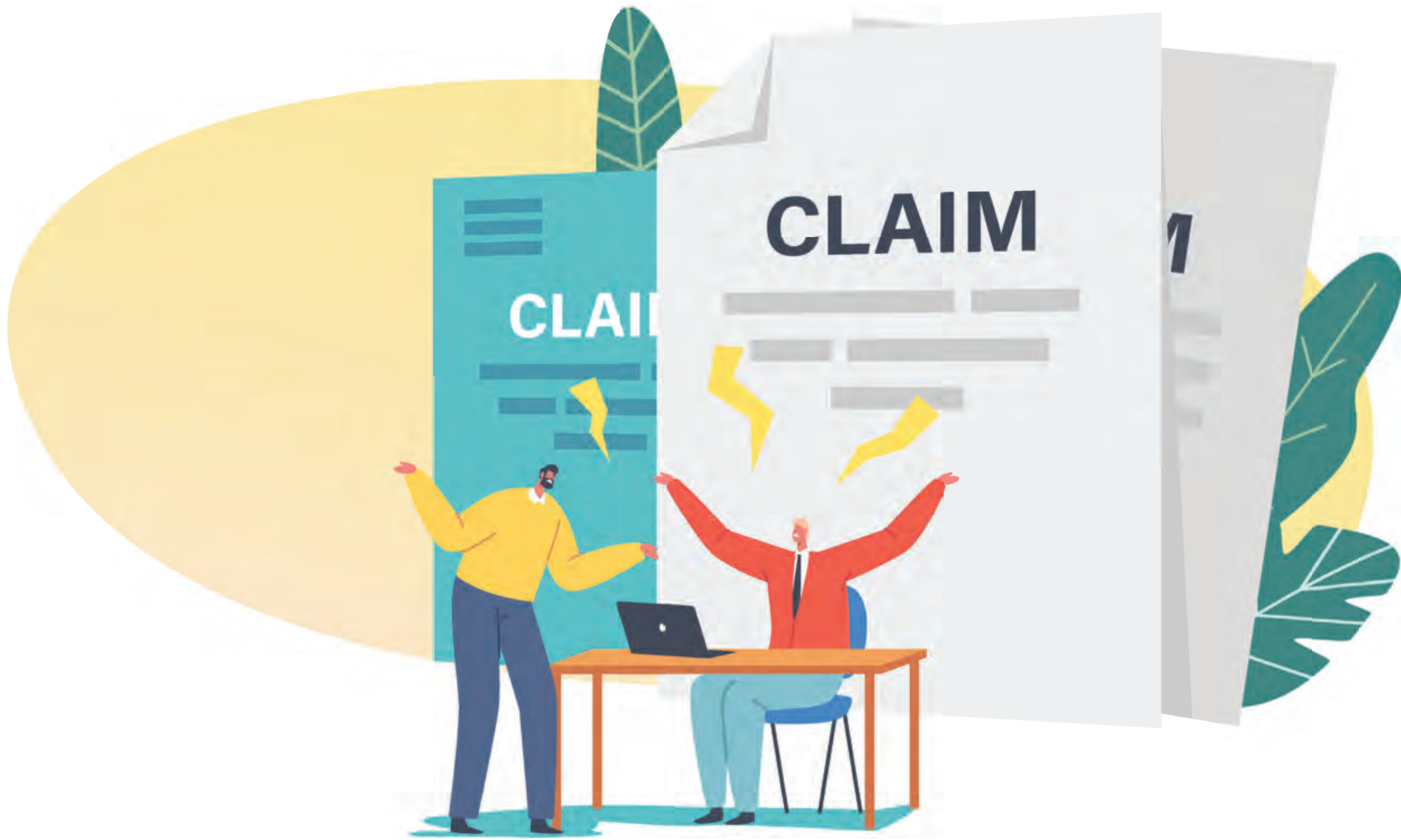

How to Properly Deny Claims

by Bill Wilson

When insurers receive a claim or suit from an insured or third party, they must first make sure that subsequent actions by all parties are in accordance with the conditions required by the policy and applicable laws and regulations. Violating such conditions and guidelines can lead to unintended consequences. For example, courts could refuse to uphold claims denials and possibly recognize bad faith suits, instead. Or an insurance department could find that the insurer broke a law and subsequently impose regulatory penalties. This article discusses how to avoid such outcomes by discussing important, but basic, dos and don'ts, illustrated through real-life examples.

