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# Do Consecutive Claims-Made Policies Create a Multi-Year Period of Seamless Coverage?

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Over the past twenty years, courts have debated whether an insurer that issues consecutive claims-made insurance policies to the same insured effectively provides the insured with a multi-year period of seamless coverage. The correct answer based on the plain language of the policies is "no," but some courts have used creative logic to reach a contrary result to further their view of equity. The recent trend in the case law is to reject or limit "seamless coverage" arguments, but insurers should be aware of the issue and prepared to address it proactively.

Claims-made professional liability policies are inherently distinct from traditional occurrence-based policies. Under a claims-made policy, coverage is triggered where a claim is both made and reported during the applicable policy period, regardless of when the alleged conduct occurred. Thus, notice to the carrier of a claim during the applicable policy period is the essence of a claims-made policy, and courts construe it as a basic condition precedent to coverage.[1] If the reporting requirement is not satisfied, coverage is not triggered and the insurer has no obligation to pay.

The nature of a claims-made policy allows greater certainty in the risk-underwriting process. At the end of the applicable policy period, the insurer should be aware of its potential exposure under the policy because claims made or reported after that time would not fall within the policy's scope of coverage. Because of this enhanced predictability and limitation on the scope of the insurer's risk, claims-made coverage is provided to the insured at a lower premium.

In *Gulf Insurance Co. v. Dolan, Fertig & Curtis*, the Florida Supreme Court noted the importance of strict adherence to the reporting requirements of claims made policies.[2] The court explained that, if it were to find coverage where an insured reported a claim after the policy period, it would be "tantamount to an extension of coverage to the insured gratis, something for which the insurer has not bargained."[3] Similarly, the New Jersey Supreme Court has confirmed that extending the reporting period in a claims-made policy would constitute an "unbargained-for expansion of coverage," that would be both inequitable and unjustified.[4]

In light of the nature of claims-made policies, issues can arise where a claim is made at the end of the policy period. In that instance, although the insured may report the claim within a reasonable amount of time after it received notice, there would be no coverage if the claim was not both first made and reported during the same policy period. This result would stand regardless of whether the insured renewed coverage with the same insurer for the subsequent policy year. In that instance, if the claim was made during policy year one, but not reported until policy year two, it would not fall within the scope of either policy's coverage. Insureds have argued that this creates a "gotcha" situation because the insured has an unintended gap in coverage despite having consecutive claims-made policies with the same carrier.

To address this scenario, many insurers include policy provisions granting the insured an extended reporting period (an "ERP") in which to report claims so as to eliminate any potential coverage gap in the event the insured is unable to report the claim prior to the end of the first policy period. In some instances, this extension of coverage applies only to claims first made during the ERP for acts that occurred before the policy period ended. Under that kind of ERP provision, an insured still would find itself with a gap in coverage if a claim was first made during the initial policy period but reported during the renewal policy period. An ERP alternatively may specify that it only applies where coverage is canceled or non-renewed and thus would not be triggered where the carrier issued consecutive claims made policies to the same insured. Thus, the specific language of the policy is dispositive in determining the trigger for and terms of ERP coverage.

## Consecutive Claims Made Policies and the Seamless Coverage Controversy

Insureds often argue that, if they have procured consecutive claims made policies with the same carrier, the policies provide seamless coverage such that claims first made during the initial policy period can properly be reported during the renewal period. To support this position, insureds point to various policy provisions, particularly ERP provisions. Although many policies include ERPs that permit claims made during one policy period to be reported after that policy period ends, often the ERP provisions do not apply where the policy is renewed by the carrier. Insureds have latched onto the distinction to bolster their seamless coverage arguments. In particular, insureds have asserted that an ERP is not provided if coverage is renewed because it is unnecessary, as claims made at any time during the period of continuous coverage could be reported at any time during that period.

Some courts initially adopted the "seamless coverage" view despite its inconsistency with the claims-made nature of the policies, and courts have construed ERP language to allow for this result. More recently, courts have rejected this view in favor of enforcing the plain language of claims-made policies. This article discusses the differing court decisions on these issues, suggests preemptive strategies for ensuring that claims-made policies are interpreted as intended, and provides suggestions for responding to an insured's seamless coverage argument.

## Early Case Law Read Consecutive Claims-Made Policies to Provide a Continuous Period of Seamless Coverage

One of the first opinions holding that consecutive claims-made policies should be read as providing a continuous period of seamless coverage was the Ohio Court of Appeals' 1995 decision in *Helberg v. National Union Fire Insurance Co.*[5] The insured in *Helberg* purchased identical consecutive claims-made policies from the same insurer. A claim was made against the insured approximately six weeks before the first policy expired, but not tendered to the insurer until almost six weeks into the subsequent renewal period. The insurer denied coverage because the claim was not first made and reported during the same policy period. The trial court granted summary judgment for the insurer, but the appellate court reversed.

