

Insurance Litigation Reporter
June 8, 2005

Feature Article

"LOOK FOR COVERAGE!"

Michael Sean Quinn [FN1]

I started working on first-party insurance claims in the early 1980s. At that time, I worked with and for Al Mueller, a senior boiler and machinery adjuster at Kemper. That type of insurance has been around for a long time, as separate policies, in fact, it has been around even longer in ocean marine insurance. Ships began to have machinery on board long before there were railroads. Some of them began to have boilers long before there were very many miles of track. (In some sense, ships running back hundreds and even thousands of years were, when taken, machines. [FN1] He taught me a principle which is crucial for expert witnesses in many insurance cases, especially those alleging bad faith. It has not played an explicit role in reported cases. Still, it is central to the insurance litigation that pertains to adjustment, so it should be explicitly explored.

Mueller was highly experienced and gifted at his job. He understood machines, boilers, insurance concepts, and accounting. He was tall, beautifully gray, heavily set, hard working and a very bright adjuster. Mueller was a smoker as well as a chewer of cigars, and was a superb horseshoe player. (Indeed, he retired to do precisely and virtually only the latter two of these.) I have lost track of him. I have, however, not lost my vivid memory of him or what he taught me. He was an excellent, heavy-duty, first-party commercial adjuster. I never saw even the most confident policyholder accountant win-out over him.

By the time I came into contact with Mueller, I had a considerable amount of education, some of it quite advanced, much of it about values, ethics, and reasoning. I did not then know much about what he did, however, whether it was looking at and examining machine disasters, judging physical loss, thinking about reasonable costs (e.g., of repair or replacement), costs, reviewing business interruption accounting, or allocating losses to various different temporal periods. Fortunately, Mueller helped me learn lots and lots quickly. Much of what he taught me was and is quite general across various first-party coverages. I have been doing some of what he taught me ever since, and I don't think I have ever deviated (at least--intellectually) from his major and fundamental principle of sound (and reasonable) adjusting he taught me.

The First Principle

The "Mueller Principle" is this: **Look for coverage!** Perhaps it should be called the "Central First Principle" ("CFP") of sound insurance adjustment. My then mentor, Mueller, described it as *the* fundamental ethical principle governing *all* first-party adjuster conduct in processing claims. The principle applies, he said quite rightly, no matter what kind of person or entity the insured was. It didn't matter, according to Mueller, whether the insured was likable or even honest. Although honesty might have something to do with some features of adjustment, it was irrelevant to a right to payment if there was a covered loss. Even the houses of swindlers and con-persons can sustain hail damage and/or non-arson caused fires. It does not matter, said Mueller, what the truthfully preserved covered claim was for or how well it was presented. Fraudulent claims are a wholly different matter, of course.

Since 1985, or so, I have repeated this exact principle to many adjusters to determine whether they agree with, or subscribe to, it. Not one has ever rejected it or expressly disagreed with it. Many have stated that they learned the same principle from whomever it was who taught them. Some of them have observed that CFP is a widely embraced principle. None have ever denied it.

One of the other adjusters who mentored me, John Moyer ("Moyer"), also then of Kemper, but now an expert witness in insurance matters, has also subscribed to the **Look for Coverage!** principle for many years, and still does. Moyer is much shorter and more trim than Mueller. He was not gray and he, too, was a heavy cigarette smoker. Interestingly, he had been a boxer in his younger life but had been an insurance claims man for many years. For one of these reasons, Moyer seemed to love, at least some, lawsuits. His experience as an adjuster was much more diversified than Mueller's, and he held more senior positions.

According to Moyer, CFP is a widespread fundamental directive across the entire insurance industry, including at least the duty-to-defend component of third-party coverage. After all, responsible adjusters read plaintiff's petitions (or, complaints) broadly to see if there is a duty to defend.

Moyer also told me that he systematically and repeatedly taught CFP in training courses. He said, however, that the principle was, to some degree, also undermined in many training sessions, because so much attention was devoted to exclusions. Moyer thought that the huge amount of time and attention spent upon exclusions tended to focus attitudes of new adjusters on getting out of coverage, rather than on finding it. Intellectually, attention and dominant attitude are not always trained together, he said. The amount of training time for exclusions, of course, has to do with the number of words involved in applicable exclusionary lists, as opposed to the usually quite short coverage positive sections. The specificity versus generality of the two substantive sections is often forgotten. Furthermore, complex definitions set forth in policies often play larger roles in understanding and construing exclusions than they play in dealing with coverage agreement sections.

As a lawyer, I have taken the depositions of numerous adjusters over the years and I have prepared witnesses for and/or defended more than a few such depositions, as well. Both series have happened in a variety of contexts, for example, bad faith cases, commercial subrogation cases, and cases involving various types of policyholders with a diversity of coverage problems. Not one adjuster-witness has ever denied the significance or wide applicability of CFP, when I have asked about it in a deposition, while preparing testimony, or at trial. Virtually all of them have said that they subscribed to it; that their (previous) insurer-employers did so; and that the current insurance company employing them did so as well. From time to time adjusters have said that they don't really fully understand CFP, but every one of them who subscribes to and/or is familiar with CFP has acknowledged over the years that it has been *a--if not the--*fundamental norm of sound adjusting. Many have said that the proposition or the idea was integral to, or at least, involved in their training. Significantly, first principles are seldom fully understood, even by the profoundly learned or wise. Occasionally, it has been worded differently.

Sometimes I suggest to other lawyers that they ask adjusters appearing as witnesses about the maxim **Look for Coverage!** This often happens when I am working as an expert witness for a policyholder - a less infrequent occurrence as the years go by. Many have followed my suggestion in depositions. None of these lawyers has ever told me that an adjuster rejected CFP. Indeed, they say the opposite. I often ask these lawyers about what the adjuster-witness says, and frequently I read their depositions. The answer adjusters give is always the same: CFP--or its equivalent--is true, helpful, endorsed, and frequently recognized.

