In the

Supreme Court of Pennsylvania

No. 45 EAP 2008

ACE AMERICAN INSURANCE COMPANY,

Petitioner

v.

UNDERWRITERS AT LLOYDS AND COMPANIES,
COLUMBIA CASUALTY COMPANY AND
GULF UNDERWRITERS INSURANCE COMPANY,

Respondents

BRIEF OF AMICI CURIAE UNISYS CORPORATION AND UNITED POLICYHOLDERS

On appeal from the December 20, 2007 Judgment of the Superior Court of Pennsylvania, Docket No. 2847 EDA 2006 (Consolidated with Docket Nos. 3006 EDA 2006 and 3246 EDA 2006) Affirming Final Judgment Entered October 17, 2006, by the Court of Common Pleas of Philadelphia County, Civil Division at No. 0077, July Term, 2001

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I. STATEMENT OF JURISDICTION, STATEMENT OF THE SCOPE AND STANDARD OF REVIEW, ORDER OR OTHER DETERMINATION IN QUESTION

Unisys Corporation and United Policyholders adopt and incorporate the Statement of Jurisdiction, Statement of the Scope and Standard of Review, Statement of the Case, and Order or Other Determination In Question filed by ACE American Insurance Company.

II. INTEREST OF *AMICI CURIAE*

A. Unisys Corporation and United Policyholders

Unisys Corporation ("Unisys"), based in Pennsylvania, is a worldwide information technology services and solutions company. Like nearly all companies that provide professional services and are publicly traded on a stock exchange, Unisys purchases professional liability ("errors and omissions," or "E&O") insurance coverage and directors and officers ("D&O") liability policies, which are, non-optionally, written on a "claims-made" form. The insurance Unisys purchases is an expensive, valuable and important asset, as it protects Unisys, its directors and officers, and its customers and, of course, shareholders from catastrophic loss. As a consumer of the types of insurance products at issue here, Unisys has a strong interest in ensuring that it obtains the full value of claims-made insurance it purchases and thus in the outcome of the issues before this Court.

United Policyholders ("UP") is a not-for-profit corporation founded in 1991 as an educational resource for the public on insurance issues and insurance consumer rights. The organization is tax-exempt under Internal Revenue Code § 501(c)(3). UP is based in California but operates nationwide and is funded by donations and grants from individuals, businesses, and foundations and governed by an eight-member Board of Directors. UP contributes on an ongoing basis to the formulation of insurance-related public policy at both the national and state level.

UP exists because businesses and individuals rely on the insurance they buy to protect themselves, their property, and their livelihoods against the risk of loss, and insurance companies are in business to earn profits by assuming that risk. Insurance is a regulated industry because the financial security insurance policies provide is an integral part of the fabric of our society and economy. UP monitors the insurance sector, works with public officials, has a nationwide network of volunteers and affiliate organizations, publishes written materials, files *amicus* briefs in cases involving coverage and claim disputes and is a general information clearinghouse on consumer issues related to commercial and personal lines insurance products. UP provides disaster aid to property owners across the U.S. via educational activities designed to illuminate and demystify the claim process.

In this brief, Unisys and UP seek to fulfill the "classic role of amicus curiae by assisting in a case of general public interest, supplementing the efforts of counsel, and drawing the court's attention to law that escaped consideration." Miller-Wohl Co. v. Commissioner of Labor & Indus., 694 F.2d 203, 204 (9th Cir. 1982). This is an appropriate role for *amici curiae*. As commentators have often stressed, an *amicus* is often in a superior position to "focus the court's attention on the broad implications of various possible rulings." R. Stern, E. Greggnian & S. Shapiro, Supreme Court Practice, 570-71 (1986) (quoting Ennis, Effective Amicus Briefs, 33 Cath. U.L. Rev. 603, 608 (1984)).

III. STATEMENT OF THE QUESTIONS INVOLVED

1. Did the Superior Court err in holding that the notice provision in a claims made policy constitutes a condition precedent to coverage, rather than a limitation, thereby placing the burden on the insured to show compliance with the condition, rather than on the insurer to show breach?

