Insurance Coverage Disputes and Declaratory Relief Actions

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A. Coverage Determinations: Substantive Review and Timing Issues

Insurers doing business in California are obligated to resolve tendered claims promptly and fairly. California law provides detailed statutory and regulatory controls over insurers, as well as well-developed decisional authority (See generally Cal. Ins. Code Section 790.03(h) and Cal. Prac. Guide Ins. Lit. 12C-D for an excellent detail of claims handling issues and obligations). This law generally requires prompt review of a claim, and a clear written policy coverage determination. While California law suggests that coverage determination must be made within 40 days, as long as no prejudice results and there is good cause for delay because of complex legal or factual issues in dispute, it seems reasonable that a coverage analysis may be delayed for a short but reasonable period, presuming the insured is kept apprised of developments and reasons for the delay. A coverage determination should only occur after a fair-minded, complete examination of the underlying facts, applicable policy provisions (always interpreted in favor of the insured where ambiguous or uncertain), and any relevant statutory or decisional authority which may address coverage issues. In relying on decision authority, the insurer should use caution in fairly interpreting applicable law, and insuring that such authority is not seriously criticized or compromised by other decisional authority. An insurer's failure to complete a coverage analysis promptly and fairly raises the specter of a breach of the insurer's implied covenant of good faith and fair dealing, and may expose the insurer to liability for damages sustained by the insured in excess of policy coverage, and for categories of loss not otherwise compensable under the policy.

Most California consumers have a bias against insurers, and the claim investigation process can be a daunting task in which the insured provides limited cooperation, and demands immediate payment or other afforded policy coverage. Further, some insureds retain counsel to represent them in the claim's submission process, which can assist the process or escalate the complexity and difficulty of adjustment process.

In this environment, insurers frequently develop basic guidelines for claims review and coverage determinations that focus on compliance with California statutory and regulatory provisions. Unfortunately, these guidelines typically fail to address the broader issues that claims personnel face daily in adjusting various types of claims. The claims adjustment process in many commercial lines of coverage, professional policies, and in other industries, such as title insurance, is far more complex, and frequently requires review and analysis of claims of third parties in pending litigation, and concurrent detailed review of a wide range of potential documents or events which are the basis of the claim and coverage

issues. Additional complications may arise in the context of co-insurance, or losses which implicate reinsurance coverage.

In this more complex claims environment, the insurer should consider developing a clear set of more detailed guidelines to insure prompt, and full communication with the insured on the progress of the investigation and any required information or personal cooperation required of the insured. And the process should include, wherever possible, an inspection of any property involved in the claim, or an in-person meeting with those most closely associated with the facts which trigger the tendered claim. Too often, the claims review process is viewed in later bad faith litigation as one-sided, preemptory, and results-oriented. Juries typically view insurers as a business that never pays, or underpays, for covered risks, hiding behind complex policy provisions and claims adjusters that have no interest in considering the reasonable interests of their insureds. It is therefore important for the insurer to instill in its claims department a strong view that each claim is important, it should be thoroughly investigated, and all communications with the insureds should be clear, forthright, and above all, courteous to someone who is under stress in facing a loss for the tendered matter. Every communication to the insured, and all internal communications, should reflect this over-riding concern for the insured, and the insured's interests. And all material communications should be in writing, or if oral, confirmed in writing.

Where insurers elect to refer claim's investigation and adjustment to outside counsel, the classic attorney-client privilege typically afforded communications between the insurer and its counsel may be compromised. In California, courts that have addressed these issues have attempted to "parse out" the lawyer's role as counsel to the insurer from those functions typically handled by a claims adjuster. If the coverage determination is authored by outside counsel, the attorney-client privilege becomes more problematic, because the insured is entitled to understand how the insurer arrived at the coverage determination, and whether its methodology was reasonable, or in bad faith.

Typically, a prompt and fair coverage determination leads to an acceptance or a rejection of the claim. If accepted with a reservation of rights, the insurer may elect to "carve out" certain issues for later determination, and reserve its rights to withdraw defense and/or indemnification coverage premised on newly determined facts which it cannot otherwise resolve when it accepts the tender of defense. Issues involving such reservations, and how they may require retention of separate Cumis counsel under California Civil Code Section 2860 will not be addressed in this article, and properly deserve separate and careful analysis by the insurer and the insured.

