How to Call Your Insurers' Bluff

Don't let legalese or a lack of knowledge force you into paying covered claims. Know the top 10 questions to ask--and the answers to listen for--when your insurance companies deny coverage.

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Public entities purchase insurance for protection from potential losses, either through several separate policies or through an umbrella policy that shields them from all potential exposures. But where will you be when your umbrella won't open, when your liability coverage is denied? Will you be mired in litigation proceedings as you take your carrier to court? Or will you have already accepted that your fate is to be drenched in claims, however bogus, because your carrier says your policy doesn't cover that particular exposure?

Neither option is a happy one. You may not want to believe that your insurer would knowingly deny you coverage, but it happens. Fortunately, you can prevent it from happening to you. Ask yourself the following 10 questions, and then ask your insurer. If you don't like the answers you hear (or if you don't get any answers at all), you may need more than just a new umbrella.

1 Is my insurance company bluffing when it denies coverage?

"Let's bluff it out, we can always buy out at a later date."--An insurance company claims manager's recommendation on how to proceed with an insured's claim.

The insurance company claims manager quoted here recommended denying coverage even though he knew the claim was covered in the policy. The insured in this instance had to you guessed it--go to court to defend its right to coverage. The case, *Farria v. United States Fid. & Guar. Co.,* 284 Ore. 453, 455 (1978), is another reminder that all too often liability insurers knowingly and willfully deny coverage for all or part of an underlying claim based on positions that are debatable, if not plain wrong. Just as frequently, public entity policyholders are not questioning such positions with enough scrutiny. The result is that many public entities are taking pennies on the dollar, or not receiving any insurance coverage at all, when they tender claims for liability coverage.

2 What kinds of claims will the provider deny?

As a risk manager, you need to know that liability insurers frequently deny coverage based upon erroneous or debatable grounds. If you have the necessary information, you can better detect

and overcome several of the common debatable or erroneous positions liability insurers take when denying coverage for long-tail liability claims, such as environmental claims. The term long-tail refers to liability exposures where the incidence of loss and the determination of damages are subject to delays that extend beyond the term during which insurance was in force. Contamination, malpractice and errors and omissions are just a few of the many types of claims that fall under this classification. Because of the time horizon and sometimes murky cause-and-effect relationship between the claimant and the entity, insurance companies can be more reluctant to cover these claims.

Long-tail liability issues exist with almost all types of liability claims and plague both private and public policyholders. For example, at least two public entities in California are engaged in heated litigation with their respective liability insurers over environmental claims liability. Two cases, *Stonewall Ins. Co. v. Cgty of Palos Verdes Estates* and *County of San Bernadino v. Pacific Indemnity Co.,* raise many of the issues discussed in this article. The cases have brought litigation at all three levels of California's civil court system, from trial court to the Court of Appeals to the Supreme Court.

3 What triggers a liability policy to provide coverage for long-tad claims?

Standard form general liability policies provide public entities with cover-

age for, among other exposures, bodily injury and property damage caused by an occurrence. In denying coverage for a long-tail claim, a liability insurer often argues that there was no triggering occurrence during its policy period. Over the years, courts and insurers alike have wrestled with a variety of trigger issues (i.e., What must happen during a policy period in order to obligate the corresponding policy to provide coverage for the underlying claim?).

Courts throughout the United States have adopted several different trigger-of-coverage rules for bodily injury and property damage claims. Most of these rules fall under the following labels and definitions:

* exposure-only trigger--provides that the only policy triggered for coverage is the policy in effect at the time the subject person or property is exposed to the injurious element.
* discovery or manifestation trigger--provides that the only policy triggered is the policy in effect at the time the bodily injury or property damage claimed was first discovered or first manifested itself.
* injury-in-fact trigger--provides that all policies in effect during the time that actual bodily injury or property damage is being sustained by the subject person or property are triggered for coverage.
* continuous trigger (also known as the triple trigger rule)--provides that all policies in effect from the time of the first exposure to the date of the claim (or the date liability is imposed upon the insured, depending upon the jurisdiction's loss in progress rules) are triggered for coverage.