2. Did the Superior Court err in declining to extend this Court's holding in Brakeman v. Potomac Insurance Co., 371 A.2d 193 (Pa. 1977), that in the context of a liability policy, the insurance company will be required to prove that the notice provision was breached and that the breach resulted in prejudice to its position, to the claims-made policy at issue in this case?

IV. SUMMARY OF ARGUMENT

One of the most fundamental and oft-followed decisions in this Court's insurance jurisprudence is Brakeman v. Potomac Insurance Co., 472 Pa. 66, 371 A.2d 193 (1977). There, the Court unambiguously held: "where an insurance company seeks to be relieved of its obligations under a liability insurance policy on the ground of late notice, the insurance company will be required to prove that the notice provision was in fact breached and that the breach resulted in prejudice to its position." Id. at 76-77, 371 A.2d at 198. While this "notice-prejudice" rule was the minority position when Brakeman was decided, it is now almost universally followed in the context of occurrence-based policies. By its terms, the holding of Brakeman applied to all liability policies, including those written on an "occurrence" form as well as those written on a "claims made" form requiring that notice be reported within a set time period.

Though insurance companies would have the Court believe otherwise, the key distinguishing feature between "occurrence" and "claims-made" policies relates not to the timing of notice, but to the event that triggers coverage. An occurrence policy is triggered by injury or damage suffered during the policy period as a result of an "occurrence" or accident regardless of when a demand or lawsuit is brought against the policyholder. A claims-made policy is triggered by the claim or lawsuit being made against the policyholder during the policy period regardless of when the alleged harm occurred. Only one claims-made policy issued by an insurance

company may be exposed to a particular claim or lawsuit against the policyholder, while an "occurrence" that continues or spans multiple policy periods (like environmental harm) can trigger many occurrence policies (and multiple limits) sold in successive years even if the continuing occurrence is the subject of only one lawsuit against the policyholder – in many cases a suit commenced years after the policy period has ended and the insured has stopped paying premiums.

Several federal courts sitting in diversity jurisdiction cases have predicted that this Court would retreat from the notice-prejudice rule if it were to consider the issue in the context of a claims-made policy that requires "reporting" of the claim within the policy period as a condition precedent to coverage.[1] Disregarding the adhesive nature of insurance contracts recognized in Brakeman, those courts wrongly presume the existence of a "bargain" in which the policyholder agrees to a Draconian notice provision (allowing for unintentional coverage forfeiture) in exchange for premiums that are (in theory) lower.

The current case does not squarely present the issue considered by the federal courts because it is undisputed that ACE reported the claim asserted by Refuse Fuels within the period of the policy at issue. Accordingly, Unisys and UP respectfully submit that the Court need not reach the question of whether notice provided after the reporting period results in automatic and arbitrary forfeiture, though it clearly does when an insurer cannot demonstrate it has been prejudiced by the timing of notice.

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[1] See Pizzini v. American Int'l Specialty Lines Ins. Co., 210 F. Supp. 2d 658, 669-70 (E.D. Pa. 2002), aff'd, 107 Fed. App'x 266 (3d Cir. 2004); Borish v. Britamco Underwriters, Inc., 869 F. Supp. 316, 320 (E.D. Pa. 1994); City of Harrisburg v. International Surplus Lines Ins. Co., 596 F. Supp. 954, 961 (M.D. Pa. 1984), aff'd without op., 770 F.2d 1067 (3d Cir. 1985).

Yet, this is the question that most often faces policyholders faced with allegations of late notice under claims-made policies, and thus, the issue of most importance to policyholders. While the issue is not squarely presented, this case nevertheless provides an opportunity for this Court to confirm that insurance companies may not avoid the notice-prejudice rule simply by making "notice" or "reporting" a more explicit condition precedent to coverage. The notice-prejudice rule is not a rule of contract interpretation, and as a result, the insurance industry should not be permitted to draft its way to a rule of easy and, from the insurance company's point of view, fortuitous forfeiture. Disproportionate forfeiture is as inequitable under a claims-made policy as under an occurrence policy.