Obviously, it is important to keep in mind that the principle **Look for Coverage!** does not entail, imply, or even suggest, the imperative *Find Coverage!* Looking for something and finding it are not the same. Similarly, CFP does not entail or imply, though some think it suggests, the principle *Use all your efforts and energy to find coverage and do nothing else!* Furthermore, CFP does not imply or suggest this principle: *Always conduct a totally full and absolutely complete investigation.* This principle means that a full and complete investigation could be accomplished only if everything was looked at, everything was examined, and no stone (whether factual, linguistic or legalistic) at all was left unturned. Nothing short of all these would constitute a full or complete adjustment. However, if the first inquiry of a CFP establishes, for example, that there is no coverage, no actionable act or event took place, or that no injury and/or damages have been sustained, it is not necessary to look further or elsewhere, look more deeply, or examine something else which might be relevant. Many policyholder lawyers adopt these three "principles" reviewed in this paragraph, at least for rhetorical purposes. Lawyers for insurers should carefully consider demolishing them through logic, law, and expert witnesses.

In contrast, CFP probably does, at least empirically, nearly entail the following principle; however: *Use reasonable and actually appropriate efforts in dealing with a loss--whether finding it or analyzing it, and to find coverage within the terms of the insurance contract.* Finding coverage entails that the terms of the policy control. Finding coverage presupposes the existence of a contract. *Finding coverage*, i.e., finding something actually covered by the contract, is not the same as finding some loss or other. Finding coverage does not require distorting the meaning of the policy. Something has to exist to be found. Inventing or imagining something and finding something which already exists are not the same. That actually would distort coverage and undermine the idea of insurance itself.

Alas, this principle is too long to be workable as a slogan in trials. Some expert witnesses will say they don't really understand it. Perhaps some don't.

The principle **Look for Coverage!** is of enormous social and economic significance in the context of a capitalistic economy. One of the fundamental principles for all businesses in anything remotely resembling a capitalist order is: *Maximize Profits!* Any insurance company which follows this principle will have a pervasive temptation to minimize claim-based payments. Insurance companies have money. They received it mostly from policyholders. Insurers cannot boldly, timely, and simply maximize profits, at least from an absolute point of view, if they pay any money out on claims. For this reason, one temptation that every insurance company faces is to find as little coverage as possible. On the other hand, this temptation, while apparently or superficially dictated by economic principles, is: (1) inconsistent with the fundamental purpose of insurance; (2) is inconsistent (therefore) with the social purpose of genuine and justified insurance companies; (3) will lead to the long-term death of insuring companies; (4) will trigger negative government reactions; and (5) will breed lawsuits. Of course, lawsuits cost enormous sums of money. Legal services in business controversies are especially expensive, not that they are cheap anywhere.

Any insurance company following the principle, *Avoid coverage whenever possible in order to maximize profits!* is profoundly immoral, as well as frequently illegal, since its conduct is anti-contractual, conceptually inconsistent with the very idea of insurance, profoundly unethical, and so forth. Consequently, insurance companies need to train those in charge of examining and adjusting claims to play a role which is fundamentally inconsistent with what is, at least, a very strong business temptation.

Of course, given that insurers should receive only reasonable premiums and pay legitimate claims fairly, they should--given these two accomplishments-- appropriately maximize their profits. There is no inconsistency between the purpose of an insurance company and the correct payment of genuine claims. However, there is an inconsistency between a company successfully taking all of its income and maximizing profits upon the receipt of those funds and the paying claims at the lowest possible level it can get away with. Hence, if for no other reason, CFP needs to be a central part of the dominant mental processes of every adjuster, and it is one of the very foundations of adjustment morality and ethics. It is not the only one.

CFP Create Fiduciary Duties?

The significance in centrality of **Look for Coverage!** does not entail or imply that an insurer is the fiduciary of its insured. The insureds' obligation to look hard at the facts and even its obligation to look expansively at language and facts to determine whether there is coverage, does not create fiduciary duties. The proposition that *Insurers are not (usually) the fiduciaries of their insureds* is not entirely undisputed. Nevertheless, it is probably true. Truth or falsity here again (probably) does not matter from the point of view of sound adjustment, although it matters from the point of view of litigation rhetoric.

One characteristic of fiduciary duties is that the fiduciary must treat as superior to its own the interests of the person or entity for which it is a fiduciary. There is nothing about CFP which entails any such tilting differentiation in favor of an insured. Sometimes, however, insurers are said to have *special relationships* with their insureds. Usually, this means that the insurer must treat the interest of the insured as equal to its own, though sometimes courts erroneously assimilate the *special relationship* to the fiduciary relationship. When viewed correctly, *special relationship* balancing is different from simple third-party relationships between business and customers, and it is not the same as a fiduciary duty.

In addition to the foregoing, fiduciaries are frequently said to have the following duties, beside the one already mentioned. Probably, not all fiduciaries have exactly the same level of high-duties. Attorneys, for example, are said to owe their clients the *highest* fiduciary duties. Obviously, if there were not different levels, attorneys could not have fiduciary duties higher than those of some others. In any case, here are some of the fiduciary duties: good faith, trustworthiness, careful observation of the relationship, scrupulous in administering the relationship, complete and total honesty, very substantial openness, very substantial candor, no deception, no concealment, full and fair disclosure of facts, complete and total maintenance of client confidences (a fiduciary duty, at least attorneys have, but also which some others have), and so forth. It seems quite clear that if an entity lacks any of these duties at any level, then it cannot--in any complete sense--really be a fiduciary.

At the same time, it is quite clear that insurers do not always, and under all circumstances, owe insureds candor and openness. Thus, for example, if the policyholder-claimant is lying to an insurer, the insurer might wish to keep its skepticism, its contrary evidence, what other witnesses have said,

and so forth, to itself until its review of the claim is elaborated. Thus, a full and complete disclosure is not at all times required. At the same time, it is perfectly true that most insurers, most of the time, owe first-party policyholder-claimants some good faith, although--perhaps not--*uberima fides*, absolutely the highest good faith lawyers owe clients. (Obviously, there is much more to be said, but the fundamentals of the case are against fiduciary status is established.

Some CFP Implications

CFP has at least three major implications. Each of them apply under all circumstances. The first two of these implications are extensions of CFP, or are very much like extensions. The third one is a qualification and may constitute a kind of limitation. Looking for truth and accuracy sometimes requires moving over the same grounds more than once, though not with mere repetition.

First, when an adjuster **looks for coverage**, the adjuster is looking *beyond* the language of the proof of loss or other report of the claim. If, for example, the owner of a commercial building reports that it has sustained storm damage to its roof as the result of a huge rainstorm--perhaps a storm with hail, lightning, wind, and so forth--the adjuster needs to look beyond the roof. This much has already been discussed. The point grows larger, however. The CFP-bound adjuster needs to go into the building and see what happened below the roof. If the roof is damaged, some of the rest of the building may have also experienced some damage from the storm as well. If the roof of the building is covered for storm damage, it's probably covered for damage inside the building as well. External walls may also need examination. Similarly, there may be damage under the building or there may be two or more covered structures on the insured property. CFP may include them all. Then again, maybe not. As we shall see, this implication has limits.

