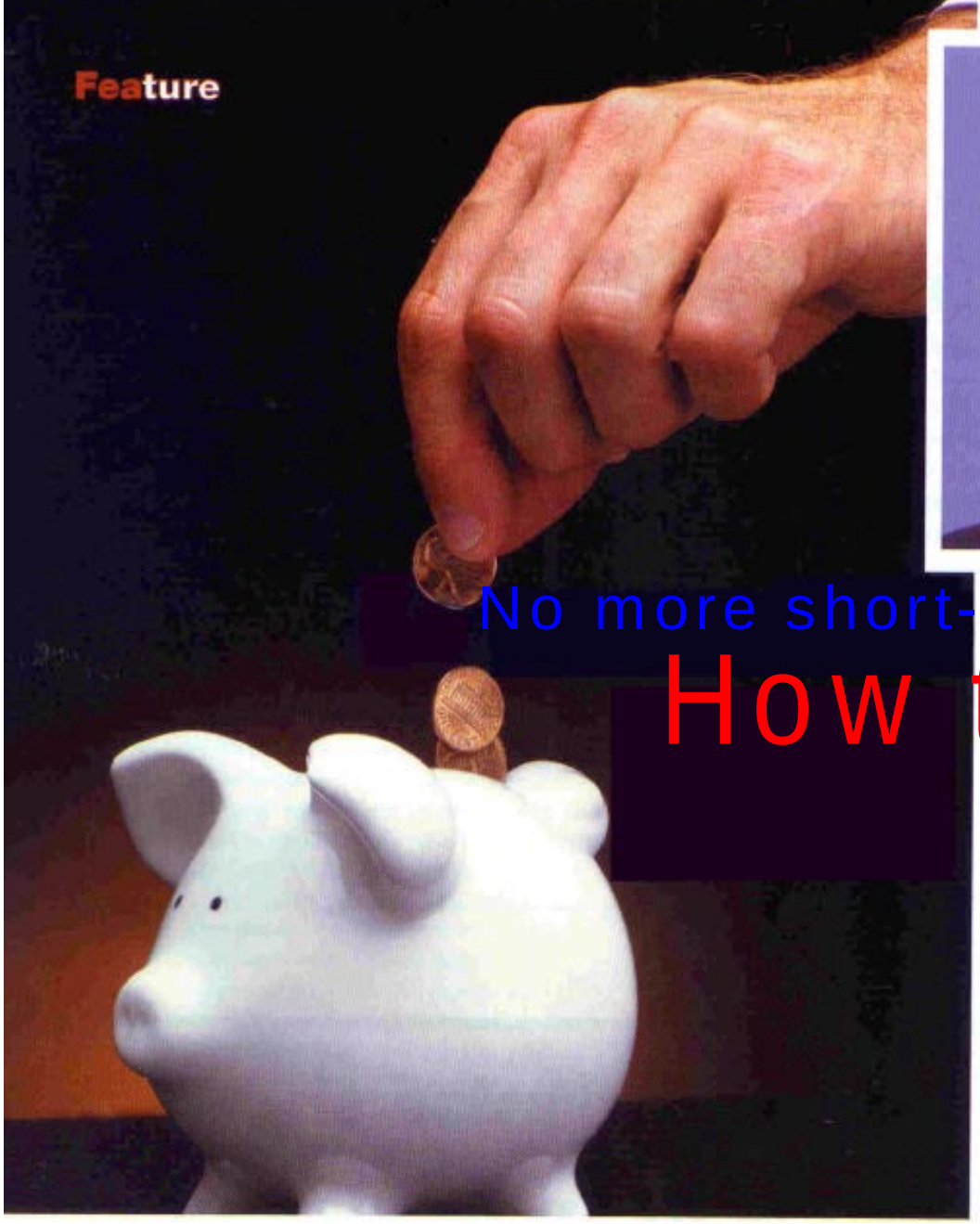


No more short-changing

How to avoid

By *Michael A. Rossi*

"Let's bluff it out, we can always buyout at a later date."