All states have unfair claim settlement practices and bad faith laws. But sometimes, insurers and their representatives inadvertently violate those laws—particularly when they edit, omit, or fail to clarify their policy language.

For example, a well-intentioned adjuster trying to paraphrase policy language in a written claims denial to make it more understandable to the insured could end up misstating what's covered in the actual policy. To avoid the unwanted consequences of such actions, insurers can employ several tried-and-true practices—and avoid several others.

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Unfair Claim Settlement Practices and Bad Faith

In addition to the policy itself, various state unfair claim settlement practices laws govern how insurers should deny claims. Through model legislation, the National Association of Insurance Commissioners (NAIC) defines over a dozen acts that constitute unfair claims practices. Some of these include:

- Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue
- Not attempting in good faith to effectuate prompt, fair, and equitable claim settlement in which liability has become reasonably clear
- Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them
- Refusing to pay claims without conducting a reasonable investigation
- Attempting to settle or settling claims for less than the amount a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed material accompanying or made part of an application
- Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions

This last item is particularly prevalent: While many written claims declinations cite policy language, far too many of them do not adequately explain why or how that language applies to support the denial.

Many states have adopted the NAIC model act, sometimes with modifications. Other states have even more stringent and/or specific provisions for what constitutes unfair claim settlement practices, methods of competition, or deceptive acts.

For example, Florida includes, "failing to promptly provide a reasonable explanation *in writing* to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement."

And the California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, says:

> Where an insurer denies or rejects a first-party claim, in whole or in part, it shall do so *in writing* and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first-party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the *written denial* shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third-party claim, in whole or in part, or disputes liability or damages shall do so in writing.

The NAIC model law has a provision that's similar, but lacks the important requirement of an explanation for how the cited policy terms apply to eliminate coverage.

New York statute 3420(d)(2), meanwhile, requires written disclaimers (not reservation of rights) in cases involving bodily injury and wrongful death. Failure to incorporate mandated language in insurance contracts or follow statutorily mandated procedures can set back a claim denial and result in substantial statutory penalties against the insurer.

Sometimes unfair claim settlement practices can approach the level of bad faith. In *Burge v. Farmers Mut. of Tennessee*, No. M2016-01604, 2017 WL 1372864 (Tenn. App. Apr. 13, 2017), the court affirmed an award that included bad-faith damages after the insurer repeatedly did not explain to the insured the basis for the claims denial.

In *Mariscal v. Old Republic Life Ins. Co.* (1996), 32 Cal.App.4th 1617, 1620 [50 Cal.Rptr.2d 224, bad faith was shown, according to the court, by the insurer's failure to properly investigate the claim. According to the court:

> When investigating a claim, an insurance company has a duty to diligently search for evidence which supports its insured's claim. If it seeks to discover only the evidence that defeats the claim, it holds its own interest above that of the insured.

While largely unsuccessful, failure to properly investigate claims has been an important part of coverage lawsuits by insureds on

COVID-19 business income claims. Even if it doesn't approach the status of bad faith, an insurer has an obligation to properly investigate a claim from the standpoint of both its and its insureds' interests.

Insurers would be well-advised to incorporate state and federal statutory and case law prescriptions for what constitutes fair claim-settlement practices and good faith into their procedural manuals. Needless to say, the spirit of such laws should also be instilled in all claims personnel at every opportunity, given that the property-casualty insurance industry is founded on *uberrimae fidei* (duty of utmost good faith).

Claims Declinations and Reservation of Rights Letters

The first rule in resolving a claim is to require a written declination of coverage. This is not only a good idea, but also probably the law. Further, courts have often found this to be relevant in evaluating the enforceability of denial and reservation of rights letters.

Most legal experts also advise that detailed denial letters cite policy language and its relevance to the claim at hand. In one claim, an insurer sent a written denial letter that stated, "You have no coverage for this loss." That is no more acceptable than an oral declination.

While any claims denial is a bitter pill for a policyholder to swallow, it may go down easier if the adjuster clearly explains why the claim isn't covered in a way the claimant can understand. They may not like it, but they may be able to see reason.