Adjusters should not restrict their looking to the policyholder's chosen language in either the proof of loss or the earlier report(s). Most policyholders are not insurance professionals. Most policyholders are trying to get their claim to the insurer quickly so that they can obtain a coverage decision, and then begin repairs or replacements. Thus, the principle **Look for coverage!** is designed to help insurers and their adjusters be *helpful* to the insureds. Insurance is to protect insureds. The "precise" wording of the claim, and the common understanding of contract language, it does not require that any of these be ignored, forgotten, disproved, or contradicted. Acts of *looking beyond* obvious facts are always appropriate and usually required. CFP is the key foundation to this idea.

Second, as long as an adjuster is at a building looking to see whether there is coverage and if so how much money needs to be paid to cover damages, the adjuster needs to look beneath his own memory of what the policy says. Often, adjusters actually need to take an actual look at actual policy language. (There is much to be said for *actuality*.) Often, the adjuster does not need to read deeply into the language of the policy. Often, the language is clear on its face. Sometimes, however, comprehensive, thoughtful, and even deep-readings are necessary. Indeed, looking for coverage in complex cases often requires that policies be *studied*. If there is a pattern of omission in adjustment processes, this is it. Perhaps this is why so many insurers are hiring frustrated, tired, or disgusted lawyers to come in house - either as adjusters themselves, or as easily reachable, quick thinking, highly knowledgeable coverage counsel, or both. I once saw a whole series of lawsuits arise involving plumbing losses in houses because a very good and very experienced adjuster thought he knew what a standardized policy said, but was wrong. This particular adjuster was so experienced, so honest, and was (or appeared to be) saving the insurer so much money (at least from temporary appearance), that the supervising examiner never really checked the adjuster's work. Unfortunately, the adjuster had misread (or, misremembered) the policy. Looking for coverage requires that the policy be grasped, and often this imperative requires that the policy actually be looked at in an adjustment process.

As already indicated, although the actual language of an insurance contract ultimately controls insurer liability, the same is not true for insurance claims. Policyholders do not always understand what they have said. They do not always understand what could or should be said under various circumstances. Adjusters should not even regard themselves as governed by recorded statements. Those doing claims need to look *beyond* the language actually used by the policyholder. They need to look *deeply* into language used in the claim, the needs of coverage, the needs of the insured resulting from injury, and the spirit of the claim, as opposed to its literal formulation. In following CFP, adjusters need to encourage the policyholder to say more; the need to inquire about what else could reasonably be said; the need to try and get the whole story, even if the whole favors the policyholder when a mere part (already given) does not.

Moreover, the language of policies is not always clear, even though this linguistic fact may not be known in advance. When policy language is less than clear, the adjuster needs to look deeply into the language of the policy and think about what it might reasonably be taken to mean under the actual circumstances of the claim. This is proof of required looking. Adjusters should not simply automatically accept the way the language has been interpreted in the past, even standardly. Linguistic habits of the past do not always determine actual meaning, especially in new circumstances. This is especially true with words like, "occurrence" and "accident," which are extremely important in liability policies. They have already been discussed.

Third, should an adjuster looking for coverage look around damaged premises, for example, to see whether there are covered injuries and damages which haven't been claimed? Parts of this have already been discussed. Part of the answer depends on the type of damages involved, as well as the types of claims. If there are multiple damages, then, even if they have not been formulated and even if the explicit claim which has been made is illegitimate and not covered, arguably, the adjuster should, at least, consider carefully informing the policyholder of existing claims and should probably do so. Such is what *taking care* (or caretaking) expansively is all about.

CFP has several dimensions: looking at already relevant facts, looking at and through claim and contract language, looking for at least some other possibly relevant facts, and possibly looking for other, perhaps, covered injuries and damages. In this context, adjusters need to be mindful of what may constitute a claim. It should therefore be remembered that even the term "claim" is ambiguous. In the context of adjustment, the insurance generally, the term has several meanings. (1) Insureds make claims for first-party insurance coverage and payment. These are not claims *against* the insurance company. They are part of the contract. They are, at least in the abstract, contemplated from the beginning. (2) In the context of liability insurance, claims may be made against insureds. The insured may turn them over to the insurance company. As claims against insureds develop, sometimes, those claims are made against insureds. It also happens before suits are filed. It sometimes happens in filing suits and in amendments. This sometimes happens in the context of litigation, for example, when an insurer is defending under a reservation of rights, the underlying claim against the insured is settled, and then there is an assignment from the insured to the tort plaintiff. All over the country, courts seem to be getting more flexible about tort plaintiffs suing both insured defendants and liability insurers in the same lawsuit. (3) Claims are sometimes made by insureds against insurers. This happens when insureds believe that insurers are not adjusting claims properly, or that they ever refused coverage when they should have admitted. In other words, sometimes, this means that the insured is pressing for a type of coverage or an amount of coverage which the insurer has tried to deny on the basis of good reasoning. In the alternative, the claim can be against the insurance company because the insured is accusing the insurer of being irrational, dishonest, or outside the purview of good faith. A claim against an insured can become a claim against a liability insurer in various ways. Sometimes in the liability context, a claim against the insurer will come from the person or entity making the original claim against the insured. Sometimes it will come from the insurer himself. CFP is relevant to claims in all three senses of the word "claim" in various and different ways.

CFP entails that adjusters should be *trying to find* some coverage following a claim. As already indicated, it does not imply that they should actually find, as it were, coverage, if it does not exist. This is not *finding* coverage; it is *inventing* coverage. It is not the case that good adjusters *shall* find some coverage in or close to it in every claim. It implies that they should be expansive, but it does not imply that they should set out to undermine the insurer. Looking for coverage does not imply creating it by (even sympathetic and/or empathetic) *fictionalization*. Adjusters are seldom novelists. Instead, CFP implies (although it is not implied by) the propositions that (1) adjusters should be appropriately knowledgeable; (2) adjusters should be objective; (3) adjusters should be fair; and (4) adjusters should be impartial.

