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REGULATORY LIMITS ON CLAIMS HANDLING

Timing for Responses and Determinations

Life insurance proceeds typically must be distributed within thirty days from the receipt of proof of death regardless of the policy terms. 18 Del. C. § 2914.

An insurer must include a policy provision that it will pay claims submitted pursuant to health insurance contracts “immediately upon receipt of due written proof of such loss.” 18 Del. C. § 3312. The Delaware Insurance Commissioner has properly adopted regulations providing more specific guidance. For instance, within 30 days, the insurer must either (1) make payment on the claim, (2) notify the insured that the claim is not covered, or (3) request additional information from the insured. Delaware Regulation # 18 1300 CDR 1310 (6.0).

The Delaware legislature has also adopted comprehensive legislation titled the “Unfair Practices in the Insurance Business,” which applies to the insurance industry in general. This Act requires an insurance company to respond “promptly” to insurance claims, which includes (1) prompt responses to communications from insureds, (2) prompt investigation of claims, (3) affirming or denying coverage “within a reasonable time after proof of loss statements have been completed,” and (4) prompt settlement of claims once liability has become reasonably clear. 18 Del. C. § 2304(16).

Pursuant to its authority under 18 Del. C. § 2312, the Insurance Commissioner has adopted various regulations regarding the statutorily required “prompt” responses discussed above. For instance, a “prompt” payment of a settled claim is defined as remittance of the check or electronic payment within 30 days of the date on which a settlement agreement is fully executed, including the settlement of a case prior to a hearing but pursuant to an action filed in court, the date a final order is issued by the court, the date that all of claimant’s documentation has been received and investigation of the claim is complete, or the last day by which an arbitration award may be appealed as provided in applicable appellate court rules, when neither party to the arbitration has elected to file an appeal. Delaware Regulation #18 900 CDR 903 (5.1). Insurers must “respond within 15 working days” to communications from insureds. Delaware Regulation # 18 900 CDR 902 (3.1.2). Insurers must commence investigations of claims within 10 working days upon receiving notice of a loss. Delaware Regulation # 18 900 CDR 902 (3.1.3). Insurers have 30 days to affirm or deny coverage after receiving proof of loss statements. Delaware Regulation # 18 900 CDR 902 (3.1.5).

The Delaware Insurance Code generally requires an insurance company to respond “promptly” to insurance claims, which includes (1) prompt responses to communications from insureds, (2) prompt investigation of claims, (3) reasonable investigation of claims based upon all available information before refusing to pay claims, (4) affirming or denying coverage “within a reasonable time after proof of loss

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statements have been completed,” and (5) prompt settlement of claims once liability has become reasonably clear. *See* 18 Del. C. § 2304 (16) (b), (c), (d), (e), and (m).

The Administrative Procedure Act, 29 Del. C. § 10101 et seq., codifies rule-making and hearing authority for Delaware state agencies and specifies the manner and extent to which action by state agencies is subject to public comment and judicial review. Except as otherwise provided in the Insurance Code (Title 18), it applies to and governs all administrative actions. 18 Del. C. § 323 sets forth generally the procedures for hearings before the Insurance Commissioner.

The Commissioner may issue regulations in accordance with 18 Del. C. § 311 “as an aid to” the administration or effectuation of the Delaware Insurance Code, Chapter 18 of the Delaware Code. (Insurance regulations are posted online at: <http://regulations.delaware.gov/AdminCode/title18/index.shtml>.)

In May 2012, the General Assembly enacted a statute to allow insurers to deliver documents and notices to their insured, provided that the insurer obtains the insured’s affirmative consent and it meets the requirements of the Uniform Electronic Transactions Act (6 Del. C. § 12A-101 et. seq.). 18 Del. C. § 107.

In August 2012, the General Assembly enacted a statute requiring insurers to “provide clear and prominent notice to residential property insurance policyholders as to the existence of deductibles for losses caused by wind, hail or hurricanes” for new policies or policy renewals issued after January 1, 2013. 18 Del. C. § 4140.

Also, effective January 1, 2013, all property and casualty insurance companies doing business in Delaware, unless otherwise exempt, must annually submit to the Department of Insurance the opinion of an appointed actuary entitled “Statement of Actuarial Opinion.” 18 Del. C. § 1131, et. seq.

Standards for Determination and Settlements

The Delaware Insurance Code imposes on insurers a duty to make good faith attempts to effectuate “prompt, fair and equitable settlements of claims in which liability has become reasonably clear.” 18 Del. C. § 2304(16)(f). Specific examples of what § 2304 requires in practice are contained in the applicable regulations. (Delaware Regulation # 18 900 CDR 902). The rules and regulations governing settlement of life and health insurance claims are discussed above. *See supra* Section I(A).

Standards for handling insurance claims are set forth in the Delaware Insurance Code, 18 Del. C. § 2304 “Unfair methods of competition and unfair or deceptive acts or practices defined”, and the above discussed regulations.

Privacy Protections (In addition to Federal Gramm-Leach-Bliley Act)

There are a host of statutes that address confidentiality of information: 16 Del C. § 1119A (the records of residents of a nursing facility or similar facility); 16 Del C. § 1210, et. seq. (personal health information) 18 Del C. § 2406 (records regarding an insurance fraud investigation or examination); 16 Del C. § 2006 (uniform health data); 29 Del C. § 7971 (long-term, acute & outpatient healthcare services); 16 Del C. § 1121 (long-term care facility resident’s rights); 21 Del. C. § 305 (motor vehicle driving history and license records); 9 Del C. § 1184 (the public right of inspection of public records which would invade a person’s right of privacy are denied); 18 Del. C. § 535 (compliance with Title V of Gramm-Leach-Bliley Act of 1999); 18 Del. C. § 3918 (enacted in 2014 to address vehicle data-reporting devices); 24 Del. C. § 3913 (privileged communications for social workers). In addition, the Insurance Commissioner has adopted comprehensive regulations protecting insureds’ privacy, including regulations captioned “Privacy of Consumer Financial and Health Information” (Delaware Regulation # 18 900 CDR 904), and “Standards for Safeguarding Customer Information.” (Delaware Regulation # 18 900 CDR 905).

PRINCIPLES OF CONTRACT INTERPRETATION

Delaware's principles of contract interpretation are summarized in the following passage from *ConAgra Foods, Inc. v. Lexington Ins. Co.*, 21 A.3d 62 (Del. 2011):

This Court has adopted traditional principles of contract interpretation. One such principle is to give effect to the plain meaning of a contract's terms and provisions when the contract is clear and unambiguous. But, when we may reasonably ascribe multiple and different interpretations to a contract, we will find that the contract is ambiguous.

We interpret insurance contracts similarly. Clear and unambiguous language in an insurance contract should be given its ordinary and usual meaning. Where the language of a policy is clear and unequivocal, the parties are to be bound by its plain meaning. In construing insurance contracts, we have held that an ambiguity does not exist where the court can determine the meaning of a contract without any other guide than a knowledge of the simple facts on which, from the nature of language in general, its meaning depends. An insurance contract is not ambiguous simply because the parties do not agree on its proper construction. Creating an ambiguity where none exists could, in effect, create a new contract with rights, liabilities and duties to which the parties had not assented. But, we also have explained that an insurance contract is ambiguous when it is reasonably or fairly susceptible of different interpretations or may have two or more different meanings.

Id. at 68-69 (citations and quotations omitted); *see also In re Viking Pump, Inc.*, 148 A.3d 633 (Del. 2016); *IDT Corp. v. U.S. Specialty Ins. Co.*, 2019 WL 413692, at *7 (Del. Super. Jan. 13, 2019).

Delaware adheres to the 'objective' theory of contracts, i.e., a contract's construction should be that which would be understood by an objective, reasonable third party. *Osborn ex rel. Osborn v. Kemp*, 991 A.2d 1153 (Del. 2010). The court will read a contract as a whole and will give each provision and term effect, so as not to render any part of the contract mere surplusage. *Id.* The court will not read a contract to render a provision or term "meaningless or illusory." *Id.* A contract must contain all material terms in order to be enforceable, and specific performance will only be granted when an agreement is clear and definite and a court does not need to supply essential contract terms." *Id.*

An unreasonable interpretation produces an absurd result or one that no reasonable person would have accepted when entering the contract. *Id.*

If a contract is ambiguous, the court will apply the doctrine of *contra proferentem* against the drafting party and interpret the contract in favor of the non-drafting party. *Id.*; *see also Verizon Comm. Inc. v. Illinois Nat'l Ins. Co.*, 2017 WL 1149118, at *8-9 (Del. Super. Mar. 2, 2017); *Lukk v. State Farm Mut. Auto. Ins. Co.*, 2014 WL 4247767, at *4 (Del. Super. Aug. 29, 2014) (holding that where one of a contract's provisions is deemed ambiguous, "the doctrine of *contra proferentem* requires that the language of an insurance policy be construed most strongly against the insurance company that drafted it" (quotations omitted)). The parties' steadfast disagreement over interpretation will not, alone, render the contract ambiguous. *Id.* The determination of ambiguity lies within the sole province of the court. *Id.* A mere split in the case law concerning the meaning of a term does not render that meaning ambiguous in the Delaware courts. *O'Brien v. Progressive Northern Ins. Co.*, 785 A.2d 281, 289 (Del. 2001). In *Eagle Ind. v. DeVilbiss Health Care*, the Delaware Supreme Court held that, where contract language is unambiguous, "extrinsic evidence may not be used to interpret the intent of the parties, to vary the terms of the contract or to create ambiguity." 702 A.2d 1228, 1232 (Del. 1997).

Ambiguous provisions in contracts of insurance are to be construed against the insurer. *Penn Mut. Life Ins. Co. v.*

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Oglesby, 695 A.2d 1146 (Del. 1997). Insurance contracts must be interpreted in a common sense manner, giving effect to all provisions so that a reasonable policyholder can understand the scope and limitation of coverage. It is the obligation of the insurer to state clearly the terms of the policy, just as it is the obligation of the issuer of securities to make the terms of the operative document understandable to a reasonable investor whose rights are affected by the document. Thus, if the contract in such a setting is ambiguous, the principle of *contra proferentem* dictates that the contract must be construed against the drafter. *Id.* The policy behind this principle is that the insurer or the issuer, as the case may be, is the entity in control of the process of articulating the terms. The other party, whether it be the ordinary insured or the investor, usually has very little say about those terms except to take them or leave them or to select from limited options offered by the insurer or issuer. Therefore, it is incumbent upon the dominant party to make terms clear. Convoluted or confusing terms are the problem of the insurer or issuer—not the insured or investor. *Id.*; see also *Cont'l Ins. Co. v. Burr*, 706 A.2d 499 (Del. 1998); *Phillips Home Builders Inc. v. Travelers Ins. Co.*, 700 A.2d 127, 129 (Del. 1997); *Emmons v. Hartford Underwriters Ins. Co.*, 697 A.2d 742, 745 (Del. 1997).

But, the court may resort to extrinsic evidence to resolve ambiguity where the two parties to the agreement were business people on an equal footing with each other who negotiated back and forth on the disputed provision and its risk-allocation consequences. See *Carey's Home Constr., LLC v. Estate of Myers*, 2014 WL 1724835, at *5 (Del. Super. Apr. 16, 2014) (citing *SI Mgmt. L.P. v. Wininger*, 707 A.2d 37, 43 (Del. 1998)).

