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Beware of an Insurer's Reservation of Rights

By Finley T. Harckham

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Insurance companies have no contractual entitlement to reserve their rights when presented with a coverage claim. Nonetheless, the reservation of rights has become an accepted practice in order to shield the insurer from liability resulting from the need to investigate a claim. Reservations of rights are frequently used improperly, though, as a sword to pressure policyholders into accepting less than full coverage and to delay the resolution of claims. They are also improperly used as a shield to protect the insurer from its bad faith claims handling tactics. To limit the effectiveness of such misconduct, policyholders must be alert to the insurance company's tactics, and prepared to respond quickly and forcefully. What the policyholder can do varies depending upon the circumstances surrounding the reservation of rights. This article addresses some common scenarios in which this problem arises.

Non-Payment on First Party Losses

In the context of a first party property or business income loss, where litigation defense is not at issue and there is no adversary suing the policyholder who can dictate the pace of events, the insurer will likely employ the most fundamental of coverage defeating tactics: the big stall. This game consists primarily of making seemingly endless requests for information that are calculated to keep the supposed investigation of the claim alive for as long as possible. For a while the policyholder likely will try to comply with the requests. Eventually, however, this tactic will frustrate the policyholder to such an extent that it cries, "Enough! I won't give you any more!" This rewards the claims handler with precisely the cover that he or she wants to be able to do nothing further and then argue that the policyholder is to blame for the fact that the claim is two years old and has not been paid. This crude but rather effective technique is often combined with the "disappearing claims handler" gambit, in which the file is passed from one claims handler to another time and time again. Each time the file is passed the new handler can delay the claim adjustment process by professing a need to get up to speed, and can then retread the same ground as all of his or her predecessors, and perhaps even come up with new requests for information or arguments against coverage.

Defeating the big stall and the disappearing claims handler gambit requires patience, perseverance and attitude. Patience is needed because although the information requests may be unreasonable and satisfying them would be a drain upon precious resources, the policyholder is obligated to cooperate with its insurer, and if the claim ever ends up in court a judge may be sympathetic to the insurance company's argument that it does not have to pay a claim simply on faith. So, it is best to comply with information requests unless to do so would both be truly burdensome and clearly serve no valid purpose. If the insurer is looking for relevant information in an unreasonable way, it is far better to provide what is requested in a manner that is less burdensome than to refuse the request outright. Perseverance is needed because the most effective way to bring delaying tactics to an end is to document each and every development in the claims handling process, and to present that written record to the claims handler in confirmatory — or accusatory — letters. Such a letter writing campaign sends a message to the claims handler that a record is

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INDUSTRY NEWS

Update: Terrorist Insurance Act

On November 26, 2002, President George W. Bush signed into law the Terrorist Risk Insurance Act, 116 Stat. 2322 (the "Terrorist Act" or "Act").

The Terrorist Act provided for reinsurance to commercial lines property and casualty insurance companies, including captive insurance companies who write direct premiums and provide for improved availability of affordable insurance for losses arising out of "certified" terrorist acts.

The Terrorist Act is due to expire on December 31, 2005. However, on November 16, 2005, the Financial Services Committee of the House of Representatives passed a version of the 2002 Terrorist Act that is now entitled the Terrorism Risk Insurance Revision Act of 2005 ("Revised Act").

There are several differences between the 2002 Act and the Revised Act, including:

» Increase of deductibles;
» Significant increases in the amount of insured losses that would trigger the Act; and
» Mandatory reimbursement to the Treasury over time to protect the taxpayers.

The Bush administration has stated that it opposes the Revised Act. Policyholders must be aware of this changing coverage. Policyholders should carefully monitor the developments with regard to the Revised Act and how it may impact their coverages.

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being made that can be used against the insurer if necessary in later court proceedings. This will cause some claims handlers to moderate their behavior, either out of concern that their improper tactics are being documented, or simply because they do not want the headache of having to respond to numerous letters. Those who continue to behave improperly put their insurance companies at risk of a bad faith judgment. Defeating insurance company stalling tactics requires attitude because many policyholders fear that if they antagonize the insurance company, they will only make a bad situation worse. When this kind of reasoning surfaces, consider what the policy of appeasement did for Chamberlain.

No Coverage Decision on Liability Claims

Frequently, when presented with a request to defend the policyholder in a lawsuit, the insurer will appoint counsel while reserving its rights to later deny coverage. This is, of course, an appropriate response when the policyholder needs immediate representation and there is a reasonable basis for the insurer to believe that an investigation of the facts surrounding the claim could give rise to coverage issues. However, often the insurer will reserve its rights but never make a coverage determination before a case is resolved. Faced with this situation, the policyholder might be inclined to do nothing, not wanting to "rock the boat" as long as the insurer is paying the defense costs. That can be a big mistake.

If the insurer's reservation is based upon the need to investigate, that should be accomplished quickly. However, the insurer may deliberately never conclude its investigation so that it can hold the threat of a coverage denial over the head of the policyholder, and use that as leverage to secure a discount off of its payment obligation at the time the lawsuit is settled. To avoid that predicament, the policyholder should aggressively seek a coverage determination and make a record of the insurer's refusals. In this situation the policyholder may also be able to put considerable pressure upon the insurer if a settlement with the underlying plaintiff can be reached within the coverage limits. The insurer's refusal to accept coverage and pay such a settlement will, in some circumstances, subject it to the possibility of having to pay all of a subsequent judgment even in excess of the policy limits.

