Damages and Recovery
in a Child Sex Abuse Case:

Dealing with Insurance Carriers

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Jason P. Amala is a named partner in the Seattle office of Pfau Cochran Vertetis Amala PLLC (http://www.pcvalaw.com).

Jason has represented hundreds of survivors of childhood sexual abuse since the Boston clergy abuse scandal broke in the early 2000s. He has recovered tens of millions of dollars for those clients, and was part of the trial team that obtained an $8 million verdict for a client who was abused at a parish run by a Catholic religious order. The verdict is one of the largest in the country against the Catholic Church.

He has successfully pursued claims against the Catholic Church, the Boy Scouts of America, the Mormon Church, and numerous schools and state institutions. He has been closely involved with a number of Catholic bankruptcies, including the Boy Scouts of America, the Christian Brothers, and the Archdiocese of Milwaukee.

In addition to his practice as a trial lawyer, Jason does his own appellate work and has been the lead appellate lawyer on a number of watershed cases that have expanded the rights of abuse survivors and crime victims. His work against the sex trafficking website “Backpage.com” led to its seizure and shut-down by the federal government.

Jason graduated with distinction from the University of Washington Honors College, and then obtained his law degree from Seattle University School of Law, where he graduated second in his class and earned top honors in ten courses. When not at work, he and his family can be found camping in the summer and skiing in the winter.

In order to effectively deal with insurance companies you must speak their language. Insurance companies generally speak in terms of risk, which means you must be able to articulate the risk they face on your client's claim (e.g., how much they owe under their policy) and the risk they face if they act in bad faith and violate the duties they owe to their insured under that policy.

1. State Law

Insurance contracts are generally governed by state law, including the state's common law and insurance regulations. Many insurance policies include state-specific endorsements (discussed below) that modify the policy to comply with state law.

2. Read the Whole Policy

An insurance policy is a contract. While they are generally long and full of boilerplate and fine print, you must read the entire policy because the policy's coverage may change dramatically based on the very last page of the policy.

3. Basic Parts of an Insurance Policy

Declarations Page: Most insurance policies start with a "Declarations" page that provides a summary of the insurance policy, including who purchased the policy, the policy period, the types of coverage, and the monetary limits of the policy.

Insuring Agreement: The insuring agreement is the standard boilerplate that explains what is covered and what is not covered in a policy. Generally speaking, this boilerplate language is consistent across all policies written by the insurer for that year – the insurer offers a basic policy and then insureds can expand or narrow the policy's coverage through endorsements.

Exclusions: The exclusions in an insurance policy state what claims or damages are not covered by the policy. Exclusions usually exist in two locations: in the insuring agreement (often in a section titled "exclusions") and in the endorsements.

Endorsements: An insurer may change the basic terms of its insurance policies for different reasons, such as eliminating coverage for significant risk (terrorism, mold, sex abuse) and complying with the law of a particular state. An individual purchaser of insurance may also seek to expand or narrow the coverage of their policy in exchange for paying a higher or lower premium.

These material, often critical changes to an insurance policy are often accomplished through one or more "endorsements." More often than not, endorsements are located at the end of the insurance policy, which underscores why it is important that you read the whole policy, assume nothing, and take nothing for granted. In some policies the very last page of a 150-page policy may be an endorsement that removes coverage for the very claim at issue. For example, since the mid-1980s most commercial liability policies have included an endorsement that excludes coverage for certain claims arising from child sexual abuse.

Insureds / Additional Insureds: The person or entity who purchased the policy is generally referred to as the "insured." However, most insurance policies provide coverage to additional people and/or entities beyond the purchaser of the policy. This additional coverage may be addressed in the insuring agreement itself, sometimes in a clause that says "Who is an insured?", but may also be included in an endorsement

because the insured requested (and often paid for) the policy be extended to provide coverage to additional people or entities.

Insurance Limits: Insurance policies usually list one or more "limits" that apply to claims made on the policy. Most modern policies include a "per occurrence" or "per accident" limit, and an "aggregate" limit. However, if you go far enough back in time, many policies did not include an "aggregate" limit.

