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Casenotes: Insurance — Professional Liability —  
Insurer Must Prove Actual Prejudice to Escape  
Liability Because of Late Notice by Insured Where  
Claims-Made Policy Is Ambiguous as to Coverage.  
St. Paul Fire & Marine Insurance Co. v. House, 315  
Md. 328, 554 A.2d 404 (1989) (4-3 decision)

Frederick W. Goundry III  
*University of Baltimore School of Law*

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## CASENOTES

INSURANCE—PROFESSIONAL LIABILITY—INSURER MUST PROVE ACTUAL PREJUDICE TO ESCAPE LIABILITY BECAUSE OF LATE NOTICE BY INSURED WHERE CLAIMS-MADE POLICY IS AMBIGUOUS AS TO COVERAGE. *St. Paul Fire & Marine Insurance Co. v. House*, 315 Md. 328, 554 A.2d 404 (1989) (4-3 decision).

Before an insurer<sup>1</sup> can disclaim coverage under a liability policy because of an insured's<sup>2</sup> late notice, article 48A, section 482 of the Maryland Code requires the insurer to establish that it was actually prejudiced by the late notice.<sup>3</sup> Actual prejudice under section 482 means that if the notice requirement had not been breached, it is likely that the insured would not have been liable.<sup>4</sup>

In *St. Paul Fire & Marine Insurance Co. v. House*,<sup>5</sup> the Court of Appeals of Maryland faced the issue of whether section 482 applies to claims-made insurance policies<sup>6</sup> when the claim was not

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1. "The underwriter or insurance company with whom a contract of insurance is made. The one who assumes risk or underwrites a policy, or the underwriter or company with whom contract of insurance is made." BLACK'S LAW DICTIONARY 808 (6th ed. 1990).
  2. "The person who obtains or is otherwise covered by insurance on his health, life, or property. The 'insured' in a policy is not limited to the insured named in the policy, but applies to anyone who is insured under the policy." *Id.*
  3. MD. ANN. CODE art. 48A, § 482 (1986). Entitled "Disclaimer of coverage because of lack of notice or cooperation from insured," § 482 provides the following:

Where any insurer seeks to disclaim coverage on any policy of liability insurance issued by it, on the ground that the insured or anyone claiming the benefits of the policy through the insured has breached the policy by failing to cooperate with the insurer or by not giving requisite notice to the insurer, such disclaimer shall be effective only if the insurer establishes, by a preponderance of affirmative evidence that such lack of cooperation or notice has resulted in actual prejudice to the insurer.

*Id.*

4. See *Harleysville Ins. Co. v. Rosenbaum*, 30 Md. App. 74, 84, 351 A.2d 197, 202 (1976) (interpreting the current version of § 482).
5. 315 Md. 328, 554 A.2d 404 (1989).
6. Claims-made (or discovery) policies "cover liability inducing events if and when a claim is made during the policy term, irrespective of when the events occurred." Parker, *The Untimely Demise of the "Claims Made" Insurance Form? A Critique of Stine v. Continental Casualty Company*, 1983 DET. C.L. REV. 25, 27.

made until after the policy had expired.<sup>7</sup> The *House* court, however, chose not to address this issue because it found that the policy issued by St. Paul was ambiguous as to whether the claim was made when the insured was notified by his patient of the claim or when the insured reported the claim to the insurer.<sup>8</sup> Because of this ambiguity, the court of appeals interpreted the policy in favor of the insured,<sup>9</sup> and held that section 482 applied to the factual setting in *House*.<sup>10</sup>

In response to the 1963 court of appeals decision in *Watson v. United States Fidelity & Guaranty Co.*,<sup>11</sup> the General Assembly of Maryland enacted section 482.<sup>12</sup> In *Watson*, the automobile liability policy required that the insured give written notice to the insurer "as soon as practicable" in the event of an accident.<sup>13</sup> The insured was involved in an automobile accident and notified the insurer thirty-six days later.<sup>14</sup> The insurer responded by sending the insured a reservation of rights letter, informing the insured that prompt notice of the accident had not been given.<sup>15</sup> The insurer later brought suit and obtained a declaratory judgment to the effect that the insurer was not required to defend the insured nor required to pay for any judgments or expenses arising from the accident.<sup>16</sup>

The court of appeals in *Watson* affirmed the trial court's decision.<sup>17</sup> The court reasoned that a requirement to notify the insurer as soon as practicable was a condition precedent which should be enforced like any other contract clause.<sup>18</sup> In addition, the court was

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7. *House*, 315 Md. at 330, 554 A.2d at 405.

8. *Id.* at 333, 554 A.2d at 407.

9. *Id.* at 340-41, 554 A.2d at 410.

10. *Id.* at 341, 554 A.2d at 410-11.

11. 231 Md. 266, 189 A.2d 625 (1963).

12. *Washington v. Federal Kemper Ins. Co.*, 60 Md. App. 288, 293, 482 A.2d 503, 505 (1984) ("In response to the Court of Appeals decision in *Watson*, the Maryland General Assembly enacted Chapter 185 of the Laws of 1964, effective June 1, 1964. This statute is now codified as Section 482 of Article 48A of the Maryland Code . . ."), *cert. denied*, 302 Md. 289, 487 A.2d 292 (1985).

13. *Watson*, 231 Md. at 269, 189 A.2d at 626. Specifically the policy in *Watson* required:

In the event of an accident, occurrence or loss, written notice containing particulars sufficient to identify the Insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the Insured to the Company or any authorized agents as soon as practicable.

*Id.* at 269 n.1, 189 A.2d at 626 n.1.

14. *Id.* at 269-70, 189 A.2d at 626.

15. *Id.* at 270, 189 A.2d at 626.

16. *Id.* at 269, 189 A.2d at 626.

17. *Id.* at 276, 189 A.2d at 630.