An insurance company claims manager's recommendation on how to proceed with an insured's claim by denying coverage for the claim when he knew it was covered. This recommendation was found in the claims file during discovery in coverage litigation brought by the insured.

This quote is just a reminder that, at least in the US, all too often, insurance carriers knowingly and willfully deny coverage for all or part of a claim based upon positions that are debatable, if not plain wrong. Just as frequently, insureds in the US are not questioning such positions with enough, if any, scrutiny. The result is that many insureds in the US are taking pennies on the dollar, or not receiving any insurance coverage at all, when they tender their claims for insurance coverage.

This article discusses some of the common debatable or erroneous positions taken by commercial general liability ('CGL') insurance carriers In the US to deny coverage for claims. It should be noted that many carriers on all lines of property and liability insurance -not just CGL insurers - very often deny coverage on erroneous or debatable grounds. The author has written several extensive papers addressing these positions taken by insurers on several lines of insurance (including property, business interruption, CGL, D&O, and others) when denying coverage. The space limitations of this article obviously do not allow for such a discussion.

Accordingly, the author has provided merely a sampling of the erroneous or debatable positions taken by CGL insurance carriers. It should be stressed that the sampling was totally arbitrary - the author's inclusion of the issues discussed should not be taken to mean that the issues are the most important issues or the ones most often raised by CGL insurers.

Rather, the author has chosen the issues discussed to try to make the following impressions upon the reader. First, a risk manager should never simply accept an insurer's explanation of no or partial coverage without first conducting an independent analysis of the coverage issues involved. Second, if the insurer's

position is just plain wrong, or debatable, the insurer's position should be challenged and coverage should be pursued. Third, and finally, coverage can be analysed, challenged and pursued by quick, efficient and cost-effective means, rather than by costly and time consuming litigation. Again, these 'truths' extend to all lines of property and liability insurance, not merely CGL insurance.

CGL Insurers at their worst. denying coverage for the entire claim

CGL insurers either accept coverage without reservation, accept coverage subject to a reservation, or deny coverage in its entirety. Some, but by no means all, of the common erroneous or debatable positions to deny full coverage are discussed below.

losing coverage

** The claim alleges intentional acts, so there is no coverage.*

Most, if not all, CGL policies sold in the US contain an exclusion for bodily injury or property damage that is either 'expected or intended' by the insured. This particular exclusion is frequently misinterpreted and applied improperly. Insurance carriers will sometimes assert that because an act is intentional in nature, the resulting bodily injury or property damage is excluded.

If coverage for a claim is denied on this basis, it should be resisted 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 exclusion, however, is not designed to preclude coverage for such acts. Rather, it is applicable only when such acts are intended to cause bodily injury or property damage.

CGL carriers also often argue that no coverage exists for an underlying claim that alleges an insured's agent or 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 in the US and should be challenged immediately. It can be argued that the 'negligent supervision' and 'vicarious liability' theories asserted in an underlying claim actually establish coverage.

With the former, the intentional injury exclusion does not bar coverage to an insured that does not inflict the injury or cause the damage, even if the insured is liable for negligently supervising the person who did. Having a similar result but a different theoretical basis is the 'vicarious liability' coverage argument. If an insured's agent or employee committed an act with the intent to cause injury, the insured's liability is not excluded, because the insured did not intend to injure the claimant.

There is an exception to this argument, however. If an insured authorises the intentionally injurious conduct of another, then coverage may be rightfully withheld. In the context of a corporate insured, in some US jurisdictions the insurer must demonstrate that either the board of directors or shareholders of the corporation ratified or authorised the intentionally injurious act for coverage not to be applicable.

If the 'Severability of Interests' or 'Separation of Insureds' clause is given effect, the insurer cannot bar coverage for all insureds merely because another insured is excluded from coverage.