The court opined that, where an insured renews its claims-made coverage with the same insurer, "such an event should not precipitate a trap wherein claims spanning the renewal are denied."[6] The court relied upon two policy provisions in reaching its conclusion: First, the prior acts exclusion referred to "the first policy issued to the named insured by this Company and *continuously renewed thereafter*. . . ."[7] The court concluded that this language "indicates that the parties expected the coverage to be continuous if the policy was renewed. . . ."[8]

Second, and more importantly in terms of the opinion's legacy, the court noted that the policy provided the insured an opportunity to purchase an unlimited extended reporting period if the policy was canceled or non-renewed. The court observed that this provision set forth the only circumstances in which the insured needed to purchase an ERP. Applying the "time honored maxim of construction, *expressio unius est exclusio alterius*," the court concluded that renewal was *not* a circumstance requiring the insured to purchase an ERP (presumably because it could report the claims during the renewal period).[9] The court ultimately concluded that the claim was covered because the policy renewal created a seamless, two-year coverage period.

The Eleventh Circuit relied on *Helberg* in its opinion in *Cast Steel Products, Inc. v. Admiral Insurance Co.*[10] The court in *Cast Steel* addressed a "somewhat alarming scenario"[11] involving identical consecutive claims-made policies: a claim was made against an insured shortly before the end of the first policy period, and the insured "immediately" reported the claim to its broker. Through "an unfortunate twist of fate," the broker failed to report the claim to the insurer until just *hours* after the first policy period expired.[12] The insurer denied coverage on the grounds that the claim was first made in one policy period and reported in another, albeit only by a few hours.

The court "generally agree[d] 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," but held that it would be "illogical and inequitable to deny coverage . . . in the scenario we are faced with here."[13] The court relied upon the policy's ERP provision, which provided for an automatic 30-day ERP in case of cancellation or non-renewal, but which was silent regarding renewal. The court adopted the reasoning of the *Helberg* opinion and held that, "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.'"[14]

The *Cast Steel* opinion distinguished the opinion in *Pantropic Power Products, Inc. v. Fireman's Fund Insurance Co.*,[15] in which the court rejected the insured's seamless coverage argument and strictly enforced the policy's reporting requirement, even though the claim at issue had been reported during a renewal policy period. The court in *Cast Steel* found it significant that the policy in *Pantropic* protected the insured by providing a 60-day grace period at the end of each policy period, but the insured did not report the claim during the 60-day period. The fact that *Cast Steel* distinguished *Pantropic* on those grounds suggested that the 11th Circuit's opinion might have come out differently if the insured had reported the claim after the automatic 30-day grace period that the policy would have provided *if* the policy had been cancelled or non-renewed.

The *Cast Steel* opinion left important questions unanswered. The court did not clarify whether it was (1) holding that consecutive claims made policies create seamless coverage such that a claim could be reported at any time during the renewal policy period; (2) giving the insured the same 30-day ERP it would have had if it had not renewed; or (3) merely rectifying what it viewed as an inequitable coverage denial such that its opinion should be strictly limited to the facts presented. The court's reliance on the *Helberg* opinion and its application of the *expressio unius* canon to the ERP provision suggest that it interpreted the policies to create a seamless, two-year coverage period. But other language in the court's opinion suggested it should be read as a fact-specific, equitable ruling limited to its unique circumstances.

## Seeing the Light – Courts Reject or Limit Seamless Coverage Arguments

In the years following the *Helberg* and *Cast Steel* opinions, other courts have grappled with seamless coverage arguments and have largely rejected or limited their application. The United States District Court for the Middle District of Florida took a step towards limiting *Cast Steel* in its 2011 opinion in *Continental Casualty Co. v. Black, Sims & Birch, LLP*.[16] In *Black Sims*, the court considered two consecutively-issued policies that both contained an automatic 60-day ERP provision that applied where the policy was canceled or nonrenewed. The policies did not address what would happen in the event of a renewal. Although the *Black Sims* court concluded that the language of the 60-day ERP provision was

ambiguous as applied to the facts presented, the court seemed to find significant that the policyholder reported the claim to the insurer "within the sixty-day extended reporting period provided for in the [first of the two policies]."[17] The *Black Sims* opinion suggested that the court read *Cast Steel* not as creating a seamless, two-year period of coverage, but as providing an insured who renews with the same ERP it would have had if it had nonrenewed or its policy was canceled.

This limited view of *Cast Steel* was endorsed in the recent 2014 opinion in *527 Orton LLC v. Continental Casualty Co*.[18] The court in *527 Orton* addressed consecutive policies with ERP provisions substantively identical to those in *Black Sims*. But in *527 Orton*, the claim was reported much later than 60 days after the end of the policy period in which it was made. The insured argued that *Cast Steel* and *Black Sims* should be interpreted as establishing seamless coverage throughout the period of continuous coverage. The court rejected this argument, citing *Pantropic* for the proposition that ,"[j]ust because the Insured renewed his first policy, does not mean that the two policies merged into one continuous policy period during which claims could be made and reported."[19] The court expressly interpreted both *Cast Steel* and *Black Sims* as providing the insured only with the same ERP it would have had if it had not renewed.

