COMMONWEALTH OF MASSACHUSETTS

APPEALS COURT

20-P-1272

MEADOWS CONSTRUCTION CO. LLC, & another[1]

vs.

WESTCHESTER FIRE INSURANCE CO.

MEMORANDUM AND ORDER PURSUANT TO RULE 23.0

At issue is whether summary judgment was properly entered in the insurer's favor in this declaratory judgment action. Because we agree with the judge that the policy required that notice of the claim be reported to the insurer during the policy period, and it is undisputed that the claim was not reported when required, we affirm.

Summary judgment "shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and responses to requests for admission under Rule 36, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Mass. R. Civ. P. 56 (c), as

[1] Michael Meadows.

amended, 436 Mass. 1404 (2002). When a motion for summary judgment is made and properly supported, "an adverse party may not rest upon the mere allegations or denials of his pleading, but his response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Mass. R. Civ. P. 56 (e), 365 Mass. 824 (1974). "[A] dispute about a material fact is 'genuine' when 'the evidence is such that a reasonable jury could return a verdict for the nonmoving party' and a fact is 'material' when it 'might affect the outcome of the suit under the governing law.'" Dennis v. Kaskel, 79 Mass. App. Ct. 736, 740-741 (2011), quoting Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). Where, as here, the party moving for summary judgment would not have the burden of proof at trial, the movant is "entitled to summary judgment if he demonstrates, by reference to material described in Mass. R. Civ. P. 56 (c), unmet by countervailing materials, that the party opposing the motion has no reasonable expectation of proving an essential element of that party's case." Kourouvacilis v. General Motors Corp., 410 Mass. 706, 716 (1991).

"The standard of review of a grant of summary judgment is whether, viewing the evidence in the light most favorable to the nonmoving party, all material facts have been established and the moving party is entitled to a judgment as a matter of law."

Augat, Inc. v. Liberty Mut. Ins. Co., 410 Mass. 117, 120 (1991). "The allowance of a motion for summary judgment is reviewed de novo." Brown v. Kalicki, 90 Mass. App. Ct. 534, 535 n.5 (2016), quoting White v. Hartigan, 464 Mass. 400, 406 (2013). "We may consider any ground supporting the judgment." Augat, supra.

This appeal turns entirely on whether the plaintiffs complied with the notice requirements of the claims-made policy at issue. "The interpretation of an insurance policy is a question of law, which we review de novo." Chenard v. Commerce Ins. Co., 440 Mass. 444, 445 (2003). "Interpretation of an insurance policy is no different from interpretation of any other contract." Citation Ins. Co. v. Gomez, 426 Mass. 379, 381 (1998). Where there is no ambiguity, "we must construe the words of the policy in their usual and ordinary sense." Hakim v. Massachusetts Insurers' Insolvency Fund, 424 Mass. 275, 280 (1997). When the language of a policy is ambiguous, "we interpret it in the way most favorable to the insured." Gomez, supra. "However, an ambiguity is not created simply because a controversy exists between parties, each favoring an interpretation contrary to the other." Lumbermens Mut. Cas. Co. v. Offices Unlimited, Inc., 419 Mass. 462, 466 (1995). "A term is ambiguous only if it is susceptible of more than one meaning and reasonably intelligent persons would differ as to which meaning is the proper one." Gomez, supra. Finally, "it is a

long-standing rule of construction that the favored interpretation of an insurance policy is one which best effectuates the main manifested design of the parties" (quotations and citations omitted). Metropolitan Prop. & Cas. Ins. Co., 58 Mass. App. Ct. 818, 823 (2003).

With these legal principles in mind, we now turn to the specifics of this case. The defendant insurer issued to Meadows Construction Company LLC (the insured) a claims-made policy for the period September 12, 2014 to September 12, 2015, which the insured did not thereafter renew. A "claims made and reported" policy is to be contrasted with an "occurrence" policy. See Chas. T. Main, Inc. v. Fireman's Fund Ins. Co., 406 Mass. 862, 863-864 (1990). A "claims made and reported" policy covers claims against an insured that are made during the policy period and reported within a specified period, whereas an "occurrence" policy covers insured events that occur during the policy period, regardless of when they are reported to the insurer. See id. A "claims made and reported" policy is designed to promote "fairness in rate setting" because it helps ensure that the insured event and the insurer's payout happen close together in time, so that an insurer will have an easier time in calculating its risk of liability and the size of that liability. Id. at 874-875. "Accordingly, the requirement that notice of the claim be given in the policy period or shortly

thereafter in [a] claims-made policy is of the essence in determining whether coverage exists." Id. at 865.

In boldface, all-capital letters on the declarations page of the policy, there is a warning that the policy coverage sections "cover only claims first made against the insured during the policy period . . . and reported to the insurer pursuant to the terms of the relevant coverage section." The pertinent notice provisions of the policy are to be found in sections E.1 (as amended by endorsement) and E.2. Section E.1 provides that the insured:

> "shall, as a condition precedent to [its] rights under this Coverage Section only, give to the Insurer written notice of any Claim made against any Insured as soon as practicable after [any of certain designated company officers] first becomes aware of such Claim, but in no event later than sixty (60) days after the end of the Policy Period, or respecting any Claim first made against the Insured during the Extended Period, if purchased,

> sixty(60) days after the end of the Extended Period" (emphasis added).[2,3]

Put simply, this provision required that the insured give notice of a claim, at the latest, within sixty days of September 12, 2015, the expiration of the policy. The insured concedes that it did not provide notice of the wage and hour class action complaint for which it sought a defense and indemnification during the policy period, or within sixty days of the policy period's expiration.[4] Thus, it is clear that the requirements of section E.1 were not satisfied.

