Nine Lessons for Litigators on Insurance Recovery

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Summary

- When your client faces a calamity, one of the first thoughts should be insurance.
- The lessons in this article apply whether the client is a multinational company or an individual facing health issues.
- Policyholders, and their lawyers, should resist taking an insurer's "no" on coverage as the final answer.

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Most people, even most lawyers, consider insurance a mystery. How many of us, when we receive an insurance policy, pick it up by one corner and quickly drop it in a file, hoping never to need to review it? In my experience, you are not alone! However, unlike death and taxes, losses are unpredictable. Storms, fire, product defects, cyber breaches, government investigations, unexpected health events, accidents, and claims of all kinds arise unexpectedly—and are the reason we and our clients all buy insurance.

When your client faces a calamity, one of the first thoughts should be insurance. Insurance is an important source of recovery and can provide resources crucial to help mitigate a loss. Those resources can include not only monetary recovery but also practical advice that insurers, when cooperative, can provide. More often than not, claims and lawsuits settle, and the most significant coverage for your client facing a third-party claim may be coverage for defense costs, including attorney fees and expenses.

I offer nine lessons learned from decades of litigating to overturn coverage denials and enforce insurance coverage and advising clients on our shores and abroad about claims big and small. These lessons are universal; they apply whether a multinational company faces thousands of claims totaling hundreds of millions of dollars, a small business faces a bet-the-company situation, or an individual faces life-and-death health issues or has lost a home and a lifetime of memories to a wildfire.

Lesson One: Go to the Source—the Insurance Policy

Find all potentially relevant insurance policies. Coverage under most liability insurance policies is triggered by injury or damage that takes place during the policy period. When damage or injury is alleged to have taken place over several years, insurance policies that expired long ago may apply.

My experience is that clients often have saved the documents that they want to use to defend liability—and tossed their insurance policies. Advise clients to retain their insurance policies (certainly their liability insurance policies) indefinitely.

If your client did not have the benefit of or follow your proactive advice, then your search is on. As if on a quest for valuable antiquities, you embark on insurance archaeology. Look through stored files. Talk to insurance brokers who may have sold the coverage. Evidence of insurance may be found in all kinds of old files not specifically categorized as insurance policies, including government filings, attachments to contracts, and many other places. All should be searched.

Many of my cases have involved a “big dig” for coverage for such long-tail claims alleging injury or damage from asbestos, plumbing systems, and other building products, or

environmental contamination from past operations. Donning our archaeologist hats, we found millions, even hundreds of millions, of dollars in old coverage. It can be worth wiping off the dust in a warehouse if an insurance policy or secondary evidence of coverage surfaces.

In the search for all available insurance policies, remember "other people's insurance." Companies and individuals both often have insurance not just under insurance policies that they have purchased but also under those purchased by business partners or others involved in the loss. Accessing "other people's insurance" increases the total amount of insurance potentially available and also can protect the limits of your client's own insurance, preserving it for the client's own liability for claims and defense costs.

Lesson Two: Read Every Word

Each policy should be read as a whole. The whole is greater than the parts in an insurance policy. One provision should not be divorced, or taken out of context, from all the others. Key terms in insurance policies, particularly in commercial insurance policies for big companies and organizations, are often found in endorsements. Many insurance policies contain voluminous endorsements that virtually rewrite the entire contract. It is crucial in analyzing any insurance policy to read the entire contract, including all endorsements, carefully. Sometimes what the standard form of the insurance policy promises, the endorsements add to—or take away.

I recently was reviewing the insurance program for an online health-services billing company. The company had grown from a one-person shop into a $20 million company, now doing all of its business online. It was a classic services company. However, the policyholder's insurance policy contained not one, not two, but three professional services exclusions, all added by endorsement. No one at the insurer or the insurance broker had pointed this out to the insured. While the endorsements did not define "professional service," a commonsense interpretation could effectively nullify the coverage this services company had sought in buying the policy. While the policyholder would have an argument to void the exclusions (that the coverage allegedly promised was otherwise illusory), why buy a policy that sets up such a coverage dispute? These increasingly ubiquitous exclusions are often added by endorsement and not included in the standard-form policy contract. This situation points out the importance of reviewing insurance policies carefully upon receipt to ensure they reflect the coverage bought and paid for, rather than tossing them unread into that file in hopes they will never be needed.

Lesson Three: With Notice, More Is More

Policyholders need to give notice early and often, as claims proceed. It is important to give notice of a claim as soon as it arises. Policyholders should give notice of demands that have not yet ripened into lawsuits. Later, if a lawsuit is filed, the policyholder should promptly give notice of the lawsuit, too.

