

Liability Insurance and Supplementary Payments

Michael Sean Quinn*
Olga Seelig**

* Partner, Jordan, Quinn & Carmona, Austin, Texas. Currently, Mr. Quinn is teaching life and health insurance at the University of Houston Bates School of Law.

** Of Counsel, Jordan, Quinn & Carmona, Austin, Texas. Ms. Seelig is one of the few bilingual (English-Spanish) coverage lawyers in her part of the country. From time to time, courts rely upon her to translate testimony authoritatively.

Standard general liability policies contain a "Supplementary Payments" provision which extends to both Coverage A and Coverage B. There is remarkably little law on this subject.¹ The insurer agrees to pay, among other things, all the expenses it incurs, certain bonds to release some attachments, so long as the amount of those bonds is within the limits of the insurance, costs taxed against an insured during the suit, certain amounts of prejudgment interest and certain amounts of post-judgment interest. Occasionally, insureds try to argue that insurers must post supersedeas bonds under this part of the insurance policy. That argument obviously lacks foundation of the policy. At the same time, an insurer may have an obligation to file a supersedeas bond as an implication of the duty to defend, but that is a different matter. Under the terms of the insurance contract discussed here, an insurer is liable to pay the supplementary payments only for suits it defends. One would suppose, off hand, that the insurer would owe similar sums for analogous expenses in suits it wrongfully fails to defend. Interestingly we have found no law on this subject but our conclusion seems obvious enough.

We will pay, with respect to any claim or *suit* we defend... [a]ll reasonable expenses incurred by the insured at our request to assist us in the investigation or defense of the claim or *suit*, including actual loss of earnings up to \$100 a day because of time off from work.²

Fairly clear, supplementary payments are incident to the duty to defend. Consequently, one would not expect them to be included within policy limit for a non-eroding general liability policy.

Furthermore, to the extent that common law insurer bad faith lies for indefensible breaches of first party insurance contracts or the first party aspects of other insurance contracts, insurer misconduct with respect to its refusal to make payments or irrational delays in making supplementary payments would be subject to the common law of insurer bad faith.

Moreover, what constitutes *reasonable* expenses is somewhat open ended, rather vague, possibly ambiguous, and certainly within the province of a jury. One could imagine that general liability carriers might be nervous about taking this kind of issue to a jury, particularly after they have asked their insured to cooperate with them and the insured has spent money doing so. This is particularly true in the light of the fact that general liability policies contain duty-to-cooperate clauses.

I. Introduction

There is another provision of standard "Supplementary Payments" clauses which is equally interesting and equally unexplicated in the caselaw. It reads as follows:

1. See the penultimate section below.

2. The term *suit* is a standard term in CGL policies. It is customarily defined as follows: "'Suit' means a civil proceeding which damages because of *bodily injury*, *property damage*, *personal injury*, or *advertising injury* to which this insurance applies are alleged. 'Suit' includes: [a] An arbitration proceeding in which such damages are claimed and to which you must submit or do submit with our consent; or [b] Any other alternative dispute resolution proceeding in which such damages are claimed and to which you submit with our consent."

II. A Hypothetical Scenario

Corp-P (“P”) sued Corp-D (“D”) on a variety of theories, including violations of the Lanham Act, false advertising, interference, and unfair competition. (The fact that this is a Coverage B case is irrelevant to the ultimate observations. It simply provides the opportunity to create more issues.) All three of D’s insurers—I-1, I-2, and I-3—at various points, defended D. The facts of underlying case were quite technical. Both of the parties to the underlying case were involved in manufacturing and distributing complex, high-tech industrial equipment (“widgets”). D prevailed in the litigation. I-1, I-2, and I-3 had disputes with each other about who owed how much pursuant to their vanilla duties to defend. D believed, however, that it was owed substantial sums by way of supplementary payments. Many of its people had devoted an enormous amount of time to developing the case. Many of its people had educated lawyers in preparation for discovery, pleading, briefing, and trial, and many of its people attended the trial. The D employees involved included computer gurus, engineers of various sorts, financial wizards, and a veterinarian.

Everyone agreed that D performed various significant activities in conjunction with the defense and processing of the underlying lawsuit. D takes the view that its assistance was *necessary* to the processing of the underlying lawsuit, i.e., that it provided the know how to win. At least some of the defendant insurers appear to concede this proposition for some of D’s activities but appear to deny it for others. Of course, the real question is whether the activity was *requested* by the insurer (whether directly or indirectly, whether expressly or impliedly, whether straightaway or through defense counsel) and/or whether the work *appeared to be reasonably necessary* to the defense of the underlying lawsuit, given the communications between representatives of the insurer and/or defense counsel, on the one hand, and representatives of the insured on the other. Necessity per se is irrelevant, as all the participants agreed. Of course, whether the work *appeared to be reasonably necessary* is a question which must be answered for a particular time. Everyone agreed that the appropriate time at which this determination should be made is the time at which the activities of D’s employees were actually or constructively

requested.