CHOICE OF LAW

Generally, Delaware Courts will honor “a contractually designed choice of law provision so long as the jurisdiction selected bears some material relationship to the transaction.” *J.S. Alberici Constr. Co. v. Mid-West Conveyor Co., Inc.*, 750 A.2d 518, 520 (Del. 2000); *Annan v. Wilmington Trust Co.*, 559 A.2d 1289, 1293 (Del. 1989). A material relationship exists where:

- A party’s principal place of business is located within the foreign jurisdiction (*Maloney-Refaie v. Bridge at Sch., Inc.*, 958 A.2d 871, 879 n. 16 (Del. Ch. 2008); *Shadewell Grove IP, LLC v. Mrs. Fields Franchising, LLC*, 2006 WL 1375106, at *7 (Del. Ch. May 8, 2006); *Hills Stores Co. v. Bozic*, 769 A.2d 88, 112 (Del. Ch. 2000));
- A majority of the activity underlying the action occurred within the foreign jurisdiction (*E.I. duPont de Nemours & Co. v. Bayer CropScience L.P.*, 958 A.2d 245, 249 n. 9 (Del. Ch. 2008)); and
- Where parties to a contract performed most of their services in the foreign state. *Bozic*, 769 A.2d at 112; see also *Knight v. Caremark Rx, Inc.*, 2007 WL 143099, at *5 n.14 (Del. Ch. Jan. 12, 2007) (“Alabama clearly satisfies this test because the claims and counterclaims that the Settlement Agreement resolved were pending in its State courts.”).

However, a foreign jurisdiction’s laws may not be used to interpret a contractual provision “in a manner repugnant to the public policy of Delaware.” *J.S. Alberici Constr. Co.*, 750 A.2d at 520. “One such policy is disfavoring forfeiture of insurance coverage when the insurer does not show prejudice resulting from the insured’s actions or omissions.” *Annestella v. GEICO Gen. Ins. Cop.*, 2014 WL 4229999, at *5 (Del. Super. Aug. 18, 2014) (citing *State Farm Mut. Auto Ins. Co. v. Johnson*, 320 A.2d 345, 347 (Del. 1974)).

Where a contract is silent on the controlling law, Delaware follows the Restatement (Second) Conflict of Laws’ “most significant relationship” test when resolving choice of law issues. *Liggett Grp. Inc. v. Affiliated FM Ins. Co.*, 788 A.2d 134, 137 (Del. Super. 2001) (citing *Hoechst Celanese Corp. v. Nat’l Union Fire Ins. Co.*, 1994 WL 721651, at *3-4 (Del. Super. Mar. 28, 1994)); see also *IDT Corp. v. U.S. Specialty Ins. Co.*, 2019 WL 413692, at *6 (Del. Super. Jan. 13, 2019). “Choice of law issues involving insurance coverage are resolved by analyzing the relevant

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contacts set forth in sections 188 (dealing with general contractual issues) and 193 (dealing specifically with fire, surety, and casualty insurance contracts) of the Restatement.” *Annestella*, at *5 (citation omitted). “These contacts must also be evaluated in light of the principles set forth in section 6 of the Restatement; one such principle is the relevant policies of the forum state.” *Id.* (citations omitted).

Before embarking on a full-blown conflicts analysis, however, Delaware courts first “compare the laws of the competing jurisdictions to determine whether the laws actually conflict.” *Deuley v. DynCorp Intern., Inc.*, 8 A.3d 1156 (Del. 2010); *Mills LP v. Liberty Mut. Ins. Co.*, 2010 WL 8250837, at *4 (Del. Super. 2010) (quoting *Penn. Emp., Benefit Trust Fund v. Zeneca, Inc.*, 710 F. Supp. 2d 458, 466 (D. Del. 2010)). A “true conflict” exists if the laws of the competing jurisdictions produce different results when applied to the facts of the case. *Id.* (citing *Travelers Indem. Co. v. Lake*, 594 A.2d 38, 46-47 (Del. 1991)). If so, the court must then conduct a choice of law analysis. *Id.* If not, then “there is no real conflict and a choice of law analysis would be superfluous.” *Great Am. Opportunities*, 2010 WL 338219, at *8; see also *Kronenberg v. Katz*, 2004 WL 5366649, at *16 (Del. Ch. May 19, 2004) (“Where the choice of law would not influence the outcome, the court may avoid making a choice.”); *ABB Flakt, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, P.A.*, 1998 WL 437137, at *5 (Del. Super. June 10, 1998) (“When a choice of law analysis does not impact the outcome of the court’s decision, no choice of law analysis need be made.”), *aff’d*, 731 A.2d 811 (Del. 1999); *Penn. Emp., Benefit Trust Fund v. Zeneca, Inc.*, 710 F. Supp. 2d at 477 (referring interchangeably to the law of the forum state and other relevant state laws with no conflict).

In the absence of a valid choice of law provision, and in the presence of a real conflict, Delaware courts use the “most significant relationship test” when conducting a contract choice of law analysis. *Travelers Indem. Co. v. Lake*, 594 A.2d 38, 41 (Del. 1991). The Restatement (Second) Conflict of Laws Section 6(2) provides that the following seven factors are relevant in conducting a choice of law inquiry:

- the needs of the interstate and international systems,
- the relevant policies of the forum,
- the relevant policies of other interested states and the relative interests of those states in the determination of the particular issue,
- the protection of justified expectations,
- the basic policies underlying the particular field of law,
- certainty, predictability and uniformity of result, and
- ease in the determination and application of the law to be applied.

Restatement (Second) of Conflict of Laws §§ 6, 188.

Section 188 directs the Court, in evaluating those principles, to pay particular attention to (a) the place of contracting, (b) the place of negotiation of the contract, (c) the place of performance, (d) the location and subject matter of the contract, and (e) the domicile, residence, nationality, place of incorporation and place of business of the parties. Restatement (Second) of Conflict of Laws § 188(2). Obviously, these factors do not provide a precise rule for choice of law. “All that can presently be done in these areas [such as contracts] is to state a general principle, such as application of the local law ‘of the state of most significant relationship’, which provides some clue to the correct approach but does not furnish precise answers. In these areas, the Court must look in each case to the underlying facts themselves” Restatement (Second) of Conflict of Laws § 6, cmt. c.

This rule is applied to insurance contracts. *Viking Pump, Inc. v. Century Indem. Co.*, 2 A.3d 76, 87 (Del. Ch. 2009); *Playtex Family Prods., Inc. v. St. Paul Surplus Lines Ins. Co.*, 564 A.2d 681 (Del. Super. 1989); see generally *Certain*

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Underwriters at Lloyds, London v. Chemtura Corp., 160 A.3d 457 (Del. 2017) (providing a succinct recitation of the choice of law analysis in Delaware); *Arch Ins. Co. v. Murdock*, 2018 WL 1129110, at *8-10 (Del. Super. Mar. 1, 2018) (same).

In considering these factors, the Court is not permitted to simply add up the interests on both sides of the equation and apply the law with the most contacts. *Monsanto Co. v. Aetna Cas. & Surety Co.*, 1991 WL 236936, at *2 (Del. Super. October 29, 1991). The outcome of every choice of law analysis turns on the specific facts of each case. *Id.*

The court must also consider Restatement (Second) of Conflicts § 193 which pertains specifically to insurance contracts. *Burlington N. R.R. Co. v. Allianz Underwriters Ins. Co.*, 1994 WL 637011, (Del. Super. Aug. 25, 1994). This provision states:

The validity of a contract of fire, surety or casualty insurance and the rights created thereby are determined by the local law of the state which the parties understood was to be the principal location of the insured risk during the term of the policy, unless with respect to the particular issue, some other state has a more significant relationship under the principles stated in § 6 to the transaction and the parties, in which event the local law of the other state will be applied. Thus under § 193 the law of the site must be applied unless some other state has a more significant relationship to the insurance contract and the parties thereto.

At least one Delaware court has chosen to apply the law of a single state to all issues in a case, notwithstanding arguments that different laws should apply to different issues as a result of the Sec. 188 - 193 analysis. *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 1994 WL 721651 (Del. Super. Mar. 28, 1994).

The Restatement also provides that, in the case of insurance contracts, a court should generally apply “the local law of the state which the parties understood was to be the principal location of the insured risk during the term of the policy.” Restatement (Second) of Conflict of Laws § 193. Where “a company obtains insurance for risks and operations in a variety of jurisdictions,” courts also apply the general choice-of-law considerations enumerated in Section 188. *Viking Pump*, 2 A.3d at 87 and n.23; *Liggett Grp. Inc. v. Affiliated FM Ins. Co.*, 788 A.2d 134, 137-38 (Del. Super. 2001); see Restatement (Second) of Conflict of Laws § 188. In applying these general rules, “Delaware courts have placed great weight on where an insured has its headquarters as the *situs* which links all the parties together.” *Viking Pump*, 2 A.3d at 87; accord *Liggett Grp.*, 788 A.2d at 138.

In the case of D&O insurance, Delaware courts have held that Delaware has an overriding interest in disputes involving coverage for fiduciary mismanagement of Delaware organizations. *Sycamore Partners Mgmt. L.P. v. Endurance Am. Ins. Co.*, 2021 WL 761639 at *8 (Del. Super. Ct. Feb. 26, 2021); *Northrop Gumman Innovations Sys., Inc. v. Zurich Am. Ins. Co.*, 2021 WL 347015 at *16 (Del. Super 2021). Therefore, Delaware law will apply in the vast majority of D&O insurance cases. See *RISU Indemnity Co. v. Murdock*, 248 A.3d 887, 900-01 (Del. 2021).

DUTIES IMPOSED BY STATE LAW

Duty to Defend

1. Standard for Determining Duty to Defend

Delaware’s Supreme Court has outlined three principles for determining whether an insurer has a

duty to defend an insured:

- (1) where there is some doubt as to whether the complaint against the insured alleges a risk insured against, that doubt should be resolved in favor of the insured; (2) any ambiguity in the pleadings should be resolved against the carrier; and (3) if even one count or theory alleged in the complaint lies within the policy coverage, the duty to defend arises.

United Westlabs, Inc. v. Greenwich Ins. Co., 2011 WL 2623932, at *8 (Del. Super. July 1, 2011) (citing *Pac. Ins. Co. v. Liberty Mut. Ins. Co.*, 956 A.2d 1246, 1254-55 (Del. 2008); *but see Winshall v. Viacom Int'l Inc.*, 76 A.3d 808, 820 (Del. 2013) (explaining that where “the contract expressly imposes only a duty to ‘indemnify,’ as opposed to ‘indemnify and defend,’ the courts generally hold that there is no duty to defend”).

Depending on the particular language in the insurance policy, “[a]n insurer’s duty to defend may be broader than its duty to indemnify an insured.” *Farm Family Cas. Co. v. Cumberland Ins. Co., Inc.*, 2013 WL 5496780, at *6 (Del. Super. Oct. 2, 2013) (citing *ConAgra Foods, Inc. v. Lexington Ins. Co.*, 21 A.3d 62, 72-73 (Del. 2011)); *see also In re Viking Pump, Inc.*, 148 A.3d 633, 658-63 (Del. 2016).

“[A]n insurer is obliged to provide a defense for an insured only when the underlying complaint reveals that the third party’s action against the insured states a claim covered by the policy, thereby triggering the duty to defend.” *Evrax Claymont Steel, Inc. v. Harleysville Mut. Ins. Co.*, 2011 WL 6000780, at *3 (Del. Super. Nov. 30, 2011) (citing *O’Brien v. Progressive N. Ins. Co.*, 785 A.2d 281, 288 (Del. 2001)). An insurer’s duty to defend “is limited to suits which assert claims for which it has assumed liability under the policy.” *Home Ins. Co. v. Am. Ins. Co.*, 2003 WL 22683008, at *2 (Del. Super. Oct. 30, 2003). Generally, the court will review only two documents in its determination of an insurer’s duty to defend: the insurance policy and the complaint. *Blue Hen Mech., Inc. v. Atl. States Ins. Co.*, 2011 WL 1598575, at *2 (Del. Super. Apr. 21, 2011). “The test is whether the underlying complaint, read as a whole, alleges a risk within the coverage of the policy. Thus, in Delaware, an insurer’s duty to defend its insured arises when the allegations of the underlying complaint show a potential that liability within coverage will be established.” *David A. Bramble, Inc. v. Old Republic Gen. Ins. Corp.*, 2017 WL 345144, at * 4 (Del. Super. Jan. 20, 2017) (footnotes omitted); *see also AR Capital, LLC v. XL Specialty Ins. Co.*, 2018 WL 6601184, at *8-9 (Del. Super. Dec. 12, 2018). The determination on the duty to defend typically is made by looking only at the allegations in the complaint against the insured and comparing these allegations with the text of the insurance policy. *Am. Ins. Grp. v. Risk Enter. Mgmt., Ltd.*, 761 A.2d 826, 829 (Del. 2000). The rationale behind this principle is that a determination on the duty to defend should be made at the outset of the litigation, so as to provide a defense to the insured and to permit the insurer to control the defense strategy. *Id.*

If the insurer does not demand a defense until after completion of discovery, however, the fully developed record must be examined to determine whether the insurer has a duty to defend. *See id.* (demand for defense made after the completion of discovery, nearly 3 years after underlying tort claim was filed).