Generally speaking, the "per occurrence" or "per accident" limit establishes the most that the insurer will pay on a claim arising from the same underlying wrongful conduct or related wrongful conduct. Unlike a car accident, where the "per occurrence" limit usually dictates the most the insurer will pay to all people injured in the accident, this issue can become complicated in child sexual abuse cases when a child is sexually abused multiple times during the same policy period. Depending on the language of the policy, each instance of abuse could trigger the "per occurrence" or "per accident" limit, or all instances of abuse during the same policy period could be limited to the same limit – if a child was abused four times in the same policy year, this could mean the difference between $100,000 in coverage and $400,000 in coverage. Similarly, if a child is abused multiple times across multiple policy periods, the language of the policy will dictate whether the child is entitled to the limits of each policy or whether the child is entitled to the limits of just one policy.

The "aggregate" limit generally states the most the insurer will pay on all claims made under the same policy. If a defendant is facing 100 claims under the same policy, the "aggregate" limit usually provides a cap on the total amount that the insurer will pay

to resolve all 100 claims. For example, if a defendant is facing claims by 100 abuse survivors who were abused during the same policy period, the aggregate limit is the most the insurer will pay to compensate all 100 abuse survivors.

4. Excess / Umbrella Insurance

The basic insurance purchased by people and individuals is referred to as their "primary insurance." For people, their primary insurance is usually their homeowner's insurance, car insurance, boat insurance, etc. For businesses, their primary insurance is usually a commercial general liability policy ("CGL").

Most primary insurance policies have maximum limits and the insurer (and/or state law) will not allow the insured to purchase a primary policy with higher limits. For example, most homeowner policies are limited to the value of the insured's home – a person with a $250,000 home generally cannot purchase homeowner's insurance that has a limit of $500,000. Similarly, most commercial general liability policies have a limit of $1,000,000 or $2,000,000, and the insured cannot purchase higher limits.

In order to obtain higher limits, an insured can purchase an "excess" or "umbrella" policy. Excess policies usually apply to commercial policies and umbrella policies usually apply to personal policies, but generally speaking they provide the same benefit to the insured – higher limits on one or more primary policies. The term "umbrella" is often used for personal policies because the umbrella policy provides a higher limit on a number of primary policies, such as a person's homeowner's insurance, car insurance, and other insurance (the policy provides an "umbrella" of higher limits on all of the underlying

primary policies). On the other hand, most excess policies provide additional limits on one policy, usually an entity's commercial general liability policy.

There are two types of excess and umbrella policies. A "follow form" policy generally provides higher limits on the primary policy without any additional or different terms – if a claim triggers the primary policy then it triggers the excess or umbrella policy. A "stand alone" policy provides higher limits on the primary policy but may have very different terms than the primary policy – for example, a stand alone policy may provide higher limits on only certain claims, or the stand alone policy may include additional exclusions that do not exist in the primary policy.

Most excess and umbrella policies require "exhaustion" of the primary policy. This means the insurer on the primary policy must pay its limits on the primary policy before the excess or umbrella policy is triggered. The exhaustion requirement differs from policy to policy and state to state. For example, if a primary insurer has gone out of business so it is unable to pay its limits, the excess or umbrella policy should address whether the exhaustion requirement must still be met, and some states have enacted laws to address this issue.

5. How to Obtain "Insurance Information"

Discovery: Although evidence rules may restrict the extent to which insurance information is admissible at trial, the civil rules of most states specifically provide for discovery of insurance policies and related information, including documents that discuss or affect coverage. One of the public policies behind the disclosure of insurance

information is to ensure all parties to a claim are aware of the available insurance, with the hope that the information may lead to the resolution of the claim.

For example, in Washington, CR 26(b)(2) states that a party may obtain discovery of insurance agreements and any documents that affect coverage, including documents "denying coverage, extending coverage, or reserving rights":

> A party may obtain discovery and production of: (i) the existence and contents of any insurance agreement under which any person carrying on an insurance business may be liable to satisfy part or all of a judgment which may be entered in the action or to indemnify or reimburse for payments made to satisfy the judgment; and (ii) any documents affecting coverage (such as denying coverage, extending coverage, or reserving rights) from or on behalf of such person to the covered person or the covered person's representative. Information concerning the insurance agreement is not by reason of disclosure admissible in evidence at trial. For purposes of this section, an application for insurance shall not be treated as part of an insurance agreement.

Insurance Broker: Most insureds, particularly businesses, use an insurance broker to purchase insurance. An insured's broker may possess copies of an insured's old insurance policies, or may have information that identifies the insurer who wrote the relevant policy, which can then allow you to ask the insurer for a copy of the policy.