Sometimes CFP has to do with policy language. Sometimes it has to do with facts. Analyses of fact are not always driven by CFP. Sometimes, they are driven by what cannot be found. This parallel has already been discussed. Here is an excellent example of one relationship between looking for coverage and facts, which have not been discussed yet. A man owned two houses. One of them he lived in most of the time in a large city. The other one was a vacation cottage 150 miles away. The vacation cottage was next to the lake. It was used for fishing on the weekends. It was used in the summer. It was a log cabin (sort of), obviously, made mostly out of wood. The country cottage was an old building. It had been painted many times.

Both buildings were insured. The insured was in severe financial trouble and needed a cash

infusion. For a month or so, he announced to everyone he knew that he was going to take a week off from work and "fix-up" the country cottage. The first thing he was going to do, he said, was clear the layers of paint off the floor, sand it down, and restore the beauty.

One weekend, the insured went to his cottage, and moved all of the furniture in the cottage out into the yard. He then poured chemicals on the floor, ostensibly so that he could begin clearing out the many layers of paint. The insured was a smoker. After pouring gallon upon gallon of the paint thinner on the floor, he went outside to smoke a cigarette. He stood with his back to the house. He had brought a box of fireplace matches outside with him. He struck one to light his cigarette, and tossed it over his shoulder. The match landed on the outside porch, which was itself wood, heavily painted, and thoroughly covered with paint thinner. The cottage burned to the ground almost immediately.

In the context of his claim, the insured told the story as recounted. He made no secret of the fact that he was in financial trouble and needed money. Naturally, it occurred to the insurance adjuster that the insured may have burned down his own cottage. The adjuster asked the insured bluntly if that was what he had done. The insured hesitated; smiled slightly, and there was a dance of achievement in his eyes. Very quickly, however, the insured unequivocally denied that he had deliberately set fire to his house.

For years, the adjuster was absolutely convinced that was precisely what the insured had done. At the same time, the claim was promptly paid. There is no way in the world arson could be proved. There was no way in the world that a claim should be denied and taken to court.

(Things could have been, at least a little, different if the insured had used the box of matches to light the cigarette of a genuine smoker, and then flipped the match over his shoulder. Things might have been different if the insured had become a smoker only recently and, therefore, did not have an on-off smoking history. It would make some difference if the insured had a history of having destroyed things he owned or burned them and so forth. The insurer's investigation, however, indicated none of these as possibilities.)

Some Other Basic Principles

There are at least three other important fundamental principles of adjustment. One such fundamental principle is this: *Insurers are not either legally or morally obligated to pay claims which are definitely not covered in applicable insurance contracts.* Perhaps this should be called the "Second First Principle" ("SFP") of insurance adjustment. Thus, insurers are not obligated to pay claims which are fraudulent, claims which are based upon provably false propositions, 100% of claims which are overstated for whatever reason, claims which are actually outside coverage, and so forth. (Of course a *provably* false proposition and a *probably* false one are quite different. A proposition which is probably false may--eventually--be "proved" to be true. The weight of evidence can support a proposition which turns out to be false, but is never known to be false. Thus, a jury may come to a false conclusion, because a proposition was "proved" to it to be true, even though it isn't and never was.)

SFP should be deployed and utilized in bad-faith litigation. Alas, it, too, involves complexity.

The insurance contract is important and determinate, at least with respect to its clear statements and fairly establishable facts. So are facts which are eventually proven to be true. From a legal point of view, facts which are *felt* to be true, *guessed* to be true, or merely *intuited* to be true, are nothing more than something like *wishful* thinking or hopes for proof. In any case, at the end, i.e., at the point of deciding coverage, feelings, guesses, invitations, wishes, and hopes are irrelevant and immaterial to correct coverage decisions. (Sometimes, of course, wishful thinking, along the way to a decision, and others of these key ideas, can play a useful role, particularly where it takes time to locate, surface, and/or scrape-off the muck concealing the surfaces of previously hidden facts.)

CFP and SFP are perfectly consistent. Given the nature of contracts, insurers do not have obligations to pay claims that are correctly determined to be outside coverage, even if they have an obligation to try to **look** for **coverage**, once the claim is made. Nevertheless, while consistent, CFP and SFP function differently. CFP tells adjusters how to receive claims, how to investigate, what epistemic spirit to have, how to think about claims, and how to treat them. More than anything else, CFP is practical normative principle. Inherent in CFP are certain other ideas: objectivity, appropriate thoroughness, energy and willfulness when it comes to investigation and thought, and a willingness to look beyond the actually stated themes and details of a claim, as well as the actual wording of a claim. Not all insureds think clearly or write well. The same is true of public adjusters and others--

e.g., lawyers--representing or assisting insureds in making claims. Some of these ideas will be discussed again later. SFP is a legalistic and linguistic principle. It even has an empirical component. It is not a norm, however, directing what ought to be done in the process of adjustment. CFP is. SFP is instead about how the social world actually is. It is not a commandment. Some might call SFP a meta-principle. In other words, SFP is about the nature of other principles, such as CFP, how they actually work, perhaps how they should work, how they fit together, and so forth. .

The situation is different, of course, if facts relevant to the claim are obscure or the insurance contract is ambiguous. If policy language is, by itself, ambiguous, at least on the surface, and it is not clarifiable by genuine and provable reference to technical standard uses, e.g., engineering, medical, trade usages, &c., or it is not disambiguate-able by references to significant facts, e.g., the actual intentions of the parties at the time of contract formation, under the law, the meaning of the language will (or should) be resolved in favor of coverage or to the benefit of the policyholder if coverage is already established. The amount of lawyerly and academic prose on this rule is, at least, enormous, and perhaps immense. (Assuming those words express different ideas.) .

What counts as *ambiguity* is not well established. Here is a pragmatic list: vagueness (consider the word "nearby"), the sandy (or, fuzzy) edges of some general terms (consider "maxim"), internal complexity ("corporate structure"), obscurity ("accident"), imprecise terms ("accepted," as in "accepted principles"), oddity ("personal injury"), queer dictionary entries ("sudden"), huge and changing ranges of reference ("pollutant"), ill-understood terms ("willful") and/or terms defined one way on one page and used differently on another, all may, in some circumstances--though not all--count as ambiguous terms. Then again, not every general term with "fuzzy" edges should be counted as ambiguous. Consider, for example, "balding," "tall," "short," "heavy, (even) "fat," "owned," "finished," "work," and many others may not be so adjudged, even if they are not words of perfect precision.

