

# CLAIMS DENIED

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## New Jersey Law Provides Coverage For Asbestos Claims

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#### Introduction

In recent years, businesses that have used, manufactured, sold or distributed asbestos in any way, shape, or form have been subject to lawsuits by persons seeking damages for various illnesses. These lawsuits have collectively resulted in over \$20 billion in damages and court costs. Now, the asbestos manufacturers who comprised the original class of defendants have largely disappeared through bankruptcy. As a result, companies which never thought that they had asbestos exposure find themselves defendants in, potentially, hundreds of lawsuits. Companies need to know that in New Jersey their general liability, or product liability, insurance policies likely provide coverage for these damages and costs.

#### 1. Missing Policies

First, a company must locate evidence of its old general or product liability policies. Under New Jersey law, all insurance policies in effect from the plaintiff's first exposure to asbestos until the policyholder is placed on notice of the damage (*i.e.*, the service of court papers) must respond. This means that if a plaintiff brings a claim in which the exposure to asbestos took place in 1960, but the illness was not discovered until 2000, there are potentially forty years of coverage. Ideally, the insured should pull out all forty of its annual policies and bring them to its lawyer. Unfortunately, most policyholders have misplaced or discarded their old policies. However, the policyholder only has the burden to prove the existence of each policy by a "preponderance of the evidence." This may be done by showing correspondence, certificates or ledger entries concerning insurance, or having the policyholder's broker testify as to the coverage. Insurers

often admit coverage when the insured has only a few scattered pieces of paper concerning insurance. If the policyholder cannot prove coverage during certain years, it may be considered self-insured for a portion of the damages.

#### 2. Absolute Asbestos Exclusions

The importance of finding old policies is heightened by the fact that the most recent policies may not provide any coverage for asbestos claims. Although the precise date varies based upon both the insured and the insurance company, many insurers have added a specific "absolute asbestos exclusion" to their policies prohibiting

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*By Thomas E. Redburn, Jr., Esq.*

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coverage for these claims. Policyholders have a strong argument that the absolute asbestos exclusion years should not be considered “self-insured” years, since coverage for asbestos was unavailable. This would leave the prior insurance policies without such exclusions responsible for the entire risk.

### **3. Allocation**

General liability policies provide coverage for both damages (indemnity) up to their limits, and a duty to defend. But with so many potential years and insurance carriers, how does one know what portion each insurance company should pay? New Jersey courts have developed a mathematical formula which considers both the amount of time on the risk and the total amount of annual coverage. Due to inflation and increased concerns about liability, companies generally purchased more insurance in the 1980’s than in the 1960’s, for example. This means that more recent policies with higher limits provide more coverage than older policies with lower limits. For example, a 1990 policy for \$5,000,000 provides 100 times more coverage than a 1960 policy for \$50,000. Thus, even if a company can only locate its ten most recent policies over a forty-year exposure period, those 10 years could provide 80% of the coverage.

### **4. Notice**

It is important to put each insurance carrier on notice. Policyholders have a duty to put their carriers on notice of a potentially covered occurrence “as soon as practicable,” and of a suit “immediately.” This rule is much more forgiving in New Jersey than New York, where late notice can mean the death of the claim. In New Jersey, an insurer must show “appreciable prejudice” before denying coverage on late notice, which is an extremely difficult standard. Nevertheless, even in New Jersey, policies only cover defense costs which are incurred after the insurance company is placed on notice.

### **5. Bad Faith**

Policyholders should also be alert to “bad faith.” If an insurer delays investigating the claim after it is put on notice, or if the claims handling process is incompetent and the company’s reasons for denying coverage have no basis in the policy and are not even fairly debatable, the policyholder may have a bad faith claim. At minimum, a well-founded claim of bad faith often results in an insurance company’s willingness to settle the case more quickly and more reasonably.

### **6. Be aggressive**

As is apparent, insurance coverage for asbestos claims involves a number of complex issues. As a

result, it is tempting for an insurance company to manipulate these issues to an unwary policyholder’s disadvantage. If your insurance company has denied coverage, or is only paying a fraction of your costs, an examination of your insurance coverage is in order.

## **Coverage 101: Occurrence v. Claims Made Coverage**

*By Lynda A. Bennett, Esq.*

Generally, there are two types of insurance coverage available to protect a company when it gets sued – “occurrence” and “claims made.” Although both policies are designed to provide liability insurance coverage, the way in which the policies are accessed and the policyholder’s obligations under those policies are significantly different. Understanding the nuances of each type of coverage is crucial because it often means the difference between coverage and claim denied.