The Delaware Supreme Court has yet to determine whether mere notice of the underlying claims triggers the insurer’s duty to defend or whether the insured must actually make a demand for a defense. *Id.* at 830.

State Privacy Laws; Insurance Regulatory Issues; Arbitration/Mediation

1. State Arbitration and Mediation Procedures

“A written agreement to submit to arbitration any controversy existing at or arising after the effective date of the agreement is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract. . . .” 10 *Del. C.* § 5701. Arbitration of disputes involving homeowners’ insurance coverage are governed by 18 *Del. C.* § 331. Arbitration of disputes involving health insurance coverage are addressed in 18 *Del. C.* § 332. Arbitration of disputes between insurance carriers and health-care providers are governed by 18 *Del. C.* § 333.

EXTRACONTRACTUAL CLAIMS AGAINST INSURERS: ELEMENTS AND REMEDIES

Bad Faith Claim Handling/Bad Faith Failure to Settle Within Limits

1. First Party

In Delaware, it is established that a first-party claim against an insurer for bad faith denial or delay in claim payments “sounds in contract and arises from the implied covenant of good faith and fair dealing.” *Choma v. Nationwide Mut. Fire Ins. Co.*, 2014 WL 3950535, at *1 (D. Del. Aug. 8, 2014) (citing *Dunlap v. State Farm Fire & Cas. Co.*, 878 A.2d 434, 440 (Del. 2005)). “[T]o maintain a claim of bad faith denial of benefits and breach of good faith and fair dealing, a plaintiff must bring suit against a defendant who is a party to the contract in question.” *Brousseau v. Laccetti*, 2009 WL 4015647, at *2 (D. Del. Nov. 16, 2009).

“Where an insurer fails to investigate or process a claim or delays payment in bad faith, it is in breach of the implied duty of good faith and fair dealing underlying all contractual obligations.” *Tackett v. State Farm Mut. Ins. Co.*, 653 A.2d 254, 264 (Del. 1995). “[A]n insurer’s actions only give rise to a bad faith breach of contract claim if the insurer’s actions first breach the contract.” *Geico Gen. Ins. Co. v. Green*, 276 A.3d 462 (TABLE) at *8 (Del. 2022). To establish a bad-faith claim, the insured must show that “the insurer lacked reasonable justification in delaying or refusing payment.” *Id.* at 262; *see also Bennett v. USAA Casualty Ins. Co.*, 158 A.3d 877 (TABLE) (Del. Mar. 13, 2017). This means that, at the time the insurer denied coverage, “there [cannot have] existed a set of facts or circumstances known to the insurer which created a bona fide dispute and therefore a meritorious defense to the insurer’s liability.” *Watson v. Metro. Prop. & Cas. Ins. Co.*, 2003 WL 22290906, at *6 (Del. Super. Oct. 2, 2003) (quoting *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 369 (Del. 1982)). “Mere delay [in processing a claim] is not [necessarily] evidence of bad faith,” but “[d]elays attributed to a ‘get tough’ policy . . . may subject the insurer to [such] a [] claim.” *Tackett*, 653 A.2d at 266; *Enrique v. State Farm Mut. Auto. Ins. Co.*, 142 A.3d 506, 511 (Del. 2016). If the delay or denial is willful or malicious, punitive damages may be awarded. *Id.* In such situations, however, there must be “an element of malice with a ‘reckless indifference’” to the plight of the insured. *Id.* (citing *Jardel v. Hughes*, 523 A.2d 518, 529 (Del. 1987)).

Furthermore, “bad faith” need not be pled with particularity like fraud, because “a bad faith claim hinges on a party’s state of mind,” a fact that may be pled generally. *Desert Equities, Inc. v. Morgan Stanley Leveraged Equity Fund, II, L.P.*, 624 A.2d 1199, 1208 (Del. 1993) (breach of limited

partnership agreement). Because bad faith is an issue of fact, a well-pleaded claim of bad faith generally cannot be resolved on the pleadings or without granting first an adequate opportunity for discovery. *Desert Equities*, 624 A.2d at 1208-09.

Under Delaware law, an implied covenant of good faith and fair dealing claim does not sound in tort; it is contractual. *ASB Allegiance Real Estate Fund v. Scion Breckenridge Managing Member, LLC*, 50 A.3d 434, 439 (Del. Ch. 2012) (citing *Wood v. Baum*, 953 A.2d 136, 143 (Del. 2008) (“The implied covenant of good faith and fair dealing is a creature of contract . . .”), *rev’d on other grounds*, 68 A.3d 665 (Del. 2013)); *accord Tekstrom, Inc. v. Savla*, 918 A.2d 1171, 2007 WL 328836, at *7 (Del. Feb. 5, 2007) (ORDER) (“The covenant of good faith and fair dealing arises under contract.”); *E.I. DuPont de Nemours and Co. v. Pressman*, 679 A.2d 436, 444-48 (Del. 1996) (recognizing implied covenant claim in employment context and specifying contractual remedies available for breach); *Tackett v. State Farm Fire & Cas. Ins. Co.*, 653 A.2d 254, 264 (Del. 1995) (holding that implied covenant claim against insurer for “bad faith” denial of claim by insured sounds in contract). An implied covenant attaches to all contracts, including insurance. *Dunlap v. State Farm Fire and Cas. Co.*, 878 A.2d 434, 442 (Del. 2005).

A court confronting a claim for breach of implied covenant of good faith and fair dealing asks whether it is clear from what was expressly agreed upon that the parties who negotiated the express terms of the contract would have agreed to proscribe the act later complained of as a breach of the implied covenant, had they thought to negotiate with respect to that matter. *Id.* at 440 (citing *Katz v. Oak Indus., Inc.*, 508 A.2d 873, 880 (Del. Ch. 1986)). A claim for breach of the implied covenant of good faith and fair dealing is not based on a “free-floating duty unattached to the underlying legal documents.” *ASB Allegiance Real Estate Fund v. Scion Breckenridge Managing Member, LLC*, 50 A.3d 434, 440 (Del. Ch. 2012) (citing *Dunlap*, 878 A.2d at 441), *rev’d on other grounds*, 68 A.3d 665 (Del. 2013)); *see also NAMA Holdings, LLC v. Related WMC LLC*, 2014 WL 6436647, at *17 (Del. Ch. Nov. 17, 2014) (“[T]he implied covenant does not establish a free-floating requirement that a party act in some morally commendable sense.” (citing *Gerber v. Enter. Prods. Holdings, LLC*, 67 A.3d 400, 418 (Del. 2013), *overruled in part on other grounds by Winshall v. Viacom Int’l, Inc.*, 76 A.3d 808 (Del. 2013))). “It does not ask what duty the law should impose on the parties given their relationship at the time of the wrong, but rather what the parties would have agreed to themselves had they considered the issue in their original bargaining positions at the time of contracting.” *ASB Allegiance Real Estate Fund*, 50 A.3d at 440 (citing *Nemec v. Shrader*, 991 A.2d 1120, 1127 (Del. 2010)). The implied covenant of good faith and fair dealing requires that a party to a contract “refrain from arbitrary or unreasonable conduct which has the effect of preventing the other party to the contract from receiving the fruits’ [sic] of its bargain.” *Id.* at 441 (quoting *Dunlap*, 878 A.2d at 442).

A contract may identify factors that a decision-maker can consider when exercising a discretionary right under the contract, and the contract may provide a contractual standard for evaluating that decision. *Id.* (citations omitted). Express contractual provisions always supersede the implied covenant of good faith and fair dealing. *Id.* (citations omitted).

Determining what conduct of a party to a contract is arbitrary or unreasonable, for purposes of a claim for breach of implied covenant of good faith and fair dealing, depends on the parties’ original contractual expectations, not a free-floating duty applied at the time of the wrong. Proving a breach of contract claim does not depend on the breaching party’s mental state. *Id.* at 442 (citing *NACCO Indus., Inc. v. Applica, Inc.*, 997 A.2d 1, 35 (Del. Ch. 2009)). Proof of a culpable

mental state is not required for a claim of breach of implied covenant of good faith and fair dealing. Parties can agree to contract terms that require a particular mental state, and a court can imply a similar provision. *Id.* at 444.

The quasi-reformation of a contract by implying contract terms to ensure that parties' reasonable expectations are fulfilled should be a rare and fact-intensive exercise, governed solely by issues of compelling fairness; a party may invoke the protections of the implied covenant of good faith and fair dealing only when it is clear from the writing that the contracting parties would have agreed to proscribe the act later complained of had they thought to negotiate with respect to that matter. *See, e.g., Wal-Mart Stores, Inc. v. AIG Life Ins. Co.*, 901 A.2d 106, 116 (Del. 2006) (finding policyholder that had purchased corporate-owned life insurance (COLI) policies for tax benefits failed to state claim against life insurers, their representatives, and brokers for breach of contract or covenant of good faith and fair dealing where the policyholder failed to identify any express contract provision that was breached or any implied contract term that it would have the trial court read into the contract).

2. Third-Party

Since bad faith denial of coverage claims are based in contract rather than tort, and third parties do not have a contractual relationship with the insurer, the general rule is that an insurer owes no duty to third parties to negotiate settlements in good faith. *See Hostetter v. Hartford Ins. Co.*, 1992 WL 179423 (Del. Super. July 13, 1992), *abrogated on other grounds by Connelly v. State Farm Mutual Automobile Insurance Co.*, 135 A.3d 1271 (Del. 2016); *but see Swain v. State Farm Mut. Auto. Ins. Co.*, 2003 WL 22853415 (Del. Super. May 29, 2003) (holding that passenger occupant of motor vehicle can assert contractual claims against driver's uninsured motorist carrier because of his third party beneficiary status); *Pierce v. Int'l Ins. Co. of Ill.*, 671 A.2d 1361, 1365-66 (Del. 1996) (holding that an insurer's duty of good faith in a dispute between a workers' compensation insurer and an employer extended to employees who are third-party beneficiaries to the insurer's promise to pay).