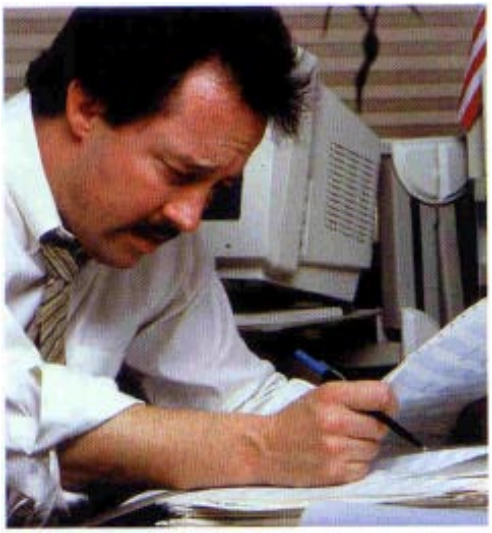
** Because one insured is excluded from coverage, coverage is barred for all insureds*

Virtually all CGL policies sold in the US contain some form of 'Severability of Interests' or 'Separation of Insureds' provision. The intent of this provision is to treat the policy as if it was separately issued to each person and entity covered by the policy. This provision frequently is overlooked and coverage improperly withheld from an insured when another insured (either named or not named in the claim or lawsuit at issue) is not covered for some reason.

If the 'Severability of Interests' or 'Separation of Insureds' clause is given effect, the insurer cannot bar coverage for all insureds merely because another insured is excluded from coverage.

For example, assume an employee of an insured company files a lawsuit for bodily injury against its employer, another company other than its employer that also is insured under the policy, and persons insured under the policy. CGL carriers will sometimes argue that the 'employee injury' exclusion in the policy bars coverage for all insureds. This argument is in error. The typical 'employee injury' exclusion in a CGL policy bars coverage for 'bodily injury' sustained by an employee of 'the insured' arising out of and during the course of employment for the insured.

Courts have held that the 'severability of interests' clause must be given effect so that the exclusion bars coverage only for the insured who is the actual employer of the claimant, not all other insureds on the policy. So in the hypothetical given, the exclusion would not bar coverage for any of the parties who are not the actual employer of the claimant, even though coverage for the employer insured is excluded.



** The claim seeks damages for breach of contract, and our policy covers only damages for negligence.*

Claims arising out of a breach of contractual obligations are quite commonplace. Unfortunately, carriers often improperly deny coverage for such claims. Insurance carriers sometimes take the position that CGL policies only cover damages arising from negligence, as opposed to breach of contract. To support their position, they use legalese to assert that their policies only respond to ex delicto damages (damages arising from negligent acts), not ex-contract damages (damages arising from breach of contract). .

Typically, when the policyholder intentionally breaches a contract such as refusing to perform the contract -coverage is not afforded .

Such carriers also typically focus on the phrase 'legally obligated to pay' used in CGL insuring agreements, arguing that this phrase means that any liability arising out of contract is not liability that the insured is 'legally obligated to pay' but rather is 'contractually obligated to pay'. In any event, the carrier's position should be examined carefully. Depending upon the facts and allegations of the claim, a declination on this basis may well be without merit. The following points should be kept in mind.

Typically, when the policyholder intentionally breaches a contract -such as refusing to perform the contract - coverage is not afforded. However, many times a claim arising out of a contractual relationship is based on negligent performance of the contract giving rise to covered injury or damage.

For example, what happens if a subcontractor installs defective doors in a house, and the doors warp and cause damage to the door jamb and other parts of the house? Some US courts have held that a claim by the general contractor against the subcontractor under such circumstances is covered, at least in part, by CGL policies.

In another example, what happens if the same act by an insured gives rise to a claim that can be based both on contract liability and tort liability? Some US courts have held that such claims are covered by CGL policies.

In both examples, courts have upheld coverage notwithstanding that there is a contractual relationship between the claimant and the insured, and but for that contractual relationship, the claim never would have been made.

** The claim involves a known loss or loss in progress, so the entire claim is denied.*

One of the many doctrines established for insurance law purposes in the US is called the 'known loss' or 'loss in progress' doctrine. This doctrine is intended to bar coverage under an insurance policy when the 'risk' insured by that policy already occurs prior to the inception of the policy. Applying this doctrine to first-party property insurance policies is fairly straightforward.