The insured, however, argues that it is entitled to an extended notice period based on the provisions of section E.2, which provides:

> "If, during the Policy Period . . . , any of the Insureds first becomes aware of facts or circumstances which may

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[2] The policy defines "Claim" as "any: a) Employment Practices Claim; or b) Third Party Claim." This case does not involve a third-party claim. "Employment Practices Claim" is defined in the policy as "a written demand against an Insured for damages or other relief," a "civil, judicial, administrative, regulatory or arbitration proceeding against an Insured seeking damages or other relief, commenced by the service of a complaint or similar pleading," or several other types of proceedings. What all the definitions of "Employment Practices Claim" have in common is some kind of proceeding before a judicial or administrative body that was commenced by the filing of a complaint or a notice of charges. Under the policy, the insurer was required to pay for losses from eligible claims first made against the insured during the policy period and reported to the insurer pursuant to the reporting provisions.

[3] There is no dispute that an Extended Period for the policy was not purchased.

[4] Indeed, the class action complaint was not filed until July 1, 2016.

> reasonably give rise to a future Claim covered under this Policy, and if the insureds, during the Policy Period or the Discovery Period, if purchased, give written notice to the insurer as soon as practicable of [certain required information,] then any Claim made subsequently arising out of such Wrongful Act shall be deemed for the purposes of this Coverage Section to have been made at the time such written notice was received by the insurer" (emphasis added).

In essence, the insured's argument is that, because it did not become aware of facts or circumstances which could reasonably give rise to the claims made in the wage and hour class action complaint until it was served with the complaint, its notice to the insurer shortly thereafter was timely. Much of the parties' briefing in this regard focuses on whether the series of events that took place during the policy period was sufficient to make the insured reasonably aware of a potential future claim. Among other things, the insured became aware of efforts to settle claims regarding unpaid wages with two employees; there was a series of communications between the insured and the Brazilian Workers Center concerning claims by employees concerning their wages; and the insured had been notified that State and Federal agencies were looking into the company's wage practices. But whether these circumstances were enough to trigger the insured's obligation under section E.2 is a question we need not answer because, regardless, it is undisputed that the insured never gave written notice to the insurer of these circumstances, let

alone during the policy period. Thus, the insured can find no safe harbor in section E.2.

Relying on Chas. T. Main, Inc., 406 Mass. At 862, and G. L. c. 175, § 112, the insured also argues that, even if notice was untimely, the insurer cannot disclaim coverage unless it can demonstrate that it was prejudiced by the late notice. To begin with, the insured misreads Chas. T. Main, Inc., where the Supreme Judicial Court held that an insurer need not show it was prejudiced by late notice in the case of a "claims made and reported" policy such as the one at issue here. Chas. T. Main, Inc., supra at 865 ("Prejudice for an untimely report in this instance is not an appropriate inquiry"). See Tenovsky v. Alliance Syndicate, 424 Mass. 678, 681 (1997) (comparing policy considered in Chas. T. Main, Inc. to similar "claims made and reported" policy, and finding that no showing of prejudice due to late notice is required). The insured's reliance on G. L. c. 175, § 112 is equally misplaced. Although, the statute provides that "[a]n insurance company shall not deny insurance coverage to an insured because of failure of an insured to seasonably notify an insurance company of an occurrence, incident, claim or of a suit founded upon an occurrence, incident or claim, which may give rise to liability insured against unless the insurance company has been prejudiced thereby," the Supreme Judicial Court has rejected the argument

that the quoted provision applies to claims-made policies such as the one at issue here. See Chas. T. Main, Inc., 406 Mass. at 865-866. "A requirement that an insurer on a claims-made policy must show that it was prejudiced by its insured's failure to report a claim within the policy period or a stated period thereafter would defeat the fundamental concept on which claims-made policies are premised." Id. at 866.

In light of our disposition of the issues above, it follows that the plaintiffs' cross motion for summary judgment in their own favor on their claims for declaratory judgment, indemnification, and damages under G. L. c. 93A & 176D, was properly denied. Where coverage was properly disclaimed, the insurer had no duty to defend or indemnify, nor did it violate chapters 93A or 176D. See Wilkinson v. Citation Ins. Co., 447 Mass. 663, 671 (2006) (insurer's duty to indemnify "arises only after the insured's liability has been established and is between the insurer and the insured"); Jet Line Servs., Inc. v. American Employers Ins. Co., 404 Mass. 706, 717 (1989) ("As a general rule, an insurance company does not act unfairly or deceptively within the meaning of G. L. c. 93A, § 2, with respect to a claim made under a policy of insurance simply by making a legally correct disclaimer of coverage"); Certain Interested Underwriters at Lloyds, London v. LeMons, 85 Mass. App. Ct. 400, 406-407 (2014) (where there is no coverage for an

event because of unambiguous language in the policy, insurer has no duty to defend or indemnify insured for claims arising out of that event).

Judgment affirmed.

By the Court (Green, C.J., Wolohojian & Hershfang, JJ.[5]),

Joseph F. Stanton

Clerk

Entered: January 18, 2022.

[5] The panelists are listed in order of seniority.