Successive Claims-Made Policies: Problems and Possible Solutions

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The Scenario

Claims-made policies typically cover claims (1) made against the insured and (2) reported to the company during the same policy period, regardless of when the covered act or omission occurred. Failure to comply with these requirements should, and often does, result in no coverage. As one court has stated:

> *"The closer in time that the 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. The purpose of a claims-made policy is to minimize the time between the insured event and payment. For that reason, the insured event is the claim being made against the insured during the policy period and the claim being reported to the insurer within that same period or a slightly extended, and specified, period. 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. Accordingly, the requirement that notice of the claim be given in the policy period or shortly thereafter in the claims made policy is of the essence in determining whether coverage exists."*

(*Chas. T. Main, Inc. v. Fireman's Fund Insurance Company*, 406 Mass. 862, 865, 551 N.E. 2d 28, 30 (1990)).

Given the way in which claims-made policies are intended to operate, one would think that determining whether coverage has been triggered is an easy task. However, life is not that simple, especially when an insurer has issued consecutive policies to the same insured. A scenario which often gives rise to coverage controversies is as follows: an insurer issues a series of consecutive, one year claims-made policies to an insured which all require, in order for coverage to exist, that during the same policy period (1) a claim be made against the insured and (2) the claim be reported in writing to the insurer.

The insured receives notice of the claim during one policy period but does not report the claim to the insurer until the next policy period. Does coverage exist for the claim under either the policy in effect when the claim was made or the policy in effect when the claim was reported to the insurer or both? One would think that the answers to these questions are an unequivocal "no", "no" and "no" because the claim was not made and reported during the same policy period. However, as with so many insurance coverage issues, the answers are "maybe", depending upon the law of the

jurisdiction and the policy language in question. This article will review the state of the case law and then make recommendations as to what insurers can do to assure that the claims-made and reported policy requirements are enforced and the intent behind them is effectuated.

The Case Law

The majority of cases that have dealt with the issue at hand have required or held that where there are consecutive claims-made policies, coverage exists only when the claim is made against the insured and reported to the company during the same policy period. See, e.g., *National Union Fire Insurance Co. of Pittsburgh, PA v. Willis*, 296 F.3d 336 (5th Cir. 2002) (Texas law); *St. Paul Reinsurance Co. v. Williams & Montgomery, Ltd.*, 2001 WL 1242891 (N.D. Ill. 2001) (Illinois law); *Pantropic Power Products, Inc. v. Fireman's Fund Ins. Co.*, 141 F. Supp. 2d 1366 (S.D. Fla. 2001) (Florida law); *National Union Fire Ins. Co. of Pittsburgh, PA v. Baker & McKenzie*, 997 F.2d 305 (7th Cir. 1993) (Illinois law); *DiLuglio v. New England Ins. Co.*, 959 F.2d 355 (1st Cir. 1992) (Rhode Island law); *National Union Fire Insurance Co. v. Talcott*, 931 F.2d 166 (1st Cir. 1991) (Massachusetts law); *Zuckerman v. National Union Fire Insurance Co.*, 100 N.J. 304, 495 A.2d 395 (1985). A few courts have deviated from the majority view and have held otherwise. See, e.g., *Cast Steel Products, Inc. v. Admiral Insurance Co.*, 348 F.3d 1298 (11th Cir. 2003); *Helberg v. National Union Fire Insurance Co.*, 102 Ohio App. 3d 679, 657 N.E.2d 832 (6th Dist. 1995). From the perspective of insurers, these "minority" cases are dangerous and controversial because they deviate from policy intent by not requiring literal compliance with the policy requirement that claims be made and reported during the same policy period. Therefore, the minority view will be discussed first.

Cast Steel Products, a case applying Florida law, is the leading "consecutive policy" case which has refused to require that a claim be made and reported in the same policy period. In that case, the insurer, Admiral Insurance Company ("Admiral"), issued two consecutive claims-made and reported policies to Cast Steel. The first policy had an effective date of January 6, 1999 and an expiration date of January 6, 2000 at 12:01 a.m., and the second policy had an effective date of January 6, 2000 and an expiration date of January 6, 2001. Cast Steel received notice of a claim on October 21, 1999, but did not report it to Admiral until January 6, 2000, a few hours after the first policy expired. Admiral denied coverage under both policies, resulting in coverage litigation. The District Court granted summary judgment in Admiral's favor on the grounds that the claim was made during the first policy period but not reported to the company until the second policy period. On appeal, the Eleventh

Circuit Court of Appeals reversed the District Court.