If an insurer includes a reservation of rights with the denial (and they almost certainly will), they may cite additional policy language that might apply as the investigation continues. However, the insurer should not include a laundry list of policy language excerpts that come close to copying and pasting the entire insurance contract into the letter. The enforceability and relevance of a denial and reservation of rights letter is not gauged by its weight or verbosity.

Insurers seek to eliminate claims based on waiver and estoppel by issuing nonwaiver agreements or reservation of rights letters. These documents advise the insured of existing coverage questions.

If the insurer undertakes an unconditional defense, it may be estopped from later denying coverage by effectively having waived the coverage issue. A reservation of rights establishes the basis for a conditional defense when it appears there is coverage, but that could change as the investigation proceeds. It also may establish additional contractual premises for potentially denying a claim beyond those cited in a declination letter.

A typical reservation of rights letter might include a statement such as:

> We will continue to handle this claim even though a coverage question exists. However, no act of any company representative while investigating or negotiating the settlement of this claim or defending a lawsuit shall be construed as waiving any of our rights. We reserve the right, under the policy, to deny coverage to you or anyone claiming coverage under the policy. There may also be other reasons why coverage does not apply, and we do not waive our right to deny coverage for any other valid reason that may arise.

The policy language citations in a reservation of rights letter should not:

- Generalize or paraphrase policy language
- Include policy language excerpts that misrepresent the intent of the language
- Copy and paste most of the policy exclusions, especially those that realistically have nothing to do with the claim

To demonstrate these points, here are five illustrations from actual claims I've consulted on, four of which are claims denials and one a coverage inquiry. In one example, the claim was actually not covered, but the adjuster cited the wrong policy provisions in the denial. In that case, the agent did the ethical thing by pointing out why the cited exclusions didn't apply but adding that there was another basis for the denial, supported by governing case law.

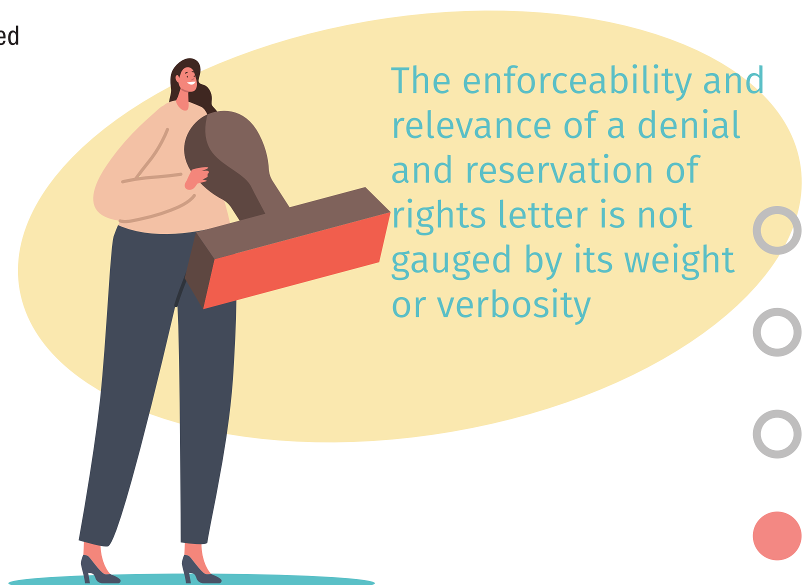
Example 1: Selectively editing policy language

An insured covered by a cybercrime policy had a bank-wired transfer intercepted and monies stolen. In the declination letter, the adjuster cited policy language saying the fraud must be "...related to the use of a computer inside the insured's premises or the premises of the bank."

Although the adjuster included quotation marks in its letter, implying that the cited language was verbatim from the insurance contract, the policy language actually said (**emphasis** added):

> ...related to **the use of any computer** to fraudulently cause a transfer of that property from inside your premises or from a banking institution or similar safe depository to a person (other than a 'messenger') outside those premises or to a place outside those premises.

So, the computer used for the fraudulent transfer did not have to be located inside the insured's or bank's premises, despite what was represented as the requirement.



How did this misinformation happen? It's possible that the adjuster was attempting to paraphrase the policy language in a way that made it clearer to the insured. However, the only thing made clear was that the adjuster did not understand the paraphrased policy provision.