Likewise, other courts around the country increasingly have rejected the seamless coverage argument. The development of the law is exemplified in a series of opinions by state and federal courts in Kentucky. Initially, Kentucky courts embraced a broad interpretation of *Cast Steel* and *Helberg*. In *AIG Domestic Claims v. Tussey*, an unpublished opinion, the Kentucky Court of Appeals held that an insured's renewal of a one-year claims-made policy created a two-year period of "continual and seamless coverage."[20] The court relied upon an ERP provision that permitted the insured to purchase a 12-month ERP in the event of cancellation or nonrenewal. Since the policy did not provide for the insured to purchase an ERP if it opted to renew the policy, the court held that the policy must be read to create seamless coverage for any claims made during the period of continuous coverage.

Federal courts in Kentucky first adopted, but then rejected, *Tussey*. Initially, the court in *C.A. Jones Mgmt. Grp., LLC v. Scottsdale Indemnity Co.*[21] followed the *Tussey* ruling and found that consecutive claims-made policies created seamless coverage. Recently, however, on the insurer's motion for reconsideration, the court reversed course and held that the *Tussey* ruling "departs from a long-held principle of Kentucky insurance law instructing courts construing an insurance policy to look to the language of the policy itself."[22] Citing *Pantropic* and other cases, the court rejected *Tussey* as inconsistent with both the plain language of the claims-made policies and the majority of case law around the country. While the motion for reconsideration was pending in *C.A. Jones*, another federal court in Kentucky rejected both *Tussey* and the initial opinion in *Jones* and held that consecutive claims-made policies do not create a period of seamless coverage.[23]

## Lessons Learned: How to Ensure Claims Made and Reported Requirements Are Enforced and Factors to Consider Where Seamless Coverage Arguments Arise

Hopefully, these recent decisions reflect the beginning of the end for *Helberg* and *Cast Steel*. Some courts, however, may still reach incorrect conclusions as the court initially did in *C.A. Jones*. Insureds in this situation will continue to argue that they reasonably expected there to be seamless coverage during the continuous coverage period. And if the facts are such that a court perceives injustice will be done if the policy's reporting requirements are enforced, the court may, like the court in *Cast Steel*, strain to find some ambiguity in the policy to avoid enforcing the reporting condition.

Thus, although the recent decisions reflect a positive development in the law for claims-made carriers, there are additional steps that insurers can take to help ensure that their claims-made policies are interpreted strictly as intended. First, a carrier should carefully review all policy language regarding any ERP coverage, and ensure that the language is clear and unambiguous. Second, an insurer should review all parts of the policy to confirm cohesion among all provisions with respect to reporting requirements, including, e.g., the insuring agreement, the notice of potential claim provisions, policy definitions, the ERP provisions, the prior knowledge/prior notice provisions, and any relevant language in the application. Finally, an insurer could include in its renewal application language specifying that there will be no coverage under either policy for any claim that was made but not reported prior to the inception of the renewal policy.

When a claims-made issue arises in the context of consecutive claims-made policies, a carrier should first review the policy language and the case law in the applicable jurisdiction and consider whether there arguably are any potential ambiguities that could be interpreted against the insurer. It is also important to consider the specific facts at issue and whether there is a "fairness factor" that needs to be taken into account in determining the most prudent strategy for proceeding. Although issues of equity should not impact how clear policy terms are interpreted, as we have seen in *Cast Steel* and myriad other cases, courts can be swayed by principles of fairness, and bad facts certainly do make for bad law.

## Endnotes

1 *Thoracic Cardiovascular Asoocs., Ltd. V. St. Paul Fire & Marine Ins. Co.*, 181 Ariz. 449, 452, 891 P.2d 916, 919 (Ariz. Ct. App. 1994).

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

3 *Id.* at 515-16.

4 *Zuckerman v. Nat'l Union Fire Ins. Co.*, 495 A.2d 395, 406 (N.J. 1985).

5 102 Ohio App.3d 679, 657 N.E.2d 832 (Ohio App. 1995).

6 *Id.* at 834.

7 *Id.*

8 *Id.*

9 *Id.* at 835.

10 *348 F.3d 1298 (11th Cir. 2003).*

11 *Id.* at 1301.

12 *Id.* at 1300.

13 *Id.*at 1303-1304.

14 *Id.* at 1304.

15 141 F. Supp. 2d 1366 (S.D. Fla. 2001).

16 Report and Recommendation, No. 10-cv-1290 (M.D. Fla. Nov. 8, 2011), *report & recommendation adopted by* No. 10-cv-1290 (M.D. Fla. Dec. 14, 2011).

17 *Id.* at 13, n.5.

18 Omnibus Order, No. 13-cv-61571 (S.D. Fla. Sept. 19, 2014).

19 *Id.* at 7.

20 *AIG Domestic Claims v. Tussey*, No. 2008-CA-001248, 2010 WL 3603844, at *4 (Sept. 7, 2010).

21 No. 5:13-CV-00173, 2014 WL 811654 (W.D. Ky. Feb. 28, 2014).

22 No. 5:13-CV-00173, 2015 WL 1393261, at *5 (W.D. Ky. March 25, 2015).

23 *Ashland Hosp. Corp. v. RLI Ins. Co.*, No. 13-143, 2015 WL 1223675 (E.D. Ky. March 17, 2015).