### **Occurrence Coverage**

The “occurrence” policy form usually provides coverage for bodily injury, personal injury, and/or property damage alleged to have taken place “during the policy period.” This means that regardless of when a lawsuit is brought against the policyholder, the occurrence policy will provide coverage for the claim as long as

it may be shown that the alleged damage took place during the policy period. Courts have also found that multiple occurrence-based policies are required to respond to the same loss if at least some of the alleged damage took place during each individual policy period.

The classic example of this “continuous trigger” concept is an environmental claim. Assume that a policyholder owned property and that it had an underground storage tank. Assume further that the policyholder can show that the tank had been leaking underground undetected for 12 years. Under a continuous trigger theory of coverage, the policyholder may obtain coverage for the claim under all 12 policies in effect while the tank was leaking.

Another important feature of the occurrence-based policy is the insurance company’s obligation to pay for attorneys’ fees and court costs when the policyholder must defend against a lawsuit. Under the “duty to defend” provision of the occurrence policy, the insurance company must defend the policyholder against any lawsuit that is potentially covered by the policy, even if the allegations of the suit are groundless, false, or fraudulent. Moreover, the insurance company’s payment of defense costs typically does not erode the indemnity limit of the

policy. In other words, if the policy has a \$1 million limit of liability and the insurance company pays \$500,000 to defend the claim, the policyholder still has the full \$1 million available to either settle the claim or pay any judgment.

Finally, the occurrence-based policy generally contains flexible language regarding the policyholder’s obligation to give notice of a claim. Indeed, most occurrence policies only require notice of an occurrence (*i.e.*, facts that may give rise to a claim) “as soon as practicable” after the policyholder learns of the occurrence and require notice of a claim (*i.e.*, a lawsuit) “immediately” after it is received. Depending on the state law that is applied to interpret these notice provisions, the policyholder may have significant leeway in terms of when it gives notice of a claim (though notice given early and broadly is always best).

For example, if New Jersey law applies, a policyholder may have coverage even if it does not give notice of a claim until 10 years after it first learns about the claim. To defeat coverage, the insurance company must demonstrate that it has suffered appreciable prejudice by the policyholder’s delay. Conversely, if New York law applies to the same facts, the policyholder is not entitled to coverage because New

York courts strictly construe the notice provision of occurrence policies. Indeed, a delay of only 32 days may nullify coverage under New York law regardless of whether the insurance company was prejudiced.

### **Claims Made Coverage**

Unlike occurrence-based coverage, claims made coverage does not turn on when the alleged damage took place. Rather, claims made coverage focuses on when the “claim” giving rise to the potential liability is made against the policyholder. Thus, most claims made policies provide coverage for any “claim” made against the policyholder during the policy period. Some claims made policies also require that the policyholder report the claim to the insurance company during the policy period before coverage will apply. In stark contrast to the occurrence-based policy, where a continuous trigger theory may be used to access multiple policies, claims made coverage generally will result in only one policy responding to the claim.

The claims made policy is also different from the occurrence policy with respect to the duty to defend. The claims made policy may not require the insurance company to provide a defense. Instead, the policy may only obligate the insurance company to reimburse the policyholder’s

defense costs while the lawsuit is proceeding or at the conclusion of the lawsuit. Alternatively, the policy may give the insurance company the option to defend or require the policyholder to conduct its own defense. More importantly, if the claims made policy provides any type of defense, the insurance company's payment of defense costs usually will erode the available limit of liability. Returning to the example discussed above, when the insurance company pays \$500,000 to defend the claim, the policyholder has only \$500,000 left of its \$1 million limit to settle or pay any judgments rendered on the claim.

Finally, unlike occurrence-based policies, claims made policies are not at all flexible with respect to giving notice of a claim. To the contrary, failure to comply with the notice provisions of a claims made policy may result in complete forfeiture of an otherwise covered claim. As noted above, most claims made policies require that notice of a "claim" be given to the insurance company during the policy period. "Claim" is often a broadly defined term that includes any demand for money damages. This means that a letter from an attorney alleging sexual harassment in the workplace with a concluding paragraph that says "We will be forced to seek compensatory damages in

court if this situation is not remedied" probably constitutes a claim that must be reported under a claims made policy. Thus, regardless of the state law applied, the notice provisions of a claims made policy will be strictly construed and enforced.

In the event that the policyholder decides not to renew a claims made policy with its current insurance company, it is vitally important to purchase the "tail" coverage that is usually available under the policy. The "tail," also known as the Extended Reporting Period, allows the policyholder to report claims that are received after the policy period has lapsed thus saving coverage for an otherwise untimely claim.

The type of insurance sought will generally govern whether insurance companies will offer the policy on an occurrence or claims made basis. As is true with all insurance policies, policyholders are best served to read and understand the coverage before a premium is paid.

