

US insurance coverage litigation: tips for claims adjusters

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When litigation ensues in the United States between an insurer and its insured, claims adjusters in the UK should understand the intricacies of the U.S. legal system in order to make informed decisions. Otherwise U.S. coverage counsel may dictate strategy and outcome with little or no input from its client insurer. Money will be saved when the adjuster better understands the issues and strategies and can provide input to, and challenge when necessary, counsel's recommendations.

This article introduces several concepts in U.S. litigation, and coverage litigation in particular, which will help enable adjusters from abroad to better understand and add value to the litigation process.

I. Jurisdiction, Judges, and Choice of Law

A. Jurisdiction: Where to Sue and Be Sued

When an insurer or insured commences litigation to determine policy coverage, the filing party may choose between two court systems: state court or federal court. Each of the 50 states has its own court system, consisting of trial courts, appellate courts, and a state supreme court. The losing party in trial court has a right to appeal to the state appellate court. The loser in the appellate court may appeal to the state supreme court, but that court has discretion whether to entertain the appeal.

Federal court is a single jurisdiction, with a similar three-tiered system of trial courts, appellate courts, and a supreme court. There are trial courts located in each of the 50 states, and the loser at the trial court has a right of appeal to one of twelve federal circuit courts of appeal. The federal circuit courts are divided by states, with each circuit court responsible for hearing appeals from trial courts in specific states. For example, the Second Circuit Court of Appeals hears appeals from decisions originating from federal courts located in Connecticut, New York, and Vermont. As with the state courts, the loser at a federal appellate court may appeal to the U.S. Supreme Court, but again, the Court has discretion whether to entertain the appeal.

The role of state courts is twofold: (1) to resolve controversies regarding interpretation of laws passed by the state legislature, and (2) to resolve controversies arising from common law. Common law is derived from the English legal system, where decisions of courts in past cases with particular facts become precedential and are binding on later cases where similar facts arise. Contract interpretation, and thus insurance-policy interpretation, is a matter of common law. When a state court decides a case involving the interpretation of a policy term, therefore, that decision will have precedential effect when a court from the same state later interprets the term.

Federal courts resolve controversies regarding interpretation of laws passed by U.S. Congress, but there is no federal common law. When an issue such as interpretation of an insurance policy arises, federal courts apply state law.

B. Diversity Jurisdiction and Removal

Yet federal courts only have jurisdiction to hear cases arising from state law when they have “diversity jurisdiction”. There must be over US\$75,000 in controversy, and all of the plaintiffs in the case must be citizens of different states (domestic or foreign) than all of the defendants.¹ A party’s citizenship is determined by the state in which the party is located. A corporation is often a citizen of two states: the state in which it is incorporated and the state in which its main offices are located.

Diversity jurisdiction was borne out of the notion that a state court might favour parties from its own state over parties from other states. Federal courts are considered impartial with respect to deciding cases between citizens of different states.

If an insured sues its insurer in a state court, the insurer may still remove the case to federal court. To do so, the insurer must demonstrate that complete diversity exists between the plaintiffs and defendants and there is more than US\$75,000 in controversy.² If these requirements are met, the federal court sitting in the same state as the original action must accept jurisdiction over the case. The defendant must remove the case to federal court within 30 days of being served with the complaint.

C. Choosing Between State and Federal Court

When diversity jurisdiction is met, it is generally preferable for an insurance company to litigate in a federal court rather than a state court. Politics play a role in the analysis. State judges are normally elected officials. If a judge is running for reelection, it may be more popular for the judge to favour insureds rather than big corporate insurance companies. Generally speaking, the voting public probably does not like a judge who favours insurance companies when the voters, themselves, are insureds with respect to home, car, and health insurance. In contrast, although federal judges are nominated by the sitting president, who likely has political motives when appointing judges, once the judge is confirmed by the U.S. Senate, he or she has a lifetime appointment and should no longer be susceptible to political influence.

In addition, federal judges often must go through a more rigorous selection process to be nominated and confirmed. Federal judges are thus often very accomplished in the legal profession and may have a better understanding of insurance coverage. Generally, state judges may have little or no experience with insurance and may be more susceptible to favouring the perceived weaker party: the insured.

Unlike judges, insurers should not consider juries when choosing between state and federal court. Jurors are selected from similar citizen pools, and in both courts, the procedures and functions of the jury are by and large the same.