The work performed by D apparently included lab testing, explaining, teaching, re-teaching, document production, assistance, help in discovery, assistance with discussions of damage allegations, discussions of business matters (such as marketing and advertising) germane to the suit, attendance at depositions, attendance at deposition preparation sessions, and—it looks like—other meetings with counsel. D alleges that its participation in the underlying litigation was extensive and intense during the three-year period. No one really denies this contention. Apparently, everyone also agrees that D successfully defended the underlying case and that it obtained a take-nothing judgment.

All of the insurance policies D had from I-1, I-2, and I-3 imposed obligations upon D with respect to the defense of the suit. Among other things, clauses require that D “must . . . [c]ooperate with [the insurers] in the investigation, settlement[,] or defense of the . . . ‘suit’[.]” Thus, the insured’s duty to cooperate is significantly open-ended and without artificial restrictions. We would not be surprised if a court were to find the term “cooperate” as used in this clause ambiguous. It is certainly an open-textured, vague term. Those linguistic features are often enough for legal ambiguity, although the mere fact that a sentence is confusing does not make any term in the sentence ambiguous. Similarly, the mere fact that something is hard to understand does not make it ambiguous. Some prose must be read slowly. These facts are widely appreciated in the socio-economic world of insurance adjustment, although less so among lawyers representing plaintiffs and policyholders. Of course, if the term “cooperation,” and its cognates, are ambiguous, since this is a standardized policy, it will almost certainly be automatically construed in favor of the insured, given the right pleadings.

In the coverage action D is seeking contract damages of \$1 million, plus costs, interest, and reasonable attorneys’ fees. In addition, it is seeking statutory damages under article § 21.55 of the Texas Insurance Code—a prompt payment statute—and under article § 21.21(4)(10)(v)(A)—a statutory bad faith clause—which provides that an insurer must, within a reasonable time, affirm or deny coverage of a claim made by a policyholder. (Treble damages available under article 21.21 for a knowing violation.)

These statutes make unreasonable delays in claims-handling a form of insurer bad faith. By implication they forbid and penalize certain forms of insurer passivity. Waiting-and-seeing is frequently inconsistent with sound adjustment practice and received norms of sound adjustment, as all of the honorable and sophisticated adjusters in the case agree. (The aforementioned statutes are being used only because that's where the authors happen to be from, and they are the statutes with which they are most familiar. There are similar statutes in many states, so that the hypo could be changed *mutatis mutandis* for a variety of states. In addition, some states can make common law bad faith actions when commercial liability policies are involved, although Texas does not, at present.)

The insurers, in their pleadings, deny various factual allegations asserted by *D*. In addition, one or another of them asserts lack of notice, late notice, violations of the duty to cooperate, the performance of work not requested by the insurer, performance of work not requested by the defense counsel, the performance of work which is not necessary, and the failure to document a request for supplementary payments adequately. In addition, some of the insurers assert that some of the work *D* performed, and therefore many of the expenses it incurred, relate to counter-claims that are not covered under the applicable policy. In addition, I-2 claims in its pleadings that "many of the activities and fees for which reimbursement is sought by [*D*] involve conduct prior to [I-2's] notice of the lawsuit." I-3 takes the same position, although I-1 did not.

Who owes what to whom? By means of what principles can this question be answered? How would this case be tried? Obviously, not all of these questions can be fully answered here, but some preliminary thoughts might be stimulating. We will add further facts as the hypothetical is developed. This is not intended to be a law review essay, it is not intended to be an encyclopedia article. Instead, it is intended to be food for thought, and it is intended to suggest a sensible approach to what will become a more and more serious and pressing problem as more and more plaintiff's and policyholder lawyers learn more and more about insurance and press claims that have not hitherto been pressed.

General Thoughts

In general, if a liability insurer asks an insured to undertake expenses or activities, or if this request is made by defense counsel in the discharge of his apparent authority, the liability insurer is legally obligated to, should, and usually does pay these expenses, after reviewing them, and sometimes after an audit, some trimming, and occasionally a little squawking. Naturally, liability insurers are cautious about this matter, since they are sensitive to issues of racketeering and fraud. (Sometimes, *sensitive-to* is an understatement.) To be sure, in the vast majority of cases, such expenses are minimal or modest, and/or they are not claimed. Sometimes this is a result of ignorance or inattention by the insured; sometimes this is a result of the insured not caring; and sometimes it is a result of insured-relief, i.e. the insured is so glad for the litigation to be over and done with, that it wants to forget about the whole thing. Perhaps there are other reasons as well. Insurer silence is a relatively constant factor.