18. *Id.* at 271, 189 A.2d at 627.

unwilling to accept the insured's argument that the notice requirement violated public policy.<sup>19</sup>

The year following the *Watson* decision, the General Assembly of Maryland enacted section 482.<sup>20</sup> One commentator has suggested three reasons which may have inspired the General Assembly to enact section 482.<sup>21</sup> First, an "aura of unfairness" surrounds a situation where an insurer is able to disclaim liability when it was not actually prejudiced by an insured's breach of a condition precedent.<sup>22</sup> Second, the *Watson* decision allowed "an unreasonable forfeiture" by permitting the insurer to deny protection which was already paid for by the insured.<sup>23</sup> Third, the *Watson* rule permitted victims of automobile accidents to remain uncompensated by their paid-for insurance coverage.<sup>24</sup>

Outside of Maryland, courts and legislatures have dealt with the *Watson*-type result in various ways.<sup>25</sup> Some jurisdictions have continued to follow the traditional rule that an insurer need not show that it was prejudiced by an insured's delay in giving notice.<sup>26</sup> Other

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19. *Id.* at 272, 189 A.2d at 627. The insured contended that in a majority of jurisdictions insurers were required to show actual prejudice in order to be relieved of obligations under their policies. However, the court of appeals concluded that the actual prejudice rule was against the weight of authority. *Id.*

20. Act of Apr. 7, 1964, ch. 185, 1964 Md. Laws 445 (codified as amended at MD. ANN. CODE art. 48A, § 482 (1986)). The original enacted form of § 482 appeared as follows:

Where any insurer seeks to disclaim coverage on any policy of motor vehicle liability insurance issued by it, on the ground that the insured or anyone claiming the benefits of the policy through the insured has breached the policy by failing to cooperate with the insurer or by not giving requisite notice to the insurer, such disclaimer shall be effective only if the insurer establishes, by a preponderance of affirmative evidence that such lack of cooperation or notice has resulted in actual prejudice to the insurer.

*Id.* at 445-46. In 1966, § 482 was repealed and re-enacted with only the words "motor vehicle" deleted from the statute. Act of Apr. 29, 1966, ch. 205, 1966 Md. Laws 445 (codified at MD. ANN. CODE art. 48A, § 482 (1986)).

21. See Note, *A Legal Process Analysis for a Statutory and Contractual Construction of Notice and Proof of Loss Insurance Disclaimers—Government Employees Insurance Co. v. Harvey*, 38 MD. L. REV. 299, 309-10 (1978).

22. *Id.* at 309.

23. *Id.* at 310.

24. *Id.*

25. See generally 8 APPLEMAN, INSURANCE LAW & PRACTICE § 4732 (1981 & Supp. 1989); Annotation, *Modern Status of Rules Requiring Liability Insurer to Show Prejudice to Escape Liability Because of Insured's Failure or Delay in Giving Notice of Accident or Claim, or in Forwarding Suit Papers*, 32 A.L.R. 4TH 141 (1984 & Supp. 1990).

26. See, e.g., *Marez v. Dairyland Ins. Co.*, 638 P.2d 286 (Colo. 1981); *Security Mut. Ins. Co. v. Acker-Fitzsimons Corp.*, 31 N.Y.2d 436, 293 N.E.2d 76, 340

courts hold that if delay in notice is unreasonable, a rebuttable presumption arises that the insurer was prejudiced by the delay, requiring the insured to prove that the delay was not prejudicial.<sup>27</sup> Another position which some courts have taken is that prejudice to the insurer should be a factor in determining the reasonableness of the insured's delay in notice.<sup>28</sup>

The modern trend and majority view is that an insurer must show that it was prejudiced by the insured's delay in order to avoid liability.<sup>29</sup> Following the modern trend, Wisconsin<sup>30</sup> and Massachusetts<sup>31</sup>

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N.Y.S.2d 902 (1972); *State Farm Fire & Casualty Co. v. Scott*, 236 Va. 116, 372 S.E.2d 383 (1988).

27. *See, e.g.*, *Tiedtke v. Fidelity & Casualty Co.*, 222 So. 2d 206 (Fla. 1969); *Henschel v. Hawkeye-Sec. Ins. Co.*, 178 N.W.2d 409 (Iowa 1970); *Zurich Ins. Co. v. Valley Steel Erectors, Inc.*, 13 Ohio App. 2d 41, 233 N.E.2d 597 (1968).
28. *See, e.g.*, *State Farm Mut. Auto. Ins. Co. v. Burgess*, 474 So. 2d 634 (Ala. 1985) (in uninsured motorist cases, prejudice to the insurer is a factor to be considered in determining the reasonableness of the delay); *Illinois Ins. Guar. Fund v. Lockhart*, 152 Ill. App. 3d 603, 504 N.E.2d 857 (1987) (absence of prejudice is a factor in determining whether notice was reasonable, but absence of prejudice does not nullify notice requirement); *Sutton Mut. Ins. Co. v. Notre Dame Arena, Inc.*, 108 N.H. 437, 237 A.2d 676 (1968) (absence of prejudice to the insurer is a factor to be considered in determining whether the insured's delay in providing notice is a substantial breach of the policy).
29. *See, e.g.*, *Clemmer v. Hartford Ins. Co.*, 22 Cal. 3d 865, 587 P.2d 1098, 151 Cal. Rptr. 285 (1978); *State Farm Mut. Auto. Ins. Co. v. Johnson*, 320 A.2d 345 (Del. 1974); *Reliance Ins. Co. v. St. Paul Ins. Cos.*, 307 Minn. 338, 239 N.W.2d 922 (1976); *Cooper v. Government Employees Ins. Co.*, 51 N.J. 86, 237 A.2d 870 (1968); *Foundation Reserve Ins. Co. v. Esquibel*, 94 N.M. 132, 607 P.2d 1150 (1980); *Brakeman v. Potomac Ins. Co.*, 472 Pa. 66, 371 A.2d 193 (1977). *See generally* Annotation, *supra* note 25, § 5[a].
30. WIS. STAT. ANN. § 631.81(1) (West 1980). Section 631.81(1) reads as follows: Provided notice or proof of loss is furnished as soon as reasonably possible and within one year after the time it was required by the policy, failure to furnish such notice or proof within the time required by the policy does not invalidate or reduce a claim unless the insurer is prejudiced thereby and it was reasonably possible to meet the time limit.
- Id.*
31. MASS. GEN. L. ch. 175, § 112 (1987). Section 112 provides: The liability of any company under a motor vehicle liability policy, as defined in section thirty-four A of chapter ninety, or under any other policy insuring against liability for loss or damage on account of bodily injury or death, or for loss or damage resulting therefrom, or on account of damage to property, shall become absolute whenever the loss or damage for which the insured is responsible occurs, and the satisfaction by the insured of a final judgment for such loss or damage shall not be a condition precedent to the right or duty of the company to make payment on account of said loss or damage. No such contract of insurance shall be cancelled or annulled by any agreement between the company and the insured after the said insured

have enacted statutes similar to Maryland's section 482.<sup>32</sup> The other states that require insurers to show prejudice before disclaiming liability have done so by case law.<sup>33</sup> Most of the courts that have adopted the modern rule require that the omission or delay of notice be unreasonable or unexcused before prejudice to the insured is even considered.<sup>34</sup>

Jurisdictions that have adopted a rule requiring insurers to show prejudice to escape liability have generally done so for two reasons. First, strictly applying conditions precedent in liability policies creates a forfeiture.<sup>35</sup> Second, since the purpose of a notice requirement is to protect the insurer's interest from being prejudiced, it is unfair for an insurer who is not prejudiced to escape liability simply because of late notice.<sup>36</sup>

Prior to *House*, no Maryland case had considered the effect of section 482 on claims-made policies.<sup>37</sup> Claims-made policies, also known as discovery policies, have become increasingly popular over the past twenty years, especially in the area of professional liability insurance.<sup>38</sup> Claims-made policies cover liability inducing events as long as the claim is made during the policy term, regardless of when the event occurred.<sup>39</sup> Occurrence policies, on the other hand, "cover liability inducing events occurring during the policy term, irrespective of when the actual claim is presented."<sup>40</sup> There are also policies

has become responsible for such loss or damage, and any such cancellation or annulment shall be void. *An 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.*

*Id.* (emphasis added).

