal. Mar. 8, 2013) (“Under a claims-made-and-reported policy, . . . ‘an insurer provides coverage for any loss resulting from claims-made during the policy period.’”) (quoting *World Health & Educ. Found. v. Carolina Cas. Ins. Co.*, 612 F. Supp. 2d 1089, 1094 n.1 (N.D. Cal. 2009) (citing *Burns v. Int’l Ins. Co.*, 929 F.2d 1422, 1424 (9th Cir. 1991)) (emphasis in original)). Consequently, “timely reporting of a claim is the event triggering coverage [and] ‘[t]hrough the coverage of a claims-made-and-reported policy is limited, the insuring agreement is still subject to the same principles of interpretation as other insurance policies.’” *Id.* (citations omitted).

167. *Simpson & Creasy, P.C.*, 770 F. Supp. 2d at 1354 (quoting *Serrmi Prods., Inc. v. Ins. Co. of Pa.*, 411 S.E.2d 305, 307 (Ga. Ct. App. 1991) (emphasis in original)).

168. *Id.*; see also *New England Reins. Corp. v. Nat’l Union Fire Ins. Co.*, 654 F. Supp. 2d 742, 747 (C.D. Cal. 1986) (“The crucial factor is certainty in the calculation of risk; a claims-made and reported policy precisely defines the scope of the insured’s risk to both the insurer and the insured. To permit an insured to receive an unbargained for coverage period beyond that clearly defined in the policy would both provide a windfall for the insured, and eliminate

In that same vein, the Rhode Island Supreme Court, in *Textron, Inc. v. Liberty Mutual Insurance Co.*, concluded that for the court to excuse the insured's delay in timely reporting the claim "would alter a fundamental term of the policy in respect to [the applicability of coverage]."¹⁶⁹

In *Davidson & Bennett v. CNA Reinsurance Co., Ltd.*, the District of South Carolina addressed coverage involving a legal malpractice insurance policy issued to a law firm. The applicable policy provided:

The Company agrees to pay on behalf of the Insured all sums in excess of the deductible that the Insured shall become legally obligated to pay as damages and claim expenses because of a **claim that is both first made against the Insured** and reported in writing to the Company **during the policy period** by reason of an act or omission in the performance of legal services by the Insured or by any person for whom the Insured is legally liable.¹⁷⁰

In *Davidson & Bennett*, a former business client (1) brought a malpractice lawsuit against the law firm in August 1999, (2) had the malpractice claim dismissed by the trial court in March 2001, and (3) served an amended complaint in April 2001.¹⁷¹ In November 2001, while in the process of seeking coverage for a subsequent policy period, the law firm first provided the carrier notice of the claim, even though it was undisputed that the law firm received notice of the malpractice lawsuit in August 1999.¹⁷² The insurer moved for summary judgment on the lack of timely notice and the district court granted the motion, noting:

The clear and unambiguous terms of the policy require that for coverage to exist, the claim be "both first made against the Insured and reported in writing to the Company during the policy period." Because the underlying claim was not first made during the policy period, no coverage exists.¹⁷³

some of the benefits arising from the certainty in the scope of coverage.") (citing *Zuckerman v. Nat'l Union Fire Ins. Co.*, 495 A.2d 395, 406 (N.J. 1985)).

169. 639 A.2d 1358, 1365 (R.I. 1994) (citing *Esmailzadeh v. Johnson & Speakman*, 869 F.2d 422, 424 (8th Cir. 1989) (under a claims-made-and-reported policy excusing delay beyond policy period "would alter a basic term of the insurance contract"); *City of Harrisburg v. Int'l Surplus Lines Ins. Co.*, 596 F. Supp. 954, 961 (M.D. Pa. 1984) (giving an extension of reporting time after policy expiration rewrites the contract between the parties); *Gulf Ins. Co. v. Dolan Fertig Curtis*, 433 So. 2d 512, 515-16 (Fla. 1983) (extending reporting time "in effect rewrites the contract between the two parties"); see also *Koransky, Bouwer & Poracky, P.C. v. Bar Plan Mut. Ins. Co.*, 712 F.3d 336, 344 (7th Cir. 2013).