Significantly, in our experience, liability insurers do not expressly invite insureds to seek these expenses. They do not, in general, remind their insureds that they may be eligible for compensation under the supplementary payments provision. I have never seen such a thing discussed in a reservation of rights letter, or anything of the sort. It is not hard to surmise (or guess) why this is true.

In our experience, most insurance adjustment organizations have a tendency towards bureaucratic rigidity. They tend to believe—or at least are tempted to believe—that if a claim is unusual, it is not covered. One of the functions of coverage counsel is to dispel this inclination when it is an error. This is also one of the functions of thoughtful, experienced senior adjustment officials, such as some of those involved in this case. (Of course the inference from *unusual* to *uncovered* is not a wild guess. When there is a standard policy issued to hundreds of thousands, if not millions, of insureds, the inference from *unusual* to *uncovered* is not entirely rational, as a statistical matter.)

An implicit point to the preceding paragraphs is that the request for supplementary payments in this hypo is quite large. Consequently, it is likely they would be beyond the immediate experience of most adjusters who manage routine (even) business

litigation matters. It is unusually large even for a commercial claim. Moreover, in our experience, adjusters are frequently out of their element when it comes to dealing with Coverage B. It is also our experience that many adjusters reflexively tend to believe that the Principle of Fortuity narrowly circumscribes the exposure of insurers under Coverage B. Of course, this general attitude rests upon an error. Furthermore, inexperience creates especially pro-active responsibilities.

Significantly, since the supplementary payments provision is part of the duty to defend, it is not subject to policy limits. As a consequence, in a Coverage B case arising out of a highly technical business involving many engineering issues, it would not be all that surprising for expenses to run high. It is relatively rare for such cases to have a full discovery schedule and go full-tilt for several years. Rarity brings with it added duties and therefore burdens. It is a received industry norm that special cases require special attention. There is nothing esoteric about this norm.

From the point of view of the thoughtful insurance company these unusual cases (e.g., large Coverage B cases) automatically create a dangerous situation. This is especially true if the adjustment hierarchy has a tendency towards seeking conformity and a company orientation. Of course, those phenomena are natural in bureaucracies, especially in bureaucracies which have a responsibility for both making substantial payments and for guarding the assets of the paying company.

Now, suppose I-1 suggested in its pleadings that if the defensive activities of an insured are undertaken on behalf of defending a claim which is not covered, then the insurer cannot possibly be liable to compensate the insured under the supplementary payments provision. This idea is a bad mistake in many states, and its falsity results from the fact that supplementary payments provision hinges on the duty to defend and not on the so-called duty to indemnify, (i.e., the duty to pay). A minority of jurisdictions have ruled that an insurer is not liable to pay for the defense of a claim for which it could possibly have a duty to pay, to be sure.³ That is not

the law in Texas⁴, and so far as we know responsible insurance adjusters know this.

A more interesting question arises from efforts expended on behalf of prudent counterclaims. Under some circumstances, such expenses would not be covered under the duty to *defend*. However, under other circumstances it would be covered. For example, if an insurer decided to go forward with counterclaims as a method of defending the lawsuit, the insurer would be responsible for paying attorneys' fees in conjunction with pressing the counterclaim and would be responsible for the activities of the insurer in the service of cooperating in that endeavor. Of course, this matter hinges on the facts of each individual case. One indicator of what is going on is whether the counterclaims are being pressed by the law firm defending the case or some other one, and whether that law firm is billing only the insurance company or whether separate bills are being sent to the insured. Another indicator would be "instructions the defending law firm received from the insurer and what discussions there were between the insurer and the insured."

Significantly, a liability insurer's duties under the supplementary payments provision turn on the meaning of the word *request*. Several propositions need to be kept in mind. First, if defense counsel makes an apparently reasonable germane request of its client the defendant-insured, that is tantamount to a request from the insurance company. This is true even though the defense law firm may not be anything more than an independent contractor with respect to the insurance company. The insured does not have to check with the insurer every time. The responsibility of the insurer for the requests issued by the defending law firm rises from the scope of mandated responsibility given to the law firm.

Second, the term *request* should not be construed narrowly. Indeed, it should be construed broadly. Quite possibly it is ambiguous. It is certainly open-sided. Consequently, and this is a third point, if an insured is requested to do X, and the doing of X requires the doing of Y, under most circumstances, the insurer will have either indirectly or impliedly

3. *Buss v. Superior Court*, 65 Cal. Rptr.2d 366, 939 P.2d 766 (Cal. 1997) (holding that insurer could seek reimbursement for costs incurred in defending those claims in underlying actions that were not even potentially covered by its policy).

4. *Texas Ass'n of Counties County Government Risk Management Pool v. Matagorda County*, 52 S.W.3d 128 (Tex. 2000).

requested that the insurer do not only *X* but also *Y*. Fourth, and this is also a consequence of the second (quite general) point, if an insurer makes a general request, and the general request involves specifications, anything the insured does which is reasonably undertaken in the performance of the general request is covered under the supplementary payments provision.