Other/Additional Insureds: As discussed above, insurance policies often provide coverage to people and entities beyond whoever purchased the policy. For example, a property owner who allows other entities to rent or lease their property for camps may purchase an insurance policy that covers the property owner and any person or entity who rents or leases their property. Similarly, a person who rents or leases a third party's property to run a camp may purchase

an insurance policy that covers themselves and the third party who owns the property. If the person or entity who purchased the policy no longer has a copy of the policy, these other or additional insureds may possess a copy.

Insurer / Insured – Other Years: If a defendant is missing its policy for a particular year, it may be possible to establish the terms of the missing policy by looking to the defendant's policies for the year(s) before and after the missing policy. For example, if a defendant purchased the same insurance for 1975, 1976, 1977, and 1979, but the policy for 1978 is missing, it may be possible to use those policies to establish the terms of the 1978 policy, particularly if the insured has proof that they paid a similar premium for every year including 1978.

Public Archives: If your case involves a public entity, or an entity that has to comply with state regulations regarding insurance (e.g., a requirement that the entity maintain certain types of insurance), public archives may have records that can lead you to the relevant insurer. Public archives may not have copies of the actual policy, but they may include "proof" that the defendant had insurance and the name of the insurer who provided the insurance. You can then use that information to ask the insurer for a copy of the policy.

Insurance Archaeologist: Every year the insurance industry issues a model insurance policy that individual insurers modify to differentiate themselves from each other. In turn, each insurer has standard forms that they use for their policies in a given year, including standard endorsements for expanding or narrowing coverage.

An insurance archaeologist is a professional, usually a lawyer or former insurance professional, who can piece together what they believe was most likely a defendant's policy for a particular year based on the industry and the insurer's standard policy forms for that year. The archaeologist will usually need at least some minimal information to move forward, such as the identity of the insurer who provided the insurance before and/or after the missing years, and/or evidence of the premium that was paid for the missing policies or the policies that are known.

6. What Information to Request

Certified Copy: When you ask for insurance information, be sure to request a certified copy of the policy to ensure no party, including the insurer, can take issue with the policy or assert it is incomplete.

Fully Policy: Given a policy's coverage can drastically change between its start and end, particularly with endorsements, it is critically important that you request the entire policy and review what you have received to see if it appears complete. If you have a policy that is missing endorsements, particularly more modern policies, it is highly likely you have an incomplete copy of the policy.

"Reservation of Rights": When an insurance company is advised of a claim (e.g., the claim is "tendered" to the insurer), they will usually respond with a letter that explains the insurer's position regarding the claim, including its understanding of the allegations and why it believes the claim may be covered or not covered based on those allegations. These letters are generally referred to as "reservation of rights" letters because the insurer usually states that it will agree to defend the insured but "reserves its

right" to withdraw the defense and/or to decline to cover the claim. The insurer may issue additional reservation of rights letters as a case proceeds.

As noted above, the discovery rules of most states specifically provide for disclosure of insurance policies and any documents that affect coverage, which generally includes reservation of rights letters.

7. Exclusions in Child Sexual Abuse Cases

Any given insurance policy may have multiple exclusions that prevent coverage of a particular claim so it is important that you read the entire policy, including all exclusions. As noted above, these exclusions are usually flagged by the insurer in its "reservation of rights" letter, which is another reason to obtain such letters.

Child Abuse/Molestation Exclusion: In the mid-1980s, two civil lawsuits against the Catholic Church and the Boy Scouts for child sexual abuse were heavily covered in the media. In response to those lawsuits the insurance industry created a standard form exclusion that attempted to disclaim coverage for certain claims based on child sexual abuse. In most policies this exclusion was included at the end of the policy as an endorsement – if you are reading a policy from 1986, the endorsement with the abuse exclusion could be the 20th endorsement and the last page of the entire policy.

Most commercial policies from the mid-1980s to present include an exclusion for certain claims arising from child abuse or molestation. The language of these exclusions changed over the years so you must read the exclusions very carefully to see if they apply to your claim. There is a significant amount of case law on this exclusion that can aid

your analysis, keeping in mind that some insurers slightly modified the exclusion and those modifications often mean the difference between coverage and no coverage.

While it may seem counterintuitive given the countless civil lawsuits that have been filed for child sexual abuse in the past 20 years, some insurers are again providing coverage for claims arising from child sexual abuse because they believe youth-serving organizations are implementing policies and procedures (today) that should result in significantly fewer claims. These insurers are either omitting the exclusion or they are allowing insureds to pay an additional premium to purchase coverage for claims arising from child sexual abuse.