170. 2006 WL 2475305, at *1 (D.S.C. Aug. 24, 2006) (emphasis in original); see *GS2 Eng'g & Envtl. Consultants, Inc. v. Zurich Am. Ins. Co.*, 956 F. Supp. 2d 686, 694 (D.S.C. 2013) (The "language of the present policy . . . clearly and repeatedly advises that coverage requires a claim to be made and reported during the same policy period.").

171. 2006 WL 2475305, at *1-2. Even though the original claim was dismissed in March 2001, the former client was apparently successful on the appeal of the dismissal and the district court recognized that the amended complaint proceeded on. *Id.* at *3.

172. *Id.* at *2.

173. *Id.* at *3; see also *Berenyi v. Landmark Am. Ins. Co.*, 2010 WL 233861, at **4-5 (D.S.C. Jan. 14, 2010).

Generally speaking, when an insurer denies a claim on the basis of “late notice,” it must demonstrate that it has been “prejudiced” and/or “substantially prejudiced” by the lack of timely notice. That is true in “occurrence” policies, as well as in most standard “claims-made” policies. On the other hand, when an insured does not properly and timely notify its insurer in a “claims-made-and-reported” policy, the prejudice issue is essentially irrelevant. For example, in *Financial Industry Regulatory Authority, Inc. v. Axis Insurance Co.*, the District of Maryland acknowledged:

Nationwide, courts’ holdings regarding the applicability of notice-prejudice rules to claims-made-and-reported policies have been uniform; “[i]n those jurisdictions that have examined the distinction between claims-made and claims-made-and-reported policies, the courts have uniformly relieved the insurers from any requirement to prove prejudice under the latter form of coverage.”¹⁷⁴

Nevertheless, some jurisdictions, such as Maryland, require that the insurer actually demonstrate that it has suffered prejudice as a matter of that particular state’s public policy.¹⁷⁵

An interesting offshoot of the notice requirement in a “claims-made-and-reported” policy was addressed by the District of Minnesota in *United Health Group, Inc. v. Columbia Casualty Co.*¹⁷⁶ The court interpreted a policy issued by National Union Fire Insurance Co. of Pittsburgh, Pa., which required notice of a claim to be made to a specific department at a specific address. The insured failed to make the required notice and the claim was denied. The insured sued, and the court granted summary judgment to National Union, stating:

Requiring that the designated recipient actually receive notice during the policy period “makes sense because insurers can then make plans and fix premiums based on a sounder actuarial footing than would be possible if there were unknown, percolating claims that might be [discovered] after the policy period ran.” Moreover, “to whom” requirements—at least insofar as they specify the exact person or department that must receive notice—“set out

174. *Fin. Indus. Regulatory Auth. v. Axis Ins. Co.*, 951 F. Supp. 2d 826, 837–38 (D. Md. 2013) (citation omitted); see *Catlin Specialty Ins. Co. v. Am. Semiconductor Corp.*, 2014 WL 840693, at *5 (Mass. Super. Ct. Jan. 29, 2014) (“That the notice requirements in a claims-made and reported policy is to be strictly enforced, without exception for lack of prejudice, is the general consensus of courts here and elsewhere. . .”).

175. *Fin. Indus. Regulatory Auth.*, 951 F. Supp. 2d at 837–838 (citing MD. CODE ANN., INS. § 19-110 (West 2014)). *Contra* *Janjer Enters., Inc. v. Exec. Risk Indem., Inc.*, 97 Fed. App’x 410, 414 (4th Cir. 2004) (“Maryland courts have held that ‘claims-made and report[ed]’ policies are not subject to its prejudice requirement.”); *Maynard v. Westport Ins. Corp.*, 208 F. Supp. 2d 568, 574 (D. Md. 2002) (quoting *Rouse Co. v. Fed. Ins. Co.*, 991 F. Supp. 2d 460, 465 (D. Md. 1998) (same)).

176. 941 F. Supp. 2d 1029 (D. Minn. 2013).

bright, discriminating lines” that “do not lend themselves to the application of [Minnesota’s normal] relaxed interpretive standard.”¹⁷⁷

“Claims-made-and-reported” insurance policies are widely used by insureds since they are less expensive than regular “claims-made” policies. Nevertheless, such policies must be strictly adhered to for coverage to apply and insureds should be very careful.

177. *Id.* at 1044 (quoting *Owatonna Clinic-Mayo Health Sys. v. Med. Prot. Co. of Fort Wayne*, 639 F.3d 806, 812 (8th Cir. 2011)).