Often, it's in the public entity's best interest to argue that many of its liability insurance policies are triggered by long-tail claims. That's what the city of Palos Verdes Estates and the county of San Bernadino did with respect to their environmental claims liability. Their respective liability insurers disagreed and argued that only those policies in effect when environmental damage was first discovered or was first manifested applied. Both entities won their battles in court. However, the trigger of coverage is only one of the hurdles that you must overcome when dealing with an intransigent liability insurer in long-tail claims.

4 Does the "loss in progress" doctrine bar coverage for long-tad claims?

One of the many doctrines established for insurance law purposes is called the loss in progress or known loss doctrine. This doctrine is intended to bar coverage under an insurance policy when the risk insured by that policy occurred prior to the policy's inception. Applying this doctrine to first-party property insurance policies is fairly straightforward. For example, a property insurance policy can't provide coverage for a building that burns down prior to the inception of the policy. The burnt building was a known loss prior to the inception of the policy, and therefore cannot be covered.

However, liability insurers often overreach the boundaries when it comes to applying the known loss doctrine to liability policies. First, most liability insurers wrongly label the doctrine as the "known risk" doctrine. Second, such liability insurers then argue that any risks known to the insured prior to the inception of the policy that later become claims aren't covered because of the doctrine. This argument is incorrect. The risk at issue for liability insurance is not the existence of injury for which the insured may be liable, but rather the imposition of liability upon the insured. Thus, an insured who foresees a risk of loss with respect to its conduct but takes a calculated risk and performs the conduct anyway an example is a public entity that lets a waste disposal site operate within its borders knowing that there's a risk of injury or damage is not precluded from coverage if a claim concerning that risk is thereafter brought against the insured. Similarly, if bodily injury or property damage occurs before the inception of the policy but liability for that injury or damage is not imposed until after, a claim for that injury or damage is not barred by the known loss doctrine. For more information on this issue, see the following cases: *Montrose Chemical Corp. v. Admiral Insurance Co.,* 10 Cal. 4th 645 (1995); *City of Johnstown, iV.Y. v. Bankers Standard Ins.,* 877 F.2d 1146, 1150 (2nd Cir. 1989); *Gulf Chemical & Metallurgical v. Associated Metals,* 1 F.3d 365, 370 (5th Cir. 1993).

Indeed, the essence of liability insurance is to insure risks of loss that might occur if the insured carries out its normal operations. In the context of long-tail claims, it doesn't matter that injury or damage occurred over many policy periods. Unless liability is imposed upon the insured prior to the policy period, the policy is triggered to provide liability insurance. Accordingly, when an insurer denies coverage under the so-called known risk doctrine, or even the correctly labeled loss in progress doctrine, the public entity policyholder should analyze the basis for the insurer's position to determine whether or not the insurer is improperly invoking the doctrine.

5 What if the damage was caused by an intentional act or by an employee or agent who expected or intended the damage?

Most, if not all, general liability policies contain some language designed to exclude coverage for bodily injury or property damage that is either expected or intended by an insured. Such exclusions are usually labeled "expected or intended injury" or "intentional acts" exclusions. Liability insurers frequently misinterpret or improperly apply these types of exclusions. They will sometimes assert that, because an act is intentional in nature, the resulting bodily injury or property damage is excluded. If your coverage for a claim is denied on this basis, you should resist vigorously. An insured's acts are frequently committed with a particular objective or end in mind. To the extent they are, these acts are intentional. The exclusions, however, are not designed to preclude coverage for such acts. Rather, they only apply when such acts are intended to cause bodily injury or property damage. [See *Gray v. Zurich Insurance Co.,* 65 Cal. 2d 263 (1966); *Western States Ins. Co. v. Bobo,* 268 Ill. App. 3d 513, 517 (1994).]

Liability insurers also often argue that no coverage exists for an underlying claim that alleges someone for whom the insured is legally liable intentionally caused bodily injury or property damage. As a matter of law, this argument is wrong in many jurisdictions and should be challenged immediately. In addition, the insured may be able to argue that the negligent supervision and vicarious liability theories asserted in an underlying claim actually establish coverage. In the instance of the negligent supervision theory, intentional act and expected or intended injury exclusions would cover an insured who didn't inflict injury or cause damage, even if the insured is liable for supervising the person who did. For example, in claims involving sexual harassment or sexual molestation, the claimant will sue the partner, supervisor or employer of the person who committed the acts alleging improper supervision. Because the insured's liability is based on its own negligence and that negligence is not excluded by an intentional act or expected or intended exclusion, coverage should not be denied.