Again, when dealing with insurers you must read the whole policy, assume nothing, and take nothing for granted – never assume that the policy at issue includes the child sexual abuse exclusion or that the exclusion will apply to your claim.

"Expected or Intended" Exclusion: As a matter of public policy, most states (if not every state) prevent insurance companies from providing coverage if an insured intentionally causes harm or damage. An insured cannot intentionally punch someone in the face and ask the insurance company to pay for the resulting injuries. Similarly, insurers are in the business of providing coverage for unexpected and unintended losses, not for losses that are expected. When a person or entity buys insurance they are almost always asked by the insurer to disclose whether they expect or intend that an insured will cause a claim to be made under the policy that is being purchased.

For the above reasons, most insurance policies include an exclusion for losses that are "expected or intended" by an insured. This exclusion is usually included in the insuring agreement, not as an endorsement.

Keep in mind that most states require the *specific loss* be expected or intended. It is usually not enough for an insurer to argue that the insured was generally aware that a loss might occur – it is not enough to argue that a defendant school knew of the danger that its students might be sexually abused by one of dozens of teachers. One way to think about this is that a plaintiff in a negligence claim generally has to show that the defendant failed to take reasonable steps to protect the plaintiff from foreseeable harm. Insurance companies generally provide coverage for negligence, so it would make no sense if an insurer could deny coverage because a harm was foreseeable – if that was true then insurers would never have to cover negligence claims because the loss in a negligence claim, by definition, was foreseeable to the defendant/insured.

On the other hand, if a plaintiff alleges a defendant intentionally allowed a loss to occur (e.g., intentionally allowed one of its agents to sexually abuse a child), an insurer could use the plaintiff's own allegations to deny coverage for the plaintiff's claim.

The language of the "expected or intended" exclusion in a particular policy is very important. For example, if a policy excludes coverage for losses that are expected or intended by "the insured," rather than "an insured" or "any insured," the exclusion may not apply to a claim against an insured who did not expect or intend for the loss to occur. For example, if a homeowner's policy states that it does cover losses that are expected or intended by "the insured," there is likely no coverage for a claim against the homeowner

who abused a child but there may be coverage for the homeowner's wife who negligently allowed the abuse to occur. Why? Because insurance policies are analyzed on an insured-by-insured basis – whereas the husband expected or intended for the abuse to occur, the wife did not. On the other hand, if the exclusion applied to losses expected or intended by "an insured" or "any insured," the exclusion would likely apply to claims against the husband and wife because the abuse was expected by one of the insureds – the husband.

8. Bad Faith

Insurance companies act in "bad faith" when they put their interests ahead of the interests of their insured. Most claims for bad faith are based on an insurer's breach of one of two duties: the duty to defend and the duty to indemnify.

Note: The law on claims for bad faith varies enormously from state to state so you must closely research the law of your individual state.

Duty to Defend: The duty to defend is an insurer's duty to provide its insured with a defense to a claim – to pay for a lawyer to defend the insured.

The duty to defend is generally broader than the duty to indemnify (discussed below) and may require the insurer to defend a claim even if the insurer ultimately is not required to pay money to resolve the claim. For many insureds, the duty to defend is more valuable than the duty to indemnify because the defense costs are often significantly higher than the amount of the loss (e.g., a car accident that results in a $10,000 jury verdict or settlement, but $50,000 in defense costs).

An insurer who receives a copy of a complaint must usually provide its insured with a defense so long as the insurer may potentially be liable for the claim. For example, in Washington, an insurer must review the "four corners" of the complaint and provide a defense if the policy conceivably covers the allegations in the complaint. Most insurers will agree to defend their insured, at least initially, but will do so pursuant to a reservation of rights letter. As time goes on, and as the insurer learns more about the claim, it may decide to pull its defense if it believes there is no chance that the claim is covered.

If an insurer refuses to defend its insured, and a court later concludes that the insurer should have provided a defense, the insured may be liable for bad faith based on its breach of the duty to defend. In some states the insured does not have to show that it was actually prejudiced by the insurer pulling its defense – if Bill Gates is being sued in Washington, and his insurer wrongfully refuses to defend him, the insurer is likely liable for bad faith even though Mr. Gates has sufficient resources to fund his own defense.