A judge will be assigned to a case and its ultimate trial at the start of proceedings, in contrast to the normal procedure in, for instance, the London Commercial Court. It is therefore appropriate for a claims adjuster to ask its U.S. counsel to research the judge with respect to possible political ties, careers in law before becoming a judge, and resolutions of other insurance-coverage cases. These may help predict how the judge might decide the case, and whether it might be better for the insurer to settle rather than to litigate.

D. Choice of Law

The next question is which state's law applies. Insurance-contract interpretation is always decided under state law (whether in state or federal court), and simply because the case is located in a particular state does not mean that same state's law applies.

A choice-of-law analysis is appropriate when there are two states closely connected with the dispute, and the laws of the states conflict as to a relevant legal issue. An example is where an insured is located in one state but suffers a loss in another state. Both states have ties to the controversy but only the law of one state may apply.

Some insurance contracts contain a so-called forum-selection clause, which dictates which state's law will apply. On the one hand, these clauses create predictability and will save the expense of litigating choice of law. On the other hand, forum-selection clauses are inflexible. When there is a dispute over a policy term, the insurer is bound by what a particular state has decided, no matter how unfavourable, without the opportunity to argue for another state's law.

Absent a forum-selection clause, parties may litigate about which state's law should apply. States have adopted one of two tests to determine choice of law. The first is called the section 188 Restatement of Contracts test, developed by a legal institute.³ The Restatement test compares the relative weight of the following factors: (1) the place of contracting; (2) the place of negotiation of the contract; (3) the place of performance of the contract; (4) the location of the subject matter of the contract; and (5) the location of the parties to the contract.⁴ Of these, most courts have said the fourth factor is the most important – the place of performance. But this does not mean that the state where the loss occurred necessarily prevails. Rather, this is a prospective test, examined at the time when the policy incepted.

The court should therefore examine where the insurer and insured could most reasonably expect a loss to occur at the time of contracting. For example, if the insured owns ten sites, eight in New York and two in California, the insurer should have the benefit of New York law, even if the loss at issue occurred in California. The Restatement test is thus a fairly objective test, with the results of the analysis being fairly certain based on the facts underlying the creation of the insurance policy.

The other test that courts have adopted is called the Leflar choice-influencing factors. A law professor argued for the application of this test in a law review article,⁵ and many states

have since adopted it as law. It examines the following factors: (1) predictability of results; (2) maintenance of interstate order; (3) simplification of the judicial task; (4) advancement of the forum state's governmental interest; and (5) application of the better rule of law.⁶ This test is not focused on contract interpretation but instead can apply to a dispute about any area of law. The factors are very subjective. For example, with respect to the fourth factor, the insurer can argue that the forum state should have an interest in upholding the plain meaning of contracts so that neither party receives more than for what they bargained, while the insured can argue that the state has an interest in ensuring that policyholders are compensated fully for their losses. Thus, application of the test is largely in the discretion of the judge, making the results very unpredictable.

While choice of law may be mundane, cases can, and often are, won or lost at this stage. Interpretation of policy terms may vary greatly from state to state, and if the selected state's law is unfavourable to the insurer, it may make litigation practically useless.

II. Dispositive Motion Practice

Now that the court and judge are final and the applicable state's law is determined, the goal of the insurer should generally be to end the case as quickly and inexpensively as possible. The best two methods for achieving this are through settlement and motion practice. The approach to settlement in the US is very similar to that in the UK.

Dispositive motions are motions that resolve the case without the need for trial. There is, of course, an equivalent procedure in England and Wales. These motions are appropriate when there are no facts in dispute and the court can decide the case as a matter of law. Juries are only necessary to decide factual disputes between the parties.

The most common dispositive motion is a motion for summary judgment. The insurer may submit a motion, demonstrating that the facts necessary to decide the case are not in dispute, and the law favours the insurer's interpretation. For example, when an insured is sued by a third-party claimant and seeks a defence and indemnity from its insurer, in many states, the insurer's duty to defend is determined solely by a comparison of the complaint in the underlying action with the terms of the insurance policy. When litigating the duty to defend, these two exhibits will normally not be in dispute, and the insurer can thus bring an early motion to determine its duties.

But what if there are several potential coverage defences, some requiring discovery, including document production and depositions, and others that do not? Discovery in U.S. litigation can be very expensive, and win or lose, parties generally pay their own attorneys' fees. Thus, depending on the strength of the defences that do not require discovery, it is best to bring an early motion and delay discovery. If unsuccessful, the parties can then proceed to discovery.

Furthermore, judges are often amenable to delaying discovery if the insurer proposes to bring an early motion for which discovery is not required. Many judges are weary of the

time commitment and expense of the discovery process and are happy to oblige early motion practice by entering an order staying discovery until the motion is decided. Adjusters should raise with counsel the option of an early dispositive motion as a means to ending the litigation efficiently and inexpensively.