32. See *supra* note 3.

33. See *supra* note 29.

34. See, e.g., *Cooper v. Government Employees Ins. Co.*, 51 N.J. 86, 94, 237 A.2d 870, 874 (1968); *Brakeman v. Potomac Ins. Co.*, 472 Pa. 66, 72, 371 A.2d 193, 196 (1977).

35. See, e.g., *Ouellette v. Maine Bonding & Casualty Co.*, 495 A.2d 1232 (Me. 1985); *Cooper*, 51 N.J. at 93-94, 237 A.2d at 873; *Brakeman*, 472 Pa. at 73-74, 371 A.2d 196-97.

36. See, e.g., *Weaver Bros., Inc. v. Chappel*, 684 P.2d 123, 125 (Alaska 1984); *Miller v. Marcantel*, 221 So. 2d 557, 559 (La. Ct. App. 1969); *Brakeman*, 472 Pa. at 75, 371 A.2d at 197.

37. *St. Paul Fire & Marine Ins. Co. v. House*, 73 Md. App. 118, 122, 533 A.2d 301, 303 (1987) ("this case presents an issue of first impression"), *aff'd*, 315 Md. 328, 554 A.2d 404 (1989).

38. See *Parker*, *supra* note 6, at 28-29; Comment, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 UCLA L. REV. 925, 926 (1975).

39. See *Parker*, *supra* note 6, at 27.

40. *Id.* The United States Supreme Court contrasted claims-made and occurrence

which are hybrids of the claims-made and occurrence policies.<sup>41</sup>

The Court of Appeals of Maryland for the first time discussed the claims-made policy in *Mutual Fire, Marine & Inland Insurance Co. v. Vollmer*.<sup>42</sup> In *Vollmer*, the court of appeals contrasted claims-made and occurrence policies.<sup>43</sup> The court indicated that claims-made policies developed out of a need to deal with situations where “an error, omission, or negligent act is difficult to pinpoint and may have occurred over an extended period of time.”<sup>44</sup> The *Vollmer* court noted that claims-made policies enable insurers to underwrite risks, compute premiums, and establish reserves with greater accuracy because insurers know that their liability is limited to the term of the policy.<sup>45</sup>

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policies in *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531 (1978). “An ‘occurrence’ policy protects the 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.” *Id.* at 535 n.3. A frequently cited definition of claims-made and occurrence policies appears in *Samuel N. Zarpas, Inc. v. Morrow*, 215 F. Supp. 887, 888 (D.N.J. 1963):

In a discovery policy the coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurance company during the period of the policy, no matter when the act occurred. In an occurrence policy the coverage is effective if the negligent or omitted act occurred during the period of the policy, whatever the date of discovery.

*Id.* Another commentator has described the distinction between claims-made and occurrence policies as follows:

In the “occurrence” policy, the peril insured is the “occurrence” itself. Once the “occurrence” takes place, coverage attaches even though the claim may not be made for some time thereafter. While in the “claims made” policy, it is the making of the claim which is the event and peril being insured and, subject to policy language, regardless of when the occurrence took place.

Kroll, *The Professional Liability Policy “Claims Made,”* 13 FORUM 842, 843 (1978).

41. See Parker, *supra* note 6, at 27-28.

42. 306 Md. 243, 508 A.2d 130 (1986). The *Vollmer* decision was in response to a certified question from the United States District Court for the District of Maryland where an insurer sought reimbursement for monies paid on behalf of the insured. *Id.* at 244, 508 A.2d at 130. The court of appeals held in favor of the insured, ruling that the claims-made policy in question covered claims of malpractice allegedly committed after the policy’s retroactive date. *Id.* at 256, 508 A.2d at 136.

43. *Id.* at 253, 508 A.2d at 135 (quoting *Stine v. Continental Casualty Co.*, 419 Mich. 89, 98, 349 N.W.2d 127, 131 (1984)).

44. *Id.* (quoting *Stine*, 419 Mich. at 99, 349 N.W.2d at 131). “Examples include a physician’s misdiagnosis, an attorney’s fraudulent concealment, or an architect’s defective design. From an underwriting perspective, occurrence policies are unrealistic for such risks because of the long or open ‘tail’ exposure which results.” *Id.* (quoting *Stine*, 419 Mich. at 99, 349 N.W.2d at 131).

45. *Id.* at 254, 508 A.2d at 135 (quoting *Stine*, 419 Mich. at 99-100, 349 N.W.2d at 131).

The *Vollmer* decision also explained some of the variations of the claims-made policy. A claims-made policy can be written to cover all claims made within the policy period regardless of when the act or omission was deemed to have occurred.<sup>46</sup> On the other end of the spectrum is the claims-made policy which requires that the claim be made during the term of the policy and that the act or omission have occurred during the term of the policy.<sup>47</sup> The claims-made policy at issue in *Vollmer* was between these two extremes—the claim must have been made during the policy and the act or omission must have allegedly occurred after the policy's retroactive date.<sup>48</sup>

A survey of cases decided outside of Maryland that have considered the effect of a prejudice requirement where a claims-made insured gave no notice of the claim within the policy period reveals that as a general rule insurers need not prove prejudice to escape liability.<sup>49</sup> In *Gulf Insurance Co. v. Dolan, Fertig & Curtis*,<sup>50</sup> the insured, a law firm, had a professional liability claims-made policy for the period from November 20, 1978 to November 20, 1979.<sup>51</sup> The policy "required that the claim arise for services performed during the policy period; that the claim be known to or made against the insured during the said period; and that the insured notify the insurer thereof during said period."<sup>52</sup> On November 19, 1979, the insured received notice of a malpractice claim from a former client.<sup>53</sup> The insured did not notify its insurer of this claim until February 12, 1980,<sup>54</sup> at which time the

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46. *Id.* at 256, 508 A.2d at 136.

47. *Id.* (citing *Stine*, 419 Mich. at 94, 349 N.W.2d at 129).