Fifth, in a long, complicated, and evolving case, the concept of a *request* should not be understood in any confined way. In a reciprocal, dynamic dialectical, evolving relationship, undertakings may be requested implicitly and subtly. Moreover, and sixth, if an insured begins to do something, and then reports his tentative steps to defense counsel and defense counsel encourages the insured to proceed, probably all of the activity is covered as requested. Although the concept of a *request* is often not temporally retroactive, in an informal, flexible, evolving, cooperative, reciprocal, team-like relationship, where one member of the relationship is more or less expected to anticipate the needs of the other, the concept of a *request* may include a dimension of retroactivity. (Musicians in bands, for example, anticipate one another and the effort improves.)

Under no circumstances should the concept of a *request*, as utilized in the supplementary payments provision, be understood narrowly or inflexibly. Experienced and rational senior adjusters who are trying to treat the interest of their insured as at least equal to the interests of the insurer know this well.

Now, suppose there is disagreement in the pleadings as to whether various components of the work performed by *D* were really *necessary* to the defense of the underlying case. This controversy is beside the point. It is entirely irrelevant whether work requested of an insured by a defending liability carrier or defense counsel is *necessary* to the defense of the underlying lawsuit. If the activities are requested, they are covered, so long as the expenses are *reasonable*.

Now add another fact to the hypo. Suppose *D* requests payment not only for such things as travel expenses for its employees, but also for their salaries. Notice that no one is seeking compensation for missing work. Instead, the policyholder is seeking salary expenses for those that had work on the

underlying torts. There is absolutely no reason whatsoever to think that salary expenses are not expenses. We have never met a liability adjuster who firmly believed that salary expenses were not covered under § 4 of the supplementary payments provision, although we have met many who have yearned to believe they are not. Similarly, the duty to cooperate language in the contract contains no reference to necessity. Indeed, it contains no explicit restriction to expenses being reasonable, although that is almost certainly implied. The term *reasonable* in the context of supplementary payments provision does not require that the performance of the requested activities actually be necessary or even helpful, in the end, if the expenses are commensurate to the requested activity.

The duty-to-defend components of liability insurance either are, or are analogous to first-party insurance. This is generally recognized amongst experienced liability adjusters, although some authority points in the other direction.⁵ That authority does not apply to the supplementary payments provision, which is absolutely indistinguishable from first-party coverage. It involves a duty to indemnify, classically understood, whenever there is a duty to defend and the insured is active in its own defense.

A Twist

Suppose that the insurers, puzzled about what to do, ask defense counsel for an account of the involvement of the insured-defendant, *D*, in the defense of the underlying case. Suppose, that defense counsel dispatches a memo or letter addressing the problem. Suppose further that the purpose of the letter of defense counsel is to narrate *D*'s involvement and to evaluate some parts, at least, of *D*'s claim for supplementary expenses. For the most part, this letter affirms the proposition that the activities undertaken by *D* employees were appropriate under the circumstances. It does not attempt to assess whether the *amounts expended* were reasonable. It only attempts to suggest that the *activities themselves* were—for the most part—reasonable. Occasionally, they are referred to as *helpful*, and

5. *Maryland Ins. Co. v. Head Indus. Coatings and Services, Inc.*, 938 S.W.2d 27 (Tex. 1996).

sometimes they are referred to as *necessary*. Many times, the report states that *D*'s activities were done at the request of defense counsel. On other occasions, the activities are said not to have been done at the request of defense counsel but to have been done with the knowledge and agreement of defense counsel.

If an insured says, "I think we should do *X* in the service of this lawsuit" and defense counsel says "I agree," all of the activities performed after the agreement are done at the request of defense counsel, and probably those which are done beforehand are as well.

Insurers tend to believe that too many lawyers attend too many depositions. No doubt, the insurers are right about this particularly when the depositions are in exciting or exotic locations such as San Francisco, New York, or London. At the same time, we think this rational evaluation (predicated as it is upon an insistence of antecedent preparation) should not apply to employees of an insured in a highly technical case. It may very well be necessary for multiple employees to attend depositions. Suppose the report from defense remarks that "it was necessary for *D*'s witnesses to attend each others' deposition[s] in order to minimize possible contradictions in the testimony." In other words, if a large number of *D*'s technical employees cannot attend depositions, they should, because they will be testifying, and it will be helpful for them to have heard antecedent testimony. More significantly, in a highly technical case, it seems to us, the process of education and recollection is an evolving matter to which a great deal of attention needs to be paid. This is particularly true when there are multiple technical expertises involved and substantial historical background. The underlying case was not a car wreck.

Something of the same is true for meetings of *D*'s defense team. Of course, this sort of thing can be overdone, but in bet-the-company litigation, which involves engineering, finance, computer technology, marketing, &c., it may be not only appropriate and advisable but necessary.