Even under a claims-made policy, the provision of notice after the reporting period in many instances will not harm the insurance company's rights, position, actions, or costs. Accordingly, the rationale of Brakeman applies equally to claims-made policies: (1) even if notice is drafted as a "condition" of coverage, insurance policies generally, and notice provisions particularly, are adhesive "and a proper analysis requires this reality to be taken into account" id. 472 Pa. at 73, 371 A.2d at 196; and (2) a "strict contractual approach" to the consideration of notice provisions is inappropriate because it can result in the arbitrary and disproportionate forfeiture of insurance coverage in the absence of substantial harm to the insurance company, id. at 73-74, 371 A.2d at 196-97. The notice provisions of claims-made policies (including the requirement that a claim be reported to the insurance company by a pre-determined cutoff), however, serve the same purpose as the notice provision in Mr. Brakeman's auto policy – to alert the insurance company to the existence of the claim for which legal liability covered by the insurance policy may be imposed.

The issues considered by the Court will have an impact far beyond the parties to this action. Every major corporation in Pennsylvania, most smaller companies, and thousands of individual professionals are covered by insurance policies that are written and sold almost exclusively on a claims-made form. Because liability insurance also protects third parties (parties who have been injured or damaged by the policyholder), the public has an overriding interest in ensuring that arbitrary and disproportionate forfeitures of insurance are prohibited.

V. ARGUMENT

A. THE INSURANCE COMPANY BEARS THE BURDEN TO ESTABLISH LATE NOTICE.

Whether notice is identified to be a "condition" or a "limitation" is immaterial to the Court's decision about placing the burden on the insurance company to prove a breach of the notice provision by the policyholder. The insurance policy at issue in Brakeman stated that no action could lie against the insurance company unless "as a condition precedent thereto, the insured shall have fully complied with all the terms of this policy." Id. 472 Pa. at 69-70, 371 A.2d at 194-95. In Brakeman, the Court noted that under the Court's prior decisions the duty to give notice was considered to be a condition precedent, the breach of which would release the insurance company from its obligations under the insurance policy unless the policyholder could prove a good excuse for notice being late or that the violation of the notice provision was *de minimis*. Id. at 71, 371 A.2d at 195. The Court in Brakeman analyzed the notice provision as a "condition of forfeiture." Id. at 76, 371 A.2d at 198.

Nonetheless, the Court held that "where an insurance company seeks to be relieved of its obligations under a liability insurance policy on the ground of late notice, the insurance company will be required to prove that the notice provision was in fact breached and that the breach resulted in prejudice to its position." Id. at 76-77, 371 A.2d at 198. The Court

explicitly departed from the "strict contractual approach" of its prior decisions. Id. at 73-74, 371 A.2d at 196-97. Accordingly, the Court's decision to place the burden on the insurance company to prove late notice was not based upon an analysis of whether the notice provision was drafted or labeled by the insurance company as a "condition" or "limitation."

Notice provisions are coverage limitations and should be treated as such, whether they are expressed as conditions, exclusions, or some other limitation of coverage. As the Texas Supreme Court recently noted, "[e]xclusions and conditions are in effect two sides of the same coin; exclusions avoid coverage if the insured does something, and conditions avoid coverage unless an insured does something." Paj, Inc. v. Hanover Ins. Co., 243 S.W.3d 630, 635 (Tex. 2008). In either instance, the insurance company is attempting to affirmatively assert facts and circumstances that would avoid coverage for a loss that falls within the basic coverage grant of the insurance policy.

This Court has long held that while the policyholder bears the burden to prove by a preponderance of the evidence that a loss falls within the coverage provisions of the insurance policy, insurance companies bear the burden to show that an exclusion or limitation of coverage clearly and unambiguously applies. Miller v. Boston Ins. Co., 420 Pa. 566, 570, 218 A.2d 275 (1966); Armon v. Aetna Cas. & Sur. Co., 369 Pa. 465, 469, 87 A.2d 302 (1952). The party asserting an affirmative defense bears the burden to prove that affirmative defense. See, e.g., Miller, 420 Pa. at 570, 218 A.2d 277 ("[a] defense based on an exception or exclusion in a policy is an affirmative one, and the burden is cast upon the defendant to establish it").