48. *Id.* ("To determine coverage it thus becomes necessary not only to look at the date when the claim was made, but also to determine if the retroactive date requirement has been satisfied."). The "retroactive date" is the first day of coverage of a claims-made policy. Services rendered on or after the retroactive date are covered under the policy, so long as the claim relating to these services is made while the policy is still in effect. See R. KEETON & A. WIDISS, *INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES* § 5.10(d)(3), at 598 (Student ed. 1988).

49. See, e.g., *City of Harrisburg v. International Surplus Lines Ins. Co.*, 596 F. Supp. 954 (M.D. Pa. 1984), *aff'd without opinion*, 770 F.2d 1067 (3d Cir. 1985); *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512 (Fla. 1983); *Zuckerman v. National Union Fire Ins. Co.*, 100 N.J. 304, 495 A.2d 395 (1985).

50. 433 So. 2d 512 (Fla. 1983).

51. *Id.* at 513.

52. *Id.*

53. *Id.*

54. *Id.* at 514. On November 20, 1979, the insured had entered into a new claims-made policy with a different insurance carrier. *Id.* at 513. The insured notified its new insurance carrier of the claim on December 6, 1979. *Id.* The new insurance carrier informed the insured on January 16, 1980 that the claim would not be covered because the claim was known to the insured before the new policy was issued. *Id.* at 513-14.

insurer denied coverage because it was not notified during the policy period.<sup>55</sup>

The Supreme Court of Florida in *Dolan* held that claims-made policies require notice to be given during the policy period.<sup>56</sup> *Dolan* reasoned that if a court were to allow claims to be made after the policy period, the insured would be receiving more than it bargained for.<sup>57</sup> The court noted that some claims-made policies allow for the insured to report a claim to the insurer within a specified period after the policy ends.<sup>58</sup> The *Dolan* court concluded by noting that the insured had the option of purchasing an endorsement which would have extended the reporting period, but the insured chose not to purchase this extended coverage.<sup>59</sup>

In *City of Harrisburg v. International Surplus Lines Insurance Co.*,<sup>60</sup> the insured, the Mayor of Harrisburg, Pennsylvania, was covered under a claims-made "Public Officials and Employees Liability Insurance" policy.<sup>61</sup> The insurer denied liability and refused to defend the insured because it did not receive notice of the insured's claim until the policy had expired.<sup>62</sup> The insured argued that under Pennsylvania law, an insurer has a duty to show prejudice from late notice before coverage can be denied.<sup>63</sup>

The United States District Court for the Middle District of Pennsylvania in *City of Harrisburg* held that the Pennsylvania

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55. *Id.* at 514.

56. *Id.* at 515 ("Coverage depends on the claim being made and reported to the insurer during the policy period."). The *Dolan* court contrasted claims-made policies with occurrence policies by noting that in occurrence policies, "[c]overage depends on when the negligent act or omission occurred and not when the claim was asserted." *Id.*

57. *Id.* at 515-16 ("This extension of coverage, by the court, so very different from a mere condition of the policy, in effect rewrites the contract between the parties. This we cannot and will not do.").

58. *Id.* at 516 (citing *James & Hackworth v. Continental Casualty Co.*, 522 F. Supp. 785 (N.D. Ala. 1980)); *Graman v. Continental Casualty Co.*, 87 Ill. App. 3d 896, 409 N.E.2d 387 (1980); *Troy & Stalder Co. v. Continental Casualty Co.*, 206 Neb. 28, 290 N.W.2d 809 (1980); *Gereboff v. Home Indem. Co.*, 119 R.I. 814, 383 A.2d 1024 (1978)).

59. *Id.* The insured in *Dolan* had 30 days from the termination of the policy to exercise this endorsement option. *Id.* at 516 & n.2.

60. 596 F. Supp. 954 (M.D. Pa. 1984), *aff'd without opinion*, 770 F.2d 1067 (3d Cir. 1985).

61. *Id.* at 958.

62. *Id.* at 957.

63. *Id.* at 960. The Supreme Court of Pennsylvania held in *Brakeman v. Potomac Insurance Co.*, 472 Pa. 66, 371 A.2d 193 (1977), 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 75-77, 371 A.2d at 198.

prejudice rule applies only to occurrence policies and is inapplicable to claims-made policies.<sup>64</sup> The court gave three reasons why an insurer should not be expected to show prejudice when a claims-made insured fails to notify its insurer during the policy period. First, the insured could have either purchased an occurrence policy or obtained a policy with an extended discovery period.<sup>65</sup> Second, finding for the insurer gave the insured exactly what was bargained for.<sup>66</sup> Third, notice provisions in claims-made policies serve a materially different purpose than notice provisions in occurrence policies.<sup>67</sup> In claims-made policies, notice clauses give the insurer a specific date after which the insurer knows that it is no longer liable under the policy.<sup>68</sup> This allows for the insurer to fix more accurately its reserves and to compute premiums with greater certainty.<sup>69</sup>

In *Zuckerman v. National Union Fire Insurance Co.*,<sup>70</sup> the insurer provided the insured, an attorney, with claims-made professional liability coverage from January 15, 1974 through February 25, 1982.<sup>71</sup> On December 28, 1982, the insured notified his insurer of a pending malpractice suit, and he requested that the insurer defend and indemnify him in the event of liability.<sup>72</sup> The insurer denied coverage because the insured did not give notice of the claim until after the policy term had expired.<sup>73</sup> The insured's policy "afforded him coverage for acts or omissions occurring at any time, provided that the claim be asserted and reported to the carrier during the policy period."<sup>74</sup>

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64. *City of Harrisburg*, 596 F. Supp. at 962.

65. *Id.* The *City of Harrisburg* court did not agree with the insured's contention that there was an inequality of bargaining power which forced the insured to take the coverage offered. *Id.* at 962 n.8.

66. *Id.* at 962 ("accepting the insurer's argument would not involve a forfeiture since the insured has paid a lower premium for coverage that is retrospective only").

67. *Id.* at 961. In an occurrence policy, the purpose of the notice provision is "to give the insurer time to investigate the claim for defense or settlement." *Id.* at 962.

68. *Id.*

69. *Id.*

70. 100 N.J. 304, 495 A.2d 395 (1985), noted in Oettle & Howard, Zuckerman and Sparks, *The Validity of "Claims Made" Insurance Policies as a Function of Retroactive Coverage*, 21 TORT & INS. L.J. 659 (1986).

71. *Zuckerman*, 100 N.J. at 306, 495 A.2d at 396. In February 1982, the insured was given the opportunity to purchase an extended reporting endorsement, which he chose not to purchase. *Id.* at 309, 495 A.2d at 397.

72. *Id.* at 307, 495 A.2d at 396.