Under certain circumstances, however, a third party "may recover on a contract made for his benefit." *Bank of Delmarva v. So. Shore Ventures, LLC*, 2014 WL 5390389, at *3 n.26 (Del. Super. Oct. 21, 2014) (quotations omitted). "To create third party beneficiary rights, a contract should confer an intended benefit on the third party, and the conferral of such benefit must be a material part of the contract's purpose." *Greater New York Mut. Ins. Co. v. Travelers Ins. Co.*, 2011 WL 4501207, at *3 (D. Del. Sept. 28, 2011) (citing *Global Energy Fin. LLC v. Peabody Energy Corp.*, 2010 WL 4056164, at * 25 (Del. Super. Oct. 14, 2010)). If the injured third party is merely an indirect beneficiary, not an intended beneficiary, then the third party may not enforce the contract. *Delmar News, Inc. v. Jacobs Oil Co.*, 584 A.2d 531, 534 (Del. 1990) (holding that a property owner failed to show that it was an intended third-party beneficiary to an insurance contract between an oil company that caused a spill on the property and its insurer); *Willis v. City of Rehoboth Beach*, 2004 WL 2419143, at *1-4 (Del. Super. Oct. 14, 2004) (holding that without language in the policy indicating that a third party was an intended beneficiary, the injured parties were merely incidental beneficiaries and could not sue the liability insurer until a judgment has been obtained against the insured). An incidental third-party beneficiary, then, must first obtain a judgment against the insured before bringing a claim against the insurer. *See Willis*, 2004 WL 2419143, at *1 ("If, however, the injured party is neither a named insured nor a third-party beneficiary, she may not recover from the liability insurer unless there has been an assignment or there has been a judgment

against the insured, such that the party has become a judgment creditor.” (citing *O/E Systems, Inc. v. InaCom Corp.*, 179 F.Supp.2d 363, 367 (D. Del. 2002))). For “a non-party [to a contract] to be a third-party beneficiary, the contracting parties must intend that the non-party receive a benefit sufficient to entitle that party to enforce the contract in the courts.” *Colbert v. Goodville Mut. Cas. Co.*, 2010 WL 2636860 (Del. Super. June 30, 2010) (citing *Delmar News, Inc., v. Jacobs Oil Co.*, 584 A.2d 531, 534 (Del. Super. 1990)); see also *Oliver B. Cannon & Sons, Inc., v. Dorr-Oliver, Inc.*, 312 A.2d 322 (Del. Super. 1973) (holding that any benefit to a plaintiff arising from a claims adjusting agreement is indirect, and does not confer third-party beneficiary status).

An assignee may enforce a contract without first receiving a judgment against the insured. *Spine Care Del., LLC v. State Farm Mut. Auto. Ins. Co.*, 2006 WL 3334964, at *2 (Del. Super. Nov. 17, 2006) (holding that medical facility providing treatment to injured insureds had standing to seek punitive damages for bad faith breach of contract and gross violations of the Consumer Fraud Act because the patients assigned their rights to the facility to recover unpaid fee balances).

The Delaware Superior Court denied an insurer’s Motion for Summary Judgment, and allowed a plaintiff to pursue a bad faith claim against a tortfeasor’s insurer based upon the insurer’s failure to interplead its policy limits. See *Gruwell v. Allstate Ins. Co.*, 988 A.2d 945 (Del. Super. 2009) (adopting legal analysis of the Third Circuit’s interpretation of Delaware law set forth in *McNally v. Nationwide Co.*, 815 F. 2d 254 (3d Cir. 1987)).

3. Damages

Even though bad faith claims sound in contract, an insured may recover punitive damages if the insurer’s breach is “particularly egregious,” i.e., whether the defendant’s conduct is “outrageous,” “because of ‘evil motive’ or ‘reckless indifference to the rights of others.’” *Tackett v. State Farm Fire & Cas. Ins. Co.*, 653 A.2d 254, 265 (Del. 1995). Third-party beneficiaries of an insurance policy may also be able to recover punitive damages. See *Swain v. State Farm Mut. Auto. Ins. Co.*, 2003 WL 22853415, at *1-2 (Del. Super. May 29, 2003).

Generally, an insured cannot recover damages for emotional distress if it prevails on a bad faith claim unless the insured suffered accompanying physical injury. *Tackett*, 653 A.2d at 265; but see *Cummings v. Pinder*, 574 A.2d 843, 845 (Del. 1990) (affirming award of damages for emotional distress because there was intentional infliction of emotional distress within the context of an attorney-client relationship, which was found to be “outrageous” (citing Restatement (Second) of Torts § 46(1) (1965))).

Fraud

“A common law fraud claim needs to allege five elements: (1) the existence of a false representation, usually one of fact, made by the defendant; (2) the defendant had knowledge or belief that the representation was false, or made the representation with requisite indifference to the truth; (3) the defendant had the intent to induce the plaintiff to act or refrain from acting; (4) the plaintiff acted or did not act in justifiable reliance on the representation; and (5) the plaintiff suffered damages as a result of such reliance.” *Northpointe Holdings, Inc. v. Nationwide Emerging Managers, LLC*, 2010 WL 3707677, at *7 (Del. Super. Sept. 14, 2010) (citing *H-M Wexford LLC v. Encorp, Inc.*, 832 A.2d 129, 144 (Del. Ch. 2003)).

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“[An] equitable fraud claim under Delaware law requires the plaintiff to prove: (1) a false representation, usually one of fact, made by the defendant; (2) an intent to induce the plaintiff to act or to refrain from acting; (3) the plaintiff’s action or inaction taken in justifiable reliance upon the representation; and (4) damage to the plaintiff as a result of such reliance.” *Westfield Ins. Co. v. Chip Slaughter Auto Wholesale, Inc.*, 717 F. Supp. 2d 433, 446 (D. Del. 2010) (citing *Zirn v. VLI Corp.*, 681 A.2d 1050, 1060-61 (Del. 1996)). Equitable fraud does not require that “the defendant have known or believed its statement to be false or to have made the statement in reckless disregard of the truth.” *Id.* (citing *Stephenson v Capano Dev., Inc.*, 462 A.2d 1069, 1074 (Del. 1983)).

A consumer may bring a private cause of action under Delaware’s Consumer Fraud Act to recover for losses suffered as a result of fraud or deception. See *Smith v. Peninsula Adjusting Co., Inc.*, 2011 WL 2791252, at *5 (Del. Super. June 16, 2011) (citing 6 Del. C. § 2513).

Moreover, Delaware’s Insurance Fraud Prevention Act prohibits fraudulent activities and provides penalties for punishing those who commit them. See 18 Del. C. § 2401 et seq. Section 2407 defines “insurance fraud”, and provides as follows:

- It shall be a fraudulent insurance act for a person to knowingly, by act or omission, with intent to injure, defraud or deceive:
 - Present, cause to be presented, prepare, assist, abet, solicit or conspire with another to prepare or make any oral or written statement with knowledge or belief that it will be presented to an insurer in connection with, or in support of, any application for the issuance of an insurance policy, containing false, incomplete or misleading information concerning any fact material to the application for issuance of an insurance policy;
 - Prepare, present or cause to be presented to any insurer, any oral or written statement including computer-generated documents as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, containing false, incomplete or misleading information concerning any fact material to such claims;
 - Assist, abet, solicit or conspire with another to prepare or present any oral or written statement, including computer-generated documents, that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, which contains false, incomplete or misleading information concerning any fact material to the claim; or
 - Prepare, present or cause to be presented to any insurer or other person, or demand or require the issuance of, a certificate of insurance that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference, or assist, abet, solicit or conspire with another to do any of the acts described in this sentence. As used in this section, “certificate of insurance” means a document or instrument, regardless of how titled or described, that is, or purports to be, prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. The term does not include a policy of insurance, insurance binder, policy endorsement, or automobile insurance identification or information card.
- It shall be a fraudulent insurance act for a practitioner to knowingly and willfully assist, conspire with, or urge any person to violate any of the provisions of this chapter, or for any person who due to such assistance, conspiracy or urging by said practitioner, knowingly and willfully benefits from the proceeds derived from the use of the fraud.

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- It shall be a fraudulent insurance act for any insurer or any person acting on behalf of such insurer to knowingly, by act or omission, with intent to injure, defraud or deceive:
 - Present or cause to be presented to an insurance claimant false, incomplete or misleading information regarding the nature, extent and terms of insurance coverage which may or might be available to such claimant under any policy of insurance, whether first or third party.
 - Present or cause to be presented to any insurance claimant false, incomplete or misleading information regarding or affecting in any fashion the extent of any claimant’s right to benefit under, or to make a claim against, any policy of insurance whether first or third party.

Upon a showing of a preponderance of the evidence that one of these provisions was violated, the Delaware Insurance Commissioner may impose a penalty of up to \$10,000. 18 Del. C. § 2411(b).

Section 2411 was amended in 2006 to provide a sizable reward to be paid “to an individual who reports to the Insurance Department an incident of insurance fraud which results in either an admission or finding of fraud.” 18 Del. C. § 2411(f). The Delaware Insurance Commissioner is authorized to order restitution to an insurer or self-insured who paid a fraudulent claim. 18 Del. C. § 2411(e).

Intentional or Negligent Infliction of Emotional Distress

Delaware Courts have adopted the Restatement (Second) of Torts § 46 in analyzing claims for IIED. *Cooper v. Bd. of Ed. of Red Clay Consol. Sch. Dist.*, 2009 WL 3022129, at *1 (Del. Super. Sept. 16, 2009) (citing *Mattern v. Hudson*, 532 A.2d 85, 86 (Del. Super. 1987)). To establish a claim for IIED, a plaintiff must establish that the defendant engaged in “extreme and outrageous conduct intentionally or recklessly,” thereby “cause[ing] severe emotional distress to another . . .” *Beckett v. Trice*, 1994 WL 710874, at *4 (Del. Super. Nov. 4, 1994) (citing Restatement (Second) of Torts § 46 (1965)), *aff’d*, 660 A.2d 393 (Del. 1995). “[L]iability for intentional infliction of emotional distress ‘is only found when the alleged conduct was so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community.’” *Adams v. Selhorst*, 779 F. Supp. 2d 378, 396 (D. Del. 2011) (citing *O’Leary v. Telecom Res. Serv., LLC*, 2011 WL 379300, at *6 (Del. Super. Jan. 14, 2011)). Mere humiliation, embarrassment, anxiety or hurt feelings do not constitute extreme emotional distress. *Beckett*, 1994 WL 710874, at *5 (citing Restatement (Second) of Torts § 46 (1965) cmt. j.); *McKnight v. Voshell*, 513 A.2d 1319, 1986 WL 17360, at *3 (Del. Aug. 6, 1986) (TABLE). So long as the conduct is viewed as “outrageous,” however, the injured party may recover damages, even if there is no accompanying bodily harm. *Id.* (citing *Cummings v. Pinder*, 574 A.2d 843, 845 (Del. 1990)). But, expert testimony is required to prove that a defendant’s actions proximately caused harm to a plaintiff. *Doe v. Wildey*, 2012 WL 1408879 (Del. Super. Mar. 29, 2012). In a third party IIED claim, i.e., where the conduct is aimed at someone other than the plaintiff, Delaware courts have required that the third party be a family member or relative who was present at the time of the alleged conduct, and that if the person is not a family member, the additional element that such distress caused by the conduct must result in bodily harm. *Cooper*, 2009 WL 3022129, at *5 (citing Restatement Second of Torts § 46(2)).

The question of whether one’s conduct was sufficiently extreme and outrageous so as to result in liability is usually a fact question for the jury. *Beckett*, 1994 WL 710874, at *5 (citing *Mattern*, 532 A.2d at 86).

NIED contains similar elements but only requires that the defendant acted negligently. Recovery is generally available only if the defendant was “in the zone of danger” and if the emotional distress caused resulting physical injury. See *Armstrong v. A.I. Dupont Hosp. for Children*, 60 A.3d 414, 423 (Del. Super. 2012) (citing *Rhinehardt v. Bright*, 2006 WL 2220972, at *5 (Del. Super. July 20, 2006) (listing the 3 necessary elements for an NIED claim));

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Knight v. Carmike Cinemas, 2011 WL 3665379, at *12 (D. Del. Aug. 22, 2011); see also *Pritchett v. Delmarva Builders, Inc.*, 1998 WL 283376, at *2-3 (Del. Super. Feb. 27, 1998) (citing *Robb v. Pa. R.R. Co.*, 210 A.2d 709, 714-715 (Del. 1965) (“[W]here negligence proximately caused fright, in one within the immediate area of physical danger from that negligence, which in turn produced physical consequences . . . the injury party is entitled to recover”)); *Bostic v. Smyrna Sch. Dist.*, 2003 WL 723262, at *7 (D. Del. Feb. 24, 2003) (applying Delaware law). Delaware courts have defined “zone of danger” as “that area where the negligent conduct causes the victim to fear for his or her own safety.” See *Fanean v. Rite Aid Corp. of Del., Inc.*, 984 A.2d 812 (Del. Super. 2009) (citing *Doe v. Green*, 2008 WL 282319, at *1 (Del. Super. Jan. 30, 2008)). Delaware courts have held that it is an issue of fact as to whether persistent “sleeplessness, headaches, crying spells, rage, nervousness, guilt, eating disorders and depression” collectively amount to the requisite physical injury. *Lupo v. Med. Ctr. Of Del., Inc.*, 1996 WL 111132, at *2-3 (Del. Super. Feb. 7, 1996).