This Court should hold that if an insurance company attempts to avoid its coverage obligations under a claims-made policy due to "late notice," the insurance company bears the burden to prove that notice was late, just like under an occurrence policy.

B. INSURANCE COMPANIES BEAR THE BURDEN TO PROVE NOT ONLY THAT NOTICE WAS LATE, BUT THAT THE INSURANCE COMPANY SUFFERED SUBSTANTIAL HARM OR PREJUDICE.

1. The Court's Holding and Rationale in Brakeman Apply Fully to All Liability Insurance Policies of All Types.

In Brakeman, the Court broke not only with the then-majority of decisions from other courts, but also with its own prior rulings, that had held that delayed notice releases the insurance company from its coverage obligations regardless of whether the insurance company suffered prejudice. Id. 472 Pa. at 71-72, 371 A.2d at 195-96. Doing so, the Court recognized "[t]he rationale underlying the strict contractual approach reflected in our past decisions is that courts should not presume to interfere with the freedom of private contracts and redraft insurance policy provisions where the intent of the parties is expressed by clear and unambiguous language." Id. at 72, 371 A.2d at 196.[2]

The Court understood that the strict contractual approach, which is advocated by insurance companies in the context of claims-made policies, "fails to recognize the true nature of the relationship between insurance companies and their insureds." Id. at 72, 371 A.2d at 196. Said the Court, "[a]n insurance contract is not a negotiated agreement; rather its conditions are by and large dictated by the insurance company to the insured." Id. at 72, 371 A.2d at 196. That

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[2] The departure from a strict contractual analysis of insurance policies was not novel when Brakeman was decided. In 1929, Roscoe Pound has stated the following about the public interest nature of insurance:

> [W]e have taken the law of insurance practically out of the category of contract, and we have listed that the duties of public service companies are not contractual, as the nineteenth century sought to make them but are instead relational; they do not flow from agreements which the public servant may make as he chooses, they flow from the calling in which he has engaged and his consequent relation to the public.

Roscoe Pound, The Spirit of Common Law 29 (1929). The concept that insurance is beyond mere contract is endorsed by the insurance industry in a textbook used to train its professionals. See James J. Markham, The Claims Environment, at 277 (1993) ("Insurance is a matter of public interest and deserves special attention by the courts to protect the public.")

is particularly true, the Court understood, with respect to the notice provisions in insurance policies which are virtually the same from one policy to another. Accordingly, "an insured is not able to choose among a variety of insurance policies materially different with respect to notice requirements, and a proper analysis requires this reality be taken into account." Id. at 73, 371 A.2d at 196.

Further, the Court reasoned that "[a] strict contractual approach is also inappropriate here because what we are concerned with is a forfeiture." Id. at 73, 371 A.2d at 196. "Allowing an insurance company, which has collected full premiums for coverage, to refuse compensation to an accident victim or insured on the ground of late notice, where it is not shown timely notice would have put the company in a more favorable position, is unduly severe and inequitable." Id. at 76, 371 A.2d at 198. The Court cited with approval a principle as true then as now, and as true with respect to claims-made as to occurrence policies: viewed in the context of forfeiture, "it becomes unreasonable to read the [notice] provision unrealistically or to find that the carrier may forfeit the coverage, even though there is no likelihood that it was prejudiced by the breach. To do so would be unfair to insureds." Id. at 74, 371 A.2d at 197 (quoting Cooper v. Government Employees Ins. Co., 51 N.J. 86, 93-94, 237 A.2d 870, 873-74 (1968)).[3]

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[3] Commentators have recognized insurance forfeitures to be draconian and inequitable. See Eugene R. Anderson, et al., Draconian Forfeitures of Insurance: Commonplace, Indefensible, and Unnecessary, 65 Fordam L. Rev. 825 (Dec. 1996); 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 (1998-1999). When insurance coverage is forfeited, policyholders lose the protection and peace of mind for which they paid. The forfeiture of insurance coverage could mean the loss of their business or bankruptcy. Often, they are not the only victim. The injured claimant may have no other recourse for recovery beyond the liability insurance possessed by the party at fault. The primary purpose of insurance is to insure, and that fundamental purpose cannot be undermined by technicalities and traps for the unwary.