73. *Id.* The insured did not notify the insurer "because he believed that the claim was 'minimal' and could be settled within the deductible limits of his insurance policy." *Id.*

74. *Id.* at 308, 495 A.2d at 397. The trial court granted summary judgment for

The Supreme Court of New Jersey in *Zuckerman* held that no consideration of public policy prevented the court from enforcing the claims-made policy at issue,<sup>75</sup> and that the New Jersey prejudice rule<sup>76</sup> did not apply to claims-made policies which met the reasonable expectations of an insured.<sup>77</sup> Therefore, the insurer was not obligated to defend or indemnify the insured. The *Zuckerman* court admitted that members of the public could be “seriously disadvantaged” where an insured fails to notify its insurer before the claims-made policy expires.<sup>78</sup> The court addressed this point, however, by adding that the public is no worse off than in situations where a professional is either uninsured or has let his or her occurrence policy lapse.<sup>79</sup>

*Zuckerman* also offered reasoning similar to that given in *Dolan* and *City of Harrisburg*. The *Zuckerman* court said that the prejudice rule should not apply to claims-made policies because of the inherent difference between notice requirements in claims-made policies and those in occurrence policies.<sup>80</sup> The court refused to extend the notice period because an extension would give the insured “an unbargained-

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the insured on the ground that the insurer had not demonstrated any prejudice resulting from the insured’s late notice. *Id.* at 309, 495 A.2d at 398. The appellate division reversed, holding that the insurer should not be required to show prejudice under a claims-made policy where notice is not given until after the policy term has expired. *Zuckerman v. National Union Fire Ins. Co.*, 194 N.J. Super. 206, 216, 476 A.2d 820, 825 (App. Div. 1984).

75. *Zuckerman*, 100 N.J. at 321, 495 A.2d at 404. “In only a small number of cases that presented special factual circumstances have courts refused to uphold the coverage limitations of ‘claims made’ policies.” *Id.* at 317, 495 A.2d at 402. These instances have occurred where the policy language was ambiguous. *Id.*

76. The New Jersey prejudice rule provides that it is “appropriate to hold that the carrier may not forfeit the bargained-for protection unless there are both a breach of the notice provision and a likelihood of appreciable prejudice.” *Cooper v. Government Employees Ins. Co.*, 51 N.J. 86, 94, 237 A.2d 870, 874 (1968).

77. *Zuckerman*, 100 N.J. at 324, 495 A.2d at 406. “The *Cooper* doctrine has a clear application to policies analogous to the automobile liability policy there involved. It has, however, no application whatsoever to a ‘claims made’ policy that fulfills the reasonable expectations of the insured with respect to the scope of coverage.” *Id.*

78. *Id.* at 322, 495 A.2d at 404.

79. *Id.* at 322, 495 A.2d at 404-05. The *Zuckerman* court stated:

The potential for public injury derives more from the termination or nonexistence of coverage than it does from the form of the policy. Accordingly, we do not consider the standard “claims made” form of coverage to contravene public policy either from the standpoint of the professional or the professional’s clients.

*Id.* at 322, 495 A.2d at 405.

80. *Id.* at 323-24, 495 A.2d at 405-06. The notice requirement in an occurrence policy aids “the insurance carrier in investigating, settling, and defending claims.” *Id.* at 323, 495 A.2d at 406.

for expansion of coverage."<sup>81</sup> The *Zuckerman* court added that if it had ruled in favor of the insured, the cost of claims-made insurance in New Jersey would have increased as a result.<sup>82</sup>

In *St. Paul Fire & Marine Insurance Co. v. House*,<sup>83</sup> Homer C. House, M.D., and his professional association, Homer C. House, M.D., P.A., had a series of claims-made physicians and surgeons professional liability policies with St. Paul Fire and Marine Insurance beginning January 1, 1983 and ending January 1, 1986.<sup>84</sup> The St. Paul policy gave Dr. House the opportunity to purchase an optional reporting endorsement which would have extended his reporting period, but Dr. House chose not to exercise this option.<sup>85</sup> On October 29, 1984, Dr. House performed surgery on Ms. Shirley J. Platzer and allegedly left part of a needle in her knee.<sup>86</sup> The needle was removed on November 27, 1984.<sup>87</sup>

Dr. House received letters from counsel for Ms. Platzer, dated June 21, 1985 and September 16, 1985, stating a claim for damages and advising Dr. House to turn the matter over to his insurance carrier.<sup>88</sup> On November 15, 1985, Ms. Platzer filed a claim with the

81. *Id.* at 324, 495 A.2d at 406. "In exchange for limiting coverage only to claims made during the policy period, the carrier provides the insured with retroactive coverage for errors and omissions that took place prior to the policy period."  
*Id.*

82. *Id.* ("So material a modification in the terms of this form of insurance widely used to provide professional liability coverage both in this State and throughout the country would be inequitable and unjustified.').

83. 315 Md. 328, 554 A.2d 404 (1989).

84. *Id.* at 330, 554 A.2d at 405. The policy had a retroactive date of January 1, 1977. *Id.*

85. *Id.* at 338, 554 A.2d at 409. The policy described the optional reporting endorsement as follows:

Your professional coverage may end because one of us chooses to cancel or not renew it. If this happens, you have the right to buy an optional extension of coverage. It's called a reporting endorsement.

This reporting endorsement will cover:

- Injuries or deaths that occur after the retroactive date and before that [sic] date this agreement ends. And
- Claims that are first made or reported to us after the ending date of this agreement and before the reporting endorsement ends.

You must request the reporting endorsement in writing within 30 days after this agreement ends. We'll then sell it to you for a premium based on the rules and rating plans we're using on the day the reporting endorsement begins.

*St. Paul Fire & Marine Ins. v. House*, 73 Md. App. 118, 132, 533 A.2d 301, 308 (1987) (emphasis omitted), *aff'd*, 315 Md. 328, 554 A.2d 404 (1989).

86. *House*, 315 Md. at 331, 554 A.2d at 405.

87. *Id.*

88. *Id.* "The record indicates that Dr. House took no action in response to these communications." *House*, 75 Md. App. at 119, 533 A.2d at 302.