In conjunction with this fact, we would expect defense counsel to be reporting to the defending insurers on a routine basis as to who is doing what. If defense counsel reports are inadequate on this point, the insurers' beef is with the lawyers, not with an insured which is vigorously trying to help. If the

insurer has an objection to the use of the defense team, it should say so. In our experience, liability insurers are not in general shy about trying to regulate unreasonable expenses and the over-involvement of lawyers and personnel. (Of course, there is an instance marketing dimension to all this, but that is irrelevant.) Alternatively, if the insurer was not routinely receiving accurate accounts from defense counsel as to what was going on, and/or if its adjusters were not in contact with corporate risk managers (or their equivalent), then if the insured mildly overdoes things, and its management of a defense team is not manifestly unreasonable, most senior adjusters would probably believe that the insurer had disqualified itself from complaining about the insured's activities. Amongst lawyers, this situation is known as estoppel, and sometimes as implied waiver. *Better safe than sorry!* is a widely accepted norm in both litigation and litigation management by insurers.

Suppose the general tenor of the defense lawyers' report is to endorse the insured's view that the following were appropriate and requested: meetings between defense counsel and multiple employees of the insured-defendant, the substantial involvement of the insured's personnel in the preparation for depositions and the attendance thereat; substantial involvement of the insured in document production; substantial involvement of the insured in testing and experimentation; involvement of the insured in clerical work pertaining to discovery; the involvement of the insured's computer team in searching databases; the interviewing of customers by competent personnel; the use of the insured's secretarial staff; the use of the insured's personnel in investigation; depositions of the insured's personnel; the preparation therefore; the purchase of some (e.g., testing) equipment; and so forth.

At the same time, suppose that defense counsel's report is not without some reservations. One pertains to how the use of an airplane belonging to *D* should be priced and charge the insurer, if at all. What happened was that *D* transported defense counsel and its employees around from deposition to deposition on its company airplane. The cost of using the plane exceeded the cost of using airlines, but the plane was at their beck and call.

If counsel's report supports the activities of *D*'s personnel, responsible, attentive, and efficient adjustment personnel would, other things being

equal, give this information considerable weight. This is particularly true if it comes from a firm that specializes in so-called insurance defense matters. If adjusters did not follow-up on this letter and quiz its author in some detail, the adjusters would have failed in their appropriate function. This might constitute bad faith. At the same time, depending on who wrote the report, insurance adjusters might be justified in forming some skepticism.

Adjuster Behavior: More of Hypo

Alvin Dennis Jahosafat ("ADJ"), an adjuster for I-2 wrote two letters to coverage and coverage litigation counsel for *D*. As we recount these letters, ask yourself whether they are routine, completely satisfying, and to be approved of in every respect, or whether they are extraordinary letters and deeply troubling, or whether they are somewhere in between.

In the former letter ADJ says, "this large of a supplementary payments claim is highly unusual[,] and we are having some difficulty understanding how this claim is consistent with policy." (Emphasis added.) If the two propositions asserted here are genuinely coordinated by the conjunction, the sentence is not only false but dangerously so, and if it conveys the insurer's position, it probably constitutes delay without a reasonable basis. The mere fact that a claim is unusual—even "highly unusual"—does not for a single moment even suggest that the claim is not consistent with the rights and duties set forth in an insurance contract. If the sentence is not intended to be understood as I just explicated it, then the sentences are irresponsibly unclear and should have been revised by the insurer when it reviewed a preliminary draft, as is quite often done in cases of this sort.

The latter letter is equally striking. For example, it states that *D*'s view of the "coverage provided [by the supplementary payment section] is overly broad[.]" Note the non-tentative, unhesitating, and unqualified use of the indicative. The letter contains no immediate support for this proposition. Further, the letter appears to adopt a narrow reading of the concept of *at the request of*. Strangest of all, the letter says that the "[supplementary payments] coverage does not cover all of the expenses of the insured that may be contemplated by the cooperation clause of the

policy[.]" The tone and thrust of these two letters from ADJ to counsel are most unfortunate. Consider how these letters might play to a jury in—as Richard Nixon used to say—Peoria.

Expense Data Submitted by the Insured

Of course, the expense data submitted by an insured seeking supplementary payments are subject to the usual audit procedures. One of the mistakes insurance companies make, it seems to us, is to react vigorously and negatively to an anomalous submission and then try to avoid doing anything at all. One of the first things they should do is to determine whether such submissions from an insured have the look of plausibility. This is to be determined not necessarily by how they shape up in comparison to other submissions by other insured but how they shape up under the circumstances of a given case. Incremental, comparative reasoning is not always the best reasoning. Sometimes, the best reasoning is contextual.