For these reasons, the notice-prejudice rule is not affected by how clearly the insurance company drafts a requirement for the policyholder to notify the insurance company of an accident, occurrence, or claim. The placement of a notice or reporting provision in a section labeled "conditions," or other policy drafting tactics, are of no moment. An insurance company should no more be permitted to draft its way out of the notice-prejudice rule than to draft a provision requiring a policyholder to prove the inapplicability of all exclusions. Thus, even when policies are drafted to require a policyholder to report a claim to the insurance company within the policy period or within a certain number of days thereafter, the insurance company still should be required to prove that notice was provided late and that the insurance company was materially prejudiced by the delay.

This does not expand the basic scope of coverage granted by a claims-made policy because the fundamental nature (and limitation) of the coverage remains the same – the claim must be asserted against the policyholder within the policy period to trigger the coverage, and no policy other than the single-one triggered will respond. The sound rationales of Brakeman apply to claims-made policies with the same force and logic as they apply to occurrence policies.

(a) Policyholders Typically Do Not Have the Option Of Purchasing An Occurrence Policy As Opposed To One That Is Claims-Made.

As when the Court decided Brakeman, the classic model of freely negotiated agreements is "far removed from the reality of the business of insurance." Robert H. Jerry, II, Understanding Insurance Law § 25C, at 139 (2d ed. 1996). This is particularly so with respect to claims-made policies and the notice provisions within them. In fact, policyholders usually do not have the option to purchase an "occurrence" form instead of one that is "claims-made."

A critical part of virtually any business's risk management program is insurance coverage such as D&O, E&O, and EPL insurance policies. Any business that is publicly traded on a stock exchange, as well as many others, has D&O insurance. A vast array of companies that provide services as well as professionals (doctors, lawyers, accountants, insurance brokers, architects, engineers, etc.) also purchase E&O insurance to protect themselves, as well as their patients, clients and customers who may be harmed by professional negligence. EPL coverage is also commonplace in the business world. Such policies provide important protection that insurance companies say is not included in commercial general liability insurance policies.

While commercial general liability coverage is still written on occurrence forms, these other types of policies are written almost exclusively on a "claims-made" form. See 23 Appleman on Insurance § 146.4 ("A small percentage of professional liability policies . . . consists of occurrence-based policies"); Slater v. Lawyers' Mut. Ins. Co., 278 Cal. Rptr. 479, 483 (Cal. App. 2d Dist. 1991) ("For decades, virtually all professional liability policies have been written on a claims-made basis."). A policyholder cannot simply shop around or agree to pay more in premiums in order to purchase D&O, E&O and EPL coverage, for example, on an occurrence rather than on a claims-made basis.

Similarly, the notice requirements of clams-made policies are, indeed, "dictated by the insurance company to the insured" in almost all instances. See Brakeman, 472 Pa. at 72, 371 A.2d at 196. Just as in automobile liability or general liability policies written on an "occurrence" form, those "notice" or "reporting" terms are non-negotiable and policyholders are not generally able to select from different notice provisions. As the Court stated in Brakeman, a proper analysis of whether it is appropriate and fair to strictly construe the notice provisions of these policies "requires this reality be taken into account." Id. at 73, 371 A.2d at 196.

(b) As With Occurrence Policies, It Is Neither Fair Nor Logical To Force A Policyholder to Forfeit Coverage Based On Delayed Notice Where The Insurance Company Is Not Prejudiced.