## Standard Of Review for Disability Claims Under ERISA

*By Thomas E. Redburn, Jr., Esq.*

Most employee disability insurance claims under private policies sold to employers are governed by the Employee Retirement Income Security Act ("ERISA"), a federal statute designed to ensure that employees receive what they are entitled to from their employers' benefit packages. This means that employees wrongfully denied long-term disability benefits are generally limited to bringing an action in federal court under ERISA to overturn the claim denial. Under the case law that has developed in this area, the employee is often at a significant disadvantage in such a lawsuit because the court is required to review the plan administrator's (*i.e.*, the insurance company or employer) coverage decision under a highly-deferential standard of review. Indeed, when a court applies this deferential standard, the employee almost always loses.

How is it that a federal statute designed to protect employees has come to be employed by insurers as a sword against them? The blame lies with the United States Supreme Court. The general rule is that a plan administrator's decision to deny benefits under an

ERISA plan is supposed to be reviewed de novo, which means that the court decides the question of coverage itself on a clean slate, with no deference being given to the plan administrator's decision. However, in the Firestone case, the Supreme Court determined that, where the plan documents give the administrator discretionary authority to determine eligibility for benefits or interpret the terms of the plan, a court can overturn an administrator's denial of benefits only if the administrator's decision was "arbitrary and capricious." In other words, the fact that the administrator made the wrong decision is not enough to obtain a reversal. Rather, the employee must show that the administrator abused its discretion based on the facts available to the administrator at the time it made the decision to deny benefits. The purpose of extending this kind of deference to the administrator's coverage decision is to keep disputes over disability and other benefits out of court and channel them into the insurance companies' internal dispute resolution processes, which are thought to be quicker and cheaper for the employee.

After Firestone was decided, most employers and insurance companies changed the terms of their employee long term disability plans to grant the plan administrator discretionary authority to

determine eligibility for benefits, so as to take advantage of the "arbitrary and capricious" standard of review. However, the Supreme Court left open an escape hatch in Firestone: if the plan administrator is operating under a conflict of interest that could cloud its decision-making process, then deferential judicial review might not be appropriate. Unfortunately, the Supreme Court did not provide much guidance as to when such a conflict might exist.

This issue has received substantial attention recently from the federal courts in and around New Jersey. Although the case law continues to evolve, these courts have held that an insurance carrier who both determines eligibility for disability benefits and pays those benefits out of its own pocket may have a conflict of interest that gives it an incentive to act in its own self-interest, rather than in the fiduciary interests of the employee, and wrongfully deny benefits. In this situation, the court must employ a "sliding scale" approach to the standard of review. The court must conduct a fact-intensive inquiry to determine the extent to which the insurer's apparent conflict tainted its analysis of the coverage issues in the particular case at hand. The court then adjusts the standard of review to match the extent of the conflict, giving less deference to

the administrator's coverage decision where the evidence of taint is strong. For example, if an insurer liable to pay benefits itself under the plan ignored or made selective use of the evidence before it or failed to follow its own internal claims-handling procedures, then the court will apply a heightened standard of review.

However, at least one federal district court in New Jersey has held that the standard of review can never be de novo where the plan gives discretionary authority to the administrator. The decision of even the most highly-conflicted plan administrator will be evaluated with only a "high degree of skepticism," not on a totally clean slate. Although this is better than traditional "arbitrary and capricious" review, the insurer still enjoys an advantage over the employee. Moreover, the intensive factual inquiry required by the "sliding scale" approach will make these cases more complicated and more expensive for the employee to litigate.

The realities of ERISA litigation make apparent the importance of obtaining the assistance of experienced disability coverage counsel when the insurance carrier initially denies the claim, before a lawsuit has become necessary. The employee must be careful to ensure that the record before the insurance carrier is

complete: that all evidence bearing on the coverage issues has been provided to the carrier and that the proper arguments have been made as to how that evidence should be interpreted. Not only will this minimize the likelihood that the denial will stand and that litigation will be required, but it will also put the employee in the best possible position to show the court that, by denying the claim, the insurer did indeed act arbitrarily and capriciously.

## The Lowenstein Sandler Insurance Practice Group Credo

Insurance should provide security and peace of mind. In exchange for a premium payment, the policyholder externalizes risk. However, the relationship of trust between policyholder and insurer that once existed has vanished. The cavalry has turned and run, the umbrella lies in tatters and the good hands are a fist. All too frequently, the insurer's response to a valid request for coverage is 'claim denied.' We, in the Lowenstein Sandler Insurance Practice Group, still believe that insurance policies provide coverage. We will advise our clients of their rights, guide our clients down the tortuous paths of claims-handling, and partner with our clients to pursue coverage through litigation when necessary. We stand prepared to be your insurance advocate.

For more information on any insurance coverage matter,  
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