Where an insurer declines or rejects a claim, typically that is the end of the matter, unless the insured thereafter files an action for recovery under the policy, or the insurer elects to seek a judicial determination of its rights through a

declaratory relief action. It is the last option, seeking a judicial determination of an insurers rights and obligations, which is addressed below.

B. Declaratory Relief Actions: A Viable Tool or Dangerous Option

Declaratory relief actions brought by insurers are relatively uncommon, in the context of the hundreds of thousands of commercial insurance claims made every year. When filed, such declaratory relief actions typically involve situations in which (1) the controversy involves a significant monetary risk of loss, (2) the policy provisions provide a reasonable basis for denial of coverage, (3) the legal responsibility for the claim is at issue or undecided under operative law, (4) the facts are uncertain or in dispute on critical coverage issues, and/or (5) where the insured has taken actions prejudicial the interests of the insurer, compromising or exonerating coverage.

Declaratory relief actions do not insulate an insurer from claims of bad faith, unless the declaratory relief action is reasonably brought under the known facts and applicable law. Suing an insured is always a serious step, which should be taken only with the advice of counsel, and taking into consideration all the facts and circumstances underlying the claim in a light most favorable to the insured. At the same time, failure to promptly seek a judicial determination of policy obligations through a declaratory relief action carries its own risks, especially if that insurer later faces a bad faith action and belatedly seeks by cross-complaint such declaratory relief.

Because coverage disputes frequently arise in the context of underlying litigation for which coverage is sought, caution must be exercised in bringing the declaratory action. The insurer should not seek resolution of coverage issues that involve facts in dispute in the underlying litigation between the insured and a third party. The insurer may not prejudice the interests of the insured by seeking resolution of disputed facts which are not only the basis of coverage, but also involve claims asserted by a third party against the insured (See generally *Montrose Chemical Corp. v. Superior Court* (1993) 6 Cal.4th 287. Unfortunately, this occurs more frequently than expected, and in an improvidently filed declaratory relief action can trigger immediate bad faith exposure, and the creation of coverage where it might not otherwise exist.

Declaratory relief actions sometimes generate a cross complaint for breach of policy coverage and bad faith. The insurer should carefully consider the strength of its coverage position, taking into consideration a reasonable interpretation of the relevant policy provisions. Insurers should avoid seeking opinions concerning coverage from those who may have a biased industry view of coverage not supported by clear policy language, measured in the context of the dispute at issue. It is typically unwise to rely on an internal adjuster coverage determination that has not been reviewed by independent counsel. A better approach is to test the declaratory relief complaint’s viability by allowing independent counsel to craft

a cross complaint the insured might file in response. This “live test” of the action frequently allows the insurer to craft a more focused complaint, which may avoid raising dangerous collateral issues. In some instances, it may dissuade the filing of the action, and reconsideration of the policy coverage decision.

In California, an insured is not entitled to automatic recovery of attorney’s fees if the insurer loses a reasonably founded declaratory relief action. However, to the contrary, if the insurer has provided no policy benefits, and the insured establishes that coverage is available, attorney’s fees and costs are typically awarded (See *Brandt v. Superior Court* (1985) 37 Cal.3d 813.

C. Summary

At the risk of over-simplifying the more complex areas of coverage analysis, an insurer should carefully consider pursing a declaratory relief action, reserving such remedies only when:

1. The insurer has completed a thorough factual investigation of the facts which support the tender of the claim, and comes to a careful and considered opinion that a coverage decision cannot be made without judicial assistance;
2. The insurer has taken all ambiguous policy terms implicated in the claim, and construed them in favor of the insured;
3. The insurer has carefully considered the possibility of a viable cross claim, and in doing so, seeks the advice of independent counsel to evaluate those potential insured claims; and
4. The insurer proceeds promptly in bring such an action, but avoids doing so where the factual issues in dispute are pending in the underlying tendered action.