For example, a property insurance policy cannot 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.

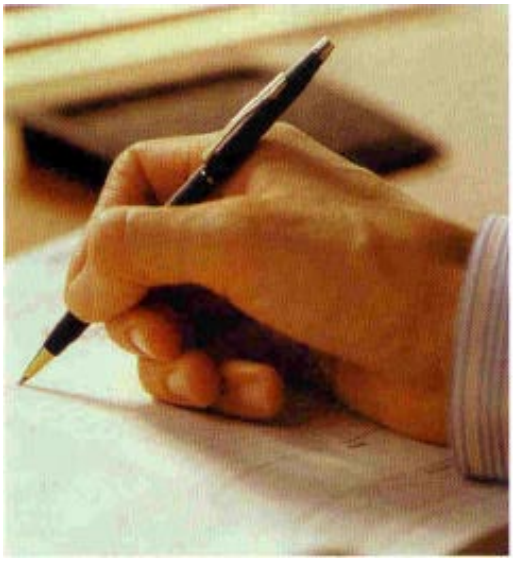
However, CGL carriers often overreach when it comes to applying the 'known loss' doctrine to liability policies. CGL carriers often erroneously label the doctrine as the 'known risk' doctrine. Such CGL carriers then argue that if any 'risk' is known to the insured prior to the inception of the policy, and the 'risk' later comes to fruition in the form of a claim, then it is not covered because of the 'known risk' 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 in any event (such as to manufacture and sell a product knowing that there is a risk of product liability claims), is not precluded from coverage if a claim concerning that risk is thereafter brought against the insured.

Similarly, if injury to person or damage to property occurs prior to the inception of the policy, but liability for that injury or damage is not imposed upon the insured prior to the inception of the policy, a claim for that injury or damage is not barred by the 'known loss' doctrine. Several Supreme Courts of US states have interpreted the 'known loss' doctrine in this manner.

CGL Insurers denying coverage for part of the claim

CGL insurers deny coverage for the entirety of a claim just as often as they accept coverage pursuant to a reservation of rights, erroneously asserting that some parts of the claim are not covered, and that some or all of the claim may not be covered, depending upon the outcome of the claim. Some of the erroneous or debatable positions used by CGL insurers to pay less than what is owed for a claim are set forth below.



A number of positions have been enumerated by US courts, of which, the most favourable to policyholders are the 'all sums' and 'pick and choose' rules.

** We do not cover punitive damages.*

Lawsuits often include a prayer for punitive damages based upon allegations that the plaintiff's injuries were wilfully inflicted by the defendant(s). A CGL insurer often asserts in its reservation of rights letter that its policy does not cover punitive damages. This position frequently is wrong. Generally, CGL policies are silent on whether they exclude coverage for punitive damages.

Some CGL policies do, however, specifically exclude coverage for such damages. Still other policies specifically include coverage for such damages. Thus, a policyholder must always read its policy to determine whether the policy has any express provisions with respect to coverage for punitive damages. A policyholder should next determine whether or not it is contrary to public policy under the law applicable to its insurance policy for insurers to indemnify insureds for punitive damage awards.

The answer may prove surprising. At present, many jurisdictions in the US permit insurance coverage for punitive damages. Of those that do not, a significant number allow insurers to respond if an insured is held vicariously liable for the intentionally injurious acts of an employee or agent.

The analysis can also be very tricky in some circumstances.

** We do not cover economic losses.*

Economic losses claimed by a plaintiff are a common element of many lawsuits. For instance, assume that an insured spills oils or some other contaminant in a river that is a heavy tourist attraction, with many hotels and other stores on and close to the river banks. Assume further that the spill causes those businesses to lose lots of money because tourism dramatically decreases due to the spill and the negative publicity about it. If those businesses sue the insured, they are going to be suing for lost profits.