Paradigmatic, common usage ambiguity is quite different. The term "ambiguity" of law means that the term has quite different meanings. Consider, "bank," "bank" and "bank." Obviously, some banks are financial institutions; some banks are slopes next to rivers; and some banks are angles at which airplanes turn. Also, consider the word "appearance." In a deposition, the following question and answer occurred:

Is your appearance here today determined by the subpoena served upon you?

No. I'm dressed the way I always dress on weekdays.

Obviously, the word "appearance" is ambiguous.

The applicability of general terms, even many with fuzzy edges should mostly be determined by reference to material empirical facts, not by reference to meaning. Interestingly, the term "ambiguous" is itself *ambiguous*. General terms with clear centers and fuzzy edges are not usually counted as ambiguous, even if they are counted as vague, to one degree or another. In many contexts, a word is *ambiguous* only if it has quite different linguistic meanings. This fact is often ignored in lawyer arguments about contract construction.

Some of the instances are central to insurance disputes. Consider, for example, the use of the word "regular" in some standard auto insurance policies. In some policies, certain autos which are "regularly used" by an insured, fall into an exclusion Here is an example of such an exclusion. Consider the following exclusion found in Form 8430 and frequently denoted B.2.

We [the insurer] do not provide Liability Coverage for the ownership, maintenance or use of any vehicle, other than your covered auto, which is owned by you, or furnished or available for your regular use.

Empirically speaking, what constitutes *regular use* may not always be empirically clear. Once a month? Twice a month? Once a week? And so on. At the same time, the word "regular" in the exclusion is probably not ambiguous. A great many central cases are easily determined from obvious facts. At the edges of the term, there is some vagueness. [FN2] It should not be taken to imply ambiguity.

Similarly, if it is unclear what happened to cause an accident, a fire, or some other property damage, an insurer may be tempted to deny a claim. In the context of liability policies of a variety of sorts, the word "occurrence" is crucial. Even though it is defined in terms of the *accidental*, the concept of *occurrence* is sometimes not easy to understand. There has been substantial controversy, for example, as to whether the two airplanes which hit the two World Trade Center buildings constituted one occurrence or two. (This is true even though the airplane which hit the Pentagon on 9/11 and was part of the same organized plot was unquestionably a separate occurrence.) Now,

consider this analogy. Suppose, a large semi-truck crosses from one side of I-20 to the other side, say, because the driver is not taking the prescription drugs he is supposed to. Suppose the truck is going 85 mph and hits Car One, drives Car Two off the road and into the water-filled ditch, hits Cars Three and Four at the same time--one on the right and one on the left, and then the truck swerves, flipping its trailer over and crushing Car Five, while the cab swings around and its forward and moving riverside side then hits Car Six. How many accidents? How many occurrences? Saying there is just one occurrence in at least some of these contexts, seems to curse ordinary language, offend ordinary common sense, and constitute a worship of the convenient. The same applies to the idea of an accident. *A Quinnian Question*: Perhaps these ideas are fully ambiguous, or something close to it.

Often when the adjustment results are cloudy, access to adjudication should be an insurer's right: "We--the company--can't figure these facts out, so we will do whatever the court tells us to do. We'll conceptualize them as the court tells us." Sometimes these attitudes are aggressive and/or unreasonable. Sometimes they even cause stupid decisions. Sometimes not. Sometimes the decisions to seek adjudication are appropriate and reasonable. Then again, sometimes the decision of an insured to seek adjudication is improper. Suppose an insurer is pretty well convinced that there would be coverage if the claim were honest, but the insurer is convinced that the claim is not honest, although it knows it cannot prove to be true--its belief. Suppose an insurer seeks adjudication in order to wear down and perhaps wear out the claimant whom it believes to be dishonest. Is that an appropriate seeking of adjudication? Probably not.

Within certain limits, some extensions through CFP are obvious enough. If the insured says that the north half of the building is damaged and it is obvious from damage to the roof that more of the building may be damaged, the insurer should look around a whole lot more. This has already been discussed some. In such cases, the insured should be told, even encouraged to expand the claim, explicitly, if the bureaucrats at the insurer need it. At the same time, it is not clear that the insurer should be looking for entirely different types of losses, when it investigates a given loss claim. Thus, an insurer need not look for theft losses when examining storm loss. The maxim, "**Look for coverage!**" does not prescribe that while investigating one type of policy, an insurer needs to imagine all types of claims which might be brought under a regular type of policy and search for each of them. This would drive up the price of insurance absurdly. He is not consistent with the spirit of the contract, which requires insureds to report losses before the insurer has an obligation to look for losses. Besides, an insured might not want an insurer to look for a loss. Indeed, it might not wish to discuss it.

At the same time, if an unreported loss is obvious, and the insured is in need of help, an adjuster for an insurer should probably point out to the insured that he has a different kind of loss and that he might want to file a claim for it. Indeed, if the loss is quite an old one, pointing it out in Year Ten might be a good idea from a variety of points of view, including some interests of the insurer, some interests of the insured, and perhaps those of various other companies.

Thus, there is a certain clarity in and certainty about CFP. Although an insurer is obligated to **look for coverage**, and it is clear that the insurer is obligated to look at empirical matters which present themselves, given the claim, it is not clear how far the insurer must, in following and obeying CFP, go beyond the actual wording of the claim. Some distance is obvious enough, especially when the insured is a bit of an amateur. Rigid, restrictive interpretation of the items of the claim is inconsistent with the spirit of insurance. Nevertheless, spending valuable, expensive time searching for all sorts of possible claims is a (at least equally) silly idea. Thus, CFP has its limits.

Another fundamental adjustment principle is this: *Sound adjusting is governed by empirical facts, not by subjective impressions*. Let's call this one the "Third Fundamental Principle" ("TFP"). Its logic and status resembles SFP more than it does CFP. Observers of the empirical world can be wrong about what has happened and/or about what caused what. Thus, a policyholder who claims that his building exploded and burned as the result of being attacked by Iraqi terrorists may not have "seen" the facts correctly when he observed events surrounding his building in rural Wyoming. (It was a building that housed harvested sugar beets.) The policyholder could be perfectly honest, through and through, but he could also be wrong about the facts. Perhaps he mis-saw what was projected at his building. Perhaps he mis-saw who did it. Maybe he was drunk. Possibly he was stoned.