The exclusivity provisions of Delaware’s Worker’s Compensation Statute bar work-related claims for intentional infliction of emotional distress. See *Owens v. Connections Cmty. Support Programs, Inc.*, 840 F. Supp. 2d 791, 799 (D. Del. 2012); 19 Del. C. §2304.

“In a breach of contract action, damages for emotional distress are not available without accompanying physical injury or actual intentional infliction of emotional distress.” *O’Leary v. Telecom Res. Serv., LLC*, 2011 WL 379300, at *6 (Del. Super. Jan. 14, 2011) (citing *E.I. DuPont de Nemours & Co. v. Pressman*, 679 A.2d 436, 444-445 (Del. 1996)).

Delaware imposes a 2-year statute of limitations on emotional distress claims. *Tri-State Energy Solutions, LLP v. KVAR Energy Sav. Inc.*, 884 F. Supp. 2d 168, 173 (D. Del. 2012) (citing *E.E.O.C. v. Avecia Inc.*, 2003 WL 22432911, at *2 (D. Del. Oct. 23, 2003) (applying 10 Del. C. § 8119)).

State Consumer Protection Laws, Rules and Regulations

1. Consumer Protections Provisions

As previously discussed above, see *supra* Section I, insurers’ conduct is regulated by statute—18 Del. C. § 2301 et seq. (“Unfair Practices in the Insurance Business”), known as Delaware’s “Unfair Trade Practices Act” (“UTPA”). 18 Del. C. § 2304(16) defines the following as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

- Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- Failing to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies;
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- Refusing to pay claims without conducting a reasonable investigation based upon all available information;
- Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;
- Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

- Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
- Attempting to settle a claim for less than the amount to which a reasonable person would have believed that person's own self was entitled by reference to written or printed advertising material accompanying or made part of an application;
- Attempting to settle claims on the basis of an application which was altered without notice to or knowledge or consent of the insured;
- Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;
- Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
- Failing to promptly settle claims, where liability has become reasonably clear under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;
- Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

18 Del. C. § 2308 provides for a cease and desist and penalty order to be issued, after hearing, against a person found to be engaging in an unfair or deceptive act or practice. The penalties for such a violation, subject to the Insurance Commissioner's discretion, may range from \$1,000 for each act in violation of the UTPA, not to exceed \$100,000 in the aggregate. 18 Del. C. § 2308(a)(1). If the person knew or should have known of the violation, the penalties may increase to \$10,000 for each act and \$150,000 in the aggregate for each 6-month period, and may also include suspension or revocation of the violator's license. 18 Del. C. § 2308(a)(1), (a)(2).

2. Private Causes of Action

The above provisions of the UTPA do not create a private cause of action; rather, they are merely enforcement provisions for the State's Insurance Commissioner. *See Thomas v. Harford Mut. Ins. Co.*, 2003 WL 220511, at *5 (Del. Super. Jan. 31, 2003) (citing *Moses v. State Farm Fire & Cas. Ins. Co.*, 1991 WL 269886, at *4 (Del. Super. Nov. 20, 1991)); Delaware Regulation #18 900 CDR 903 (9.0); Delaware Regulation #18 1300 CDR 1310 (8.0); *but see Brown v. Liberty Mut. Ins. Co.*, 1997 WL 855723, at *2 (Del. Super. Dec. 4, 1997) (no challenge to action for unfair claims settlement practices under 10 Del. C. § 2304(16), other than for failure to state a claim); *Morgan v. Hartford Life Ins. Co.*, 1988 WL 25388, at *1-2 (Del. Super. Mar. 3, 1988) (allowing plaintiff to amend complaint to include a violation of the Unfair Claims Settlement Practices Act, under 18 Del. C. § 2304(16), but disallowing plaintiff's amendment to complaint and relation back under Deceptive Trade Practices Act, 18 Del. C. §§ 2532 and 2533, as time-barred).

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“Under the [UTPA], only the Insurance Commissioner has authority to examine and investigate alleged bad faith acts and file claims against any such person [who] has been engag[ed] . . . in any unfair or deceptive act or practice, whether or not defined in [the Act].” *Davidson v. Travelers Home and Marine Ins. Co.*, 2011 WL 7063521, at *2 (Del. Super. Dec. 30, 2011) (citing 18 Del. C. § 2306). Nonetheless, the UTPA does not preempt other available statutory or common law claims. See *DiSimplico v. Equitable Variable Life Ins. Co.*, 1988 WL 15394, at *2 (Del. Super. Jan. 29, 1988) (allowing claims against insurer under theories of common law fraud and the Delaware Consumer Fraud Act, 6 Del. C. § 2511 et seq.); *Grand Ventures, Inc. v. Whaley*, 622 A.2d 655, 664 (Del. Super. 1992) (concluding that UTPA does not preempt claims under Delaware’s Deceptive Trade Practices Act (“DTPA”), 6 Del. C. § 2531 et seq.), *aff’d*, 632 A.2d 63 (Del. 1993); *Correa v. Pa. Mfrs. Assoc. Ins. Co.*, 618 F. Supp. 915, 926 (D. Del. 1985) (applying Delaware law and holding that UTPA does not bar a worker’s compensation claimant from asserting a bad faith claim against employer’s insurance carrier). As a result, an insured can assert claims against an insurer under various common law and statutory theories, such as fraud, bad faith denial of coverage, violation of the Consumer Fraud Act, 6 Del. C. § 2511 et seq., and violation of the Delaware Deceptive Trade Practices Act, 6 Del. C. § 2531 et seq.

3. State Class Actions

Delaware’s two Constitutional trial courts, the Delaware Court of Chancery (equity) and the Delaware Superior Court (law), have adopted a Rule 23 that is modeled on Federal Rule of Civil Procedure 23. See, e.g., *Prezant v. DeAngelis*, 636 A.2d 915, 920 (Del. 1994). Cases interpreting the federal rule are given weight in interpreting Delaware’s versions of Rule 23. See generally *id.* at 920-21.

DISCOVERY ISSUES IN ACTIONS AGAINST INSURERS

Discoverability of Claims Files Generally

An insurer’s claim file may be relevant to claims an insured brings against the insurer. *Tackett v. State Farm Fire & Cas.*, 558 A.2d 1098, 1101-02 (Del. Super. 1988) (bad faith claim), *aff’d*, 653 A.2d 254 (Del. 1995); *Nat’l Union Fire Ins. Co. of Pitts., Pa. v. Stauffer Chem. Co.*, 558 A.2d 1091, 1093-96 (Del. Super. 1989) (interpretation of policy language). Under certain circumstances, even the insurer’s claims files of non-party insureds may be discoverable. *Nat’l Union*, 558 A.2d at 1093-96; *but see Clark Equip. Co. v. Liberty Mut. Ins. Co.*, 1995 WL 867344, at *2-3 (Del. Super. Apr. 21, 1995) (denying Motion to Compel other policyholder claims based on burden, among other reasons).

There is no *per se* waiver of the attorney-client privilege in bad faith cases. *Tackett*, 653 A.2d at 260. Many documents contained in an insurer’s claim file are privileged, however, absent a compelling need for information; the mere filing of a bad faith claim does not require that an insurer must produce these privileged documents. *Williams Union Boiler v. Travelers Indem. Co.*, 2003 WL 22853534, at *1 (Del. Super. July 31, 2003) (denying Motion to Compel coverage opinion letter; denying deposition of coverage counsel). But if the insurer “makes factual assertions in defense of a claim which incorporate, expressly or implicitly, the advice and judgment of its counsel,” i.e., a defense that the insurer handled the insured’s claim in the normal, routine manner, then the insurer effectively waives the privilege as to documents in the claim file. See *Tackett*, 653 A.2d at 259-260 (finding implicit waiver, assuming the insured has no alternative means of obtaining the information, and had a “compelling” need for mental impressions that were directed toward a “pivotal issue”). Nonetheless, subsequent decisions have re-emphasized the importance of the privilege and have reiterated that the privilege is waived only

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when the insurer affirmatively represents during discovery that it relied on the advice of its legal counsel. See *Clausen v. Nat'l Grange Mut. Ins. Co.*, 730 A.2d 133, 143 (Del. Super. 1997); see also *Ruger v. Commonwealth Land Title Ins. Co.*, 1996 WL 769793, at *3 (Del. Super. Nov. 27, 1996); but see *Tenneco Auto. Inc. v. El Paso Corp.*, 2001 WL 1456487, at *3-4 (Del. Ch. Nov. 7, 2001).

A similar but slightly different test (the “substantial need” test) determines whether the attorney work product doctrine has been waived. *Tackett*, 653 A.2d at 261-63 (citing Del. Super. Ct. Civil Rule 26(b)(3)). Courts are extremely reluctant to order production of “opinion work product,” as opposed to “fact work product,” as one court recently noted that Delaware courts have only done so on two occasions. See *Saito v. McKesson HBOC, Inc.*, 2002 WL 31657622, at *11 n.63 (Del. Ch. Nov. 13, 2002) (“Delaware law protects opinion work product in all but the most compelling circumstances where those mental impressions are critical to the pivotal issue in the litigation and no other means of proving that issue exists.”)

Discoverability of Reserves

Courts typically conclude that information regarding an insurer’s loss reserves is inadmissible because “reserves are general estimates of potential liability which may not involve a detailed factual and legal basis.” *Nat'l Union Fire Ins. Co. of Pitts., Pa. v. Stauffer Chem. Co.*, 558 A.2d 1091, 1097-98 (Del. Super. Jan. 31, 1989) (finding request for reserves information is not reasonably calculated to lead to the discovery of admissible evidence); see also *Clark Equip. Co. v. Liberty Mut. Ins. Co.*, 1995 WL 867344, at *2 (Del. Super. Apr. 21, 1995); *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co. of Pitts., Pa.*, 623 A.2d 1099, 1109-10 (Del. Super. 1991) (“[R]eserves do not represent an admission or evaluation of liability and are irrelevant to the issues between insurer and insured.”) (citing *Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Stauffer Chem. Co.*, 558 A.2d 1091, 1097-1098 (Del. Super. 1989)). However, in a case not involving an insurance coverage dispute, the court permitted discovery of the insured’s loss reserves to investigate possible mismanagement or improper conduct by the insurer. *Magid v. Acceptance Ins. Cos., Inc.*, 2001 WL 1497177 (Del. Ch. Nov. 15, 2001) (in context of shareholder action under § 220 of the Delaware General Corporation Law, 8 Del. C. § 220).

Discoverability of Existence of Reinsurance and Communications with Reinsurers

Decisions as to whether communications between an insurer and its reinsurer are relevant to, and therefore admissible in, coverage disputes must be made on a case-by-case basis. See *Monsanto Co. v. Aetna Cas. & Sur. Co.*, 1991 WL 190336, at *3 (Del. Super. Sept. 6, 1991). Accordingly, some courts have ordered the production of such communications. *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co. of Pitts., Pa.*, 623 A.2d 1099, 1107-08 (Del. Super. 1991); *Nat'l Union Fire Ins. Co. of Pitts., Pa. v. Stauffer Chem. Co.*, 558 A.2d 1091, 1096-97 (Del. Super. 1989) (ordering production of re-insurance information because it was “relevant to the issue of whether insurers believed that the[se] policies covered claims against the policy holder”). Some courts have reached the opposite conclusion. *Clark Equip. Co. v. Liberty Mut. Ins. Co.*, 1995 WL 867344, at *2 (Del. Super. Apr. 21, 1995) (denying Motion to Compel reinsurance documents; “leaving open” the future possibility of allowing narrowly tailored, relevant requests); *Monsanto*, 1991 WL 190336, at *3.