The *Cast Steel* decision begins by "tipping" the court's hand on the way its decision will turn out, stating:

> *"[t]he district court's decision presents a somewhat alarming scenario. Faced with two consecutive insurance policies that created apparently seamless coverage over two policy periods, the court nevertheless found that a claim accruing within the two periods was somehow not covered by either policy . . . At a glance, one would be hard pressed to imagine how a claim accruing in the middle of the two policy periods would not be covered by one of the policies. But because a claims-made policy is designed to cover only claims both accruing and reported during the specified policy period, the district court held that a claim which accrued late in the first policy period but was not reported until early in the second was covered by neither policy."* 1348 F.3d at 1301.

The *Cast Steel* court clearly was troubled by the fact that the District Court made a finding of no coverage even though the insured had "apparently seamless" coverage. What it failed to demonstrate anywhere in its opinion, however, was an understanding of the fundamental principle behind claims-made policies: namely, that the insured event is the claim being made and reported during the same policy period. Rather, to achieve the result it wanted to achieve, the Cast Steel court focused on the "Extended Discovery Period" provision of the first policy, which provided as follows:

> *"If the policy is cancelled or not renewed by the Named Insured an automatic thirty (30) day Claims Extension Period shall apply to claims, provided such claims are not covered under any subsequent insurance purchased by the Named Insured, or that would be covered but for the exhaustion of the amount of insurance applicable to such claims."*

It accepted Cast Steel's argument that because the first policy automatically extends by thirty days the period in which to report claims made during the first policy period if the insured elects to cancel or non-renew the policy, an ambiguity existed as to whether renewal provides a similar reporting extension. Further, it rejected Admiral's contention that because the policy does not discuss a reporting extension when the policy is renewed, "*the policy's silence can only mean that the same reporting extension does not accompany renewal.*" (*Cast Steel*, 1348 F.3d at 1302).

In arriving at its decision, the *Cast Steel* court cited *Helberg v. Nat'l Union Fire Ins. Co.*, 102 Ohio App. 3d 679, 657 N.E.2d 832 (6th Dist. 1995), a case with similar facts

(including a similar extended reporting endorsement) and stated:

> *"Though we . . . would generally agree that the lower premium charged for a claims-made policy should entitle an insured to lesser coverage than a broader, and more expensive, occurrence policy, we find it both illogical and inequitable to deny coverage to the insured who chooses to renew its claims-made policy for successive years with the same insurer – particularly in the scenario we are faced with here. Cast Steel's claim was reported to Admiral mere hours after the expiration of the 99 Policy, and during a time period in which the 00 Policy had become effective. As the Helberg court noted, if choosing to cancel or non-renew provided the insured with an extended reporting period, electing to continue to do business with the same insurer by renewing the claims-made policy certainly "should not precipitate a trap wherein claims spanning the renewal are denied.*
>
> *It seems to us that the most reasonable interpretation of the extended reporting clause is that it automatically extends the reporting period through renewal. The clause is clearly ambiguous on this point."* (*Cast Steel,* 348 F.3d at 1303-04).

The *Cast Steel* court's rationale is troubling because Cast Steel had ample time to report the claim during the first policy period (it had almost three months to report the claim before the policy expired). The case did not involve an eleventh hour claim made near the end of the policy period.

Perhaps the leading case trumpeting the majority view and finding no coverage is *National Union Fire Insurance Co. v. Talcott*, a case applying Massachusetts law. In that case, the insured was sued in policy period one but did not report the suit to the insurer until policy period two. The insurer denied coverage, resulting in coverage litigation. In an effort to secure coverage, the insured argued that "*the policy is contrary to public interest (and hence unenforceable) because it excludes claims that arise late in the policy year and are reported only after expiration of the policy period*." (*Talcott*, 931 F.2d at 168). Rejecting this argument, the court stated that "the policy at issue does provide for an extended reporting period which allows the insured to purchase coverage at an additional (fractional) cost for claims first made after the expiration of the policy period and of which he simply did not avail himself."