Example 2: Selectively omitting policy language

A condo owner rented the community's clubhouse for his child's birthday party. The property management company required at least $300,000 of liability insurance. Fortunately, this was a coverage inquiry, not a claims denial, though the agent may have made the mistake of posing the question to the Underwriting, rather than the Claims, Department.

An underwriter responded that while the insured's limits were adequate, there would be no coverage under his homeowners policy and that the agent should procure a special events policy for the insured. In the email response, the underwriter cited this liability exclusion:

> e. Arising out of a premises:
>
> (2) Rented to an "insured"

The problem with this policy language citation is that it does not include the exception to the exclusion that appeared at the end of a list of three categories of excluded premises:

> e. Arising out of a premises:
>
> (1) Owned by an "insured";
>
> (2) Rented to an "insured";
>
> (3) Rented to others by an "insured";
>
> *that is not an "insured location";*

The definition of "insured location" includes "any part of a premises occasionally rented to an 'insured' for other than 'business' use." In other words, the clubhouse is an "insured location," so the exclusion does not apply.

It is unknown whether this was an oversight or a deliberate attempt to conceal relevant policy language. The moral for everyone involved is RTFP (otherwise known as, read the fine print)!

Example 3: Including policy language irrelevant to the loss

An insured left home for work at 7:30 a.m. and, when she returned home at 4 p.m., water was running from underneath the front door. Much of the first floor of the house had flooded due to a burst water pipe in the kitchen. There had allegedly never been a water leak known to the insured prior to this occurrence.

In his denial letter, the adjuster cited over a dozen exclusions—everything from wear and tear; to pollution, to birds, vermin, rodents, and insects; to "water damage" from neglect; to faulty construction. Many of the citations were simply blocks of exclusions copied and pasted into the letter. But clearly, the loss had nothing to do with birds and pollution, just to name two.

In addition, while citing exclusionary provisions completely unrelated to the claim, the adjuster omitted critical parts of the policy language. For example, in one listing of eight exclusions (from wear and tear, to agricultural smudging smoke, to the "animals" exclusion), the adjuster neglected to reference the critically important coverage-granting paragraph at the end of the listing:

> If any of these cause water damage not otherwise excluded, from a plumbing, heating, air-conditioning, or automatic fire-protective sprinkler system or household appliance, we cover loss caused by the water....

The cited exclusion for faulty, inadequate, or defective construction also had a similar exception: "However, any ensuing loss to property described in coverages A and B not excluded or excepted in this policy is covered."

In addition, although no history of damage existed, the adjuster cited an exclusion for "constant or repeated seepage or leakage of water...over a period of weeks, months, or years...." Also cited was the "neglect" exclusion, even though the insured reported the claim the day the leak occurred and within two hours of discovering it.

What might have contributed to this flawed understanding is the following sequence of events:

- August 19 — Water damage loss occurred.
- August 27 — Adjuster issuing the declination was licensed by the state as an adjuster.
- September 22 — Date of the denial letter.

The insurer ultimately paid the claim when the agent took it to the supervisory level of the insurer's claims department. Clearly, the basis for the denial was not the insurance contract, but rather the likelihood that the newly licensed adjuster was not adequately trained, had little or no field experience, or simply lacked the cognitive faculties to evaluate the meaning of insurance contract language within the context of an actual claim.