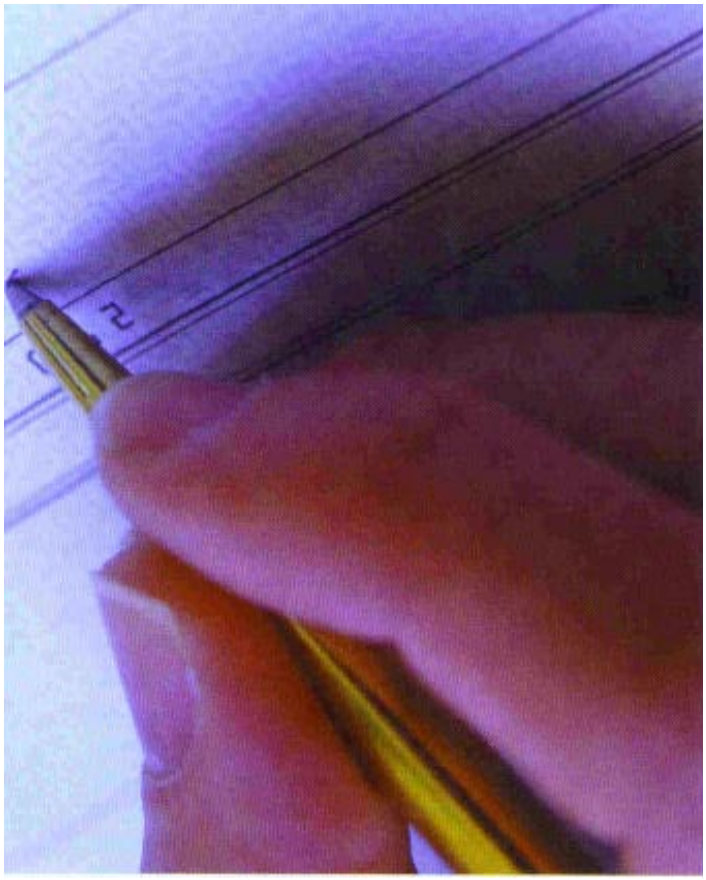
Likewise, if an insured's product is installed in a building and it malfunctions causing substantial damage, the building owner may seek compensation for lost profits in addition to the cost of repairing the damage. When faced with claims of this nature, some carriers maintain that economic losses suffered by the claimants are not covered by their policy. A few US jurisdictions accept this position, but as a matter of law the vast majority do not.

The majority position typically derives from one of two rationales; the first is called the 'measurement of damage' approach, and the second the 'consequential loss' approach. CGL policies promise to afford coverage for 'damages...because of' covered 'bodily injury', 'property damage', 'personal injury', or 'advertising injury'.

Because of such language, courts have generally perceived covered injury or damage to be a prerequisite to coverage for economic loss. Such courts do not equate economic loss with the covered injury or damage. Rather, some courts hold that economic loss is a measurement of the value of the covered injury or damage. Other courts hold that economic loss is a consequence of or results from covered injury or damage, and therefore falls within the 'damages...because of' language in the insuring agreement of CGL policies. That is, the policy provides coverage for all damages for which the insured is liable, including economic losses of a third party claimant, that are a consequence of or result from covered injury or damage.

** Because the claim is covered by policies in addition to our own, we will pay only a portion of the defence and indemnity costs',*

When several policies are 'triggered' by the same claim - whether all the policies were issued for the same year or were issued for successive years over a several year period -a question that arises is what is the obligation of anyone of the 'triggered' policies? At issue is whether or not each 'triggered' policy has a separate and distinct obligation to fully defend and indemnify an insured for a given claim (subject, of course, to the applicable limits) or, if not, whether the cost to defend and indemnify an insured can be allocated across several 'triggered' policies or 'triggered' time periods (if no coverage was in



place). This issue often is referred to in the US as the 'scope of coverage' issue.

A number of positions have been enumerated by US courts, of which, the most favourable to policyholders are the 'all sums' and 'pick and choose' rules. Under the 'all sums' rule, each 'triggered' policy has a separate and indivisible obligation to fully defend and indemnify an insured for a claim. A corollary to the 'all sums' rules is the 'pick and choose' rule, which permits an insured to select any 'triggered' policy to respond to the claim (subject to rights of contribution and reimbursement from other 'triggered' policies).

