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Sometimes You Have to Sweat the Small Stuff: Technicality Renders $10M Excess Policy Valueless

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For nearly 100 years, courts across the country have followed the established majority view that an excess insurer may not avoid its coverage obligation by imposing technical requirements on the manner in which underlying insurance is exhausted. For example, the Second Circuit, in *Zeig v. Massachusetts Bonding & Ins. Co.*,[1] rejected an insurer's argument that a policyholder had *voided all coverage* under an excess policy when it settled with primary insurers for less than their full underlying limits. The court held the excess insurer had "no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies." In so holding, the court refused to reach "[a] result harmful to the insured, and of no rational advantage to the insurer," which would, "in many, if not most, cases involve delay, promote litigation, and prevent an adjustment of dispute which is both convenient and commendable." *Zeig*, among many other opinions nationwide, recognizes the common sense reality that policyholders do not purchase excess insurance expecting to face a series of different coverage positions in the same tower of insurance.

In the 96 years since *Zeig*, excess insurers have sought to erode this rule by inserting various "condition precedent" provisions into their policies. For example, excess insurers sometimes insert an "actual payment" condition in their policies–requiring that all underlying insurers fully fund their layer before excess coverage applies. As illustrated in a recent decision by the United States Court of Appeals for the Third Circuit, some excess insurers have begun to insert even more stringent conditions that threaten to render their policies effectively valueless if policyholders do not pay careful attention to the precise words contained in ***all*** their policies before settling with underlying insurers.

In *Pharmacia Corporation v. Arch Specialty Insurance Company*,[2] an eighth-level excess insurer leveraged a hyper-technical condition to avoid coverage altogether, even though it was undisputed that each and every underlying insurer had *actually paid its full policy limit*. The court's decision relied on language in the excess policy requiring that all the underlying insurers have "duly admitted liability" before coverage attached. The Third Circuit rejected the policyholder's view that full payment by every underlying insurer is tantamount to an admission of liability and enforced the condition to the letter, despite the absence of prejudice caused by the policyholder's inability to secure an express admission of liability from each of the seven underlying insurers.[3]

The *Pharmacia* opinion is troubling because it invites excess insurers to continue to insert conditions on coverage that have no rational connection to the rights of the parties and become a trap for the unwary, particularly at the upper-layer levels of a coverage tower where policy language rarely receives scrutiny during the policy placement or renewal process. An "admission of liability" requirement in a high-level excess policy seriously impedes the policyholder's (and other insurers') ability to resolve a contested claim, since an express admission of liability in the context of settlement is exceedingly rare. An excess policy including such a requirement is therefore arguably valueless, since multimillion-dollar claims that reach high-level excess layers are most often resolved through negotiated resolution.

Nevertheless, the opinion serves as a timely reminder that policyholders should follow several best practices when negotiating the terms of excess policies and when resolving claims implicating excess coverage:

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[1] 23 F.2d 665, 666 (2d Cir. 1928).
[2] 2024 WL 208146 (3d Cir. Jan. 19, 2024).
[3] The *Pharmacia* opinion arguably overlooked Supreme Court of New Jersey precedent requiring "a showing of prejudice before a contract of insurance may be avoided." *Pfizer, Inc. v. Emps. Ins. of Wasau*, 154 N.J. 187, 206 (1998). New Jersey courts have uniformly required a showing of "appreciable prejudice" before an insurer may avoid coverage on the basis that a "condition precedent" was not satisfied. *See Cooper v. Government Employees. Insurance. Co.*, 51 N.J. 86, 94 (1968) (an insurer "may not forfeit the bargained-for protection unless there are both a breach of the notice provision and a likelihood of appreciable prejudice"); *KnightBrook Ins. Co. v. Tandazo-Calopina*, 472 N.J. Super. 158, 168 (App. Div. 2022) (New Jersey courts have "extended [the] 'appreciable prejudice' [requirement] to situations where an insured breaches a contractual duty to cooperate with an insurer.").

- **Negotiate the Removal of Limitations on Exhaustion in Excess Policies**

Policyholders should be aware of, and actively negotiate the removal of, limitations placed on the "exhaustion" of underlying limits in their excess policies. These limitations can vary among insurers and policies and even within a single tower of insurance. Policyholders should negotiate the removal of language requiring "actual payment" and/or an "admission of liability" before coverage attaches, like in *Pharmacia*. Policyholders should, instead, request language making clear that underlying limits may be "exhausted" by the satisfaction of loss–whether paid by underlying insurers, the insured, or any other source.

- **Exercise Caution When Settling Contested Claims**

Policyholders should think strategically when resolving contested insurance claims. While a business facing significant liability may be incentivized to quickly pursue a commercial resolution for the claim from compliant primary and lower-level excess insurers, it is important to first carefully review the exhaustion language in every implicated and/or potentially implicated excess policy. Policyholders should not assume that each excess insurer will readily line up behind the primary insurer to pay their share of the liability. As *Pharmacia* illustrates, some excess insurers may prefer to lie in wait, hoping that the insured will trip over a technical requirement in their policy, allowing the excess insurer to issue a surprising late-stage denial of coverage. In situations involving problematic exhaustion language, policyholders would do well to adopt a top-down approach to settlement with excess insurers instead of working from the bottom up.

- **Utilize Knowledgeable Professionals When Placing Coverage**

Policyholders should utilize the talents of a knowledgeable and experienced insurance broker and/or coverage counsel when placing coverage for key risks. This is particularly important when a policyholder's insurance program will involve significant limits and include many layers of excess insurance. Insurance coverage professionals regularly review the language used in policies making up a large tower of insurance to ensure that the terms and conditions in each are consistent and will allow for seamless access to coverage when policyholders need it most. By taking steps to proactively place appropriate and consistent coverage, policyholders can avoid the type of unhappy surprise that led to a significant forfeiture in *Pharmacia*.

Contacts

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