The present case shows that even sophisticated companies, indeed sophisticated *insurance* companies like ACE, can face a claim of forfeiture as a result of allegedly late notice. Policyholders sometimes make mistakes or fail to communicate internally about new or incipient claim circumstances in an ideal and timely way, resulting in notice being provided later than required by the strict terms of the policy. Increasing the risk of a notice trap for the policyholder, what constitutes a "claim" may be undefined, unclear or unknown to the policyholder or most of its staff.[4] Accordingly, a policyholder may not immediately recognize that a letter it receives or some demand made upon it could be considered a "claim" about which it must inform its insurance company within a defined period of time – at the risk of forfeiting insurance coverage it has purchased as an integral part of its overall risk management program. The policyholder also may not recognize the potential liability as something that may be covered by insurance. Later, when that letter or demand evolves into a lawsuit, the strict notice provisions in claims-made policies may prompt the insurance company to deny coverage based solely on the basis that the policyholder did not inform the insurance company of the initial letter when first received. The insurance company on the risk for the following policy period will of course deny coverage on the ground that the claim was made *prior* to the policy it issued.

As this Court stated in Brakeman, "it follows neither logic nor fairness to relieve the insurance company of its obligations under the policy in such a situation." Id. 472 Pa. at 75,

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[4] When actually defined, what constitutes a "claim" can vary among claims-made policies and be confusing, particularly to the untrained eye. The definition of a "claim" in the insurance policy may include a "demand for monetary or non-monetary relief." Understanding what constitutes a "demand for non-monetary relief" could be difficult for an experienced judge or lawyer, let alone an architect, accountant or engineer.

371 A.2d at 197. Where forfeiture is a disproportionate consequence for the non-performance of a contract condition, the non-performance should be excused. Restatement (Second) of Contracts § 229.[5] The Court recognized and applied this rule in Brakeman. There, the Court held "[w]e have in the past excused a condition of forfeiture where to give it effect would have been purely arbitrary and without reason, and we are of the opinion that, in the absence of prejudice to the insurance company, such a situation exists in the context of a late notice of accident." Brakeman, 472 Pa. at 76, 371 A.2d at 198.

This Court's reasoning in Brakeman is as true for occurrence-based policies as claims-made. Allowing an insurance company to collect full premiums yet refuse coverage based on a mistake or technicality where the insurance company cannot demonstrate that it would have acted materially differently had it received notice earlier or that its costs will now be higher simply "is unduly severe and inequitable." Id. at 76, 371 A.2d at 198. Forfeiture is only justified where the insurance company can prove that it is "placed in a substantially less favorable position than it would have been in had timely notice been provided." Id. at 74-75, 371 A.2d at 197.

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[5] The Restatement discusses the rationale by which a court should determine whether forfeiture is disproportionate to the non-performance:

> [A] court must weigh the extent of the forfeiture by the obligee against the importance to the obligor of the risk from which he sought to be protected and the degree to which the protection will be lost if the non-occurrence of the condition is excused to the extent required to prevent forfeiture. The character of the agreement may, as in the case of insurance agreements, affect the rigor with which the requirement is applied.

Restatement (Second) of Contracts § 229, cmt. b; see also, Jennings v. League of Civic Orgs., 180 Pa. Super. 398, 401-02, 119 A.2d 608, 610 (1956) (when determining whether a forfeiture should result, courts "must weigh the purpose to be served, the desire to be gratified, the excuse for deviation from the letter, [and] the cruelty of enforced adherence").

Given this Court's strong holding in Brakeman against disproportionate and arbitrary forfeitures, the notice-prejudice rule is rightly applicable to all variations of liability insurance policies, including claims-made policies.

2. Arguments for Not Applying The Notice-Prejudice Rule to Claims-Made Policies Are Based on Faulty Assumptions.

Though in several decisions courts predicted that the Court will not extend the Brakeman notice-prejudice rule to claims-made policies, the reasoning in those cases – and others like them in other jurisdictions – are predicated upon faulty rationales and unsupported assumptions. See, e.g., Pizzini v. American Int'l Specialty Lines Ins. Co., 210 F. Supp. 2d 658, 669-70 (E.D. Pa. 2002), aff'd, 107 Fed. App'x 266 (3d Cir. 2004); Borish v. Britamco Underwriters, Inc., 869 F. Supp. 316, 320 (E.D. Pa. 1994); City of Harrisburg v. International Surplus Lines Ins. Co., 596 F. Supp. 954, 961 (M.D. Pa. 1984), aff'd without op., 770 F.2d 1067 (3d Cir. 1985).[6]

