Maximizing Insurance Recovery for Newly Reopened Abuse Claims

By: Martin Bienstock

New York and New Jersey recently changed their laws to permit individuals now to bring lawsuits alleging that as children they had been victims of sexual abuse.[1] By altering the "statute of limitations," the legislatures have created windows for plaintiffs to bring such claims between now (August in New York; December in New Jersey) and sunset dates of 2020 in New York and 2021 in New Jersey.

These statutes will have the effect of stimulating the assertion of childhood abuse claims during this litigation window. Similar legislation adopted by California in 2002 spurred lawsuits that cost the Catholic Church more than $1.4 billion, at an average cost of more than $1 million per claim.

Schools, camps and similar institutions in New York and New Jersey therefore face a likely wave of lawsuits from plaintiffs alleging that they had been sexually-abused many years ago. In some instances, these suits may allow deserving victims to be reimbursed for terrible injuries they may have suffered. In other instances, plaintiffs may allege meritless claims, or seek reimbursement from institutions even when the institutions are blameless.

Whatever their merits, these lawsuits will impose potentially bankrupting costs on numerous affected institutions. Insurance proceeds can mitigate the financial impact of these lawsuits. Insurance can provide settlement funds to pay deserving victims; it can pay defense costs to fight unmeritorious claims.

In recent weeks, the Archdiocese of New York and Roosevelt Hospital have filed lawsuits seeking a declaration that their insurers were responsible to provide coverage of the sex-abuse claims against them. These institutions are not typical however; they face unusually heinous allegations of longstanding and widespread abuse, with hundreds of complainants alleging the knowing acquiescence of supervisors and senior personnel.

Other affected institutions will face their own unique challenges to obtaining insurance payments. Some insurers will work cooperatively with their insureds; others will be wholly recalcitrant; and others will fall somewhere in-between. Factual allegations will vary widely, as will the manner in which legal claims are asserted. Each institution will need to devise its own strategy for maximizing recovery of insurance proceeds.

This memorandum will introduce the issues that an affected institution will face as it fights to maximize insurance proceeds. The memorandum first will describe how institutions can

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overcome the substantial challenges they face in providing mandatory notice to their insurers for claims that may be many years old. It will then describe the potential benefits of providing notice for covered claims: coverage both for defense costs and for the costs of funding a reasonable settlement. It will then explore the potential for accessing multiple years of coverage, so that reimbursement could be aggregated from multiple years' policy limits. Finally, it will identify some common insurer defenses, along with potential responses. Ultimately, each institution should carefully evaluate its options so it can craft the position that maximizes coverage for itself, based on its own unique circumstances.

A. Affected Institutions Must Overcome Significant Challenges to Providing Required Notice under Their Policies.

1. Failure to Provide Notice May Bar a Claim.

Insurance policies typically include a "Notice" provision requiring the insured to provide notice to the insurer within a specified period. If the insured fails to provide the required notice, it may in some circumstances forfeit its claims. In New York, a policyholder's delay in providing notice on an pre-2009, occurrence-based policy can bar its claim even if the delay did not prejudice the insurer.[2] In New Jersey, an insurer always must demonstrate that it had suffered prejudice before barring coverage on an occurrence-based policy.[3]

In addition to potentially forfeiting claims under occurrence-based policies, an insured that provides late notice also may forfeit coverage under a claims-made policy, even if the late notice did not prejudice the insurance company.[4] In addition, CGL policies typically prohibit insureds from incurring any expense without prior consent, a provision that creates significant risk that insurers will refuse to reimburse costs incurred prior to receiving notice.

Accordingly, an insured who does not provide notice immediately upon an allegation of abuse creates an unnecessary risk that the insurer will deny coverage, or that it will forfeit coverage of pre-notice costs.

2. Providing Notice for Long-Ago Policy Periods Presents Challenges.

In order to provide timely notice, it typically is necessary to identify the relevant insurance policies and comply with their terms. But in cases going back decades, an institution may no longer retain copies of the relevant insurance policies. Brokers may not have all the relevant policies either.

In such an instance, it may be necessary for a forensic investigator to assist the institution in finding the relevant insurance policies. If necessary, an expert also can help reconstruct the history of coverage to identify the likely policies and insurers that were in place during the

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relevant time period. These initial efforts frequently may be rewarded by later recoveries of significant insurance proceeds.

B. Once Notice Has Been Provided, Insurers Have a Duty to Defend and to Settle When Reasonable.

Once notice has been provided, the insurer has a duty to defend the lawsuit and fund a reasonable settlement. While the general rules are well-settled, insureds can anticipate significant skirmishing concerning the precise scope of an insurer's duties in any particular case.