The vicarious liability coverage ar-

gument has a similar result but a different theoretical basis. If, in the sexual harassment scenario, the insured's employee or agent is committing the sexually abusive acts, then the claimant may sue the insured, contending that the insured can be held vicariously liable. The insured's liability coverage is not excluded, because the insured did not intend to injure the claimant. See *Fireman's Fund Ins. Co. v. City of Turlock,* 170 Cal. App. 3d 988 (1985); Keeton, *Insurance Law,* 293 (1971).

When applying the correct rules regarding intentional acts by the public entity and/or its agents or employees in long-tail claims, a liability insurer will have a very difficult time showing that the public entity is not entitled to coverage based upon any expected or intended injury or intentional act exclusions in the policy.

6 What if our policies are subject to self-insurance obligations?

As more courts throughout the United States adopt favorable rulings for insureds on coverage issues in long-tail claims, more liability insurers are scurrying for cover under allocation theories. These theories seek to force policyholders to assume much of the costs when any of their policies are subject to self-insurance obligations, such as deductibles, self-insured retentions, retrospective premiums, "fronting" arrangements and the like. With respect to long-tail claims that trigger successive liability policies over many years, if not decades, the application of an unfavorable allocation rule to the insured's claim can be devastating.

Indeed, a ruling addressing these issues currently is on appeal before the California Court of Appeals in *County of San Bernadino v. Pacific Indemnity Co.,* where the liability insurers have argued that San Bernadino County must share in the cost of its own defense in underlying environmental claims because, since the 1970s, the county has maintained a self-insured primary layer of insurance in its general liability insurance program. The California Court of Appeals addressed similar allocation issues in the Palos Verdes case. The court ruled that the city must exhaust its policies horizontally by layer rather than vertically by policy period, and that the city must pay the full amount of the self-insured retention in each policy that the city asks to respond to the claim.

Applying such an unfavorable allocation rule can wipe out much, if not all, of a public entity's coverage, even if the entity overcomes all of the other hurdles to obtaining coverage for long-tail claims. There are at least three straightforward rules many courts follow that would greatly favor any public entity faced with these allocation issues: vertical exhaustion of triggered policies, pro rata application of self-insurance obligations and noncumulation of self-insurance obligations.

You should know and understand these roles and use them if you're ever faced with long-tail liability claims. As you continue to ask yourself these questions, note the relevant precedents in the court cases listed. Keeping history in mind will help you focus your arguments.

7 What is the practical result of exhausting policies vertically rather than being forced to exhaust policies horizontally by layer?

Some jurisdictions let the insured exhaust vertically all policies in a particular triggered policy period to cover all the costs incurred in connection with an underlying claim, rather than requiring the insured to exhaust its policies horizontally by layer. Coupled with the right to vertically exhaust all policies in a single particular triggered policy period is the rule that the insurers who issued the policies can't seek contribution and/or reimbursement from the insured's other policies, including self-insurance policies, in a way that would impose ultimate liability on the insured. Several courts have applied this favorable allocation rule. [See *New Castle County v. Continental Cas. Co.,* 725 F. Supp. 800, 817 (D. Del. 1989); *Dayton Independent School Dist. v. National Gypsum Co.,* 682 F. Supp. 1403, 1411 n.21 (E.D. Tex. 1988).]

To see how the vertical exhaustion of triggered policies works, assume the following: Your public entity has 30 years of liability insurance (each of the 30 one-year policy periods having a $1 million primary, $5 million umbrella and an additional $30 million in various excess liability policies). All of that insurance is triggered by a $30 million long-tail environmental claim. Assume further that the first 15 years of the insurance program is not subject to any self-insurance mechanism. Finally, assume that the primary-layer policy in each year of the last 15 years of the program is subject to a $500,000 self-insured retention. Under the rule of vertical exhaustion, coupled with the. correct contribution and reimbursement rule, your entity can place the entire $30 million liability in any one of the first 15 years, and the entire $30 million is covered. While the chosen insurers can seek contribution and/or reimbursement from your other insurers, you won't be obligated to pay any of the self-insured retention obligations in the last 15 years of primary-layer policies as long as the correct contribution and reimbursement rule is applied.