TFP works well in bad-faith litigation, so long as the idea of subjectivity is maximized. The idea refers to that which is mental only and not obviously connected by truth and/or evidence to the outside world. The purely subjective is very much like guesswork by an adjuster.

Sound adjusting can have something to do with *subjective impressions*, and even intuitions, of course, as already indicated. The adjuster must always include reference in her reports to an

examination of what propositions relevant people believe (and/or appear to believe), and what they believe they have empirically observed, as well as what is actually establishable. Subjective impressions are fine when they are no more than hypotheses. Memory is important, of course, though it, too, is subjective. Clear memory is even more important. Reliable memory even more so. This fact is particularly true when causal processes are leading to possibly covered losses with sudden, mysterious, not actually physically observed, and so forth. Subjective contents of minds may be important, but they are frequently not decisive. This is true even when a given person's memory is often reliable. This is particularly true when a witness's memory is inconsistent with establishable facts. Looking for coverage does not require that the subjective triumph over the objective.

Now is it the literal truth of the normative spirit of CFP to require that an insurer or the insurer's adjuster absurdly assumed that a claimant is an insured. Determining whether there is coverage requires determining whether a claimant is a party to or otherwise included as an insured within an insurance contract. With respect to whether someone is a named insured, the insurer has to look at the contract, look at the names, and look at the facts. It is not required to be particularly expansive, however. This proposition is true even if the language of the contract has to be reformed. A misspelled name, for example, does not create coverage for anyone other than the intended named insured. The situation is somewhat different, probably, when there are additional insureds included by categories within a policy, and one of the terms creating additional insureds is ambiguous. It is probably not radically different, however. The doctrine regarding ambiguities and interpretation is not usually applied to proper names.

A fourth fundamental, "first" principle ("FFP") of adjusting is this: *Unresolvable empirical doubts should be treated in favor of coverage*. If it is unclear what happened, or it is unclear what the policy says, the insurer should pay the just amount of the loss, given the character of the coverage. The insurer should not reduce the size of its covered costs as a result of the monetary amount of the legitimate doubts. At the same time, if a claim is genuinely doubtful, it can be tried and thereby determined in a court of law, and under certain circumstances it should be. It is a well-established law, of course, that genuine contractual doubts about the meaning of language in a policy should be resolved in favor of coverage. Indeed, they should not only be resolved in favor of coverage, they should be resolved in favor of amounts of loss, where coverage is undisputed.

FFP explicitly extends this fundamental principle from construing policy language only also to construing ambiguous and unclear facts. This extension is particularly true when the probabilities of opposing factual scenarios are indeterminable and must be treated as though they are approximately the same. In contrast, if one probabilistic account of the nature of a loss, and what caused it, is quite high and the probability of its alternative is quite low, an insurer may rationally embrace the more likely account of what happened. If, on the other hand, the probabilities for alternative accounts are indeterminable and not strikingly--dramatically--different, then the insurer should choose to be governed by the empirical or historical account that favors the insured. Such is the essence of FFP.

CFP does not imply the existence of a fiduciary duty running from an insurer to an insured. At most, it implies a *special relationship*, if it implies any sort of relationship. Similarly, FFP is not derived from the nature of the insurer-insured relationship. It is true because it stands in strong analogy with the legal principle governing the proper interpretation of contracts (including insurance contracts) which turn out to have used ambiguous language. (Of course, the principle of a contract interpretation pertaining to ambiguous language is extremely important when it comes to adjusting claims. Nevertheless, it is not--after the manner of CFP--a practical, morally based, normative principle of adjustment. It is a well-established principle of law and therefore, affects adjustment principles. Consequently, it need not be discussed as part of a group at which CFP is at the center.)

FFP is not usually quickly embraced by adjusters when they recognize the difference between it and CFP. Nevertheless, the same moral, justice, and public policy arguments support both. Policyholders consider trying to talk adjusters into adopting this principle.

How does the principle **Look for Coverage!** fit in with these other principles? CFP is supposed to be *suggestive*. It is supposed to be *generative*. Any principle which is both of these must be very strong and a bit obscure at the same time. Like many suggestive principles, CFP is fundamentally and significantly ambiguous. This linguistic fact is not a bad thing. The core idea expressed in CFP is not ambiguous, and the ambiguity of the central term encourages those who embrace it to interpret it broadly. It's fundamental power lies in its core, its attractiveness, and its potential influence. The term can be powerful without being completely precise. Words like, "freedom," "liberty," "justice," and "benevolence" are all like this.

CFP is ambiguous in another way also. The word "look" is not absolutely clear on the surface of

the language, precisely because it is broad and suggestive. Indeed, the word "look" involves multiple meanings, and the concept of *looking* is itself multi-dimensional. Perhaps, therefore, at least arguably, CFP should be, itself construed in favor of the insured, although this fact--if that's what it is--should not include importing undenoted, unimplied, or unsuggested ideas into the concepts which are central to the principle; i.e., really looking and actually finding coverage.

Of course, whatever else is true, a crucially important purpose of CFP is to *motivate* the rational adjuster. It orients the attentions and the actions of the rational and properly committed adjuster and insurer. It is not perfect, however. Imperfections relate to problems. There is tension between CFP and TFP. **Look for Coverage!** implies work; it implies effort; it implies concentration; it implies sympathy; it may even imply staring, a bit. This means pushing beyond the empirically obvious. At the same time, looking for coverage does not imply inventing coverage. It does not require saying you see something when you don't. There is no inconsistency between CFP and TFP, even if there is tension.

CFP and Fairness

In order to consider **Look for Coverage!** thoroughly, it is necessary to ask how it is justified. It is necessary to ask why it is so completely true and central. Obviously, CFP is attached to and implied by certain very important values. Some of the most important fundamental values are knowledgeableness, impartiality, objectivity, and there is another one which is also extremely important, namely, fairness. All four of these have already been mentioned and will be again.