Read the notice provision, which is usually in the Conditions section and supplemented by information in the Policy Declarations. Follow the terms to the letter. Who uses faxes today? Insurers, for one. If the notice provision says to give notice by fax, then send the notice by fax (perhaps supplemented by more modern forms of communication). Send notice to the broker or agent, too. Confirm all oral communications in writing, and keep the writings safely stored. Notice can be a condition precedent to coverage. In some kinds of policies, notice is the event that triggers coverage. No trigger, no coverage.

Some policyholders fear giving notice: "What if the insurer raises our premiums?" A claim can always be withdrawn. Policyholders buy insurance to protect assets and to pay claims when they arise. It should not be a one-way transaction.

Insurance is matter of state law, and some states still follow the antiquated rule that a failure to give immediate notice can let the insurer off the hook entirely. Even in states with more liberal notice laws, a cynical insurer faced with a loss in seven, eight, or larger figures can use any perceived delay in giving notice of a claim as an excuse to deny coverage and thus prevent, or at least delay, payment. In insurance, as in life, time is money, and delay in payment of defense costs and valid claims can be problematic for you and your client.

Commercial insurance programs typically involve many layers of excess coverage above the primary, or first-layer, policy. Even in states following the antiquated rule (yes, Virginia, we mean you), notice to the excess insurers is not required until the policyholder's liability threatens to exhaust underlying coverage. Err on the side of caution as to when that threat of exhaustion occurs. Again, give notice, and let the insurer say "no" or "not yet."

Lesson Four: Secure the Duty to Defend

This may be the most important lesson for litigators. The defense costs you protect may be your own legal fees! The general rule, accepted across the board, is that the duty to defend is broader than the duty to indemnify.

Typically, liability insurance policies explicitly impose a duty to defend, an obligation that provides an important form of "litigation insurance." The duty attaches at the moment a claim is made and continues until resolution of the claim through all appeals or a declaratory judgment rejecting coverage. Even when a liability policy does not explicitly

impose a duty to defend, an argument can be made that a promise to pay for defense costs is subject to the same legal standard that governs the duty to defend. The *Restatement of the Law: Liability Insurance* supports this rule.

The legal standard on the applicability of the duty to defend is very broad. Under the almost universally accepted rule, the duty to defend applies if there is any conceivable basis for coverage under the policy. The existence of a duty to defend is determined by comparing two documents: the insurance policy and the complaint or claim against the insured. The law does not allow coverage denials based on facts outside the "eight corners" of those two documents. As the *Restatement of Liability Insurance* says, if extrinsic facts are considered in determining whether the duty to defend applies, it is a "one-way rule": Extrinsic facts are considered only to support coverage, not to deny it.

Likewise, fact-based defenses to coverage should not preclude the duty to defend. Those facts, unless they support an open-and-shut case appropriate for summary judgment, are reserved for trial on the insurer's duty to indemnify. Even a successful fact-based defense to liability coverage does not preclude the duty to defend from attaching from the get-go and extending throughout the proceedings on the liability of the insured.

If an insurer refuses to honor its duty to defend, consider carefully whether to bring a declaratory judgment action and an early motion for summary judgment. Given the breadth of the standard for the duty to defend, this should be a relatively easy motion to win. Because insurers have the burden to prove the applicability of exclusionary provisions, genuine issues of material fact should prevent a ruling against the policyholder on an insurer's cross-motion for summary judgment.

If the coverage litigation proceeds to a jury trial, remember to play to the audience. As analyses by jury consultants typically show, most jurors view insurers with great suspicion. Jurors relate to the individual or company faced with a disputed claim, regardless of size of the policyholder. The policyholder's case theme should focus on insurance. The insurer will try to divert the attention to the policyholder's conduct, but keeping the focus on insurance helps secure recovery.

Lesson Five: Stay in Touch

Once the duty to defend is secured and defense of the claim is under way, it is important to stay in touch with all insurers. Respond promptly to all communications received from the insurer. Insurers are obligated to respond timely to notices of claim. They often send what they call "reservations of rights," staking out the reasons they might not pay out on the claim. What is not to like about a 12-page, single-spaced letter overflowing with quotations of policy provision after policy provision? These letters can be daunting.

Respond to all of them. If the substance is overwhelming or completely off-base, at a minimum, respond to say, “We do not agree with your position.” Leave no room for argument that your client somehow agreed with the insurer’s position. Do not worry about offending the insurer. Insurers are in the litigation business and surely have heard worse.