If, on the other hand, the reservation is based upon the possibility that the proof at trial could bring the claim within or outside coverage, a conflict of interest exists between the insurer and the policyholder. That conflict creates an incentive for the insurer and the defense counsel it is paying to steer a case to an outcome that supports a denial of coverage. For example, if negligent conduct

Q WHO SAID WHAT?

"The immediate purpose of the reservation of rights is to allow the insurer to provide the insured with a defense against non-covered and frivolous claims without jeopardizing the defenses to coverage. In addition, the reservation of rights acts as notice to the insured of a potential conflict of interest between the insurer and the insured during the investigation, settlement and trial of the underlying lawsuit."

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is covered but willful misconduct is not, the insurance company would benefit from a ruling that the policyholder committed an intentional wrong. Such a conflict may entitle the policyholder to separate representation paid for by the insurance company. The policyholder should explore this issue at the beginning of the insurance company's involvement with the case so it can get the assistance of its own counsel as early as possible.

Also, insurance companies often seek to reserve their right to recoup the attorneys fees they incur in defense of the policyholder if it turns out the claim is not covered. Policyholders should be wary of agreeing to such a reservation. While some policies specifically reserve this right, if it is not provided for contractually, some states will not allow reimbursement absent a separate agreement of the parties. The insurance company has no right to force such an agreement upon the policyholder, and any insistence upon it as a condition of accepting the defense obligation may constitute bad faith.

Conclusion

There is an old joke about a pig wrestling in the mud with a claims adjuster and realizing that the adjuster likes it. Few policyholders relish the thought of wrestling in the mud with a claims handler, but that is what they must be prepared to do in order to get a fair recovery on their insurance claims. Unfortunately, a reservation of rights letter might just be the bell for the first round.

Finley T. Harckham is a senior stockholder in the law firm of Anderson Kill & Olick, P.C. Mr. Harckham regularly represents and advises corporate policyholders in insurance coverage matters and has successfully litigated, arbitrated and settled hundreds of complex coverage claims. Mr. Harckham's areas of particular expertise include property loss, business interruption, director & officers liability, and general liability claims. Mr. Harckham can be reached at (212) 278-1543 and fharckham@andersonkill.com.

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American Insurance Association and **National Association of Independent Insurers** Brief of AMICI CURIAE American Insurance Association and the National Association of Independent Insurers, dated Jan. 18, 1994 at 10, *Meridian Oil Production Inc. v. Hartford Accident and Indemnity Co.*, No. 93-7463 (5th Cir.).

RECENT DEVELOPMENTS

Refusal to Settle for Policy Limits was Bad Faith. *Princeton Ins. Co. v. Qureshi, M.D.* A New Jersey Appeals Court has ruled that Princeton Ins. Co. ("Princeton") acted in bad faith when it refused to settle a claim against a corporation for policy limits, rendering it liable for $5.4 million medical malpractice judgment.

In 2001, Sherrance Henderson ("Henderson") sued Shams Qureshi, M.D. ("Qureshi") and his two wholly owned corporations, Spine Orthopedic and Sports Rehabilitation Center ("Spine Orthopedic") and Pain Center of North Jersey ("Pain Center"), for injuries she sustained when Qureshi injected a solution into her spinal cord. As a result, Henderson is totally disabled. Her economic loss is $2.7 million with an additional $1.5 million in future medical expenses. Qureshi and his two corporations were insured under a single policy issued by Princeton. After Henderson filed suit, Princeton offered a defense to each of the three policyholders without any reservation of rights.

In settlement talks, however, Princeton favored Qureshi over the interests of the two corporations. A jury rendered a verdict against Qureshi in the amount of $5.4 million, plus pre- and post-judgment interest. Princeton tendered payment of $1 million to Henderson on behalf of Qureshi and filed a declaratory judgment in Essex County Superior Court to establish the absence of applicable coverage for the Pain Center and Spine Orthopedic. Henderson counterclaimed, alleging that Princeton had acted in bad faith when it failed to settle the underlying action within policy limits for all three defendants. The Superior Court granted Summary Judgment to Henderson. Princeton appealed, arguing that when the assets of an

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individual and his two wholly owned corporations are involved, the interests of the corporations can be subordinated to that of the individual. The New Jersey Superior Court Appellate Division disagreed, stressing that $1 million policy limit applied to each policyholder. The Appeals Court concluded that Princeton acted in bad faith regarding Henderson's settlement demand to the corporate entities, and that it was improper to assign a single defense counsel to represent the interests of multiple policyholders with conflicting interests.

—Claudia Ilie

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John B. Berringer (jberringer@andersonkill.com) Real Estate and Construction Industry Group, (973) 642-5133;
John N. Ellison (jellison@andersonkill.com) Petroleum and Chemicals Industry Group, (215) 568-4710;
Mark Garbowski (mgarbowski@andersonkill.com) Editor-in-Chief, (212) 278-1169;
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Finley T. Harckham (fharckham@andersonkill.com) International Editor, (212) 278-1543;
Claudia Ilie (cilie@andersonkill.com) Legal Researcher, (212) 278-1024;
Richard P. Lewis (rlewis@andersonkill.com) Pharmaceuticals and Healthcare Industry Group, (212) 278-1822;
Richard Mansfield (rmansfield@publishingresources.com) Publisher, (856) 380-0760;
William G. Passannante (wpassannante@andersonkill.com) Petroleum and Chemicals Industry Group, (212) 278-1328.

Anderson Kill & Olick, P.C.
1251 Avenue of the Americas
New York, NY 10020