III. The Insured's Arguments in Coverage Litigation

An insurer most often succeeds in coverage litigation by focusing on the policy terms. But the insured has a variety of arguments that often belittle the substance of the insurance policy, focusing instead on the insurer's conduct and general fairness. These arguments are often smoke and mirrors and can easily be defeated.

A. Bad Faith

The concept of insurer bad faith has gained a strong foothold in the United States. While there is no policy term stating that an insurer must act in good faith, many courts and some state legislatures have implied a covenant of good faith and fair dealing in every insurance contract. The consequences of acting in bad faith are exposure to tort liability, thus extending liability beyond the contractual policy limits, as well as negative publicity.

Every state has vastly different law and rules concerning the type of bad-faith claims that can be brought, the insured's burden of proof, and the remedies available. Some states do not even have bad faith, and others only have the action in limited contexts. Coverage counsel should determine if the insured even has a right to assert the type of bad-faith action appearing in its complaint; if not, a motion to dismiss can quickly strike the claim from the litigation.

Assuming the bad-faith claim is recognized under applicable state law, the insured's burden of proof is almost always exceedingly high. For example, where an insurer denies a claim, the insured must often prove that no *reasonable* insurer would have denied the claim under similar circumstances. In other words, it is not bad faith if a court decides the insurer's coverage denial was wrong, but bad faith only applies if there was no reasonable argument for the denial.

With the high standards for proving bad faith in mind, prevention is fairly intuitive. From a claims-handling perspective, adjusters should save and maintain all correspondence on a claim. If electronic discovery reveals that the adjuster has deleted emails concerning the claim, it creates an appearance of impropriety, no matter how benign the content of the deleted emails. The insurer should also promptly respond to and give due investigation to all insurance claims, no matter how meritless. Furthermore, if the insured chooses to challenge coverage through written correspondence, respond promptly and politely, no matter how irritating the insured becomes—insurance companies, too, should practice the golden rule, if not out of kindness, to avoid undue financial exposure.

Preventing bad faith from a coverage perspective is equally intuitive. Whenever a coverage defence is asserted, have a reasonable, good-faith basis for asserting it. Advice of counsel

is helpful, but most importantly, the insurer must have a good-faith position based on applicable state law. Bad-faith prevention is simple, but it is imperative that the process begins from the day the claim is noticed, through its entire life.

B. Arguments Concerning Contractual Interpretation

In addition to bad-faith, insureds may also include one or more interpretative arguments, essentially complaining that the insurer's coverage position simply is not fair. The arguments effectively detract attention from what the policy terms actually say, focusing instead on their results. Like bad faith, these arguments are often easily defeated.

The first argument is that the policy term on which the insurer relies is ambiguous. In most states, to prove ambiguity, the insured must demonstrate that the term is susceptible to more than one reasonable interpretation. In other words, while the insurer applies the term to defeat coverage in this context, it is equally plausible that the insurer meant to have the term apply in another, inapplicable context.

Defeating the ambiguity argument begins with a concentration on the word "reasonable": is the other interpretation the insured suggests a reasonable one? Often it is not. The insurer may also argue that even if there are two reasonable interpretations for an exclusion, the context of the policy term demonstrates that it should apply more broadly than in just a single circumstance.

The insured may next argue that the insurer's policy interpretation violates the insured's reasonable expectations of coverage. The doctrine of reasonable expectations varies greatly from state to state but is generally premised on the notion that when the insured obtained insurance, it had a "reasonable expectation" that a certain type of loss would be covered. Again, one should focus on the applicable state's standard. Often reasonable expectations involves a broker's promise to the insured that it would obtain *full* coverage, but that is usually the broker's problem, not the insurer's.

The insured's third interpretive argument is the doctrine of illusory coverage. This is where the insured concedes that under the policy terms, coverage is barred, but if there is no coverage for a loss such as this, it appears that there is practically no coverage at all. One example is a pollution-liability exclusion in a policy for petrol stations. The insured could argue that a petrol station's foremost potential liability is petrol leaking onto other's property, and thus if the policy does not provide coverage for such leakage, then coverage is illusory.

While such arguments may have appeal at first blush, many states have not adopted the doctrine or only apply it in very limited contexts. This is based on the notion that an insurance policy is a contract, and the insured and its broker should have some understanding of the contract terms before entering into it. From a prevention perspective, so long as the insurer is not burying important policy terms in endorsements that essentially bar almost all coverage, an argument for illusory coverage should fail.