Suppose the submissions of *D* are the kinds of things one would expect a committedly cooperating insured commercial defendant to do in a complex case. Suppose further that *D*'s time logs are on the sketchy side. If an insured has not been instructed as to how time logs should be prepared, and if *D* is not normally in a business where it is required to send out detailed billings, the chances are that its time logs will be on the sketchy side. In our experience, this is particularly true for engineers. Just because data was not prepared in conformity with the customs of the legal profession, the requirement of that trade should not be imposed upon an insured. If the insurer wanted detailed data for each activity, it should have provided the insured with standards and examples, as liability insurers often do with lawyers. If, the report from defense counsel tends to support the insured's expense data, taken as a whole, the insurers may not be able to complain.

It is important to remember, in this context, that the underlying (hypothetical) tort case was involved, complex, technical, lengthy, and beset by multiple aspects, including engineering, statistics, marketing, (e.g. advertising and customer contact), finance, accounting, and managerial concerns including internal communications. It is important to remember that services are expensive. It is

inappropriate, given the language of the policy, for the insurers to try to claim that they are not liable for salaries. From an accounting standpoint, salaries are treated as an expense, and the policy provision covers expenses taken as a general category.

Suppose *D*'s expenses are being billed at quite a reasonable rate. Suppose that expert witnesses cost a good deal more than the prices *D* has used in calculating its claim for supplementary. It is not clear that the duty to cooperate would require an insured to make its engineering staff available for lengthy and burdensome participation and expert discovery. That is exactly what *D* did here.

Statutory Bad Faith: More Hypo

Now suppose there is insurance litigation. Suppose *D* has sued I-1, I-2, and I-3 for failure to make appropriate payments under the supplementary payments provisions of their policies. Suppose further that, according to the pleadings, *D* is seeking recovery under art. 21.55 and art. 21.21. Also, *D* has been trying for some time to get its supplementary payments claim paid. By hypothesis evidence suggests that the insurers have actively sought to provide foundation for *D*'s claim and/or detailed criticism about it. As stated, we believe that supplementary payments claims are, in the classic sense, indemnity claims. The insured has already spent money and is seeking reimbursement.⁶ This means that such claims either are themselves or are very much like first-party insurance claims. Consequently, the generally received industry adjustment norm is that the insurer must *Look for coverage!* This maxim is not merely the expression of an ideal. It is a fundamental, ground-floor-level maxim, although adjusters often feel the need to violate it, and financial officials in insurance companies frequently create artificial pressures to cause its violation. No evidence suggests that the insurers have done any such thing. No information suggests that the insurers have sought to take detailed interviews or performed audits of the insured's expense submissions. Insurer passivity in the face of a documentary first-party claim (or its

equivalent) is never acceptable and should never be indulged. This is true even if the insurer is bewildered by the claim. It is the immediate responsibility of an insurer when faced with an unusual claim to obtain coverage advice, to make empirical inquiries, and to engage in dialogue with the insured. There is a whole field of accounting denoted to the provision of these services.

Things would be different, perhaps, if one or more of the insurers had made a partial payment. Even then, that insurer's problem would not be completely solved. It would be necessary for that insurer to demonstrate the rationality of the amount of the payment it made. Oddly enough, the situation might be even tougher for the insurer that made a partial payment than for the insurers that made no payment at all. Clearly, if I-2 and I-3 believe they didn't owe any money, and I-2 believed that it did owe some money, but it wasn't sure how much, its problems of proof would be more complicated (at least possibly) than those of the other two.

In addition, this litigation has some of the earmarks of a controversy amongst the insurers. Experienced, sophisticated, honorable adjusters believe that quite frequently, when insurers have a dispute to which the insured is not really a party, the insured should be, in the lingo of the trade, "gotten out of the way." This means that the insured's claim should be paid and then the insurers should argue amongst themselves as to who should pay how much. If, and to the extent that, not all of an insured's claim is accepted, the largest agreed amount should be paid without any prejudice to the insured to seek more.

In summary, we think that there may very well be statutory insurer bad faith in this hypothetical case. There is no reason to believe that the pleaded sections of art. 21.21 do not apply. The issue of art. 21.55 is slightly more difficult. (Remember: Article 21.55 of the Texas Insurance Code is a late payment penalty statute.) On the one hand, there is authority that art. 21.55 applies to the duty to defend (and hence to supplementary payments).⁷ On the other hand, some of the language of 21.55 suggests that it is restricted

6. Indemnity defined: Security against hurt, loss, or damage. MERRIAM WEBSTER'S COLLEGIATE DICTIONARY, (10th Ed. 1996); Reimbursement. BLACK'S (6th Ed. 1990). Indemnification defined: To make compensation to for incurred hurt, loss, or damage. MERRIAM WEBSTER'S COLLEGIATE DICTIONARY, (10th Ed. 1996).