Health Arbitration Claims Board, and she properly served Dr. House on January 6, 1986.<sup>89</sup> On February 12, 1986, Dr. House reported the incident to Swope-Offut & Company, Inc., St. Paul's agent, and St. Paul learned of the claim shortly thereafter.<sup>90</sup> St. Paul declined to defend Dr. House on the ground that notice was not received within the policy period, and that therefore, the claim was not a covered risk.<sup>91</sup>

On July 1, 1986, Dr. House filed a declaratory judgment action in the Circuit Court for Baltimore City,<sup>92</sup> seeking an order requiring St. Paul to represent him before the Health Claims Arbitration Board in the Platzer case.<sup>93</sup> Dr. House argued that section 482<sup>94</sup> required St. Paul to prove that it was actually prejudiced by Dr. House's late notice before it could deny coverage.<sup>95</sup> Both St. Paul and Dr. House moved for summary judgment.<sup>96</sup> The trial court held that as a matter of law section 482 was applicable, granted Dr. House's motion for summary judgment, and ordered St. Paul to defend Dr. House in his case before the Health Claims Arbitration Board.<sup>97</sup>

St. Paul appealed to the court of special appeals, arguing that section 482 should not apply to claims-made notice provisions where an insured fails to notify its insurer until after the policy period has expired.<sup>98</sup> St. Paul contended that applying section 482 to claims-

89. *House*, 315 Md. at 331, 554 A.2d at 405-06.

90. *House*, 73 Md. App. at 120, 533 A.2d at 302.

91. *House*, 315 Md. at 331, 554 A.2d at 406.

92. Circuit Court Judge Thomas Ward presided. *Id.* at 328, 554 A.2d at 404.

93. *Id.* at 331, 554 A.2d at 406.

94. MD. ANN. CODE art. 48A, § 482 (1986); see *supra* note 3 (quoting § 482).

95. *House*, 315 Md. at 331, 554 A.2d at 406.

96. *Id.*

97. *Id.* The trial judge, in a written opinion concluded:

[T]his Court finds that the language of Section 482 is dispositive of the issue. The language of our Maryland General Assembly says what it says, and should not be bent or twisted and given meaning beyond that intended by our legislative bodies. If claims made policies are to be exempted, then the Maryland General Assembly must say it.

.....

As to the issue of prejudice itself, it would be premature for this Court to determine this issue, for this is a matter to be determined by the trial court (panel). The Defendant must defend the Plaintiff's case before the Health Claims Arbitration Panel, and the issue of prejudice, if raised, must be determined by that Honorable body. Section 482 of the Maryland Insurance Code applies to this case, and requires that the Defendant establish actual prejudice before it can disclaim coverage due to the Plaintiff's late notice of claim.

Brief for Appellant at app. 8-9, *House* (No. 87-186).

98. *House*, 73 Md. App. at 121, 533 A.2d at 303. "Appellant notes that in a 'claims made' policy the 'operative event' pertinent to the insurer's liability is the date of notification to the insurer; in an 'occurrence' policy, however, the operative event is the date of the allegedly negligent act." *Id.*

made policies amounted to rewriting the policy and giving the insured more coverage than was bargained for.<sup>99</sup> Dr. House argued that the plain language of section 482, and the court of special appeals' earlier applications of section 482, mandated that the statute should apply to the claims-made policy.<sup>100</sup>

The court of special appeals in *House*<sup>101</sup> considered the differences between occurrence and claims-made policies,<sup>102</sup> and examined the holdings in *Dolan*, *City of Harrisburg*, and *Zuckerman*.<sup>103</sup> The court found that the claims-made policy at issue "unambiguously" stated that a claim was made on the date an incident or injury was reported to St. Paul or its agent.<sup>104</sup> Although the court thought St. Paul's arguments and cases in support to be persuasive, it found the language of section 482 to be dispositive, and as a result, it affirmed the trial court's decision.<sup>105</sup>

The court of appeals in *House* granted certiorari to determine whether section 482 applies when an insurer maintains that there is no coverage under a claims-made insurance policy because the insured failed to make the claim within the policy period.<sup>106</sup> The four-member majority<sup>107</sup> found, however, that this issue was not presented in *House* because the policy in question was ambiguous as to whether a claim was made when the insured reported an incident or injury to the insurer or when the insured became aware of an incident or injury.<sup>108</sup> The *House* court reasoned that the ambiguity should be resolved against the party who drafted the policy.<sup>109</sup> As a result of

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99. *Id.* at 121-22, 533 A.2d at 303.

100. *Id.* at 122, 533 A.2d at 303. Dr. House referred to *Washington v. Federal Kemper Ins. Co.*, 60 Md. App. 288, 482 A.2d 503 (1984), *cert. denied*, 302 Md. 289, 487 A.2d 292 (1985) and *Medical Mutual Liability Ins. Soc'y of Md. v. Miller*, 52 Md. App. 602, 451 A.2d 930 (1982).

101. The three-judge panel at the court of special appeals consisted of Chief Judge Gilbert, Judge Alpert, and Judge Rosalyn B. Bell, and Judge Alpert issued the opinion. *House*, 73 Md. App. at 119, 533 A.2d at 301.

102. *Id.* at 122-25, 533 A.2d at 303-05.

103. *Id.* at 125-31, 533 A.2d at 305-07. For a discussion of these cases, *see supra* notes 49-82 and accompanying text.

104. *House*, 73 Md. App. at 132, 533 A.2d at 308. "Information relating to the 'type of claim . . . anticipate[d]' must be supplied to St. Paul. Thus, the insured, not a third party, 'makes the claim' by reporting an incident or injury." *Id.*

105. *Id.* at 132-35, 533 A.2d at 308-09. "[T]he policy at issue . . . clearly falls within the language of the statute. The language of the statute is very broad, and we find nothing to suggest an intent to exclude 'claims made' type policies." *Id.* at 135, 533 A.2d at 309.

106. *House*, 315 Md. at 330, 554 A.2d at 405 (1989).

107. The majority consisted of Judges Eldridge, Cole, Rodowsky, and Adkins, and Judge Rodowsky issued the opinion. *See id.* at 329-30, 554 A.2d at 404-05.

108. *Id.* at 330, 333, 554 A.2d at 405, 407.

109. *Id.* at 340-41, 554 A.2d at 410.

the ambiguity, and the alternative interpretation of when a claim could be made, the court of appeals held that section 482 was applicable to the claims-made policy at issue in *House*, and affirmed the decision of the court of special appeals.<sup>110</sup>

The *House* court explained its alternative interpretation theory by starting with the premise that the “ordinary meaning” of when a claim is made “refers to the assertion of a claim by or on behalf of the injured person against the insured.”<sup>111</sup> The court then examined the following two clauses of the St. Paul policy which gave rise to the ambiguity:

**WHEN YOU’RE COVERED [Basic Coverage Clause]**

To be covered the professional service must have been performed (or should have been performed) after your retroactive date that applies. The claim must also *first* be made while this agreement is in effect.