The last of these four implies another fundamental principle of adjustment--a fifth fundamental principle: *Treat the claimant fairly!* (5FP) Notice that 5FP refers to claimants not policyholders, while the remainder of the chapter refers to policyholders. Of course, most claimants are policyholders. Sometimes, one makes a claim when they are not a policyholder. This happened not long ago in my office. One of the lawyers had a tree fall on her house. She called her agent to see who her insurance company was. Her agent said it was the ABC Insurance Company. The agent was wrong. It turned out to be the XYZ Insurance Company. Thus, so far as ABC was concerned, the claimant was not a policyholder, though she was a claimant. Once the claim was made to XYZ, my colleague became both claimant and a policyholder. The general point of 5 FP is that insurers should treat all claimants alike and should treat them as if they were policyholders. Naturally, one of the first questions which comes up in applying CFP is this one: Is the claimant a policyholder? If the answer is clearly not, the insurance company need do nothing further. It has already done everything it needs to do to **look for coverage**. (Perhaps, there are exceptions. If the ABC Insurance Company is part of a group, the adjuster at ABC might check unified computer records if they exist, to see if the claimant is insured by another member of the group and then give appropriate notice.) Fair treatment is a complex idea. In the context of insurance adjustment, the idea of fairness moves in two directions. First, if every policyholder should be treated fairly, then no policyholder should be treated better than any other. Wealthy policyholders should not be treated better than poor ones. Similarly, impoverished policyholders should not be treated better than rich policyholders. Asian policyholders should not be treated better than Native American policyholders. Policyholders from Mexico (or of Latino ancestry) should not be treated better than policyholders who are African-American, African, Iraqi, Afghanistanian and so forth. Policyholders attempting to defraud the company should not be abused or treated worse than honest policyholders, although, it is perfectly appropriate to try to catch people committing fraud. [FN3]

Second, the insurer itself should not be treated differently than any policyholder. This second sense of fairness is one hard to grasp. Fairness usually has to do with treating like cases alike. An insurer and an insured qualify as like cases. At the same time, favoring an insured over the policyholder is, in some sense, unfair, given the function of insurance. Thus, the idea of fairness has at least two separate and independent dimensions. Thus, the general idea of fairness implies that adjusters should treat the interests of the policyholder as at least equal in importance to those of the insurer. Many people say that the insured should treat the interest of the policy as more important than its own. This is one of the reasons why some are tempted to call insurers the fiduciaries of their insureds. [FN4] The ideas of equality of interests, and the idea of balanced interests, both travel with the idea of fairness.

This second dimension of fairness raises an extreme problem for adjusters. Adjusters, are, to some extent, advocates, as well as experts on property damage, other kinds of damage, and negotiators. Claims representatives are not lawyers, or pseudolawyers, advocates on behalf of

insurers, as opposed to insureds. They are not exactly advocates for insureds either. Rather, they are advocates on behalf of actual as opposed to fictitious coverage. (This is true both as to whether injuries and damages are covered and with respect to what amounts should be paid pursuant to coverage.) Adjusters are advocates on behalf of truth, as opposed to profitability (to whomever the profits might flow) and they are advocates on behalf of impartiality and fairness.

It is sometimes difficult for insurers to understand or fully embrace these principles. Sound adjusters generally do, at least intuitively, however. One of the responsibilities of senior and supervising adjusters is to teach others in insurance companies the truth and importance of these fundamental principles. That's not always easy.

Justifying Principles

It might be useful, in something close to a conclusion, to look at how CFP might be justified. In this context, it might be useful to take a look at some theories of business ethics and so forth. Several have already been mentioned and explored to some degree. Those already mentioned can be formulated:

- Insurers should be appropriately knowledgeable when it comes to adjustment.
- Insurers should be fair to claimants when it comes to adjustment. [FN5]
- Insurers should be impartial when it comes to adjustment.
- Insurers should be objective when it comes to adjustment. [FN6]
- Insurers should treat claimants rationally so far as their claims are concerned in the process of adjustment. [FN7]
- Insurers should treat claimants reasonably in the process of adjustment.
- Each of these principles is true, of course, and each of them implies that the adjusters either employed by, or working for the insurer should be the same. Here are two more:
 - Insurers should treat claimants in morally appropriate ways during the processes of adjustment.
 - Insurers should observe the Golden Rule in dealing with claimants in the adjustment process.

It is a virtual certainty that CFP is justified by some even more fundamental principle. While CFP is a principle of insurance business ethics, it is not an obvious principle that leaps out at one. This fact suggests the need for justification. Although it is a fundamental principle of *adjustment*, it is not a fundamental principle of general business, business custom, [FN8] or morality in general.

Oddly enough, none of these (probably) true even more basic principles, by itself entails CFP. A more interesting question, of course, is whether two or more of them in combination entail CFP. In short, however, not every combination of two or more principles can be reviewed here. Hence, this nearly concluding section will examine each of them by itself as a possible foundation for CFP.

Does the requirement of knowledgeability entail CFP? If the idea of *being knowledgeable* means being knowledgeable about an insured's business, about what the insured does, about how his machines work, about how his house fits together, and so forth, the requirement of knowledgeability does not entail CFP. An adjuster should be appropriately knowledgeable, of course.

Does the requirement of fairness to claimants entail CFP? The answer is *Probably Not*, if the idea of fairness focuses on how different claimants should be treated--if the idea of fairness in claimants is understood as the idea that all claimants should be treated alike. If this were true, then an insurer might treat claimants fairly, but not very well.

Does the requirement of impartiality entail CFP? The answer is, again, *Probably Not*. The reason is that if an insurer were required to treat insureds impartially but was permitted to construe all claims narrowly, then the requirement of impartiality would be met, but the requirement of CFP would not. Exactly the same point applies to the requirement of objectivity.

The requirements of rationality and reasonable treatment are too vague to constitute the foundation for CFP. This is true, even though CFP is probably always reasonable, at least within some limits, and probably always rational. There are limits, as has been observed above. At the level of common sense, there are interesting questions. If an insured has a \$10,000.00 claim, it would cost \$150,000.00 to investigate the claim, what does CFP require? What does rationality require? What does reasonable treatment require? There is a sense in which rationality does not require the expenditure of \$150,000.00. At the same time, CFP may require that the money be spent or--more likely--that the claim simply be paid because it is too expensive to **look** for **coverage** and claims which are indeterminate should be paid if looking is a bad idea. (Obviously, this last observation,

while quite common, is puzzling in some sense.)

Does the Golden Rule establish CFP? Obviously, to the extent that the Golden Rule is a moral principle, it comes close. Most insurers would agree that when their insurance claim is at stake, they want it examined very carefully and expansively. Consequently, the Golden Rule entails that this is how insurers should treat their own insureds. Nevertheless, it is not completely clear that the Golden Rule is a universal principle. It is not even clear that it is as universal as CFP, granting that the latter is, in some sense, narrow, since it applies to insurance adjustment and not to all human relations.