Generally, under New York and New Jersey law, an insurer must defend a lawsuit whenever the four corners of the complaint suggests a reasonable possibility of coverage.[5] The duty to defend typically extends both to covered and uncovered claims within a lawsuit, so long as the defense of both are intertwined.[6]

Frequently, an insurer will issue a reservation-of-rights letter, in which it proffers a defense but reserves the right later to deny coverage based on currently unresolved factual questions. Such a reservation-of-rights letter can create a conflict of interest on the part of the insured's attorney. In such an instance, the law typically requires the insurer to pay for defense counsel of the insured's choosing.[7]

In both New York and New Jersey, an insurer has the duty to settle the case within policy limits if such a settlement is reasonable.[8] An insurer's failure to fund a reasonable settlement offer can make it liable to the insured for bad faith.[9]

C. Affected Institutions May Be Able to Fund Defense Costs and Settlements from Multiple Insurance Policies.

The insurance programs in place at affected institutions vary from one institution to another. Similarly, the allegations of abuse and asserted legal theories may vary widely. Each affected institution therefore should, with the aid of counsel, review and analyze its circumstances to adopt the position best suited to maximize recovery.

Generally speaking, affected institutions will have multiple polices under which they may be able to obtain indemnification. In most cases, an institution will have in place a Commercial General Liability Policy ("CGL") and a Directors and Officers Policy ("D&O") and may also have purchased an Umbrella Policy. Most institutions will have purchased these programs of insurance for many years.

In recent years, insurers began excluding or limiting coverage for abuse claims. Nevertheless, policies that were in effect years ago, when an alleged incident might have taken place, are unaffected by the terms of current policies and can still provide coverage. Accordingly, after

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first looking to its current policies, affected institutions should look to the policies that were in effect at the time of the first incident of alleged abuse. Then, if the abuse or injury to a victim continued over time, coverage may be available for subsequent years as well. Coverage also may be available from multiple policies in place for each year, so that, for example, if primary coverage is exhausted, coverage from an umbrella policy may be available.

By accessing multiple policies over multiple years, an affected institution can obtain reimbursement in amounts that far exceed its policy limits in any given year. Careful investigation and attention to the full scope of an institution's polices may yield significant amounts of coverage.

Insurers may respond by arguing that each incident of abuse constitutes only a single occurrence under the general CGL Policy. Many CGL policies define an occurrence to include "continuous or repeated exposure to substantially the same harmful conditions." Insurers therefore may argue that, under the terms of such policies, incidents should be aggregated by victim or by assailant, and not treated as separate occurrences. Such an approach would reduce the amount of coverage available. There are however strong arguments in favor of a policyholder position that multiple incidents of abuse are multiple "occurrences" and can be reimbursed across multiple policy years.[10]

In some instances, however, it might benefit the policyholder to classify a series of incidents as a single occurrence, such as when a large deductible exceeds the costs associated with a single incident.[11] Again, careful attention must be paid to the unique circumstances of each institution in order to maximize recovery.

D. Affected Institutions Should be Prepared to Respond to Additional Insurer Arguments.

1. Affected Institutions Should be Prepared to Respond to Insurer Arguments that the Injury Was "Expected or Intended."

CGL policies frequently exclude loss from an injury that is "expected or intended from the standpoint of the insured." (Some policies instead use the phrase ". . . standpoint of *an* insured.) Insurers frequently will argue that sexual abuse was "expected or intended" from the standpoint of the assailant, and therefore excluded.

The question of whether the "intended or expected" language will exclude coverage depends in part on the language of the policy and the culpability of the insured party. In New York[12] and elsewhere,[13] courts have rejected the argument that an assailant's bad intentions are attributable to all insureds. They have held that the appropriate question is not whether the alleged assailant intended harm, but whether the insured (*i.e.* the person or entity seeking indemnification) intended harm. Where, from the perspective of the insured, the assault was an accident, the

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"affected or intended" defense does not apply to its claims.[14] However, where the insured knew of the abuse and failed to stop it, the injury can be deemed "expected" from its perspective, and may not be covered.[15]

In New Jersey, some cases have analyzed exclusions for injury that was "intended or expected from the standpoint of *an* insured." These cases have held that the term "an insured" unambiguously encompasses "any insured," so that the bad intentions of the assailant is imputed to all insureds, and no coverage is available.[16] However, CGL polices frequently include a separation of coverage provision, which affords each insured coverage as if he were the only insured. Such a provision would negate the effect of an exclusion of coverage intended or expected from the standpoint of an (*i.e.* any) insured.[17]

2. Affected Institutions Should be Prepared to Respond to Insurer Arguments that the Injury Was Not an "Accident."

An "occurrence" frequently is defined to mean an "accident." Insurers therefore will sometimes argue that alleged abuse is not an "accident," and is not covered under the policy.

However, the underlying claim against the institution frequently contains an allegation that the institution was negligent in hiring, retaining or supervising staff. Courts have held that such negligence is an accident, giving rise to coverage under a CGL policy.[18]

3. Affected Institutions Should be Prepared to Respond to Insurer Arguments that an Assault and Battery or Sexual Abuse Exclusion Applies.

CGL policies may on occasion exclude claims for damages "arising out of any assault or battery," including any "act, error or omission relating to such assault or battery." This exclusion, which is not typical, is similar in scope to the exclusion for sexual assault contained in some current policies. These exclusions may extend broadly even to claims for negligent hiring, retention and supervision if such negligence contributed to sexual abuse. [19] Policyholders faced with such exclusions should examine them carefully to identify exceptions to the exclusion, and creatively look to other policies and coverages for indemnification.