Apparently, the policy at issue contained an extended reporting period option in situations where the policy is renewed: the insured could have exercised this option, but did not do so. Accordingly, the holding of no coverage would seem consistent with *Cast Steel*. However, and more importantly, the *Talcott* court did go on to state the following:

> *"Similarly unavailing is appellant's argument that the fact that the notice was received when he was still covered by another policy from the same insurance company compels a different result. The argument fails for the simple reasons that continuous coverage was wholly immaterial to the underlying rationale of Main [(the leading Massachusetts case on claims-made coverage and cited above)]. The essence of that decision was the right of the insurer to set its future premiums and reserves with full knowledge of the outstanding claims it is obligated to meet, and this circumstance requires strict adherence to the notice requirement regardless of whether the same company continued to provide coverage (through a different policy) at the date the notice was received."* (*Talcott*, 931 F.2d at 168-69).

This language suggests that the First Circuit is, in fact, willing to enforce the literal claims made and reported language found in claims made policies.

A year later, the First Circuit arrived at a similar result in *DeLuglio v. New England Insurance Co.*, a case applying Rhode Island Law. In that case, the First Circuit stated as follows:

> *"Finally, appellant contends that an exception should be recognized in the present circumstances, since he maintained continuous coverage under a series of successive one-year "claims-made" policies with the same insurance company. The attempted distinction is untenable. In Talcott, we expressly rejected a similar argument, holding that "[t]he essence of [Main] was the right of the insurer to set its future premiums and reserves with full knowledge of the outstanding claims it is obligated to meet," and that "continuous coverage was wholly immaterial to the underlying rationale."* (*DiLuglio*, 959 F.2d at 360).

There is no mention in *DiLuglio*, one way or the other, about the existence or non-existence of an extended reporting period.

At least three cases – *Pantropic Power Products, Inc. v. Fireman's Fund Insurance Company*, *Checkrite Limited, Inc. v. Illinois National Ins. Co.*, and *Ehrgood v. Coregis Ins. Co.* – involved situations like that in *Cast Steel*, where for an additional premium the policies in question offered an extended reporting period in cases of non-renewal or cancellation, but not renewal. In each of those cases, the insured argued that this created an ambiguity (*Pantropic and Checkrite*) or violated public policy (*Ehrgood*) or the reasonable expectations of the insured (*Ehrgood*) and that as a result, coverage should exist under the policy in effect when the claim was reported to the insurer (as opposed to when the claim was first made). These arguments were soundly rejected. For example, in Ehrgood, the insured contended that "*because an*

insured who cancels or does not renew a policy can extend the reporting period, surely an insured who does renew must be given the same extension." (59 F.Supp. 2d at 446). In rejecting this argument, the Ehrgood court stated:

> *"At first blush, this argument has some intuitive appeal. It seems only logical that an insured who renews receive greater, or at least not less, protection than one who cancels or fails to renew. This approach, however, ignores the nature of the policy at issue. Each of the three policies issued by Coregis is a claims-made policy, which the court previously distinguished from an occurrence policy. . . [T]he notice, or reporting period, in a claims made policy defines coverage: "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." . . . "Thus, an extension of the notice period in a 'claims-made' policy constitutes an unbargained-for expansion of coverage, gratis, resulting in the insurance company's exposure to a risk substantially broader than expressly insured against in the policy."* (*Ehrgood*, 59 F. Supp. 2d at 446-47).

It then went on to say that the insurer's "*failure to make the extended reporting period option available to policy renewals neither violates public policy nor the [insureds'] reasonable expectations*."

Checkrite is also instructive because in that case the insured argued ambiguity, not public policy or reasonable expectations. There, the court rejected the "ambiguity" argument, finding no ambiguity. In so holding, it stated "*[n]owhere in the contract does it say that renewal creates a continuous period of coverage during which the insured may report claims without regard to the policy in which they were first made.*" (*Checkrite Ltd., Inc.*, 95 F. Supp. 2d at 193).