Duty to Indemnify: The duty to indemnify is an insurer's duty to pay an amount for which its insured becomes legally obligated to pay, up to its limits, so long as the loss is covered by the policy. Insurers are generally required to make a good faith effort to resolve a covered claim up to their policy limits so that their insured is protected from a judgment or award in excess of the policy limits. For example, an insurer may not be required to pay its policy limits without any investigation of a claim, but an insurer may breach its duty to indemnify if it rejects a settlement offer within policy limits after it has had a reasonable opportunity to investigate the claim. The insurer must make a good faith effort to protect its insured by settling within policy limits, so the insurer must balance

its desire to “fully investigate” a claim with the risk that an offer within policy limits expires and its insured is exposed to a verdict or judgment that exceeds the policy limits.

Policy Limits Demand: The most common claim for bad faith based on a breach of the duty to indemnify is when an insurer refuses to accept an offer to settle a claim within policy limits after the insurer has had a reasonable opportunity to investigate the claim. In most states the insurer must have an opportunity to settle *within* policy limits – if you make a settlement offer that exceeds the policy limits then the insurer can usually reject the offer without committing bad faith because its duty is to settle within policy limits. If you offer to settle for $550,000, and the insurer’s limit is $500,000, the insurer can usually reject the offer and not commit bad faith unless its insured offers to pay the $50,000 difference and demands the insurer pay its limits of $500,000.

In many states a policy limits demand can be an effective way to pressure an insurer to resolve a claim because the insurer may fear being sued for bad faith if it refuses to resolve the claim. If you intend to make a policy limits demand, make sure the offer is made in writing, outside the context of any mediation privilege that might bar you from admitting the offer into evidence in the bad faith litigation, and that you provide a firm deadline on the offer so the insurer’s refusal to accept the offer is clear.

How to Pursue a Claim for Bad Faith: As noted above, state law regarding when an insured has a viable bad faith claim varies widely. The available remedies also vary by state, but most states allow the insured to recover the damages they suffered as a result of the insurer acting in bad faith. Some states also allow the insured to recover

their attorney's fees in pursuing the bad faith claim, some provide exemplary damages, and others provide for punitive damages.

A bad faith claim generally requires that the insured be damaged as a result of the insurer's bad faith conduct, usually in the form of a verdict or judgment that exceeds the policy limits. If a plaintiff goes to trial and receives a verdict in excess of the policy limits, then the insured has a right to sue its insurer for bad faith to force the insurer to pay the full amount of the verdict – the amount within policy limits and the amount that exceeds the policy limits. Why? Because the insurer had an opportunity to settle the claim within policy limits, but failed to do so, so the insured's damages are the amount of the verdict. (If the plaintiff receives a verdict within policy limits, there is likely no bad faith claim because the insurer will usually just pay the verdict so the insured suffered no damage.)

However, most bad faith claims are not pursued after a jury verdict. Instead, a plaintiff makes an offer to settle within policy limits, the insurer rejects the offer, and the plaintiff then enters into a stipulated or covenant judgment with the defendant/insured for a reasonable amount that will fairly compensate the plaintiff. If the insurer acted in bad faith, then the amount of the stipulated or covenant judgment becomes the amount of the insured's damages. At the same time, the plaintiff and the defendant/insured usually agree that the defendant/insured will assign its bad faith claim to the plaintiff and that the judgment will be satisfied in whole or in part solely by whatever the plaintiff recovers on the bad faith claim. If the plaintiff is ultimately successful, the insured/defendant has eliminated its risk by assigning its bad faith claim to the plaintiff and the plaintiff has

recovered more, and perhaps substantially more, than if the insurer had accepted the plaintiff's offer to settle within policy limits.

Keep in mind that the defendant/insured is attempting to protect itself from the plaintiff obtaining a large verdict, so the amount of the stipulated or covenant judgment can usually be an amount that a reasonable jury would award to the plaintiff if the case went to trial and the plaintiff obtained a favorable award. The plaintiff usually does not have to agree to a judgment amount that is within the policy limits – the entire point is that the insurer forfeited its right to pay only its policy limits when it acted in bad faith. In turn, the insured/defendant is entitled to protect itself by entering into agreements with the plaintiff that insulate the insured/defendant from any financial exposure.

Most states have a substantial amount of case law on how to pursue bad faith claims and this is an ever-changing area of the law. Given most bad faith claims involve the plaintiff agreeing to pursue a recovery solely from the insurer, you want to exercise extreme caution and likely consult with someone who is familiar with this area of the law in your particular state.