E. Conclusion

Legislation extending the statutes of limitation on sex-abuse claims has the potential to impose significant costs on affected schools, camps and other institutions. By adopting a proactive and aggressive approach to insurance recovery, affected institutions can potentially increase recoveries and mitigate the negative impact on their financial condition.

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[1] NY L. 2019, Ch. 11; NJ P.L 2019, Ch. 120.

[2] Prior to 2009, New York courts held that a notice requirement was a material policy term; accordingly, when a policyholder failed to provide the required notice, an insurer could deny the claim. *In re Brandon (Nationwide Mut. Ins. Co.),* 97 N.Y.2d 491, 496 (2002). In 2009, New York enacted legislation to mitigate the harsh effects of this rule. L.2008, c. 388, §§ 2 to 6, eff. Jan. 17, 2009 ("[f]ailure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim by the insured, injured person or any other claimant, unless the failure to provide timely notice has prejudiced the insurer.") Under the legislation, late notice on an occurrence-based policy could only bar a claim when the delay caused prejudice to the insurer. The new law applies only to policies entered after the legislation went into effect, however. Insurance Law § 3420 (a) (5). Policies entered prior to 2009 still are governed by the harsh rule that bars claims for late notice. *Id. See Freeway Co., LLC v. Technology Ins. Co*., Inc., 138 AD3d 623, 624 (1st Dept 2016)("[Section 3420(a)(5) expressly applies to policies issued on or after its effective date, January 17, 2009;" dismissing late-noticed claims without requiring prejudice).

[3] *Cooper v. Gov't Emp. Ins. Co*., 51 N.J. 86, 94, 237 A.2d 870, 874 (1968).

[4] *Travelers Indem. Co. v. Northrop Grumman Corp*., No. 12 CIV. 3040 (KBF), 2013 WL 12325152, at *12 (S.D.N.Y. Nov. 4, 2013); *Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 224 N.J. 189, 207, 129 A.3d 1069, 1079 (2016).

[5] *Cont'l Cas. Co. v. Rapid-Am. Corp*., 609 N.E.2d 506, 509 (N.Y. 1993); *Abouzaid v. Mansard Gardens Associates LLC*, 207 N.J. 67 (2011).

[6] *See Hebela v. Healthcare Ins. Co*., 370 N.J. Super. 260, 851 A.2d 75 (App. Div. 2004); *Seaboard Surety Co. v. Gillette Co.,* 64 N.Y.2d 304, 310, 486 N.Y.S.2d 873, 876 (1984).

[7] *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 401, 425 N.E.2d 810 (1981). The law in New Jersey is slightly unsettled on this issue. *Compare Burd v. Sussex Mut. Ins. Co.,* 56 N.J. 383, 267 A.2d 7 (1970)(limiting reimbursement of defense costs so as to be coterminous with liability) *with Flomerfelt v. Cardiello*, 202 N.J. 432, 997 A.2d 991 (2010) (ordering payment of defense costs as incurred, but without overruling *Burd).*

[8] *Pavia v. State Farm Mut. Auto. Ins. Co*., 82 N.Y.2d 445, 452, 626 N.E.2d 24, 26 (1993); *Rova Farms Resort, Inc. v. Inv'rs Ins. Co. of Am*., 65 N.J. 474, 496, 323 A.2d 495, 507 (1974).

[9] *Id.*

[10] New York courts have held in some cases that injury from sexual abuse is not a result of "continuous or repeated exposure." *Roman Catholic Diocese of Brooklyn v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa*., 21 N.Y.3d 139, 151, 991 N.E.2d 666, 674 (2013). In those cases, they held that the abuse claims were multiple occurrences, and therefore could be the subject of separate limits for multiple policy years. Other courts have similarly held that each instances of abuse constitutes a separate claim. *See, e.g., In re Diocese of Duluth,* 565 B.R. 914, 925 (B.R. Minn. 2017).

[11] *See, e.g., Appalachian Ins. Co. v. Gen. Elec. Co.,* 8 N.Y.3d 162 (2007)(rejecting policyholders argument for single occurrence, subject to a single deductible).

[12] *RJC Realty Holding Corp. v. Republic Franklin Ins. Co*., 2 N.Y.3d 158, 164, 808 N.E.2d 1263 (2004).

[13] *See, e.g., Diocese of Winona v. Interstate Fire & Cas. Co.,* 89 F.3d 1386, 1391 (8th Cir. 1996).

[14] *Id.*

[15] *See Diocese of Winona, supra.*

[16] *Villa v. Short*, 195 N.J. 15, 24, 947 A.2d 1217, 1222 (2008).

[17] *Minkler v. Safeco Ins. Co. of Am.*, 49 Cal. 4th 315, 323, 232 P.3d 612, 617.

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[18] *Liberty Surplus Ins. Corp. v. Ledesma & Meyer Constr. Co*., 5 Cal. 5th 216, 418 P.3d 400 (2018), *as modified* (July 25, 2018).
[19] *See Nautilus Ins. Co. v. Motel Mgmt. Servs., Inc*., No. 18-2290, 2019 WL 3283221, at *2 (3d Cir. July 22, 2019).

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