The *Pantropic*, *Ehrgood* and *Checkrite* trilogy of cases is seemingly persuasive authority for the proposition that no coverage exists when the dates on which claims are made and reported are split between successive policy periods. But, it should be noted that in *Pantropic* and *Ehrgood*, the policies in question had a so-called 60 day "grace period" or "reporting window". The difference between an extended reporting period and grace period is subtle, but important.

In an extended reporting period situation, the claim must be made and reported during the policy period, as extended. Often, there is a requirement that the "Wrongful Act" being insured against occur prior to the expiration of the original policy period at issue. In a "grace period" or "reporting window" situation, on the other hand, the claim must be made during the original policy period but can be

reported to the insurer during the "grace period" or "reporting window."

The grace period in *Pantropic* and *Ehrgood* required that the claim be reported to the insurer "*as soon as practicable after the claim is made (but in no event more than 60 days following the end of policy period)*", and in both cases, the insured failed to report the claim during that "window" or "grace period." Policyholders will no doubt seize on this distinction to validate the rationale of *Cast Steel* because in that case, the policies apparently did not contain a so-called "grace period." However, nothing in *Pantropic* and *Ehrgood* indicates that the existence of a "grace period" was determinative. What was determinative was the failure to report the claims to the insurer during the same policy period in which they were made. The courts in those cases clearly realized that by focusing on the claims-made and reported requirements, the true intent behind a claims-made policy (i.e., minimizing the time between the insured event and the insurer's payment) would be effectuated.

In the context of successive policies, what do all of the cases mean? What controlling principles can be gleaned from them? Perhaps the only overriding principle that can be extracted from these cases is that coverage clearly exists if the claim is made and reported during the same policy period. If that does not occur and the claim is first made and reported during different policy periods, one must look to the jurisdiction, the specific policy language at issue and what the insured purchased in order to determine if the policy provides coverage. For example, it must be determined whether the policy has a "grace" period and whether the insured purchased an extended reporting period and, if yes, what that reporting period says.

Avoiding The "Problem"

The problem that appears to be of overriding concern to courts and policyholders arises when the claim is made late in the policy period and compliance with the reporting requirement is difficult, if not impossible. The classic example involves a calendar year policy where the insured, who is out of town on vacation, is served with a complaint on December 31, hours before his policy is to expire and the new one is to take effect. Compliance with the reporting requirement under these circumstances is impossible. Another problem is where a claim is filed but not yet served on the insured. For example, a lawsuit is filed in court during policy period one but not served on the insured until policy period two. In both situations, admittedly unjust consequences can result if the claim must be made and reported during the same policy period in order for coverage to exist. The problem with *Cast Steel* is that it did not involve either situation. The insured was late in reporting the claim for no apparent reason.

To avoid having a policy deemed unenforceable on public policy grounds, at a minimum a "grace" period should be included in the policy that provides for a thirty or sixty day reporting window. Inclusion of such a provision would avoid many of the unfair results that may flow when a claim is made late in the policy period or when the claim is filed during policy period one but not served until policy period two. Courts would likely view policies with such a provision as more "palatable."

This then raises the next issue, which is whether policies should include extended reporting periods, and if "yes", what they should include. Many policies contain extended reporting periods like the one found in *Cast Steel* (i.e., covering cancellation or non-renewal but not renewal). The *Cast Steel* court's holding that the policy was ambiguous because the extended reporting provision did not cover renewals was a "stretch" and hopefully will be rejected by other courts. Some may say a "stretch" was needed because the policy in Cast Steel did not have a reporting "grace period." Perhaps, if it did contain such a provision, the *Cast Steel* court would not have found an ambiguity.

All of this begs the ultimate question – whether insurers must now offer extended reporting periods in cases of renewals. If that indeed becomes a requirement of the courts (and at least three courts have said "no"), it would seem that the very nature of claims-made polices would be changed and they would become hybrids, taking on some characteristics of an occurrence policy because the time between the insured event and payment would be extended. This may be a non-issue if the policy at issue contains a "grace period." However, where it does not, insurers will have to make a decision whether they want to offer extended reporting in cases of renewals. At least in Florida and Ohio, the answer should probably be "yes."

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