Send defense bills promptly, and demand payment. “Demand,” in the insurance-coverage context, can be a magic word. Litigation can be expensive. Insurers sometimes make the absurd argument that lawyer rates from 20 or more years ago or in some far-off jurisdiction or from an irrelevant practice area should apply in your client’s case. A rule of reason should apply instead. That means that the going rate for defending your particular kind of claim in your particular jurisdiction should govern decisions about what constitutes “reasonable” defense costs. Submit your defense costs as soon as possible, and be prepared to justify their reasonableness.

Send regular updates on the status of the underlying litigation. Your client need not waive privilege in these communications. The report should be a straightforward discussion of the status of the claim or suit that would cause no qualms if shared with the judge or opposing counsel. Unless the insurer has affirmatively accepted the policyholder’s defense without any reservation of rights, the insurer is not part of the privileged attorney-client-insurer relationship that in many states is called the “tripartite relationship” for privilege analysis.

Failure to keep an insurer apprised generally of the status of a claim, even an insurer that has rejected the duty to defend, can lead to an argument that the insured has violated its “duty to cooperate” with the insurer. This duty is not a one-way street. If the insurer has rejected coverage, that breach of contract should prevent an insurer from relying on any defense that arises out of the contract. Nonetheless, this is one defense that is easy to avoid. For that reason, provide regular updates of the status of the claim. Keep a written record of all such communications.

Lesson Six: Remember the Statute of Limitations

An insurance policy is a contract, so a cause of action for breach arises at the time of the breach. In the insurance context, the cause of action for breach accrues when the insurer denies coverage. A reservation of rights is not considered a denial of coverage. Because a reservation of rights does not breach the contract, it does not cause the claim for breach of contract to accrue or the statute of limitations to begin to run. If there is any doubt about whether the insurer’s communication is a coverage denial, and thus a breach, or a reservation of rights, it is safest to assume that the time bar clock started to tick at the time of the ambiguous communication from the insurer.

Also check the insurance policies to see whether they include other timing provisions that may cause a limitations period to begin to run. Such provisions are common in property insurance policies. Courts have typically found that "suit limitation provisions" that identify a time period in which suit must be brought (often found in the policy conditions) function as contractual statutes of limitation. These periods can be extended by written agreement with the insurer, but they warrant close monitoring.

Lesson Seven: Don't Take "No" for an Answer

Insurance companies win by saying no. As I like to say, if you take "no" for an answer, then the answer is no. I have observed that as many as half of policyholders and insureds with legitimate claims decline to fight even an obviously wrong denial of coverage. Insurers, who are in the business of litigation and negotiation, understand and count on this trait of human nature.

Closely tied is fighting the "three-digit exclusion." I learned early in my career that an insurance claim with a $1,000 price tag is likely to get paid while the same kind of claim costing $1,000,000 requires a fight. Those extra digits operate as a practical, if noncontractual, form of exclusion. Claims in the high seven or eight digits, or involving long-term health care or disability payments, can bring in legions of lawyers to deny coverage at the very moment the insured needs those "good hands" or that "piece of the rock" the most. The Delaware Supreme Court has explained it this way: "Insurance is different. Once an insured files a claim, the insurer has a strong incentive to conserve its financial resources balanced against the effect on its reputation of a 'hard-ball' approach." *E.I. duPont de Nemours & Co. v. Pressley*, 679 A.2d 436, 447 (Del. 1996).

Lesson Eight: Remember the Burdens of Proof

After the policyholder meets its burden to show a prima facie case for coverage, the burden then shifts to the insurer to show the applicability of any provision with an exclusionary effect. Exclusionary effect, not placement in the insurance policy, governs. Defenses to coverage often involve disputed facts. Insurers have the burden to prove that those facts, combined with a reasonable reading of applicable policy provisions, preclude coverage. Any ambiguity—a favorite policyholder argument—favors coverage for the insured.

Lesson Nine: Get a Trial Date and Seek Mediation

Insurers want to avoid juries at all costs. This is in part why insurers in commercial insurance policies like to include mandatory arbitration clauses for coverage disputes, finding arbitration to be more insurer friendly. When a trial date is set and, even better, looming, insurers often come to the table, ready to pay money to settle the underlying claim. Pursuit of early settlement or mediation can be a winner, pleasing not only your client but courts and even opponents as well. Early mediation in an appropriate case can help resolve the claim and coverage dispute in as timely a fashion as possible.

In applying all of these lessons, it is important to remember the golden rule in insurance coverage: The purpose of insurance is to insure. An insurance policy is the prototypical boilerplate contract. Insurance is a state law matter, which can vary on important issues from state to state. Almost all states, however, construe ambiguities in boilerplate contract terms against the drafter—the insurance company. Policyholders, and their lawyers, should resist taking an insurer's "no" on coverage as the final answer.

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