Attorney/Client Communications

When an insurer hires legal counsel to defend its insured, neither the insurer nor the insured can invoke the attorney-client privilege against the other because they are considered joint clients with a common interest. See *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 623 A.2d 1118, 1123-24 (Del. Super. 1992) (citing Delaware Uniform Rule of Evidence 502(d)(5), now at 502(d)(6)); see also *Tenneco Auto. v. El Paso Corp.*,

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2001 WL 1456487, at *2-3 (Del. Ch. Nov. 7, 2001) (communications between two entities that previously had common interest could not be withheld from each other based on privilege; however, because one entity's insurer joined its insured in seeking production from the other entity, the other entity could claim privilege as to both of them).

DEFENSES IN ACTIONS AGAINST INSURERS

Misrepresentations/Omissions: During Underwriting or During Claim

Under 18 Del. C. § 2711, if an insured made a misrepresentation when filling out an application for insurance, this may prevent recovery under a policy if (1) the misrepresentation was fraudulent, (2) was material to the acceptance of the risk or hazard assumed by the insurer, or (3) if the insurer in good faith would not have issued the policy, or would not have issued it at the same rate or for the same amount of coverage if the true facts had been disclosed. *See generally Mulrooney v. Life Ins. Co. of the SW.*, 2014 WL 4407854, at *8-9 (Del. Super. Sept. 3, 2014) (finding that “[s]ection 2711 permits an insurer to void a policy because of an untrue statement” even if the application required only that applicants answer questions “to the best of [their] knowledge and belief,” where plaintiff had actual knowledge that statement was false). Accordingly, a threshold question is whether the insured made a misrepresentation in the first place. *Hampton v. Titan Indemnity Co.*, 2017 WL 2733760, at *4 (Del. Super. June 23, 2017). An insured's duty of fairness requires taking the initiative in checking to make sure that the answers provided in the application are accurate. *Johnson v. Am. Modern Home Ins. Co.*, 2021 WL 274314 at *3 (Del. Super. Ct. Jan. 26, 2021).

18 Del. C. § 2920, which applies to “annuities,” provides that for statements (other than statements regarding age, sex and identity) required as a pre-condition to the issuance of an “annuity,” such statement cannot be used as a basis to contest the policy “after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer” With respect to misstatements by an applicant regarding his or her age or sex, the amount of benefits payable under the policy shall be adjusted accordingly. 18 Del. C. § 2922.

18 Del. C. § 3306(a) requires that all health insurance policies contain a provision that provides:

Time Limit on Certain Defenses:

- After 2 years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred as disability (as defined in the policy) commencing after the expiration of such 2-year period.
- No claim for loss incurred as disability (as defined in the policy) commencing 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

If an insurer fails to include a “fraudulent misstatement” exception to the two-year rule provided in § 3306, then the insurer is precluded from denying coverage or voiding a policy more than two years after the issuance of the policy due to fraudulent statements made during the application process. *Penn Mut. Life Ins. Co. v. Oglesby*, 695 A.2d 1146, 1149-52 (Del. 1997).

Failure to Comply with Conditions

“In order for an insured to establish the contractual liability of an insurer for breach of an insurance contract, the insured must show that he has complied with all conditions precedent to the insurer’s performance.” *Rhone-Poulenc Basic Chems. Co. v. Am. Motorists Ins. Co.*, 616 A.2d 1192, 1198 (Del. 1992) (duty to mitigate damages) (citing *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 365 (Del. Super. 1982) (duty to provide information, cooperate with insurer, and to mitigate damages)); see also *Shaw v. Nationwide Ins.*, 2011 WL 6402200, at *5 (Del. Super. Dec. 14, 2011).

Some courts have required that the condition precedent be “material” or that the insurer demonstrate actual prejudice before it concludes that a failure of the condition precludes recovery. See, e.g., *Jones v. State Farm Fire & Cas. Ins. Co.*, 703 A.2d 644 (Del. 1997) (citing *State Farm Mut. Auto. Ins. Co. v. Johnson*, 320 A.2d 345, 346 (Del. 1974)); see also *Monsanto Co. v. Aetna Cas. & Sur. Co.*, 1993 WL 563245, at *11 (Del. Super. Dec. 21, 1993) (applying Missouri law), *aff’d*, 653 A.2d 305 (Del. 1994); *Eisenmann Corp. v. Gen. Motors Corp.*, 2000 WL 140781, at *18 n.16 (Del. Super. Jan. 28, 2000) (citing Restatement (Second) of Contracts § 229) (non-insurance case).

“Failure to comply with a condition may result in forfeiture, a harsh result.” *Ewell v. Those Certain Underwriters of Lloyd’s, London*, 2010 WL 3447570, at *4 (Del. Super. Aug. 27, 2010) (citing *Stoltz Realty Co. v. Paul*, 1995 WL 654152, at *9 (Del. Super. Sept. 20, 1995)). Where contract language is clear and unambiguous, however, the Court must give that language its plain meaning. *Id.* (citing *Commonwealth Constr. Co. v. Cornerstone Fellowship Baptist Church, Inc.*, 2006 WL 2567916, at *21 (Del. Super. Aug. 31, 2006) (citing *AES Puerto Rico, LP v. Alstom Power, Inc.*, 429 F. Supp. 2d 713, 717 (D. Del. 2006) (applying Delaware law). No ambiguity exists where a court can determine an insurance contract’s plain meaning based on the facts and language of the contract. *Id.* (citing *Woodward v. Farm Family Cas. Ins. Co.*, 796 A.2d 638, 642 (Del. 2002)). However, an insurer cannot argue that an insured failed to satisfy a condition precedent if the insurer is largely responsible for the insured’s omission. See *Casson*, 455 A.2d at 365-66.

The Delaware Supreme Court recently held that the “minor deviation” rule controls whether a motor vehicle’s use falls outside of an insurance policy’s omnibus provision relating to coverage. *Hudson v. Old Guard Ins. Co.*, 3 A.3d 246, 331 (Del. 2010).

Challenging Stipulated Judgments: Consent and/or No-Action Clause

Delaware courts apply contract principles in interpreting “consent-to-settle” provisions. *Federal Ins. Co. v. Hilco Capital, LP*, 2008 WL 3021109, at *5 (Del. Super. Aug. 5, 2008) (applying Missouri law).

Although many liability insurance policies contain “consent-to-settlement” provisions, an insured’s breach of such a provision does not absolve the insurer from liability unless the insurer suffers prejudice. *E.I. DuPont de Nemours & Co. v. Admiral Ins. Co.*, 1995 WL 654010, at *10 (Del. Super. Oct. 27, 1995) (citing *Bryant v. Fed. Kemper Ins. Co.*, 542 A.2d 347, 349 (Del. Super. 1988)). However, the insured has the burden to prove “by competent evidence” that the breach did not cause the insurer any prejudice. *Id.* (citing *Hall v. All State Ins. Co.*, 1985 WL 1137299 (Del. Super. Jan. 11, 1985)). In addition, if an insurer denies liability and refuses to defend its insured, and then the insured settles the underlying dispute and seeks recovery from the insurer, the insurer cannot use the insured’s breach of the consent-to-settlement provision as a defense. See *Process Indus., Inc. v. Del. Ins. Guar. Assoc.*, 1994 WL 318965, at *10-11 (Del. Super. May 25, 1994); *Shook v. Hertz Corp.*, 349 A.2d 874, 876-77 (Del. Super. 1975).

Preexisting Illness or Disease Clauses

In order to bring the health insurance provisions of the Delaware Code in compliance with the federal Patient Protection and Affordable Care Act, 18 Del. C. § 3606—regarding preexisting conditions—was amended in 2013 to provide:

- Notwithstanding § 3306 of this title, if an insurer or a health service corporation elects to use a simplified application form, with or without a question as to the applicant’s health at the time of application, but without any questions concerning the insurer’s health history or medical treatment history, the policy must cover any loss from any preexisting condition, and the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.
- Notwithstanding subsection (a) of this section and § 3306 of this title, an insurer or a health service corporation which issues a specified disease policy, regardless of whether such policy is issued on the basis of a detailed application form, a simplified application form or an enrollment form, may not deny a claim for any covered loss that begins after the policy has been in force. Except for rescission for misrepresentation, no other defenses based upon preexisting conditions are permitted.

See also 18 Del. C. § 3403(b) (preexisting conditions in Medicare policies).

18 Del. C. § 3517, regarding preexisting conditions for group health insurance policies, was similarly amended in 2013 to provide:

- A group health insurance policy shall not include a provision that excludes coverage, and a health insurer shall not deny a claim under the policy, as a result of a disease or physical condition of a person effective on the date of the person’s loss, which existed prior to the effective date of the person’s coverage under the policy. This subsection shall not apply to accident only; credit; dental; vision; Medicare supplement; benefits for long-term care, home health care, community-based care or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance; specified disease, hospital indemnity or other limited benefit health insurance policies; or automobile medical payment insurance.
- For those policies not subject to subsection (a) of this section, a group health insurance policy shall contain a provision specifying the additional exclusion or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person’s coverage by name or specific description effective on the date of the person’s loss, which existed prior to the effective date of the person’s coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the 12 months prior to the effective date of the person’s coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:
 - The end of a continuous period of 12 months commencing on or after the effective date of the person’s coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and
 - The end of the 2-year period commencing on the effective date of the person’s coverage.

In addition, 18 Del. C. § 7105(c)(1), which governs long-term care insurance, precludes policies from having “pre-existing condition” definitions more restrictive than “a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective

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date of coverage of an insured person.” The statute further provides:

The definition of “pre-existing condition” shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant; and, on the basis of the answers on that application, from underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether or not it is disclosed on the application, need not be covered until the waiting period described in paragraph (2) of this subsection expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (2) of this section.

18 Del. C. § 7105(c)(4).

Under the doctrine of *contra proferentem*, ambiguities in pre-existing condition exclusionary clauses are generally construed against the insurer. *Penn Mut. Life Ins. Co. v. Oglesby*, 695 A.2d 1146, 1150-51 (Del. 1997).

Statutes of Limitations and Repose

In general, insurance coverage disputes are subject to the three year statute of limitations for contract actions contained in 10 Del. C. § 8106. See *Wal-Mart Stores, Inc. v. AIG Life Ins. Co.*, 860 A.2d 312, 319 (Del. 2005) (applying statute to plaintiff’s tort, contract, and fiduciary duty claims against insurer of its corporate-owned life insurance policies); see also *Witco Corp. v. Adriatic Ins. Co.*, 2000 WL 302079, at *2 (Del. Super. Jan. 31, 2000) (citing *Allstate Ins. Co. v. Spinelli*, 443 A.2d 1286 (Del. 1982)); *Harper v. State Farm Mut. Auto. Ins. Co.*, 703 A.2d 136, 137 (Del. 1997) (claim against insurance company for personal injury protection benefits under Delaware No-Fault Insurance statute is statutory based (not contractual), but the three-year limitations period contained in § 8106 still governs). The limitations period typically begins to run from the date of breach, i.e., when the insurer informs the insured that it has denied coverage under the policy. *Witco Corp.*, 2000 WL 302079, at *2 (citation omitted). But, under 18 Del. C. § 3315, health insurance contracts must contain a “Legal Actions” provision stating:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Insurance policy provisions that shorten the statute of limitations and alter when the claim “accrues” for limitations purposes are generally enforceable. *Woodward v. Farm Family Cas. Ins. Co.*, 796 A.2d 638, 642-43 (Del. 2002); *Closser v. Penn Mut. Fire Ins. Co.*, 457 A.2d 1086, 1083-84 (Del. 1983). However, statutes of limitations in life insurance policies may not be shortened. 18 Del. C. § 2926 (although, pursuant to subsection (d), this prohibition does not apply to “group life insurance”).