7. See *E&R Rubalcava Const., Inc. v. Burlington Ins. Co.*, 148 F. Supp.2d 746 (N.D. Texas 2001).

to first-party claims. Then again, a claim for supplementary payments either is or is very much like a first-party claim. Recall the well recognized, applicable prescriptive norm in the social world of adjustment. *Look for coverage!*

Additional Materials For One to Review

As this type of case develops, it would probably be a good idea for the policyholder's attorney to take a look at the claim files of the liability insurers. Of most special interest are status letters and other materials from defense counsel to the liability insurers. Status letters often indicate who attended depositions, for example. Other materials to review are submissions from defense counsel to the insurers such as deposition summaries, those too might have a list of those present. There might well be minutes of defense team meetings. There might be sign-in sheets for such meetings. There might be e-mails describing such meetings, &c. And there might well be scribbled notations as to phone calls.

In the normal course of things, we would expect a liability insurer which was conducting a defense in a prudent manner to have extensive familiarity with the level of involvement of the insured. The higher the level of the defending insurer's knowledge, the deeper its bad faith in refusing to make supplementary payments forthwith after the claim is submitted. The lower the level of the insurer's knowledge as to the insured's involvement, the higher its obligation to investigate the supplementary payment claims with dispatch.

For similar reasons, it might be a good idea to take a look at the defense law firm's billing statements and transmittal letters. These frequently contain information about insurer involvement, and include tidbits such as phone conversations and so forth. Of course, there may be other materials which one would wish to review as the case develops, such as some depositions.

Case Law on Supplementary Payments

Most of the cases pertaining to "Clause d" of the Supplementary Payments section of the policy—the clause under discussion in this essay—concern attorneys' fees under various circumstances. When an insured fails to notify an insurer of a loss, it has no entitlement to the attorneys' fees it incurs in defending the lawsuit against it, and this rule is "powerfully underscored" by the Supplementary Payments provision.⁸ Usually, the Supplementary Payments clauses are not necessary to require an insured to pay defense attorneys' fees pursuant to the duty-to-defend provisions of the contract. If those provisions of the contract are breached, then damages are appropriately awarded. There is an occasional exception as we discuss presently.

Several cases have focused on the question as to whether the insured that succeeds in a declaratory judgment action can recover the fees it expends under "Clause d." Historically, the answer was clear. Attorneys' fees were not expenses within the meaning of that clause, and they were not incurred at the request of the insurer.⁹ This is true if the insurer sues the insured, and if the insured sues the insurer.¹⁰

There appear to be two significant cases inclined in the other direction, however. Neither of them is an easily understood case. The judicial prose in both cases is opaque and cumbersome.

In *Olympic Steamship Company, Inc. v. Centennial Ins. Co.*,¹¹ Olympic crimped cans of salmon it received from others in order to label them. Olympic overdid it, and a large number of cans of salmon had to be recalled. The insurer denied coverage on the basis of the sistership exclusion and the exclusion for the withdrawal of products. The court eventually held that the cans were not the product of Olympic, since it received them from its vendees for the purposes of storing and labeling and hence that these exclusions did not apply. Also, the court held that Olympic did not "handle" the cans in the sense required for the

8. *Interface Flooring Systems, Inc. v. Aetna Casualty & Surety Co.*, 2001 W.L. 238148 (Conn. Super. 2001).

9. *Milwaukee Mechanic's Insurance Company v. Davis*, 198 F.2d 441, 445 (5th Cir. 1952). See *Farmer's Insurance Company of Washington v. Rees*, 617 P.2d 747, 749 (Wash. App. 1980).

10. *Litbo Color, Inc. v. Pacific Employers Ins. Co.*, 991 P.2d 638, 647-48 (Wash. App. 1999); *Int'l Ins. Co. v. Rollprint Packaging Products, Inc.*, 728 N.E.2d 680, 695 (Ill. App. 2000); *Concept Enter., Inc. v. Hartford Ins. Co. of the Midwest*, 2001 WL 34050685, at *9 (C.D. Cal. May 22, 2001); *Aetna Cas. and Surety Co. v. O'rourke Bros., Inc.*, 776 N.E.2d 588, 598-9 (Ill. App. 2002).

11. 811 P.2d 673 (Wash. 1991) (*en banc*).

pertinent exclusions.¹² In any case, Olympic initiated suit against Continental and incurred attorneys' fees. The court held that Olympic was entitled to an award of fees pursuant to "Clause d" of its policy. The court made no attempt to derive its conclusion from the meanings of the words in this clause. This part of the opinion was pure dogma. Instead, it advanced interrelated arguments, alternative pertaining to the received archetype of the cheap, penny-pinching, refusal-oriented, burdensome, over-weening insurer. "An insured who is compelled to assume the burden of legal action to obtain the benefit of its insurance contract is entitled to attorneys' fees, regardless of whether the duty to defend is at issue."¹³