These rules are premised upon certain language in CGL policies, which says the insurer will pay for 'all sums' which the insured is legally obligated to pay as damages. While a majority of courts endorse the 'all sums' and 'pick and choose' rules, a significant minority still require an allocation across the 'triggered' policies or 'triggered' time periods (if no coverage was in place).

** We have the right to seek contribution and/or reimbursement from other policies subject to a self-insurance obligation.*

The discussion above regarding 'scope of coverage' addresses only part of the problem that arises when more than one policy is 'triggered' by the same claim. Even if the insured gets to pick anyone particular 'triggered' policy to respond in full to the claim, the insurer that is chosen by the insured to respond in full to the claim may be entitled to contribution and/or reimbursement from the other 'triggered' policies.

Unfortunately, certain of those other 'triggered' policies may be issued to the policyholder and may be subject to some type of self-insurance obligation - such as a deductible, self-insured retention, retrospective premium, side indemnity agreement, fronting arrangement, etc.

Thus, if the chosen insurer seeks contribution or reimbursement from other 'triggered' policies that are subject to any form of self-insurance mechanism, the insured ultimately may be obligated to pay a portion of the defence and/or indemnity of the underlying claim.

However, the insured should object to, and prohibit, any attempt on the part of a chosen insurer to seek participation of the insurers that issued other 'triggered' policies if such an effort would result in the imposition of any ultimate liability upon the insured by reason of any self-insurance mechanism. Many courts recognise that such an indirect imposition of liability on the insured would defeat its right to obtain a full and complete defence under the policy that the insured chose in the first place to respond in full to the underlying claim. In other words, the only way to give effect to the 'all sums' and 'pick and choose' rules with respect to the 'scope-of coverage' issue is to limit a chosen insurer's contribution and/or reimbursement right -the right must be exercised in such a way that does not impose liability upon the insured.

Some 'tricks of the trade' from a policyholder coverage lawyer

The author has seen over seven years' worth of erroneous or debatable positions taken by insurers on virtually all lines of property and liability policies. Along the way the author has developed a checklist of sorts that all policyholders should keep in mind when reviewing claims for coverage, regardless of what type of insurance policy is at issue. It should be noted that the issues discussed above already have highlighted the points made below.

** 1. What does the insurance policy say?*

A common mistake made by many risk managers, and even lawyers, is to assume what language is contained in the policy at issue. How many of us believe we 'know' what standard form policies say?

How many of us believe we don't need to look at a policy in order to 'know' what coverage the policy affords? This is a trap for the unwary. Insurance coverage is a matter of contract -the policy of insurance. The words of that contract spell out the rights and obligations of insurer and policyholder. Thus, for any coverage claim, a copy of the contract between the parties - the actual insurance policy involved, as it was issued by the insurer - should be obtained and reviewed, page by page, to analyse coverage.

Over the years the author has discovered provisions unknown to the risk manager, or believed by the risk manager to be worded manner differently than actually worded, by conducting this fundamental exercise. Sometimes such a discovery helps obtain coverage. Other times, such a discovery

helps avoid a costly coverage battle that the insured likely would not have won.

* 2. *Which states law applies to interpret the insurance policy?*

In the US, insurance law for the most part is a matter of state law. That is, the coverage afforded by a particular insurance policy typically is determined by reason of what state's law applies to interpret the policy and what that state's law says about coverage. As hopefully demonstrated in the first part of this article, different states in the US have developed markedly different rules of insurance law on the same exact policy provisions.