**WHEN IS A CLAIM MADE? [Accelerated Coverage Clause]**

A claim is made on the date you *first* report an incident or injury to us or our agent. You must include the following information:

- Date, time and place of the incident.
- What happened and what professional service you performed.
- Type of claim you anticipate.*
- Name and address of injured party.
- Name and address of any witness.<sup>112</sup>

The court found that the first clause fit the court’s “ordinary meaning” of when a claim is made.<sup>113</sup> As for the second clause, the court stated that the provision could be construed to require the reporting of a claim during the policy period, but that since the insured had to report the type of claim anticipated, the clause only addressed part of the claims spectrum.<sup>114</sup>

The *House* court examined St. Paul’s optional reporting endorsement, which Dr. House had elected not to purchase, to show that St. Paul’s definition of “when a claim is made” was inconsistent within the policy.<sup>115</sup> The optional reporting endorsement read in pertinent part:

This reporting endorsement will cover:

- Injuries or deaths that occur after the retroactive date and

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110. *Id.* at 341, 554 A.2d at 410-11.

111. *Id.* at 333, 554 A.2d at 407.

112. *Id.* at 334-35, 554 A.2d at 407 (court’s emphasis).

113. *Id.* at 335, 554 A.2d at 407.

114. *Id.* at 335, 554 A.2d at 407-08.

115. *Id.* at 338, 554 A.2d at 409.

before that date this agreement ends. And

- Claims that are *first made or reported* to us after the ending date of this agreement and before the reporting endorsement ends.<sup>116</sup>

The court interpreted this endorsement as requiring either the reporting of the claim to the insured or the reporting of the claim to the insurer within the policy period.<sup>117</sup> Therefore, the court held that reporting to the insurer could not be the exclusive meaning of "when a claim is made" as St. Paul had contended.<sup>118</sup>

The court of appeals also briefly examined the decisions in *Zuckerman* and *City of Harrisburg*,<sup>119</sup> but it found that the claims-made policies in those cases clearly required an insured to report claims to the insurer within the policy period.<sup>120</sup> In addition, the court gave a public policy reason for why it should hold against St. Paul. The court said that St. Paul's interpretation of when a claim was made means that reporting a claim "becomes increasingly more difficult the closer a claim is made (in the ordinary meaning) to a policy's expiration."<sup>121</sup> This problem, the court held, is avoided if

116. *Id.* (court's emphasis).

117. *Id.* at 339, 554 A.2d at 409.

118. *Id.*

119. For a discussion of these cases, see *supra* notes 60-82 and accompanying text.

120. *House*, 315 Md. at 335-37, 554 A.2d at 408. The policy in *Zuckerman v. National Union Fire Ins. Co.*, 100 N.J. 304, 495 A.2d 395 (1985) read in pertinent part:

To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as money damages because of any claim or claims first made against the insured and reported to the company during the policy period, arising out of an act or omission of the insured in rendering . . . , professional services for others . . . .

*Id.* at 307, 495 A.2d at 396-97. The coverage clause of the policy in *City of Harrisburg v. International Surplus Lines Ins. Co.*, 596 F. Supp. 954 (M.D. Pa. 1984), *aff'd without opinion*, 770 F.2d 1067 (3d Cir. 1985) read:

The Company will pay on behalf of the Insureds all Loss the Insureds shall be legally obligated to pay for any civil claim or claims first made against them because of a Wrongful Act, provided that the claim is first made during the policy period and written notice of said claim is received by the Company during the policy period.

*Id.* at 958. The *House* court also considered the case of *New England Reinsurance Corp. v. National Union Fire Ins. Co.*, 654 F. Supp. 742 (C.D. Cal. 1986), *rev'd*, 822 F.2d 887, *vacated, withdrawn, reh'g granted*, 829 F.2d 840 (9th Cir. 1987), but it found that the case also clearly required reporting within the policy period. *House*, 315 Md. at 336-37, 554 A.2d at 408 (insurer was obligated "to indemnify the insured on account of damages paid 'because of any claim or claims . . . first made against the insured and reported to the Company during the policy period.'").

121. *House*, 315 Md. at 340, 554 A.2d at 410. "If coverage can be obtained only by reporting, reporting ultimately becomes practically impossible within the policy period, e.g., when the injured person asserts an unanticipated claim late on the last day of the policy period." *Id.*

the “ordinary meaning” is used for defining “when a claim is made.”<sup>122</sup> The court concluded by adding that St. Paul did not make clear its definition of when a claim was made, at least in part, because the plain English<sup>123</sup> language of the policy sacrificed the “precision of language on the finer points of coverage.”<sup>124</sup>

There are some weaknesses in the court of appeals’ reasoning in *House*. First, the court raised the ambiguity issue sua sponte, and resolved the case only on that issue. Neither St. Paul, nor Dr. House, nor the court of special appeals saw any ambiguity in the policy.<sup>125</sup> Dr. House conceded that under the St. Paul policy a claim could only be made “when the insured notifies the insurer that a claim has been made against him.”<sup>126</sup> Moreover, neither party briefed the ambiguity issue.<sup>127</sup> Second, the majority used the optional reporting endorsement to establish ambiguity, even though the endorsement never became part of the insurance agreement.<sup>128</sup>

Third, the *House* court offered its “ordinary meaning” of when a claim was made without citing any authority for its definition.<sup>129</sup> The three-member dissent<sup>130</sup> addressed this point by stating, “[B]y attaching its own self-created labels to selected policy provisions, the majority clouds the interpretation and meaning of an essentially straightforward liability policy.”<sup>131</sup> The dissent maintained that the majority created an ambiguity where none existed.<sup>132</sup>

The dissent then addressed the issue for which certiorari was granted—whether section 482 should apply to claims-made policies when the claim is not reported until after the policy period.<sup>133</sup> The

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122. *Id.*

123. “The policy advises that ‘[w]e [*i.e.*, St. Paul] have written this policy in plain English’ and ‘in clear, straightforward English.’” *Id.* at 334, 554 A.2d at 407.

124. *Id.* at 340, 554 A.2d at 410.

125. *See* St. Paul Fire & Marine Ins. Co. v. House, 73 Md. App. 118, 132, 533 A.2d 301, 308 (1987), *aff’d*, 315 Md. 328, 554 A.2d 404 (1989) (“The policy unambiguously states that a claim is made on the date an incident or injury is reported to St. Paul or its agent.”).

126. Brief for Appellees at 35, *House* (No. 87-186). “According to the Appellees’ policy, a claim is made only after the Appellees have ‘reported,’ or given notice, of the ‘incident or injury’ to the Appellant.” *Id.* at 39. “The Appellees submit that the insurance policy provision . . . is not ambiguous.” *Id.* at 40.

127. *See* Brief for Appellant at 1-2, *House* (No. 87-186); Brief for Appellees at 3, *House* (No. 87-186).

128. *See House*, 315 Md. at 338-39, 554 A.2d at 409.

129. *See id.* at 333, 554 A.2d at 407.