First, these courts recite the oft-cited but unsupported notion that by providing a date-certain after which an insurance company knows it is no longer liable under the policy, the notice-provision in claims-made policy "allows the insurer to more accurately fix its reserves for future liabilities and compute premiums with greater certainty." See, e.g., City of Harrisburg, 596 F. Supp. at 962. Second, again apparently absent evidence, these courts state that claims-made policies are less expensive than occurrence policies (and thus no forfeiture based on late

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[6] Other courts have made the same erroneous assumptions. See DiLuglio v. New England Ins. Co., 959 F.2d 355 (1st Cir. 1992) (holding that since reporting period prescribed in claims-made policy defines scope of coverage and allows insurance company to set premiums below levels charged for comparable occurrence policies prejudice to insurance companies presumed when notice not provided within policy period); Stine v. Continental Cas. Co., 349 N.W.2d 127, 131 (Mich. 1984) ("Since the insurer can limit the duration of its exposure to the term of the policy currently in force, the more precise actuarial data available enable it to charge a lower premium than would be necessary for an occurrence policy"); 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").

notice results because the policyholder paid a lower premium for less coverage). See, e.g., City of Harrisburg, 596 F. Supp. at 962.[7]

In reality, however, there is no practical distinction between the purpose of notice provisions in occurrence policies and claims-made policies. In each, the purpose of the notice provision is to alert the insurance company to the claim so that the insurance company can both assess (and provide) coverage and protect its own interests. Accordingly, as the Court stated in Brakeman, "[i]n short, the function of a notice requirement is to protect the insurance company's interests from being prejudiced." Id. 472 Pa. at 75, 371 A.2d at 197. In this light, claims-made policies are often different from occurrence policies in certain important respects that actually reduce the chance that a claims-made insurance company will be prejudiced by late-notice.

First, in most claims-made policies, the insurance company does not assume a "duty to defend" the claim or suit against the policyholder, but rather simply advances defense costs to the policyholder. The litigation, accordingly, is controlled not by the insurance company but by the policyholder. The insurance company may be only minimally involved other than receiving periodic updates and being informed of settlement opportunities.

Second, claims-made policies often contain substantial self-insured retentions or deductibles. Only after such self-insured retentions or deductibles are exhausted must the

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[7] To the extent premiums are lower for claims-made policies (and that remains unproven or even the opposite), it is more likely due to the fact that only one policy (not many, as with occurrence policies) can be triggered for any alleged harm than to the notion that an insured must provide notice of a claim received within the policy period or multiple factors other than notice. In an occurrence policy, the triggering event is liability for damage or injury suffered by a third party in the policy period, regardless of when the claim is made seeking redress for that damage or injury. Under "occurrence" policy forms, if one manufactures a product in 1970 (e.g., asbestos), that causes continuous bodily injury to someone from 1975-2005, the person discovers the injury in 2006, and sues in 2007, the relevant insurance policies are those sold from 1975-2005. See, e.g., J.H. France Refractories Co. v. Allstate Ins. Co., 534 Pa. 29, 626 A.2d 502 (1993). Accordingly, an insurance company that sold an "occurrence" policy in 1975, may be liable to pay a claim on that policy that is made decades later. In contrast, if the liability policy were issued on a claims-made liability insurance policy form, the relevant insurance policy would be the one sold in 2007, assuming no "claim" was made before suit was filed, so there is no "long tail" on claims made liabilities.

insurance company pay any defense costs or indemnity for any settlement or judgment. So, it can be months or years, if at all, after a claim is noticed – even if noticed timely – before the insurance company actually faces financial exposure.