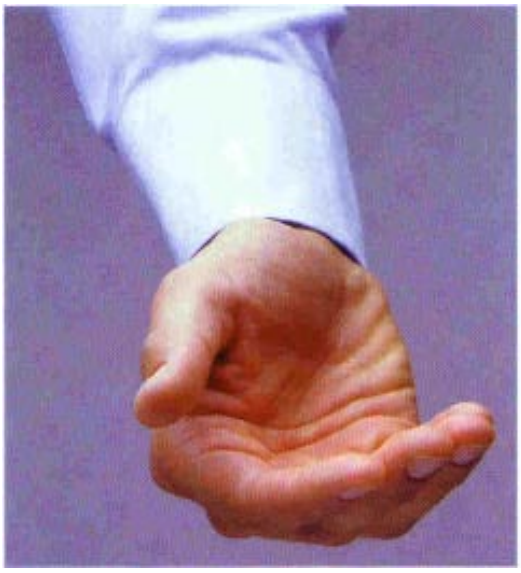
That is, what could be covered under a policy if that policy is interpreted under California law, might not be covered under the same exact policy if that policy is interpreted under New York law, and vice versa. Therefore, it is imperative in any coverage situation to analyse coverage issues from the standpoint of which state's law could apply to the insurance policy(ies) at issue.

Often, the insurer relies on law that does not apply to the policy. The reason for such a misapplication of law is that the insurer either does not know which state's law applies, or simply is applying the most favourable law for the insurer on a particular issue, without regard for the fact that the law of another state might apply to the policy.

How does a risk manager know which state's law applies to an insurance policy? A 'choice of law' analysis must be conducted. Each state has its own 'choice of law' rules that it uses to determine which state's law applies to an insurance policy. Some states provide that the law of the state where the insurance contract was made (e.g., signed) is the law that applies.

Some states provide that the state with the 'most significant relationship' to the policy applies to interpret the coverage it affords. Some states provide that the state whose government has the greatest interest in having its laws apply to the policy will have its laws applied to interpret the policy. Still other states have some variation of the foregoing or some other rule. Notwithstanding that the analysis can get confusing, it is imperative that such an analysis be conducted in any coverage situation, so the insured knows which state's law it can use to assess its rights to coverage for the particular claim at issue.

* 3. *Has the carrier ever covered a similar claim for the insured?*



Insurers often ignore a little-known principle of insurance contract interpretation known as the doctrine of 'practical construction'.

Insurers often ignore a little-known principle of insurance contract interpretation known as the doctrine of 'practical construction.' That doctrine provides that parties to a contract, by their conduct, can give meaning to the contract. The Supreme Court of California explained the doctrine of 'practical construction' as follows:

"[The] rule of practical construction is predicated on the common sense concept that 'actions speak louder than words'...When the parties to a contract perform under [a contract] and demonstrate by their conduct that they knew what they were talking about the courts should enforce that intent ...[It is true that] this doctrine of practical construction can only be applied when the contract is ambiguous...[Citations omitted.] But the question involved in such cases is ambiguous to whom?

"Words frequently mean different things to different people. Here the contracting parties demonstrated by their actions that they knew what the words meant and were intended to mean. Thus, even if it be assumed that the words standing alone might mean one thing to the members of this court, where the parties have demonstrated by their actions and performance that to them the contract meant something quite different, the meaning and intent of the parties should be enforced. In such a situation the parties by their actions have created the 'ambiguity' required to bring the rule [of practical construction] into operation. If this were not the rule the courts would be enforcing one contract when both parties have demonstrated that they meant and intended the contract to be quite different."

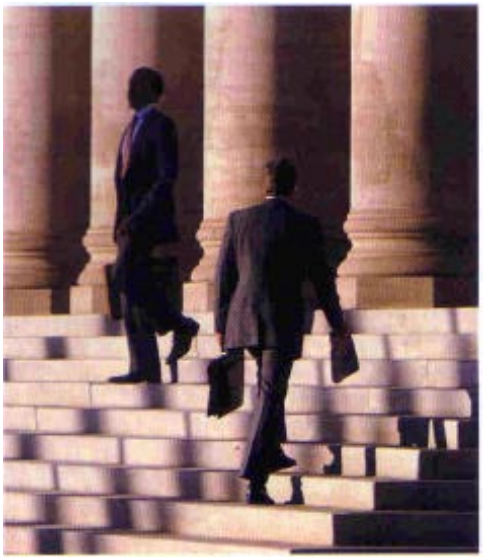
Accordingly, one thing a risk manager should always ask is whether the insured and insurer have previously adjusted a similar loss on either the same policy or prior policy containing the same or similar language than the current policy. If so, it should be determined whether the insurer's past conduct can be used to the insured's advantage for the claim at issue. For example, has the insurer covered a prior claim similar to the one it now denies? If so, the insurer should be held to have construed the policy to cover such claims.