130. Chief Judge Murphy authored the dissenting opinion, in which Judges McAuliffe and Blackwell joined. *Id.* at 341, 554 A.2d at 411 (Murphy, C.J., dissenting).

131. *Id.* at 342, 554 A.2d at 411 (Murphy, C.J., dissenting).

132. *Id.* (Murphy, C.J., dissenting).

133. *Id.* at 343, 554 A.2d at 411 (Murphy, C.J., dissenting).

dissent considered the purposes behind section 482,<sup>134</sup> explained differences between claims-made and occurrence policies,<sup>135</sup> and analyzed the opinions of the courts in *Dolan*, *City of Harrisburg*, and *Zuckerman*.<sup>136</sup> The dissent found that section 482 requires an insurer to prove that it was prejudiced only in situations where an insured breached an insurance policy.<sup>137</sup> The dissent reasoned that once Dr. House's claims-made policy expired, "[t]he policy could not be breached because there was no longer a policy to be breached."<sup>138</sup> Therefore, the dissent concluded that since there was no coverage, there could be no breach and that as a result, section 482 should not have been applied by the trial court in *House*.<sup>139</sup>

One interpretation of *House* is that the court of appeals decided the case narrowly and held only that section 482 applied to the claims-made policy at issue under the facts of the case. The court of special appeals decision in *House* may be persuasive on other courts faced with the issue of whether section 482 applies to claims-made policies.<sup>140</sup> Therefore, until either the court of appeals addresses the issue or the legislature chooses to intervene,<sup>141</sup> Maryland tribunals

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134. *Id.* at 343-48, 554 A.2d at 411-14 (Murphy, C.J., dissenting).

135. *Id.* at 348-52, 554 A.2d at 414-16 (Murphy, C.J., dissenting).

136. *Id.* at 357-60, 554 A.2d at 418-20 (Murphy, C.J., dissenting).

137. *Id.* at 355, 554 A.2d at 417 (Murphy, C.J., dissenting) ("[Section] 482 encompasses a two-part test. Without the required breach of the notice provision, prejudice to the insurer is immaterial and the statute does not apply."); see *supra* note 3 (quoting § 482) ("Where any insurer seeks to disclaim coverage . . . on the ground that the insured . . . has breached the policy by failing to cooperate with the insurer or by not giving requisite notice to the insurer . . .").

138. *House*, 315 Md. at 356, 554 A.2d at 418 (Murphy, C.J., dissenting). "Any claim made after its expiration is of the same effect as an accident or event which occurs after the 'expiration' of an occurrence policy." *Id.* (Murphy, C.J., dissenting).

139. *Id.* (Murphy, C.J., dissenting).

140. For example, even after the court of appeal's decision in *House*, the court of special appeals' holding in *House* has continued to be cited by at least one commentator and in the annotations to § 482 as the law in Maryland. Anderson, *Current Issues in Claims-Made Insurance Policies*, 14 ALI-ABA COURSE MATERIALS J. 57, 70 (Oct. 1989); MD. ANN. CODE art. 48A, § 482 (1986 & Supp. 1990) (annotations).

141. During the 1988 legislative session of the General Assembly of Maryland, and between the court of special appeals and the court of appeals decisions in *House*, Senate Bill 503, entitled "AN ACT concerning Disclaimer of Coverage—Claims-Made Insurance Policies," was proposed to amend § 482. See S. 503, 1988 Md. Senate Bills. The proposed version of § 482 read as follows:

(A) Where any insurer seeks to disclaim coverage on [any] A policy of liability insurance issued by it, on the ground that the insured or anyone claiming the benefits of the policy through the insured has breached the policy by failing to cooperate with the insurer or by not giving requisite notice to the insurer, such disclaimer shall be effective

may apply section 482 to claims-made policies even where a claim is not made during the policy period.

If section 482 is applied to claims-made policies, claims-made insurers will be exposed to risks for a substantially broader period than the insureds have bargained for.<sup>142</sup> Such an extension of coverage may significantly affect the actuarial basis upon which premiums have been calculated.<sup>143</sup> As the Insurance Commissioner of the State of Maryland argued in its *amicus curiae* brief before the court of appeals in *House*: "The end result could be that these lines of insurance will become unavailable, or prohibitively expensive, to Maryland insureds."<sup>144</sup>

The Court of Appeals of Maryland, in *St. Paul Fire & Marine Insurance Co. v. House*, declined to give its final word on whether Article 48A, section 482, of the Maryland Code applies to claims-made insurance policies when an insured fails to notify its insurer of a claim until after the policy period has expired. The *House* court found that the policy at issue was ambiguous as to when a claim was made. Because of the ambiguity, there was room to find that Dr. House's claim was made during the policy period. As a result, the court of appeals held that section 482 applied to this particular policy in this given set of facts.

The court of appeals, in so ruling, affirmed the court of special appeals which had held that section 482 applies to claims-made policies as a matter of law even when a claim is made after the policy period has expired. The court of special appeals holding leaves the continued existence of claims-made policies in a state of uncertainty. As Maryland's Insurance Commissioner has suggested, requiring an insurer to prove that it was actually prejudiced even where

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only if the insurer establishes, by a preponderance of affirmative evidence that such lack of cooperation or notice has resulted in actual prejudice to the insurer.

(B) A SHOWING OF ACTUAL PREJUDICE TO THE INSURER SHALL NOT BE REQUIRED WHEN COVERAGE IS DENIED OR DISCLAIMED BASED ON LACK OF NOTICE TO THE INSURER UNDER A POLICY OF LIABILITY INSURANCE FOR WHICH COVERAGE IS PROVIDED ONLY FOR THOSE CLAIMS WHICH ARE REPORTED TO THE INSURER OR ITS AGENT WITHIN THE APPLICABLE POLICY PERIOD.

*Id.* The demise of Senate Bill 503 does not appear to express the intent of the General Assembly, since the General Assembly never considered the bill on its merits. Reply Brief for Appellant at 2, *House* (No. 87-186) (citing Daily Record, Apr. 20, 1988, at 3, 9).

142. See *Zuckerman v. National Union Fire Ins. Co.*, 100 N.J. 304, 324, 495 A.2d 395, 406 (1985); see also *supra* notes 81-82 and accompanying text.

143. See *Zuckerman*, 100 N.J. at 324, 495 A.2d at 406.

144. *Amicus Curiae Brief for the Insurance Commissioner of the State of Maryland* at 17, *House* (No. 87-186).

a policy had expired creates an unwarranted and unbargained-for extension of coverage, and may result in either the extinction of claims-made policies from the Maryland market or would make claims-made policies prohibitively expensive to Maryland consumers.

*Frederick W. Goundry, III*