Third, with claims-made policies, the insurance company is exposed only under the policy issued in the year the claim was first brought against the policyholder. Under occurrence policies, which are triggered by the occurrence or accident, the same insurance company may be exposed under policies that span several years if the occurrence is one that continues over time (such as in environmental or asbestos claims). Accordingly, applying the notice-prejudice rule to a claims-made policy will not subject the claims-made insurance company to increased exposure to so called "long-tail" claims, but rather simply may require the insurance company to honor the obligation for which the policyholder paid – to accept the risk for claims first-made against the policyholder in that one particular policy period.

A delay in alerting a claims-made insurance company to a claim may make no material difference whatsoever to the insurance company. If, in a particular case, an insurance company and policyholder negotiated and agreed on a lower premium in exchange for a strict notice provision or the claim would cost the insurance company significantly more than if it had been alerted earlier, then, under the notice-prejudice rule, the insurance company will have the opportunity to prove those facts with admissible evidence as a potential basis for forfeiture. But, just as the Court held in Brakeman, "[a]llowing an insurance company, which has collected full premiums for coverage, to refuse compensation to an accident victim or insured on the ground of late notice, where it is not shown timely notice would have put the company in a more favorable position, is unduly severe and inequitable." 472 Pa. at 76, 371 A.2d at 198. Again, this is as true under claims-made as occurrence policies.

This Court should not revert to the "strict contractual approach" it firmly and correctly eschewed in Brakeman. In Pennsylvania, it should have been clear all along that this Court meant what it said in Brakeman – that an insurance company bears the burden to prove both late notice and prejudice caused by late notice before affecting a forfeiture of the policyholder's liability insurance coverage. See Brakeman, 472 Pa. at 76-77, 371 A.2d at 198. This case presents a perfect and important opportunity for this court to confirm that it meant what it said in Brakeman.

3. Application of the Notice-Prejudice Rule To All Liability Policies Is The Developing Trend.

Commentators observe that a trend is developing toward application of the notice-prejudice rule to all insurance policies, including claims-made policies. See Kenneth W. Lucas, A Prejudicial Requirement: The Ongoing Development of Liability Policy Notice-Prejudice Issues, Coverage, Vol. 18, No. 3 (May/June 2008). Indeed, some states have so clearly identified the inequity of permitting an insurance company to deny coverage based on late notice where the insurance company is not prejudiced that they codified the notice-prejudice rule, applying the rule to claims-made policies, too. See Lexington Ins. Co. v. Rugg & Knopp, Inc., 165 F.3d 1087, 1090 (7th Cir. 1999) (applying Wisconsin law) (rejecting argument that notice-prejudice rule does not apply to claims-made policies since Wisconsin statute expressly incorporates a notice-prejudice rule for "all" liability policies); Sherlock v. Perry, 605 F. Supp. 1001, 1005 (E.D. Mich. 1985) (pursuant to an express provision in Michigan Insurance Code, liability insurance companies cannot deny coverage based on a policyholder's failure to timely report claim unless it can show prejudice by delay). In addition, the United States Court of Appeals for the Fifth Circuit recently certified a notice-prejudice question to the Texas Supreme Court in order to clarify the uncertainty created by Texas appellate courts regarding when prejudice must

be proven. See XL Specialty Ins. Co. v. Financial Indus. Corp., No. 06-51683, 2007 WL 4461190 (5th Cir. Dec. 19, 2007).

VI. CONCLUSION

The Superior Court erred by holding that: (1) the policyholder (ACE) was required to bear the burden to show that its notice was timely, rather than requiring the insurance company (Lloyds) to show that notice was late; and (2) an insurance company need not bear the burden to prove that the policyholder's breach of the notice provision resulted in prejudice to the insurance company before causing a forfeiture of coverage. This Court should rule that the notice-prejudice rule it set forth in Brakeman applies with equal force to claims-made policies.

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CERTIFICATE OF SERVICE

I hereby certify that on this date, two copies of the foregoing Brief of *Amici Curiae* Unisys Corporation and United Policyholders was served by First Class Mail upon the following parties:

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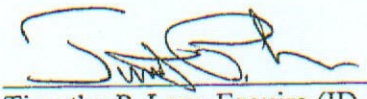

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