C. Waiver and Estoppel

Finally, an insured may argue that the insurer waived, or is estopped from asserting, a certain coverage defence. These concepts are distinct, although courts will often conflate and confuse the two.

Waiver is a party's intentional relinquishment of a known right.⁷ It is most often applicable in the insurance context when the insurer issues a coverage-position letter that includes some, but not all, of the insurer's known coverage defences. If the insurer later realizes it missed a defence, a court may not allow the insurer to raise it later in order to defeat coverage. This is premised on the notion that the insured has a right to know the insurer's position and may be relying on that position. But in the situation where the insurer does not have access to facts that give rise to a defence, an insurer's delay in raising the defence soon after it learns of it should not be subject to waiver.

Estoppel applies where (1) an insurer makes a representation of fact; (2) the insured relies on that representation; and (3) the insurer changes its position, causing prejudice to the insured.⁸ Estoppel often arises in the liability context when the insurer is providing a defence to the insured; the insured accepts the defence (reliance on the representation of coverage); and then the insurer realizes a coverage defence and withdraws defence counsel. The insured is prejudiced because it must now retain its own defence counsel, which is particularly troublesome if litigation has reached later stages.

Like bad faith, waiver and estoppel are easily prevented. Insurers must always issue thorough reservation-of-rights letters, including any and all possible coverage defences. This begins with detailed attention to both the claim submitted and the policy terms. Adjusters should not rely on coverage counsel to ascertain all possible defences. The adjuster is often more familiar with the policy terms, so before approving any coverage-position letter to the insured, the adjuster should read the entire policy to verify that no defences were missed. This can be a painstaking task but can save much time and money in the event a defence is omitted.

IV. Strategies for Appeal

As discussed, whether in state or federal court, a losing party at the trial court always has a right to appeal the adverse ruling to the applicable court of appeals. It is often worthwhile to appeal a trial court's adverse ruling, as appellate courts will not hesitate to reverse an incorrect ruling.

A factual determination made by a jury or a trial judge should rarely be appealed. The trial court's factual determination will only be overruled if under no circumstances could a rational finder of fact have decided how it did. Appeals on issues of facts are by and large losers. In contrast, insurers should focus on the legal issues when appealing. Unlike factual issues, appellate courts apply a *de novo* standard of review to legal issues.

As a final consideration, appeals are where precedent is formed. In state court, trial judges are bound by the rulings of their own state's appellate courts, but not other trial courts. In order for a ruling to be binding in later cases, insurers must win the issue on appeal.

The same is true in federal court. Federal trial courts are bound by their respective circuit-appellate courts' decisions. But federal courts apply state law to insurance contracts. Thus, a federal appellate decision will only be binding on a later federal trial court if the appellate court was interpreting the same state's law.

And decisions of federal appellate courts are not binding on state courts, even if the federal court was applying the same state's law. But if an insurer is in a state court, the insurer should always use a helpful federal appellate decision to support its argument. Even though the decision will not be binding on the state court, it can often persuade the state judge to follow the decision, based on the respect and prestige normally afforded to federal-appellate courts. Thus, if the insurer would like to make law based on the interpretation of a policy term, it is worthwhile to take the issue on appeal, where both binding and persuasive authority are formed.

V. Conclusion

Determining where to sue, which state's law should apply, whether to remove from state to federal court, when to settle, when to litigate, and when to take an issue on appeal can be daunting, especially for those unfamiliar with the intricacies of U.S. litigation. But claims adjusters from the UK and other areas abroad should not cede litigation strategy to U.S. coverage counsel. Adjusters should instead seek an understanding of U.S. law and courts in order to better collaborate with counsel's proposed strategies. This will put the insurer in the best position to dictate what is best for the company and ultimately position itself to save valuable time and money.

Endnotes

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¹ See 28 U.S.C. § 1332.

² See 28 U.S.C. § 1441.

³ The Restatement of Contracts was developed by the American Law Institute. For more information, see <http://ali.org>.

⁴ See, e.g., *Sybron Transition Corp. v. Sec. Ins. Co. of Hartford*, 107 F.3d 1250, 1255 (7th Cir. 1997).

⁵ See Robert A. Leflar, *Choice-Influencing Considerations in Conflicts Law*, 41 N.Y.U. L. REV. 267 (1966).

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⁷ See, e.g., *Western Cas. & Sur. Co. v. Brochu*, 475 N.E.2d 872, 877 (Ill. 1985).
⁸ See, e.g., *Dumenric v. Union Oil Co. of Cal.*, 606 N.E.2d 230, 233-34 (Ill.