If, however, horizontal exhaustion rules are applied, the policies will cover only $22.5 million unless other favorable allocation rules involving self-insurance mechanisms are employed. As the insured, you'll have to pay the $500,000 self-insured retention in each of the last 15 primary-layer policies because $1 million is allocated to each of the 30 years, or each of the 30 primary-layer policies.

8 If horizontal exhaustion rules apply, how can I minimize my payments?

You can make sure you'll pay less if you keep the pro rata application of self-insurance obligations in mind, especially if your jurisdiction requires horizontal exhaustion. This rule states that if liability is going to be allocated among all triggered policy periods horizontally, then the public entity should have to pay only a proportionate share of the self-insurance obligation in each triggered policy. If the same public entity described above had an environmental claim, this allocation rule would cover a whopping $29,750,000 of the $30 million because only 3.33 percent of the overall liability ($1 million of the $30 million) is being allocated to each triggered policy period. Thus, the public entity must pay only 3.33 percent of the $500,000 self-insured retention in each of the 15 years (which totals $250,000). Rest assured, however, that most liability insurers will not advise their public entity policyholders of this useful allocation rule. If faced with the situation above, they'll try to stick the public entity with at least $7.5 million of the $30 million claim.

9 Are self-insurance obligations cumulative?

Not always. A third rule applied by courts is that payment of one self-insurance amount for a particular policy period can satisfy the self-insurance obligation for another policy period triggered by the same claim. Applying this rule to the hypothetical $30 million claim would result in $29,500,000 of covered losses, with the public entity paying only $500,000 (the amount of one self-insured retention). Again, however, a public entity's liability insurers won't advise them

of this allocation rule. Rather, most will attempt to foist upon the entity at least $7.5 million of the $30 million loss.

The numbers used in this scenario are bad enough. Now, consider the consequences for a public entity facing a smaller claim (in the range of $5 million) that triggers 20 years of liability policies, all of which are subject to a self-insured retention of $250,000. The result in such a situation can be no coverage, even if the public entity prevails on all other coverage arguments. The $5 million could be allocated to each of the 20 years, and the public entity could be forced to satisfy the full amount of self-insured retention in each of the years (20 multiplied by $250,000 is $5 million, which is the entire claim!). It's vital for public entities to understand these three allocation rules in order to know their rights and avoid being overwhelmed by long-tail claims.

10 If there an alternative to long, drawn-out coverage litigation?

Notwithstanding the plethora of litigation over insurance coverage issues, you can often overcome an insurer's erroneously based denial of coverage without costly litigation.

Cost-effective, nonlitigation dispute resolution techniques are available to all public entities and are successful on many occasions. Often, the insurer is merely bluffing Other times, the claims adjuster handling the claim for the insurer simply does not know the law. In such situations, a letter outlining why the insurer's declination is wrong is all you'll need to reinstate coverage. If a letter's not enough, set up a meeting to discuss your entity's coverage position.

If you need to do something else, there still are alternatives to litigation. The entity can suggest that the coverage dispute be resolved by mediation or binding arbitration.

If such nonlitigation dispute resolution techniques do not overcome the claim denial, the entity might be able to institute quick, cost-effective litigation by filing a lawsuit and then immediately filing a motion for summary judgment on the key coverage question(s) in dispute, such as whether the liability insurer has a duty to defend the underlying claim. If the entity wins the motion for summary judgment, then the insurer may be more willing to settle the coverage dispute on terms favorable for the entity. That entire litigation and settlement process can take as little as a few months, rather than the years it takes to conduct all-out war in the courts. Keep these dispute resolution techniques in mind when deciding if, and how, you will try to overcome a denial of coverage.

In the final analysis, never simply accept a liability insurer's explanation of partial coverage or no coverage at all without first conducting an independent analysis of the coverage issues involved. If the liability insurer's position is just plain wrong, or even debatable, you can and should challenge it and pursue coverage. It can mean the difference between a claim that depletes or destroys your entity's financial reserves and the coverage you deserve as a purchaser of liability insurance. ■