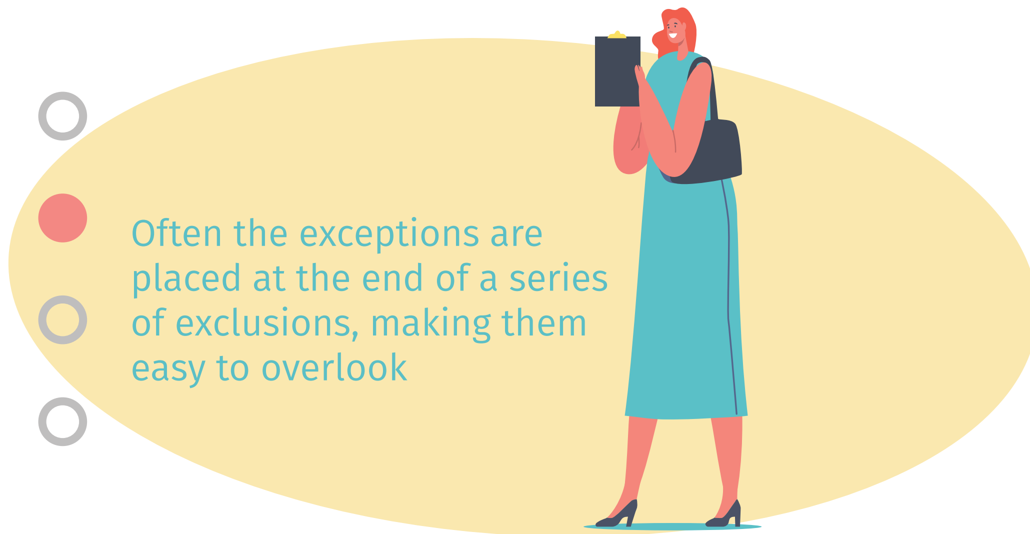
My experience has been that claims denials that cite exclusions while ignoring exceptions to the exclusions, as in the last two examples, are not uncommon. Not that this is a valid excuse, but often the exceptions are placed at the end of a series of exclusions, making them easy to overlook.

Example 4: Including irrelevant policy language while omitting language that actually excludes the loss

A dentist's computer system was hit by ransomware that encrypted all of his customer files (personal information, x-rays, insurance information, accounting records, etc.), including backups. The dentist experienced significant business income, extra expense, and accounts receivable losses.

In a voluminous denial letter, the adjuster cited exclusions for everything from "wear and tear" and "mechanical breakdown" to "faulty workmanship." None of the cited exclusions were relevant to the claim.

What was not cited but was relevant was that no "direct physical loss" resulted, although required by the policy form's insuring agreement to trigger coverage. So, the loss wasn't covered, but not for any reason cited in the denial letter.



Example 5: Not explaining how the language excludes the loss

A crane inspector overloaded a crane during a test, causing it to collapse and resulting in property damage. His CGL insurer denied the claim.

The written denial doesn't really say why the loss isn't covered, and the reservation of rights paragraph is so broad as to presumably allow denial by some sort of divine intervention at a later date. The 10-page letter cites, word for word, the Coverage A Insuring Agreement, Exclusions j.(1)-(6), k., l., m., n., and t. (And for the record, Exclusion n. is for product recall, which is not even remotely applicable to the claim.)

The letter goes on to cite, verbatim, every definition referenced from the insuring agreement and exclusions, but again, never says which exclusions apply and why. It is unknown whether this approach resulted from laziness, indecisiveness, or ignorance, or if it was a "just in case" tactic or, worse, a deliberate attempt to obfuscate. The lesser of these evils is not reassuring.

Is this a legitimate denial and reservation of rights letter? In his *Coverage Opinions* newsletter (Vol. 6, Issue 9), attorney Randy Maniloff, who has written and spoken about reservation of rights issues for years, discusses *Harleysville Group Insurance v. Heritage Communities*, 803 S.E.2d 288 (S.C. 2017), where the state Supreme Court opined:

> [I]t is axiomatic that an insured must be provided sufficient information to understand the reasons the insurer believes the policy may not provide coverage. We agree with the Special Referee that generic denials of coverage coupled with furnishing the insured with a copy of all or most of the policy provisions (through a cut-and-paste method) is not sufficient.[1]

Rules of the Road

To summarize, by following these three basic guidelines, insurers can properly deny claims:

1. All claims denials should be in writing; never present or accept an oral claims denial.
2. All claims denials should cite the specific policy language—and only that language that applies to the present denial. Unless realistically supporting a reservation of rights, a denial letter should not consist of inapplicable verbiage or of a litany of policy exclusions and limitations that have been copied and pasted in full.
3. All claims denials should explain why and how the cited insurance contract language works to exclude coverage in the subject claim without generalizing or paraphrasing policy language or excerpting policy language that misrepresents the intent of the coverage.

And, most importantly, never forget that you cannot resolve coverage or claims issues without applying the RTFP doctrine. ■

For more information on this topic, contact the author at Bill@InsuranceCommentary.com.

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1. More information on the "adequately inform" standard required by many courts can be found on Randy Maniloff's website, coverageopinions.info.