Delaware imposes a 2-year statute of limitations on emotional distress claims. *Tri-State Energy Solutions, LLP v. KVAR Energy Sav. Inc.*, 884 F. Supp. 2d 168, 173 (D. Del. 2012) (citing *E.E.O.C. v. Avecia Inc.*, 2003 WL 22432911, at *2 (D. Del. Oct. 23, 2003) (applying 10 Del. C. § 8119)).

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Delaware No-Fault Insurance statute is statutory based (not contractual), but the three-year limitations period contained in § 8106 still governs). The limitations period begins to run from the date of breach, i.e., when the insurer informs the insured that it has denied coverage under the policy. *Witco Corp.*, 2000 WL 302079, at *2.

A UM/UIM claim is subject to a 3-year limitation period applicable to contract claims, rather than the 2-year statute applicable to tort claims. See *Allstate Ins. Co. v. Spinelli*, 443 A.2d 1286, 1289-1290 (Del. 1982) (“[A] suit for recovery of uninsured motorist benefits is more nearly akin to a contract claim than a tort action and, hence, should be controlled by [Delaware’s] contract, rather than . . . tort statute of limitations”). “[T]he statute of limitations is triggered by the alleged breach of contract, not the underlying injury.” *Wilhelm v. Nationwide Gen. Ins. Co.*, 2011 WL 4448061, at *3 (Del. Super. May 11, 2011). On a UM claim, the statute of limitations begins to run when the insurer denies payment. *Id.* (citing *Allstate Ins. Co. v. Spinelli*, 443 A.2d 1286, 1287-90 (Del. 1982)). However, an insured cannot intentionally delay simply to prevent the limitations period from being triggered. *Mast v. Galante*, 1996 WL 111177, at *3 (Del. Super. Jan. 25, 1996).

Insurance policy provisions that shorten the statute of limitations and alter when the claim “accrues” for limitations purposes are generally enforceable. *Woodward v. Farm Family Cas. Ins. Co.*, 796 A.2d 638, 642-43 (Del. 2002); *Closser v. Penn Mut. Fire Ins. Co.*, 457 A.2d 1086, 1083-84 (Del. 1983); but see *Parisi v. State Farm Mut. Auto. Ins. Co.*, 2012 WL 2161597 (Del. Super. June 13, 2012) (holding that a policy provision shortening the statute of limitation on UIM claims to 2 years was unenforceable as against public policy). By recent amendment in May 2008, however, an insurance contract may not require that a claim be filed less than one year from the denial of a claim by an insurer. 10 Del. C. § 8106(b)(1).

Insurers who receive a claim pursuant to a casualty insurance policy must promptly notify “the claimant” as to the applicable statute of limitations. 18 Del. C. § 3914; but see *LaFayette v. Christian*, 2012 WL 3608690, at *3 (Del. Super. Aug. 21, 2012) (holding that 18 Del. C. § 3914 “does not apply to out-of-state insurers issuing any policy covering a non-Delaware resident, non-Delaware property, or activities to be performed outside of Delaware”); *Ndieng v. Woodward*, 2012 WL 6915205, at *2 (Del. Super. Dec. 19, 2012) (finding Section 3914 inapplicable to out-of-state, insured residents). “[A] plaintiff is not required to submit a formal claim to the defendant so long as his actions, as well as the actions of the defendant and the defendant’s insurer, taken together, collectively demonstrate that the insurance company was aware that at least a provisional claim was pending.” *Adams v. Griffin*, 2014 WL 7009530, at *2 (Del. Super. Nov. 26, 2014) (holding that a finding that defendant’s insurer did not have notice of claim where it received documents including requests for reimbursement of medical PIP benefits “would fail to give due regard to the broad construction to be accorded to the statute”). “Claimant” does not refer solely to an insured, but includes third-party claimants as well. *Stop & Shop Cos., Inc. v. Gonzales*, 619 A.2d 896, 899 (Del. 1993); see also *Montgomery v. William More Agency*, 2015 WL 1056326, at *4 (Del. Super. Feb. 27, 2015) (“The statutory notice requirement . . . is not restricted to those in a contractual relationship with the insurer.”) (citation omitted). If an insurer fails to comply with § 3914, the insurer will be precluded from asserting a statute of limitations defense. See *Bray v. Wal-Mart Stores, Inc.*, 2014 WL 1228909, at *2 (Del. Super. Mar. 24, 2014) (citing *Lankford v. Richter*, 570 A.2d 1148 (Del. 1990)); but see *Woodward*, 796 A.2d at 646-47 (finding § 3914 inapplicable to homeowner’s claims for property damage under a policy of property insurance).

TRIGGER AND ALLOCATION ISSUES FOR LONG-TAIL CLAIMS

Trigger of Coverage

To trigger the duty to defend under a CGL policy, the allegations in the underlying complaint must allege bodily injury or property damage occurred during the policy period. *Tyson Foods, Inc. v. Allstate Ins. Co.*, 2011 WL 3926195, at *7 (Del. Super. Aug. 31, 2011) (citing *Monsanto Co. C.E. Health Comp. & Liab. Ins. Co.*, 652 A.2d 30, 34–35 (Del. 1994)). Whether coverage is “triggered” at the time the injury is sustained or when a claim is made to the insurer largely depends on the specific language of the policy. See generally *Homsey Architects, Inc. v. Harry David Zutz Ins., Inc.*, 2000 WL 973285, at *12 (Del. Super. May 25, 2000); see also *Deutsche Bank Trust Co. Ams. v. Royal Surplus Lines Ins. Co.*, 2012 WL 2898478 (Del. Super. July 12, 2012). However, absent clear policy language, when faced with “continuous” damage such as pollution, Delaware courts tend to apply a “continuous trigger,” meaning that “any policy on the risk during the entire injurious process, meaning during exposure, progression and manifestation” provides the insured with coverage. *E.I. DuPont de Nemours & Co. v. Admiral Ins. Co.*, 1995 WL 654020, at *8 (Del. Super. Oct. 27, 1995); see also *Nat’l Union Fire Ins. Co. v. Rhone-Poulenc Basic Chems. Co.*, 1992 WL 22690, at *18-19 (Del. Super. Jan. 16, 1992) (finding that “every policy from the start of the injurious process is triggered”) (citing *New Castle Cnty. v. Cont’l Cas. Co.*, 725 F. Supp. 800, 809-812 (D. Del. 1989)), *aff’d in part, rev’d in part, New Castle County v. Hartford Acc. and Indem. Co.*, 933 F.2d 1162 (3d Cir. 1991)); but see *Olde Colonial Vill. Condo. Council v. Millers Mut. Ins. Co.*, 2002 WL 122885 (Del. Super. Jan. 28, 2002) (rejecting the continuous trigger analysis, finding that an engineer’s recommendations to evacuate a building, coupled with the condemnation of the building equated to the “collapse” of the building: “a collapse provision’s trigger is the collapse itself, not what led to it”).

Allocation Among Insurers

The appropriate allocation of liability among multiple insurers largely depends on the language of the applicable policies and the relevant factual and equitable circumstances of the case. For instance, in one case, the court allocated damages among the insurers under a modified *pro rata* method, i.e., when multiple insurers were liable over a period of time spanning multiple “policy periods” under a “continuous trigger” theory, “each insurer [will be] liable in proportion to the amount of time they insured the risk.” *E.I. DuPont de Nemours & Co. v. Admiral Ins. Co.*, 1995 WL 654020, at *15 (Del. Super. Oct. 27, 1995) (imposing *pro rata* allocation based on time on the risk on equitable grounds: “it is illogical to compress all of this damage into one policy period and hold each insurer fully liable. The presumption of continuous damage logically and fairly requires the imposition of the modified *pro rata* allocation of damage”). However, without overruling *DuPont*, the Delaware Supreme Court has rejected a *pro rata* approach under the circumstances and imposed joint and several liability on the insurers. *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481, 491 (Del. 2001) (holding that “*pro rata* allocation is inconsistent with the ‘all sums’ provisions in the [applicable] policies” and finding that insurers who agreed to indemnify for “all sums” in policies covering the applicable period were jointly and severally liable). For other cases discussing the allocation issue, see *Viking Pump, Inc. v. Century Indem. Co.*, 2013 WL 7098824 (Del. Super. Oct. 31, 2013); *Hoechst Celanese Corp. v. Nat’l Union Fire Ins. Co. of Pitts., Pa.*, 623 A.2d 1133, 1139-40 (Del. Super. 1992); *E.I. du Pont de Nemours & Co. v. Stonewall Ins. Co.*, 2008 WL 7020668 (Del. Super. Aug. 14, 2008), *aff’d*, 996 A.2d 1254 (Del. 2010); *E.I. du Pont de Nemours & Co. v. Allstate Ins. Co.*, 879 A.2d 929, 941 (Del. Super. 2004); *Monsanto Co. v. C.E. Heath Comp. & Liab. Ins. Co.*, 652 A.2d 30 (Del. 1994) (applying Missouri law); *N. Am. Philips Corp. v. Aetna Cas. & Sur., Co.*, 1995 WL 626052 (Del. Super. Apr. 28, 1995) (applying New York law).

CONTRIBUTION ACTIONS

Claim in Equity vs. Statutory

Under Delaware’s Uniform Contribution Among Tortfeasors Law (“DUCATL”), 10 Del. C. §§ 6301-6308, a joint

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tortfeasor may bring an action for contribution against another joint tortfeasor in certain circumstances. Under DUCATL, “joint tortfeasors” means two or more persons jointly or severally liable in tort for the same injury to person or property, whether or not judgment has been recovered against all or some of them. 10 Del. C. § 6301. Notably, Delaware courts have held that an insurer may both maintain an action for contribution or be sued in an action for contribution under DUCATL. See *PMA Ins. Co. v. Reddy*, 2010 WL 369342 (Del. Super. Jan. 26, 2010) (allowing subrogee insurer to maintain action for contribution against joint tortfeasor); *Evans v. Stuard*, 1989 WL 167406, at *4 (Del. Super. Oct. 6, 1989) (allowing joint tortfeasor to assert claim for contribution against plaintiff’s uninsured motorist carrier for the torts of an unknown tortfeasor).

10 Del. C. § 6302 provides the contours of the right of contribution:

- The right of contribution exists among joint tortfeasors.
- A joint tortfeasor is not entitled to a money judgment for contribution until he or she has by payment discharged the common liability or has paid more than his or her pro rata share thereof.
- A joint tortfeasor who enters into a settlement with the injured person is not entitled to recover contribution from another joint tortfeasor whose liability to the injured person is not extinguished by the settlement.
- When there is such a disproportion of fault among joint tortfeasors as to render inequitable an equal distribution among them of the common liability by contribution, the relative degrees of fault of the joint tortfeasors shall be considered in determining their pro rata shares.

Additionally, the recovery of a judgment by the injured person against one joint tortfeasor does not discharge the other joint tortfeasors. 10 Del. C. § 6303. Moreover, 10 Del. C. § 6304 details the effect of the release of one joint tortfeasor:

- A release by the injured person of 1 joint tortfeasor, whether before or after judgment, does not discharge the other tortfeasor unless the release so provides; but reduces the claim against the other tortfeasors in the amount of the consideration paid for the release, or in any amount or proportion by which the release provides that the total claim shall be reduced, if greater than the consideration paid.
- A release by the injured person of 1 joint tortfeasor does not relieve the 1 joint tortfeasor from liability to make contribution to another joint tortfeasor unless the release is given before the right of the other tortfeasor to secure a money judgment for contribution has accrued, and provides for a reduction, to the extent of the pro rata share of the released tortfeasor, of the injured person’s damages recoverable against all the other tortfeasors.