* 4. *Has the insurer ever covered a similar claim for another insured*

Insurers often overlook the rule of insurance contract construction that its own conduct in connection with claims for

other insureds can give meaning to its policy. If an insurer takes a particular position that you know is contrary to a position that it has taken on a similar claim by another insured, such conduct can be used to argue that the language should be interpreted in the same manner for your claim.

In other words, insurers cannot provide coverage for one insured under a form of policy, but deny coverage for another insured under the same form of policy for the same type of claim (unless, of course, the law applicable to the two policies at issue is different). This is a very 'hot' issue in the US right now, and there are several court decisions in favour of a policyholder's right to 'other insured' information from its insurers.



If dispute resolution means other than litigation simply do not work, the insured still might be able to avoid costly, drawn out litigation.

* 5. *Litigation is the final, not the first option.*

It must be emphasised that many times, an insurer's declination of coverage based on erroneous or debatable positions can be overcome without having to resort to costly litigation. Indeed, cost-effective, non-litigation dispute resolution techniques are available in the US and do result in overcoming carrier declinations.

Often, the carrier is merely bluffing or does not know the law. In such situations, a letter clearly and concisely setting forth the reasons why the insurer's declination is wrong is all that is needed to overcome a declination. If just a letter does not do, many times meetings to discuss the insured's coverage position set forth in any coverage position letter(s) will work to overcome a carrier declination. If something more is needed, there still are alternatives to litigation. The insured can suggest that the coverage dispute be resolved by mediation or binding arbitration. .

If dispute resolution means other than litigation simply do not work, the insured still might be able to avoid costly, drawn out litigation. The insured might be able to institute quick, cost-effective litigation by filing a lawsuit and immediately thereafter filing a motion for summary judgment on the key coverage question(s) in dispute.

If the insured wins the motion for summary judgment, then the carrier may be more willing to settle the coverage dispute on terms favourable for the insured. 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' litigation in US courts. The insured should always keep these dispute resolution techniques in mind when deciding whether, and how, it will try to overcome a declination of coverage.

* 6. *Coverage counsel can be used 'behind the scenes'.*

In line with the notion that litigation is the final, not the first, option, is the tactic of using coverage counsel 'behind the scenes'. If the risk manager does not want to take the time, or cannot take the time, to conduct the necessary analysis of coverage issues, review of carrier correspondence and/or drafting of responses to carriers, the risk manager can always retain good coverage counsel to do the work.

Such coverage counsel can work 'behind the scenes' by 'ghost writing' letters for the risk manager to sign on company letterhead, leaving out citation to cases and merely setting forth the arguments for why coverage is afforded for the claim. In other words, the carrier never needs to know that the risk manager has retained coverage counsel. The author has spent much of the last seven years playing such 'behind the scenes' roles for a variety of different types of clients. This method can, and often does, work to overcome claim denials.

Concluding remarks

Policyholders pay valuable premium dollars for insurance policies in order to protect their assets, yet often fail to take full, if any, advantage of the coverage afforded by such policies. Insurers -on all lines of property and liability insurance - often take erroneous or debatable positions to deny all or part of a claim that quite simply are not challenged by risk managers.

Risk managers must learn to identify and challenge debatable or erroneous positions taken by their insurance carriers when they deny coverage for all or part of a claim. Otherwise, the risk manager's company might find itself in the unenviable position of giving valuable premium dollars for its insurance policies, but taking pennies on the dollar for its insurance claims. ■