Here are the problems with the Golden Rule. For one thing, this Rule may work for people but not corporate entities. Insurance companies need rules they can embrace not only for employees, but themselves as well. Only this attitude will make training really work. For another, this rule presupposes that all people wish to be treated in roughly the same way. That thesis is probably false. To be sure, most people don't like to be irrationally criticized and verbally attacked. Others, however, do like it and subtly encourage it, because they like debate, they enjoy abusing others verbally, and so forth. Not all people wish to be treated in the same way, then the Golden Rule is problematic as a universalistic principle of morality. In addition, some people may wonder whether the principle applies well to corporate entities, as opposed to people.

Finally, we look to the idea that all appropriateness--or, universalistic principles of moral appropriateness--entail CFP. One recent influential thinker on the operation of businesses has a negative suggestion. John C. Maxwell, the author of a number of books on leadership and corporate organization, has suggested that there is no such thing as "business" ethics. [FN9] The reason to refer to Maxwell's view is that the idea of principles of moral appropriateness contains the bullet-pointed list and certainly supposes that there are not only such things as perfectly general moral principles, but also principles applicable to much narrower ranges of business. This suggests that Maxwell is wrong and that there are principles which function as business ethics. Such restricted principles may be derived from more general principles, but they are not identical to more general moral principles. CFP may be like this.

The problem now arises. In order to work out the answer to the foregoing question, it is necessary to think through what constitutes objectively establishable, general moral principles. That enterprise cannot be conducted in this short paper. However, a reasonable hypothesis is the following. The Eighteenth Century famous, Enlightenment German philosopher, Immanuel Kant (1724- 1804), had it right. The fundamental moral principle is *Treat each person as an end, and never merely as a means*. [FN10] If the insurer follows this principle in adjusting claims, it will be going in the right direction and will embrace CFP. The paradoxical problem is that Kant's Principle may not be completely consistent with capitalism.

Conclusion

This paper started with a hypothesis that **Look for coverage!** is one of-- if not, *the*--fundamental principles of really good adjustment practice. The surface themes of this paper are to explore CFP and some other related principles. The underlying theme of the paper is that CFP has enormous implications for the way to conduct insurance litigation, especially when an insurer is accused of bad faith. The policyholder lawyer ought to try to establish, at least, these two propositions: the first is that there is coverage, while the second is that the insurer did not follow CFP. The strategy of the insurer should be to try to show that there is no coverage, but that if there is, it followed CFP. The more detailed that the CFP-related part of the case can be articulated, developed and concluded, the more likely it is who will win the case.

[FN1]. **Michael Sean Quinn**, THE LAW FIRM OF **MICHAEL SEAN QUINN**, 2630 Exposition Blvd., Suite G-10, Austin, Texas 78703, Telephone: (512) 542-9243, Fax: (512) 542-9249. Email mquinn@msquinnlaw.com. Expert Witness Website: www.michaelseanquinn.com. (Resumes may be found here.). Mr. Quinn is a licensed adjuster in Texas, as well as an attorney, and an occasional college professor, including some law schools. He also testifies from time to time in insurance cases, among others. His Ph.D. dissertation concerned problems of ethics and jurisprudence.

[FN1]. "The practice of marine insurance may be regarded as the earliest form of indemnity, antedating other kinds of insurance by many hundreds [of] years. Even centuries before the introduction of marine underwriting as we know it today, the commercial nations of the ancient world secured the benefits of insurance through the so-called 'loans on bottomry,' e.g., loans made on the

security of a ship and cargo at high rates of interest, and with the understanding that the principal with interest was to be paid only in the event of the safe arrival of the vessel, and that the lender to forfeit both principal and interest in case of loss. Instead, then, of paying a premium before starting the voyage, as is now the case, and receiving the indemnity after a loss is incurred[,] the insured under the bottomry loan received the indemnity in advance and only returned the same plus a premium after safe termination of the voyage." Lester W. Zartman and William H. Price, Eds., PROPERTY INSURANCE 3 (2d Ed. 1914). This book is subtitled YALE READINGS IN INSURANCE. It mostly consists of lectures given at Yale, but the Second Edition has a few additions. The ENCYCLOPEDIA BRITANNICA in its article on insurance says that bottomry contracts were known by Babylonian merchants 5000-6000 years ago, to Hammurabi and their code in about 2100 BC, to Hindus in 600 BC, to Athens by the 4th Century BC, and that they were widely used in Rome.

[FN2]. See Timothy Williamson, VAGUENESS (1994). See also Rosanna Keefen Petersmith, Eds., VAGUENESS: A READER (1999).

[FN3]. Several Authors, *Fraud Showdown At The PC Corral!*, Crackdown! (June 2005) ("A Special Supplement to Claims in National Underwriter Magazines.")

[FN4]. See William T. Barker, & Others, *Is An Insurer A Fiduciary To Its Insureds?*, 25 TORTS & INS. L.J. 1 (Fall 1989).

[FN5]. Nicholas Rescher, FAIRNESS; THEORY & PRACTICE OF DISTRIBUTIVE JUSTICE (2002)

[FN6]. See Nicholas Rescher, OBJECTIVITY: THE OBLIGATIONS OF IMPERSONAL REASON (1997).

[FN7]. See Robert Fogelin, WALKING THE TIGHTROPE OF REASON: THE PRECARIOUS LIFE OF A RATIONAL ANIMAL (2003).

[FN8]. See Ekkehart Schlicht, ON CUSTOM IN THE ECONOMY (Oxford University Press 1998).

[FN9]. John C. Maxwell, ETHICS 101: WHAT EVERY LEADER NEEDS TO KNOW, PREFACE (2003). This book was originally published as THERE'S NO SUCH THING AS "BUSINESS" ETHICS. As indicated, Maxwell is a leading thinker and teacher when it comes to issues of business leadership. See John C. Maxwell, DEVELOPING THE LEADER WITHIN YOU (1993), and many other works.

[FN10]. Interestingly, founding fathers of the United States, Adams, Hamilton, Jefferson, Madison, and so forth, read many Eighteenth Century European thinkers: Burice, Voltaire, Diderot, and so forth. They did not read Kant, apparently. One can understand why. The prose is difficult. See, for example, Ron Chernow, ALEXANDER HAMILTON (2004).
27 No. 9 INSLITREP 461

END OF DOCUMENT

© 2006 Thomson/West. No Claim to Orig. U.S. Govt. Works.