The other case was a reinsurance case, *Employers' Reinsurance Corporation v. Mid-Continent Casualty Company*.¹⁴ Mid-Continent's insureds were sued for various reasons. Mid-Continent denied coverage. Insureds sought both attorneys' fees paid for in the underlying litigation and attorneys' fees in the declaratory judgment action against Mid-Continent. The insurer lost these cases, and had to pay both sets of fees. It now made a claim under its reinsurance policy. That agreement stated that reinsurer would pay "claims expenses," and that phrase was defined to mean "all payment under the supplementary payment provisions of [the Mid-Continent] policy, including court costs, interest upon judgments, and allocated investigation, adjustment, and legal expenses." The issue was whether the reinsurer had to pay these expenses at all, and if it did whether it had to pay so-called unallocated adjustment expenses which were estimated by Mid-Continent. Mid-Continent's Supplementary Payments provision contained "Clause d." Indeed it was orthodox in every respect. The district court found as follows:

The plain reading of the supplementary payments provision indicates that it covers [Mid-Continent's] declaratory judgment fees and expenses. The provision provides that [Mid-Continent] will pay all expenses which it

incurs with respect to any claim it investigates. Certainly, [Mid-Continent] investigated the claims for which it litigated coverage. Moreover, the fees and expenses which [Mid-Continent] incurred in the declaratory judgment proceeding are expenses which it incurred with respect to such claims. Accordingly, the declaratory judgment fees and expenses fall within the plain and ordinary meaning of the supplementary payments provision.¹⁵

The language of this quote is not easily understood. Given the facts of the case, in which Mid-Continent paid not only its own attorneys' fees but those of its insureds in the declaratory judgment actions, one would think that "Clause d" is implicated, and we assume that it is. At the same time, if only the insurers' legal fees in the declaratory judgment action were at issue in the reinsurance case, then only another part of the Supplementary Payments provision would be implicated, to-wit that part which promissorially requires the insurer to pay all expenses it incurs in investigating or settling any claim or suit.

What do these cases mean and suggest? From the perspective of insurers, it might be well to tighten-up the relatively standardized language of the Supplementary Payments provision so that fees in coverage litigation would be excluded. From the point of view of insureds, it should be recognized that the supplementary payments provision is a potential goldfield if mined correctly. Under the present wording, insureds should study documents in coverage disputes carefully looking for the word "request" and its synonyms. Policyholders might consider trying to induce insurers to say things like, "we really want you to answer this coverage lawsuit." Thereafter, of course, the policyholder would take the position that they were spending attorneys' fees in the coverage action at the request of the insurer. (Ah! The set up—the set up! No wonder insurers feel beleaguered.)

12. *Id.* at 680. This holding seems almost certainly mistaken to us.

13. *Id.* at 682.

14. 202 F.Supp. 2d 1221 (D. Kan. 2002). One Kansas federal district court has said that if an insurer files a DJ action, it has "requested" under Clause d. *Citizens Ins. Co. of Am. v. Charity*, 871 F. Supp. 1401, 1404 (D. Kan. 1994).

15. *Id.* at 1236.

Conclusion

What are the practical upshots of all this? Here are some suggestions. First, liability insurers with supplementary payment clauses in their policy should be obligated to notify insureds of their existence. The insurer should provide some indication as to how to keep records and what the insurer thinks about the contours of the coverage.

Second, lawyers for policyholders ought to advise their clients early on to keep careful records of virtually everything they do in the service of defending a lawsuit and of all expenses they have, whether those expenses involve immediate cash flow commitments or simply involve crewel.

Third, defense lawyers ought to indicate to insureds that they may wish to get explicit permission from the insurer before making expenditures. In that context, the law firms might wish to say that they do not have the authority to make such a request on behalf of the insured for the insured to incur expenses or to approve a request on behalf of the insurer for the insured to incur expenses.

Fourth, insurers should work out standardized, minimalistic schedules of expenses which are automatically authorized for which there is an automatic (constructive) request. The insurer ought

to make clear that anything outside the parameters of that matrix requires an explicit request from the insurer that the expense be undertaken.

Fifth, courts are to recognize that the duty to defend is first party insurance and that it is subject to the law of bad faith. This would make bad faith failures to make supplementary payments subject to the law of common law bad faith.

Sixth, policyholder lawyers ought to advise their clients to file supplementary payment claims on a rolling basis so that there can be no late notice complaint. Probably, the risk manager for the insured should raise the issue with the adjuster and determine how frequently they want them. This will obviate any possibility of a bad faith claim.

Seventh, lawyers for policyholders and policyholder risk managers should admonish policyholders not to be extravagant in filing these claims and to be prudent in, for example, how many of their employees they send to a deposition, or something of the sort.

No doubt there are countless other suggestions. Naturally, both we and the Journal welcome comments, rejoinders, replies, responses, rebuttals, and debates.