This provision of the statute has been interpreted to require a two-step calculation. “First, determine the amount under subsection (a) by totalling [sic] the amount paid by all released tortfeasors.” *Farrall v. A.C. & S. Co., Inc.*, 586 A.2d 662, 668 (Del. Super. 1990). Next, “determine the amount under subsection (b) by totalling [sic] the share (percentage) of all released tortfeasors as determined by the verdict and multiplying that percentage against the damage award to that plaintiff.” *Id.* “The greater of the above amounts is subtracted from the damage award to give the amount of the liability of the remaining tortfeasor defendants to that plaintiff.” *Id.*; see also *In re Rural/Metro Corp. Stockholders Litig.*, 102 A.3d 205 (Del. Ch. 2014) (finding tortfeasor “entitled to a reduction in its liability equal to the greater of (i) the share of responsibility attributable to the joint tortfeasors or (ii) the settlement payments made by the joint tortfeasors”). In short, “the released tortfeasors stand as a class whose collective payments or share determine the amount by which the award to plaintiff against the non-settling tortfeasors is reduced as a single reduction.” *Farrall* at 668.

Equitable Contribution

“An equitable right of contribution arises when one of several obligors liable on a common debt discharges all, or greater than its share, of the joint obligation for the benefit of all the obligors. *Levy v. HLI Operating Co.*, 924 A.2d 210, 220 (Del. Ch. 2007). “In the insurance context . . . contribution exists only among the insurers, and only absent a contractual understanding between the insurers as to how liability on the common debt is to be divided. *Id.* Accordingly, “the right of contribution has no place between insurer and insured, which have contracted with each other,” and, in contrast to the rights of subrogation and indemnity, “contribution will not relieve an obligor from the entire burden of a loss, but only from its equitable share.” *Id.*

“To succeed on an equitable contribution claim, a party must show concurrent obligations existed to the same entities, and that the obligors essentially insured the same interests and the same risks.” *Id.* (citing *Home Ins. Co. v. Cincinnati Ins. Co.*, 821 N.E.2d 269, 276 (Ill. 2004) (noting that equitable contribution “applies to multiple, concurrent insurance situations and is only available where the concurrent policies insure the same entities, the same interests, and the same risks”)).

DUTY TO SETTLE

The Delaware Insurance Code imposes on insurers a duty to make good faith attempts to effectuate “prompt, fair and equitable settlements of claims in which liability has become reasonably clear.” 18 Del. C. § 2304(16)(f). Specific examples of what this provision requires in practice are contained in the applicable regulations. See Delaware Regulation # 18 900 CDR 902.

LH&D BENEFICIARY ISSUES

Change of Beneficiary

The exercise of a right given to an insured by his policy to change his beneficiary is subject to no condition except such as may be imposed by statute or is expressed or necessarily implied in the terms of the contract itself, and where no conditions are so imposed the courts will recognize a change as having been effectually accomplished, where the insured person declares in any appropriate manner the change he desires to make. Unless prescribed by statute or required by the contract, an actual change in the instrument or policy of life insurance itself is not necessary to effect a change of beneficiary.

Rosen v. Am. Agency Life Ins. Co., 1986 WL 545133, at *1 (Del. C.P. Feb. 4, 1986) (citing 44 Am. Jur. 2d Insurance § 1753).

Accordingly, “when the insured has an unrestricted right to change beneficiaries, forwards to the insurer a signed change of beneficiary form and subsequently dies before the documents reach the insurer, the form will be given full effect.” *Holladay v. Patton*, 1995 WL 54437, at *3 (Del. Ch. Jan. 4, 1995) (citing 5 George J. Couch et. al., *Couch on Insurance* § 28:85 (rev. ed. 1984)).

Effect of Divorce on Beneficiary Designation

Delaware statutorily precludes a change of beneficiary on a life policy after a petition for divorce or annulment has been served. The Delaware Code provides that upon the filing of a petition for divorce, a preliminary injunction shall issue against the parties enjoining them from:

Transferring, encumbering, concealing or in any way disposing of any property except in the usual course of business or for the necessities of life, and requiring the parties to notify the other of any proposed extraordinary expenditures and to account to the Court for all extraordinary expenditures after the preliminary injunction becomes effective

13 Del C. § 1509(a)(1).

In a divorce proceeding, “[t]he Court may . . . direct the continued maintenance and beneficiary designations of existing policies insuring the life of either party. The Court’s power under this subsection shall extend only to policies originally purchased during the marriage and owned by or within the effective control of either party.” 13 Del. C. §1513(e).

Health Insurance

“Health insurance” is defined in the Delaware Insurance Code as “insurance of human beings against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto.” 18 Del. C. § 903.

Chapter 33 of Title 18 of the Delaware Code, 18 Del. C. § 3301 et seq., governs health insurance contracts in general. The following Chapters in Title 18 of the Delaware Code govern specific areas of “health”-related insurance: 34 (Medicare Supplement Insurance Minimum Standards); 35 (Group & Blanket Health Insurance); 36 (Individual Health Insurance Minimum Standards); 38 (Dental Plan Organizational Act); 40 (Health Insurance for Children & Persons on Medicaid); 46 (Life-Care Registration Act); 64 (Regulation of Managed Care Organizations); 68 (Health Care Medical Negligence Insurance & Litigation); 71 (Long-Term Care Insurance); 72 (Small Employer Health Insurance); 73 (Pharmacy Access Act); 74 (The HIV Testing for Insurance Act); and 76 (Discount Medical Plans).

INTERPLEADER ACTIONS

Availability of Fee Recovery

“In Delaware, it is well-established that ordinary court costs are usually allowed to a prevailing party. But allowance of counsel fees as part of the costs is the exception to the general rule. As [the Delaware] Supreme Court has noted, ‘[w]isely our courts have been very cautious in approving exceptions to that general rule.’” *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 369 (Del. Super. 1982) (quoting *Walsh v. Hotel Corp. of Am.*, 231 A.2d 458, 462 (Del. 1967)) (citations omitted). With that caveat, under appropriate circumstances an interpleading party may seek to deduct its attorneys’ fees from the interpleaded fund. However, whether a court will award attorneys’ fees to an interpleading party in part depends on the particular court’s jurisdiction.

Differences in State vs. Federal

- State Court

The Superior Court now has exclusive jurisdiction over interpleader actions. *Poppiti v. Newport Garden Apartment Assocs.*, 1990 WL 102442, at *1 (Del. Ch. June 20, 1990) (holding that the Court of Chancery “no longer has jurisdiction over interpleader actions” because Superior Court Rule 22 “now specifically provides that interpleader actions may be filed in the Superior Court” and “[t]hat court, therefore, can now provide an adequate remedy”) (citation omitted). Traditionally, the Court of Chancery had held that it “has discretion to award fees to an interpleading party out of the interpleaded fund.” *Sec. Conn. Life Ins. Co. v. Dudziak*, 1986 WL 4493, at *1 (Del. Ch. Apr. 14, 1986) (citations omitted); *see also Prof'l Underwriters Liab. Ins. Co. v. Zakrzewski*, 2006 WL 3872847, at *1 (Del. Super. Dec. 8, 2006) (“[I]t is clear that the Court of Chancery has, in the past, awarded attorneys’ fees in interpleader actions in appropriate cases.”). Notably, when awarding attorneys’ fees to an interpleader the Court of Chancery had generally relied on its equitable powers under 10 Del. C. § 5106, which provides that “[t]he Court of Chancery shall make such order concerning costs in every case as is agreeable to equity.” *See Dudziak*, 1986 WL 4493 at *1 (citing statute); *see also Del. Trust Co. v. Everitt*, 140 A.2d 778, 788 (Del. Ch. 1958) (citing statute and explaining that when assessing claims for attorneys’ fees “the court is involved in an area where the equities of each particular case may be considered”), *aff’d sub nom, Everitt v. Everitt*, 146 A.2d 388 (Del. 1958).

In contrast, “[i]n an action at law, a court may not order the payment of attorney’s fees as part of costs to be paid by the losing party unless the payment of such fees is authorized by some provision of statute or contract.” *Casson*, 455 A.2d at 370 (citation omitted); *see also Damron v. Grambau*, 1985 WL 664555, at *1 (Del. C.P. July 16, 1985) (“[W]hile the Court of Chancery has the discretion to award attorneys [sic] fees in an interpleader action, a court of law does not have such authority apart from statute.”). Because Superior Court Rule 22 and 10 Del. C. § 3910 now vest the Superior Court with exclusive jurisdiction to hear interpleader actions, but neither contains specific provisions for the award of attorneys’ fees, the question remained whether the Superior Court could draw upon the equitable origins of the interpleader action as a basis to award attorneys’ fees in appropriate cases. In answering that question in the affirmative, the Superior Court recently explained:

[I]nterpleader is, by its nature, an equitable device by which a limited fund may be distributed among several claimants. By virtue of its adoption of Rule 22, this Court has recognized the utility of this procedural device as a means to resolve certain actions at law The fact that interpleader has been adopted as a procedural device by a law court does not diminish the equitable principles upon which the remedy is based. Given that interpleader is based upon equitable principles, the Court is satisfied that it has authority to award attorneys’ fees as costs to the stakeholder/interpleader plaintiff in appropriate cases.

Zakrzewski, 2006 WL 3872847, at *3 (citations omitted).

- Federal Court

The District Court for the District of Delaware is granted original jurisdiction to hear “statutory” interpleader actions pursuant to 28 U.S.C. § 1335, provided the requirements of the statute are met. *See NYLife Distribs., Inc. v. Adherence Grp., Inc.*, 72 F.3d 371, 374 (3d Cir. 1995) (noting that “although the citizenship of the stakeholder is irrelevant for jurisdictional purposes, the statute calls for diversity of citizenship between two or more of the adverse claimants, requires that the amount in controversy . . . be

\$500, and compels the stakeholder to deposit the money . . . at issue in the court's Registry or, in the alternative, to give a bond payable to the clerk of courts in the appropriate amount"); *see also* 28 U.S.C. § 2361 (providing for nationwide service on all claimants in statutory interpleader actions and allowing a district court to enjoin any state or federal proceedings affecting the stake); 28 U.S.C. § 1397 (providing that statutory interpleader cases may be brought where one or more of the claimants reside). Additionally, the District Court may hear "rule" interpleader actions under Federal Rule of Civil Procedure 22, provided it has traditional subject matter jurisdiction over the case.

In the federal system, "[t]he awarding of attorney fees in an interpleader complaint is 'committed to the sound discretion of the trial court.'" *Banner Life Ins. Co. v. U.S. Bank, NA*, 931 F. Supp. 2d 629, 632 (D. Del. 2013) (quoting *Mut. of Omaha Ins. Co. v. Dolby*, 531 F. Supp. 511, 516 (E.D. Pa. 1982)); *see also* *Nationwide Mut. Ins. Co. v. Eckman*, 555 F. Supp. 775, 782 (D. Del. 1983) ("[T]he Court has discretion in awarding attorneys' fees to the stakeholder."). While "often times a disinterested stakeholder will be able to collect fees if he has admitted liability," the District Court has noted that grounds to deny attorneys' fees may exist where an interpleader excessively delays filing its claim or causes a delay in the distribution of funds by "impos[ing] its presence in every facet of the negotiations" between the competing claimants. *Eckman*, 555 F. Supp. At 782. Moreover, the District Court has held that, since "[m]aking a determination as to which claim prevails is the ordinary business of insurance companies," awarding attorneys' fees is not generally appropriate because it "would shift their ordinary business expenses to the claimants . . ." *Banner Life Ins. Co.*, 931 F. Supp. at 632. Notably, the Superior Court has, at least on one occasion, expressly rejected this rationale for denying attorneys' fees to an interpleader:

A few courts have suggested that insurance-company stakeholders may be denied their attorneys' fees and costs because they satisfy a self interest [sic] in not paying the wrong beneficiary by filing in interpleader. Others have noted that filing interpleader proceedings because of the conflicting claims of beneficiaries is part of the ordinary course of business for insurers and those costs should not be born [sic] by the fund. Insofar as these decisions rest on the notion that the stakeholder benefits by being discharged, they are wrongly decided because all stakeholders benefit by being able to use interpleader and that alone does not negate the equitable considerations supporting an award of attorneys [sic] fees. Further, the cost-of-business rationale fails to recognize that other equitable concerns should be consulted in determining whether fees or costs are warranted.

Zakrzewski, 2006 WL 3872847, at *3 and n.18.